SISC III
HEALTH BENEFITS PROGRAM
BOARD OF DIRECTORS MEETING
NOVEMBER 15, 2006 - 1:00 P.M.

A G E N D A

I. **CONSENT CALENDAR**

A. Approval of Minutes for October 2006 Board of Directors Meeting — Russell Bigler

B. Report of Activity for the Month of October 2006 and ratification of payment as follows: — Russell Bigler

SISC DENTAL CLAIMS	$ 3,131,897.40	
SISC ASO	$ 205,765.64	
DENTAL COALITION CLAIMS	$ 671,086.69	
DENTAL COALITION ASO	$ 44,093.95	
DELTACARE/PMI PREMIUM	$ 4,787.68	
TOTAL DENTAL		**$ 4,057,631.36**
VSP CLAIMS	$ 661,234.42	
ASO	$ 84,603.40	
MES CLAIMS	$ 20,073.17	
ASO	$ 4,249.90	
TOTAL VISION		**$ 770,160.89**
PACIFIC CARE BEHAV HLTH	$ 432,906.28	
CIGNA BEHAVIORAL HEALTH (MCC SELECT)	$ 18,213.45	
SEC HOR PREM (PACIFICARE)	$ 8,778.13	
SENIOR ADVANTAGE PREM (KAISER)	$ 24,478.00	
SENIORITY PLUS PREM (HEALTHNET)	$ 86,624.33	
BLUE SHIELD HMO PREM	$ 1,611,696.27	
BLUE SHIELD FULLY INSURED PPO	$ 97,919.61	
HEALTH NET PREMIUM	$ 761,184.41	
CAL CARE PREMIUM	$ 851,193.79	
KAISER PREMIUM	$ 2,292,856.81	
PACIFIC CARE PREM	$ 18,285.07	
PACIFIC UNION DENTAL PREMIUM	$ 2,179.51	
UNITED HEALTHCARE (LIFE INS)	$ 129,785.72	
NAT'L BENEFIT RESOURCES (STOP LOSS)	$ 76,233.54	
BLUE CROSS HEALTH CLAIMS	$33,749,069.78	
BLUE SHIELD HEALTH CLAIMS	$ 1,393,377.01	
BEHAVIORAL HEALTH CLAIMS	$ 344,432.92	
ITS CLAIMS	$ 1,410,564.15	
COMPANION CARE CLAIMS	$ 114,578.81	
TOTAL BLUE CROSS AND BLUE SHIELD CLAIMS		**$ 37,012,022.67**

BLUE CROSS NETWORK ASO	$ 1,000,476.92	
FOUNDATION ADJUDICATION ASO	$ 503,336.96	
BLUE SHIELD ASO	$ 92,634.38	
BEHAVIORAL HEALTH ASO	$ 141,199.19	
ITS ASO	$ 110,675.27	
COMPANION CARE ASO	$ 26,832.71	
TOTAL BLUE CROSS AND BLUE SHIELD ADMIN.		**$ 1,875,155.43**
TOTAL BLUE CROSS AND BLUE SHIELD		**$ 38,887,178.40**
MERCK CLAIMS	$ 9,259,694.04	
ASO - COPAY	$ 310,704.03	
CLAIMS - DISCOUNT CARDS	$ 73,438.99	
ASO DISCOUNT CARD	$ 3,654.00	
CLAIMS - MEDICARE PART D	$ 22,216.54	
ASO - MEDICARE PART D	$ 7,688.50	
AHC CLAIMS	$ 740,466.94	
AHC - ASO	$ 37,235.00	
TOTAL RX CLAIMS		**$ 10,455,098.04**
TOTAL BC, BSC and Rx		**$ 49,342,276.14**

II. PUBLIC COMMENT

III. ACTION ITEMS

A. Financial Report – Presentation of Financial Statement for the Month of October Will Be Submitted for Approval — Cindy Sproles

IV. DISCUSSION AND INFORMATION ITEMS

A Show the Monthly Blue Cross/SISC PPO Trend Factor for October 2006 — John Stenerson

