CENTRAL JERSEY HEALTH INSURANCE FUND
OPEN MINUTES
MARCH 15, 2017
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 2017 EXECUTIVE COMMITTEE:

CHAIRPERSON		
Thomas Nolan	Borough of Brielle	Present
SECRETARY		
William Rieker	Township of Lakewood	Present
EXECUTIVE	**COMMITTEE**	
Joseph Gilsenan	Township of Brick	Present
Diane Lapp	Township of Manchester	Present
Adam Hubeny	Borough of Atlantic Highlands	Absent
Eugenia Poulos	Township of Red Bank	Present
Donato Nieman	Township of Montgomery	Present
ALTERNATES:		
Brian Valentino	Western Monmouth MUA	Present 1:39
Brian Brach	MRRSA	Present

APPOINTED OFFICIALS PRESENT:

Executive Director/Administrator	PERMA Risk Management Services	**Paul Laracy** **Emily Koval** **Karen Kamprath**	Present Present Present
Program Manager	Conner Strong & Buckelew	**Brandon Lodics**	Present Present
Attorney	Berry, Sahradnik, Kotzas & Benson	**Matthew Thompson**	Present
Treasurer		**Stephen Mayer**	Present
Network & Medical Claims Service	Qualcare Inc.	**Gary Epstein**	Present
Network & Medical Claims Service	Aetna	**Kim Ward**	Absent

Network & Medical Claims Service	**AmeriHealth**	**Michael Murphy** **Michael Zangrilli** **Christine Lyons**	Present Present Present
Dental Claims Service	Delta Dental	**Amy Lehrer**	Present
Rx Administrator	Express Scripts	**Jeff Basile**	Absent
Auditor	Holman & Frenia	**Rodney Haines**	Absent

OTHERS PRESENT:
Cindy Toye, TRMUA
Mary Hlywiak, Doyle Alliance Group
Rachel Stippier, Doyle Alliance Group
Diance Peterson, Conner Strong & Buckelew
Charles Casagrande, Danskin Insurance Agency
Suzanne Veitengruber, Shrewsbury Township
Dom Cinelli, Brown & Brown

CORRESPONDENCE: None

APPROVAL OF MINUTES: JANUARY 18, 2017 OPEN:

MOTION TO APPROVE OPEN MINUTES OF JANUARY 18, 2017:

MOTION:	Commissioner Nieman
SECOND:	Commissioner Gilsenan
VOTE:	6 Ayes, 0 Nays, 1 Abstain (Commissioner Poulos)

EXECUTIVE DIRECTOR'S REPORT

FINANCIAL FAST TRACK - Executive Director said the surplus continues to be strong and is above the necessary retention or contingencies. He said the Fund has the ability to declare a more substantial dividend that in prior years. He suggested waiting until after the annual audit is complete in July.

MUNICIPAL REINSURANCE HEALTH INSURANCE FUND - The Municipal Reinsurance Health Insurance Fund met on February 8 to reorganize for 2017. The Committee reviewed the new reinsurance policies which are available for all Commissioners' review.

STATE EXAMINATION - The examination by the Department of Banking and Insurance of the CJHIF is complete and they are working with the Controllers to finalize the audit. No adverse findings or recommendations are expected and the exam verified Fund financial statements as of 12/31/2015.

WELLNESS COMMITTEE - The Wellness committee met prior to the meeting to review the grant responses. Ms. Koval said the Committee reviewed the 5 responses and are recommending approval which can be adopted in resolution 15-17. She said there are still additional funds available if any member is interested.

2017 MEL & MR HIF EDUCATIONAL SEMINAR - The 7th annual seminar is scheduled for Friday, April 21st beginning at 9:00 AM at the National Conference Center in 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.

COODINATION OF BENEFITS WITH MEDICARE FOR DISABLED DEPENDENTS -Entities with less than 100 employees have Medicare primary coverage for disabled persons. However, HIF claims agents have not applied the coordination of benefits rule because the HIF was interpreted to be a "multiemployer" plan under federal law. The MRHIF claims adjuster and attorney have challenged this interpretation because, under the HIF structure, member entities remain as the plan sponsor. To resolve the question, the MRHIF fund attorney is seeking a private letter ruling from Medicare on the matter. If the new interpretation is correct, the HIFs collectively will have the opportunity to save some millions per year. We will keep the executive committee advised of our progress on this matter.

