**PUBLIC SESSION MINUTES**
**EMPLOYEE BENEFITS ADVISORY COMMITTEE MEETING**
**THURSDAY, SEPTEMBER 12, 2019**

**A meeting of the Employee Benefits Advisory Committee was held at 11:00 a.m., Thursday, September 12, 2019, in the City Council Conference Room – 7th Floor/Mesa City Plaza Building, 20 E. Main St.**

**MEMBERS PRESENT:** Councilmember Kevin Thompson, Vice Mayor Mark Freeman, John Pombier, Mary Cameli, Amy Trethaway

**MEMBERS EXCUSED:** N/A

**OTHERS PRESENT:** Teri Overbey, Human Resources Interim Director
Janice (Jan) Ashley, Employee Benefits Administrator
Cecilia Damron, Assistant Employee Benefits Administrator
Alicia White, City Counsel Assistant
Erica Navarro, Employee Benefits Supervisor - Secretary

**The meeting was called to order at 11:04 a.m. by Councilmember Thompson**

**Agenda Item #1: Approval of Previous Meeting Minutes**

- Mary Cameli moved to adopt the meeting minutes from September 6, 2018. Amy Trethaway seconded the motion, and all were in favor. The vote was unanimous.

**Agenda Item #2: Authorize the approval of meeting minutes by the Secretary, after circulation to all EBAC members and finalization of edits**

- Councilmember Thompson moved to authorize the approval of meeting minutes by the Secretary. This authorization allows meeting minutes to be finalized, authorized and posted within a reasonable time frame following the EBAC meeting instead of remaining in draft until the next EBAC meeting occurs (up to a year later). Amy Trethaway seconded the motion, and all were in favor. The vote was unanimous.

**Agenda Item #3: Hear a presentation, discuss, and provide direction on Summary of Health Plan Document Change Recommendations for 2020.**

- Jan Ashley provided an overview of the Summary of Changes to the City's Health Plan Document Summary Plan Description for calendar year 2020 and answered any questions for the Committee.
- The recommended changes are as follows:

    - **Language updates and corrections**: Update dependent eligibility document verification requirements and processes; document legal guardianship child age-out at age 18.
    - **Language updates and corrections**: Clarify retirees enrolled in one of the City's retiree medical plans (during the first 18-months of retiree medical plan coverage) and their family/household members are eligible to use the EAP program sponsored and paid by the City of Mesa, similar to both active employee and COBRA participant eligibility.
    - **Language updates and corrections**: Added medical plan balance billing reminders for all applicable out-of-network Schedule of Benefits in the Plan Document.
    - **Language updates and corrections**: Update the general description of US Preventive Services Task Force (USPSTF), Center for Medicare Services (CMS) related guidelines (and mandated PPACA requirements) for preventive screenings and services for adults, men, women and

children. Added Definitions section specific listing of preventive codes in addition to USPSTF, CMS or PPACA requirements or recommendations under Supplemental Preventive Codes.

- **Language updates and corrections**: Clarified orthodontia treatment started before the patient's effective date with the City of Mesa Dental Choice Plus Plan is not reimbursable/covered.
- **Language updates and corrections**: Aligned the determination of reasonable charges by a non-network provider for professional or ancillary services, with the same determination for out-of-network charges for inpatient or outpatient facility charges, and these reasonable charges shall be the lesser of: (a) charges billed by the facility or professional services or ancillary provider or, (b) rates negotiated by the primary provider-payer network contracted by the Plan or, (c) rates negotiated by any secondary provider-payer network utilized by the Appropriate Claims Administrator or, (d) rates negotiated by any cost-containment bill review and complex claims review program utilized by the Appropriate Claims Administrator and if each of these determinations is exhausted or not applicable to the particular claim, then (e) a maximum allowable amount not to exceed 200% of the Medicare Allowable (or Medicare Similar) amount (reduced by cost share amounts) for like services, procedures, drugs and devices by licensed facilities and providers in the same general geographic area.
- **Cost containment**: Medical Benefits – Basic, Choice and Copay plan – Out-of-Network deductibles increasing in 2020 to $1,500 per person; $4,500 per family.
- **Cost containment**: Medical Benefits – Choice and Copay plans – Out-of-Network member coinsurance increasing in 2020 to 50% after deductible (except for those benefits already "no coverage" when out-of-network).
- **Cost containment**: Medical Benefits – Chiropractic services – remain limited to 25 visits per person but changed to per rolling twelve months instead of per calendar year for out-of-network chiropractic services; remains per calendar year for in-network chiropractic services; both in and out-of-network chiropractic services remain subject to pre-certification review above 25 visits per person per calendar or rolling twelve months, as may apply.
- **Cost containment**: Chemotherapy/Radiation therapy treatment updated to require pre-certification review rather than "recommend pre-certification review"; enables member coordination of complex care, information about in-network providers and centers of excellence and ensures members are receiving all ancillary services that help support the cancer recovery journey.
- **Plan Enhancements:** Behavioral Health Services **- i**n addition to the City's separate standalone EAP program, medical plan behavioral health benefits through Cigna Behavioral Health have a subset (narrower) network of EAP counselors to provide three, 100% covered, in-network, outpatient EAP counseling visits per person, per plan year, in addition to, or instead of the separate Employee Assistance Program Benefits described in the EAP section of the Plan Document; include services that enhances behavioral health benefit levels at no additional cost to the Plan or member.
- **Plan Enhancements:** Vision Plan Benefits – added a third vision plan design option (Vision Premium Plus Plan), with enhanced benefit levels under VSP; includes VSP EasyOptions upgrades to Vision Plus benefits during final year of current vision care insurance contract period. Members can choose one of the following upgrades per covered person per year: $250 frame allowance or $300 contacts allowance or fully covered premium or custom progressive lenses, or fully covered light-reactive lenses or anti-glare coating. All vision plans will have modest rate increases as well after four years with no increases.
- **Compliance Requirement:** AZ House Bill 2502 compliance effective August 3, 2018 for public safety employees/sworn officers participating in the Public Safety Personnel Retirement System; eligible for enhanced EAP program benefits to a maximum of thirty-six (36) behavioral health

