SISC
Self-Insured Schools of California
Schools Helping Schools

HEALTH BENEFITS
BOARD OF DIRECTORS MEETING
OCTOBER 17, 2019
2:30 P.M.

AGENDA

I. Consent Agenda

A. Approval of Minutes for September 2019 Board of Directors Meeting — Nick Kouklis

B. Report of Activity for the Month of September 2019 and the Ratification of Payment as follows: — Nick Kouklis

DELTA DENTAL CLAIMS		9,648,182.37	
DELTA DENTAL ASO		564,419.54	
		TOTAL DENTAL	10,212,601.91
VSP CLAIMS		1,110,055.18	
MES CLAIMS		126,431.96	
VSP ASO		133,231.20	
MES ASO		16,628.76	
		TOTAL VISION	1,386,347.10
ANTHEM BLUE CROSS HEALTH CLAIMS		77,521,095.44	
BLUE SHIELD HEALTH CLAIMS		28,150,106.28	
ANTHEM BC COMPANION CARE RETIREE CLAIMS		477,251.75	
	TOTAL HEALTH CLAIMS	106,148,453.47	

ANTHEM BLUE CROSS ASO		3,442,169.08	
BLUE SHIELD PPO ASO		542,692.29	
ANTHEM BC COMPANION CARE RETIREE ASO		107,833.04	
FOUNDATION CLMS PROCESSING ASO		596,986.88	
	TOTAL HEALTH ASO	4,689,681.29	
		TOTAL HEALTH	110,838,134.76
EXPRESS SCRIPTS CLAIMS		8,881,014.92	
NAVITUS RX CLAIMS		25,272,642.97	
EXPRESS SCRIPTS ASO		109,903.90	
NAVITUS RX ASO		520,053.77	
RX N GO		18,717.85	
		TOTAL RX	34,802,333.41
INSURED PRODUCTS			
ANTHEM BC HMO CLAIMS		4,228,962.07	
ANTHEM BC HMO ADMIN FEE		3,863,350.88	
ANTHEM BC EAP		288,888.16	
BLUE SHIELD HMO CLAIMS		3,737,305.20	
BLUE SHIELD HMO ADMIN FEE		3,210,754.74	
KAISER HMO		36,437,584.46	
SIMNSA		294,714.00	
DELTACARE/PMI DENTAL		14,394.07	
MES-FULLY INSURED		27,972.95	
KAISER SENIOR ADVANTAGE RETIREE PLAN		278,653.00	
BLUE SHIELD MEDICARE ADVANTAGE		27,536.00	
MUTUAL OF OMAHA LIFE INS		305,505.13	
		TOTAL INSURED	52,715,620.66
SISC FLEX CLAIMS			0.00
GOVERNMENT FEES			0.00
WELLNESS			6,377.58
ALL OTHER			923,655.53
		TOTAL III PAYMENTS	210,885,070.95

Moved______________________2nd______________________

Yes_____No______Abstain______Roll Call Vote__________

II. Public Comment

III. Action Items

A. Financial Report – Presentation of Financial Statements for the Month of September 2019 Will Be Submitted for Approval — Kim Sloan

Moved______________________2nd____________________

Yes______No______Abstain______Roll Call Vote____________

IV. Information and Discussion Items

A. Review Monthly Budget-to-Actual through September 2019 — John Stenerson

B. Review of Medical Trend and the Impact of Large Claims — John Stenerson

C. Provider Contracting-Review of the Current Landscape, Future Trends and the Challenge to Keep Healthcare Affordable — John Stenerson

D. Comments from the Board of Directors Will Be Heard — Nick Kouklis

E. Next Meeting: — Nick Kouklis
Thursday, November 21, 2019
1:00 p.m.
SISC Board Room, 4th Floor – Larry E. Reider Education Center
2000 K Street, Bakersfield, CA 93301

F. Adjournment — Nick Kouklis

Moved__________________2nd__________________

Yes______No______Abstain______Roll Call Vote______

Any materials required by law to be made available to the public prior to a meeting of the Governing Board of the SISC III JPA can be inspected at the following address during normal business hours at:
2000 K Street, Bakersfield, CA. 93301
For more 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 Kristy Comstock at 661-636-4682 or krcomstock@kern.org

*The number of Board Members needed to form a quorum for this meeting is eight

HEALTH BENEFITS TERMINOLOGY

Adjudication: Refers to the process of paying claims submitted or denying them after comparing claims to the benefit or coverage requirements.

