METROPOLITAN
HEALTH INSURANCE FUND

AGENDA AND REPORTS
JULY 17, 2025
ZOOM
CONFERENCE CALL
12:00 PM

ZOOM:
https://permainc.zoom.us/j/91871777522
Meeting ID: 918 7177 7522

One tap mobile
+16469313860,,91871777522# US
+19292056099,,91871777522# US (New York)

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: JULY 17, 2025
CONFERENCE CALL - ZOOM
12:00 PM

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

APPROVAL OF MINUTES
March 20, 2025 Open ..... **Appendix I**
June 12, 2025 Open ..... **Appendix I**

CORRESPONDENCE – None

EXECUTIVE DIRECTOR – PERMA – Brandon Lodics
Executive Director's Report ..... **Page 4**
Resolution 19-25: Approval of the 2024 Fund Audit ..... **Page 14**
Resolution 20-25: Change to QPA Threshold ..... **Page 17**
Resolution 21-25: Appointing the Deputy Treasurer ..... **Page 18**

PROGRAM MANAGER – PERMA – Crystal Bailey
Executive Director's Report ..... **Page 20**

FUND COODINATOR – Eagle Rock Management Group – Joseph DiVincenzo
Fund Coordinator's Report ..... **Page 24**

ATTORNEY – Ramon Rivera

TREASURER – Laracy Associates
Voucher List June and July 2025 ..... **Page 25**
Resolution 22-25: Approval of the June and July 2025 Bills List ..... **Page 32**

THIRD PARTY ADMINISTRATOR – Aetna – Jason Silverstein

OLD BUSINESS

NEW BUSINESS

PUBLIC COMMENT
Motion to Open
Motion to Close

MEETING ADJOURNED

Metropolitan Health Insurance Fund
Executive Director's Report
July 17, 2025

FINANCES

PRO FORMA REPORTS

- **Fast Track Financial Reports –** As of April and May 2025 (page 9)
  - **Historical Income Statement**
  - **Consolidated Balance Sheet**
  - **Indices and Ratios Report**

2024 FUND YEAR AUDIT

The 2024 Fund Year Audit will be ready for review at the meeting. A request to extend the filing due date to July 1, 2025 was sent to the State.

A representative from Donohue, Gironda, Doria and Tomkins LLC will be in attendance to review the financial statements. A draft has been sent with this agenda, although a final version may be presented.

Resolution 19-25 is included in the agenda with an affidavit for all signature of all present commissioners.

NO SURPRISES ACT LEGISLATION CLAIMS

Row Labels	Sum of Arb Fee	Sum of Admin Fee	Sum of Arb Decision Amount	Count of Arb Decision/Result
Closed by IDRE Due to Incorrect Batching				1
Dismissed	$4,558.00	$2,070.00		32
Loss	$34,821.00	$7,015.00	$1,596,553.03	63
Rebutted	$4,703.00	$1,035.00		14
Summary Judgment	$15,335.00	$3,220.00	$674,209.52	33
Win	$2,441.00	$575.00		5
Withdrawn	$1,875.00	$345.00		3
(blank)	$22,808.00	$5,290.00		
Grand Total	**$86,541.00**	**$19,550.00**	**$2,270,762.55**	**151**

The No Surprises Act (NSA) took effect January 1, 2022, and was designed to protect patients from surprise medical bills, particularly in emergency and out-of-network (OON) situations. While successful in curbing balance billing for consumers, the implementation of the law has led to significant unintended consequences for employer-sponsored health plans, particularly those that are self-funded. The Independent Dispute Resolution (IDR) process, a core element of the NSA, has been marked by high volume, provider-favorable outcomes, and substantial administrative burdens. This summary outlines the law's mechanics, its financial and operational impact on employers, and the urgent need for reform.

Understanding the NSA and the IDR Process - Under the NSA, when a patient receives OON emergency care or services from ancillary providers at in-network facilities, the provider and health plan must negotiate reimbursement without billing the patient beyond in-network cost sharing. If no agreement is reached, either party may initiate the IDR process, wherein a certified arbitrator selects one party's proposed payment. Initially, the "Qualified Payment Amount" (QPA) was intended to serve as the primary benchmark in IDR cases. The QPA represents the median in-network rate for a service in a geographic area. However, legal challenges and court rulings have allowed arbitrators to weigh other factors more heavily, such as provider experience and case complexity. Right or wrong, this has diluted the intended cost-containment role of the QPA.

The Disproportionate Impact on Employers Plan Sponsors – Employers and Plan Sponsors, and particularly those with self-funded plans, are bearing the brunt of NSA-related cost increases. The financial impact arises from both the direct cost of arbitration awards and the indirect administrative expenses tied to compliance and dispute resolution. Here are some data points that put the added costs into perspective:

1. **Provider-Favored Arbitration Outcomes**
   - Providers win an estimated 85% of emergency-related IDR cases.
   - Average payment awards in these cases are roughly 2.7x the QPA, with some cases reaching as high as 4x Medicare rates.

2. **High Prevalence of Emergency Room Disputes**
   - Approximately two-thirds of all IDR disputes relate to emergency services.
   - From Q1 2023 to Q2 2024, about 1.24 million surprise billing disputes were filed, over 40% of which resulted in arbitration.

3. **Escalating Employer Costs Consider a 'mid-sized' self-funded employer encountering 200 ER-related IDR cases annually (examples):**
   - QPA (benchmark): $600
   - Typical Award: $1,620 (2.7x the QPA)
   - Incremental Cost/Case: $1,020

IMPACT:
   - Annual Impact: $204,000 in additional claims cost
   - IDR Fees: $315 to $1,300 per case = $63,000 to $260,000 annually

4. National Cost Exposure
   - With an estimated 500,000 ER-related disputes resolved over 15 months, total added cost to the system could be as much as $500 million to $700 million annually.
   - Administrative and certified IDR entity fees alone add another $105 million or more.

5. Administrative Burden and Compliance Risk
   - Employers must ensure TPAs comply with IDR timelines and manage disputes. The costs of which are simply passed back to the employer.
   - Compliance involves tracking QPAs, submitting documentation, and responding within strict timeframes.

- Legal volatility due to shifting federal court rulings has made consistent compliance difficult.

NSA Reform Proposals - There is growing recognition of the strain NSA has placed on employers and plan sponsors. Legislative and regulatory proposals are emerging from Congress and the administration. HR 9572 in the US House offers a series of fixes intended to rein in payments that are far more than the QPA that lead to increased financial exposure to self-funded plans.

QPA THRESHOLD

The State Treasurer recently increased the minimum bid threshold to $53,000 for bids using a QPA. The Fund QPA recommended Resolution 20-25 for action to recognize this change.

DEPUTY TREASURER

The Fund Treasurer has recommended appointing a Deputy Treasurer to provide backup support for ACH transfers and other Treasurer responsibilities. This role would also ensure the continued monitoring of cash and receivables during any absence of the Treasurer. The fund received four quotes and the Fund Treasurer is recommending Derek Maccia for deputy treasurer due to pricing and experience.

Resolution 21-25 is included on page 18

METRO RUN OUT - PARTIAL RECONCILIATION

When the Metropolitan HIF separated from the BMED on 1/1/2024, the BMED retained funds to allow for the run out of claims still coming out of the BMED operating account on behalf of the Metro members. The Fund received $200,000 in May. After additional run out and MRHIF receivables, the BMED will perform a final reconciliation.

MRHIF UPDATE

The MRHIF met twice since the last meeting. Commissioner Cox was in attendance.

The following action items were taken:

1. Final Audit was approved and filed with the State. There were no comments or recommendations
2. An almost $7M dividend was released. A portion of the BMED amount belongs to the METRO members and will be included in the runout payable from the BMED.

COOPERATIVE PURCHASING SYSTEM – MEDICAL THIRD-PARTY ADMINISTRATOR (TPA) BID

After months of discussion with the Office of the State Comptroller, the Health Insurance Cooperative Purchasing System (HICPS) is preparing Medical TPA prequalification regulations that must be presented and adopted at a public hearing prior to bid release. On June 19th, the local

Fund HICPS representatives held a meeting to review and discuss the regulations, which a BMED representative was in attendance.

A public hearing was held on July 1st at 3:00 PM via Zoom. This hearing specifically allowed the opportunity to comment, review, and adopt the prequalification regulations which will be used to determine qualified bidders for the Medical TPA bid specification for all Funds within the HICPS.

A certified copy of the prequalification regulations was filed with the Division of Local Government Services and recently approved. The final approval is with the Office of the State Comptroller. Once released, the responses from the prospective bidders will be reviewed and those that are determined to be qualified bidders will receive the bid specifications for the TPA services.

The final evaluation will be reviewed by the Cooperative representatives from each local Fund then recommend the contract award in early Fall.

PCORI AND A4 SURCHARGE FEES

The PCORI is an independent, nonprofit research organization that seeks to empower patients and others with actionable information about their health and healthcare choices.

As part of the Affordable Care Act (ACA) group health plans are required to pay an annual fee, which is a certain dollar amount per enrollee contributing to the PCORI effort. The fee is considered in the Fund's budget development and paid by the PERMA Accounting team on behalf of all our medical groups. This fee will be paid in July.

In addition, all School Board members that are not in the State Health Benefits Fund are surcharged for retiree benefits. The Fund has one School Board that the Fund will pay this fee in July on its behalf, which was included in its rates upon joining the Fund.

MEL/MRHIF EDUCATIONAL SEMINAR FOLLOW UP PRESENTATION

On June 5th, Joe DiBella and Tammy Brown, from Conner Strong & Buckelew, hosted a second webinar presentation following the MEL/MRHIF Education Seminar. The discussion focused on newer, material cost drivers for GLP-1 medications and the rising out of-of-network providers experienced by the public sectors. The presentation was sent out as an attachment to the agenda. If you were not able to attend, the recording can be viewed by clicking here or visiting the METRO website.

INDEMNITY AND TRUST AGREEMENTS

PERMA sent Indemnity and Trust Agreements and Resolutions to be adopted by the governing bodies to renew membership with the Fund for an additional 3 years. Below is a list of members who have renewing agreements have expired. Please reach out to

hifadmin@permainc.com for a blank form to be executed. The list was last updated on May 5, 2025.

MEMBER	I&T Agreement Expiration
Plainfield BOE	6/30/2024
Morristown	6/30/2025
Millburn	12/31/2025

IMPORTANT FUND INFORMATION
Website: www.metrohif.com
W-9: Appendix II
Address: 9 Campus Drive, Suite 216, Parsippany, NJ 07054
EIN: 93-4065414
HIF Admin: hifadmin@permainc.com

METRO MUNICIPAL EMPLOYEE BENEFITS FUND

FINANCIAL FAST TRACK REPORT

AS OF April 30, 2025

			THIS MONTH	*YTD CHANGE*	*PRIOR YEAR END*	*FUND BALANCE*
1.	**UNDERWRITING INCOME**		**7,304,039**	**28,612,663**	**207,950,683**	**236,563,346**
2.	**CLAIM EXPENSES**					
	Paid Claims		8,209,760	25,790,967	180,131,885	**205,922,852**
	IBNR		123,254	715,052	6,202,000	**6,917,052**
	Less Specific Excess		268,276	(267,328)	(5,740,079)	**(6,007,407)**
	Less Aggregate Excess		-	-	-	**-**
	TOTAL CLAIMS		**8,601,289**	**26,238,691**	**180,593,806**	**206,832,497**
3.	**EXPENSES**					
	MA & HMO Premiums		1,018,093	4,005,692	15,510,298	**19,515,990**
	Excess Premiums		212,567	845,622	3,986,606	**4,832,228**
	Administrative		468,017	1,934,068	11,349,468	**13,283,536**
	TOTAL EXPENSES		**1,698,677**	**6,785,382**	**30,846,371**	**37,631,754**
4.	**UNDERWRITING PROFIT/(LOSS) (1-2-3)**		(2,995,927)	(4,411,411)	(3,489,494)	**(7,900,905)**
5.	**INVESTMENT INCOME**		19,762	97,523	603,103	**700,626**
6.	**DIVIDEND INCOME**		-	-	-	**-**
7.	**STATUTORY PROFIT/(LOSS) (4+5+6)**		**(2,976,165)**	**(4,313,887)**	**(2,886,391)**	**(7,200,279)**
8.	**DIVIDEND**		-	-	-	**-**
9.	**Transferred Surplus IN**		-	-	-	**-**
10.	**Transferred Surplus OUT**		-	-	-	**-**
	STATUTORY SURPLUS (7-8+9)		**(2,976,165)**	**(4,313,887)**	**(2,886,391)**	**(7,200,279)**
			SURPLUS (DEFICITS) BY FUND YEAR			
	Closed	**Surplus**	1,014	(12,921)	6,445,636	**6,432,715**
		Cash	1,059	27,532	6,399,926	**6,427,458**
	2023	**Surplus**	(74,568)	(180,639)	(6,529,177)	**(6,709,816)**
		Cash	118,375	(90,865)	(5,462,067)	**(5,552,932)**
	2024	**Surplus**	(1,755,583)	(3,042,359)	(2,802,851)	**(5,845,209)**
		Cash	(1,667,252)	(8,589,180)	2,904,238	**(5,684,942)**
	2025	**Surplus**	(1,147,028)	(1,077,969)		**(1,077,969)**
		Cash	(956,489)	9,519,597		**9,519,597**
	TOTAL SURPLUS (DEFICITS)		**(2,976,165)**	**(4,313,887)**	**(2,886,392)**	**(7,200,279)**
	TOTAL CASH		**(2,504,307)**	**867,085**	**3,842,097**	**4,709,181**
			CLAIM ANALYSIS BY FUND YEAR			
	TOTAL CLOSED YEAR CLAIMS		**1,953**	**38,577**	**52,434,149**	**52,472,727**
	FUND YEAR 2023					
	Paid Claims		73,163	404,746	65,699,417	**66,104,163**
	IBNR		-	-	-	**-**
	Less Specific Excess		1,680	(221,722)	(3,609,371)	**(3,831,092)**
	Less Aggregate Excess		-	-	-	**-**
	TOTAL FY 2023 CLAIMS		**74,843**	**183,024**	**62,090,046**	**62,273,070**
	FUND YEAR 2024					
	Paid Claims		1,798,596	8,686,003	60,757,659	**69,443,662**
	IBNR		(310,100)	(5,581,800)	6,202,000	**620,200**
	Less Specific Excess		266,596	(45,606)	(890,049)	**(935,655)**
	Less Aggregate Excess		-	-	-	**-**
	TOTAL FY 2024 CLAIMS		**1,755,092**	**3,058,597**	**66,069,610**	**69,128,207**
	FUND YEAR 2025					
	Paid Claims		6,336,048	16,661,641		**16,661,641**
	IBNR		433,354	6,296,852		**6,296,852**
	Less Specific Excess		-	-		**-**
	Less Aggregate Excess		-	-		**-**
	TOTAL FY 2025 CLAIMS		**6,769,402**	**22,958,492**		**22,958,492**
	COMBINED TOTAL CLAIMS		**8,601,289**	**26,238,691**	**180,593,806**	**206,832,497**

This report is based upon information which has not been audited nor certified by an actuary and as such may not truly represent the condition of the fund.