B. Update the Board on SISC's GASB 45 Program — Cindy Sproles

C. Show the Board a Newspaper Article on Employers Auditing Health Plans for Ineligible Dependents — Russell Bigler

D. Show The Board A Newspaper Article On What The Two Candidates For Governor Are Saying About Health Care — Russell Bigler

E. Show The Board An E-Mail From The Sacramento Bee On Americans' View On Health Care — Russell Bigler

F. Show The Board An Article Discussing How First Data Bank Plays A Powerful Role In Determining What Americans Pay For Prescription Drugs. — Russell Bigler

G. Show The Board An Article From Business Insurance Concerning Consumer Driven Health Plans, CDHP — Russell Bigler

H. Inform the Board About a Situation That Recently Occurred Regarding a Box of Membership Information for 23 SISC Member Districts — Russell Bigler

I. Comments from the Board of Directors Will Be Heard

J. Adjournment

K. Next Meeting: Wednesday, December 20, 2006
1:00 p.m.
SISC Board Room - City Centre

SISC III
HEALTH BENEFITS TERMINOLOGY

Adjudication: Determination of the amount of payment for a claim.

Administrative Services Only (ASO): An arrangement under which an insurance carrier or an independent organization will, for a fee, handle the administration of claims, benefits and other administrative functions for a self-insured group but does not assume any financial risk for the payment of benefits.

Balance bill: Refers to the leftover sum that a provider bills to the patient after insurance has only partially paid the charge that was initially billed.

Calendar Year Deductible: The dollar amount for covered services that must be paid during the calendar year (January 1 – December 31) by members before any benefits are paid by the Plan.

Centers of Expertise (COE) Network: The network of health care providers that have entered into contracts with the carrier and/or one or more of its affiliates. These providers have agreed to participate in a transplant program or other designated specialty program that is/are to be based upon the member's benefit agreements.

Coinsurance: An arrangement under which the member pays a fixed percentage of the cost of medical care after the deductible has been paid. For example, an insurance plan might pay 80% of the allowable charge, with the member responsible for the remaining 20%, which is then referred to as the coinsurance amount.

Coinsurance Maximum: The total amount of coinsurance that an individual pays each year before the carrier pays 100% of allowable charges for covered services. Coinsurance amounts differ with each contract.

Coordination of Benefits: The anti-duplication provision to limit benefits for multiple group health insurance in a particular case to 100% of the covered charges and to designate the order in which the multiple carriers are to pay benefits. Under a COB provision, one Plan is determined to be primary and its benefits are applied to the claim. The unpaid balance is usually paid by the secondary Plan to the limit of its liability.

Co-Payment: The fixed dollar amount a patient pays for a medical service.

Deductible: An amount the covered person must pay before payments for covered services begin. The deductible is usually a fixed amount. For example, an insurance plan might require the insured to pay the first $250 of covered expense during a calendar year.

Dependent: Person, (spouse or child), other than the subscriber who is covered under the subscriber's benefit certificate.

Employee Assistance Program (EAP): A worksite-based program that is designed to assist in the identification and resolution of productivity problems associated with personal concerns of employees. The program provides employees and their dependents with access to confidential, short-term counseling by qualified practitioners, in person or over the phone.

Explanation of Benefits (EOB): A form sent to the covered person after a claim for payment has been processed by the carrier that explains the action taken on that claim. This explanation might include the amount that will be paid, the benefits available, reasons for denying payment, or the claims appeal process.

Flexible Spending Account: Accounts that let workers set aside pre-tax money from their paycheck toward premiums or costs not covered by their health plan, such as co-payments. All the money must be used within the plan year or it is lost.

Health Assessment – More companies are asking workers to fill out such assessments, which give health improvement tips. Companies can give workers financial incentives to do so.

Health Insurance Portability and Accountability Act (HIPAA): A federal health benefits law passed in 1996, effective July 1, 1997, which among other things, restricts pre-existing condition exclusion periods to ensure portability of health-care coverage between plans, group and individual; requires guaranteed issue and renewal of insurance coverage; prohibits plans from charging individuals higher premiums, co-payments, and/or deductibles based on health status.

