SISC III
HEALTH BENEFITS PROGRAM
BOARD OF DIRECTORS MEETING
MARCH 28, 2012
1:00 P.M.

A G E N D A

I. CONSENT AGENDA

A. Approval of Minutes for February 2012 Board of Directors Meeting — Nick Kouklis

B. Report of Activity for the Month of February 2012 and Ratification of Payment as Follows: — Nick Kouklis

DELTA DENTAL CLAIMS		10,214,520.57	
DELTA DENTAL ASO		654,781.07	
		TOTAL DENTAL	**10,869,301.64**
VSP CLAIMS		968,879.00	
MES CLAIMS		138,470.43	
VSP ASO		74,649.00	
MES ASO		16,722.20	
		TOTAL VISION	**1,198,720.63**
ANTHEM BLUE CROSS HEALTH CLAIMS		47,446,596.71	
BLUE SHIELD HEALTH CLAIMS		12,157,148.01	
ANTHEM BC COMPANION CARE RETIREE CLAIMS		374,100.20	
MEDCO DISCOUNT CARD CLAIMS		26,622.79	
	TOTAL HEALTH CLAIMS	60,004,467.71	
ANTHEM BLUE CROSS ASO		1,688,111.25	
BLUE SHIELD PPO ASO		365,842.57	
ANTHEM BC COMPANION CARE RETIREE ASO		86,928.08	
FOUNDATION CLMS PROCESSING ASO		567,062.53	
MEDCO DISCOUNT CARD ASO		385.80	
	TOTAL HEALTH ASO	2,708,330.23	
		TOTAL HEALTH	**62,712,797.94**
MEDCO CLAIMS		14,331,919.17	
AMERICAN HEALTH CARE CLAIMS		2,575,153.54	
MEDCO ASO		135,735.97	

AMERICAN HEALTH CARE ASO	62,466.70	
BC RX	13,864.44	
	TOTAL RX	**17,119,139.82**

INSURED PRODUCTS

ANTHEM BC HMO CLAIMS	2,413,100.98	
ANTHEM BC HMO ADMIN FEE	1,556,117.60	
ANTHEM BC EAP	139,071.47	
BLUE SHIELD HMO CLAIMS	1,363,389.76	
BLUE SHIELD HMO ADMIN FEE	1,497,595.36	
KAISER HMO	7,999,169.31	
SIMNSA	51,375.34	
DELTACARE/PMI DENTAL	3,845.56	
KAISER SENIOR ADVANTAGE RETIREE PLAN	79,973.00	
MUTUAL OF OMAHA LIFE INS	178,596.85	
ZURICH LIFE	13,657.00	
	TOTAL INSURED	**15,295,892.23**

SISC FLEX CLAIMS		**237,362.53**
WELLNESS		**379,300.00**
ALL OTHER		**594,393.93**
	TOTAL III PAYMENTS	**108,406,908.72**

Moved_____2nd_____Vote____

II. PUBLIC COMMENT

III. ACTION ITEMS

A. Financial Report - Presentation of Financial Statements for the Month of February 2012 Will Be Submitted for Approval — Cindy Mattern

Moved_____2nd_____Vote____

B. Request Approval of the 2010-2011 Independent Financial Audit — Cindy Mattern

Moved_____2nd_____Vote____

C. Request Approval of the 2012-2013 Vision Premiums — John Stenerson

Moved_____2nd_____Vote____

D. Request Approval of the 2012-2013 Dental Premiums — John Stenerson

Moved_____2nd_____Vote____

E. Request Approval of the 2012-2013 Prescription Premiums — John Stenerson

Moved_____2nd_____Vote____

F. Request Approval of the 2012-2013 SISC Medical Premiums — John Stenerson

Moved_____2nd_____Vote____

IV. DISCUSSION AND INFORMATION ITEMS

A. Review Monthly PPO Trend and Budget-to-Actual through February 2012 — John Stenerson

B. What's Up With Health Care? Informational Lunch, April 24, 2012 — Nick Kouklis

C. Comments from the Board of Directors Will Be Heard

D. Next Meeting: Wednesday, April 18, 2012
1:00 p.m.
SISC Board Room - City Centre

E. Adjournment

Moved_____2nd_____Vote____

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

For information regarding how, to whom, and when a request for disability-related modification or accommodation, including auxiliary aids or services, may be made by a person with a disability who requires a modification or accommodation to participate in the public meeting, please contact Laurie Swan at 661-636-4887 or laswan@kern.org .

