ST. LOUIS COUNTY
HEALTH INSURANCE COMMITTEE

The St. Louis County Health Insurance Committee met on Wednesday, May 17, 2017 at 9:00 a.m. in the County Board Conference Room. The meeting was called to order by Don Dicklich, Committee Co-Chair.

Members Present:	Lori Ulvi	Christina Hansen for Angie Mattson
	Don Dicklich	Tom Hadrava for Gordy Halverson
	Heather Ninefeldt	Nancy Hintsa
	Connie Westlund	Marsha Ness

Others Present:	Jeff Coenen	Tiffany Kari	Kim Hoffmockel
	Beth Menor	Charlie Hopkins	
	Dave Kuschel	Kay Lokken	

The February minutes were tabled due to the lack of a management quorum. No changes were requested.

PRESENTATIONS

1. The first item from the agenda was the Health Care Insights Report presented by Charlie Hopkins with BlueCross and BlueShield of Minnesota (BCBSMN). Mr. Hopkins provided handouts titled *Financial Comparison for St. Louis County and 2016 Health Care Insights*. Mr. Hopkins noted the following from his handouts:

    - The reports analyzed 2016 data and compared it to both the BlueCross BlueShield of MN book of business and to the City/County reference which included 80% of all Minnesota counties and two-thirds of the cities in Minnesota. Practices and utilization tend to be unique among public employers so this comparison proved useful and relevant.
    - The per member per month (PMPM) cost in 2016 ($598.20) was almost the same as the PMPM in 2015 ($596.63) which was significantly more than 2014 ($514.94). The expectation was that 2015 was an outlier year and that 2016 would settle back down to 2014 levels. This did not transpire because
        - Outpatient services increased 3.5% and cost per service increased 1.8%.
        - The most significant difference between St. Louis County and the City/County reference for both 2015 and 2016 was under professional services and was due to surgical follow up office visits from a high utilization of joint replacements (double that of the reference population).
    - The percent paid on high cases (those over $75,000) was 26%, much lower than the public employer reference where high cases account for 32% of spend.

- Active employees, as a group, had a decrease in PMPM, retirees PMPM increased.
- Psychiatry was the only practice category in the top 6 by spend that was not in the City/County reference's top 6.
- Illness burden was higher because the plan has more early retirees (those under 65) than the reference population.
- There is considerably less competition among medical providers in Northeastern Minnesota so the plan and its members pay the second highest prices in the state surpassed only by the Mayo system.
- Impatient admits, outpatient and professional were all higher due to the high utilization of surgical procedures.
- Emergency room (ER) visits continue to be significantly higher than the reference and cost more here ($1,517 vs. $1,450).
- The most common reason for ER visits was back pain.
- A major joint replacement costs $22,712, almost $5,000 less than the average cost within the reference population but utilization was high.
- Every joint replacement case over $10,000 was case-managed by BCBSMN.

Mr. Hopkins added that the high ER utilization could be explained by the joint replacements which often cause complication with backs. Committee members inquired on if it could also be caused by drug seekers or long waiting lists to see back specialist in the Twin Ports. Mr. Hopkins committed to drilling down into the data to see if either was a contributing factor.

OLD BUSINESS

2. The next item from the agenda was an update on the Find the Doctor Tool. Ms. Menor provided background on the Cook Community Hospital search conducted at the last meeting. She reported that the website was now up and working and the hospital was in-network at a tier 1 level of benefits. She cautioned committee members that when searching they should search by keyword(s) only. Searching "Raiter Clinic" for example would yield no results whereas searching just "Raiter" would yield in-network, tier 1. Mr. Kuschel committed to investigating as to whether this could be resolved. Ms. Menor also read the excerpt below from the Benefits Booklet to address the question about coverage at the lab in Cook that services both the hospital and the clinic.

- **Special Circumstances**

There may be circumstances where you require medical or surgical care and you do not have the opportunity to select the provider of care, such as hospital-based providers (e.g., anesthesiologists) who may not be Participating Providers. Typically, when you receive care from Nonparticipating Providers, you are responsible for the difference between the allowed amount and the provider's billed charges. However, in circumstances where you needed care, and were not able to choose the provider who rendered such care, the Claims Administrator may pay an additional amount. The extent of reimbursement in certain medical emergency circumstances may also be subject to federal law. Please refer to Emergency Care for benefits.

