LMBC Meeting Minutes

February 4, 2020
Conference Room 202, Portland Building
Attendance

LMBC Members present
Tom Armstrong
Dave Benson
Margaret Evans
Alan Ferschweiler
Mark Gipson
Jeannette Hopson
Christina Harris for Jamie Doscher
Craig Morgan
Rachel Whiteside

LMBC Members absent
Jamaal Anthony
Jamie Doscher
Leslie Goodlow
Ashlie Grundy
Claire Houston

Staff
Michelle Taylor
Joel Michels
Anne Hogan

Presenters
Anne Thompson (Aon)
Emily Shettel (Aon)
Shelley Zhao (Aon)

1. **Meeting Called to Order** – Co-chair Alan Ferschweiler called the meeting to order at 1:32 pm.

2. **Meeting Minutes Discussion**

Alan asked the committee to review the January 21st meeting minutes for any needed changes or additions. There were no objections to the minutes and the committee agreed to approve them as written.

3. **Preliminary 2020/21 plan year renewal report (Aon)**

Emily Shettel began the discussion by focusing on the updated Renewal Report slide deck. She let committee members know the bold, green font highlighted throughout the handout signified additional information Aon was able to compile. The focus for today's meeting is to have a broader discussion about potential Kaiser plan design changes and to prioritize the proposed plan changes members are interested in pursuing.

Self-insured plan final renewal costs were presented. Using City Health Operating Fund Reserves to reduce the CityCore medical and prescription costs, the premium increase would be 4.5%, a $2,647,254 million increase from previous plan year.

Emily presented one-year rate renewal proposals made by Kaiser, the fully insured plan, for medical, vision and prescription coverage on slide 7. Aon had slightly adjusted the numbers from the previous meeting. If the current plan design stays the same, rates will increase by 3.3% or $1,024,563 for the next plan year. Proposed plan changes that could lessen the impact include:

Tiers	Enrolled	Option 1: Rx Two Tier to Three Tier	Option 2: OOPM $600/$1200 to $1000/$2000	Option 3: Add Hospital Inpatient Copay (currently $0)	Option 4: Options 1-3 combined
Employee	571	$687. 69	$688.03	$689.07	$683.86
Employee + One	461	$1,341.00	$1,341.68	$1,343.70	$1,333.54
Employee + Two or More	853	$1,925.54	$1,925.50	$1,929.40	$1,914.84
Total Annual Cost	***1,885***	***$31,840,291***	***$31,856,209***	***$31,904,194***	***$31,663,254***
% Change Over Current		***2.9%***	***2.9%***	***3.1%***	***2.3%***
$ Change Over Current		***$896,710***	***$912,628***	***$960,613***	***$719,673***

Slide 8 highlighted these proposals in more detail:

- **Item 1 – Option 1 - Change Rx two tier copay to a three-tier copay -** Currently, it's $15 for generic and $30 for a 90-day supply through mail order. With this change, a third tier would be added: $50 for specialty medications.
    - **Member Impact: 452** members would pay a $30 copay, up from a $15 copay; **204** members would pay a $50 copay, up from a $15 copay; member cost sharing would increase by **$83,000**

- **Item 2 – Option 2 - Change Out of Pocket Maximum.** Currently, it's $600 for individuals and $1,200 for families. With change, the OOPM would be $1,000 for individuals and $2,000 for families.
    - **Member Impact: 262** members hit the $600 OOP maximum; **88** members would have hit a $1,000 OOP maximum

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- **Item 3 – Option 3 - Add Hospital Inpatient Copay** - Currently, there's no charge ($0) for hospital stays. With change, the copay per day would be $50, with a $250 maximum per admission.
    - **Member Impact**: **246** members spent at least one day in the hospital and would have paid at least a $50 per copay

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- **Item 4 – Options 1-3 Combined -** The rate increase would be 2.3% rather than the status quo increase of 3.3%, a difference of $304,890

Dave Benson wanted to know if any of these potential options resonated with committee members. Dave added that plan changes have been made to the CityCore plan in previous years when costs increased but not to the Kaiser plan. Craig Morgan responded by questioning why these plan changes are needed. There is little change between plans from year to year and enrollment numbers appear to be stable. He would like to wait on making changes until the committee is faced with hard choices. Rachel Whiteside and Alan Ferschweiler agreed. Emily mentioned that Aon could take a closer look at the enrollment numbers to better understand the trend these past years. Members asked Michelle Taylor to explain why making plan changes now would be preferable. She clarified making smaller incremental changes now could minimize the future ups and downs of both plans. Margaret Evans asked her if new employees choose the Kaiser plan and Michelle responded that new hires with families see the difference between the individual out-of-pocket maximums—$600 versus $1,800 on the self-funded plan—and may be inclined to choose Kaiser.