PROGRAM MANAGER'S REPORT

CONNER STRONG & BUCKELEW'S NEW MOBILE WELLNESS APP
Conner Strong & Buckelew is pleased to announce the launch of its new mobile wellness app, *HealthyLife*, our mobile application that is compatible with our award winning member wellness portal, *HealthyLearn.com/connerstrong*

Our new mobile wellness app is a powerful addition to our portfolio of wellness tools and services to help clients further promote contemporary wellness approaches. Powered by the American Institute for Preventive Medicine, the web site and mobile app are unique solutions for Conner Strong & Buckelew clients and their benefit plan participants. The mobile app provides access to a host of wellness tools including a wellness tip of the day, information on health conditions, healthy living, financial wellness, healthcare consumerism, safety, first aid and a host of other source based tools and features.

Our wellness mobile app can be easily downloaded from the iTunes or Android app stores. The name of the app is *HealthyLife Mobile*. For apples users, here is a link to the app: https://appsto.re/us/R1Ey8.i. After downloading the app, the code to use it is CSB (all caps).

Program manager said a payroll stuffer was generated and can be distributed to all members electronically.

WELLNESS PLANS –COMPLIANCE OVERVIEW
While HIPAA nondiscrimination rules have historically been the major compliance focus for many wellness plan sponsors, final rules published by the Equal Employment Opportunity Commission (EEOC) addressing how wellness programs must comply with American Disabilities Act (ADA) and Genetic Information Nondiscrimination Act (GINA), has focused even more attention on these laws and further added compliance complexities. To assist with understanding the implications of the EEOC's final rules related to the ADA, GINA, and wellness programs, Conner, Strong & Buckelew

has published updates to help guide you through the intricate compliance rules. If you or your risk manager have questions or would like to discuss, please reach out to Marybeth Visconti

1095 FORMS FOR AETNA MEDICARE ADVANTAGE

1095-B notices

The Affordable Care Act includes a mandate for most individuals to have health insurance or potentially pay a penalty for noncompliance. Individuals will be required to maintain minimum essential coverage for themselves.

In late December through January, CMS will be mailing 1095-B notices to the following beneficiary populations for 2016 tax purposes:

- All individuals under the age of 65 with Medicare Part A;
- Those who enrolled in Medicare Part A for the first time in 2016
- Those who had Medicare Part A coverage for part of 2016

The notices will consist of a cover letter from CMS and the IRS Form 1095-B. If a Medicare member contacts Aetna with questions about minimum essential coverage,(including the 1095-B **mailed by CMS**) they should be referred to 1-800-MEDICARE (TTY: 1-877-486-2048) or Medicare.gov.

NJ OPIOID LAW

New Jersey Governor Chris Christie has signed legislation aimed at curbing the state's opioid addiction epidemic. The law curbs initial opioid prescriptions to a five-day supply, making NJ's the most stringent limit in the nation. The new law also mandates state-regulated health insurers, namely fully insured plans and plans run by the state (including the State Health Benefits Program and the School Employees Health Benefits Program), to cover inpatient and outpatient treatment for drug addiction. The part of the law that speaks to plan design and utilization management will not automatically apply to self funded benefit plans that can voluntarily choose to follow the new law or not. The new law is a part of the NJ Governor's pledge to devote his last year in office to combating the opioid crisis plaguing the state. The law takes effect 90 days from the date it was signed although generally this shall require that insured plans will have to begin to cover the new requirements upon their next renewal on or after May 16, 2017. Below are the primary provisions of the new law.

Prescription Drug Requirements

- Initial opioid prescriptions written may not be more than for a five-day supply. The five-day limit will not apply to cancer and chronic pain patients and for end-of-life care. The aspects of the law will apply to all NJ patients, including those covered by insured or self funded plans.
- Any prescription for acute pain must be for the lowest effective dose of immediate-release opioid drug. In cases of acute or chronic pain, prior to issuing an initial prescription of a course of treatment that includes a controlled dangerous substance or any other opioid drug, a practitioner must document the patient's medical history, develop a treatment plan, conform with a monitoring requirement, limit the supply of opioid drug prescriptions and comply with state and federal laws. These aspects of the law will apply to all NJ patients, including those covered by insured or self funded plans.
- The benefits for outpatient prescription drugs used to treat substance abuse disorder must be provided (when medically necessary) by the person's provider without any prior authorization or other prospective utilization management requirements.