METRO MUNICIPAL EMPLOYEE BENEFITS FUND

FINANCIAL FAST TRACK REPORT

AS OF May 31, 2025

			THIS MONTH	YTD CHANGE	PRIOR YEAR END	FUND BALANCE
1.	**UNDERWRITING INCOME**		**7,284,013**	**35,896,676**	**207,950,683**	**243,847,359**
2.	**CLAIM EXPENSES**					
	Paid Claims		8,059,501	33,850,468	180,131,885	**213,982,353**
	IBNR		69,543	784,595	6,202,000	**6,986,595**
	Less Specific Excess		-	(267,328)	(5,740,079)	**(6,007,407)**
	Less Aggregate Excess		-	-	-	**-**
	TOTAL CLAIMS		**8,129,044**	**34,367,735**	**180,593,806**	**214,961,541**
3.	**EXPENSES**					
	MA & HMO Premiums		1,000,717	5,006,409	15,510,298	**20,516,707**
	Excess Premiums		211,778	1,057,400	3,986,606	**5,044,006**
	Administrative		495,590	2,429,658	11,349,468	**13,779,125**
	TOTAL EXPENSES		**1,708,085**	**8,493,467**	**30,846,371**	**39,339,838**
4.	**UNDERWRITING PROFIT/(LOSS) (1-2-3)**		(2,553,116)	(6,964,526)	(3,489,494)	**(10,454,020)**
5.	**INVESTMENT INCOME**		18,409	115,933	603,103	**719,035**
6.	**DIVIDEND INCOME**		-	-	-	**-**
7.	**STATUTORY PROFIT/(LOSS) (4+5+6)**		**(2,534,706)**	**(6,848,594)**	**(2,886,391)**	**(9,734,985)**
8.	**DIVIDEND**		-	-	-	**-**
9.	**Transferred Surplus IN**		-	-	-	**-**
10.	**Transferred Surplus OUT**		-	-	-	**-**
	STATUTORY SURPLUS (7-8+9)		**(2,534,706)**	**(6,848,594)**	**(2,886,391)**	**(9,734,985)**
			SURPLUS (DEFICITS) BY FUND YEAR			
	Closed	**Surplus**	(177,364)	(190,284)	6,445,636	**6,255,352**
		Cash	(177,425)	(149,893)	6,399,926	**6,250,034**
	2023	**Surplus**	(97,329)	(277,968)	(6,529,177)	**(6,807,145)**
		Cash	(296,851)	(387,716)	(5,462,067)	**(5,849,783)**
	2024	**Surplus**	(1,032,980)	(4,075,339)	(2,802,851)	**(6,878,189)**
		Cash	(1,460,643)	(10,049,824)	2,904,238	**(7,145,586)**
	2025	**Surplus**	(1,227,034)	(2,305,003)		**(2,305,003)**
		Cash	873,798	10,393,396		**10,393,396**
	TOTAL SURPLUS (DEFICITS)		**(2,534,706)**	**(6,848,594)**	**(2,886,392)**	**(9,734,985)**
	TOTAL CASH		**(1,061,121)**	**(194,037)**	**3,842,097**	**3,648,060**
			CLAIM ANALYSIS BY FUND YEAR			
	TOTAL CLOSED YEAR CLAIMS		**181,127**	**219,704**	**52,434,149**	**52,653,853**
	FUND YEAR 2023					
	Paid Claims		97,677	502,423	65,699,417	**66,201,840**
	IBNR		-	-	-	**-**
	Less Specific Excess		-	(221,722)	(3,609,371)	**(3,831,092)**
	Less Aggregate Excess		-	-	-	**-**
	TOTAL FY 2023 CLAIMS		**97,677**	**280,701**	**62,090,046**	**62,370,748**
	FUND YEAR 2024					
	Paid Claims		1,170,518	9,856,522	60,757,659	**70,614,180**
	IBNR		(155,050)	(5,736,850)	6,202,000	**465,150**
	Less Specific Excess		-	(45,606)	(890,049)	**(935,655)**
	Less Aggregate Excess		-	-	-	**-**
	TOTAL FY 2024 CLAIMS		**1,015,468**	**4,074,066**	**66,069,610**	**70,143,675**
	FUND YEAR 2025					
	Paid Claims		6,610,178	23,271,819		**23,271,819**
	IBNR		224,593	6,521,445		**6,521,445**
	Less Specific Excess		-	-		**-**
	Less Aggregate Excess		-	-		**-**
	TOTAL FY 2025 CLAIMS		**6,834,772**	**29,793,264**		**29,793,264**
	COMBINED TOTAL CLAIMS		**8,129,044**	**34,367,735**	**180,593,806**	**214,961,540**

This report is based upon information which has not been audited nor certified by an actuary and as such may not truly represent the condition of the fund.

METRO HEALTH INSURANCE FUND

RATIOS

							FY2025
INDICES	**2024**	**JAN**	**FEB**	**MAR**	**APR**	**MAY**	**JUN**
Cash Position	3,842,097	$ 6,460,472	$ 7,124,681	$ 7,213,488	$ 4,709,181	$ 3,648,060	
IBNR	6,202,000	$ 6,379,664	$ 6,567,209	$ 6,793,798	$ 6,917,052	$ 6,986,595	
Assets	5,041,139	$ 4,666,942	$ 5,010,026	$ 4,759,502	$ 1,982,800	$ (427,505)	
Liabilities	7,927,531	$ 8,444,978	$ 8,687,019	$ 8,983,617	$ 9,183,079	$ 9,307,480	
Surplus	(2,886,392)	$ (3,778,036)	$ (3,676,994)	$ (4,224,114)	$ (7,200,279)	$ (9,734,985)	
Claims Paid -- Month	6,252,986	$ 6,353,824	$ 5,319,100	$ 5,908,283	$ 8,209,760	$ 8,059,501	
Claims Budget -- Month	4,614,842	$ 5,324,120	$ 5,465,452	$ 5,465,942	$ 5,474,485	$ 5,479,557	
Claims Paid -- YTD	72,784,814	$ 6,353,824	$ 11,672,924	$ 17,581,207	$ 25,790,967	$ 33,850,468	
Claims Budget -- YTD	62,899,992	$ 5,324,120	$ 10,789,572	$ 16,231,412	$ 21,709,638	$ 27,183,256	
RATIOS							
Cash Position to Claims Paid	0.61	1.02	1.34	1.22	0.57	0.45	
Claims Paid to Claims Budget -- Month	1.35	1.19	0.97	1.08	1.5	1.47	
Claims Paid to Claims Budget -- YTD	1.16	1.19	1.08	1.1	1.2	1.3	
Cash Position to IBNR	0.62	1.01	1.08	1.06	0.68	0.52	
Assets to Liabilities	0.64	0.55	0.58	0.53	0.22	-0.05	
Surplus as Months of Claims	(0.63)	(0.71)	(0.67)	-0.77	-1.32	-1.78	
IBNR to Claims Budget -- Month	1.34	1.20	1.20	1.24	1.26	1.28	

METRO Fund
2025 Budget Report
as of May 31, 2025

	Cumulative	Annualized	Latest filed	Cumulative	$ Variance	% Variance
Expected Losses				Expensed		
Medical Claims Aetna	25,419,828	62,520,313	53,539,937	27,850,746	(2,430,918)	-10%
Prescription Claims - Excl Bloomfield	1,655,576	4,007,975	1,961,095	1,362,248	(199,463)	-17%
Prescription Formulary Rebates	(529,784)	(1,282,554)	(627,550)	Included Above in Prescription Claims		
Prescription Claims - Bloomfield	36,993	88,664	87,552	Included Above in Prescription Claims		
Dental Claims	600,642	1,514,641	1,023,681	580,271	20,372	3%
Subtotal	27,183,256	66,849,039	55,984,715	29,793,264	(2,610,008)	-10%
HMO/DMO Premiums	14,636	34,302	27,646	25,638	(11,002)	-75%
Medicare Advantage / EGWP	4,993,774	12,069,652	9,304,294	4,980,772	13,002	0%
Reinsurance						
Specific	1,058,540	2,551,861	2,158,296	1,057,400	1,140	0%
Total Loss Fund	33,250,205	81,504,854	67,474,950	35,857,073	(2,606,868)	-8%
Surplus Retention Regeneration	333,333	800,000	800,000	0	333,333	0%
Expenses						
Legal	12,750	30,600	30,600	7,050	5,700	45%
Treasurer	9,308	22,338	22,338	11,250	(1,943)	-21%
Administrator/Benefits Consultant	389,124	939,191	793,661	388,581	543	0%
Risk Management Consultants	763,441	1,845,687	1,553,293	758,927	4,514	1%
Fund Coordinator	387,170	937,335	748,272	386,554	616	0%
TPA - Claims Agent Aetna	477,287	1,150,614	1,021,816	476,773	514	0%
Dental TPA	31,486	79,495	48,737	31,433	53	0%
Actuary	7,438	17,850	17,850	7,434	4	0%
Auditor	9,350	22,440	22,440	9,350	-	0%
Benefits Consultant						
Board Advisor						
Claims Audit	16,667	40,000	40,000	13,332	3,335	20%
Medicare Advantage Implementation	0	0	0	0	-	
Subtotal Expenses	2,104,020	5,085,550	4,299,008	2,090,683	13,336	1%
Miscelleneous and Special Services						
Misc/Cont	7,520	18,048	18,048	4,483	3,037	40%
Wellness, Disease, Case Management	41,667	100,000	100,000	34,104	7,563	18%
Affordable Care Act Taxes	6,491	15,649	13,235	6,462	29	0%
A4 Surcharge	266,306	667,132	638,598	265,950	356	0%
Plan Documents	4,167	10,000	10,000	0	4,167	100%
Subtotal Misc/Sp Svcs	326,150	810,828	779,881	310,999	15,151	5%
Total Expenses	2,430,170	5,896,378	5,078,888	2,401,683	28,487	1%
Total Budget	36,013,709	88,201,232	73,353,839	38,258,756	(2,245,047)	-6%

Metro Municipal Employee Benefits Fund

CONSOLIDATED BALANCE SHEET

AS OF MAY 31, 2025

BY FUND YEAR

	METRO 2025	METRO 2024	METRO 2023	CLOSED YEAR	FUND BALANCE
ASSETS					
Cash & Cash Equivalents	10,393,396	(7,145,586)	(5,849,783)	6,250,034	3,648,060
Assesstments Receivable (Prepaid)	(4,838,285)	(279,096)	168,984	2,542	(4,945,854)
Interest Receivable	-	-	(472)	2,776	2,304
Specific Excess Receivable	-	194,009	-	-	194,009
Aggregate Excess Receivable	-	-	70,943	-	70,943
Dividend Receivable	-	-	-	-	-
Prepaid Admin Fees	1,487	-	-	-	1,487
Other Assets	401,546	1,396,818	(1,196,818)	-	601,546
Total Assets	5,958,144	(5,833,855)	(6,807,145)	6,255,352	(427,505)
LIABILITIES					
Accounts Payable	389,208	255,296	-	-	644,503
IBNR Reserve	6,521,445	465,150	-	-	6,986,595
A4 Retiree Surcharge	265,950	301,888	-	-	567,838
Dividends Payable	-	-	-	-	-
Retained Dividends	-	-	-	-	-
Accrued/Other Liabilities	1,086,544	22,000	-	-	1,108,544
Total Liabilities	8,263,147	1,044,334	-	-	9,307,480
EQUITY					
Surplus / (Deficit)	(2,305,003)	(6,878,189)	(6,807,145)	6,255,352	(9,734,985)
Total Equity	(2,305,003)	(6,878,189)	(6,807,145)	6,255,352	(9,734,985)
Total Liabilities & Equity	5,958,144	(5,833,855)	(6,807,145)	6,255,352	(427,505)
BALANCE	-	-	-	-	(0)

This report is based upon information which has not been audited nor certified by an actuary and as such may not truly represent the condition of the fund.

Fund Year allocation of claims have been estimated.

7-Apr-25

RESOLUTION NO. 19-25

METROPOLITAN HEALTH INSURANCE FUND
CERTIFICATION OF ANNUAL AUDIT REPORT FOR
PERIOD ENDING DECEMBER 31, 2024

WHEREAS, N.J.S.A. 40A:5-4 requires the governing body of every local unit to have made an annual audit of its books, accounts and financial transactions, and

WHEREAS, the Annual Report of Audit for the year 2024 has been filed by the appointed Fund Auditor with the Secretary of the Fund as per the requirements of N.J.S.A. 40A:5-6 and N.J.S.A. 40A:10-36, and a copy has been received by each Fund Commissioner, and

WHEREAS, the Local Finance Board of the State of New Jersey is authorized to prescribe reports pertaining to the local fiscal affairs, as per R.S. 52:27BB-34, and

WHEREAS, the Local Finance Board has promulgated a regulation requiring that the Fund Commissioners of the Fund shall, by resolution, certify to the Local Finance Board of the State of New Jersey that all Fund Commissioners have reviewed, as a minimum, the sections of the annual audit entitled:

General Comments
and
Recommendations

, and

WHEREAS, the Fund Commissioners have personally reviewed, as a minimum, the Annual Report of Audit, and specifically the sections of the Annual Audit entitled:

General Comments
and
Recommendations

as evidenced by the group affidavit form of the Fund Commissioners.

WHEREAS, such resolution of certification shall be adopted by the Fund Commissioners no later than forty-five days after the receipt of the annual audit, as per the regulations of the Local Finance Board, and

WHEREAS, all Fund Commissioners have received and have familiarized themselves with, at least, the minimum requirements of the Local Finance Board of the State of New Jersey, as stated aforesaid and have subscribed to the affidavit, as provided by the Local Finance Board, and

WHEREAS, failure to comply with the promulgations of the Local Finance Board of the State of New Jersey may subject the Fund Commissioners to the penalty provisions of R.S. 52:27BB-52 - to wit:

> R.S. 52:27BB-52 - "A local officer or member of a local governing body who, after a date fixed for compliance, fails or refuses to obey an order of the director (Director of Local Government Services), under the provisions of this Article, shall be guilty of a misdemeanor and, upon conviction, may be fined not more than one thousand dollars ($1,000.00) or imprisoned for not more than one year, or both, in addition shall forfeit his office."

NOW, THEREFORE, BE IT RESOLVED, that the Executive Committee hereby states that they have complied with the promulgation of the Local Finance Board of the State of New Jersey, dated July 30, 1968, and does hereby submit a certified copy of this resolution and the required affidavit to said Board to show evidence of said compliance.

ADOPTED: JULY 17, 2025

BY:

_____

CHAIRPERSON

ATTEST:

_____

SECRETARY

GROUP AFFIDAVIT FORM
CERTIFICATION OF FUND COMMISSIONERS
Of the
METROPOLITAN HEALTH INSURANCE FUND

We, the Fund Commissioners of the Metropolitan Health Insurance Fund, of full age, being duly sworn according to law, upon our oath depose and say:

1. We are duly elected members Fund Commissioners of the Metropolitan Health Insurance Fund
2. In the performance of our duties, and pursuant to the Local Finance Board Regulation, we have familiarized ourselves with the contents of the Annual Fund Audit filed with the Secretary of the Fund pursuant to N.J.S.A. 40A:5-6 and N.J.S.A. 40A:10-36 for the year 2024
3. We certify that we have personally reviewed and are familiar with, as a minimum, the sections of the Annual Report of Audit entitled:

GENERAL COMMENTS - RECOMMENDATIONS

_____ (L.S.)

_____ (L.S.)

_____ (L.S.)

_____ (L.S.)

_____ (L.S.)

_____ (L.S.)

_____ (L.S.)

Attest:

_____
Secretary to the Fund

The Secretary of the Fund shall set forth the reason for the absence of signature of any members of the Executive Committee.
Important: This certificate must be sent to the Division of Local Government Services, CN 803, Trenton, NJ 08625.

