# Pima County Health Care Benefits Trust Board Meeting
# May 9, 2019, 9:00 a.m.

Pursuant to A.R.S. § 38-431.02, notice is hereby given that the Pima County Health Care Benefits Trust held a meeting open to the public on **Thursday, May 9, 2019, at 9:00 a.m**. The meeting was in the Human Resources Training Room located on the 4th floor of 150 W. Congress, Tucson, Arizona.

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## MINUTES

### A. Roll Call

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| Present | Henry Boice, Chair, Board Member<br>Keith Dommer, Board Member<br>Daisy Jenkins, Board Member<br>Dr. Francisco Garcia, Board Member – arrived after roll call<br>Ellen Wheeler, Board Member |
| Absent | None |
| Also Present | Marchelle Pappas, Board Coordinator<br>Cathy Bohland, Pima County, Human Resources<br>Matt Weel, CVS Health<br>Jennifer Billa, Pima County, Human Resources<br>Mike Zucarelli, CBIZ<br>Eric Rustand, CBIZ<br>Ana Roth, CBIZ<br>Andy Welch, Pima County, Finance<br>Gayl Zambo, Pima County, Human Resources<br>Erin Marts, Pima County, Human Resources<br>Debbie Knutson, Pima County, Human Resources<br>Zulema Adame, Pima County, Finance<br>Karen Peters, Aetna<br>Xavier Rendon, Pima County, Finance<br>Tom Burke, Pima County, Admin<br>Casey Lawton, Ameritas<br>Ray Eveleth, Aetna |

Meeting was called to order at 9:00 a.m.

### B. Pledge of Allegiance

All present joined in the pledge of allegiance.

**C. Approval of February 14, 2019 Meeting Minutes**

Mr. Dommer moved to approve the minutes as presented. Ms. Jenkins seconded. Vote taken – 5:0 to approve minutes, motion passes unanimously.

**D. Aetna Presentation (30 minutes)** - presented by Ray Eveleth and Karen Peters

1. **Medical Utilization Review**
   - Third quarter – 7/1/18 through 3/31/19 comparing to 7/1/17 through 3/31/2018, for processed paid claims
   - Demographics – Little changes
   - Claim Segmentation – majority of claims for spend is male/female, 45-64 and make up 53% of medical spend
   - Financial Summary – Seeing an up-tick in spend. A high in-patient volume with increase in in maternity and a slight up-tick in severity of claims. There are underwriting cycles which occur typically every 3 to 4 years. Nothing standing out that a volume of high cost claims; it appears to be a trend.
   - Impact of High Cost Claimants – 50% increase in number of high cost claims. 26.1% of high cost claims are at $100,000 or more.
   - Top 10 Claimants – two mental health/substance abuse; 3 cancer, 3 renal disease; 1 inherited metabolic disorder; 1 heart disease with other chronic diseases. Majority are engaged through Aetna In Touch Care with a case manager. Ms. Jenkins claims #2 and #7, both have the history of relapse – how are we going to manage out of network claims going forward, will the plan be able to limit out of network spend on individuals that are not complaint with treatment. Mr. Rustand provides that per the Health Parody Act, if we exclude out-of-network for mental health/substance abuse, we must exclude out-of-network for medical. If we reduce the amount of reimbursement rates schedule the likelihood is that the facility will not take the member. Mr. Dommer raises questions if these negatively effects other members by trying to take care of these two members, if we limit reimbursements.
   - Medical Utilization – Admissions up 37.7%, due to increase in maternity and surgeries
   - Utilization by Relationship – Total admissions are high double digit increases. Surgeries for employees increased by 12%. Primary care visits have gone down. ER visits remaining relatively flat at 3.9.
   - Top 5 Disease Categories – Prevalence number that sticks out is obesity at 7.2%. Ms. Jenkins asked if HR initiatives are aligned with the areas of spend. HR is looking into a weight management program. Ms. Jenkins asks if there is an incentive program. HR provides a reduction in premiums for participating in wellness activities. The County can no longer get a direct incentive tied to preventative care due to recent Court rulings. Dr. Garcia suggests thinking about some County policy related solutions, such as the vending policy (healthy items in the vending machines).

- Top 5 Diagnostic Categories – Musculoskeletal/Connective is at the top with an increase in digestive, kidney and nervous system.
- Network Summary – Remaining issue with out-of-network and could have significant savings with in-network. Mr. Boice questions the increase in claims and whether it is to be expected with the Plan's maturity. Aetna responds that it is the population that has remained here that is having the issues due to age, thus maturity of the plan. Mr. Boice confirms that Aetna is not saying there is a concern at this time. Aetna agrees and suggests a performance network, the Aetna Banner network, may be assistive due to integration between care providers and facilities in order to follow members. Dr. Garcia states that for high utilizers that makes sense, but for typical employee who has modest charges, it may not. Dr. Garcia suggests focusing in on the areas that are increasing as the labor force continues to change to prepare for more consumption in disease categories and population health trends for ongoing future years and have a healthy reserve to absorb those anticipated events/cycles.

