PUBLIC SESSION MINUTES
EMPLOYEE BENEFITS ADVISORY COMMITTEE MEETING
THURSDAY, SEPTEMBER 03, 2026

A meeting of the Employee Benefits Advisory Committee was held at 11:00 a.m., Thursday, September 03, 2026, in the City Council Conference Room – 7th Floor/Mesa City Hall, 20 E. Main St.

MEMBERS PRESENT: Councilmember Taylor, Mirand DeWitt, Mary Cameli, Candace Cannistraro

MEMBERS EXCUSED: Councilmember Duff

OTHERS PRESENT: Teri Overbey, Human Resources Director
Janice (Jan) Ashley, Employee Benefits Administrator
Stephanie Drake, Assistant Employee Benefits Administrator
Erica Navarro, Employee Benefits Supervisor – Secretary

The meeting was called to order at 11:03 a.m. by Erica Navarro

Agenda Item #1: Hear a presentation, discuss, and provide direction on Summary of Health Plan Document Change Recommendations for 2027

Jan Ashley began by providing an overview of the plan's financial drivers such as MSK, cancer treatment, prescription drug cost, etc. She let the group know that City plans cover more than 16,000 total members comprised of active and retired employees and eligible covered family members. She then moved on to the Summary of Changes to the City's Health Plan Document and Summary Plan Description for calendar year 2027 (Plan) and answered questions for the Committee.

The recommended changes include:

- **Enhancement**: Basic, Choice and Copay Plans **addition of in-network Cigna/Pathwell Bone and Joint (PB&J) Musculoskeletal (MSK) services and Hinge Health virtual MSK clinician supported exercise therapy services**: PB&J Case Management and facilitation services with administration fees paid by the Plan and no charge to members - with potential of $0 cost to patients for use of PB&J specialized network for authorized MSK surgeries and significant Plan savings for that utilization. Hinge Health virtual services (and digital app services) administration and service fees paid by the Plan and no charge to utilizing members.
- **Enhancement/Cost Containment**: Basic and Choice Plans: alignment of benefit levels for **In-Network labs, X-rays and Ultrasounds to provide 100% coverage** (no deductibles, co-insurance or copays) and match current 100% coverage for In-Network High Tech Radiology services (and also align with all of these current services' coverage in the Copay Plan). This enhancement maximizes adherence to provider recommended tools for early awareness and chronic condition monitoring by removing patient "financial barriers" and the possibility of balance billing "surprises". With these 100% In-Network coverage measures installed in the Basic and Choice plans, these same plans will move to **"no coverage" for out-of-network, outpatient lab and radiology services** (except emergencies).
- **Cost Containment: Basic and Choice Plans: no coverage for elective Out-of-Network Inpatient Hospital and Specialized Health Care Facility services** - medical, surgical and/or behavioral health hospital and professional services. Provides member incentive to use quality, in-network providers and facilities that have leveraged network discounts against billed charges and balance billing or "surprise" billing

protections for members while protecting the Plan from high cost non-network inpatient hospital claims for medical and behavioral health services.

