State Health Benefits Program
Plan Design Committee
Open Session Minutes: June 26, 2019 1:00 p.m.

Adequate notice of this meeting was provided through the annual notice of the schedule of regular meetings of the Committee filed with and prominently posted in the offices of the Secretary of State. A meeting notice was mailed to the Secretary of State, Star Ledger and the Trenton Times on April 12, 2019.

The meeting of the State Health Benefits Program Plan Design Committee of New Jersey was called to order on Wednesday, June 26, 2019 at 1:00 p.m. The meeting was held at the Division of Pensions and Benefits in Trenton, NJ.

The text of Resolution B (Executive Session) – was read in its entirety in the event that the Committee desires, at any point in the meeting, to approve a motion to go into closed session.

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

Roll Call

Committee Members:

Dini Ajmani, Assistant Treasurer
Patrick Nowlan, AAUP – AFT (Chair) (Appearing Telephonically)
Jennifer Keyes-Maloney, Assistant Treasurer (Co-Chair)
Abdur R. Yasin, NJ FMBA (Appearing Telephonically)
Michael Zanyor , NJSTFA
Kevin Lyons, NJ State PBA
Justin Zimmerman, Chief of Staff, Department of Banking and Insurance
David Ridolfino, Director, Office of Management and Budget
Hetty Rosenstein, New Jersey Area Director, CWA/District 1 (Appearing Telephonically)
Tennille McCoy, Assistant Commissioner of Human Capital Strategies, Department of Labor and Workforce Development
Kimberly Holmes EEO/AA Officer, Department of Community Affairs
Robert Little, AFSCME Department of Research (Appearing Telephonically)

Also Present:
Christopher Meyer, Deputy Attorney General
Mark Cipriano, Division of Pensions and Benefits
Nicole Ludwig, Division of Pensions and Benefits

Meeting Minutes

Committee member Little made a motion to approve the PDC meeting minutes from March 19, 2019, April 16, 2019 and May 20, 2019. Committee member Zaynor seconded the motion; all voted in favor.

Acting Secretary Nicole Ludwig advised that the order of the agenda would be rearranged. Resolutions 7 & 8 would be presented first. Committee member Ridolfino made a motion to rearrange the order of the agenda. Committee member Ajmani seconded the motion; all voted in favor.

Resolution 2019-8: Readopting Resolutions 2016-2, 2016-3 & 2016-5 Related To Generic Substitution, Formulary Management Reimbursement Of OON Rates For PT

Chairperson Nowlan read the resolution for the Committee. Committee member Zaynor made a Nowlan made a motion to pass resolution 2019-8. Committee member Ajmani seconded the motion; all voted in favor.

Resolution 2019-9: Reduction of Retiree Prescription Drug Copayment for Mail Order Preferred Brand Copays

Chairperson Nowlan read the resolution and noted there was one amendment stating the resolution was for plan year 2020. Committee member Zaynor made a motion to amend the Resolution. Committee member Ajmani seconded the motion; all voted in favor.

Committee member Holmes made a motion to adopt Resolution 2019-9. Committee member Zaynor seconded the motion; all voted in favor.

Resolution 2019-7 Allowing Employers Flexibility In Plan Parameters As To Prescription Plans For Retirees

Chairperson Nowlan read the resolution for the Committee. Committee member Lyons made a motion to pass resolution 2019-7. Committee member McCoy seconded the motion, all voted in favor.

Quarterly Reports Presented By R-Health And Paldina Health

Presentation by Paladina Health:

Craig Peterson and Matt Weissert of Paladina Health presented on the quarterly reports provided to the Committee members. Mr. Peterson advised that at the end of the first quarter there was an increase of 85% in enrollment. Mr. Weissert went on to explain that currently Paladina has a 55% capture rate, he

explained this is the actual face-to-face visits within the first 180 days. Mr. Peterson shared the following statistics: 49% of enrollees are state employees, 51% are dependents; 42% are male and 58% are female. The average age of enrollees is 36 years of age, 77% are adults (18+) and 23% are children.

Mr. Weissert went on to explain that Paladina has started to look at the engagement and have identified incidents of chronic conditions. It has been identified that 66% of state members have at least one chronic condition. The idea of the study is to assist in proactive engagements on the Physician's part to make sure that the chronic conditions are being addressed. The two most common chronic conditions identified are hypertension and anxiety.

Mr. Peterson explained utilization by clinic, stating that currently there are two clinics, one in Hamilton Township, and one in Clifton. The Clifton office has a higher percentage of visits. The assumption is that there is a lower competitive market in Clifton, mostly due to the R-Health location in Ewing. He advised that Paladina will be opening a new location in Jersey City this summer.