RESOLUTION NO. 20-25

METROPOLITAN HEALTH INSURANCE FUND
RESOLUTION TO INCREASE BID THRESHOLD

WHEREAS, pursuant to *N.J.S.A.* 40A:1 l -3, the State Treasurer increased the minimum bid threshold to $53,000.00 for the execution of contracts without public bid by the Qualified Purchasing Agent when said contracts do not exceed $53,000.00 in aggregate for the contract year in those municipalities whose purchasing agents possess a Qualified Purchasing Agent (QPA) certificate awarded by the Division of Local Government Services; and

WHEREAS, as a result the new quote threshold for the above noted municipalities with a Qualified Purchasing Agent (QPA) is now $7,950.00 (15% of the $53,000 QPA bid threshold); and

WHEREAS, the Metropolitan Health Insurance Fund has had an appointed Qualified Purchasing Agent (QPA) as required under *N.J.S.A.* 40A:11-3 and in accordance with *N.J.S.A* 40A:l1-9; and

WHEREAS, the Metropolitan Health Insurance Fund finds it is in the interest of efficiency and economy for the Metropolitan Health Insurance Fund to continue with the increase in the bid threshold and as a result the quote threshold, pursuant to *N.J.S.A.* 40A:11-3; and.

NOW, THEREFORE, BE IT RESOLVED by the Metropolitan Health Insurance Fund, pursuant to *N.J.S.A.* 40A:11-3, that its bid threshold is increased to $53,000.00 and as a result the quote threshold shall be $7,950.00.

BE IT FURTHER RESOLVED, that such contracts as may be awarded under this Resolution shall comply with all other applicable laws, including but not limited to certification of funds by the Chief Financial Officer where required.

ADOPTED: JULY 17, 2025

BY:_____
CHAIRPERSON

ATTEST:

_____
SECRETARY

RESOLUTION NO. 21-25

METROPOLITAN HEALTH INSURANCE FUND
RESOLUTION APPOINTING A DEPUTY FUND TREASURER

WHEREAS the Metropolitan Health Insurance Fund ("Fund") has determined that there exists a need for contract with a Deputy Fund Treasurer as a non-fair and open contract pursuant to the provisions of NJSA 19:44A-20.4-20.5; and

WHEREAS the Fund Treasurer has determined and certified that the value of the services will exceed $17,500; and

WHEREAS Derek Maccia, holds a New Jersey Certified CMFO license, has shown interest in accepting the Deputy Fund Treasurer contract at a fee of $7,500 per year ($625 per month), and has not made any reportable contributions to a political or candidate committee in the previous one year, and that the contract will prohibit Mr. Maccia from making any reportable contributions through the term of the contract; and

WHEREAS the Fund Treasurer hereby certifies that funds are available in the amount of $7,500 for the deputy treasurer services;

NOW THEREFORE BE IT RESOLVED that the Metropolitan Health Insurance Fund hereby appoint Derek Maccia as the Deputy Fund Treasurer and award a Professional Services Agreement effective August 1, 2025, until December 31, 2026; and

BE IT FURTHER RESOLVED that the Determination of Value be placed on file with the resolution; and

BE IT FURTHER RESOLVED that notification of this contract award shall be published in the Star Ledger as required by R.S. 18A:18A-5 (a)(2).

ADOPTED: JULY 17, 2025

BY:_____
CHAIRPERSON

ATTEST:

_____
SECRETARY

METROPOLITAN HEALTH INSURANCE FUND
YEAR: 2025

Monthly Items	Filing Status
Budget	**Filed**
Assessments	**Filed**
Actuarial Certification	**Filed**
Reinsurance Policies	**Filed**
Fund Commissioners	**Filed**
Fund Officers	**Filed**
Renewal Resolutions	**Filed**
Indemnity and Trust	**Filed**
New Members	**Filed as New Members are approved**
Withdrawals	**Filed as Members Withdrawal**
Risk Management Plan and By Laws	**Filed**
Cash Management Plan	**Filed**
Unaudited Financials	**Filed through Q3 2024**
Annual Audit	**2024 to be filed**
Budget Changes	**N/A**
Transfers	**N/A**
Additional Assessments	**N/A**
Professional Changes	**N/A**
Officer Changes	**N/A**
RMP Changes	**N/A**
Bylaw Amendments	**N/A**
Contracts	**Filed**
Benefit Changes	**N/A**

Metropolitan Health Insurance Fund
Program Manager Report
July 2025
Program Manager: PERMA

Operational Updates:

Eligibility/Enrollment:

Please direct any eligibility, enrollment, or system related questions to our dedicated Client Services Team:

- Alexander Koch, akoch@permainc.com, 856-552-4478
- Victoria Friday: vfriday@permainc.com, 856-552-4748

System training (new and refresher) is provided to all contacts with WEX access **every 3rd Wednesday at 10AM**. Please contact HIFtraining@permainc.com for additional information or to request an invite.

In the subject line of the email, please include ***Training – Fund Name and Client Name***. Please be sure to add the date of the training you would like to attend in your email so an invite can be sent.

WEX:

WEX COBRA/Direct Bill Administration Update – Effective 7/1/2025

Effective July 1, 2025, WEX will be transitioning all COBRA and Direct Bill members from the BenefitExpress platform to their WEX Health Inc. (WEX) platform. WEX is a parent company of BenefitExpress and this update will ensure participants have access to their most enhanced platform, resources and support services.

Please note the following:

- Takeover/Welcome Notice to current participants will be sent starting **June 26th through July 15th (Sent by WEX)**
  - Date range reflects notices will be sent to members after their June premium payment is processed
  - The notice will include new coupons, instructions on WEX account setup and new mailing address for future payments
- Termination Notice to current participants will be sent to starting **July 7th through July 15th** (**Sent by WEX on behalf of BenefitExpress)**
  - Notices will be sent after service through BenefitExpress expires and after the participant is issued their Takeover/Welcome Notice

- Reference to the Termination Notice is mentioned in the Takeover/Welcome Notice

Please note to remain compliant both the Takeover/Welcome Notice and Termination Notice must be sent to all current participants, there is not an option to suppress the termination notice.

Attached is a sample of the Takeover/Welcome Notice that current participants will receive explaining the transition. Please note the following:

- WEX will transfer the participant's current contact information as it noted in BenefitExpress
- WEX will transfer all active ACH accounts to the new platform and are expected to complete the process by July 1st
  - If a participant signs into the portal and it still reflects the BenefitExpress logo information, their account has not yet been transitioned. They can call into WEX using the contact information on the attached to have their account updated. We recommend they allow time for the transition as the ACH will occur once the transition is complete; June payment is received and
- Participants who send their payments to WEX via US Mail will have a new remittance address to submit future payments, as outlined in the attached letter
  - We are currently confirming if July payments that have already been mailed will be transferred to the new PO Box and are being applied to participants accounts with WEX

WEX is prepared to accept calls from participants and answer questions they have related to the transition, their account set up status, payment status, etc.

PLEASE NOTE: Participants' coverages will not be terminated if they experience an issue due to the transition.

New groups joining the HIFs effective 7/1/25 and after will be on the WEX platform all other groups prior to 7/1/25 will be transitioned to the new platform as outlined above.

Coverage Updates:

Express Scrips Updates:

2025 National Preferred Formulary (NPF) and SaveOn – Effective 7/1/25

Brokers were sent the updated 2025 Formulary and Exclusions lists effective July 1, 2025, on April 23, 2025. There were 2 members in the METRO Fund impacted by the formulary change. Please reference the appendix for the updated lists . Please note the following:

NPF:

- NPF Exclusions List, please note the following:

- **Humalog** - excluded for members with a new prescription as of 1/1/25, members currently taking the drug will be excluded effective 1/1/26
    - Members should share the covered preferred alternatives provided in the list with their providers
    - The number of impacted members will be provided later in 2025

- **Humira** - excluded for members with a new prescription as of 1/1/25, members currently taking the drug will be excluded effective 7/1/25
    - Members should share the covered preferred alternatives provided in the listing with their providers

- Impacted members (2) will be notified by ESI. The notification will include covered preferred alternatives under the NPF

Encircle Program (GLP-1 Weight Loss)

Effective September 1, 2024:

- Members with new prescriptions, including renewal prescriptions for expired prior authorizations (PA), will need to meet the following criteria to be approved for a GLP-1 weight loss medication:
    - BMI $\geq$ 32 OR
    - BMI between 27 $\leq$ 32 WITH 2 or more documented comorbidities
- Members with an active approved PA prior to 9/1/2024 will be grandfathered
    - Upon renewal of their PA, members will need to meet the above BMI requirements to be considered for approval
- PA renewals will need to include documentation to support the above BMI requirements for all members, regardless of members have been approved in the past.

Effective January 1, 2025:

Members who have an approved PA (active and new) will need to meet the following guidelines:

- Members will receive a welcome kit from Omada free of charge. The kit includes a digital scale and information on downloading the mobile app and/or using the web browser. The scale is programmed to the member's ESI active account prior to delivery. The scale will record each weigh-in and will update the member's file automatically. Members must weigh-in a minimum of 4 times a month
- Members must engage with an assigned online Omada coach via a mobile application or web browser a minimum of 4 times a month

If members do not adhere to both of the requirements outlined above, the following month in which they are non-compliant, they will not be able to refill their weight loss

prescription. Members will be required to complete the missing weigh-ins and/or online coaching engagement in order to refill their prescription.

2025 LEGISLATIVE REVIEW:

Medical and Rx Reporting: None

No Surprise Billing and Transparency Act– Continued Delays

The Health Insurance Funds, including Metropolitan, protect plan members from surprise billing with involuntary out of network balance bills with a hold harmless clause:

- Example: an in-network surgeon contracts with an out of network anesthesiologist. Should the out of network anesthesiologist balance bill the patient, the Funds would hold the member harmless, paying up to the invoiced amount.

The law also imposes certain requirements on the Carriers, PBMs and healthcare providers. Many of these requirements continue to be delayed, but we will continue to work with the insurance providers to assure the Metropolitan HIF remains compliant.

- Issuing updated ID Cards with additional out of pocket information
- Providing transparency in coverage machine-readable files
- Providing price comparison tools
- Healthcare providers should work with insurance carriers to provide potential patients with good faith estimates of costs

Appeals:

Carrier Appeals: None

IRO Submissions: None

Metro Small Claims Committee Appeals: None

Prospective Client	Agency	Product		Effective Date	Note(s)
Maplewood Twp	David Balken	Dental	155	6/1/2025	Added Dental effective 6/1
North Caldwell Borough	R.D. Parisi & Associates	Medical & Pharmacy	43	10/1/2025	Client intends on joining the MHIF effective 10/1
Jersey City	R.D. Parisi & Associates	Medicare Advantage	2452	10/1/2025	Waiting on the client to advise intentions
Town of Seacaucus	TBD	Medical & Pharmacy	200	10/1/2025	Proposal received. Waiting on client to advise intentions
Fort Lee BOE	Brown&Brown	Medical & Pharmacy	425	10/1/2025	Currently with UW
South Orange /Maplewood BOE	Brown&Brown	Medical & Pharmacy	700	10/1/2025	Currently with UW

Contact Information	Title	Email		Phone
Joseph DiVincenzo	President	joed@eaglerockmg.com		856-420-2989 x4685
Diane Romano	Senior Account Manager	dianer@eaglerockmg.com		856-420-2989 x3633
Thomas Kelly	Account Manager	tom@eaglerockmg.com		856-420-2989 x3938

BERGEN MUNICIPAL EMPLOYEE BENEFITS FUND (METRO FUND)
BILLS LIST

Resolution No. _____ **MAY 2025**

WHEREAS, the Treasurer has certified that funding is available to pay the following bills:

BE IT RESOLVED that the Bergen Municipal Employee Benefit Fund's Executive Board, hereby authorizes the Fund treasurer to issue warrants in payment of the following claims; and

FURTHER, that this authorization shall be made a permanent part of the records of the Fund.

FUND YEAR 2023

VendorName	Comment	InvoiceAmount
METROPOLITAN HEALTH INS FUND	RUN OUT PARTIAL RECONCILIATION	200,000.00
		200,000.00
	Total Payments FY 2023	**200,000.00**
	TOTAL PAYMENTS ALL FUND YEARS	**200,000.00**

_____
Chairperson

Attest:

_____ Dated: _____

I hereby certify the availability of sufficient unencumbered funds in the proper accounts to fully pay the above claims.

_____
Treasurer

METROPOLITAN HEALTH INSURANCE FUND
BILLS LIST

JUNE 2025

WHEREAS, the Treasurer has certified that funding is available to pay the following bills:

BE IT RESOLVED that the Metropolitan Health Insurance Fund's Executive Board, hereby authorizes the Fund treasurer to issue warrants in payment of the following claims; and

FURTHER, that this authorization shall be made a permanent part of the records of the Fund.

FUND YEAR 2024

VendorName	Comment	InvoiceAmount
PERMA	POSTAGE 11/24	547.88
PERMA	ADMIN FEES 12/24	41,265.00
		41,812.88
PERMA	PROGRAM MANAGER 12/24	50,435.00
		50,435.00
MUNICIPAL REINSURANCE H.I.F.	SPECIFIC REINSURANCE 12/24	157,298.15
		157,298.15
	TOTAL CHECKS 2024	**249,546.03**
	Total Payments FY 2024	**249,546.03**

FUND YEAR 2025

VendorName	Comment	InvoiceAmount
WELLNESS COACHES USA LLC	VOID AND REISSUE	-9,280.00
		-9,280.00
WELLNESS COACHES USA LLC	VOID AND REISSUE	-6,844.00
		-6,844.00
THE CANNING GROUP LLC	QPA METRO 2025-06	166.67
		166.67
SOUTHERN NEW JERSEY EBF	REIMB-K. HARRIS OSC/RPF REVIEW FOR 5/25	254.90
		254.90
ANTONELLI KANTOR RIVERA	ATTORNEY FEES- 3/5/25-3/28/25 INV 21560	6,555.00
ANTONELLI KANTOR RIVERA	ATTORNEY FEES-4/9/25-4/29/25 INV 21644	1,980.00
ANTONELLI KANTOR RIVERA	ATTORNEY FEES- 3/7/25-3/28/25-INV 21561	2,715.00
ANTONELLI KANTOR RIVERA	ATTORNEY FEES-4/2/25-4/30/25 INV 21645	1,275.00
		12,525.00
WELLNESS COACHES USA LLC	WELLNESS COACHES INV 38827 03-25-2025	9,280.00
WELLNESS COACHES USA LLC	WELLNESS COACHES INV 38917 04/25/25	6,844.00
WELLNESS COACHES USA LLC	WELLNESS COACHES INV 39012 5/25/25	9,280.00
		25,404.00
ACRISURE NJ PARTNERS INS. SERVICES, LLC	BROKER FEES 06/25	58,453.62
		58,453.62
BROWN & BROWN METRO, LLC	BROKER CREDIT-MAPLEWOOD 06/25	-5,000.00
BROWN & BROWN METRO, LLC	BROKER FEES 06/25	13,648.01
		8,648.01
	TOTAL CHECKS 2025	**89,328.20**

AETNA HEALTH MANAGEMENT, LLC	MEDICARE ADVANTAGE 06/25	923,055.57
		923,055.57
UNITED HEALTHCARE INS COMPANY	MEDICARE ADVANTAGE 06/25	90,084.95
		90,084.95
DELTA DENTAL INSURANCE COMPANY	DENTAL- BE006575478 FI-7871900000 6/25	5,044.34
		5,044.34
FAIRVIEW INSURANCE AGENCY ASSOCIATES	BROKER FEES 06/25	34,833.43
		34,833.43
ACRISURE NJ PARTNERS INS. SERVICES, LLC	BROKER FEES 06/25	47,095.62
		47,095.62
EAGLE ROCK MANAGEMENT GROUP, LLC	FUND COORDINATOR 06/25	78,367.00
		78,367.00
DELTA DENTAL OF NEW JERSEY INC.	DENTAL TPA FEES 06/25	6,389.42
		6,389.42
AETNA	MEDICAL TPA FEES 06/25	96,438.06
		96,438.06
INSURANCE SOLUTIONS, INC	BROKER FEES 06/25	5,368.00
INSURANCE SOLUTIONS, INC	ONE TIME BROKER CREDIT 06/25	-5,000.00
		368.00
POINT ACCOUNTING GROUP	TREASURER FEE 06/25	2,250.00
		2,250.00
	ACH TOTALS	**1,283,926.39**
	Total Payments FY 2025	**1,373,254.59**
	TOTAL PAYMENTS ALL FUND YEAR	**1,622,800.62**

_____

Chairperson

Attest:

_____ Dated: _____

I hereby certify the availability of sufficient unencumbered funds in the proper accounts to fully pay the above claims.

