# January 15, 2019
# Minutes
# Health Care Review Committee Meeting

A Health Plan Review Committee Meeting was held on January 15, 2019 in the 3rd floor conference room, City Hall, 212 SW 9th Street, Lawton, Ok at 10:07 am and was presided over by Chairman Rusty Whisenhunt.

The agenda for the meeting was posted on the bulletin board in City Hall in compliance with the Oklahoma Open Meeting Act.

## I. Roll Call

Members Present: Rusty Whisenhunt
Britt Hubbard
Albert Ozuna
John Schwenk
Richard Rogalski
David Raynor

Members Absent: James Churchwell
Bob Bigham
Bruce Kizarr

Others Present: Warren Wick, HR Director
Cindy Griffin, Benefits Coordinator
Kristin Huntley, Finance Accountant
Todd Chapman, NFP, Vice President Select Market
Jona O'Hagan, NFP, Senior Account Executive
Melanie Welchel, HCH, Account Executive

## II. Financial report by Kristin Huntley

### Supplemental Bank Reconciliation

| | |
|---|---|
| Bank balance as of Dec 31, 2018 | $ 1,050,193.83 |
| Outstanding Deposits | $ 389,297.03 |
| Cleared Checks as of 01/11/19 | $ 370,258.45 |
| Outstanding Claims (Self Funded) | $ |
| Deposits in Transit | $ |
| Adjusted Balance as of Jan 11, 2019 | $ 1,069,232.41 |

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**Motion to approve financial report by Ozuna and second by Schwenk. Ayes: Rogalski, Hubbard, Raynor, Whisenhunt. Nayes: None Motion carried.**

## III. Wellness update:

### a. Wellness incentive update

Griffin reported a total of 33 employees received the $100 physical incentive for this quarter. Those incentives will be on the January 18th paycheck. Whisenhunt asked how many qualified during the 1st Qtr, Griffin reported 49. Whisenhunt commented that we are already close to the number of employees that participated in the catapult last year. We are on target to double the numbers and this is more of a complete physical than the catapult. Rogalski suggested sending out a short survey prior to getting their $100 to see if there was anything caught on their physical that they were not aware of, this would be helpful to have the data also in case someone was to ask later down the road what our intentions were to do it this way. Griffin will send a quick electronic survey to the employees who have already participated. Griffin also reported that February 8th will be the blood drive in the Banquet Hall and once she receives the posters from OBI she will distribute those throughout the departments.

## IV. Minutes

Whisenhunt asked if there were any corrections to the minutes. No corrections were reported.

**A motion was made by Ozuna to approve the minutes, second by Hubbard. Ayes, Schwenk, Rogalski, Whisenhunt, Raynor. Motion Carried.**

Whisenhunt asked the committee to move the meeting out of order and go directly in executive session.

**EXECUTIVE SESSION:**

**Motion was made by Rogalski to move into executive session, second by Hubbard. All Ayes.**

**Motion made by Ozuna to go out of executive session and back to General session, second by Rogalski. All Ayes.**

**Motion was made out of executive session by Rogalski to table the appeals discussed in executive session, second by Ozuna. Ayes, Hubbard, Raynor, Whisenhunt. Abstain Schwenk.**

## V. OLD BUSINESS

### a. Review Summary Plan Document & take action if necessary

Whisenhunt asked if everyone had received the Summary Plan Document that was emailed.

Whisenhunt asked if everyone had a chance to review the document. Raynor replied he did not receive it. Griffin commented that it was emailed to his City email address.

Chapman said they found one typo on page 11 under physician services, where it say's lab x-ray and surgery w/o office visit 100% no deductible. Surgery should not be in there. Welchel commented that surgery should have been the next bullet point 'Surgery without an office visit will be subject to the deductible or coinsurance'.

Whisenhunt commented that as you look though it you will notice that the three plans are each on there and its really the coverage is the same under the three plans it depends on how much it pays and what the co pays and deductibles, but you must list them separately.