- The law requires new continuing education requirements for professionals who prescribe opioid drugs.

Health Plan Requirements

- Insurers must provide unlimited benefits for inpatient and outpatient treatment of substance use disorders at in-network facilities.
- Benefits for the first 180 days per plan year of "inpatient and outpatient" treatment of substance abuse disorder must be approved without any prior authorization or other prospective utilization management requirements. Benefits for inpatient and outpatient treatment of substance abuse disorder after the first 180 days per plan year are subject to the medical necessity determination of the insurer and may be subject to prior authorization, retrospective reviews and other utilization management requirements of their health plan.
- Benefits for the first 28 days of an "inpatient" stay during each plan year must be provided without any retrospective review or concurrent review. The benefits beyond 28 days of inpatient care are subject to concurrent review and other approval requirements of the patient's health plan. Insurers cannot initiate concurrent review (monitoring of the necessity of care) more frequently than once every two-weeks.
- Benefits for the first 28 days of "intensive outpatient or partial hospitalization" services must be provided without any retrospective review. The benefits beyond 28 days of intensive outpatient or partial hospitalization services are subject to retrospective review other approval requirements of the patient's health plan.
- If there is no in-network facility immediately available for a covered person, insurers must provide necessary exceptions to their network to ensure admission in a treatment facility within 24 hours.

PERMA is still discussing potential impact and adherence with the fund attorney. At this point, no formal decision has been made for compliance.

Program Manager said opioids will only be prescribed for 5 days for new prescriptions. Commissioner Gilsenan said he is concerned there could be a delay to get additional supply if necessary.

AETNA NETWORK UPDATE – RWJ/BARNABAS IMPACTED FACILITIES

Aetna's contract with Robert Wood Johnson and Barnabas Health is set to expire on April 15, 2017. Aetna is very optimistic that this will be settled prior to the contract termination date.

RWJ/Barnabas Impacted Facilities:	
RWJUH-New Brunswick	Community Medical Center
RWJUH-Somerset	Monmouth Medical Center
RWJUH-Hamilton	Newark Beth Israel
RWJUH-Rahway	Clara Maass Medical Center
Jersey City Medical Center	Saint Barnabas Medical Center
	Monmouth Medical Center -Southern Campus

MEMBER IMPACT
Aetna has identified 506 unique CJHIF members who have utilized one of these providers in the past 12 months.

MEMBER COMMUNICATIONS:

AETNA:

- Notification letters to impacted members of Medicare and Commercial plans will be mailed at least 30 days prior to termination.
- If an agreement is reached after these notices have been mailed, retraction letters will be sent to all members who received the initial notification.

CJHIF:

- Attached in your report is a letter that the CJHIF is prepared to distribute electronically to all CJHIF groups with AETNA participation. Should the contract not settle prior to April 15, 2017 and these facilities are no longer participating, the Fund will honor scheduled and prior authorized procedures/visits as in network.
- Also included in the letter are instructions for locating other participating facilities within the AETNA networks

OTHER PARTICIPATING PROVIDERS:

MERIDIAN NETWORK

OCEAN COUNTY:

- Ocean Medical Center
- Southern Ocean Medical Center

MONMOUTH COUNTY:

- Jersey Shore University Medical Center
- K. Hovnanian Children's Hospital
- Bayshore Community Hospital
- Riverview Medical Center

Program Manager said the expiration date for the contract is now April 22, 2017. He said Aetna is confident this will be resolved. He said no letters have gone out at this point. He said the Fund will honor anything that has been prescheduled.

AMERIHEALTH ADMINISTRATORS - AmeriHealth Administrators is an option for CJHIF members as of Fall 2016. We have confirmed that RWJ/Barnabas facilities are in network. To review participating providers/facilities in AmeriHealth Administrators visit www.ahatpa.com and click on "find a provider." Program Manager introduced representatives from Amerihealth Administrators.

INDUSTRY RX TRENDS - A recently issued report from the Department of Health and Human Services highlights s a distressing but common trend with specialty medications. The report analyzed pharmacy cost data for 2015 and found that the 10 specialty drugs below accounted for nearly one-third of all catastrophic pharmacy costs. Two of the top three are related to Hepatitis-C and other

new medications that hit the market hard in 2015. The CJHIF was clearly not alone in dealing with the impact of these new specialty meds.

