# Pima County Health Care Benefits Trust Board Meeting
# August 8, 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, August 8, 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 | Mr. Keith Dommer, Board Member<br>Ms. Daisy Jenkins, Board Member<br>Dr. Francisco Garcia, Board Member<br>Ms. Ellen Wheeler, Board Member |
| Absent | None |
| Also Present | Aurora Hernandez, Pima County, Coordinator<br>Cathy Bohland, Pima County, Human Resources<br>Gayl Zambo, Pima County, Human Resources<br>Jennifer Billa, Pima County, Human Resources<br>Erin Higdon, Pima County, Human Resources<br>Debbie Knutson, Pima County, Human Resources<br>Emily Kruspig, Pima County, Human Resources<br>Tom Burke, Pima County, Admin<br>Zulema Adame, Pima County, Finance<br>Mike Zucarelli, CBIZ<br>Eric Rustand, CBIZ<br>Jessica Velasquez, CBIZ<br>Ray Eveleth, Aetna<br>Karen Peters, Aetna<br>Matt Weel, CVS Health<br>Rose Stamps-Proper, Ameritas |

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 May 9, 2019 Meeting Minutes**

Moved by Mr. Dommer, seconded by Dr. Garcia, approved 4:0.

**D. Discussion and Action for new HCBT roles**

**1. Chairperson**

Mr. Dommer calls for nominations for a Chairperson. Ms. Jenkins moves the nomination of Mr. Dommer. Dr. Garcia seconds the motion. Motion passes unanimously.

**2. Vice Chair**

Mr. Dommer calls for nominations for a Vice Chair. Ms. Wheeler moves the nomination of Ms. Jenkins. Mr. Dommer seconds the motion. Motion passes unanimously.

**3. Secretary**

Mr. Dommer calls for nominations for Secretary. Question from Dr. Garcia if a secretary is necessary. Discussion on the role and purpose of the Secretary position. Dr. Garcia moves the nomination of Ms. Wheeler. Ms. Jenkins seconds the motion. Motion passes unanimously.

**E. Gender Dysphoria – by Eric Rustand**

**1. Caremark - Ongoing Rx cost of hormone replacement therapy and post-surgery**

Mr. Rustand discussed ongoing Rx cost of hormone replacement therapy and post-surgery. The Rx costs are estimated to be .016 PEPM or appx $2,100 annually based on national averages; cost $4,000 for Male to Female (Mtf); cost $230 for Female to Male (FtM) annually.

**2. Aetna – number of times this type of surgery has been performed on individual under the age of majority**

Mr. Rustand discussed the item. Surgery on minors has not been approved yet for under age 18 but that doesn't mean it cannot be. CBiz recommends that Pima County provide coverage for Gender Dysphoria as set forth in Aetna Clinical Policy Bulletin 615, which does not recommend irreversible surgery be performed on members under the age of 18. The Trust is permitted to state that a member must reach age of majority in the country in which they reside. Dr. Garcia states that since dependents can remain on parents' coverage until the age of 26 there is not a pressing need to permit coverage for irreversible surgery for individuals under the age of majority. In addition, this is a multi-year process and the individual and County would be best served by not permitting irreversible surgery under age 18.

**3. CBIZ – Challenges of medical necessity &**

**4. CBIZ – "Top" surgery (medical necessity vs. cosmetic)**

Mr. Rustand discussed the item. There is a long list of items that are deemed "medical necessity." Whether breast reconstruction (or "top" procedure) is deemed "medical necessity" depends on whether it is for breast cancer-reconstruction (usually medical necessity) vs. surgery for gender dysphoria/construction (usually not deemed medical necessity). Mr. Rustand advises that Aetna can and should be the entity to review proposed surgery and make the determination regarding medical necessity, rather than individuals coming to the Trust or HR.

**5. CBIZ/Aetna – Appeal process and frequency of appeals**

First Level Appeal - How does it read in the Plan? (Is it a covered service?)

Second Level Appeal – Peer to peer review with provider and the Chief Medical Director of Aetna to determine whether medically necessary when the item is contained in the list of exclusions.

Third Level Appeal – Put in place by the ACA and is a process outside of Aetna and the County. This is an independent review that will make the determination of whether the procedure is medically necessary.

Mr. Rustand recommends that the appeal process not include the County.

Mr. Dommer – Asks for clarification on "medically necessary" to remove breasts when FtM but not "medically necessary" to add breasts for MtF. Mr. Rustand clarifies that this is a "may" and therefore it could be deemed "medical necessity" but not necessarily exclusive. Mr. Dommer wants to ensure that breast reconstruction be treated the same for all, i.e. breast cancer vs. gender dysphoria.

Mr. Rustand recommends that Trust follow the most recent updated Aetna Clinical Policy Bulletin 615.

Ms. Wheeler requests that the Trust Board be provided any updates to the Aetna Clinical Policy Bulletin 615 as they are made.

Mr. Rustand states that there is no way to determine the pent-up demand for gender dysphoria treatment. However, he did point out that individuals still need to go through the qualifying process. Dr. Garcia states that there could be individuals who are receiving hormonal therapy and are in some step of the process. The process would need to start from scratch for those individuals.