Mr. Peterson stated that Union participation has been key in getting more employees participating in the DPCMH programs.

Committee member Ajmani asked what data Paladina is getting from Horizon. Mr. Weissert advised Horizon is providing historical data which is used to compare to that of the population in Paladina Health; specifically to see who is not enrolled. This is being used to compare costs before and after the members are enrolled in the program. Committee member Ajmani asked for that data to be shared at a later meeting.

Presentation by R-Health:

Mason Rainer and Amber Van Nierkerk of R-Health presented the quarterly report provided to the Committee members. Mr. Rainer explained that there is continued growth in the program. Mr. Rainer focused on the goals of R-health stating that their focus is on members with chronic conditions and monitoring their engagement, along with the results of the program. He provided an example, stated that 51% of members who previously had uncontrolled diabetes have now reduced their A1C levels to a controlled level.

Mr. Rainer explained that in May R-Health rolled out their E-Console platform, which enables primary care physicians, when medically appropriate, to have virtual consults with a specialist. The goal is to reduce the need to refer members to specialty care, providing PCPs with the necessary tools to continue managing the care of members in house.

He went on to review utilization, stating that the average number of visits per hundred people per year is about four times the national average for general practitioners. He added this is just for office visits, the virtual and digital engagements are also on the rise as 44% of employees have joined Spruce, the online health app.

Mr. Rainer stated there are currently six R-Health locations, with two additional locations opening later this year: West Orange and Bucks County, PA.

Committee member Little asked for a breakdown by department from locations. Mr. Reiner advised this would be provided at a later meeting.

Chairperson Nowlan asked if there has been any additional research into offering DCPMH to retirees. Mr. Rainer advised that he has been in contact with Aetna and the issue at hand is that since the MA plan is a fully-insured product, the DCPMH would have to be built in and added in the future.

CARRIER DISCUSSION: MOST COMMONLY DENIED CLIAMS

Co-Chairperson Keyes-Maloney explained the conversation should be a high-level overview with a further discussion at a later meeting.

Presentation by OptumRx:

Paul Eberle of OptumRx presented on the most commonly denied claims. Mr. Eberle explained that the five most common rejection codes are the same across both the Commercial and EGWP populations. The five most commonly denied claims are:

1) Product/Services are not covered, this is where a doctor prescribes a medication that is not covered. This accounts for 7% of all rejected claims.
2) Drug Utilization Rejection: this is where a drug is rejected because there is a negative drug-drug interaction, a duplicate therapy. These drugs reject because there could be a potential danger to the member.
3) Plan Limitation Exceeded, this is where the quantity limit of a drug is being exceeded. Again these drugs reject as there could be a potential danger to the member.
4) Prior Authorization (PA) Required, this is where a medication would require the prescriber to complete a short form to indicate the medical necessity of the medication.
5) Fill Too Soon, this is when a member is trying to fill the prescriptions too soon.

Co-Chairperson Nowlan stated that two of the rejections are temporary denials, the fill too soon and the PA required. Mr. Eberle agreed. Co-Chairperson Nowlan asked if the exclusion includes when there is an Over the Counter (OTC) drug available. Mr. Eberle said that anything that is not on the Formulary would be rejected. He went on to explain that OptumRx has rolled out a program for prescribers called Pre-Check My Script. This would allow a prescriber to see if a medication is covered by the plan prior to prescribing. This is designed to inform the prescriber if the medication is covered, and would allow the doctors to discuss with the patient before they left the office, or would allow for the doctor to find a medication that is not excluded.

Committee member Zaynor stated this was a good tool, because the most common complaint that he hears is that the members go to the pharmacy and find out the medication is not covered, and then they have to go back to the doctor's office for another prescription. Mr. Eberle stated that the Pharmacist would also be able to assist the member, because they have the ability to contact the provider and request another medication. Also since the SHBP has mandatory Generics, the pharmacist can always switch to the generics at the point of sale.

Committee member Zaynor asked if there was a way to track any trends in exclusions. If there is a way to track the trend so the Union Reps can be on the lookout- even if it on the prescriber side. Mr. Eberle said that he could provide the top 5 within a category of drugs that are trending in the exclusions category.

Committee member Yasin asked about the appeals, and how many patients are winning their appeals? Mr. Eberle said that if the appeals are for excluded drugs, OptumRx is administering the plan as stated in the contract, therefore it is rare that the commission approve an appeal for an excluded drug. Co-Chairperson Nowlan stated that when he was on the Commission there were certain appeals where the members would meet certain medical necessity, and additional information was brought to light which resulted in the appeal being approved.

