METROPOLITAN
HEALTH INSURANCE FUND

AGENDA AND REPORTS
JUNE 12, 2025
ZOOM
CONFERENCE CALL
SPECIAL MEETING
10:00 AM

ZOOM:
https://permainc.zoom.us/j/97045873435
Meeting ID: 970 4587 3435

One tap mobile
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+13017158592,,97045873435# US (Washington DC)

OPEN PUBLIC MEETINGS ACT - In accordance with the Open Public Meetings Act, notice of this meeting was given by:

I. Sending sufficient notice to **The Record and The Star Ledger**
II. Filing advance written notice of this meeting with the Clerk/Administrator of each member municipality and school boards,
III. Posting notice on the Public Bulletin Board of all member municipalities and school boards.
IV. During the business session portion of this Remote Public Meeting, the audio of all members of the public meeting will be muted. At the end of the business session of the meeting, a time for public comment will be available. Members of the public who desire to provide comment shall raise their virtual hand in the Zoom application and/or submit a written comment via the text message section of the application. The meeting moderator will queue the members of the public that wish to provide comment and the Chairperson will recognize them in order. Public comment shall be concise and to the point, and shall not contain abusive, defamatory, or obscene language.

METROPOLITIAN HEALTH INSURANCE FUND
AGENDA MEETING: JUNE 12, 2025
SPECIAL MEETING - CONFERENCE CALL - ZOOM
10:00 AM

MEETING CALLED TO ORDER - OPEN PUBLIC MEETING NOTICE READ

PLEDGE OF ALLEGENCE

ROLL CALL OF 2025 EXECUTIVE COMMITTEE

Fund Commissioner	**Entity**
Jenny Mundell, Chairwoman	Bloomfield Public Library
Kimberly Duva, Secretary	Bloomfield Township
Cameron Cox, Executive Committee Member	Plainfield Public Schools
Nikole Baltycki, Executive Committee Member	West Caldwell Township
Chris Hartwyk, Executive Committee Member	City of Orange
Margaret Heisey, Executive Committee Member	Scotch Plains Twp
Patrick Wherry, Executive Committee Member	Maplewood Township

CORRESPONDENCE – None

AGENDA TOPIC:
OUT OF NETWORK UTILIZATION
Presented by:
Joe DiBella
Tammy Brown
Joe DiVincenzo

OLD BUSINESS

NEW BUSINESS

PUBLIC COMMENT

MEETING ADJOURNED

Executive Summary
Metropolitan Health Insurance Fund
Out of Network Utilization

I. Purpose of Executive Summary

The purpose of this Executive Summary is to review the Performance Results of the Metropolitan Fund and, more specifically, increases in costs associated with out of network providers.

The role of the Health Insurance Fund has always been to ensure its long-term financial stability. The Fund previously identified and addressed predatory out of network provider billing practices. As a result of its swift and decisive action, effective February 1, 2024, the reimbursement for varicose vein procedures being conducted out of network was capped at the in-network reimbursement level, significantly reducing the liability to the Fund. The savings per claim was estimated to be approximately $35,000 and is a testimony to the stewardship of the Executive Director's team to manage all accounts that reside in the Health Insurance Funds. While this action was a positive step in the right direction, a global solution to unsustainable increases in out of network utilization is required to ensure the Fund's long-term financial stability into the future.

In addition to expanding upon the drivers leading to increased costs for the Fund, this document will summarize and recommend proactive steps to address any potential member confusion once implemented.

II. Overview

The Metropolitan Fund has experienced severe cost increases beyond ordinary medical trend which threatens the financial stability of the Fund. The table below illustrates how the Fund's surplus has deteriorated in recent months:

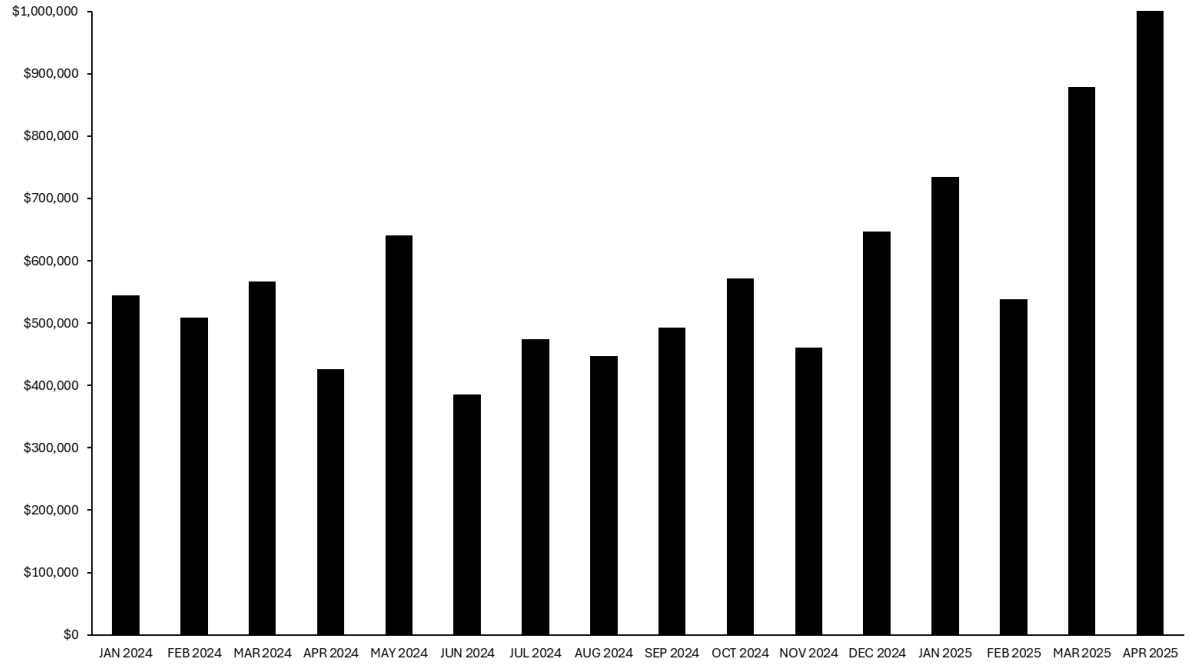
Metropolitan Fund Statutory Surplus / (Deficit)

December 31, 2023	$2,077,788
December 31, 2024	($2,886,392)
March 31, 2025	($4,224,114)

The current trajectory is unsustainable and changes to the "reasonable and customary" schedule are warranted.

Out of network costs for the Metropolitan Fund continue to rise significantly, resulting in increased costs for the Fund that must be addressed immediately. The table below illustrates this growing problem and the need to act swiftly.

Out of Network Claim Payments



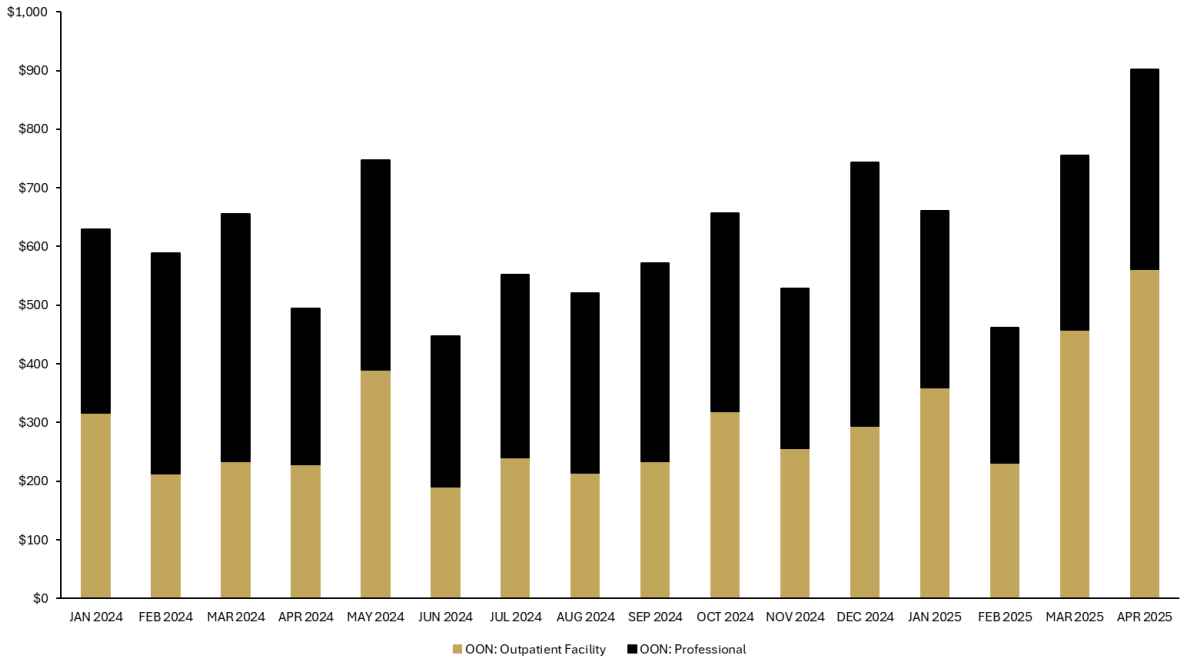
Out of network utilization typically ranges between 10-15% of overall medical claims. However, the Fund has experienced 30% out of network utilization consistently since its inception. This shocking rise in out of network utilization is despite the fact that provider networks in the region are expansive – in particular the northern part of New Jersey and the metropolitan areas of New York. Limited out-of-pocket maximums and generous fee schedules are contributing to this unusual trend.