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.

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.

Mark-Up (As it relates to Congress): During a “mark-up”, the Committee members discuss the proposals in the legislation and agree or disagree on what should be included in a final bill that is voted out of the Committee.

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

HEALTH BENEFITS PROGRAM
BOARD OF DIRECTORS MEETING
WEDNESDAY, FEBRUARY 22, 2012
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 1:01 p.m. on Wednesday, February 18, 2012 by Director Kouklis, in the SISC Board Room on the Fifth Floor of the Kern County Superintendent of Schools Office, 1300 17th Street, Bakersfield, California, with the following in attendance:

MEMBERS PRESENT:	**ALTERNATES PRESENT:**	**OTHERS PRESENT:**
Nick Kouklis	Russ Bigler	Laurie Swan
John Caudle	Judy Marty	Cindy Mattern
Karen Cox		Bonnie Bowles
Chris Crawford		Megan Hanson
Kip Hearron		John Stenerson
Steve McClain		Jennifer Bennett
Gary Pickavet		Lauri Phillips
Richard Stotler		Lola Nickell
		Raquel Acebedo
		Dan Bly
		Natalie Seaman
		Boris Young
		Carolyn Temple
		Greg Worth
		Bettina Taylor
		Armen Khorozyan
		Jennifer Thomas
		Susan Wooden
		Fred Bayles – Wells Fargo Advisors, LLC
		Rich Edwards – Merrill Lynch

CONSENT AGENDA

Motion was made by Director Caudle, seconded by Director Cox and carried 9-0, to approve the Consent Agenda as follows:

Minutes. Minutes for the January 2012 Board of Directors Meeting.

Claims.

DELTA DENTAL CLAIMS	9,051,709.53	
DELTA DENTAL ASO	582,915.58	
	TOTAL DENTAL	**9,634,625.11**
VSP CLAIMS	1,336,959.30	
MES CLAIMS	200,273.98	

VSP ASO		74,703.00	
MES ASO		16,639.62	
		TOTAL VISION	**1,628,575.90**
ANTHEM BLUE CROSS HEALTH CLAIMS		**50,303,373.05**	
BLUE SHIELD HEALTH CLAIMS		11,800,426.96	
ANTHEM BC COMPANION CARE RETIREE CLAIMS		**286,054.92**	
MEDCO DISCOUNT CARD CLAIMS		28,924.31	
	TOTAL HEALTH CLAIMS	62,418,779.24	
ANTHEM BLUE CROSS ASO		**1,676,761.74**	
BLUE SHIELD PPO ASO		371,562.72	
ANTHEM BC COMPANION CARE RETIREE ASO		52,394.30	
FOUNDATION CLMS PROCESSING ASO		569,359.44	
MEDCO DISCOUNT CARD ASO		791.19	
	TOTAL HEALTH ASO	2,670,869.39	
		TOTAL HEALTH	**65,089,648.63**
MEDCO CLAIMS		13,764,578.53	
AMERICAN HEALTH CARE CLAIMS		2,510,075.18	
MEDCO ASO		232,756.28	
AMERICAN HEALTH CARE ASO		66,431.40	
BC RX		13,950.00	
		TOTAL RX	**16,587,791.39**
INSURED PRODUCTS			
ANTHEM BC HMO CLAIMS		1,758,184.65	
ANTHEM BC HMO ADMIN FEE		1,599,184.58	
ANTHEM BC EAP		139,535.61	
BLUE SHIELD HMO CLAIMS		1,370,281.51	
BLUE SHIELD HMO ADMIN FEE		1,488,547.74	
KAISER HMO		7,950,363.35	
SIMNSA		53,725.76	
DELTACARE/PMI DENTAL		8,030.40	
KAISER SENIOR ADVANTAGE RETIREE PLAN		81,759.00	
MUTUAL OF OMAHA LIFE INS		174,620.40	
ZURICH LIFE		13,720.60	
		TOTAL INSURED	**14,637,953.60**
SISC FLEX CLAIMS			**261,890.78**
WELLNESS			**130,946.64**
ALL OTHER			**213,816.01**
		TOTAL III PAYMENTS	**108,185,248.06**