<u>Presentation by Horizon:</u>

Janice Zucker, Mary Hollywood, and Kathy McCann of Horizon presented on the most commonly denied claims. Mrs. Zucker advised that the request for the information came very late, and due to the size of the file there was not a lot of time to do a deep dive into the denials, however Horizon would do their best to walk the Committee members through. Mrs. Hollywood stated that across the Commercial and EGWP population the top three denials are due to:

1) Coordination of Benefits (COB), members are sent a letter once a year asking them to contact Horizon to confirm to see if there is a secondary insurance. If members do not respond claims are not paid until a response is received.
2) Plan Limitations, this is when a member has met the maximum reimbursement. The most common denials are for Chiropractic, PT, and Acupuncture.
3) Claims are not separately reimbursable (CBC), this is where one code is rejecting for not being covered, but it is part of a larger code. The full procedure code would be rejected.
4) Specific Procedures are excluded, this is when a service is not covered. For example cosmetic surgery, or experimental codes.

Committee member Ajmani asked if you call to coordinate the benefits after the letter is sent, and claims are denied, can there be a retroactive fix? Mrs. Hollywood confirmed once COB is done, the rejected claims are paid.

Co-Chairperson Nowlan asked about the Claims not being separately reimbursable. He asked if it is common that the CBC rejections are coming over a duplicate claims. Mrs. Hollywood agreed, that if the provider entered a CBC code, and individual lines that have the same codes it would reject for duplicate claims.

Committee member Lyons stated that the denials all seem to be clerical and asked if there is any way to identify the top 5 denied services. Mrs. Hollywood agreed, and stated this would require additional research and could be presented at a later time. Committee member Lyons stated the biggest complaint from members is related to Prior Authorizations (PA), and how long they take to be completed. Committee member Ajmani asked if Horizon could further investigate what procedures are denied, and if those require a PA how long it generally takes to secure the PA.

Presentation by Aetna:

Kim Ward and Mary Carr of Aetna presented on the most commonly denied claims. Similar to Horizon, there was little time to prepare and therefore the information is not as detailed as the Committee may have wanted. Aetna looked at a 6 month timeframe and their top five denials are:

1) Referrals, this refers to the HMO population, where a member goes to a specialist without securing a referral first.
2) Limitations on Services, similar to Horizon these services are Acupuncture, PT, and Chiropractic when the maximum reimbursement is met.
3) Requested information was not provided, this is where a provider is asked to provide additional information, but does not.
4) Medical Necessity, where a service is covered only with the patient meets a certain criteria.
5) Fill too Soon, similar to OptumRx this applies to Durable Medical Equipment when a member tries to fill too soon. The most commonly denied claim is for CPAP machines.

Mrs. Ward asked if the Committee would like Aetna to come back at the next PDC to provide additional information to which Co-Chair Nowlan agreed.

Resolution 2019-6 Allowing Certain State and Local Government Early Retirees Access To More Plan Options

Co-Chairperson Nowlan read the resolution in its entirety to the Committee. Co-Chairperson Keyes Maloney made a motion to approve Resolution 2019-6 but clarified that this relates totally to the availability to the plan options, providing a broad canopy of options for the Early Retirees. Committee member Lyons asked if this would make all the plans available to all retirees. Co-Chairperson Keyes-Maloney agreed, and stated the resolution was necessary as the intent of Resolution 2019-4 and 2019-6 was to have these plans offered to early retirees as well. Committee member Lyons stated that the reimbursement for Chapter 330 is based on the lowest plan available, if these plans change the lowest cost managed plan available to retirees, then those reimbursements would go down. Committee member Rosenstein stated the new plans are not the lowest cost plans. Committee member Lyons has asked for clarification from the Division.

DPB Representative David Pointer stated that the lowest prices plan is the PPO 2030 or the 2035, that the High Deductible plan does not count, and neither does the Tiered Network. Committee member Lyons asked if a clause can be added that Resolution 2019-6 does not apply to Chapter 330 Retirees. Committee member Rosenstein agreed. Co-Chair Keyes-Maloney confirmed with the Division that there is not an issue with this.

Co-Chair Keyes-Maloney made a motion to approve Resolution 2019-6. Committee member McCoy seconded the motion. All voted in favor and Committee member Zaynor asked that it be noted that a yes vote does not waive any rights to negotiations, or resolutions. Committee member Lyons again stated that the motion does not apply to Chapter 330.

Co-Chair Nowlan thanked both State and Union representation for a productive meeting, and that he hopes that the PDC continues to make progress including plan designs, lowering costs, and maintaining the quality of benefits to the members.