The current out of network fee schedules that are paying the 90th percentile of FAIR may be valued at 300% to 350% (or more) of Medicare. These more generous fee schedules are based on billed provider charges and are promoting more out of network utilization. Not only is the payment significantly higher than Medicare and in-network rates, the projected increase in those payments over time compared to Medicare increases is alarming and unsustainable.

III. Out of Network Costs

A review of out of network payments since January 2024 illustrates the alarming increase in out of network costs paid by the Fund. The following table illustrates these cost increases for outpatient facility and professional services conducted by out of network providers:

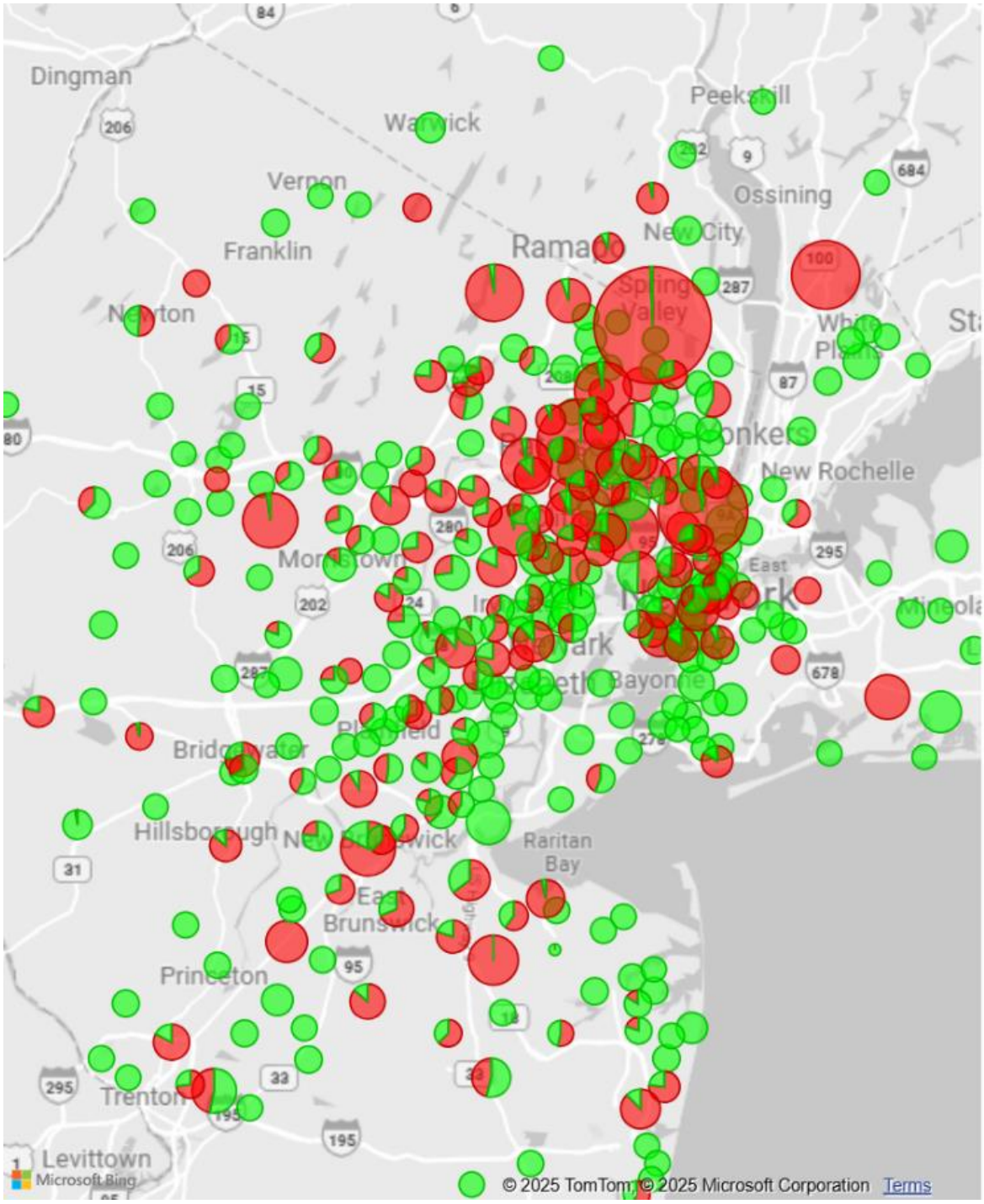
Out of Network Cost Increases (PEPM)