counseling visits per person, per issue, per year for traumatic event counseling and therapy services following exposure to these events in the line of duty.

- **Compliance Requirement:** Inclusion of required notice (The Newborns' and Mothers' Health Protection Act of 1996 - the Newborns' Act) in Plan Document, in addition to existing posting on www.Mesaaz.gov/benefits and application of the Act provisions in the Pre-Certification section of the Plan Document. This Act requires health plans that offer maternity coverage to pay/provide benefit coverage for at least a 48-hour hospital stay following childbirth (96-hour stay in the case of a cesarean section).
- **Compliance Requirement:** Health Flexible Spending Account (FSA) Annual Maximum election amount: increased by $50 per account to $2,700 in 2020. Clarification language documented to alert members that non-tax qualified tax dependents (e.g. Committed Partner, non—student children over age 18, children over age 24, other relatives, friends, neighbors) are ineligible for Health FSA reimbursement under employee's health FSA account even though a subset of these ineligible tax dependents may be eligible for coverage in medical, dental or vision plans (e.g. Committed Partner, children to age 26) .

- Jan elaborated on the dependent eligibility audit process that is planned for 2020. New dependent eligibility verification processes are designed to re-verify and validate the dependent eligibility of all family members covered under the City's medical, dental and vision care plans to ensure that only eligible dependents continue to be covered (currently only new hires and qualifying event additions are required to document/verify eligibility). Examples of documents required in the audit process (and ongoing new hire or qualifying event process): for a spouse - marriage certificate and current financial documentation verifying marital status, household address or financial inter-dependence (e.g. tax return records, mortgage/lease joint records); for children - birth certificate and legal or court records as may apply to verify dependent status (legal guardianship, foster, adoption etc.). Legal Guardianship status verification is first phase of the audit process - underway during the Open Enrollment period for 2020 coverage.
- Amy Trethaway asked if the benefits department can report the findings of the dependent eligibility audit to EBAC?
  - Jan Ashely replied that report of findings can be provided to the EBAC Committee by September/October 2020. Audit will be conducted in phases during 2020 to use available internal resources at no additional administrative costs to the City.
- Mary Cameli asked what the eligibility difference is for Legal Guardianship children and why is this status being verified first?
  - Jan Ashley replied that this status was identified as important to address since the Plan Document now clarifies Legal Guardianship status ends at age 18 not age 26, like most other "children" statuses, so easy for employees and retirees to misunderstand.
- Vice Mayor Freeman asked if the balance billing language is highlighted in each area of the plan document?
  - Jan Ashely replied that balance billing will be indicated on every page of the Medical Schedule of Benefits in the Plan Document, that discusses out-of-network coverage. The balance billing language is currently in the fine print of the header section of the Schedule of Benefits, but now it will also be included when each benefit/coverage is described.
- Mary Cameli asked if balance billing would also apply to services where the patient had no control over the usage of an out-of-network provider?
  - Jan Ashley replied that balance billing for out-of-network emergency services is unlikely to occur, but if it does occur, the Plan protects the member by paying benefits at in-network benefit levels

and using billing charges as the allowed or reasonable charges amount. The Plan also protects the member when out-of-network ancillary services (anesthesiologist, Certified Registered Nurse Anesthetists, assistant surgeon etc.) are inadvertently used in connection with otherwise authorized in-network services for a surgeon and facility, by paying these benefits at in-network levels. However, the member still remains liable for balance billing or "surprise" billing from these out-of-network ancillary providers because there could be a difference between their billed charges and the allowed or reasonable charges that the Plan considered. Members must do their due diligence to assure all involved in their care are in-network.