**E. Caremark/CVS Presentation (20 minutes)**

Matt Weel from CVS Caremark presented the Pharmacy Utilization review to include data and RX detail. Currently CVS will look at quarter over quarter as there is no prior year information in which to compare.

- Key Metrics – Provides comparisons to other governmental groups and private sector. Monthly utilizers stayed consistent. $6.00 increase per member/per month due to specialty gross costs which increased $4.00. Member costs $87.13 which has increased in 3rd quarter due to type of plan being HDHP; however, is a good cost and does not include rebates. Generic dispensing rate of 87.5%. Typically decreases as meet deductible, but good to see that it is increasing and not going to non-generic after deductible met. Members are choosing to fill the 90 day supply at CVS stores.
- Specialty Pharmacy Trend – 106 Specialty Utilizers this quarter. 1% of utilizers contribute to 40% of the gross costs. The current Plan design is very pro-active.
- Financial Review of Specialty Population – Largest percentage comes from rheumatoid arthritis, which the prevalence slightly higher than benchmarks. Five new users of the oncology utilization has the highest spent at $264,622.
- Top 10 Therapeutic Class – Anti-diabetics is the largest cost - $18.07 per member/per month, which is not uncommon. Anti-inflammatory is second which is where the rheumatoid arthritis sits. Ranked number 5 Psychotherapeutic Neurological; however, multiple sclerosis is the majority of spend in that class.
- Top 25 Drugs – 14 of the top 25 are specialty medications, contributing 40% of the overall costs.

Mr. Weel stated that they have outreached to 14 members for high costs members and are successful having reached 13 who are engaging in conversation/texts with nurses or case manager.

Mr. Weel states that they are helping members locate rebates. Dr. Garcia mentions the discounts and the concerns that are being articulated broadly nationwide and the price transparency issues will be something to watch as that conversation occurs. Mr. Weel advises that for specialty drugs that come out of the CVS specialty stores, only what they are paying out of pocket is going to their deductible. Ms. Zambo asked Mr. Weel for CVS to verify whether this is correct that the coupon is not indeed going towards the deductible.

**F. Ameritas Presentation (15 minutes)** – presented by Casey Lawton

**1. Dental Utilization Review**

- Paid claims – by next quarter there will be an adjusted projection based on 1st and 2nd quarter.
- Monthly Paid Claims – higher spike in the PEMP than last year. Lower than the projection due to trending more in network.
- Clarification from Mrs. Zambo that this plan operates on a calendar year.
- Paid Claims by Type – slight trend closer to the bench mark. Type 1 and 2 procedure types have more claims in these categories. Reason could be that preventive work is now covered at 100% and more in network usage.
- Paid Claims by Procedure – same trends as last slide, but broken down by procedure.
- Network Utilization by Procedure – more claims submitted in network (4% increase), especially in preventive services which is good.
- The plan is seeing a lot of Mexico network usage as well.
- Question from Mr. Boice on what would be our goal percentage of in network. Mr. Lawton said in the state of AZ it is about 80%, which we are slowly trending to.
- Mr. Rustand explained specialists tend to stay out of network.
- Follow up on previous issue brought up by Dr. Garcia about fluorination in water and if there was any data related to costs compared to areas that fluorinate their water. Mr. Lawton explained that there is no data specifically, but with more information on the areas in question further research can be done. The Board does not request further information at this time.

**G. CBIZ Presentation (15 minutes)** – Presented by Eric Rustand

**1. Inclusion of Gender Dysphoria Coverage Discussion -**

Mr. Rustand addresses the inclusion of Gender Dysphoria which is the identification to a gender that a person is not assigned at birth. As part of the ACA law, the specific coverage is line-itemed that those entities that receive Federal funds are required to carry it, such as Aetna. Pima County is a public sector and self-funded and not required to provide this coverage; however, Aetna already provides this coverage. Three surgeries are considered medically necessary. Recommend that we mirror the coverage that Aetna already provides. The recommendation is to cover this benefit based upon the Aetna Clinical Policy Bulletin 615.

- Mr. Eveleth stated there is a .003 (1 per year) claims projection without the potential pent-up demand. The average cost for the entire procedure package is about $100K. Factors effecting are costs, meeting criteria, and physicians that can provide the surgery. Only 5,000 are nationally performed.

Ms. Jenkins asked about the percentage of cost for medically necessary vs. cosmetic procedures. Mr. Rustand stated the medical provider would make the decision and that cosmetic surgery is not covered. Aetna exclusions would also apply. Dr. Garcia explained how medical necessary procedures are reviewed by a medical panel. Does not think that will occur in the first year but over the next 5 to 10 years. If the health plan deems a procedure cosmetic and not medically necessary, HSA dollars may not be used. All non-medically necessary procedures would not go towards the member's deductible/co-insurance.