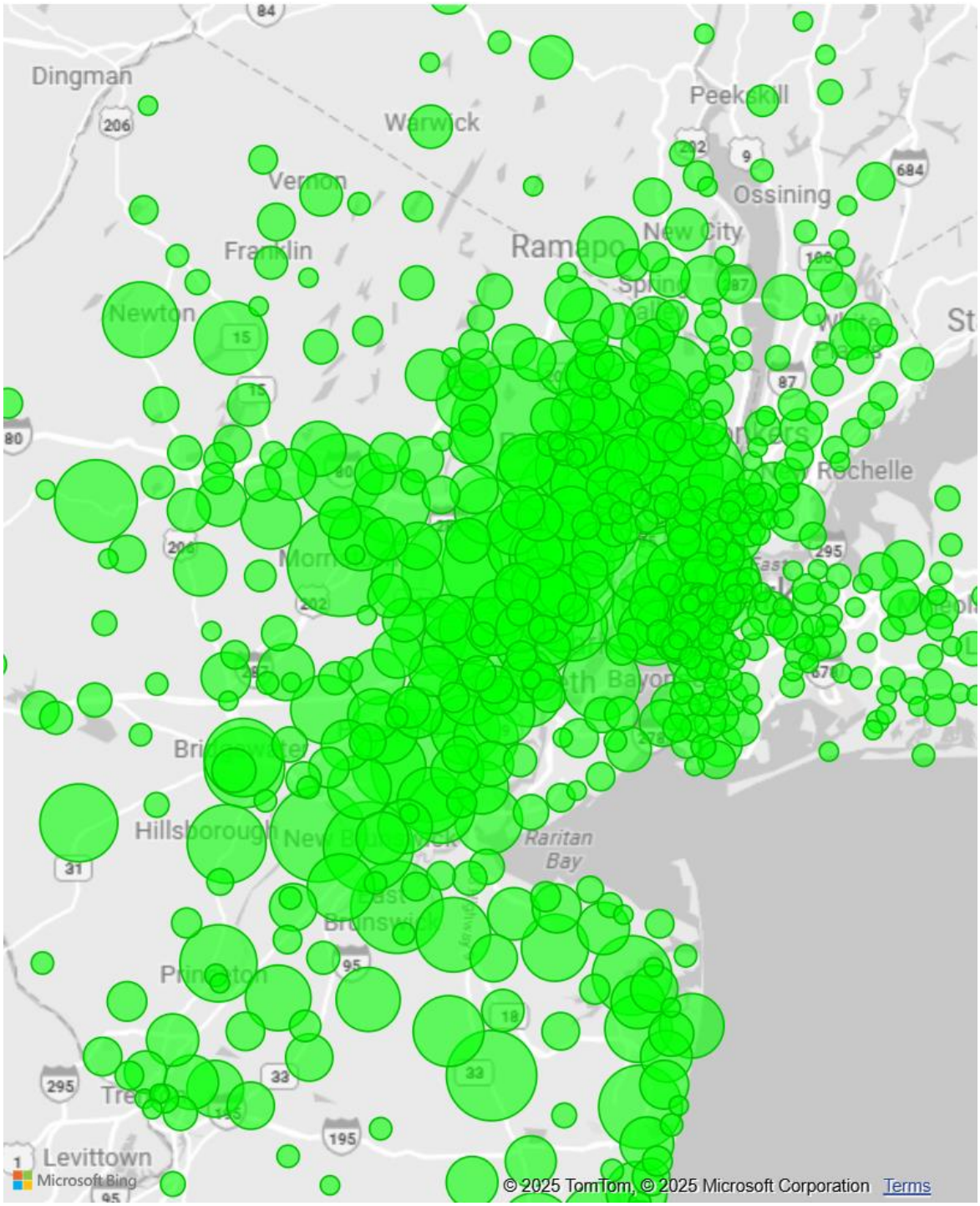
The utilization of out of network providers puts upward pressure on medical trends since the reimbursement for these services is much greater than in-network fee schedules. However, despite the expansive provider network in New Jersey and the metropolitan areas of New York, out of network utilization continues to grow. Geo-access reporting consistently demonstrates well over 90% provider access within 5 miles, indicating the Fund's membership has access to quality provider networks at reasonable in-network reimbursement levels. Limited out-of-pocket maximums and generous fee schedules are contributing to this unusual trend.