_____

Treasurer

METROPOLITAN HEALTH INSURANCE FUND
BILLS LIST

JULY 2025

WHEREAS, the Treasurer has certified that funding is available to pay the following bills:

BE IT RESOLVED that the Metropolitan Health Insurance Fund's Executive Board, hereby authorizes the Fund treasurer to issue warrants in payment of the following claims; and

FURTHER, that this authorization shall be made a permanent part of the records of the Fund.

FUND YEAR 2024

VendorName	Comment	InvoiceAmount
STATE OF NJ HEALTH BENFTS FUND	2024 ACTUAL SURCHARGE 07/25	235,291.00
		235,291.00
PERMA	POSTAGE 12/24	445.87
PERMA	RETIREE FIRST-UNION 12012024	5,304.00
		5,749.87
	TOTAL 2024 CHECKS	**241,040.87**
	Total Payments FY 2024	**241,040.87**

FUND YEAR 2025

VendorName	Comment	InvoiceAmount
STATE OF NJ HEALTH BENFTS FUND	2025 ESTIMATED SURCHARGE 07/25	238,873.00
		238,873.00
THE CANNING GROUP LLC	QPA METRO 2025-07	166.67
		166.67
ANTONELLI KANTOR RIVERA	ATTORNEY- GENERAL INV 21224 FOR 02/25	7,485.00
		7,485.00
WELLNESS COACHES USA LLC	WELLNESS COACHES INV 39110 FOR 6/25	7,076.00
		7,076.00
ACRISURE NJ PARTNERS INS. SERVICES, LLC	BROKER FEES 07/25	58,106.06
		58,106.06
BROWN & BROWN METRO, LLC	BROKER FEES 07/25	16,788.44
		16,788.44
	TOTAL 2025 CHECKS	**328,495.17**
UNITED HEALTHCARE INS COMPANY	MEDICARE ADVANTAGE 07/25	90,481.80
		90,481.80
DELTA DENTAL INSURANCE COMPANY	DENTAL- BE006631681 FI-7871900000 7/25	5,168.24
		5,168.24

FAIRVIEW INSURANCE AGENCY ASSOCIATES	BROKER FEES 07/25	34,912.73
		34,912.73
ACRISURE NJ PARTNERS INS. SERVICES, LLC	BROKER FEES 07/25	46,876.92
		46,876.92
EAGLE ROCK MANAGEMENT GROUP, LLC	FUND COORDINATOR 07/25	79,481.00
		79,481.00
DELTA DENTAL OF NEW JERSEY INC.	DENTAL TPA FEES 07/25	7,388.08
		7,388.08
AETNA	TPA FEES 07/25	96,714.84
		96,714.84
INSURANCE SOLUTIONS, INC	BROKER FEES 07/25	854.00
		854.00
POINT ACCOUNTING GROUP	TREASURER FEES 07/25	2,250.00
		2,250.00
ACTUARIAL SOLUTIONS, LLC	ACTUARY FEES Q3 2025	4,460.00
		4,460.00
DEPARTMENT OF TREASURY	PCORI FEES 2025	17,808.04
		17,808.04
AETNA HEALTH MANAGEMENT, LLC	MEDICARE ADVANTAGE 07/25	926,251.05
		926,251.05
	TOTAL ACH 2025	**1,312,646.70**
	Total Payments FY 2025	**1,641,141.87**
	TOTAL PAYMENTS ALL FUND YEAR	**1,882,182.74**

_____

Chairperson

Attest:

_____ Dated: _____

I hereby certify the availability of sufficient unencumbered funds in the proper accounts to fully pay the above claims.

_____

Treasurer

CERTIFICATION AND RECONCILIATION OF CLAIMS PAYMENTS AND RECOVERIES

Metro Employee Benefits Fund

Month May
Current Fund Year 2025

Policy Year	Coverage	1. Calc. Net Paid Thru Last Month	2. Monthly Net Paid May	3. Monthly Recoveries May	4. Calc. Net Paid Thru May	5. TPA Net Paid Thru May	6. Variance To Be Reconciled	7. Delinquent Unreconciled Variance From	8. Change This Month
2025	Medical	15,327,633.31	6,191,927.16	0.00	21,519,560.47	0.00	21,519,560.47	15,327,633.31	6,191,927.16
	Dental	389,568.37	114,494.90	0.00	504,063.27	0.00	504,063.27	389,568.37	114,494.90
	Rx	1,286,164.37	394,488.80	0.00	1,680,653.17	0.00	1,680,653.17	1,286,164.37	394,488.80
	Vision	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Total	**17,003,366.05**	**6,700,910.86**	**0.00**	**23,704,276.91**	**0.00**	**23,704,276.91**	**17,003,366.05**	**6,700,910.86**

Metro Employee Benefits Fund

SUMMARY OF CASH TRANSACTIONS - ALL FUND YEARS COMBINED

Current Fund Year: 2025
Month Ending: May

	Medical	Dental	Rx	Vision	Run-In	Reinsurance	RSR	Admin	Dividend Reserve	BMED Interfund	TOTAL
OPEN BALANCE	1,239,775.10	141,531.06	(555,269.64)	0.00	0.00	1,306,069.88	517,645.42	1,184,906.14	0.00	0.00	3,834,657.96
RECEIPTS											
Assessments	7,381,136.41	139,868.56	282,103.22	0.00	0.00	254,918.42	80,413.49	572,058.62	0.00	0.00	8,710,498.72
Refunds	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Invest Pymnts	10,146.28	186.52	0.00	0.00	0.00	1,721.27	682.21	1,561.59	0.00	0.00	14,297.87
Invest Adj	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Subtotal Invest	10,146.28	186.52	0.00	0.00	0.00	1,721.27	682.21	1,561.59	0.00	0.00	14,297.87
Other *	96,585.29	0.00	96,018.58	0.00	0.00	0.00	0.00	0.00	0.00	0.00	192,603.87
TOTAL	7,487,867.98	140,055.08	378,121.80	0.00	0.00	256,639.69	81,095.70	573,620.21	0.00	0.00	8,917,400.46
EXPENSES											
Claims Transfers	7,360,264.24	116,676.30	394,488.80	0.00	0.00	0.00	0.00	0.00	0.00	0.00	7,871,429.34
Expenses	995,397.95	5,319.24	0.00	0.00	0.00	199,844.24	0.00	432,254.91	0.00	0.00	1,632,816.34
Other *	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
TOTAL	8,355,662.19	121,995.54	394,488.80	0.00	0.00	199,844.24	0.00	432,254.91	0.00	0.00	9,504,245.68
END BALANCE	**371,980.89**	**159,590.60**	**(571,636.64)**	**0.00**	**0.00**	**1,362,865.33**	**598,741.12**	**1,326,271.44**	**0.00**	**0.00**	**3,247,812.74**

SUMMARY OF CASH AND INVESTMENT INSTRUMENTS			
Metro Employee Benefits Fund			
ALL FUND YEARS COMBINED			
CURRENT MONTH		**May**	
CURRENT FUND YEAR		**2025**	
		Description:	**CHECKING**
		ID Number:	
		Maturity (Yrs)	
		Purchase Yield:	
		TOTAL for All Accts & instruments	
Opening Cash & Investment Balance		**$3,834,657.99**	**3834657.99**
Opening Interest Accrual Balance		**$0.00**	**0**
1	Interest Accrued and/or Interest Cost	$0.00	$0.00
2	Interest Accrued - discounted Instr.s	$0.00	$0.00
3	(Amortization and/or Interest Cost)	$0.00	$0.00
4	Accretion	$0.00	$0.00
5	Interest Paid - Cash Instr.s	$14,297.86	$14,297.86
6	Interest Paid - Term Instr.s	$0.00	$0.00
7	Realized Gain (Loss)	$0.00	$0.00
8	Net Investment Income	$14,297.86	$14,297.86
9	Deposits - Purchases	$8,903,102.59	$8,903,102.59
10	(Withdrawals - Sales)	-$9,504,245.68	-$9,504,245.68
Ending Cash & Investment Balance		$3,247,812.76	$3,247,812.76
Ending Interest Accrual Balance		$0.00	$0.00
Plus Outstanding Checks		$17,624.00	$17,624.00
(Less Deposits in Transit)		$0.00	$0.00
Balance per Bank		$3,265,436.76	**$3,265,436.76**

RESOLUTION NO. 22-25

METROPOLITAN HEALTH INSURANCE FUND
APPROVAL OF THE JUNE AND JULY 2025 BILLS LIST

WHEREAS, the **Metropolitan Health Insurance Fund** held a Public Meeting on **July 17, 2025** for the purposes of conducting the official business of the Fund; and

WHEREAS, The Treasurer for the Fund presented bills lists to satisfy outstanding costs incurred for operating the Fund during the month of June and July 2025 for consideration and approval of the Executive Committee and

WHEREAS, a quorum of the Commissioners was present thereby conforming with the Policies and Procedures of the Fund to conduct official business of the Fund,

NOW THEREFORE BE IT RESOLVED the of the Metropolitan Health Insurance Fund hereby approve the Bills List for June and July 2025 prepared by the Treasurer of the Fund and duly authorize and concur said bills to be paid expeditiously, in accordance with the laws and regulations promulgated by the State of New Jersey for Insurance Funds.

ADOPTED: July 17, 2025

BY:_____
CHAIRPERSON

ATTEST:

_____
SECRETARY

METRO CLAIMS

Monthly Claim Activity Report

July 17, 2025

METRO

	MEDICAL CLAIMS PAID 2024	# OF EES	PER EE	MEDICAL CLAIMS PAID 2025	# OF EES	PER EE
JANUARY	$724,016	2,682	**$ 270**	$4,688,076	2,369	**$ 1,979**
FEBRUARY	$3,974,566	2,658	**$ 1,495**	$4,919,355	2,436	**$ 2,019**
MARCH	$5,419,303	2,666	**$ 2,033**	$5,699,838	2,426	**$ 2,349**
APRIL	$6,007,197	2,624	**$ 2,289**	$7,407,692	2,431	**$ 3,047**
MAY	$4,346,049	2,630	**$ 1,652**	$7,222,409	2,434	**$ 2,967**
JUNE	$5,971,793	2,627	**$ 2,273**			
JULY	$6,220,272	2,649	**$ 2,348**			
AUGUST	$4,753,326	2,643	**$ 1,798**			
SEPTEMBER	$4,750,184	2,627	**$ 1,808**			
OCTOBER	$5,943,377	2,713	**$ 2,191**			
NOVEMBER	$5,722,476	2,719	**$ 2,105**			
DECEMBER	$6,521,762	2,118	**$ 3,079**			
TOTALS	**$60,354,319**			**$29,937,369**		
				2025 Average	**2,419**	**$ 2,472**
				2024 Average	**2,613**	**$ 1,945**

RUN OUT

	MEDICAL CLAIMS PAID 2025	# OF EES	PER EE
JANUARY	$194,623	2,369	$ 82
FEBRUARY	$106,504	2,436	$ 44
MARCH	$67,081	2,426	$ 28
APRIL	$75,116	2,431	$ 31
MAY	$278,804	2,434	$ 115
JUNE			
JULY			
AUGUST			
SEPTEMBER			
OCTOBER			
NOVEMBER			
DECEMBER			
TOTALS	**$722,127**		

Large Claimant Report (Drilldown) - Claims Over $100000

Plan Sponsor Unique ID :	All	**Paid Dates:**	04/01/2025 - 04/30/2025
Customer:	**METRO**	**Service Dates:**	01/01/2011 - 04/30/2025
Group / Control:	00232370,00232371 - METRO FUND	**Line of Business:**	All

	Paid Amt	Diagnosis/Treatment
	$249,291.77	ANEURYSM OF THE ASCENDING AORTA, RUPTURED
	$210,412.96	SPONDYLOSIS WITHOUT MYELOPATHY OR
	$193,544.70	SPINAL STENOSIS, LUMBAR REGION WITHOUT
	$170,726.29	MALIGNANT NEOPLASM OF UNSPECIFIED SITE OF
	$113,805.00	OTHER SPECIFIED DISORDERS OF BREAST
	$106,405.18	VARICOSE VEINS OF RIGHT LOWER EXTREMITY WITH
	$101,238.01	ST ELEVATION (STEMI) MYOCARDIAL INFARCTION
Total:	**$1,145,423.91**	

Large Claimant Report (Drilldown) - Claims Over $100000

Plan Sponsor Unique ID : All
Customer: **METRO**
Group / Control: 00232370,00232371 - METRO FUND

Paid Dates: 05/01/2025 - 05/31/2025
Service Dates: 01/01/2011 - 05/31/2025
Line of Business: All

	Paid Amt	Diagnosis/Treatment
	$319,483.77	ANEURYSM OF THE ASCENDING AORTA, WITHOUT RUPTURE
	$174,660.07	SPONDYLOSIS WITHOUT MYELOPATHY OR
	$152,895.97	SPONDYLOSIS WITHOUT MYELOPATHY OR
	$142,838.93	ATRIOVENTRICULAR BLOCK, COMPLETE
	$114,785.48	VARICOSE VEINS OF RIGHT LOWER EXTREMITY WITH
	$106,974.62	OTHER PULMONARY EMBOLISM WITHOUT ACUTE
	$105,623.37	ALCOHOLIC CIRRHOSIS OF LIVER WITH ASCITES
	$104,918.35	VARICOSE VEINS OF RIGHT LOWER EXTREMITY WITH
Total:	**$1,222,180.56**	

aetna™

Metropolitan Health Insurance Fund

6/1/24 thru 5/31/25 (unless otherwise noted)

Dashboard

Medical Claims Paid: January 2025 thru May 2025

Total Medical Paid per EE: **$2,472**

** Claims Run-Out under old BMED control*

Network Discounts

Inpatient:	**68.4%**
Ambulatory:	**65.7%**
Physician/Other:	**63.5%**
TOTAL:	**65.5%**

Provider Network

% Admissions In-Network:	**94.0%**
% Physician Office:	**91.0%**

Aetna Book of Business:
Admissions 97%; Physician 91.9%

Top Facilities Utilized

(by total Medical Spend)