With no further matters to discuss, Committee member Zaynor made a motion to adjourn. Committee member Holmes seconded the motion; and all voted in favor. The meeting adjourned at 2:45 pm.

Respectfully Submitted,

Nicole Ludwig

Acting Secretary SHBP PDC

SHBP PDC Resolution #2019-6

RESOLUTION OF THE STATE HEALTH BENEFITS PROGRAM PLAN DESIGN COMMITTEE TO ALLOW CERTAIN STATE AND LOCAL GOVERNMENT EARLY RETIREES ACCESS TO MORE PLAN OPTIONS

WHEREAS, pursuant to N.J.S.A. 52:14-17.29 et seq. the State Health Benefits Program (SHBP) provides health coverage to qualified employees and retirees of the State and participating local employers; and

WHEREAS, the SHBP was enacted in 1961 for the purpose of providing affordable, quality health care coverage for public employees on a cost-effective basis; and

WHEREAS, all SHBP plans, with the exception of Medicare Advantage plans, are self-funded, which means that the money paid out for benefits comes directly from an SHBP fund funded by State appropriations, participating local employers, and member premiums; and

WHEREAS, consistent with the intent of 2019-4 and 2019-5, this Resolution addresses the availability of plan options for early retirees; and

WHEREAS, the SHBP Plan Design Committee (SHBP PDC) aims to provide early retirees with lower cost plan options;

NOW, THEREFORE, BE IT RESOLVED:

1. That the tiered network plans, currently Horizon's Omnia and Aetna's Liberty plans, the CWA PPO Plan (a/k/a the CWA Unity Direct and CWA Unity Freedom Plans), the PPO Plan (a/k/a the NJDIRECT and NJFREEDOM), as well as the PPO HD 1500 plans, without the employer HSA funding, be offered as plan options to any early retiree, defined as a person who is not yet eligible for Medicare, without regard to the date on which the early retiree accrued 25 years of non-consecutive or consecutive service credit or otherwise qualified for retiree health benefits and without regard to the date on which the early retiree retired;

2. The SHBP PDC directs the Division of Pensions and Benefits to take such steps as necessary in order to have the current vendors, Horizon and Aetna, offer the plans referenced in paragraph 1 above to early retirees as soon as practicable but no later than October 1, 2019;

3. This resolution does not apply to Chapter 330 plan participants.

4. This resolution shall take effect immediately.

SHBP PDC Resolution #2019-7

RESOLUTION OF THE STATE HEALTH BENEFITS PROGRAM PLAN DESIGN COMMITTEE ALLOWING EMPLOYERS FLEXIBILITY IN PLAN PARAMETERS AS TO PRESCRIPTION PLANS FOR RETIREES

WHEREAS, pursuant to N.J.S.A. 52:14-17.29 et seq., the State Health Benefits Program (SHBP) provides health coverage to qualified employees and retirees of the State and participating local employers; and

WHEREAS, the SHBP was enacted in 1961 for the purpose of providing affordable health care coverage for public employees on a cost effective basis; and

WHEREAS, while the SHBP has authority over plan design, the State Health Benefits Commission has authority over plan authorization and structure; and

WHEREAS, all SHBP plans, with the exception of Medicare Advantage plans, are self-funded, which means that the money paid out for benefits comes directly from a SHBP fund supplied by the State, participating local employers, and member premiums; and

WHEREAS, the Division of Pensions and Benefits has had a long standing position based on N.J.A.C. 17:9-6.10 (b) that co-payments required under the prescription drug plan are separate and distinct from the medical portion of any SHBP plan; and

WHEREAS, The State of New Jersey has 565 separate municipalities most with separate Collective Negotiations Agreements (CNA) with different labor organizations; and

WHEREAS, the different levels of benefits, especially those promised to current retirees in their CNAs, creates a barrier for employers to move their active and retired members into the State Health Benefits Plan; and

WHEREAS, it is widely recognized that the larger the pool of members in the State Health Benefits Plan, the more stable the premiums should be and the stronger the purchasing power would be to maintain stable health care costs;

NOW, THEREFORE, BE IT RESOLVED:

That the SHBP PDC encourages the State Health Benefits Commission to direct the Division of Pensions and Benefits to create all current retiree plans with and without prescription benefits to allow employers to offer a “carve out” plan that will comply with the employees’ retirement benefits under the applicable CNA;