The maps below illustrate the Fund's in-network and out of network costs in the Metropolitan Fund's primary service areas as well as the breadth of the Fund's current provider network.

In-Network vs. Out of Network Costs in Primary Service Areas



In-Network Providers in Primary Service Areas



As previously referenced and illustrated in the above map of in-network providers, geo-access reporting conducted on the Metropolitan Fund's behalf consistently demonstrates well over 90% in-network provider access and upwards of 99.5% in-network provider access to specialists within a 5-mile radius. These geo-access results are summarized in the following chart:

Metropolitan Fund Geo-Access Results (5-Mile Radius)

All Employees										
Employee		Provider	Access Results			Counts[1]			Average Distance	
Group	#	Group / Access Standard		#	%	#	P	L	1	2
All EEs	5,178	AdultPCP / 2 in 5 miles	With	5,154	99.5	844,852	264,658	108,313	0.6	0.7
		AdultPCP / 2 in 5 miles	W/o	24	0.5				4.8	6.1
		Pediatricians / 2 in 5 miles	With	5,074	98.0	331,364	90,722	38,362	0.8	1.0
		Pediatricians / 2 in 5 miles	W/o	104	2.0				6.0	6.8
		OB/GYN / 2 in 5 miles	With	5,043	97.4	183,415	41,588	25,366	1.1	1.3
		OB/GYN / 2 in 5 miles	W/o	135	2.6				6.6	7.7
		Specialists / 2 in 5 miles	With	5,173	99.9	8,676,307	1,587,180	360,750	0.3	0.4
		Specialists / 2 in 5 miles	W/o	5	0.1				5.4	6.1
		Hospitals / 1 in 5 miles	With	4,722	91.2	12,691	6,338	9,599	2.4	3.4
		Hospitals / 1 in 5 miles	W/o	456	8.8				7.5	9.5

