**State Health Benefits Commission**
**Meeting Minutes**
**September 12, 2018; 1:00 PM**

Adequate notice of this meeting was provided through the annual notice of the schedule of regular meetings of the Commission filed with and prominently posted in the offices of the Secretary of State. The annual meeting notice was mailed to the Secretary of State, Star Ledger and the Trenton Times on January 3, 2018.

The meeting of the State Health Benefits Commission of New Jersey was called to order on Wednesday, September 12, 2018 at 10:00 AM. The meeting was held at the Division of Pensions and Benefits, 50 West State Street in Trenton.

The text of Resolution A (Closed Session) and Resolution B (Executive Session) were read in their entirety in the event that the Commission desires, at any point in the meeting, to approve a motion to go into closed or executive session.

Acting Secretary Nicole Ludwig took Roll Call and established that a quorum was present.

**Roll Call**

**Commissioners:**

**Susanne Culliton**, Chairperson, representing State Treasurer Elizabeth Maher Muoio
**Holly Gaenzle-** representing Commissioner of the Department of Banking and Insurance Marlene Caride
**Dudley Burdge**, Representative for Local Government Employees
**Deirdre Webster-Cobb**, CEO, Civil Service Commission
**Debra Davis**, Representative for State Government Employees

**Also Present**:

**John Megariotis,** New Jersey Division of Pensions and Benefits
**David Pointer,** New Jersey Division of Pensions and Benefits

**Mark Cipriano**, New Jersey Division of Pensions and Benefits
**Joseph Palladino**, New Jersey Division of Pensions and Benefits
**Nicole Ludwig**, New Jersey Division of Pensions and Benefits
**Danielle Schimmel**, Deputy Attorney General
**Alex Jaloway,** Aon
**Michelle Engle,** Aon

## Minutes for Approval

Chairperson Culliton made a motion to approve the Meeting Minutes for July 11, 2018, including executive session. Commissioner Davis seconded the motion and all voted in favor.

## Rate Renewals

Michelle Engle from Aon gave a brief overview of the revised 2019 Rate Renewals:
In Plan Year 2019 for medical and prescription drug combined, the state group will have a projected aggregate cost of 2.4 billion and the Local Government group will have a projected aggregate cost of 1.55 billion. The recent plan changes reaffirmed by the PDC will help to reduce the Plan Year 2019 costs.

For the state group the aggregate rate renewal decrease for medical and prescription drug is 3.5%, while the aggregate rate renewal decrease for Local Government group is 7.6%.

Alex Jaloway presented the recommended rate renewal reports:

For the State Group in Plan Year 2019, the recommended premium rate changes are as follows: a 0.6% decrease for Active Employees, a 4.1% increase for Early Retirees, and a 32.6% decrease for Medicare Retirees. In aggregate, these recommendations represent an overall rate decrease for the State Group 4 of 3.5%. The Plan Year 2019 Renewal assumes the following: Plan Year 2018 medical and prescription drug claim experience paid through June 2018 has been reflected.

Recommended trends are developed by incorporating actual SHBP plan experience (adjusted for expectations of future cost increases) along with medical and prescription drug vendor trend recommendations, Aon's national trend guidance (which is reflective of Pharmacy Benefit Manager (PBM) surveys), national benchmarking data and other external sources. Active PPO medical trend has been reduced to 4.50% and 5.00% for Plan Years 2018 and 2019, respectively. Plan Years 2018 and 2019 prescription drug trends have been lowered by 50 basis points to 8.00% for Actives, Early Retirees and Medicare Retirees from the trends

recommended in the Plan Year 2019 Renewal Report provided on July 11, 2018. Plan Year 2019 projected Medicare Advantage fully insured premiums are equal to the rates provided in Aetna's Medicare Advantage RFP Response. This resulted in a savings of $60 million and a reduction to the total Medicare Retiree premium rate recommendation of approximately 22%. All other actuarial assumptions are based on those disclosed in the Plan Year 2019 Renewal Reports that were presented on July 11, 2018. Plan Year 2019 projected cost for the State Group is approximately $2.4 billion ($1.8 billion for Actives and $0.6 billion for Retirees).