**6. CBIZ - Proposing language to exclude surgery for minors**

Language was provided earlier. Mr. Burke requested clarification on the version of the Aetna Clinical Policy Bulletin 615 to use to make a decision. Dr. Garcia stated that the Trust Board members are not Subject Matter Experts in this area and recommends that the Trust allow Aetna to determine eligibility criteria for this benefit. Mr. Rustand provided insight to how claims will

be paid based upon the most recent Clinical Policy Bulletin and recommends not changing the language too much.

**F. Action Item - Gender Dysphoria**

Ms. Jenkins moves to provide coverage for Gender Dysphoria pursuant to the most recent Aetna Clinical Policy Bulletin 615 and to modify the age of majority requirements to read age of majority must be satisfied (18 years and older) for irreversible surgeries. Dr. Garcia seconds the motion.

Dr. Garcia requests that the Trust be advised of any future changes to the Aetna Clinical Policy Bulletin 615. Clarification is made as to when the Gender Dysphoria coverage will be implemented. Material modifications to coverage require 60 days.

The motion is modified to include the effective date of October 8, 2019. Roll call for each member is: Ellen Wheeler – Aye; Keith Dommer – Aye; Daisy Jenkins – Aye; Francisco Garcia – Aye. Motion passes unanimously.

**G. Aetna Presentation - by Ray Eveleth and Karen Peters**

**1. Medical Utilization Review**

**Demographics** – Comparing the period July 1, 2017 to June 30, 2018 to the period July 1, 2018 to June 30, 2019. The Trust requests an annual update of demographics. Numbers remain consistent. 54% of medical spend remains with males and females 45 to 64. Increase of 16% to total medical paid amount and 49.1% in the inpatient paid amount per member. The overwhelming majority of increase is due to the high cost claimants. Further clarification that we are seeing increase in severity, as well as facility costs. Mr. Rustand confirms the increase nationally to facility costs.

**High Cost Claimants** – Increase 29.6% for the number of claimants and 21.1% for the average paid per catastrophic claimant. This amounts to 31.6% of total paid amount.

**Summary of Top 10 Claimants** – Eight are continuing treatment. Two project a reduction in spend. Of the 10, eight are actively engaged in care management; either with Aetna or with another vendor such as DaVita (an outpatient dialysis facility). For the high cost claimants by category, cancer is at the top, mention is given to the substance abuse disorders that remain significant.

**Medical Utilization** – 40.8% increase driven by maternity, newborns, and digestive procedures. Dr. Garcia clarifies digestive procedures – two liver transplants are included in this area. Also clarification on increase in number of pregnancies or severity of health issues to newborns – both are the cause.

**Top Disease Categories** – These have remained the same.

**Top Diagnostic Categories** – 24% drop in musculoskeletal; however increases in digestive, kidney and nervous system. Also increase in skin category. Dr. Garcia asks if this is related to dermatology screening. The results from the mobile units would not be processed yet, so this might cause an increase.

**Summary** – 6% drop in in-network admissions. Mr. Rustand states that this drop is not unique to the County's Plan but a problem throughout the industry.

Ms. Wheeler asks about covered bariatric services and asks if there are some statistics to share. Ms. Peters advises that it is too soon to tell and that it takes approximately a year.

Further discussion regarding out-of-network care. There is not a certain facility that individuals are using, the facilities are all over the Country. Dr. Garcia states that the County needs to get ahead of this and develop relationships with out-of-network facilities that are willing to establish a rate, percentage, per diem or flat fee. Human Resources and CBIZ are directed to explore and put together a plan to see if a contract could be established, with CBIZ making contact with the facilities.

**H. Caremark/CVS Presentation – by Matt Weel**

1. **Pharmacy Utilization Review –** Comparing the period January 2019 to March 2019 to the period April 2019 to June 2019.

**Eligibility** – Not much of a change.

**Costs -** $500,000 increase due to: 1) the member cost share decreased in that the member has met their deductible; and, 2) Gross Cost in per member/per month to 16.2%

**Drug Mix** – Not much of a change.

**Utilization** – Slight increase due to more members. Majority of prescriptions are filled in retail pharmacy (30 day supply), CVS mail Order, and Maintenance Choice (90 day supply at CVS pharmacy).

**Specialty** – Eight more specialty utilizers and more prescriptions resulting in $300,000 increase in gross costs. Small group of utilizers are increasing the spend by 43%; however, this is not unusual compared to the book of business.

**Top 10 Therapeutic –** Rheumatoid Arthritis remains the number one high cost spend, with one additional utilizer in this category. There is not one specific therapeutic class that is sticking out.

Dr. Garcia inquires about the top three and whether it is infusion therapy or oral medication. CVS states that it is driven by both.