- **Cost Containment: Basic and Choice Plans: Physical Therapy/Occupational Therapy/Speech Therapy (PT/OT/ST) and Chiropractic rehabilitation therapies not covered Out-of-Network** for treatment of medical conditions. If rehabilitation therapies are provided in connection with behavioral health diagnoses, these services will continue to have out-of-network coverage levels available.
- **Compliance:** Change in AMA recommendations for **billing processes for In-Network maternity professional services for pre-natal, delivery and post-partum care**. Potential move to "fee for service" type billing model rather than member paid $400 Global Maternity Fee structure for professional maternity care services. This will potentially mean that each plan option's deductibles, coinsurance and/or applicable copays will apply for these same types of services e.g. office visits, lab and ultrasound services, delivery services, c-section surgery, mid-wife services etc. This change in billing and claims practices will apply to all three medical plan options.
- **Cost Containment:** Continuation of ***One Prescription Drug Rx Plan for All*** (i.e. members have the same outpatient prescription drug coverage regardless of the medical plan in which they are enrolled). Prescription drug costs and utilization continue to be a major driver of overall health plan expense and medical plan premium rate increases especially in the high-cost non-specialty Brand drug categories and the very high cost Specialty Drug categories. In 2027 there will be **increases in member out-of-pocket expense (and related mitigation of some Plan expense**) with increases in Brand drug copay maximums and maximum out-of-pocket levels (RX MOOP's) and for Specialty Drugs, changes in minimums, maximums and coinsurance levels. These changes/increases will also include variations on these copay/out-of-pocket cost elements between Medicare Part D EGWP/Wrap coverage (for Medicare Eligible retirees and individuals) as compared to Commercial RX Prescription Drug coverage (for active employees and non-Medicare eligible retirees and respective eligible family members). Two different options were reviewed for Commercial Plan copay maximums – a standard model with modest increases to maximums and a hybrid model with even higher increases to maximums for brand drugs that are eligible for manufacturer copayment assistance (MAP) thru the Plan's PBM MedImpact, if this latter plan design can be systematically adjudicated at the pharmacy level.
- **Compliance and Enhancement: Health Flexible Spending Account Annual maximum and Rollover Maximums** and FSA Dependent Care Annual Maximums **-** 2027 Health FSA annual election maximum increased to $3,400 and health rollover maximum increased to $680. Dependent Care FSA annual election maximum remains at $7,500 for single, head of household or married filing jointly and $3,750 for married filing separately.

Committee Discussion:

- Miranda DeWitt asked if the intent for 100% coverage on labs is only for certain lab services?
  - Jan Ashley explained that the intent is to remove any financial barrier to receiving necessary physician requested labs when/if patient out-of-pocket cost is a deciding factor. Current plan design already provides standard preventive lab screening services at 100% coverage – a compliance requirement. This enhancement will add other provider ordered diagnostic labs to the 100% coverage category and further enhance adherence for early detection and monitoring activities.

- Mary Cameli asked how the 100% coverage for labs and radiology would work with Medicare?
  - Jan Ashley explained that this situation only applies to Medicare eligible retirees/individuals not active employees covered in the City plans (who may also have some Medicare coverage that would be considered secondary to the City's coverage). However if for a retiree Medicare is their primary coverage, once Medicare pays their portion which may be 80% after a Medicare deductible (or 100%

for preventive labs), the city plan would pay the remaining balance if any, because the secondary benefit will be set to cover 100%. If it were a service that was not covered by Medicare, but otherwise a covered City plan service, then the city plan would take the primary position and pay 100%.

- Council member Taylor asked if this is going to cost the plan more with 100% lab and radiology?
  - Jan Ashley explained that there is additional liability to the plan with this recommended enhancement, but the liability must be weighed with the short-term vs. long-term benefit outcomes of receiving preventive and diagnostic lab adherence vs. not getting them completed due to a patient cost factor (and missing a chronic condition indicator or other health risk factor that later results in higher Plan spend).

- Councilmember Taylor asked if the 100% coverage will increase the monthly health plan premiums?
  - Jan Ashley responded that the additional liability to the Plan is very low and outweighed by other cost containment savings that are anticipated. Plan premiums for the City's self-insured health plans are recommended annually and take into account national cost drivers, previous year overall spend, plan cost drivers and EBT Trust Fund projections plus information and analysis gathered and presented by the City's contracted employee benefits consulting firm.
  - Candace Cannistraro explained that the city is self-funded and explained how the city conducts regular analysis and forecasting with the OMB department to have a sustainable plan over a long period of time.

- Councilmember Taylor shared that she has been conducting research on how to incentivize employees to be healthier and how to incorporate health into a daily regimen.
  - Candace Cannistraro observed that the City's culture of health and wellness and the Mesa Wellness 360 program is specifically designed to incentivize and motivate employees to incorporate health into their daily life. Candace explained how there are points earned for completing certain preventive medical services and how you can earn gift cards for taking offered classes, webinars and participating in wellness events and challenges.

- Councilmember Taylor asked what would happen if, for example, a person undergoing cancer treatment goes out of network for treatment?
  - Janice Ashley responded that the change to 100% coverage in-network (and no coverage for these same services when out-of-network) is for outpatient labs and radiology services. Cancer treatment chemotherapy and radiation therapy services remain covered at standard benefit levels by Plan both in and out-of-network.