Health Maintenance Organization (HMO): An organization that provides a wide range of comprehensive health care services for a specified group at a fixed periodic payment; a prepaid health care plan under which people may enroll by paying a set annual fee. Members then receive all the medical services they need through a group of contracting doctors and hospitals, often with no additional copayments or fees. Members are generally limited to using providers designated by the HMO.

Health Savings Account – The accounts are paired with a high deductible. Employees can fund these accounts, tax-free, to help offset the deductible. Employers can also fund such plans. Money not used within the plan year is rolled over to the next year.

ID Card/Identification Card: A card issued by a carrier to a covered person, which allows the individual to identify himself or his covered dependents to a provider for health care services. The card is subsequently used by the provider to determine benefit levels and to prepare billing statement.

IBNR: An acronym for "incurred but not reported". This is an accounting estimate used by health plans to accrue for care that was provided "incurred" in one accounting period, but not paid or "reported" until another accounting period.

In-Network: Refers to the use of providers who participate in the carrier's provider network. Many benefit plans encourage covered persons to use participating (in-network) providers to reduce the individual's out of pocket expense.

Lifetime Maximum: Maximum amount the plan will pay toward a member's coverage in a lifetime.

Medigap: A private insurance policy purchased by many of the elderly to pay for expenses not covered by Medicare.

Negotiated Rate: The amount participating providers agree to accept as payment in full for covered services. It is usually lower than their normal charge. Negotiated rates are determined by Participating Provider Agreements.

Open Enrollment: For employers with a dual or multiple choice of health plans, the annual time period in which employees can select among the plans offered.

Out-Of-Network: The use of health care providers who have not contracted with the carrier to provide services. HMO members are generally not reimbursed if they go out-of-network except in emergency situations. Covered persons of preferred provider organizations and HMOs with point-of-service options may go out-of-network, but must pay additional costs including deductibles and co-insurance.

Participating Provider: A physician, hospital, pharmacy, laboratory or other appropriately licensed provider of health care services or supplies, that has entered into an agreement with a managed care entity to provide such services or supplies to a patient enrolled in a health benefit plan.

Pre-Authorization: A procedure used to review and assess the medical necessity and appropriateness of elective hospital admissions and non-emergency outpatient services before the services are provided.

Preferred Provider Organization (PPO): A type of managed care organization that has a panel of preferred providers who are paid according to a discounted fee schedule. The enrollees do have the option to go to out-of-network providers at a higher level of cost sharing.

Reasonable and Customary: The amount customarily charged for the service by other physicians in the area (often defined as a specific percentile of all charges in the community) and the reasonable cost of services for a given patient after medical review of the case. Also known as Usual and Customary (U&C) or Customary and Reasonable (C&R).

Skilled Nursing Facility: An institution (or a distinct part of an institution) that is primarily engaged in providing skilled nursing care and related services for patients who require medical care, nursing care or rehabilitation services.

Subscriber: The individual in whose name a contract is issued or the employee covered under an employer's group health contract.

Transparency. With regard to medical care it means: The ability for patients to have easy access to understandable information about the cost and quality of their health care options. They should be able to obtain this information from their health plan and medical providers prior to the time of treatment.

SISC III

HEALTH BENEFITS PROGRAM
BOARD OF DIRECTORS MEETING
WEDNESDAY, OCTOBER 18, 2006
1:00 P.M.

M I N U T E S

The regular meeting of the Board of Directors of SISC III Health Benefits Program was called to order at 1:10 p.m. on Wednesday, October 18, 2006, in the SISC Board Room on the Fifth Floor of the Kern County Superintendent of Schools Office, 1300 17tth Street, Bakersfield, California, with the following in attendance:

MEMBERS PRESENT:	ALTERNATES PRESENT:	OTHERS PRESENT:
Russell Bigler	Paul Baxter	Wanda Carl
John Caudle	Richard Graham	Bonnie Bowles
Dennis Franey	Judy Marty	Carmen Gonzales
Dan Munis	John Stenerson	Carmen Gonzales
Gary Pickavet	Bill Voss	Janet Clary, Kern Foundation
		Judy Fussel, Buckman-Mitchell
		Jennifer Bennett

CONSENT CALENDAR

Motion was made by Director Pickavet, seconded by Director Franey and carried to approve the Consent Calendar as follows:

Minutes. Minutes for the September 2006 Regular Board of Directors Meeting.

