SISC
Self-Insured Schools of California
Schools Helping Schools

HEALTH BENEFITS
BOARD OF DIRECTORS MEETING
DECEMBER 16, 2021
1:00 P.M.
AGENDA

*Beginning with its November 18, 2021 regular Board meeting, Self-Insured Schools of California will be returning to an in-person meeting format. Members of the public wishing to observe the meeting or comment on matters within the Board's jurisdiction will need to attend the meeting in person to do so, at the time and place stated on the meeting agenda. The agenda can be accessed at sisc.kern.org.

The Board in the future may need to return to a teleconferencing format as permitted by the Ralph M. Brown Act based on conditions relating to the ongoing pandemic or as otherwise permitted by law. The meeting agendas will clearly indicate whether this is the case.

I. Consent Agenda

A. Approval of Minutes for November 2021 Board of Directors Meeting — Nick Kouklis

B. Report of Activity for the Month of November 2021 and the Ratification of Payment as follows: — Nick Kouklis

DELTA DENTAL CLAIMS		8,452,392.65	
DELTA DENTAL ASO		493,619.50	
ANTHEM DENTAL CLAIMS		201,295.71	
ANTHEM DENTAL ASO		9,168.00	
		TOTAL DENTAL	9,156,475.86
VSP CLAIMS		1,232,465.46	
MES CLAIMS		89,513.74	
VSP ASO		144,187.20	

MES ASO		13,045.83	
		TOTAL VISION	1,479,212.23
ANTHEM BLUE CROSS HEALTH CLAIMS		98,171,616.84	
BLUE SHIELD HEALTH CLAIMS		30,165,617.75	
ANTHEM BC COMPANION CARE RETIREE CLAIMS		502,825.90	
	TOTAL HEALTH CLAIMS	128,840,060.49	
ANTHEM BLUE CROSS ASO		3,562,987.92	
BLUE SHIELD PPO ASO		617,386.38	
ANTHEM BC COMPANION CARE RETIREE ASO		115,786.52	
FOUNDATION CLMS PROCESSING ASO		583,245.72	
	TOTAL HEALTH ASO	4,879,406.54	
		TOTAL HEALTH	133,719,467.03
EXPRESS SCRIPTS CLAIMS		6,916,524.75	
NAVITUS RX CLAIMS		29,830,630.19	
EXPRESS SCRIPTS ASO		302,506.80	
NAVITUS RX ASO		806,549.16	
RX N GO		23,985.04	
		TOTAL RX	37,880,195.94
INSURED PRODUCTS			
ANTHEM BC HMO CLAIMS		5,585,114.87	
ANTHEM BC HMO ADMIN FEE		874,058.82	
ANTHEM BC EAP		281,947.65	
ANTHEM VIVITY		131,333.58	
ANTHEM HMO CAPITATION		6,377,536.60	
BLUE SHIELD HMO CLAIMS		2,281,233.40	
BLUE SHIELD HMO ADMIN FEE		3,704,888.49	
KAISER HMO		60,451,491.07	
SIMNSA		366,286.00	
DELTACARE/PMI DENTAL		32,207.14	
MES-FULLY INSURED		74,644.58	
KAISER SENIOR ADVANTAGE RETIREE PLAN		0.00	
BLUE SHIELD MEDICARE ADVANTAGE		28,435.00	
LINCOLN FINANCIAL LIFE INSURANCE		308,494.73	

		TOTAL INSURED	80,497,671.93
WELLNESS			13,509.54
ALL OTHER			1,381,104.06
		TOTAL III PAYMENTS	264,127,636.59

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 November 2021 Will Be Submitted for Approval — Kim Sloan

Moved_____2nd_____

Yes_____No_____Abstain_____Roll Call Vote_____

B. Request Approval of the 2022 Defined Benefit Plan Budget — Kim Sloan

Moved_____2nd_____

Yes_____No_____Abstain_____Roll Call Vote_____

IV. Information and Discussion Items

A. Review Monthly Budget-to-Actual through November 2021 — John Stenerson

B. Review Paper Published by the Journal of the American Medical Association (JAMA) Using Data from the SISC Pharmacy Program — John Stenerson

C. Review SISC Symposium Survey Results — Nicole Henry

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

E. Next Meeting: — Nick Kouklis
Thursday, January 20, 2022
1:00 p.m.
Room 204, 2nd 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.