Schwenk asked on about medically necessary on the gender reassignment. Chapman replied that there's movement of that being a psychological disorder. Schwenk asked what would medical necessary to do a gender reassignment. Chapman replied if the Dr say's it the mental welfare of the patient. Schwenk replied that he made a motion several months ago that they deny that and Ayala or someone interrupted and it died after that. Whisenhunt replied that there were questions on if the affordable health care act was requiring that, but he did not remember. Chapman replied that he did not think it does. Chapman replied that the ACA gives you all things to fall back on and definitions to use, but we can do anything outside of the ACA. Schwenk asked if plastic surgery was covered, Jona replied yes,

however, you cannot just have it done just because you don't like a part of your body. Schwenk asked but what if it causes you so much anguish that you cannot sleep or function? Chapman replied No.

Chapman commented that to his knowledge there is no requirement to cover gender reassignment. Schwenk commented that he would imagine it would be an expensive surgery. Chapman replied it would be.

**Schwenk made a motion that they not cover gender reassignment**

Welchel commented that on the old plan document it does have it as excluded on page 46 of the old one. Welchel asked Whisenhunt if he wants them to verify the ACA mandates. Jona replied that it was added in the plan built. Schwenk asked if it was excluded with blue cross. Whisenhunt replied it was. Wick asked how it was stated in the document. Welchel replied " It say's with gender reassignment surgery or any treatment leading to or in connection with gender reassignment surgery. Wick asked what the new one said. Welchel replied, covered as medically necessary.

**Whisenhunt stated they had a motion to exclude it and asked for a second. Hubbard seconded it.**

Schwenk asked about foot disorders. Chapman explained that any type of procedures the first thing they are going to look at is if it is a covered procedures, then what do they want to do. Are these procedures to the body area covered? Yes, so what do they want to do? Are those medically proved procedures for that part of the body? So if it's not medically approved for that part of the body then they are not going to cover it because it is experimental. Whisenhunt replied that a foot disorder is bone spur that is a covered procedure; it's not experimental because it's been established as a medical procedure. Chapman replied if someone wants to do an experimental procedure that they can, but will have to pay for it themselves.

Whisenhunt commented that addressing on the medial side addresses the vision does not put a $35.00 cap; he does not have any objection to it. Jona said it seems to be standard. This plan does cover for the eye exam but not for any glasses. It did exempt out some of the cataract surgeries. Jona commented that it usually goes through medical. Welchel replied that it does say that cataract surgery is 90% after deductible. Whisenhunt asked if it was cataract and Lasik? Welchel said it would depend on how they submit the claim. Whisenhunt said if it is just to correct vision then it would not be

covered but if it to use the laser to remove part of a cataract surgery then it could be. Welchel replied yes.

**Motion by Schwenk and second by Hubbard to delete the gender reassignment from the plan.**
Rogalski asked if the entire document was up for approval. Whisenhunt replied it would be after we make this change. Rogalski asked if they could amend the motion to approve with that out. Whisenhunt asked if there were any other corrections that need to be made; they can still edit because it is a living document and is up for edit for all time. The problem is with the stop loss the coverage, modification to the document that cost money would have to be paid outside of the stop loss guarantee through this year's contract. Doesn't mean we cannot pay it, means it would be paid by exception outside the stop loss coverage. Do we want to amend the document with that modification as is? With modifications to leaving the gender reassignment and the correction of the physician's services for surgery. Schwenk stated he would modify his motion, Hubbard second.

**Schwenk reaffirmed that the motion was to approve it but to take out the surgery on the gender reassignment and correcting physician services for surgery. Ayes, Rogalski, Ozuna, Hubbard, Raynor, Whisenhunt.**

**b. <u>EOB's</u>**

Whisenhunt commented that on the HCH portal he has been 6 weeks in without getting on the portal. He can see his claims but not the spouse. Welchel reported that one of the things that they did do from the last meeting was the cookies that when you go online, some of those are being retained and even when they reset passwords that some of those cookies are being resaved, and they have also had issues with if you just google Healthcare Highways and if you just click on one then it may not be the correct one for the city of Lawton. That was part of the error that was occurring, so what IT did was they went and it it's been enabled so that members can only reset itself one time as a member number. Sheppard updated Welchel on Whisenhunt situation and where they were at, she is going to get with Whisenhunt to completely reset both of the accounts but has to have their permission. There is also matching criteria behind the

scenes what we see is your member number, your wife and your social Whisenhunt said they wiped it last week. Welchel said they are going to wipe it all out. Whisenhunt said it worked fine until they did their updates on the log ins. Welchel stated they had a total of 25 people who have had an issue (not necessarily the same as his) and some of it has been just user error and it has been as simple as re-setting and deleting things. Denise was here yesterday on site to sit with them and work through them as well and they have reached out to the employees and called them 2 to 3 times and they are just waiting on them to return the call back to HCH. Whisenhunt replied that until they get those fixed he wants the EOB's mailed out. Chapman replied he thinks they are down to 3 to 4 people.