- Jan also explained that there are 3 occasions when OON services that are no longer covered (or may still be eligible for out-of-network coverage levels), will be eligible to be covered at in-network benefit levels if: 1) There was an emergent need for care at an OON facility or with an OON provider – patient seeks care at nearest available service center under emergency or urgent conditions. 2) If there was a gap in care/services, meaning there were no INN providers in the immediate geographic area of the patient, that could provide the non-emergency services the patient needs. This type of OON care being covered at in-network benefit levels would need to be prior authorized (PA) by Cigna. 3) If the OON care was an ancillary service and likely unknow to the patient of the OON status: e.g.: you received your surgery from an INN surgeon at an INN facility but the anesthesiologist care was not in-network. These 3 exceptions would be examples where claims would be adjudicated at INN rates and the provider payment negotiated by Cigna to provide as much balance billing protection to the patient as possible.

- Jan mentioned that OON services currently eligible for coverage under the Copay Plan will continue to remain covered at OON benefit levels i.e. will not be removed from OON coverage as will some of these services in the Basic or Choice Plan. Jan also explained that only 8% of our population is in the Copay plan which is a very high coverage plan with very high premiums. Jan mentioned that the Basic and Choice plans have our largest enrollment numbers across both active and retiree populations, so much more plan exposure if members were to continue to utilize OON services under those plans.
    - Candace Cannistraro explained how the Copay plan can be seen as a benefit for someone who is going to experience a complex, high expense related medical situation or across a number of covered family members. They can sign up for the Copay plan when first eligible or during Open Enrollment, yes pay very high monthly premiums but know that they will only pay specific copays for their in-network services (no deductibles to meet first) and also have broad access to OON coverage levels, which for many is a relief vs. figuring out deductibles and coinsurance and owing money to many different doctors and facilities while managing a complex health condition or conditions.

- Janice Ashley noted that the removal of OON coverage levels for Inpatient Hospital services in our heavily populated Basic and Choice Plans is driven by health plan compliance rules that require both medical/surgical and behavioral health inpatient services be treated the same (or better if behavioral health related) in terms of coverage and requirements, regardless of whether or not one area of inpatient service has more risk, exposure or utilization in the Plan.

- Candace Cannistraro asked how would a “gap in care” circumstance apply to behavioral health OON inpatient claims?
    - Janice Ashley replied that if there were a gap in care, (meaning no INN facility/beds available to provide the behavioral health hospitalization in the geographic area of the patient) and Cigna pre-authorized the OON inpatient stay as eligible to be considered a gap in care authorization, then the claim could be adjudicated at INN benefit levels rather than “no coverage”. Cigna has robust INN Behavioral Health provider professional services and facilities in our most populated geographic areas. This is further incentive for patients to stay In-Network for all behavioral health services in addition to the 100% in-network coverage for all behavioral health services that was introduced by the Plan a couple of years ago.

- Miranda DeWitt asked what is an example of an “elective” inpatient admission?
    - Jan Ashley gave an example: you are considering a surgery with an INN surgeon and you are advised that this surgery and recovery will require an inpatient admission. If your surgeon proposes the surgery at an OON hospital or OON free standing surgery center that has inpatient capabilities, that OON service center would not be covered because it is an elective decision of the provider and patient when there are other INN in-patient facilities available and for which the surgeon has privileges and the patient would have coverage. This would be talked about in the Prior Authorization process that is required before any Inpatient admission.
    - Stephanie Drake added that the benefits office has researched with Cigna to ensure our plan has strong network access of INN facilities to choose from.
    - Jan Ashley added that OON outpatient services are not being recommended for change at this time and will still be processed at OON benefit levels by plan option.

- Councilmember Taylor commented about maternity billing. She said: “If I were pregnant, the provider would only get the initial payment for the office visit to start my maternity care, then have to wait until after delivery and my post-partum care was complete to receive payment for all of my maternity care with that provider?”
    - Janice Ashley responded, yes, that is how maternity “bundled” billing practices work today – it’s called a Global Maternity billing practice. However, with new AMA recommendations in 2027, we expect providers to bill “fee for service” as the provider services occur, so the Plan has adjusted benefit levels in anticipation of this.