Mr. Rustand mentions it is not up to Pima County to determine whether they can use HSA; it is an audit that would uncover that. Neither can the amounts paid go to a deductible. Dr. Garcia thinks this would be a good approach. Mr. Rustand provides that members also have appeal rights. Mr. Rustand requests Aetna to provide information regarding the appeals process. (TABLED FOR DISCUSSION IN AUGUST)

Ms. Jenkins mentions the conservative nature of the state and larger, what would be the public reaction to this type of procedure being performed and use of tax payer dollars, also mentioning that this is a very emotional topic. Mr. Rustand mentioned the ACA only requires fully insured plans to cover this benefit and that self-insured plans are not required to cover the benefit.

Dr. Garcia talks about hormonal maintenance and asks if CVS is aware of long-term costs. The drug costs for hormones are relatively low. Currently the plan does not cover the hormones and if approved, so this part of the plan would need to be changed to include it.

Mr. Dommer asks about the hormone therapy coverage for children. Question is posed as to whether there is coverage for the pre-surgical costs for behavioral mental medications and Mr. Rustand provides it would be covered.

**2. Out of Network Reimbursable Amount**

Ms. Jenkins wants to know what we can do to manage the OON costs for individuals with mental health/substance abuse (MH/SA). Mr. Rustand stated we are limited in our ability to remove OON facilities due to the Mental Health Parity Act. We can work to regulate the employer portion of the claims to be at 110 percent of Medicare vs. 200 percent. This will put more of the cost burden on the individual, rather than the County. Currently 2 members are listed under the top 10 high-cost claimants for MH/SA.

**3. Claim Review**

- January – March average 111% cost increase due to increased inpatients and specialty pharmacy.
- Rebates on pharmacy have doubled to $1.5 million. Pharmacy spend is overall lower.
- Total paid claims show an actual PEPM of $715, but with runout projected to be $749. Total runout for following year is $2.2 million.
- Plan costs are up and member costs are down due to utilization in later months of the year.
- Dr. Garcia wanted to know what percentage of employees hit deductible. Mrs. Zambo stated that 35% met half of deductible.
- Dr. Garcia would like to see how we manage the money spent after deductible has been met, so it is more predictable.

**H. Action Item (10 minutes)**

Mr. Rustand recommends that Pima County cover the benefit based upon the Aetna 615 CPB. Mr. Burke and Dr. Garcia stated they have heard of interest in members who want this benefit included. Dr. Garcia believes we should take action sooner rather than later. Mrs. Wheeler asked if the BOS needs to approve and Mr. Burke said they do not.

Mr. Dommer is concerned about the details relating to "Top Surgery" and would like more information provided to the Board. Dr. Garcia agrees certain components need to be defined. He believes the addition of this benefit may impact the decision of future hires within Pima County.

Dr. Garcia requests the ongoing cost of hormone replacement therapy and post-surgery Rx costs.

Ms. Jenkins is concerned that the majority age (18 and over) is a factor in her decision and would request that Aetna to exclude the benefit for under the majority of age. Dr. Garcia requests that Aetna provide the number of times this procedure has been conducted for individuals under the age of majority.

Mr. Boice identified he was hearing that the Board would like to table the discussion until the next meeting in August. Mr. Boice moved to table the vote for a future meeting in order further review additional information to include:

- Minors
- Rx
- Top Surgery
- Appeals
- Challenge of medical necessity

Mr. Dommer seconded. Vote taken – 5:0 to table the action item, motion passes unanimously.

4. **Pima County Finance (20 minutes)** – Presented by Andy Welch
    1. **Quarterly Review**
        - Total current assets are down by $1 million due to timing and way that pay periods fall.
        - Deferred outflows of resources only change annually.
        - Total net position is down $1.7 million. We are intentionally trying to lower the fund and only have a six month reserve or approximately $25 million balance.
        - Operating revenues are up due to the trust paying for employees. Other revenue is up due to pharmacy rebates increase.
        - Operating expenses are up due to medical claims being up $1.7 million.
        - Operating Income Loss of $8.7 million which is intentionally to reduce fund.
        - Investment income is up due to increased return on investments.

    2. **Investment Review**
        - Long term pool has $25.9 million. It requires that the money remain in it for 18 months and can only be withdrawn once a month. Earnings to date are $619,000.
        - Treasurer's pool is more liquid and has a balance of $14.6 million and has earned $219,000 as of February.

5. **Call to the Audience**

    Mr. Burke spoke noting that the Pima County Board of Supervisors adopted a policy to televise all Boards and Commissions. The Clerk of The Board is in the process of rolling out a schedule and this Board will be included in the schedule. The meetings will be televised and recorded as part of the public meeting requirements.

    Ms. Bohland took the opportunity to thank Mr. Boice for his service as part of the Health Benefits Trust Board. Mr. Boice's term expires the end of May 2019, so this will be his last meeting.

6. **Next Meeting Date –** August 8, 2019 at 9:00 A.M**.**

7. **Adjournment at 11:02 A.M.**