

**Benefits Focus Group Minutes
(6/10/02)**

Committee members, alternates and staff advisors present:

Benita Saldutti
Dick Minster
John Glanden
Veda Mahadi
Kevin Stiff
Joyce Dolan
Andy St. John
Casey Humpert
Dolly Gamble
Rick Winters
Pat Horan
Janice Cox
Gil Fernandez
Jim Godshall
Suzy Milburn
Gib Mitchell
Robert Blinch-Edwards
Linda McKinney
April Bryan

Benita Saldutti called meeting to order at 1:00 p.m., June 10, 2002, in the City Commission Chambers. Roll was called.

Linda McKinney handed out two pages showing amounts of revenue for 5%, 10%, 15% and 20% across the board increases in dependent premiums.

Another page showed total projected cost savings for plan change options. Ms. McKinney pointed out that Option 1 & 2 and 8 & 9 are either/or, not both.

There was discussion about the disease management plan. Dick Minster asked about the handout showing \$50,000 credit for this program. At the last meeting the Group discussed the plan and voted to set the copay at \$15/visit. On a previous handout, it was indicated that this would be an expense of \$25,000 rather than a credit. He said that he felt this should be shown as a zero rather than a credit. The consensus of the group was to change the amount zero.

Mr. Minster said that the group had approved the mandatory generic requirement on prescriptions with a medically necessary provision at the previous meeting. That sheet had indicated a \$33,000 credit. Is today's handout showing the same thing, or something different? On option 1, the credit changed from \$33,000 to \$5,300. Which one is correct? Robert Blinch-Edwards said he thinks the reason the figure changed is that EMI provided the Gehring Group with some additional information from Caremark.

He may have based the figures on the new information. Linda said she would verify that with Mr. Gehring.

The Group had already discussed and voted on the mandatory generic requirement for prescriptions with a “medically necessary” provision at the meeting of June 5.

Mr. Blinch-Edwards said the information from Caremark on the drug step therapy should be available by June 15. It is not known at the present time if that will be a significant credit.

Kevin Stiff asked if there was any projection of savings for people moving from PPO to EPO2. Ms. McKinney said not at this time, but it was still the Group’s recommendation that the plan be introduced with the hope that it will produce a cost saving. Ms. Saldutti said they were not making any projections of plan behavior - that instituting one thing is going to make people do one thing or the other. Mr. Stiff said he is still looking for an answer to a question he had asked previously about someone in EPO needing medical care when out of town. Ms. McKinney explained that on the EPO2, if the employee lives inside the six county area, but has a dependent living outside the area, the dependent would be eligible to use the Beech Street network, but the employee would not be eligible. If you are out of town and need non-emergency health care, your EPO doctor could not refer you to another doctor. Your only option would be emergency care. If you want that additional coverage when you are traveling, your option is the PPO.

Suzy Milburn said she was under the impression that Ms. McKinney had told them earlier that you could call your physician for a referral. Ms. McKinney said she had given wrong information – that she was confusing EPO with THO. Under THO if you are out of network and need a referral, your THO doctor can do that, but in EPO there is no physician referral outside the local network.

Gil Fernandez asked about the spousal surcharge and how the number of 30 was determined. Ms. McKinney said she had talked with Cindy Thompson of the Gehring Groups and she was going to try to find out how that figure was chosen. It could either be an estimate of people who currently have working spouses (based on an exact profile of our employees) or an industry average. Mr. Fernandez said he thought that estimate could be a little high. Ms. McKinney agreed, but pointed out that the real savings would not be generated on the money collected per month, but from those people no longer being primary under our coverage and becoming secondary.

Discussion about Options 8 & 9 regarding increasing the EPO copay to \$20 or \$25/physician visit. Ms. Milburn said she would rather see the copay be \$20 for regular office visits and \$25 for specialists. Ms. McKinney reported that she had asked Mr. Gehring to get some information about the maximum copay that could be charged. Per Erisa, the maximum amount that can be charged currently is \$15/visit. Mr. Blinch-Edwards said that since the City is exempt from Erisa because they are self-funded, they can charge anything they like, but it is recommended to stay within the Erisa guidelines. If you charge a high copay, you might discourage people from getting needed care early. The copay for Sarasota County is \$15. Ms. Saldutti said that she

was reluctant to recommend something that was outside of industry standards. However, considering that the City's dependent coverage is so much less than the County's she could agree to the higher copay.