- Cooperman Barnabas Medical Ctr
- JFK University Medical Center
- Hackensack University Medical Ctr
- Overlook Medical Center
- RWJUH New Brunswick

Catastrophic Claim Impact January 2025 – May 2025

Number of Claims Over $50,000: **87**
Claimants per 1000 members: **15.5**
Avg. Paid per Claimant: **$132,723**
Percent of Total Paid: **41.9%**

- **Aetna BOB- HCC account for an average of 45.0% of total Medical Cost**

Aetna One Flex Member Outreach: Through May 2025

Total Members Identified: **1,828**
Members Targeted for 1:1 Nurse Support : **399**
Members Targeted for Digital Activity: **1,429**
Member 1:1 outreach completed: **377**
Member 1:1 Outreach in Progress: **22**

CVS Health. CVS Virtual Care January 2025 – May 2025

Completed Visits in March: **17**
Unique Patients in March: **17**
Completed Visits in 2025 : **90**
Unique Patients in 2025: **62**
Total Scheduled Visits in 2025: **123**
Average visit duration: **10** Minutes
BoB: Average First Available: **42** minutes
BoB: Average First Available (6am-6pm)
33 Minutes

Service Center Performance Goal Metrics YTD 2024

Customer Service Performance

1st Call Resolution:	**93.88%**
Abandonment Rate:	**0.45%**
Avg. Speed of Answer:	**15.2 sec**

Claims Performance

Financial Accuracy: *Q1 2025 -	**98.68%***
90% processed w/in:	**7.2 days**
95% processed w/in:	**14.9 days**

****

Claims Performance (Monthly)

(March 2025)

90% processed w/in:	**8.4 days**
95% processed w/in:	**16.8 days**

(Note: This is not a PG metric)

****

Performance Goals

1st Call Resolution:	90%
Abandonment Rate less than:	3.0%
Average Speed of Answer:	30 sec
Financial Accuracy:	99%
Turnaround Time	
90% processed w/in:	14 days
95% processed w/in:	30 days


EXPRESS SCRIPTS®

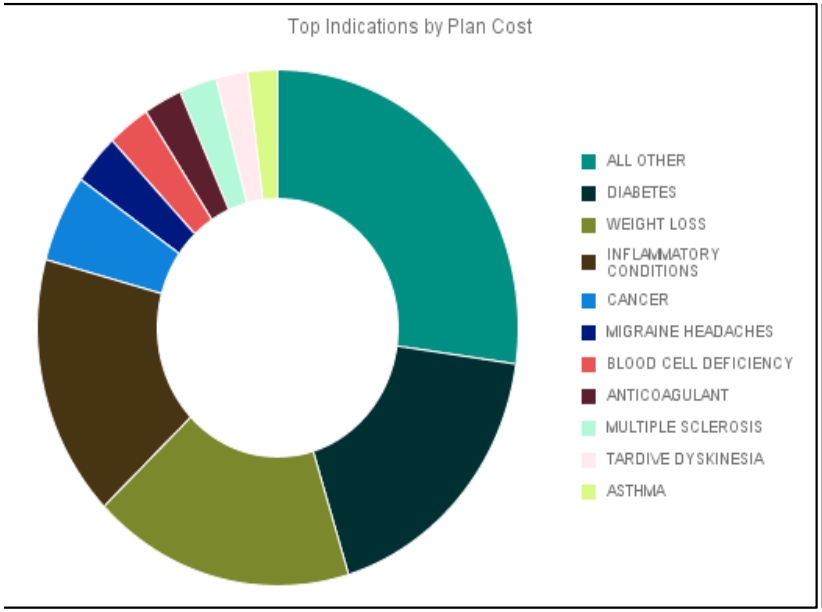
Metropolitan Health Insurance Fund

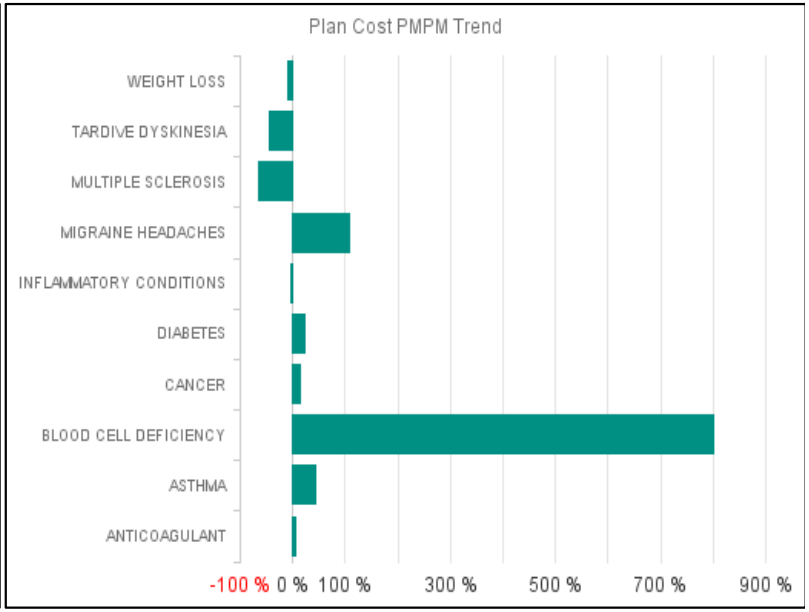
Total Component/Date of Service (Month)	2024 01	2024 02	2024 03	2024 Q1	2024 04	2024 05	2024 06	2024 Q2	2024 07	2024 08	2024 09	2024 Q3	2024 10	2024 11	2024 12	2024 Q4	2024 YTD
Membership	972	963	960	965	970	965	957	964	946	947	952	948	968	990	984	981	965
Total Days	24,314	27,528	27,455	79,297	29,053	32,052	27,820	88,925	30,797	29,467	30,030	90,294	34,030	32,808	35,417	102,255	360,771
Total Patients	284	292	308	465	318	308	301	485	303	307	315	469	357	353	362	539	715
Total Plan Cost	$153,801	$106,316	$117,731	$377,849	$138,031	$171,454	$156,213	$465,697	$205,353	$187,823	$167,234	$560,409	$274,108	$179,016	$214,628	$667,752	$2,071,708
Generic Fill Rate (GFR) - Total	86.2%	85.8%	86.1%	86.0%	86.5%	84.1%	84.0%	84.9%	83.7%	80.2%	80.4%	81.5%	81.2%	84.4%	81.9%	82.5%	83.6%
Plan Cost PMPM	$158.23	$110.40	$122.64	$130.52	$142.30	$177.67	$163.23	$161.03	$217.07	$198.33	$175.67	$196.98	$283.17	$180.82	$218.12	$226.97	$179.00
Total Specialty Plan Cost	$80,389	$23,717	$27,003	$131,108	$54,301	$37,700	$48,055	$140,057	$76,068	$71,220	$48,563	$195,851	$161,184	$53,548	$70,817	$285,549	$752,565
Specialty % of Total Specialty Plan Cost	52.3%	22.3%	22.9%	34.7%	39.3%	22.0%	30.8%	30.1%	37.0%	37.9%	29.0%	34.9%	58.8%	29.9%	33.0%	42.8%	36.3%

Total Component/Date of Service (Month)	2025 01	2025 02	2025 03	2025 Q1	2025 04	2025 05	2025 06	2025 Q2	2025 07	2025 08	2025 09	2025 Q3	2025 10	2025 11	2025 12	2025 Q4	2025 YTD
Membership	1,583	1,745	1,738	1,689	1,736	1,735											
Total Days	59,833	60,345	70,456	190,634	65,736	61,151											
Total Patients	550	598	602	927	596	545											
Total Plan Cost	$360,333	$263,585	$400,194	$1,024,112	$369,565	$337,505											
Generic Fill Rate (GFR) - Total	85.1%	84.0%	82.7%	83.9%	84.6%	84.1%											
Plan Cost PMPM	$227.63	$151.05	$230.26	$202.15	$212.88	$194.53											
% Change Plan Cost PMPM	43.9%	36.8%	87.8%	54.9%	49.6%	9.5%											
Total Specialty Plan Cost	$144,724	$50,528	$138,310	$333,561	$144,054	$107,491											
Specialty % of Total Specialty Plan Cost	40.2%	19.2%	34.6%	32.6%	39.0%	31.8%											

Top Indications

Metropolitan Health Insurance (Current Period 01/2025 - 05/2025 vs. Previous Period 08/2024 - 12/2024) Peer = Government - National Preferred Formulary





			Current Period						Previous Period						Trend
Rank	Peer Rank	Indication	Market Share	Adjusted Rxs	Plan Cost	Plan Cost PMPM	GFR	Peer GFR	Market Share	Adjusted Rxs	Plan Cost	Plan Cost PMPM	GFR	Peer GFR	Plan Cost PMPM
1	1	DIABETES	24.7 %	982	$311,616	$36.50	32.6 %	24.1 %	20.5 %	450	$145,534	$30.06	31.8 %	25.1 %	21.4 %
2	4	WEIGHT LOSS	24.2 %	283	$304,552	$35.67	0.7 %	4.3 %	26.4 %	167	$188,052	$38.85	0.0 %	4.3 %	-8.2 %
3	2	INFLAMMATORY CONDITIONS	22.6 %	133	$284,197	$33.29	62.4 %	30.5 %	23.6 %	57	$168,120	$34.73	47.4 %	30.9 %	-4.1 %
4	3	CANCER	7.5 %	25	$94,863	$11.11	80.0 %	75.8 %	6.7 %	29	$47,446	$9.80	93.1 %	75.5 %	13.4 %
5	5	MIGRAINE HEADACHES	4.4 %	79	$55,004	$6.44	39.2 %	51.5 %	2.1 %	26	$14,939	$3.09	65.4 %	52.6 %	108.8 %
6	9	BLOOD CELL DEFICIENCY	3.9 %	6	$49,597	$5.81	0.0 %	1.2 %	0.4 %	1	$3,127	$0.65	0.0 %	0.3 %	799.5 %
7	8	ANTICOAGULANT	3.5 %	95	$44,318	$5.19	9.5 %	18.4 %	3.3 %	62	$23,568	$4.87	3.2 %	18.0 %	6.6 %
8	7	MULTIPLE SCLEROSIS	3.5 %	6	$43,493	$5.09	50.0 %	48.4 %	9.7 %	12	$68,719	$14.20	50.0 %	49.5 %	-64.1 %
9	10	TARDIVE DYSKINESIA	3.0 %	6	$37,210	$4.36	0.0 %	4.4 %	5.3 %	5	$37,703	$7.79	0.0 %	6.0 %	-44.0 %
10	6	ASTHMA	2.8 %	436	$34,682	$4.06	87.4 %	88.2 %	1.9 %	240	$13,841	$2.86	89.2 %	88.5 %	42.1 %
		Total Top 10		**2,051**	**$1,259,531**	**$147.54**	**41.4 %**	**40.0 %**		**1,049**	**$711,050**	**$146.88**	**41.6 %**	**40.9 %**	**0.4 %**

Top Drugs

Metropolitan Health Insurance (Current Period 01/2025 - 05/2025 vs. Previous Period 08/2024 - 12/2024) Peer = Government - National Preferred Formulary

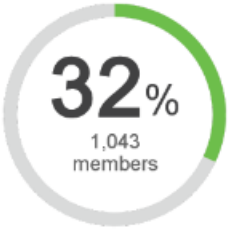
					Current Period				Previous Period				Trend
Rank	Peer Rank	Brand Name	Indication	Specialty Drug	Adjusted Rxs	Patients	Plan Cost	Plan Cost PMPM	Adjusted Rxs	Patients	Plan Cost	Plan Cost PMPM	Plan Cost PMPM
1	8	ZEPBOUND	WEIGHT LOSS	N	165	42	$164,714	$19.29	79	20	$77,844	$16.08	20.0 %
2	14	WEGOVY	WEIGHT LOSS	N	112	28	$138,691	$16.25	87	25	$110,028	$22.73	-28.5 %
3	203	SCEMBLIX	CANCER	Y	5	1	$94,710	$11.09	2	1	$31,555	$6.52	70.2 %
4	4	OZEMPIC	DIABETES	N	85	18	$74,277	$8.70	52	13	$45,992	$9.50	-8.4 %
5	1	MOUNJARO	DIABETES	N	71	18	$70,535	$8.26	29	7	$29,086	$6.01	37.5 %
6	32	SKYRIZI ON-BODY	INFLAMMATORY CONDITIONS	Y	6	1	$59,650	$6.99	6	1	$62,232	$12.86	-45.6 %
7	84	PROMACTA	BLOOD CELL DEFICIENCY	Y	5	1	$48,957	$5.73	NA	NA	NA	NA	NA
8	10	JARDIANCE	DIABETES	N	78	18	$44,514	$5.21	30	6	$16,691	$3.45	51.2 %
9	12	SKYRIZI PEN	INFLAMMATORY CONDITIONS	Y	6	1	$37,557	$4.40	4	1	$29,042	$6.00	-26.7 %
10	179	INGREZZA	TARDIVE DYSKINESIA	Y	6	1	$37,210	$4.36	5	1	$37,703	$7.79	-44.0 %
11	22	HUMIRA(CF) PEN	INFLAMMATORY CONDITIONS	Y	6	1	$33,999	$3.98	3	1	$19,999	$4.13	-3.6 %
12	127	VUMERITY	MULTIPLE SCLEROSIS	Y	3	1	$27,452	$3.22	6	1	$36,637	$7.57	-57.5 %
13	195	ACTEMRA ACTPEN	INFLAMMATORY CONDITIONS	Y	6	1	$25,331	$2.97	6	1	$20,605	$4.26	-30.3 %
14	24	ELIQUIS	ANTICOAGULANT	N	55	11	$25,159	$2.95	40	5	$13,093	$2.70	9.0 %
15	33	NURTEC ODT	MIGRAINE HEADACHES	N	15	6	$23,886	$2.80	6	2	$10,459	$2.16	29.5 %
16	34	TRULICITY	DIABETES	N	23	6	$21,148	$2.48	12	3	$10,945	$2.26	9.6 %
17	68	XELJANZ XR	INFLAMMATORY CONDITIONS	Y	5	1	$20,725	$2.43	NA	NA	NA	NA	NA
18	198	SOTYKTU	INFLAMMATORY CONDITIONS	Y	4	1	$19,315	$2.26	NA	NA	NA	NA	NA
19	200	HUMIRA(CF)	INFLAMMATORY CONDITIONS	Y	4	1	$18,666	$2.19	NA	NA	NA	NA	NA
20	16	RINVOQ	INFLAMMATORY CONDITIONS	Y	2	1	$17,831	$2.09	NA	NA	NA	NA	NA
21	23	FARXIGA	DIABETES	N	33	8	$17,513	$2.05	3	1	$1,368	$0.28	626.1 %
22	18	ENBREL SURECLICK	INFLAMMATORY CONDITIONS	Y	3	1	$16,891	$1.98	NA	NA	NA	NA	NA
23	45	XARELTO	ANTICOAGULANT	N	31	7	$16,829	$1.97	20	4	$10,384	$2.14	-8.1 %
24	160	DIMETHYL FUMARATE	MULTIPLE SCLEROSIS	Y	3	1	$16,041	$1.88	6	1	$32,082	$6.63	-71.6 %
25	40	QULIPTA	MIGRAINE HEADACHES	N	15	3	$15,773	$1.85	3	1	$3,119	$0.64	186.7 %
			Total Top 25		**747**		**$1,087,373**	**$127.37**	**399**		**$598,865**	**$123.71**	**3.0 %**