- John Pombier asked if the City could provide members of the Plan with a form for use in letting hospitals, and providers know that members do not want "hidden" out-of-network providers to provide services. He also asked if the benefits department can reach out to providers when out-of-network services are used inadvertently, and members are in a balance billing situation?
    - Jan Ashley replied that she does not believe a form of this nature would have any standing on this matter (aside from the difficulty of the patient remembering to bring it with them when checking in for services) and at worst could result in the patient's procedure being delayed or re-scheduled. Most patients do find however that the balance billing provider is willing to write off the amount in question if the patient lodges a complaint and has not previously signed any documentation saying they will be responsible for out-of-network balance billed amounts. Employee Benefits currently assists any member who has a balance billing situation and the Plan's third party administrator, Cigna, helps with reach out on behalf of those members in a balance billing situation as well. Ultimately however, neither Cigna nor the Plan can force the balance billing provider to write off amounts for the member, so Employee Benefits has focused on this "peril" in website communications, open enrollment guide and seminars during Benefits Fair to enhance member awareness and education.
- Councilmember Thompson asked if there is an option to remove all out-of- network services from plan coverage?
    - Jan Ashely responded that is an option since there is no compliance requirement to provide out-of-network coverage in a health plan. However, so doing would make the City's Plans less competitive/desirable for members, with a reduction in benefit levels and provider choice creating "noise" from employees who have long term provider relationships and providers who make business decisions about the networks in which they participate on an annual basis. The City recognizes that provider choice is very important to members. Current plan designs provide that choice, with the understanding that members have more out-of-pocket expense if they choose out-of-network providers. The benefits department will continue to educate members on the financial "perils" of out-of-network usage and make plan design changes that shift costs to members to incentivize movement away from out-of-network usage.
- Councilmember Thompson asked why the preventive care services language update needs to indicate adults, men, women and children?
    - Jan Ashely replied that the terms are used because some services are specific to all adults and some services are specific to men and some to women.
- Mary Cameli asked if orthodontia treatment that started before enrollment in the Dental Choice Plus plan could be submitted as a flexible spending expense?

- Jan Ashley replied yes, the expense must have occurred in the same flexible spending plan year to be recognized and considered.

- Councilmember Freeman asked if there is a known savings for the out-of-network coinsurance cost shift on the Choice and Copay medical plans?
  - Jan Ashely replied that the savings is not currently known.
- Amy Trethaway asked why there is cost share or any coverage at all on out-of-network, why doesn't the employee pay the full cost on all out-of-network services?
  - Jan Ashley replied that strategic interim steps are recommended before going to that extreme measure on some or all of our medical plans. Employee benefits will closely monitor out-of-network costs, provider networks in general and competitive plan design options to ensure that future Plan Document recommendations recognize the then current trends and options.
- Mary Cameli asked if Jan could explain a rolling calendar year in regard to cost containment for out-of-network Chiropractic services?
  - Jan Ashley explained that the Plan allows up to 25 chiropractic visits without a medical necessity review by the third party administrator. If done on a calendar year basis only, this could mean that member utilization may maximize 25 visits a year, continue year after year with that same maximum utilization and not ever have a medical necessity review that might identify unnecessary utilization. Since out-of-network costs for chiropractic may be higher for the Plan than similar in-network Chiropractic services, it makes sense to ensure that medical necessity review is occurring after a rolling 25 visits, again to ensure that unnecessary utilization in this more costly out-of-network area is curbed. Although this may cause some member disruption and inconvenience, it is also an incentive to consider in-network utilization instead.
- Amy Trethaway asked if a member does not get a pre-certification on Chemotherapy/Radiation treatment, does the member have to wait for services until it is approved?
  - Jan Ashely replied that pre-certification is a normal process that most providers are used to requesting and are more than likely currently setting up for current Chemo and Radiation patients even though the Plan has not specifically required it so far. With a pre-certification in place Cigna will be able to facilitate care and ensure access to Concierge Customer Service, Case Management or Disease Management services, all of which are of great benefit to the patient during a very complex and potentially confusing cancer treatment journey.
- Councilmember Freeman asked how often members are covered for prescription frames and lenses under the vision care plans?
  - Jan Ashely replied that the City offers three vision care plans, one of which is the Basic Vision plan that offers covered vision materials' purchasing every two years. The other two plan options (Vision Plus and Vision Premium Plus) cover vision materials' purchasing once every calendar year. Employees and retirees can change their vision plan option during Open Enrollment for the next calendar year.
- John Pombier asked if non-sworn police department employees (crime scene technicians and 9-1-1 communications staff) are, or could be, included in the 36 EAP visits per traumatic event benefit?
  - Jan Ashely replied no, these employees are not currently included in this statutory benefit but are eligible for up to 8 counseling visits per person, per issue/event, per year under the regular EAP program that the City offers to all employees and their household members. Additionally, these

same employees may be eligible for unlimited counseling visits with either a copay or coinsurance responsibility under the City's medical plan benefits. For the 36 visit statutory benefit to be extended to non-sworn employees would more than likely come at a cost to the City that is not currently budgeted. The City will issue an RFP in 2020 for EAP program services in 2021 and beyond. This potential plan design feature can be incorporated in that process and negotiated and costed in the overall award recommendation.

- Amy Trethaway motioned to adopt Agenda Item #3 Plan Document recommended changes. Mary Cameli seconded the motion, and all were in favor. The vote was unanimous.

**The meeting was adjourned at 11:59 a.m.**

Prepared by: Erica Navarro, Secretary to the Board