Report of Activity for the Month of September 2006 and Ratification of Payment as follows:

DELTA DENTAL	Claims	$ 3,643,585.10	
ASO		239,383.56	
DENTAL COALITION	Claims	765,040.91	
DENTAL COALITION ASO		50,279.34	
DELTACARE/PMI PREMIUM		0.00	
TOTAL			$4,698,288.91
VISION SERVICE	Claims	$ 688,231.62	
ASO		84,658.58	
MES CLAIMS		17,474.15	
ASO		2,739.60	
TOTAL			$ 793,103.95

PACIFICARE/BEHAV HLTH		$ 408,745.33	
CIGNA BEHAV. HEALTH (MCC SELECT)		$ 18,281.01	
SECURE HORIZONS PREM (PACIFICARE)	$ 9,209.43		
SENIOR ADVANTAGE PREM (KAISER)		$ 33,408.00	
SENIORITY PLUS PREM (HEALTHNET)	$ 87,848.33		
BLUE SHIELD HMO PREMIUM		$ 740,763.40	
BLUE SHIELD FULLY INSURED PPO	$ 19,584.70		
HEALTH NET PREMIUM		$ 805,344.24	
CALIFORNIA CARE PREMIUM		$ 720,842.41	
KAISER PREMIUM		$ 1,913,279.81	
PACIFICARE PREMIUM		$ 18,276.31	
PACIFIC UNION DENTAL PREMIUM		$ 1,856.32	
LIFE – UNITED HEALTH		$ 94,479.34	
NAT'L BENEFIT RESOURCES (Stop Loss)	$ 75,018.84		
BLUE CROSS HEALTH CLAIMS	$31,260.658.67		
BLUE SHIELD HEALTH CLAIMS		$ 1,454,020.05	
BEHAVIORAL HEALTH CLAIMS			$ 277,618.43
ITS CLAIMS		$ 1,211,154.25	
COMPANION CARE CLAIMS	$ 134,087.57		
TOTAL BLUE CROSS AND BLUE SHIELD CLAIMS			$ 34,337,538.97
BLUE CROSS NETWORK ASO		$ 922,869.65	
FOUNDATION ADJUDICATION ASO		$ 470,601.67	
BLUE SHIELD ASO		$ 99,983.17	
BEHAVIORAL HEALTH ASO		$ 137,027.31	
ITS ASO	$ 90,198.88		
COMPANION CARE ASO	$ 23,599.65		
TOTAL BLUE CROSS AND BLUE SHIELD ADMIN.			$ 1,744,280.33
TOTAL BLUE CROSS AND BLUE SHIELD			$ 36,081,819.30
MERCK CLAIMS		$ 9,446,122.06	
ASO-COPAY		359,790.68	
M/O - DISCOUNT CARD		98,496.79	
ASO-DISCOUNT CARD		4,292.99	
TOTAL MERCK CLAIMS			$ 9,908,702.52
TOTAL BC, BSC AND MERCK			$ 45,990,521.82

PUBLIC COMMENT

ACTION ITEMS

Financial Report. Bonnie Bowles reviewed with the Board the Financial Report for the period ending September 30, 2006. She noted that the LAIF rate is 5.02. Revolving Fund Expenditures for the period April 2006-September 2006 were also reviewed. After discussion, motion was made by Director Baxter, seconded by Director Voss and carried approving the Financial Report as presented.

INFORMATION AND DISCUSSION ITEMS

Monthly Blue Cross/SISC PPO Trend History Through September 2006. John Stenerson reviewed the monthly Blue Cross/SISC PPO Trend History through September 2006.