- Councilmember Taylor asked what would be a non-preferred drug under our plan?
    - Candace Cannistraro explained how there could be several drugs to treat your condition but the one our plan considers non-preferred (which is determined by the PBM Formulary that is used by the plan) happens to be the one your doctor requested that you take. You pay a higher cost for that drug because it is not the preferred brand (in all likelihood it is more expensive than other like drugs in the preferred brand category). You and your doctor could decide to move you to one that is preferred and it could also cost both you and the plan less.
    - Janice Ashley explained how drugs adjudicate at the pharmacy level. Wholesale ingredient cost (that differs from pharmacy to pharmacy) and dispensing fees minus discount arrangements with the PBM = final total cost of the drug, which is then divided up into plan cost share and member cost share (with “maximums” protection on that member copay cost share by channel and tier of coverage).

- Mary Cameli asked if all drugs have to be FDA approved to be covered under our plan?
    - Jan Ashley replied, yes, all drugs the plan covers must be FDA approved and conversely not all FDA approved drugs must be covered by the plan. The PBM Formulary that the plan uses determines which drugs are preferred, non-preferred and in some cases not covered at all, even if they are otherwise FDA approved.

- Candace Cannistraro asked, regarding the prescription plan manufacturer copay assistance program (MAP) (that MedImpact makes available to members through its MedAssist services since January , 2026), does this mean that if plan coinsurance or maximum copays increase for certain Brand drugs included in the MAP program, the member would be incentivized to apply for the manufacturer copay assistance because the manufacturer is paying a large part of the employee’s portion with their copay assistance funds instead of the member or the plan?
    - Jan Ashley responded, that is correct.

- Candace Cannistraro asked, can I be reimbursed if I get a copay assistance coupon after a first fill with no assistance?
    - Erica Navarro responded, yes, if you go back to the pharmacy within 7 days of filling your script, they can usually reverse the claim and reprocess it with the copay assistance coupon in place.

- Councilmember Taylor asked, is the higher maximum copays and coinsurance on brand name drugs basically pushing someone to do the couponing if it is available?

- Jan Ashley responded, yes, that is both the member incentive and the plan is also able to reduce some liability as well. In the Specialty Drug arena, the City introduced Specialty Drug Advocacy Services with PaydHealth in 2022. The services identify both significant copayment assistance for members on these very high-cost, complex or rare condition drugs and also identify benefactor or foundation funding options for members, as well as providing significant plan savings.

- Mary Cameli asked, has the City always been self-insured?
  - Jan Ashley responded, yes, as far as I am aware.
  - Candace Cannistraro replied, "in the early 90's we had both self-insured/self-administered with a fully insured HMO plan as a plan option as well".

- Miranda DeWitt asked, do you have to be on a City medical plan to be part of the Mesa Wellness 360 program? Do we know how many people are not on city insurance?
  - Jan Ashley responded, yes, for the Web MD points system, gift cards and payroll medical premium credits you do need to be in a city medical plan.
  - A discussion was held by the group on the importance of the Wellness 360 program and how beneficial it is to be covered by a City plan to get the usage of the free wellness center alone.
  - Stephanie Drake mentioned that 397 employees are otherwise eligible but not covered under a City plan.
  - Miranda DeWitt observed that the City should consider allowing non-medical plan members to participate in Mesa Wellness 360 and Health and Wellness Center usage, but understood that there are short and long-term cost considerations to evaluate.

- Candace Cannistraro asked, can over the counter items be covered by your FSA health plan?
  - Jan Ashley responded, yes, as long as they are medically necessary. Some may require a doctor's note to be submitted to Navia to justify the medical necessity. You should check the Navia Benefit Solutions website for a listing of eligible flexible spending over the counter items.

Agenda Item #2: Motion to approve the recommended changes

Candace Cannistraro motioned to approve the recommended changes as presented and discussed. Mary Cameli seconded the motioned and all were in favor. The vote was unanimous.

Agenda Item #3: Adjournment

Erica Navarro motioned to adjourn the meeting.

The meeting was adjourned at 12:45 p.m.

Prepared by: Erica Navarro, Secretary to the Board