For the Local Government Group in Plan Year 2019, the recommended premium rate changes are as follows: a 1.7% increase for Active Employees, a 37.1 % decrease for Early Retirees, and a 36.9% decrease for Medicare Retirees. In aggregate, these recommendations represent an overall rate decrease for the Local Government Group of 7.6%. The Plan Year 2019 Renewal assumes the following: Plan Year 2018 medical and prescription drug claim experience paid through June 2018 has been reflected. Recommended trends are developed by incorporating actual SHBP plan experience (adjusted for expectations of future cost increases) along with medical and prescription drug vendor trend recommendations, Aon's national trend guidance (which is reflective of Pharmacy Benefit Manager (PBM) surveys), national benchmarking data and other external sources. Active PPO medical trend has been reduced to 5.50% for Plan Years 2018. Plan Years 2018 and 2019 prescription drug trends have been lowered by 50 basis points to 8.00% for Actives, Early Retirees and Medicare Retirees from the trends recommended in the Plan Year 2019 Renewal Report provided on July 11, 2018. The premium increases for Plan Year 2019 are projected to produce a $22 million loss for Local Government Actives and a $135 million loss for Local Government Retirees. The Active and Retiree Claim Stabilization reserves are expected to decrease in Plan Year 2019 to achieve the recommended rate increases for Active Employees and Retirees. Including the projected reduction in the reserves, the total Active and Retiree aggregate Claim Stabilization Reserve is projected to be 2.4 months of plan costs as of December 31, 2019, which is above the target level of 2.0 months of plan costs as of December 31, 2019. The projected Claim Stabilization Reserve as of December 31, 2019 is 2.0 months of plan costs for Actives and 3.5 months of plan costs for Retirees. The one-time reductions in the Claim Stabilization Reserves reduced Active, Early Retiree and Medicare Retiree premium increases by approximately 0.3%, 31.3% and 8.2%, respectively. Plan Year 2019 projected Medicare Advantage fully insured premiums are equal to the rates provided in Aetna's Medicare Advantage RFP Response. This resulted in a savings of $26 million and a reduction to the total Medicare Retiree premium rate recommendation of approximately 16%. The actuarial coverage tier assumptions have been updated to be consistent with the Plan Year 2018 coverage tier assumptions. All other actuarial assumptions are based on those disclosed in the Plan Year 2019 Renewal Reports that were presented on July 11, 2018. Plan Year 2019 projected cost for the Local Government Group is approximately $1.6 billion ($1.1 billion for Actives and $0.5 billion for Retirees).

Commissioner Webster-Cobb made a motion to accept the rates for State, Local Government and Dental groups as presented by Aon. Chairperson Culliton seconded the motion. The motion passed 3-0-2 (Commissioners Burdge and Davis abstained).

***The Following Cases were heard Open Session:***

**Member Appeals**

**Case #09121801 (member present):** This appeal regarding eligibility for the Retiree Wellness Program was previously tabled. The issue is whether the member is eligible to enroll in the Retiree Wellness Program to have free health benefits in retirement based on when she reached 25 years of service.

Chairperson Culliton made a motion to go into Executive Session to seek advice from counsel, Commissioner Davis seconded the motion, and all voted in favor.

Upon return from Executive Session, Commission Burdge made a motion to deny the appeal because the member did not have 25 years of service credit by the date required by both Chapter 78 and the applicable collective bargaining agreement to be eligible for the Retiree Wellness Program. Commissioner Davis seconded the motion and all voted in favor.

**Case #09121802 (member present):** This previously tabled appeal is a request for enrollment as a retiree in the SHBP. The member was denied enrollment because the member did not have continuous coverage prior to retirement, and the member did not elect COBRA coverage for the gap.
Commissioner Davis made a motion to go into Executive session to seek advice from counsel, Commissioner Burdge seconded the motion and all voted in favor.

Upon return from Executive session, Chairperson Culliton made a motion to deny the appeal because the member did not have continuous coverage as required by regulation.
Commissioner Webster-Cobb seconded the motion and all voted in favor.

**Case #09121803:** This is a previously tabled appeal for Medicare reimbursement. The member was denied Medicare reimbursement because the member's hire date was after July 1, 1995 therefore making the member ineligible for any Medicare part-B reimbursement.

Chairperson Culliton made a motion to go into Executive Session to seek advice from court. Commissioner Burdge seconded the motion and all voted in favor.

Upon return from Executive Session, Commissioner Burge made a motion to approve the member's appeal for a monthly reimbursement in the amount of $46.10. Commissioner Davis seconded the motion. The motion failed 1-3-1 ( Commissioners Culliton, Webster-Cobb, and Gaenzle nay; Commissioner Davis abstained).

Chairperson Culliton made a motion to deny the member's appeal. Commissioner Webster-Cobb seconded the motion. The motion passed 3:2 (Commissioners Burdge and Davis nay).

Chairperson Culliton made a motion to go into Closed Session. Commissioner Davis seconded the motion and all voted in favor.

**The following cases, due to HIPAA regulations, were heard in Closed Session:**

**Case #09121804 (member present):** This appeal is for additional reimbursement for a medical prosthesis. The member indicated that prior prosthetics had been covered or reimbursed at a greater rate. The member explained the specifics of this prosthetic and the process by which the prosthetic was acquired. The member admitted that the provider stated prior to the ordering of the prosthetic that the provider would not submit insurance claims and the member must pay the entire cost for the prosthetic and then seek reimbursement. The member asserted that another member received more reimbursement for a similar prosthetic

Horizon explained that claim was paid in accordance with the Orthotics and Prosthetics Mandate of 2008, which applies to the SHBP.

Chairperson Culliton made a motion to go into Executive session to seek advice from counsel, Commissioner Burdge seconded the motion and all voted in favor.

The Commission returned to Closed Session to ask Horizon If they had any information about the other member and about coding.