Update the Board on the SISC/CSAC-EIA Agreement. Director Bigler advised the Board that the SISC III JPA will earn over $400,000 this fiscal year. John Stenerson mentioned that employee time is minimal.

Update the Board on Companion Care as it Relates to Medicare D. Director Bigler reminded the Board that at the last Board Meeting John Stenerson presented an update and mentioned that SISC III was going live with this program effective October 1, 2006. John Stenerson advised the Board that the program is proceeding smoothly. John Stenerson also brought the Board up to date on the American Health Care pilot program that started the same time, got off and running.

Show the Board an Article from <u>The New Yorker</u> Magazine. Director Bigler advised that this is a great article that we can use to understand how retirees that are furnished medical benefits by their district will impact the active employees. As you are aware, this is what GASB-45 is all about.

Show the Board a Copy of the Memorandum on National Customer Service Week. Director Bigler reviewed with the Board a copy of a memo that went to each SISC member district.

Show the Board an Article on Medicare Part D. Director Bigler reviewed with the Board the enclosed article on Medicare Part D.

Show the Board an Article on Wellpoint. Director Bigler reminded the Board that, Wellpoint (the parent of Blue Cross of California) merged with Anthem. Although the merged name is Wellpoint, the home office is at the Anthem home office in Indianapolis, Indiana. He further advised the Board that the attached document shows a new organizational structure is concerned that they may be creating a structure that will not allow the people that presently serve us to make the decisions and provide us with the service they are now allowed to make or provide.

Show the Board an Article on the U.S. Allowing Canadian Drug Imports. The Board was advised that this has to do with Medicare D. It will not be something that SISC III retirees would need.

Show the Board an Article Concerning the Governor and the Insurance Industry in California in General. Director Bigler advised the Board that this is an article that discusses how the Governor is handling this and who he is talking to concerning various types of insurance.

Comments From the Board of Directors. There were no comments from the Board members at this time.

ADJOURNMENT

There being no further business to come before the Board, motion was made by Director Franey, seconded by Director Baxter Miller and carried adjourning the meeting at 1:35 p.m.

NEXT MEETING

The next meeting of the Board of Directors will be held **Wednesday, November 15, 2006,** at 1:00 p.m. in the SISC Board Room on the Fifth Floor of the Kern County Superintendent of Schools Office, 1300 17th Street, Bakersfield, California.

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DOUG MILLER, Secretary

SISC III

INFORMATION ITEMS

A. Monthly Blue Cross/SISC PPO Trend Factor for October 2006. The Blue Cross/SISC PPO monthly trend factor for the month of October 2006 will be shown at the meeting.

B. Update the Board on SISC'S GASB 45 Program. Cindy Sproles will update you on this product.

C. Show the Board a Newspaper Article on Employers Auditing Health Plans for Ineligible dependents. This is something we might want to implement or have districts implement.

D. Show the Board A Newspaper Article On What the Two Candidates For Governor Are Saying About Health Care. The article mentions that health care reform will be a major issue in California next year no matter who is elected.

E. Show the Board An E-Mail From <u>The Sacramento Bee</u> on Americans' View on Health Care.

- Excess Profits Of Drug Companies And Insurance Companies
- Medical Malpractice Lawsuits
- Fraud And Waste
- Overpaid Doctors
- Administrative Costs
- Unnecessary Treatments
- Unhealthy Lifestyles
- Expensive New Treatments
- The Aging Population
- Better Medical Care

F. Show the Board An Article Discussing How First Data Bank Plays a Powerful Role in Determining What Americans Pay for Prescription Drugs. I will go over the attached article.

G. Show the Board An Article from Business Insurance Concerning Consumer Driven Health Plans, CDHP. You need to know that Consumer Driven Health Care, CDHP, continues to gain in popularity as the way employers are providing health care for their employees.

H. Inform the Board About a Situation That Recently Occurred Regarding a Box of Membership Information for 23 SISC Member Districts. See attached article and list of member districts. Blue Cross is sending each member a letter.