SISC III
HEALTH BENEFITS PROGRAM
BOARD OF DIRECTORS MEETING
DECEMBER 15, 2010
1:00 P.M.

A G E N D A

I. **CONSENT CALENDAR**

A. Approval of Minutes for November 2010 Board of Directors Meeting — Russell Bigler

B. Report of Activity for the Month of November 2010 and ratification of payment as follows: — Russell Bigler

DELTA DENTAL CLAIMS		$5,068,407.59	
DELTA DENTAL ASO		326,912.37	
	TOTAL DENTAL		**$5,395,319.96**
VISION SERVICE CLAIMS		642,181.86	
MES CLAIMS		118,001.02	
VSP ASO		82,497.66	
MES ASO		17,061.49	
	TOTAL VISION		**859,742.03**
ANTHEM BLUE CROSS HEALTH CLAIMS		48,933,691.95	
BLUE SHIELD HEALTH CLAIMS		9,590,244.06	
ANTHEM BC BEHAVIORAL HEALTH CLAIMS		8,113.07	
ANTHEM BC COMPANION CARE RETIREE CLAIMS		240,565.93	
MEDCO DISCOUNT CARD CLAIMS		34,742.94	
TOTAL HEALTH CLAIMS		**58,807,357.95**	
ANTHEM BLUE CROSS ASO		1,590,914.29	
BLUE SHIELD ASO		277,288.40	
ANTHEM BC BEHAVIORAL HEALTH ASO		132,166.95	
ANTHEM BC COMPANION CARE RETIREE ASO		49,322.59	
FOUNDATION CLMS PROCESSING ASO		560,046.24	
MEDCO DISCOUNT CARD ASO		1,010.22	
	TOTAL HEALTH ASO	**2,610,748.69**	
TOTAL HEALTH			**61,418,106.64**
MEDCO CLAIMS		12,156,239.69	
AMERICAN HEALTH CARE CLAIMS		2,108,466.75	
MEDCO ASO		273,169.14	
AMERICAN HEALTH CARE ASO		59,076.20	
	TOTAL RX		**14,596,951.78**

INSURED PRODUCTS		
ANTHEM BC HMO CLAIMS	3,122,853.51	
ANTHEM BC HMO ADMIN FEE	1,693,017.16	
BLUE SHIELD HMO CLAIMS	129,166.95	
BLUE SHIELD HMO ADMIN FEE	1,791,600.83	
BLUE SHIELD HMO ADMIN FEE	902,547.07	
AETNA HMO	NONE DUE	
HEALTH NET HMO	NONE DUE	
KAISER HMO	4,053,760.43	
PACIFICARE BEHAVIORAL HEALTH	NONE DUE	
CIGNA BEHAVIORAL HEALTH	NONE DUE	
UNITED HEALTH CARE DENTAL	912.30	
DELTACARE/PMI DENTAL	3,835.88	
KASIER SENIOR ADVANTAGE RETIREE PLAN	62,318.00	
HEALTH NET SENIORITY PLUS RETIREE PLAN	NONE DUE	
AETNA INSURED PPO	NONE DUE	
MUTUAL OF OMAHA LIFE	127,385.44	
ZURICH LIFE	13,066.60	
TOTAL BLUE CROSS AND BLUE SHIELD CLAIMS		**11,900,464.17**
SISC FLEX CLAIMS	**177,786.08**	
WELLNESS	**0.00**	
ALL OTHER	**796,280.01**	
TOTAL SISC III PAYMENTS		**95,144,650.67**

II. PUBLIC COMMENT

III. ACTION ITEMS

A. Financial Report - Financial Statements For Prior Month Presented For Approval — Cindy Mattern

B. Approval of 2011 Defined Benefit Budget — Cindy Mattern

C. Approval of the Defined Benefit Investment Policy — Cindy Mattern

IV. DISCUSSION AND INFORMATION ITEMS

A. Show the Monthly SISC PPO Claims History Through November 2010 — John Stenerson

B. Update the Board on the Banking Arrangements Between SISC and Anthem Blue Cross — Russell Bigler

C. Show the Board the 2011 Defined Benefit Contribution Rate Letter — Russell Bigler

D. Update the Board on SISC's 2010 Subrogation Revenue After Three Quarters — Russell Bigler

E. Update the Board on CECHCR's Push to Create a Single Pool Administrator for All California School Districts — Russell Bigler

F. Additional Topics from the Board of Directors Will Be Heard

G. Adjournment

H. Next Meeting: Wednesday, January 19, 2011
1:00 p.m.
SISC Board Room - City Centre

Any materials required by law to be made available to the public prior to a meeting of the Board of Directors of the Joint Powers Authority can be inspected at the following address during normal business hours at 1300 17th Street, Bakersfield, Ca. 93301

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.

Adverse Events/Never Events: Accidents that happen in hospitals that are considered preventable.

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.

Best of Both Worlds Service: An American board-certified surgeon(s) travels with the patient to perform procedures overseas.

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.

Condition Care: Helps promote and improve the overall health status and quality of life of members and helps promote and/or prevent disease progression and avoid and/or prevent the complications associated with the conditions.

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 co-payments 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.

Medical Tourism: To have medical care outside the United States.

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
INFORMATION ITEMS

December 15, 2010

A. **Monthly SISC PPO Claims History Through November 2010.** The SISC PPO claims history through November 2010 will be shown at the meeting.

B. **Update the Board on the Banking Arrangements Between SISC and Anthem Blue Cross.** Cindy Mattern will go over this at the Board meeting.

C. **Show the Board the 2011 Defined Benefit Contribution Rate Letter.** See Attachment.

D. **Update the Board on SISC's Subrogation Revenue After Three Quarters.** Director Bigler will update the Board.

E. **Update the Board on CECHCR's Push to Create a Single Pool Administrator for All California School Districts.** Two years ago Director Bigler mentioned to you the California Education Coalition for Health Care Reform (CECHCR) wanted to put together a single administrator to administer the health and welfare benefits for the schools of the State of California. CECHCR is made up of representation from nine different professional school entities – CASBO, CTA, CSEA, CSBA, and ACSA being the biggest.

About a year ago we made a presentation, along with five others, to an entity CECHCR has selected to administer the selection process. On November 29, 2010 we made our second presentation. I have enclosed the discussion points and will review the presentation at the board meeting.

F. **Additional Topics from the Board of Directors.** Additional topics from members of the Board will be heard at this time.