10 Drugs Accounted for Nearly One-Third of Spending in Catastrophic Coverage, 2015

Drug Name	Company Manufacturer*	Key Indications/Treats	FDA Approval Year	Average Price per Month**	Total Spending in Catastrophic Coverage
Harvoni	Gilead Sciences	Hepatitis C	2014	$33,811	$6,284,357,265
Relimid	Celgene	Cancers of the Blood	2005	$11,516	$1,718,263,750
Sovaldi	Gilead Sciences	Hepatitis C	2013	$30,217	$1,209,329,646
Humira	AbbVie, Inc.	Inflammatory Conditions	2002	$3,930	$1,205,270,252
Copaxone	Teva Pharms USA	Multiple Sclerosis	1996	$5,642	$1,143,986,768
Gleevec	Novartis	Various Cancers	2001	$9,299	$1,021,721,929
Enbrel	Amgen	Inflammatory Conditions	1998	$3,540	$938,254,647
Tecfidera	Biogen Idec, Inc.	Multiple Sclerosis	2013	$5,595	$735,215,799
Renvela	Sanofi	Chronic Kidney Disease	2007	$1,158	$675,261,441
Xtandi	Astellas	Prostate Cancer	2012	$8,673	$635,500,941
Total					**$15,567,162,441**

*The term "company" refers to New Drug Application holder or Biologics License Application holder.
**Note: The price is the amount paid to the pharmacy by all payers. It is negotiated between the sponsors and their network pharmacies for the drug, or is the usual and customary price paid to out-of-network pharmacies. It is not adjusted for rebates or other price concessions. SOURCE: HHS Office of Inspector General Analysis of Prescription Drug Event records, published in the OIG report, "High-Price Drugs Are Increasing Federal Payments for Medicare Part D Catastrophic Coverage" (OEI-02-16-00270)

Program Manager distributed materials regarding industry rx trend. He said the Fund saw changes in enrollment on the medical side due to some larger groups leaving the Fund as well as the Aetna MA transition. He said the loss ratio does not include IBNR so that would add an additional 7-10% on the loss ratio. He said in network utilization increased about 3%. He said rx is trending down due in part to the utilization management programs put in place. He said each point the brand generic goes up is equal to about $100,000 in savings.

Program Manager said there was an issue with Qualcare regarding service inconsistencies with one entity specifically, he said Mr. Epstein and his team has been working to correct the issue. He said his team is currently working with Qualcare on an enrollment disconnect regarding vision reimbursement. He said an RFP may be released for a standalone vision vendor for 2018.

TREASURER – Fund Treasurer distributed his report. He said the Fund earned $63,000 in interest and $34,000 in capital gain.

MOTION TO APPROVE THE CLAIMS CERTIFICATION:

MOTION:	Commissioner Lapp
SECOND:	Commissioner Nieman
VOTE:	All in Favor

FEBRUARY 2017 – Confirmation of Payment

FUND YEAR 2016	**$2,608.67**
FUND YEAR 2017	**$379,928.81**
TOTAL ALL FUND YEARS	**$382,537.48**

MARCH 2017 – Resolution 16-17

FUND YEAR 2016	**$245.00**
FUND YEAR 2017	**$381,504.64**
TOTAL ALL FUND YEARS	**$381,749.64**

ATTORNEY: Mr. Thompson introduced himself and said he has nothing to report.

QUALCARE: Mr. Epstein distributed the claims report for January and February including the runout. He said consistency is key for service and they will make sure that happens going forward.

AETNA: Report included in Agenda

EXPRESS SCRIPTS: Report included in Agenda.

DELTA DENTAL: Ms. Lehrer said the program continues to run well.

NEW BUSINESS: None

OLD BUSINESS: None

PUBLIC COMMENT: Mike Murphy, Christine Lyons and Mike Zangrilli from AmeriHealth introduced themselves and said they are exited to work with the Fund. Program Manager said Tuckerton BOE is joining on 4/1 with enrollment in AmeriHealth.

MOTION TO APPROVE THE CONSENT AGENDA, AS DISCUSSED:

MOTION: Commissioner Nieman
SECOND: Commissioner Poulos
VOTE: 8 Ayes, 0 Nays (Commissioners Nieman and Poulos Abstain on resolution 15-17)

MOTION TO ADJOURN MEETING:

MOTION: Commissioner Lapp
SECOND: Commissioner Gilsenan
VOTE: Unanimous

MEETING ADJOURNED: 1:50 pm