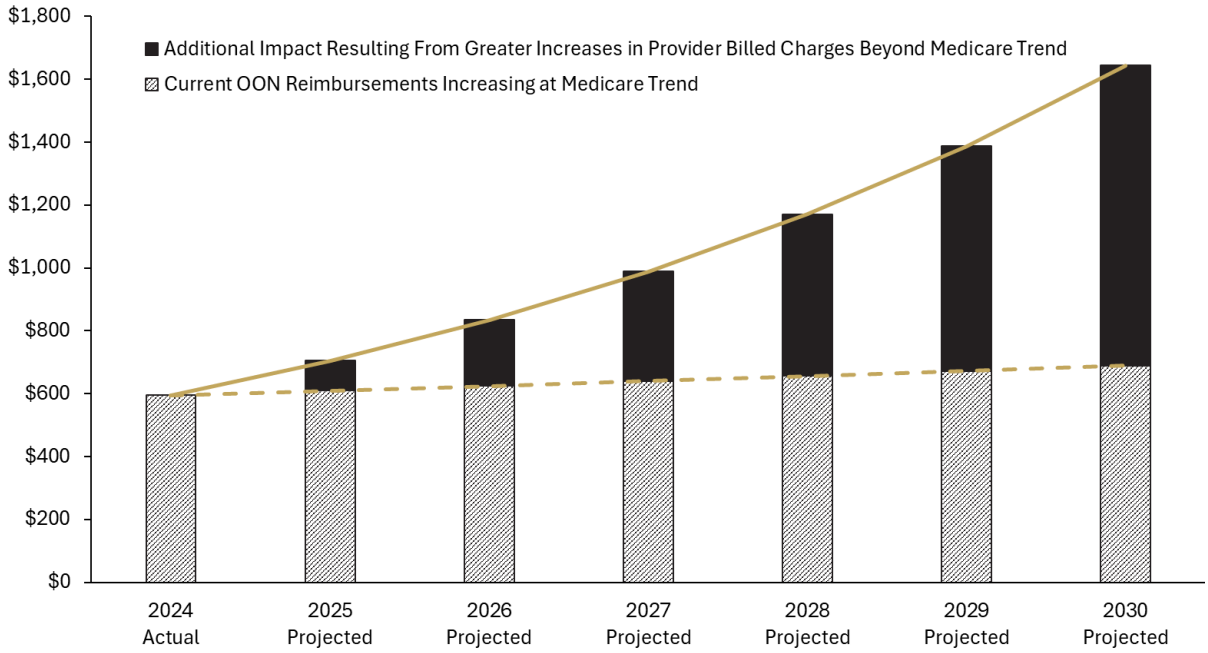
IV. The Case for a Medicare-Based Fee Schedule

The current out of network fee schedules that are paying the 90th percentile of FAIR may be valued at 300% to 350% (or more) of Medicare. These more generous fee schedules are based on billed provider charges and promote more out of network utilization resulting from predatory provider billing practices.

Not only is the billed charge and resulting reimbursement significantly higher than Medicare and in-network rates, the increase in billed charges (and, thus, the Fund's payments) compared to the more manageable and predictable Medicare-based increases is alarming and unsustainable.

For illustrative purposes, the chart below highlights two trendlines projecting the Fund's exposure to out of network cost increases through 2030. The bottom portion of the chart illustrates a reasonable expectation of increases in out of network spend through 2030 based on actual Metropolitan Fund out of network claim expenditures. The top portion of the chart represents the Fund's exposure to additional out of network cost increases over and above Medicare trend. These additional costs are avoidable and are a direct result of provider billed charges increasing at a much higher rate than Medicare. If left unchecked, these additional costs will compound and will result in unsustainable premium rate increases that may threaten the very solvency of the Metropolitan Fund.

Out of Network Reimbursements in Excess of Medicare Trend (PEPM)



Medicare is a proven and acceptable reimbursement for medical services which is often considered "reasonable and customary". Medicare payments reflect a variety of factors including but not limited to: geographic differences in costs, the complexity of the service being performed, conversion factors, and an allocation for provider profit. By offering a reimbursement which exceeds ordinary Medicare as proposed herein, providers are made more than whole for the services they perform and the Fund is better protected against egregious and unchecked increases in billed provider charges.

V. Estimated Financial Impact

To address rising out of network costs and to support the future financial stability of the Fund, an out of network reimbursement equal to 150% of Medicare must be adopted and implemented effective August 1, 2025.