Hubbard brought in a blog in from a lady that runs the breast center, it claims that there were 6 claims were processed incorrectly and that people are trying to pay their bills, and she is telling them they need to go and look to see if that the claims are processed correctly. Welchel asked if they had a contact name that she could call. Whisenhunt replied that it did not and it only had a name at the top. Welchel asked for a copy of the blog.

## VI. NEW BUSINESS

### Subrogation of Claims

Whisenhunt questioned on subrogation that is to recover money to the plan if there has been an accident. Previously those were being processed and paid the questionnaire was being sent out but they were still being processed and paid, they are not now. Welchel replied that if the claims $1,000 or over then it is denied. If it is under the $1,000 cap then they process it, if subrogation is involved the Mcaffee recoups the money on the back end. If you want them all denied up front then they can do that. Whisenhunt replied that before they were not denied up front they were paid but the subrogation letter and questionnaire and they were going to recover it and that how it was handled prior. If they are denying them then it needs to be timely. The letters relaying to that seems to be taking 1 to 2 month which is way too long. Welchel will look and find out what the frequency is and look into this and find out what is going on.

## VII. Comments/Communication

Whisenhunt reported on behalf a Kizarr that the MRI cash cost was $500 & something vs. $1,100 if it processed through the insurance. Out of pocket, he would have had to pay $1,000 for deductible then 1,100 for a total of $2,100. Welchel asked if it was at Memorial. Whisenhunt replied he was not given that information so was unsure where exactly. Welchel is going to reach out to Kizarr to find out where it was. Whisenhunt commented that he wants the $500 to count toward his out of pocket, which means he has to file a claim himself, but he has to have the codes and full billing information to send the claim in. Then it will be counted toward his deductible since it was less cost. Whisenhunt explained that one of the issues they are running into is at CCMH because it is a 24 hr a day service you are paying a premium there, we could actually save money if we could negotiate a contract with say like the imaging center or someone who only does these MRI etc. Welchel responded that without knowing who the providers are that there are two different issues.

1. If you are going to a contracted provider then and they are offering you to pay a cash up front price and not go toward their provider contract or go towards the insurance benefits if the contract is being held with HCH network then that is something that we can address, because that is prohibited and not allowed in the contract. If the provider is not contracted with us we have no control over that provider. Whisenhunt replied that the he imaging center is a Tier 2 provider and they are offering it. Chapman replied that it would be outside their contract and whatever price they are offering should be offered within their contract. Welchel commented that their outside of their contract if they are doing that and we have no idea they are doing it until someone brings it to their attention. Whisenhunt said he knows of 3 people that have had it at the imaging center, CCMH would not give them a price up front and they kept pushing them until they finally gave them a cost then they contacted the imaging center and they offered to do it at cash price. Welchel said they can look into it and address it, but when you're looking at freestanding facility vs. a hospital then there is going to be a difference. Whisenhunt commented that we could save our plan some money if we worked with that free standing facility. Chapman stated they need to find out what their in network reimbursement rate is. Is it cheaper then what their in network reimbursement rate is? That is the question and if so then that is way outside of their contract and we should be getting that in network rate that they are willing to take. Whisenhunt commented that this was the 4$^{th}$ time that the MRI issues have come around regarding the cash price. If we can get that rate in network then we will save the employee and plan money. Welchel asked Whisenhunt to give her the names of the four people he referenced earlier to her after the meeting.