SHBP PDC RESOLUTION #2019-8

RESOLUTION OF THE STATE HEALTH BENEFITS PROGRAM PLAN DESIGN COMMITTEE TO CONTINUE RESOLUTIONS 2016-2, 2016-3, AND 2016-5 RELATED TO GENERIC SUBSTITION, FORMULARY REIMBURSEMENT AND OUT OF NETWORK REIMBURSEMENT RATES FOR PHYSICAL THERAPY

WHEREAS, pursuant to N.J.S.A. 52:14-17.29 et seq. the State Health Benefits Program (SHBP) provides health coverage to qualified employees and retirees of the State and participating local employers; and

WHEREAS, the SHBP was enacted in 1961 for the purpose of providing affordable health care coverage for public employees on a cost effective basis; and

WHEREAS, on August 29, 2016, after reviewing multiple recommendations and reports of AON Consulting, Inc., Horizon and Aetna, the SHBP Plan Design Committee adopted Resolution #2 on generic substitution (attached), Resolution #3 on formulary management (attached), and Resolution #5 on out of network physical therapy reimbursements (attached), finding these changes to be in the best interest of the State, local employers, and employees; and

WHEREAS, the Resolutions #2, #3, and #5, adopted on August 29, 2016, authorized the respective programs for one year, upon which time a review was required; and

WHEREAS, the Resolutions #2, #3, and #5, adopted on August 29, 2016 were reviewed by the SHBP Plan Design Committee on July 27, 2017; and

WHEREAS, on July 27, 2017, the SHBP Plan Design Committee, adopted Resolution 2017-01, which extended Resolutions #2, #3, and #5, adopted on August 29, 2016, for a period of one year; and

WHEREAS, the SHBP Plan Design Committee continues to find that generic substitution, formulary management, and structured out of network physical therapy reimbursements are in the best interest of the State, local employers, and employees and desires to continue these plan design provisions.

NOW THEREFORE, BE IT RESOLVED AS FOLLOWS:

1. The generic substitution approved by the SHBP Plan Design Committee on August 29, 2016 in Resolution #2 (attached) and continued by the SHBP Plan Design Committee on July 27, 2017 in Resolutions #2017-01 (attached), is continued;

2. The formulary management approved by the SHBP Plan Design Committee on August 29, 2016 in Resolution #3 (attached) and continued by the SHBP Plan Design Committee on July 27, 2017 in Resolutions #2017-01 (attached), is continued;

3. The structured out of network reimbursement rates for physical therapy approved by the SHBP Plan Design Committee on August 29, 2016 in Resolution #5 (attached), and continued by the SHBP Plan Design Committee on July 27, 2017 in Resolutions #2017-01 (attached), is continued.

4. This provision shall continue for one (1) plan year and may only be continued upon affirmative vote by the PDC

DATED: June 26, 2019

SHBP PDC RESOLUTION #2019-9

RESOLUTION OF THE STATE HEALTH BENEFITS PROGRAM PLAN DESIGN COMMITTEE TO REDUCE THE RETIREE PRESCIPTION DRUG COPAYMENT FOR MAIL ORDER PREFERRED BRAND COPAYS

WHEREAS, pursuant to N.J.S.A. 52:14-17.29 et seq. the State Health Benefits Program (SHBP) provides health coverage to qualified employees and retirees of the State and participating local employers; and

WHEREAS, the SHBP was enacted in 1961 for the purpose of providing affordable health care coverage for public employees on a cost effective basis; and

WHEREAS, the SHBP Plan Design Committee finds that incenting retirees to use cost effective preferred medications through mail service by reducing the copayment for retiree prescription drug copayments for mail order preferred brand copayments in the PPO 10 and 15 plans is in the best interest of the State, local employers, and retirees;

WHEREAS, on July 27, 2017, the SHBP Plan Design Committee, adopted Resolution 2017-03 (attached), which reduced the retiree copayments in the Retiree Prescription Drug Plan associated with the PPO 10 and 15 medical plans from $33 per 90-day prescription to $28 per 90-day prescription for Plan Year 2018; and

WHEREAS, the SHBP Plan Design Committee continues to find that incenting retirees to use cost effective preferred medications through mail service by reducing the copayment for retiree prescription drug copayments for mail order preferred brand copayments in the PPO 10 and 15 plans is in the best interest of the State, local employers, and retirees;

NOW THEREFORE, BE IT RESOLVED AS FOLLOWS:

1. The retiree copayments in the Retiree Prescription Drug Plan associated with the PPO 10 and 15 medical plans shall continue to be set at $28 per 90-day prescription for Plan Year 2019
2. This provision shall only be continued beyond Plan Year 2019 upon an affirmative vote of the SHBP Plan Design Committee.

DATED: June 26, 2019