Chairperson Culliton made a motion to return to Executive Session to seek advice from the Deputy Attorney General. Commissioner Webster-Cobb seconded the motion and all voted in favor.

Chairperson Culliton made a motion to table the appeal so that Horizon could provide more details regarding the claim, and the denial. Commissioner Davis seconded the motion and all voted in favor.

**Case #09121805 (member present):** The member appeals the reimbursement for out-of-network pain management services. The member claims the services were emergency services and should be reimbursed at an in-network rate. The member admitted knowledge that the provider was out-of-network at the time of service, that Horizon confirmed prior to the service that the provider was out-of-network and the member declined Horizon's offer to provide a list of in-network providers.

Chairperson Culliton made a motion to deny the claim. There was no second. Commissioner Burdge made a motion to table the appeal to allow the member to supply documentation from the physician that the claim was emergent in nature. Commissioner Davis seconded the motion to table the appeal. The motion passed: 4-1 (Chairperson Culliton nay)

**Case #09121806:** The member appeals the denial of reimbursement of an incidental procedure billed by an out-of-network physician. Commissioner Davis made a motion to deny the appeal as incidental procedures are not a covered benefit under the plan. Commissioner Burdge seconded the motion and all voted in favor.

Commissioner Burdge made a motion for the Commission to take a short recess. Commissioner Davis seconded and all voted in favor.

Upon re-convening, Commissioner Davis made a motion to go into Open Session, Commissioner Burdge seconded and all voted in favor.

**Office of Administrative Law Requests:**

**Case #09121807(member representative present) –** The member requested a hearing in the Office of Administrative Law (OAL) on the Commission's denial of the request to continue

Chairperson Culliton made a motion to approve the member's request to transmit the case to the OAL. Commissioner Davis seconded the motion and all voted in favor.

**Case #09121808 (member present)** – The member appealed the Commission's prior determination that member would be eligible for retired SHBP coverage if the member paid retroactive COBRA premiums for the time for which there was a break in coverage just prior to the member's retirement. The member asserted that the employer should have paid for coverage and that the member did not want or se COBRA coverage. The Commission explained to the member that in order to be eligible for retired SHBP coverage, the member, who was employed by an SHBP participating employer, must maintain SHBP active coverage up until retirement. Because the member had a break in coverage of several months, and based on the member's unique circumstances, the Commission permitted the member to retroactively pay for COBRA coverage in order to be eligible for retired SHBP coverage. The Commission explained that if the member did not pay for the COBRA coverage, the member could not be eligible for retired SHBP coverage. The member indicated that payment has been difficult until this point, but if payment for COBRA was required, the member could make the payments if given three months. Commissioner Culliton made a motion to allow the member 90 days from the date of the meeting to pay the outstanding COBRA bill in full. Commissioner Davis seconded the motion and all voted in favor.

***Settlement Proposals***

**Case #091218109 –** Chairperson Culliton made a motion to approve the settlement authority as requested by Equian. Commissioner Davis seconded the motion and all voted in favor.

Chairperson Culliton made a motion to return to Closed Session. Commissioner Davis seconded the motion and all voted in favor**.**

**The following cases, due to HIPAA regulations, were heard in Closed Session:**

**Case #09121810:** The member appeals OptumRx's denial of coverage for a drug considered a DESI drug, which is not an FDA approved prescription. OptumRx explained the category of drugs known as DESI drugs, and reviewed the process a manufacture must go through to receive FDA approval. OptumRx explained that the plan design states non-FDA approved drugs are excluded

from the formulary. Commissioner Gaenzle asked if there was an equivalent drug that was FDA approved, OptumRx stated that there was not.

Chairperson Culliton made a motion to table the case so that OptumRx could reach out to the member's medical provider to determine if there is medical necessity for the drug. Commissioner Davis seconded the motion and all voted in favor.

**Case #09121811:** The member appeals OptumRx's denial of progesterone for fertility. The claim was denied because the member is over age 45. The information subsequently submitted to OptumRX confirms that the progesterone is not for fertility but rather to maintain a healthy pregnancy, as the member is already pregnant. Chairperson Culliton made a motion to approve the coverage. Commissioner Davis seconded the motion and all voted in favor.

**Case #09121812:** The member appealed OptumRx's denial of coverage for pre-natal vitamins. OptumRx explained that there are FDA approved pre-natal vitamins and the member sought coverage for non-FDA approved prenatal vitamins. The member did fill a subsequent prescription that was covered, for a different, FDA approved, pre-natal vitamin. Chairperson Culliton made a motion to deny the member's appeal. Commissioner Burdge seconded the motion and all voted in favor.

Commissioner Davis made a motion to go into Open Session, Commissioner Burdge seconded the motion and all voted in favor.

**Adjournment**

Commissioner Davis made a motion to adjourn. Commissioner Burdge seconded the motion and all voted in favor. There being no further the business, the meeting adjourned at 4:06 p.m.

Respectfully Submitted,

Nicole Ludwig

Nicole Ludwig

Acting Secretary, State Health Benefits Commission