Mr. Stiff expressed his concern about increasing the dependent premiums along with the copays, deductibles and out of pockets. Ms. McKinney said that the Group had asked her to come up with a way to regenerate the over \$200,000 income to the plan that could have been accomplished by separating out the dental.

Mr. Stiff said his issue was what the total increase of the entire package would be to the employee. He did not want to make it too hard on the employees. He asked what the projected increase is from the City. Ms. McKinney said the City has already made a \$1.7 million increase and they do not see that going away - that they would continue with the \$6.7 amount, which will just keep the fund at zero. If the Group wants the fund to generate any type of stability, part of that cost has to come from the employees.

Mr. Minster said that the plan changes voted on at the last meeting amounted to \$570,000. Some changes have been made in the credits, so the Group needs to look at the plan changes that were approved and put the new dollar amounts on them to arrive at a total. Instead of rehashing what has already been voted on, just need to assign the new dollar amounts to them. He also reminded the Group that the recommendations made in April should generate \$300,000. The results of that recommendation will not be known until September.

Ms. McKinney said the cost of prescription drugs is rising and the City is still paying more than it did in the year 2000.

The Group took a short break so Ms. McKinney could contact Gehring's office to ask why the amounts had changed on the projections.

Ms McKinney reported that the prescription credit estimate changed because of additional information received from Caremark. Previously they had used industry standards for some of the projections and that is why they changed. Options 12 & 13 are a reflection of ALL claims from active employees and retirees. Some costs were credited at the time the April changes were made that probably should not have been because the retirees did not go into those changes. She thinks they corrected most of those errors, but some of them may have gotten through.

The discussion continued about increasing dependent premiums.

Ms. Saldutti said that at one time, Mr. Blinch-Edwards had given the group a breakdown of claims by age groups. It would be interesting to see a breakdown of claims by employees and dependents. If it is the dependents that are causing the biggest expense then they should pay more, but if not, then they should not pay. Ms. McKinney said the only option for revenue source is the dependents. If the employees are not going to be charged, then dependents are the only choice available.

Mr. Minster said that if the dependent premiums were raised 5% that would produce \$122,000. That amount added to the other items approved for the recommendation and

the \$300,000 from the April changes would total approximately \$1 million. Ms. Saldutti said that since the \$300,000 was for the period April - December, an additional \$100,000 can be projected for the next plan year.

The consensus of the Group was to not approve the 12-month wait and see option (#4). The Group also decided to set copays at \$20/physician visit and \$25/specialist visit for EPO.

Ms. Saldutti reiterated changes for recommendation:

The Group agrees to Options 1, 5, 7, 11, 12, and 13. Also 10, although the cost is zero, the member will pay \$15/session instead of \$10. Dependent coverage will be increased 5% across the board. Mr. Minster made motion to approve all changes. Ms. Milburn seconded. Mr. Stiff said that while he understands the work of the committee is very good and thought through, the PBA reserves any right to negotiate any changes to the healthcare program. Andy St. John said the same goes for the Teamsters. Motion passed.

Ms. Saldutti said she would have a draft memo by Wednesday's meeting. Mr. McNees will be contacted for a time to meet. At the next meeting, the Group will go over the draft memo and discuss a meeting schedule and taking a break for a while.

John Glanden said he would like to see a summary, on one sheet if possible, to take/send to retirees to help them understand the changes.

Ms. McKinney said she and KayKae Thomas are working on providing monthly educational sessions in different locations throughout the City. These would be question and answer sessions and they would let people know that they can request a one on one appointment for more information and help. These sessions will probably be implemented after the hiring of a new HR director.

Next meeting is June 12, 2002, at 1:00 p.m., at Public Works, 1761 12th Street.

Meeting adjourned at 2:40 p.m.

Minutes Approved: August 7, 2002

Benita Saldutti, Vice Chairperson