DELTA DENTAL®

METROPOLITAN HEALTH INSURANCE FUND

Group 03606 | 3,278 Members | Q1 2024 - Q4 2024

Healthy



Peers 38%

These members had preventive care only

Moderate

Peers 18%

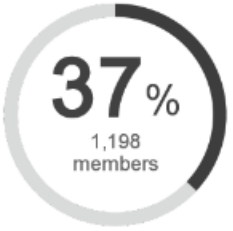
These members primarily had preventive care and treatment

Serious

Peers 12%

These members had emergency care only or extensive care

No Visit



Peers 28%

These members had no dental claims

Your Oral Health Score

37th Percentile

Your national benchmark comparison comes from Healthentic's database of over 60 million members from all 50 states

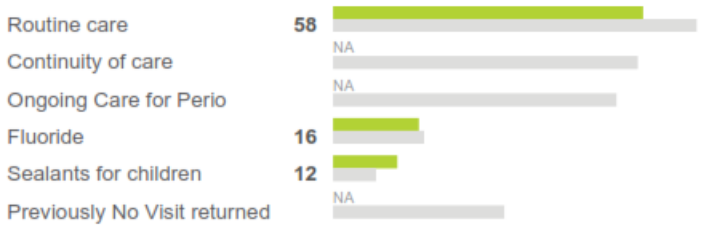
Dental Action Report

Crista C. Odonnell
Account Manager
codonnell@deltadentalnj.com

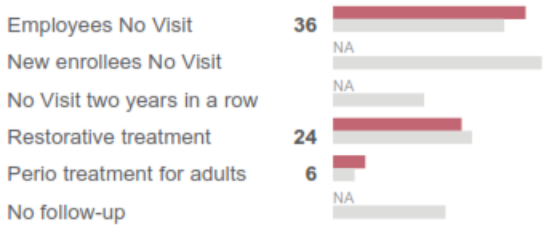
DELTA DENTAL

Healthentic

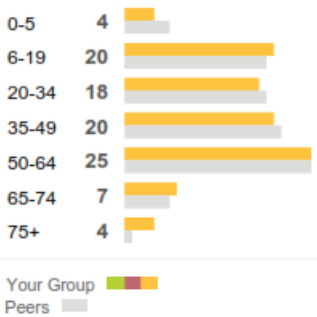
Members with care



Oral health opportunities



Age



Your Peer Comparison

19 groups in Insurance Carriers and Related Activities, statewide

100+ members

High % of visits in NJ (your group has 95%)

APPENDIX I

METROPOLITIAN HEALTH INSURANCE FUND
MINUTES
OPEN MEETING: MAY 15, 2025
CONFERENCE CALL – ZOOM
12:00 P.M.

Meeting called to order by Chair Mundell. The Open Public Meeting Notice was read into the record.

PLEDGE OF ALLEGENCE

ROLL CALL OF 2025 EXECUTIVE COMMITTEE

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

APPOINTED OFFICIALS PRESENT:

Executive Director/ Administrator	**PERMA Risk Management Services**	Brandon Lodics, Executive Director Emily Koval, Associate Executive Director John Lajewski Crystal Bailey
Fund Coordinator	**Eagle Rock Management Group**	Joseph DiVincenzo Jennifer McHugh Thomas Kelly Diane Romano
Attorney	**Antonelli Kantor Rivera**	Asia Hartgrove
Treasurer	**Point Accounting Group (Formerly Laracy Associates)**	Matt Laracy
Third Party Administrator	**Aetna**	Jason Silverstein
Dental Claims Administrator	**Delta Dental of NJ, Inc.**	Crista O'Donnell
Auditor	**Donohue, Gironda, Doria & Tomkins**	Absent
Actuary	**John Vataha**	Absent

RX Administrator	**Express Scripts**	Hiteksha Patel

Others Present:

Alysa Sauchelli
Anders Hasseler
Cait Perkins
Jackie Ortiz
Jacob Krakower
John Ditinyak
Jordyn Robinson
Julie Servidio
Capriglione
Kenny H.
Lisa Narcise
Matt Rudman
Tammy Brown
Timothy Hoffman
Katherine Polanco

APPROVAL OF MINUTES: March 20, 2025 Open

Motion: Commissioner Heisey
Second: Commissioner Wherry
Vote: All in Favor

CORRESPONDENCE – None

EXECUTIVE DIRECTOR'S REPORT

FAST TRACK FINANCAL REPORT – Mrs. Koval reviewed the financial fast track reports for the months of January, February, and March. She emphasized that the March report would be the main focus, as it is a cumulative report. Mrs. Koval noted that both January and March reflected deficits, while February showed a small surplus. She reported that the year-to-date loss stands at approximately $1.3 million, primarily within the 2023 and 2024 fund years. However, she shared that the 2025 fund year is currently reflecting a surplus of about $69,000.
Mrs. Koval informed the committee that the high claimant report through the end of April had recently been received. Based on this report, the fund is anticipating a reimbursement of approximately $900,000 from the MRHIF for claims that exceeded the specific stop-loss limit. These funds will be reflected in the April financials, which are scheduled to be developed in the coming weeks, and are expected to positively impact the fund's financial position.

2024 FUND YEAR AUDIT
Mrs. Koval provided an update on the 2024 fund audit, noting that since the fund is new and lacks a prior year for comparison, additional time is required to complete the audit. She explained that the auditor assigned to the task is one that the PERMA accounting team has not previously worked with. Therefore, Mrs. Koval requested that the committee consider a motion to file for an extension with the State of New Jersey, allowing until July 31st to submit the 2024 financial audit. She confirmed that the final report would be presented at the July Executive Committee meeting and also reviewed with the Finance Committee beforehand.
MOTION: *Motion to allow the finance committee to review the Fund Year 2024 Financial Audit for approval and filing or extension request to the State of New Jersey.*

Motion: Commissioner Cox
Second: Commissioner Wherry
Vote: All in Favor

DEPUTY TREASURER

Mrs. Koval introduced one item not originally listed on the agenda. She explained that, following recent discussions with the fund treasurer, there is growing concern over the increase in fraud related to checks, wires, and ACH transactions. As a result, she proposed that the committee consider allowing the release of quotes to obtain a Deputy Fund Treasurer. This role would serve as a backup to attest to ACH receivables and disbursements, supporting the fund treasurer in safeguarding financial transactions. Mrs. Koval emphasized that PERMA does not handle any cash directly, and the current responsibility falls entirely on the treasurer. Implementing a third party in this capacity was described as a best practice.

Mrs. Koval clarified that the estimated cost of this contract would be approximately $10,000 and would likely only extend over the next six months, keeping it under the procurement threshold. She asked the committee for approval to proceed with releasing quotes and invited members to suggest potential candidates, especially any CMFOs in the area who may be suitable.

MOTION: *Motion to allow the Fund to go out for RFP for a 3rd party deputy treasurer to assist the fund treasurer.*

Motion: Commissioner Cox
Second: Commissioner Heisey
Vote: All in Favor

PROGRAM MANAGERS REPORT

Mrs. Bailey reviewed the Program Manager report.

Eligibility/Enrollment:

Please direct any eligibility, enrollment, or system related questions to our dedicated Client Services Team:

- Alexander Koch, akoch@permainc.com, 856-552-4478
- Victoria Friday: vfriday@permainc.com, 856-552-4748

System training (new and refresher) is provided to all contacts with WEX access **every 3rd Wednesday at 10AM**. Please contact HIFtraining@permainc.com for additional information or to request an invite.

In the subject line of the email, please include ***Training – Fund Name and Client Name***. Please be sure to add the date of the training you would like to attend in your email so an invite can be sent.

Coverage Updates:
Express Scrips Updates:
2025 National Preferred Formulary (NPF) and SaveOn – Effective 7/1/25

Brokers were sent the updated 2025 Formulary and Exclusions lists effective July 1, 2025, on April 23, 2025. There were 2 members of the METRO Fund impacted by the formulary change. Please reference the appendix for the updated lists. Please note the following:
NPF:

- NPF Exclusions List, please note the following:
  - **Humalog** - excluded for members with a new prescription as of 1/1/25, members currently taking the drug will be excluded effective 1/1/26
    - Members should share the covered preferred alternatives provided in the list with their providers
    - The number of impacted members will be provided later in 2025

  - **Humira** - excluded for members with a new prescription as of 1/1/25, members currently taking the drug will be excluded effective 7/1/25
    - Members should share the covered preferred alternatives provided in the listing with their providers
  - Impacted members (2) will be notified by ESI. The notification will include covered preferred alternatives under the NPF

SaveOn – Effective 7/1/25

Brokers were sent the updated 2025 SaveOn List effective July 1, 2025, on May 6, 2025. Please note the following:

- Drugs highlighted in green (21) were added to the list effective July 1, 2025
- Drugs highlighted in red (5) were removed from the list effective July 1, 2025
  - There were no METRO members impacted by the drugs removed from the list

4Q2024 SaveOn Savings (3/1/2024 through 12/31/24)
In 4Q2024, the Metropolitan Health Insurance Fund saved $70,600 for members enrolled in SaveOn, an additional $17,524 in savings from 3Q2024. There are currently 9 participants in the program, an increase of 2 members compared to 3Q2024. In 2024, Metro Fund members who used SaveOn saved a total of $784 in copays. The average savings per prescription to date was $1,906. See Appendix for the full report.
Top Therapeutic Categories:

- Inflammatory Conditions
  - 6 members, totaling $30,634 in savings (increase of 1 member from the prior period)
- Miscellaneous Diseases
  - 1 member, totaling $12,534 (no change from the previous period)
- Multiple Sclerosis

    - 1 member, totaling $17, 439
- Cancer
    - 1 member, totaling $9,993 (new from the previous period)

Encircle Program (GLP-1 Weight Loss)

- No new updates

2025 LEGISLATIVE REVIEW:

Medical and Rx Reporting: None

No Surprise Billing and Transparency Act– Continued Delays

Appeals: - please refence the chart in the May 15th agenda.

FUND COORDINATOR – Mr. DiVincenzo began his report by covering both new and pending business. He stated that the dental population for the Township of Maplewood successfully migrated to the Metro as of June 1st and extended his thanks to Mr. Wherry for his efforts in that transition.

Mr. DiVincenzo reported that proposals have been submitted for the Borough of North Caldwell, which includes approximately 45 members, and for the Jersey City Medicare population, which includes around 2,500 members. The proposal for North Caldwell is effective July 1st, while the Jersey City Medicare proposal is targeted for either September 1st or October 1st.

Mr. DiVincenzo also informed the group that experience data has been requested from three additional entities: Secaucus Township, the Fort Lee Board of Education, and the South Orange Maplewood Board of Education. In response to renewed interest, the fund is reevaluating Glen Ridge Borough and South Orange Village due to concerns arising from the current status of the State Health Benefits Plan and the State Education Health Benefits Plan. He noted that future prospects are being closely monitored, including East Orange Township and North Bergen Township.

Mr. DiVincenzo stated that a key issue that has been discussed over the past few months is the rising use of out-of-network (OON) healthcare providers, particularly in Central and North New Jersey. He explained that OON utilization is significantly high in these areas and outlined several contributing factors, including the ability of hospitals and physicians to opt in and out of networks at will, and the arbitrary nature of what is considered "reasonable and customary" for OON charges. Compounding the issue is the fact that many OON providers are waiving member deductibles and accepting whatever payment is made by the insurer, which removes cost concerns for members and encourages providers to remain or move OON. These excessive reimbursements also contribute to increasing overall plan costs, as roughly 20–30% of the fund's total claims spend is now attributed to OON utilization.

Mr. DiVincenzo and the Metro fund professionals recommended implementing an OON fee schedule of 150% of Medicare rates. This change would create a more predictable pricing model, better cost controls, and discourage abusive billing practices. Aetna has estimated that this policy could yield annual savings of approximately $750,000. If adopted, a process would

also be established internally to manage egregious balance billing cases, with input and guidance from PERMA and legal counsel.
Mr. DiVincenzo stressed that this is not an isolated concern limited to the Metro fund, but a statewide issue also affecting the State Health Benefits and Direct Plans. He warned that without proactive measures like this, public entity plan sponsors may soon find themselves unable to sustain their benefits programs. He noted that the BMED fund, also part of the High Fund family, approved a similar measure two weeks ago for implementation effective July 1st. Mr. DiVincenzo encouraged the Commissioners to consider following that lead, reiterating that it is the fund's responsibility to protect not only its members but also their families and local taxpayers. He concluded by opening the floor for questions and further discussion on the matter.

Mrs. Mundell began the discussion by expressing appreciation for the fund's focus on cost containment. She emphasized that for municipalities and participating entities, it is critical to act as responsible stewards of taxpayer dollars. She acknowledged that health insurance costs continue to rise and, while ensuring that employees receive quality care and competitive rates remains a priority, the financial responsibility ultimately falls on the taxpayers. Mrs. Mundell voiced support for exploring strategies that are both proactive and financially sustainable. She requested that any recommendations or changes be presented in a clear, written format that can be easily communicated to each entity's governing body to demonstrate how such changes will benefit their respective organizations.
Mrs. Brown, representing the Connor Strong team, added to the discussion by stating that the next step will be to provide a comprehensive analysis detailing anticipated cost savings, communication strategies for members, and the proposed implementation plan. She noted that the figures referenced by Mr. DiVincenzo were based on data through December 2024, and her team would now examine first-quarter 2025 data to confirm the continued relevance of those savings. Mrs. Brown highlighted that out-of-network utilization specifically within the Metro Fund is approximately 27%, which underscores the opportunity for cost savings. She also indicated that a GeoAccess report will be included in the analysis, demonstrating the availability of in-network care options within close proximity to members. She reassured the group that her team has been closely collaborating with Mr. DiVincenzo's office and that a detailed white paper would be made available within the next 7 to 10 days.
Mr. Cox expressed that his main concern was having clear, data-driven information that he could share with his district. He inquired about the timeline for both receiving the necessary information and when the Commissioners would be asked to make a formal decision. Mrs. Brown responded that while July 1st had been the initial target date, this would be contingent upon Aetna's capacity to implement reimbursement changes. She confirmed the goal of delivering the full analysis shortly.
Mr. DiVincenzo clarified that, should the Commissioners approve the proposed reimbursement policy, the Fund would establish formal procedures to manage any member balance billing issues, ensuring protection for both plan sponsors and members.
Mr. Wherry then asked whether shifting to a reimbursement rate of 150% of Medicare would involve a change in the benefit plans offered or if this would simply apply to all current plans. Mr. DiVincenzo confirmed that the change refers specifically to how out-of-network

providers are reimbursed under the CMS Medicare schedule and would not alter member benefits. Mrs. Brown further clarified that while the benefit structure (e.g., 100% in-network, 80% out-of-network) remains unchanged, the reimbursement to the out-of-network provider would be calculated differently. She noted that this adjustment is not typically subject to union negotiations, citing similar changes made by the State Health Benefits Plan without union involvement. However, she emphasized the importance of transparency and stated that her team would include an analysis of how this change could reduce member contributions due to lower premiums.

Mr. DiVincenzo added that the State Health Benefits Plan has the authority to implement such changes unilaterally and that similar changes may soon be required statewide. Mrs. Brown noted that while the change may not be simple to implement, her team is committed to equipping Commissioners with the necessary data and tools. She acknowledged that some members may feel the impact of the change, but emphasized that it is ultimately a step toward long-term financial sustainability. She cited the BMED Fund's recent implementation of a similar policy as a positive precedent.