Based on the Metropolitan Fund's actual paid claims for out of network services through April 2025, if fully adopted, the Fund could reduce payments on egregious and inflated out of network costs by more than $3 million per year, or approximately 5% of total medical claims spend. These out of network reimbursement savings will directly support the statutory requirements of the Fund.

VI. Out of Network Reimbursement Appeal Process

On an exception basis, plan participants will have the ability to appeal out of network reimbursements to a Third-Party Independent Review team for an additional review. The purpose of the review is to determine if the claim payment was in fact "reasonable and

customary" as compared to the established multiple of Medicare dictated by the Fund. Any request for additional review shall be sent to the Program Manager as a written request. Plan participants will have 30 days to file an appeal for an exception.

The Program Manager will conduct a preliminary review and submit to the Third-Party Independent Review team within five (5) business days of the receipt of the request for an external review. The Program Manager shall then forward an eligible, complete request for external review to the Third-Party Independent Review Team designated by the Fund who shall be required to conduct its review in an impartial, independent, and unbiased manner and in accordance with applicable law. The purpose of the review is to determine the level of reimbursement based on reasonable and customary pricing as determined using geographic differences in costs and case complexity.

The Third-Party Independent Review team shall complete the external review and provide written notice of its final reasonable and customary assessment within forty-five (45) days of the receipt of the request for the external review.

The Third-Party Independent Review team shall deliver notice of its final out of network assessment to both the claimant and to the Program Manager for all external reviews conducted.

The notice of decision shall contain:

- General description of reason for the out of network determination.
- Date of review assignment and date of the decision.
- References to the documentation and information considered.
- Discussion of the rationale for the final decision and any evidence-based standards relied upon in making the decision.

VII. Next Steps

The Fund's surplus has depleted and is operating on a "cash" basis currently. If large deficits continue, the Metropolitan Fund will run out of cash and could default. If no action is taken to address the egregious rise in out of network utilization, the Fund risks financial instability as out of network costs continue to rise unchecked.

The Metropolitan Fund has historically been proactive and decisive to mitigate the effect of disturbing trends which threaten its financial stability. While the previous actions taken by the Fund were positive steps in the right direction, a global solution is vital to the Fund's long-term financial stability and is urged to adopt an out of network reimbursement equal to 150% of Medicare.

The Metropolitan Fund is scheduled to meet on June 12th and again on July 17th.

Respectfully submitted,

Joseph DiBella, National Employee Benefits Practice Leader

Tammy Brown, Health Insurance Funds Business Lead

Brandon Lodics, PERMA Executive Director

RESOLUTION NO. 18-25

METROPOLITAN HEALTH INSURANCE FUND
RESOLUTION TO REVISE MEMBER PLAN DOCUMENTS TO REFLECT OUT OF NETWORK FEE SCHEDULE

WHEREAS, the Metropolitan Health Insurance Fund (hereinafter "the Fund") places the public trust above all else and remains steadfast in its commitment to the highest ethical standards in the conduct of its business on behalf of the taxpayers of the Fund members; and

WHEREAS, the Fund medical claims spend has increased significantly which is reducing member's retained surplus;

WHEREAS, the Fund is fiduciary and holds a contract with Aetna as a Third-Party Administrator to adjudicate claims as outlined in the member plan documents and Summary Benefits;

WHEREAS, the Executive Director and Aetna performed a review of out of network spend for member's plan documents listing the out of network fee schedule on the FAIR schedule and concluded that it is not reasonable and customary;

WHEREAS, the Executive Committee reviewed the impact of the out-of-network spend and deemed it necessary to change members with the FAIR schedule to non-facility 150% of Medicare, facility 175% of Medicare;

WHEREAS, the Executive Committee evaluated the analysis and projected savings provided by the Executive Director and Aetna and assessed changing the member plan documents, as described, and will allow the Benefits Consultant to handle participant appeals on an individual basis should there be an increase in out of pocket expenses;

NOW, THEREFORE, BE IT RESOLVED the revisions and/or corrections listed above included in this resolution be reflected in the claims adjudication system with the Third-Party Administrator and the member plan documents retroactive to August 1, 2025, and will continue indefinitely unless the savings impact is no longer achievable.

ADOPTED: June 12, 2025

BY:_____
CHAIR

ATTEST:

_____
SECRETARY