Committee members agreed they don't think now is the time for any Kaiser plan changes. Emily asked members to think about what types of options sound more feasible: Smaller changes which impact a larger group or bigger changes which impact a smaller group? Craig stated that employees who choose Kaiser like the transparency of their copay system. He suggested increasing the copay ($10.00 to $15.00 or $20.00) rather than changing the out-of-pocket maximum or adding other fees which may confuse members. Members of the committee agreed

with his suggestion and Aon will review the potential impact of increased copays for future plan design options.

Moving on to slide 12 and Moda's proposed optional benefit changes:

- **Item 1 – Limit in-network transplant coverage to Center of Excellence (COE) facilities:** Currently, COEs are not required for transplants. Moda notes that COEs have rigorous standards based on best practices and exceptional skills and expertise in managing patients with transplant needs cost-effectively. Moda can also coordinate with COEs to get the best contracted rate, but transplants are not a frequently utilized benefit. There were no transplants in the 2018-2019 plan year.

Emily highlighted the additional information Moda provided that addressed members' questions. COE certification is determined by third parties visiting these potential Centers of Excellence and evaluating a facility based on the following criteria:

1. Program outcomes (annual case volume, survival rates)
2. Program structure (Accreditations, program and physician experience)
3. Program process (Eligibility criteria, protocols)

These COEs are not the same for all types of transplants. Each specific transplant program is evaluated independently. Currently in Oregon, Legacy Good Samaritan Hospital has been certified as a COE for kidney transplants, Northwest Marrow Transplant Program for blood and marrow transplants and OHSU for kidney and liver transplants. Heart, lung, and pancreas transplant recipients would have to travel to the University of Washington Medical Center in Seattle as there is no COE for these types of transplants in Oregon.

As members mulled over implementing this change, Mark Gipson added it's hard to predict how travel would impact transplant recipients and their families. Tom Armstrong wanted to know if this change was not enacted, whether recipients could still travel to a COE outside of Oregon and have the transplant covered? Aon will request this information from Moda. Joel Michels added that the number of transplants a facility performs annually does matter as the transplant team will have greater experience and usually better patient outcomes. Committee members have interest in communicating the importance of choosing a COE facility but do not want to require patients to have their transplants performed at a COE.

Slide 13 listed the next Moda proposed benefit change:

- **Item 2 – Increase Cost Sharing for Naturopath Visits to Specialist Benefits:** Currently, naturopathic physicians are paid at PCP benefit level (members pay a $20 copay for office visits). With this proposed change, copays for naturopathic physicians would increase to the specialist benefit level—$35 per visit—unless they are credentialed as a PCP. However, this change would not impact the payment to the provider.
    - **The average PCP allowed amount is $216.25 and a naturopath is $162.61**

This change would affect approximately 180 members. Members questioned why we would want to implement this change if it would cost the plan less money in provider payments. Emily responded that some naturopathic providers may not have the same professional access/experiences as a traditional PCP. Joel added that among healthcare professionals, most believe that it's beneficial for patients to develop a relationship with a PCP for overall care.

Emily asked the committee about their thoughts on slides 14/15 and the proposed revision to the maximum plan allowable calculation:

- **Item 3 – Revise Maximum Plan Allowable (MPA):** Currently, the methodology for calculating the MPA for out-of-network services the same for all types of out-of-network providers. Moda recommends revising the definition of Maximum Plan Allowable (MPA) to summarize by removing the sequence of methodologies per service, giving a higher-level description of methodologies that may be used.

a. The MPA is the maximum amount Moda Health will reimburse providers. For an in-network provider, the MPA is the amount the provider has agreed to accept for a service.
b. This change would reduce reimbursement amounts for out-of-network providers and would primarily affect Alternative Care, Mental Health/Chemical Dependency, and Specialist claims.
c. Depending on what the provider chooses to do, they may "balance bill" the member if the MPA is reduced. This means that a member may be billed for the difference between the provider's charge and the MPA. For example, if the provider's charge is $100 and the MPA is $70, the provider may bill a member for the remaining $30.
d. Moda's intent with these changes is to incentivize bringing frequently utilized out-of-network providers into the Moda network, rather than the provider being incentivized to remain out-of-network. Moda notes that in some cases, out-of-network providers are receiving higher compensation than in-network providers.
e. Approximately **634** members could be affected but it could reduce claims by $375,000 (.72%)