Mrs. Mundell asked whether this reimbursement change was designed to encourage members to return to in-network providers. Mrs. Brown confirmed that this was one of the primary goals and noted that members experiencing significantly higher out-of-pocket costs would be supported by an independent third-party review process. This administrator would objectively assess whether the billing amount was reasonable and resolve member concerns accordingly.

Mrs. Mundell then asked whether the Fund would call a special meeting to further discuss this issue. Mr. DiVincenzo confirmed that a special meeting would be scheduled once all relevant information and supporting materials were prepared. He emphasized that this initiative reflects a long-term strategy in response to cost trends over the past two years. Mrs. Mundell concluded by echoing the importance of taking action to curb rising costs, a burden she noted cannot continue to increase at its current pace without placing undue strain on participating entities and taxpayers.

Mrs. Duva addressed both Mrs. Brown and Mr. DiVincenzo, requesting that the forthcoming white paper include a clearly articulated explanation of how the proposed reimbursement change does not constitute a change to collectively bargained benefits. She emphasized that, although technically not a benefit modification, if an employee experiences a significant cost increase—for example, receiving a $5,000 bill where they previously paid $500—it could understandably raise concerns. Mrs. Duva expressed concern that, without a clear explanation, labor attorneys may need to be consulted, adding unnecessary cost and confusion. She supported the initiative to control costs but stressed the importance of proactive and transparent communication to prevent misinterpretation and grievances.

In response, Mrs. Brown affirmed the importance of that point and acknowledged the concern.

Ms. Hartgrove from Antonelli, Kantor & Rivera joined the discussion, confirming that she had been working closely with both Mrs. Brown and Mr. DiVincenzo on the rollout and legal considerations of the proposed change. She emphasized that while controlling costs remains a

primary objective, a parallel priority is maintaining open communication with union representatives. She noted that addressing union concerns upfront would be a key component of the rollout strategy and reassured the committee that transparency and fairness would guide the process. Ms. Hartgrove outlined that the plan would include a formal appeals process, allowing employees to contest any significant increases in out-of-pocket costs. She reiterated that the goal is to maintain the quality and administration of benefits while managing costs, and that any potential financial impacts to members would be addressed through this structured process. Details of this fund-supported appeal mechanism would be fully outlined in the forthcoming white paper.

Mrs. Mundell concluded the discussion by reiterating the importance of ensuring that all member entities are properly equipped with information and context ahead of any changes. She emphasized the value of being able to hold informed conversations with stakeholders, particularly employees and unions, in advance of implementation to minimize confusion and potential resistance.

ATTORNEY – Asia Hartgrove joined the discussion above.

TREASURER – Mr. Laracy presented the treasurers report discussing the April and May bills list.

MOTION TO APPROVE RESOLUTION 17-25:

Motion:	Commissioner Cox
Second:	Commissioner Wherry
Vote:	6 Ayes, 0 Nays

Mr. Laracy addressed the committee to provide a final comment regarding the proposed Deputy Treasurer role. He clarified that the issue at hand is not related to workload—as previously stated by Ms. Koval—but rather a matter of financial control. He emphasized that, as a best practice, no single individual should be both initiating and approving their own wire transfers. Establishing a Deputy Treasurer position would serve as a critical safeguard in the fund's financial operations.
Mr. Laracy noted that the anticipated cost for the position would be minimal, as mentioned earlier by Ms. Koval, and reiterated that this type of financial control measure is something all health insurance funds (HIFs) should be implementing. He concluded by affirming that the objective is simply to ensure proper internal controls are in place and that the fund adheres to the same standards it expects from others on the insurance side. He stated that, unless there were any questions, this concluded his report.
Chairwoman Mundell then opened the floor for questions from the committee.

Mr. Cox inquired for further clarification on the Deputy Treasurer procurement process. He asked whether the intention was to obtain quotes for individuals to fill the role, and whether this would follow a standard procurement protocol—specifically one that ensures separation of duties, such as separating purchasing responsibilities from accounts payable (AP) functions.
Mr. Laracy confirmed Mr. Cox's understanding, explaining that while check payments are appropriately controlled—being issued by PERMA and then reviewed and approved by him—the current process for wires and ACH transactions lacks a secondary reviewer, as PERMA does not have direct banking access. He stressed that this gap means one individual is currently initiating significant ACH payments, such as those to Aetna and other major vendors, without a second layer of approval.
He reiterated that the primary goal is to implement proper controls—namely, to prevent the same person from initiating and approving wire transfers—which aligns with industry best practices in banking and public finance. Mr. Laracy added that although some government operations have been slow to adopt these protocols, it is important that the fund act proactively, especially given the size of the transactions involved

AETNA – Mr. Silverstien reviewed the claims report for the month of March and the High Cost claimants for the months of February and March. He stated that the dashboard metrics through march continue to preform well. He reviewed the One Flex program offered by Aetna.

Mr. Silverstien gave an update on RWJBarnabus. As of April 1st they ended negotiations and came to an agreement. There were no disruptions in service. Aetna has a 3 year contract with the facility.

EXPRESS SCRIPTS – Mrs. Patel reviewed the monthly utilization report through the 1st quarter of 2025. She reviewed the top 10 conditions, noting the top three conditions are weight loss, diabetes, and cancer. Mrs. Patel reviewed the top 10 drugs.

DELTA DENTAL – Crista O' Donnell reviewed the claims summary for the year of 2024.

OLD BUSINESS: - None

NEW BUSINESS: - None

PUBLIC COMMENT: - None

MEETING ADJOURNED

Motion: Commissioner Cox
Second: Commissioner Heisey

MEETING ADJOURNED: 12:43pm

NEXT MEETING: July 17, 2025 12:00PM

Zoom

_____
Jordyn Robinson, Assisting Secretary

for

_____
KIMBERLY DUVA, SECRETARY

METROPOLITIAN HEALTH INSURANCE FUND

MINUTES
OPEN MEETING: JUNE 12, 2025
CONFERENCE CALL – ZOOM
10:00 A.M.

Meeting called to order by Chair Mundell. The Open Public Meeting Notice was read into the record.

PLEDGE OF ALLEGENCE

ROLL CALL OF 2025 EXECUTIVE COMMITTEE

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

Executive Director/ Administrator	**PERMA Risk Management Services**	Brandon Lodics, Executive Director Emily Koval John Lajewski Joe Dibella Tammy Brown
Fund Coordinator	**Eagle Rock Management Group**	Joseph DiVincenzo Jennifer McHugh Thomas Kelly Diane Romano
Attorney	**Antonelli Kantor Rivera**	Ramon Rivera Asia Hartgrove
Treasurer	**Point Accounting Group (Formerly Laracy Associates)**	Matt Laracy
Third Party Administrator	**Aetna**	Jason Silverstein
Dental Claims Administrator	**Delta Dental of NJ, Inc.**	Absent
Auditor	**Donohue, Gironda, Doria & Tomkins**	Absent
Actuary	**John Vataha**	Absent
RX Administrator	**Express Scripts**	Absent

Others Present:

Alexander McDonald	Alysa Sauchelli
Carrie Specht	Brandon Lodics
Cait Perkins	Timothy Hoffman
Jordyn Robinson	Emily Koval
Jacob Krakower	Melanie Chavez
Brian Kiely	John Ditinyak
Jillian Barrick	John Lajewski
Jordyn Robinson	Jackie Ortiz
Julie Servidio	Katherine Polanco
Susan Sandelli	Lisa Narcise
Anders Hasseler	Matt Rudman
Jim Rhodes	Philip Chiyuto
Jason Silverstein	
Tom Fletcher	

Out of Network Utilization

Mr. DiBella, representing the Executive Director's office, opened the meeting by addressing the rising healthcare costs affecting both public and private sectors. He noted that while these trends are widespread, the State Health Benefit Program and the Metropolitan Health Fund are particularly impacted. The Fund is facing increased costs, mainly due to a spike in out-of-network utilization—especially in northern New Jersey—despite robust in-network options like Aetna. Data shows members often bypass nearby in-network providers in favor of out-of-network care, which drives costs significantly.

Out-of-network providers, not contracted with Aetna, are reimbursed based on "reasonable and customary" charges using an external pricing schedule. This often results in payments 300–350% above Medicare rates. Many such providers also waive patient cost-sharing, further encouraging out-of-network use. Mr. DiBella highlighted that out-of-network utilization in the Metro area has reached 30%, double the industry norm. Despite 99.5% of members having multiple in-network specialists within five miles, a small number of high-claim areas are skewing costs.

To address this, the Fund proposes moving from the FAIR schedule (90th percentile of charges) to a Medicare-based reimbursement model—150% for physicians and 175% for hospitals. This is projected to save $3 million annually (about 5% of total medical spend). He acknowledged concerns about balance billing but stated members can appeal such bills, which would be reviewed by an independent third party for fairness.

The Medicare-based model offers transparency, consistency, and alignment with widely accepted standards. Mr. DiBella urged adoption of Resolution 18-25 to implement this change and ensure the Fund's long-term financial sustainability.

During the meeting, Commissioner Cox raised a question regarding the implications of modifying the out-of-network reimbursement structure. He referenced Mr. DiBella's earlier point that 93% of doctors already accept the Medicare rate, and asked whether offering a more enticing in-network fee could encourage doctors currently out-of-network to join the Aetna network. He also inquired about the disparity between the proposed 150% Medicare rate and current in-network reimbursement. In response, Mr. DiBella acknowledged the observation, explaining that in-network rates would likely remain lower than 150% of Medicare. However, many patients prefer in-network providers due to lower copays, no deductible, and avoidance of balance billing. While the proposed change might not necessarily attract new in-network providers, it could help slow the departure of existing ones.

Jenny Mundell then opened the floor to additional questions. Commissioner Baltycki voiced concerns from her township's perspective, specifically regarding the speed of implementation and the lack of a formal legal opinion accompanying the financial analysis. She emphasized the importance of transparency with union members and requested either a delay in implementation or formal legal guidance, noting that any potential legal challenges would likely target the municipalities, not the fund. She appreciated the financial rationale behind the proposal but asked for more time to confer with her labor counsel and employees.

Mr. DiBella indicated that fund counsel had been consulted and introduced Ramon Rivera, who confirmed that his firm had conducted extensive research. Rivera explained that the change only affects out-of-network reimbursement rates and does not legally constitute a change in benefits requiring union negotiation. He added that an appeals process would be in place to address any perceived inequities, allowing members to be made whole if reimbursement is deemed unreasonable.

Commissioner Cox then raised a follow-up question, noting that many school employees schedule medical procedures during the summer. He proposed delaying the implementation to September 1 to avoid disrupting pre-scheduled care, particularly for ten-month employees. DiBella responded that delaying implementation might not significantly impact outcomes or savings, but acknowledged that it could help ease concerns. He reiterated that no formal participant notification was legally required and that reimbursement schedules change frequently. However, he remained open to a delay if the Commissioners felt it necessary.

Fund Attorney Ramon Rivera supported the idea of a thoughtful implementation, including clear notice to minimize disruption, especially for members with scheduled procedures who may be caught off guard. He emphasized the importance of transparency and communication, even if not legally required.

Fund Coordinator DiVincenzo stressed the urgency of addressing rising healthcare costs, especially due to out-of-network usage. He noted that other entities, including the State

Health Benefits Plan, are facing similar challenges and making comparable changes. He encouraged action, pointing out that while member needs are important, municipalities must also consider budgetary impacts.

Mr. DiBella reinforced this sentiment, citing the state's precedent of adjusting out-of-network schedules without extensive consultation. He emphasized that the fund's process—seeking member input—was a strength, but ultimately, the resolution should proceed with provisions for notice and appeals to ensure fairness and compliance. He proposed that the resolution include language requiring notification and implementation of appeal protocols to address any potential issues that arise post-implementation.

Mr. Rivera agreed, stating that if proper notice is given, the timing of implementation becomes less of a concern. He believed a well-communicated change would minimize disruption and legal exposure.

Chairwoman Jenny Mundell summarized the conversation and sought confirmation from Commissioner Baltycki and Commissioner Cox on whether passing the resolution with a September 1 implementation date and the added notice and appeals stipulations would satisfy their concerns. Commissioner Baltycki responded that while she appreciated the efforts to accommodate, she would still prefer a short delay in voting to allow time for a legal memo and further internal discussions. She reiterated her fiduciary responsibility to her township and the need to approach the change thoughtfully to avoid unintended consequences such as litigation.

The meeting concluded with mutual acknowledgment of the need for cost-saving measures, the importance of member transparency, and the shared goal of finding a balanced and legally sound path forward.

During the meeting, Commissioner Baltycki expressed concerns about feeling rushed into a decision that deviated from her usual process in West Caldwell. She advocated for a delay of two weeks to allow for further legal discussion and to ensure that the process did not negatively impact her municipality. She emphasized that while she believed the financial changes were necessary, she would be more comfortable voting after additional review. Commissioner Baltycki suggested either an August 1st or September 1st implementation date, contingent on having adequate time to prepare.

Commissioner Cox acknowledged the importance of the discussion and stated that the dialogue helped him better understand the matter. He noted that the legal counsel's assurance—based on appropriate amendments and notifications—made him comfortable moving forward. He requested that a legal memo be distributed to Commissioners within the following week to formally provide counsel's opinion.

Commissioner Baltycki followed up to confirm whether legal counsel could provide the memo within the requested timeframe. The legal counsel confirmed this could be done, which led Commissioner Baltycki to say that receiving the memo within the week made her feel much more comfortable moving forward with the resolution.

Commissioner Kim Duva asked whether the legal memo would include case references from PERC affirming that the proposed changes were non-negotiable. She also shared personal reasons for abstaining from the vote, citing ongoing medical treatment. Legal counsel confirmed that the memo would contain relevant legal citations and analysis, including UCR standards and the implications of changes to out-of-network benefits.

Mr. DiBella summarized the proposed resolution structure, suggesting that any adoption should be contingent upon receiving the legal memo substantiating the changes and completing any required participant notifications. This approach was supported by multiple members.

Timothy Hoffman inquired whether, in the absence of a communication requirement, any information would still be sent to members. Mr. DiBella responded that legal counsel's recommendation would dictate the necessity of communication and, if so, a draft would be circulated to Commissioners prior to any distribution.

Chairwoman Mundell and Mr. DiBella agreed that communications should come from the fund itself, not PERMA, to maintain consistency and reinforce that the decisions are fund-based. They emphasized the importance of clear, uniform messaging to ensure members do not perceive a loss in benefits. Legal counsel confirmed they could provide a standard communication template to support this goal.

Commissioner Margaret Heisey asked if members could access data on how the proposed changes might affect their organizations. Executive Director Brandon Lodics affirmed this and offered to provide aggregate utilization reports on out-of-network versus in-network usage, highlighting that these reports would be de-identified and could provide insights to reduce concerns about potential disruptions.

A motion was then made to approve the resolution revising member plan documents to reflect an out-of-network fee schedule, contingent upon receiving the legal memo, issuance of appropriate communications, and pre-approval of those communications by the Commissioners.

The motion was made by Cameron Cox and seconded by Margaret Heisey.

A roll call vote followed. Resolution 18-25 passed with the following results:

- *Margaret Heisey: Yes*

- *Christopher Hartwick: Yes*
- *Nicole Baltycki: Yes*
- *Cameron Cox: Yes*
- *Kimberly Duva: Abstained*
- *Jenny Mundell: Yes*

The motion passed, and the Chair thanked everyone for their hard work and thoughtful discussion.