Schwenk asked about someone that went to the ER twice in the last several months and one time was admitted and once was not but both claims were denied by HCH and when called they were told that they thought they had secondary insurance. Welchel commented that that was standard and whenever they set the plan that was a question during part of the implementation 'do you want coordination of benefits asked on an annual basis' and it was answered… "Yes we do" so that will be an automatic for everyone. That falls into the same guidelines to that if the claims fall into the

$1000 or more then it's automatically denied, and if it is less like for a Dr's office they may pay it but still request it. And they can either go online or fill out the information Schwenk asked if anyone's claim is over $1000 they are going to be automatically denied? Welchel responded that if they have not verified that they do not have other coverage yet.

**CLAIMS DATA INFORMATION**

Chapman handed out the claims data information

Chapman went over the claims:
Enrollment – 768
Medical - $1,214,750
Pharmacy YTD - $1,0741
Admin Fees - $392.910
Total Plan - $2,682.511
Est Funding YTD - $3,772,086
Loss Ratio - $90.3%

Chapman stated that from a midyear look; from a plan performance, things are performing really well.

Whisenhunt stated that the renewal will be coming up in the process the administrative fees were covered under renewal the stop loss was not part of the renewal addressed as a fixed number. When are we going to start seeing those?

Chapman replied they are going to get the exact council dates from Griffin and Wick so that they can give the plan committee the make sure you have a good number to look at. They cannot provide stop loss number right now because they do not have a lot of claims data to look at, so they cannot give you first stop loss. They have some discussions to do with them before they can push it to 120 days if not then we can market the stop loss in case it was a bad stop loss renewal and if it comes in good then we will move on. But will have the information before hand so you can present to council.

Whisenhunt stated that he is still getting complaints from employees. It's not that it is not getting worked out; it's just that the aggravating issues it should be easier now that we are 6 months in.

Chapman commented that from their experience with other groups that once you got the pharmacy issue worked out and now the online portal worked out. It is really not out of normal problems you face when you move from a carrier that you have had for 15 years. Not only do the employees get use to that carrier but the providers to.

Whisenhunt it seems to me that the timeliness it seems to drag for a long time before it becomes a issue to getting it fixed. Once Melanie get it in her hands then it gets fixed, but once it gets close to the meeting then things starts getting it done. Schwenk replied that there are a lot of employees frustrated with the customer service at HCH. They get no help. Nothing gets done unless we go to Melani or Jona.

Whisenhunt stated that Mitch had stated during the last meeting that there was going to be a lot of changes and if Welchel knew what those changes would be? Welchel replied they have a meeting on the 31st. to discuss some of those changes and part of it is revamping the customer service team and starting from scratch.

Whisenhunt – putting the plan document in the hands of the employees will help. May not solve the problems but it will help to let them see it and suggested distributing it out at pre-enrollment time to give it to employees. Putting it on the p drive alone will not get it done because most of the field employees do not have access to the computer.

Raynor suggested to put it on the website because most of the employees in his age group would prefer to read it on the website instead of paper

Whisenhunt stated they were given to all new hires in the past and was produced for all employees for every 4 – 5 years. It was not something done every year. If we are going to renew and do renew then we should hand one out to all employees.

Chapman will get together a cost

Whisenhunt said they can be handed down to the divisions and given out with on a payday Friday like they use to do. Whisenhunt said bcbs was required to provide the cost for the documents.

Jona would like to have more discussion on when to give them out. Because when she does talk to people at open enrollment, it is not a bad idea to have when they ask questions to include the SBC.

Raynor suggested they do not print one for everyone, because most of the younger employees prefer to look on the website

Jona said would you say that maybe we don't' print one for everyone and maybe have it on like Liazon but if they would like to take one then they are welcome to during open enrollment that way we don't spend the cost of printing one for everyone.

Whisenhunt responded that once you produce 100, 700 not that much more expensive.

Whisenhunt would like the final copy back and printing and providing for the committee to have.

Warren suggested we always have a potential to run up against the directors meeting and maybe need to change to Wednesday's

Whisenhunt replied that we will table the discussion to change the meeting to next Wednesday on the Feb 19th meeting.

**Motion made by Ozuna to adjourn, Second by Schwenk. Ayes: All.**

Adjournment:
Whisenhunt announced adjournment at 12:27

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**Next meeting scheduled for February 19, 2019 @ 10am, 3rd floor conference rm.**