**Top 25 Drugs** – Dr. Garcia asks if there are opportunities to achieve savings through a contracting mechanism for infusion therapies. Mr. Zucarelli clarifies that the data for this flows through Aetna as it is administered in-patient or in private medical offices. Mr. Zucarelli states that the CVS information is only for patient-administered drugs. 42% of spending is on specialty drugs. Dr. Garcia states that not all the costs for pharmacy show up on CVS data and that there is spending that is incurred in facilities and requests that Aetna provide this data in some useful format. Mr. Eveleth states that the information is available to share on a categorical level and that currently there is a decrease in spending.

**Adherence Metrics** – Numbers appear good. Dr. Garcia notes that it does not mean that the individual is taking the prescription, it means that the individual has purchased it. Further clarification given that the reported number of individuals obtaining diabetes medications does not include all those plan members that have diabetes, but only those who are being treated. Mr. Burke asked whether Aetna reaches out to encourage members to take the medication and it was confirmed they do. Ms. Jenkins requests Human Resources use this information for wellness purposes. Ms. Jenkins requests a book of business comparison on the adherence metrics.

Mr. Dommer asks if it takes options and convenience away from members when you move towards the right on the continuum profile power point slide. CVS confirms that is correct. Mr. Rustand discusses disruption vs. costs and where that decision point is made. Mr. Burke states it is a philosophical and procedural question as to how to get the most benefit at a reasonable cost.

## I. Ameritas Presentation – by Rose Stamps-Proper

**Dental Utilization Review** – Comparing fiscal trends from 2017-2020.

**Paid Claims** –Discussion ensues. Projection for 2020 is estimated amount with a slight increase, but still below annual trend. Projections are for a gradual increase.

**Monthly Paid Claims –** Discussion ensues. Remains consistent, but with a slight increase.

**Paid Claims by Type –** Discussion ensues. Higher percentage in preventive procedure type is desirable. Slight increase in preventive procedure type percentage, but also slight increase in all other types.

**Paid Claims by Procedure** – Discussion ensues. The County is consistent with benchmark or even lower. The orthodonture category has a slight increase. Discussion from Mr. Rustand that preventive services are not being utilized as much as they should which would decrease the need for more costly procedures.

**Network Utilization by Procedure** – Discussion ensues. Majority of claims are in-network which is preferred.

## J. CBIZ Presentation – by Eric Rustand

### 1. Claims Review

Mr. Rustand states that actual claims for the plan year ending June 30, 2019, were 87.2% of projected claims. There has been an uptick in the claims later in the year versus the actual projections. Some of this is cyclical.

Numbers provide a $740 PEPM, with no run-out included. A run-out of 4.5% increase in actual claims is expected.

The Premium Adequacy Report (PAR) is sent to Finance. A year-end wrap up will be presented at the next meeting.

In the last six months there has been significant increase in claims, which is due to members reaching their deductible earlier in the year. Mr. Rustand discusses the pharmacy rebates and that one more check is coming for the 4th quarter, with the average amount received at $750,000, which will offset some of the costs for the Plan year.

The numbers identify a 5.6% increase over last year for pharmacy and medical, with the rebates included (this percentage does not include dental). Though historically it has been at a low level, it is normal to have ebbs and flows. Mr. Burke mentions that the County has been able to keep rates the same or decreased. Mr. Dommer questioned if it is the Trust's responsibility to make all decisions. Mr. Burke answers that Finance and Human Resources can make changes to Plan. The Trust should monitor the costs and expenditures to ensure that it is financially sound.

## K. Human Resources Items

### 1. Annual Enrollment results – by Jennifer Billa

In March, the Wellness Program was changed to a points-based program. Roughly 500 employees attended the presentations/fairs to learn of the changes. Participation was good and evaluations were provided to gain feedback. 89% of employees are receiving a discount to their premiums. Discussion on including educational presentations during Annual Enrollment on new prevention screenings and bariatric surgery enhancements.

Little change in enrollment numbers. The EDS enrollment into the Ameritas enrollment were the largest change.

**2. Short Term Disability – by Jennifer Billa**

The Short-Term Disability Benefit was effective April 2, 2019. To date, Human Resources has processed 60 claims. Currently 19 are open and 41 are closed.

**3. Dental Plan Proposed Changes for FY2020/21 – by Debbie Knutson**

Dental contracts expire June 30, 2020. The County plans to go out to bid this Fall. The County intends to continue to offer two dental plans, the Indemnity Plan and DMO Plan. A survey was conducted of seven other government agencies in Arizona. It was found that Pima County provides a lower employer contribution amount towards premiums than comparable agencies. Human Resources is recommending that the County cover 70% of the premiums and the employee pay 30% for all tiers.

Additionally recommend that the Plan increase coverage to $3,000 per participant annually. Dr. Garcia asked if we have the information of who reaches the current $2,000 per participant amount. Human Resources will provide the information.

**L. Call to the Audience**

None

**M. Next Meeting Date – November, 14, 2019 at 9:00 A.M.**

1. Future Discussion Items
    - Information to be provided on reducing out of network substance abuse claims
    - Additional CBIZ analytics reporting Versend
    - Provide updated Aetna Clinical Policy Bulletin 615
    - Additional information on J-code pharmacy costs processed and paid under the medical plan with Aetna

**N. Adjournment at 11:00 A.M.**