OLD BUSINESS: - None

NEW BUSINESS: - None

PUBLIC COMMENT: - None

MEETING ADJOURNED

Motion: Commissioner Cox
Second: Commissioner Heisey

MEETING ADJOURNED: 11:00am

NEXT MEETING: July 17, 2025 12:00PM

Zoom

_____
Jordyn Robinson, Assisting Secretary

for

_____
KIMBERLY DUVA, SECRETARY

Southern New Jersey Regional Employee Benefits Fund
Date: July 1, 2025
Time: 3:00pm
Location: Zoom Platform

Certification Statement:

I hereby certify that the attached meeting minutes are an accurate and complete representation of the discussions, decisions, and actions taken during the meeting referenced above.

Prepared and Certified By:

Signature: Jordyn Robinson

Name: Jordyn Robinson
Title: Interim Clerk
Date Prepared: July 2, 2025

This certification ensures the integrity and reliability of the meeting records for future reference.

SOUTHERN NEW JERSEY REGIONAL EMPLOYEE BENEFITS FUND
OPEN MINUTES
July 1, 2025
ZOOM MEETING
3:00 PM

Meeting of Executive Committee called to order by Chair Mevoli. Open Public Meetings notice read into record.

PLEDGE OF ALLEGIANCE AND MOMENT OF SILENCE

ROLL CALL OF 2025 EXECUTIVE COMMITTEE

Michael Mevoli, Chairman	Borough of Brooklawn	Present
Louis Di Angelo	Borough of Bellmawr	Absent
Terry Shannon	Borough of Barrington	Absent
Edward Hill	CCBOSS	Present
Gary Passanante	Borough of Somerdale	Absent
Brian Morrell	Gloucester City	Absent
Kenneth Cheeseman	Laurel Springs	Present
Elanor Kelly	Borough of Runnemede	Absent
Joseph Gallagher	Winslow Twp	Present
Elizabeth Peddicord	Pennsauken	Present

APPOINTED PROFESSIONALS PRESENT:

Executive Director/Adm.	PERMA Risk Management Services **Brandon Lodics** **Emily Koval** **Jordyn Robinson**
Program Manager	Conner Strong & Buckelew **Crystal Bailey** **John Lajewski**
Attorney	**J. Kenneth Harris, Esq.**
Medical TPA – AmeriHealth	**Kristina Strain**
Medical TPA – Aetna	**Jason Silverstein**
Express Scripts	**Absent**
Treasurer	**Lorraine Verrill**

Delta Dental **Absent**

OTHERS PRESENT:

Joseph DiBella	Robert Weil
Vikki Holmstrom	Tyler Jackson
Sean Canning	Robert Weil
Richard Kunze	Randi Gerber
Dave Vozza	Lorraine Sacco
G Hayes	Georganna Marian
Carrie Specht	

FUND ATTORNEY:

Chairman Mevoli asked Mr. Harrris to address the primary item for discussion.

Mr. Harris explained the primary agenda item for discusion was related to the SNJ Fund serving as the Lead Agency for 297HICPS and the necessary process to advance seeking bids for the provision of third party claim administration services for all of the Registered Members of the 297HICPS.

Mr. Harris spoke in detail about the two separate prequalification regulations that were the focus of the discussion. The first regulation identified as Prequal. Reg. 2025-01, pertains to the Aetna network. The second, Prequal. Reg. 2025-02, relates to the AmeriHealth network. These regulations are designed to establish the baseline capabilities of potential third-party administrators who may seek to manage services for the health insurance funds associated with the Cooperative. The adoption of the prequalification regulations is an essential step to the ultimate release of bid specifications.

Mr. Harris provided a thorough explanation of the contents and purpose of the presented documents. He noted that the regulations outline specific requirements that potential bidders must address in their submissions. One key element is the inclusion of census data. For the Aetna network, this data covers all seven member funds: Bergen Municipal Employee Benefits Fund, Central Jersey Health Insurance Fund, Metropolitan Health Insurance Fund, North Jersey Regional Employee Benefits Fund, Schools Health Insurance Fund, Southern Coastal Regional Employee Benefits Fund and the SNJ Fund. The data identifies each enrolled employee's location by zip code and their type of enrollment, whether it be single, employee plus family, or employee plus dependent.

Another component of the prequalification package includes a complete listing of all plan designs used by each member of the Cooperative, down to the individual municipality or school board level. Mr. Harris emphasized that this level of detail ensures bidders have a full understanding of the diversity and complexity of coverage needs within the Cooperative.

Further, the regulations require that bidders disclose their management and reporting capabilities. This section provides insight into how each administrator handles oversight, data reporting, and day-to-day operations. Bidders are also asked to provide any performance guarantees they are willing to commit to as part of their proposal.

Lastly, Mr. Harris described the requirement for bidders to report on the discounts they are able to secure from their provider networks—referred to as self-reported discounts. This allows the Cooperative to evaluate the relative financial advantages each network may bring based on provider reimbursement rates and negotiated discounts.

Mr. Harris concluded the presentation by reiterating the comprehensive nature of the two proposed prequalification regulations and the importance of ensuring that all bidders meet the high standards expected by the Cooperative. Mr. Harris suggested that the meeting be opened to the public and that the pre-qualifications be read aloud for purposes of absolute clarity:

MOTION TO OPEN THE MEETING TO THE PUBLIC TO READ THE PREQUALIFICATIONS REQUIREMENTS OF 2025-01

Moved:	Commissioner Mevoli
Second:	Commissioner Peddicord
Vote:	All In Favor

Mrs. Koval read the entirety of the below Prequalification Regulations Statements of General Notice and the Statements of Bidders Qualifications/Criteria for Evaluating Prospective Bidders:

PREQUALIFICATION REGULATIONS FOR
THIRD PARTY CLAIM ADMINISTRATION SERVICES

Southern New Jersey Regional Employee Benefits Fund ("SNJ Fund") as the Lead Agency for 297HICPS (Health Insurance Cooperative Pricing System)

STATEMENT OF GENERAL NOTICE

The SNJ Fund as the Lead Agency for 297HICPS, consisting of the following joint self-insured health plans: Bergen Municipal Employee Benefits Fund, Central Jersey Health Insurance Fund, Metropolitan Health Insurance Fund, North Jersey Regional Employee Benefits Fund, Schools Health Insurance Fund, Southern Coastal Regional Employee Benefits Fund, Southern New Jersey Regional Employee Benefits Fund (collectively the Registered Members" and individually, "Registered Member") is seeking bids for the provision of third party claim administration services for all of the Registered Members of the 297HICPS. The successful bidder must be able to provide access to a network of healthcare providers serving the 21 counties in New Jersey as well as nationally to accommodate active members in New Jersey and

retired participants that may reside outside of New Jersey or active members who may need to access care outside of New Jersey. The current network provider is Aetna.

The scope of work consists of a single contract for: Third party claim administration services inclusive of the provision of a comprehensive national provider network; provide a robust plan design selection that will match existing benefit designs so that they are "equal to or better than" current designs; strong claim administration processes inclusive of claims adjudication, medical care management and medical policy administration; accept electronic enrollment and eligibility in pre-formatted structure to allow individual entities to be separately tracked with individualized reporting; provide detailed monthly reporting of paid claims and other reports to measure performance and claim management effectiveness; accept electronic claim payments on a weekly basis and provide claims and data reports on an individual basis.

The owner's project contact is Brandon Lodics, Executive Director, 2 Cooper Street Camden, NJ 08102.
Phone: 856-552-4628 Email Address: blodics@permainc.com.

The Qualified Purchasing Agent for this contract is**:** The Canning Group, LLC, 45 S. Park Place 183, Morristown, NJ 07960 Attn: Sean P. Canning
Phone: 862-228-3563 Email Address: scanning@thecanninggroup.org

Fact Sheets providing plan design information, census data, reporting and data collection requirements and related administrative services information are attached.

Procurement regulations require that prospective bidders must submit a completed Qualifications Statement as set forth herein. A completed Bidder's Qualifications Statement must be submitted in four (4) hard copies and one (1) electronic copy to **PERMA Risk Management Services 2 Cooper Street Camden, NJ 08102 Attn: Brandon Lodics** by 3:00 P.M. prevailing time on July 29, 2025. Failure to complete the Bidder's Qualifications Statement could result in disqualification of the prospective bidder.

The qualifications of prospective bidders will be evaluated by representatives of the SNJ Fund and the QPA in accordance with the Evaluation Criteria set forth herein. Prospective bidders whose Bidder's Qualifications Statements are determined to be acceptable will be identified as Qualified Bidders. Prospective bidders who are not identified as Qualified Bidders will be notified.

The SNJ Fund will notify in writing the Prospective Bidders who have been determined to be Qualified Bidders. The SNJ Fund's governing body will issue bid proposal forms and specifications only to Qualified Bidders. Only bids received from Qualified Bidders will be opened.

STATEMENT OF BIDDER'S QUALIFICATIONS/CRITERIA FOR EVALUATING PROSPECTIVE BIDDERS

The following six (6) criteria will be used for evaluating the qualifications of prospective bidders. The evaluation will be based on information in the Statement of Qualifications provided by prospective bidders as well as information supplied by the bidders' references.

- *Comprehensive National Prover Network* – Provide a network of contracted providers that meets reasonable access and disruption standards over the 21 counties in New Jersey and nationally to accommodate active members in New Jersey, retired participants that may reside outside of New Jersey or active members who may need to access care outside of New Jersey. A comprehensive network will be able to provide reasonable access to a broad range of network providers and offer a network that has limited disruption when compared to the current network of providers used by the Registered Members. For New Jersey, acceptable access (distance) and disruption (match) results need to minimally be 90% or more. See the attached Exhibit "A" which contains census data for the Lead Agency and Registered Members of the 297HICPS. Prospective bidders must be able to serve this population.
- *Structural Plan Design* – Be able to duplicate the plan of benefits for the local units of the Lead Agency and Registered Members so that the benefit designs are "equal to or better than" current plan designs. This includes and is not limited to matching structural items like copayments, coinsurance, deductibles, visit limits or maximums and out of network fee schedules. To satisfy this requirement, bidders must submit a letter of attestation that they shall comply with this criteria. See the attached Exhibit "B" which contains a listing of all of the plan designs currently in place for the Lead Agency and the Registered Members of the 297HICPS.
- *Administrative Design and Management* – Be able to administer the plan design as it related to claims administration and medical management in a way that largely replicates the current administration as outlined in the attached Exhibit "C" which contains a detailed listing of the services to be provided. This includes administration around claims adjudication (i.e., coordination of benefits handling, subrogation, etc.), medical care management and medical policy administration. This also includes a willingness and capacity to collaborate around the reasonable administration of policies that may be requested. To satisfy this requirement, bidders must submit a letter of attestation that they shall comply with this criteria. See the attached Exhibit "C" which outlines the administrative and reporting requirements that a prospective bidder must be able to provide to the Lead Agency and the Registered Members of the 297HICPS as well as performance criteria and network discounts .

- *Eligibility* – Be able to accept electronic enrollment and eligibility in a pre-formatted structure that allows for each entity to be separated for tracking and reporting purposes. This includes accepting weekly electronic eligibility files, process eligibility updates, issue discrepancy reporting and issue timely ID cards and enrollment data from said files. To satisfy this requirement, bidders must submit a letter of attestation that they shall comply with this criteria.

- *Reporting* – Be able to issue a monthly complete, detailed paid claims report in the specified record layout to the claims data warehouse used. Further, issue other performance and claims management reporting applicable to allow for performance management and oversight. To satisfy this requirement, bidders must submit a letter of attestation that they shall comply with this criteria.

- *Banking and Treasury* – Be able to accept claim payments electronically, on a weekly basis, for the SNJ Fund and the Registered Members as whole and structurally, be able to properly allocate claims and data reports as such on a group by group basis. To satisfy this requirement, bidders must submit a letter of attestation that they shall comply with this criteria.

Chair Mevoli opened the meeting to the public and asked for any questions or comments. There were none.

MOTION TO CLOSE THE MEETING TO THE PUBLIC TO READ THE PREQUALIFICATIONS REQUIREMENTS OF 2025-01

Moved:	Commissioner Cheeseman
Second:	Commissioner Gallagher
Vote:	5 ayes, 0 nays

MOTION TO OPEN THE MEETING TO THE PUBLIC TO READ THE PREQUALIFICATIONS REQUIREMENTS OF 2025-02

Moved:	Commissioner Mevoli
Second:	Commissioner Gallagher
Vote:	All In Favor

Mr. Harris continued the meeting by addressing the second of the two prequalification regulations, Prequal. Reg. 2025-02, which pertains specifically to the AmeriHealth network. He stated that there are four funds that utilize the AmeriHealth network: the Central Jersey Health Insurance Fund, the Southern Coastal Regional Employee Benefits Fund, the Schools Health Insurance Fund, and the Southern New Jersey Regional Employee Benefits Fund.

Mr. Harris explained that this prequalification regulation is identical in structure and content to the one pertaining to the Aetna network, with the exception of the data and exhibits being tailored to the AmeriHealth network. Specifically, the census data in this version reflects only the members and geographic data associated with the four AmeriHealth-participating funds. Likewise, Exhibit B, which contains plan design information, outlines only the health plans used by these four funds under the AmeriHealth network.

Mr. Harris further clarified that the managerial criteria and the section on self-reported discounts are identical in both versions of the regulations. These sections provide a consistent framework for evaluating each potential administrator's capabilities and provider network performance.

Mr. Harris noted that while the textual content of the two prequalification regulations remains consistent, the only distinctions are those directly related to the respective networks—Aetna in Prequal. Reg. 2025-01 and AmeriHealth in Prequal. Reg. 2025-02.

Chair Mevoli opened the meeting to the public and asked for any questions or comments. There were none.

MOTION TO CLOSE THE MEETING TO THE PUBLIC TO READ THE PREQUALIFICATIONS REQUIREMENTS OF 2025-02

Moved:	Commissioner Cheeseman
Second:	Commissioner Peddicord
Vote:	All In Favor

MOTION TO APPROVE RESOLUTION 27-25:

Moved:	Commissioner Gallagher
Second:	Commissioner Cheeseman
Vote:	5 Ayes, 0 Nays

With the adoption of both Resolutions, Mr. Harris indicated that the Prequalifications will be submitted to the Department of Local Government Services.

OLD BUSINESS: None

NEW BUSINESS: Mr. Lodics took a moment to acknowledge and express appreciation for the efforts of key contributors involved in the development of the prequalification regulations. He recognized the valuable work of the Qualified Purchasing Agent Sean Canning, the Fund Attorney, and the team at Conner Strong & Buckelew. Mr. Lodics noted that their collaboration and support were instrumental in bringing the process to its current stage of completion.

MOTION TO DESIGNATE MRS. ROBINSON AS THE CLERK FOR THE PURPOSES OF SIGNING THE CERTIFICATIONS IN ABSENCE OF THE FUND SECRETARY:

Moved:	Commissioner Cheeseman
Second:	Commissioner Peddicord
Vote:	All In Favor

PUBLIC COMMENT: Chair Mevoli thanked everyone for their efforts in this matter.

MOTION TO ADJOURN:

Moved:	Commissioner Gallagher
Second:	Commissioner Cheeseman
Vote:	All In Favor

MEETING ADJOURNED: 3:45pm
NEXT MEETING: July 28, 2025 4:15PM
ZOOM

Jordyn Robinson

Jordyn Robinson , Assisting Secretary
for

SECRETARY