NEW BUSINESS

3. The next item from the agenda was the Claims Driver's report. Ms. Menor provided the report and noted the following:

    - The report was based on 2017 claims and that due to run-out it contained, at best, just a few months of data.
    - Pharmacy spend was slightly up and professional charges were slightly down – perhaps due to new contracting with Essentia. Inpatient was also up but it was too early in the year to determine a trend.
    - Diseases of the heart was the number one primary diagnosis among high cases. Cancer remained prevalent among high cases. Ms. Menor asked BCBM to bring back details about the vague high-case diagnosis of *Complications* and she also inquired if the diagnosis of *Fractures* was a continuation of the 2016 case. Mr. Kuschel committed to investigate and report back.
    - There was little change in the Top 10 providers but a separate report showed that Essentia's 2017 PMPM was lower than St. Luke's.
    - Generic utilization continued to increase and was almost up to 84%.
    - The Hepatitis C drugs were no longer on the report so the member must have completed treatment.
    - The average cost of brand-name drugs continued to skyrocket. Ms. Menor was told by the Prime Therapeutics account manager that the spike was all due to specialty medications and that non-specialty spend was down.
    - The 90-day utilization continued to increase but was no longer a cost saver to the plan as discounts have drastically declined for purchasing 90day supplies and the savings on dispensing fees are not enough to make up for the lost discounts.
    - The top drugs by spend included two that treat cancer, three that treat auto-immune diseases and four that treat diabetes.

4. The next item from the agenda was the County Auditor's financial report. Mr. Dicklich commended the Committee for its good work that led to a better-than-expected 2016 year-end health fund balance of $4,715,798. He cautioned the members that they shouldn't rest on their laurels and should be ever-vigilant. He added that there were now enough assets to cover the OPEB liability of $4,419,906 in full but that it would be payable over time.

OTHER BUSINESS

5. The first item brought up under Other Business was the current state of negotiations between Children's Hospital and BCBSM. Mr. Kuschel informed the Committee that Children's facilities could go to an out-of-network status on

July 5, 2017. Children's facilities were located in the metro area only. Last year, the St. Louis County self-insured health plan covered 22 visits to Children's facilities. Those members would be sent a letter from Children's and BCBSM within days. Mr. Kuschel noted that this negotiation was unusual in that Children's termed the contract prior to its expiration. Ms. Menor shared that our members would still be covered but with higher out-of-pocket costs. She also noted the Continuity of Care clause (below) where the plan will still cover patients at a higher benefit level until the patient can move to another provider without having a detrimental effect on his/her health.

Continuity of Care for Current Members

If you are a current member or dependent, this section applies to you. If the relationship between your In-Network primary care clinic or physician and the Claims Administrator ends, rendering your clinic or provider nonparticipating with the Claims Administrator, and the termination was by the Claims Administrator and not for cause, you may request to continue to receive care for a special medical need or condition, for a reasonable period of time before transferring to an In-Network provider as required under the terms of your coverage with this

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Plan. The Claims Administrator will authorize this continuation of care for a terminal illness in the final stages or for the rest of your life if a physician certifies that your life expectancy is 180 days or less. The Claims Administrator will also authorize this continuation of care if you are engaged in a current course of treatment for any of the following conditions or situations:

Continuation for up to 120 days if you:

1. have an acute condition;
2. have a life-threatening mental or physical illness;
3. have a physical or mental disability rendering you unable to engage in one or more major life activities provided that the disability has lasted or can be expected to last for at least one year, or that has a terminal outcome;
4. have a disabling or chronic condition in an acute phase or that is expected to last permanently;
5. are receiving culturally appropriate services from a provider with special expertise in delivering those services; or
6. are receiving services from a provider that are delivered in a language other than English.

Continuation through the postpartum period (six (6) weeks post-delivery) for a pregnancy beyond the first trimester.

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6. The next item brought up under Other Business was the legal obligation of school districts to offer speech therapy to children on the Autism spectrum. Ms. Lokken shared that school districts must provide services like speech therapy for children in the Autism spectrum. She gave testimony of one family where insurance was paying in error because the school failed to meet its legal obligation. Mr. Hopkins reported that he hadn't seen an outlier in autism services

in his report but cautioned that it may not be coded as such but that the diagnosis of Autism was not in the top 20 for spend.

With no further business the meeting was adjourned.

Respectfully submitted,

Beth J. Menor
Senior Benefits Advisor