PUBLIC COMMENT
None

ACTION ITEMS

Financial Report. Cindy Mattern reviewed with the Board the Financial Report for the period ending January 31, 2012. Cindy reviewed the Income Statement and Balance Sheet, noting that HMO is up and that we have added districts to Kaiser. Dental and Vision claims are high because benefits renew in January and many people schedule appointments the first of the year. Cindy noted that the LAIF rate was at .39% for the month of January and .38% for the quarter. After discussion, motion was made by Director Hearron, seconded by Director McClain and carried, 9-0, approving the Financial Report as presented.

Request Approval to Discontinue Coverage for Over-The-Counter Proton Pump inhibitors and Non-Sedating Antihistamines. After discussion, motion was made by Director Cox, seconded by Director Stotler and carried, 9-0, approving the discontinuation of coverage for over-the counter (OTC) proton pump inhibitors (PPIs) and non-sedating antihistamines (NSAs) effective October 1, 2012.

Change of Date for May Board Meeting. The SISC Board Meeting for May will be held May 16-17 at the Stockdale Country Club. The format will be the same as last year, with a Wednesday night dinner meeting and breakfast speaker at the Thursday morning Board Meeting. A motion was made by Director Cox, seconded by Director Stotler and carried, 9-0, to move the May Board Meeting from May 17-18 to May 16-17 at Stockdale Country Club.

INFORMATION AND DISCUSSION ITEMS

Monthly SISC PPO Trend and Budget-to-Actual Through January 2012. John Stenerson reviewed the monthly SISC PPO Trend and Budget-to-Actual through January 2012. John noted the trend is slowing down for all health in California. John reported we are looking at pretty close to a break-even year and he is fairly certain we will run better than budgeted. Director Caudle asked if this included ERP money. John stated this does not include funds and that ERP had announced on Friday that funds have been exhausted. John reported that Bob Hunter did a great job on this project.

Show the Board the Results of the Revenue SISC Received from Phia Subrogation. Director Kouklis reviewed this letter with the Board and reported that he had a follow-up discussion with Adam Russo, CEO of the The Phia Group.

Report to the Board on the New Web Site Appearance. Director Kouklis asked Board Members to take a look at the new SISC web site. The web site has been updated and has a new look.

Show the Board an Article from dailynews.com, "Catholic Healthcare West Changing Its Name to Dignity Health" Director Kouklis reviewed this article with the Board.

Show the Board an Article from the Los Angeles Times, "Diabetes Patients Improve Quickly With Monthly Care, Study Shows. Director Kouklis reviewed this article with the Board and noted this is an active program that we continue to monitor.

Show the Board an Article from WebMD, "Oral Health: The Mouth-Body Connection" Director Kouklis reviewed this article with the Board.

Comments from the Board of Directors. In response to questions on provider contracting, generated at a previous Board Meeting, Gregory Worth, Regional Vice President, Network Development, Provider Engagement & Contracting, provided an overview of Anthem's contracting strategy.

Director Kouklis reported that he has been asked to sit on the Anthem Community Relations Committee.

ADJOURNMENT

There being no further business to come before the Board, a motion was made by Director Cox, seconded by Director Stotler and the motion carried 9-0 adjourning the meeting at 2:13 p.m.

NEXT MEETING

The next meeting of the Board of Directors will be held **Wednesday March 28, 2012,** 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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KAREN COX, Secretary

SISC III
INFORMATION AND DISCUSSION ITEMS
MARCH 28, 2012

A. **Monthly SISC PPO Trend and Budget-to-Actual Through February 2012.** The monthly SISC PPO Trend and Budget-to-Actual through February 2012 will be presented.

B. **What's Up With Health Care?** An Informational lunch will be held April 24, 2012 at Seven Oaks Country Club. Paul Markovich, the Chief Operating Officer of Blue Shield, will discuss what is happening with health care in the marketplace.

C. **Comments from the Board of Directors.** Additional comments from members of the Board will be heard at this time.