Among other public entities, the City of Portland and one other local group have not adopted this change. Members were concerned about the possibility of an employee being billed for the remaining balance of services if this change was implemented. Asked for her thoughts on this change, Michelle answered she was concerned that as many as 634 members could be negatively impacted—especially those who may be seeing mental health and substance abuse providers. The possibility of a disruption to those services could be a real hardship. There has been a successful push by Moda to bring providers into the Connexus network and she would recommend the committee reevaluate next year.

Jumping to slide 24 and the proposed Moda optional dental plan changes, Emily discussed this change with members and emphasized that if a patient is seeing an in-network provider this change would have no impact.

- Item 1 – Retreatment of Retrograde Filings – Currently, retrograde fillings are covered regardless of frequency. Moda would like to change the plan so that a retrograde filling by the same dentist within a 2-year period of the initial retrograde filling would not be covered. Services billed by a different dentist would be covered.

a. Moda's position is the retreatment of a retrograde filling would be included in the charge for the original care. In-network dentists would write off the charge, but out-of-network dentists may charge the member.
b. Seven members had retreatment charges/services in the past plan year, but all were in-network.

- Item 2 – Limit Osseous Surgery Quadrants per Date – Currently, these surgeries are unlimited. With this change, osseous surgery would be limited to 2 quadrants per date of service. This change aligns with standard dental practice. More than 2 quadrants in one day may be difficult for a member to handle. Would not apply to emergency surgeries.

Committee members saw no problems with items 1 and 2 and would most likely agree to its implementation.

- Item 3 – Limit re-cementing or re-bonding implants/abutment supported crown or fixed partial dentures to once in any 12-month period – Currently, these procedures are covered with no restrictions. The rational for this change is that faulty workmanship or underlying issues with the implant/abutment need to be addressed first.

It was discussed that communicating this change to employees would be difficult because the coverage would vary depending on whether the same dental provider or a different provider performed the procedure. Committee members were not interested in pursuing this change.

Slide 26 highlighted the optional coordination of benefits proposed change:

- Item 4 – Adjust Coordination of Benefits to Standard – Currently, Accidental injury coverage was always secondary to medical. This change allows Moda to use standard COB rules (such as dependent/nondependent status, the birthday rule, effective date of coverage, etc.) to determine which plan (medical or dental) is primary.

This change would align dental coordination of benefits with medical COB and provide consistency. However, this change may not affect all employees equally depending on the secondary coverage, etc.

Moving on to slide 29, Emily asked committee members about the proposed changes in the VSP benefit as it would have a sizable premium impact particularly on the buy-up plan:

- Item 1 – Add Suncare Benefit - With change, members can use their frame allowance toward non-prescription sunglasses from their VSP provider's frame board, exhausting both their lens, frame, or elective contacts eligibility. **Premiums for would increase by 3.2% per year.**

- Item 2 – Enhance coverage and add suncare benefit to the buy-up plan:

a. Add Suncare Benefit
b. Increase Frame/Elective Contact Lenses to $200
c. Cover Standard Progressives with a $0 copay
d. Cover Premium & Custom Progressives with a $30 copay (currently $50 allowance)
e. Cover Anti-Reflective Coating with $30 copay (currently $30 allowance)
f. **Premiums for the Buy-Up plan would increase by 33.1%**

The consensus among committee members was that most employees would not use the benefit and the increase would not be justified.

As the end of the meeting was approaching, Emily moved on to slide 31 and the option to continue the behavioral health benefit enhancement (includes both mental health and substance abuse) which waives provider copays and fixes the cost of associated medications to a $15 copay for a 30-day supply. Though broad data was not available regarding member outcomes and costs and it will likely take another plan year to fully understand the trends, committee members agreed this program was important and wanted to continue the benefit for another year.

Aon encouraged members to review the rest of the slide deck handout and the additional information highlighted in bold, green font.

3. **Other Business**: None
4. **Public Comment:** None
5. **Next Meeting:** February 18, 2020. The meeting will begin at 1:30 PM and will be scheduled to go until 3:00 PM. February's meeting is scheduled in Conference Room 204 at the Portland Building, 1120 SW Fifth Ave.
6. **The meeting was adjourned at 3:00 pm.**