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: The amount you could be responsible for (in addition to any co-payments, deductibles or coinsurance) if you use an out-of-network provider and the fee for the particular service exceeds the allowable charge. 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 Medical Excellence (CME): Health care providers designated as a selected facility for specified medical services. Providers participating in a CME network have an agreement to accept an agreed upon amount as payment in full for covered services.

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.

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: This is the process by which a health insurance company determines if it should be the primary or secondary payer of medical claims for a patient who has coverage from more than one health insurance policy.
Co-Payment: A specific charge that a health plan may require a member to pay for a specific medical service or supply, after which the insurance company pays the remainder of the charge.

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 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): A plan that offers a wide range of health care services through a network of providers who agree to provide services to members at a pre-negotiated rate. Members of an HMO choose a primary care physician who will provide most of the health care and refer members to HMO specialists as needed.

Health Savings Account: A tax advantaged savings account to be used in conjunction with certain high-deductible (low premium) health insurance plans to pay for qualifying medical expenses, such as deductibles. Contributions may be made to the account on a tax-free basis. Funds remain in the account from year to year and may be invested at the discretion of the individual owning the account. Interest or investment returns accrue tax-free. Penalties may apply when funds are withdrawn to pay for anything other than qualifying medical expenses. Employers can also fund such plans.

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.

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

Medigap: Refers to various private health insurance plans sold to supplement 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: A time period during which eligible employees can select among the plans offered by their employer as well as make any other dependent changes.

Out-Of-Network: The use of health care providers who have not contracted with the carrier to provide services. Members are generally not reimbursed if they go out-of-network except in emergency situations.

Out-Of-Pocket: The most a member would pay for covered medical expenses in a plan year through copays, deductibles and coinsurance before your insurance plan begins to pay 100 percent of the covered medical expense.

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: This refers to the standard or most common charge for a particular medical service when rendered in a particular geographic area. Also known as Usual, Customary and Reasonable (UCR).

Skilled Nursing Facility: An inpatient healthcare facility with the staff and equipment to provide skilled care, rehabilitation and other related health services to patients who need nursing care, but do not require hospitalization.

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

Transparency: 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
Self-Insured Schools of California
Schools Helping Schools

HEALTH BENEFITS
BOARD OF DIRECTORS MEETING
SEPTEMBER 26, 2019
1:00 P.M.

MINUTES

The Regular Meeting of the Board of Directors of SISC III Health Benefits Program was called to order by Director Kouklis at 1:08 p.m. on Thursday, September 26, 2019 in the SISC Board Room on the 4th floor, Reider Center, 2000 K Street, Bakersfield, California 93301.The following individuals were in attendance:

MEMBERS PRESENT:	ALTERNATES PRESENT:	OTHERS PRESENT:
Nick Kouklis	Chris Hall	Kim Sloan
Erica Andrews	Dan Weirather	Megan Hanson
Mike McGrath		Kristy Comstock
Glenn Imke		Fred Bayles
Ramon Hendrix		Rich Edwards
Dr. Mike Zulfa		John Stenerson
Jackie Martin		Nicole Henry
Tonya Davis		Lola Nickell
Bill Ridgeway		Kim Lyon
Eva Chavez		Lauri Phillips
Doug Kimberly		Carmen Gonzales
		Judy Fussel
		Susan Wooden
		Monica Matallana
		Tara Hernandez
		Annette Charlton
		Tiffany Garcia
		Yvonne Trawinski

Consent Agenda

Motion was made by Director Hendrix seconded, by Director Andrews and by roll call vote of 11-Yes, 0-No, and 0-Abstention (11-0-0) to approve the Consent Agenda as follows:

Minutes

Approval of Minutes for August 2019 Board of Directors Meeting

DELTA DENTAL CLAIMS		14,399,487.22	
DELTA DENTAL ASO		842,370.99	
		TOTAL DENTAL	15,241,858.21
VSP CLAIMS		1,656,376.30	
MES CLAIMS		174,912.46	
VSP ASO		130,527.36	
MES ASO		16,663.93	
		TOTAL VISION	1,978,480.05
ANTHEM BLUE CROSS HEALTH CLAIMS		86,731,488.55	
BLUE SHIELD HEALTH CLAIMS		26,278,694.28	
ANTHEM BC COMPANION CARE RETIREE CLAIMS		576,392.47	
	TOTAL HEALTH CLAIMS	113,586,575.30	
ANTHEM BLUE CROSS ASO		3,324,541.95	
BLUE SHIELD PPO ASO		540,432.01	
ANTHEM BC COMPANION CARE RETIREE ASO		107,731.82	
FOUNDATION CLMS PROCESSING ASO		583,874.26	
	TOTAL HEALTH ASO	4,556,580.04	
		TOTAL HEALTH	118,143,155.34
EXPRESS SCRIPTS CLAIMS		6,493,720.87	
NAVITUS RX CLAIMS		25,362,458.87	
EXPRESS SCRIPTS ASO		108,384.90	
NAVITUS RX ASO		529,772.29	
RX N GO		21,027.87	
		TOTAL RX	32,515,364.80
INSURED PRODUCTS			
ANTHEM BC HMO CLAIMS		4,575,481.20	
ANTHEM BC HMO ADMIN FEE		5,427,779.09	

ANTHEM BC EAP		284,375.85	
BLUE SHIELD HMO CLAIMS		1,763,689.21	
BLUE SHIELD HMO ADMIN FEE		3,255,478.65	
KAISER HMO		35,966,017.56	
SIMNSA		285,462.00	
DELTACARE/PMI DENTAL		18,001.27	
MES-FULLY INSURED		29,686.71	
KAISER SENIOR ADVANTAGE RETIREE PLAN		747,284.60	
BLUE SHIELD MEDICARE ADVANTAGE		25,210.00	
MUTUAL OF OMAHA LIFE INS		305,574.58	
		TOTAL INSURED	52,684,040.72
SISC FLEX CLAIMS			0.00
GOVERNMENT FEES			0.00
WELLNESS			7,939.04
ALL OTHER			1,165,187.79
		TOTAL III PAYMENTS	221,736,025.95

Public Comment
None

Action Items

Financial Report
Kim Sloan reviewed with the Board the Financial Report for the period ending August 31, 2019. Kim reported the LAIF rate for the month of August 2019 dropped slightly to 2.34% from last month at 2.38%. After discussion, motion was made by Director Chavez, seconded by Director Hendrix and by roll call vote of 11-0-0, approving the Financial Reports as submitted.

Request Approval of the 2019-2020 SISC III Budget
Kim Sloan presented the 2019-2020 budget to the board of approval. After discussion, a motion was made by Director Andrews, seconded by Director Davis and by roll call vote of 11-0-0, approving the SISC III Budget as submitted.

Information and Discussion Items

Review Monthly Budget-to-Actual
John Stenerson reviewed the monthly budget-to-actual with the board.

Comments from the Board of Directors
John Stenerson discussed with the board a new program called Hinge Health that will be billed through Anthem as a claim. Health Benefits will be sending out a postcard with more information to each member. An Anthem contractor will be speaking at the Annual Board Meeting about the impact from large claims. Director Kouklis announced that Lola Nickell was promoted to Health Benefits Supervisor. He also announced that John Stenerson will be having an interview with the Wall Street Journal.

Adjournment

There being no further business to come before the Board, motion was made by Director McGrath, seconded by Director Hendrix and by roll call vote of 11-0-0, adjourning the meeting at 1:31 p.m.

Next Meeting

The next meeting of the Board of Directors will be held **Thursday, October 17th at** 1:00 p.m., in the Georgie O'Connor Board Room. Lucia Mar Unified School District, 602 Orchard St. Arroyo Grande, Ca 93420.

____

Eva Chavez, Secretary