

## SISC III

# HEALTH BENEFITS PROGRAM BOARD OF DIRECTORS MEETING FEBRUARY 20, 2008 - 1:00 P.M.

## A G E N D A

### I. CONSENT CALENDAR

- A. Approval of Minutes for January 2008 Board of Directors Meeting Russell Bigler
- B. Report of Activity for the Month of January 2008 and ratification of payment as follows: Russell Bigler

DELTA DENTAL CLAIMS	6,117,754.28	
SISC ASO	401,324.68	
DENTAL COALITION CLAIMS	1,046,070.20	
DENTAL COALITION ASO	68,622.21	
DELTACARE/PMI PREMIUM	4,007.08	
	<b>TOTAL DENTAL</b>	<b>\$7,637,778.45</b>
VISION SERVICE CLAIMS	1,191,524.56	
VSP ASO	90,545.04	
MES CLAIMS	40,099.53	
MES ASO	4,417.55	
	<b>TOTAL VISION</b>	<b>\$1,326,586.68</b>
PACIFICARE/BEHAV HEALTH	462,875.63	
CIGNA BEHAV. HEALTH (MCC SLECT)	17,125.33	
SECURE HORIZONS PREM (PACIFICARE)	7,830.86	
SENIOR ADVANTAGE PREM (KAISER)	40,150.00	
SENIORITY PLUS PREM (HEALTHNET)	35,357.00	
BLUE SHIELD HMO PREMIUM	1,907,213.09	
BLUE SHIELD FULLY INSURED PPO	86,703.89	
HEALTH NET PREMIUM	1,583,401.51	
CALIFORNIA CARE PREMIUM	1,016,328.00	
KAISER PREMIUM	2,708,965.80	
PACIFICARE PREMIUM (No Longer Offered)	0.00	
UNITED HEALTHCARE (FORMERLY PACIFIC UNION DENTAL)	1,480.46	
UNITED HEALTHCARE SPECIALTY BENEFITS (LIFE)	119,030.46	
NAT'L BENEFIT RESOURCES (STOP LOSS)	56,622.00	
BLUE CROSS HEALTH CLAIMS	41,205,830.21	
BLUE SHIELD HEALTH CLAIMS	3,688,839.59	
BEHAVIORAL HEALTH CLAIMS	329,198.96	
ITS CLAIMS	1,157,815.81	
COMPANION CARE CLAIMS	187,354.75	
	<b>TOTAL BLUE CROSS AND BLUE SHIELD CLAIMS</b>	<b>\$46,569,039.32</b>

BLUE CROSS NETWORK ASO	1,241,263.67	
FOUNDATION ADJUDICATION ASO	559,109.07	
BLUE SHIELD ASO	10,688.64	
BEHAVIORAL HEALTH ASO	154,549.88	
ITS ASO	67,794.43	
COMPANION CARE ASO	37,232.97	
<b>TOTAL BLUE CROSS AND BLUE SHIELD ADMIN.</b>		<b>\$2,070,638.66</b>
<b>TOTAL BLUE CROSS AND BLUE SHIELD</b>		<b>\$48,639,677.98</b>
MERCK CLAIMS	9,442,032.67	
ASO-COPAY	355,286.85	
CLAIMS - DISCOUNT CARD	67,306.76	
ASO - DISCOUNT CARD	3,504.15	
CLAIMS - MEDICARE PART D	313,945.76	
ASO - MEDICARE PART D	10,805.52	
AHC - CLAIMS	1,968,631.89	
AHC - ASO	72,548.60	
<b>TOTAL RX CLAIMS</b>		<b>\$12,234,062.20</b>
<b>TOTAL BC, BSC AND RX</b>		<b>\$60,873,740.18</b>

**II. PUBLIC COMMENT**

**III. ACTION ITEMS**

- A. Financial Report - Financial Statements For Prior Month Presented For Approval Cindy Sproles
- B. Request Approval of the 2006-2007 Independent Financial Audit Russ Bigler

**IV. DISCUSSION AND INFORMATION ITEMS**

- A. Show the Monthly SISC PPO Claims History Through January 2008 John Stenerson
- B. Update the Board on Phia Recoveries Russ Bigler
- C. Update the Board on SISC's Health Improvement Program Russ Bigler
- D. Update the Board on the CHCC Presentation given at the December Board Meeting Russ Bigler
- E. Update the Board on the SISC Flex Program Russ Bigler
- F. Show the Board a Comparison between the PERS and SISC GASB 45 Plans Russ Bigler
- G. Mention Blue Cross of California Name Change Russ Bigler
- H. Review an Article from the L.A. Times Russ Bigler
- I. Comments from the Board of Directors Will Be Heard
- J. Adjournment
- K. Next Meeting: Wednesday, March 26, 2008  
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.

**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 BOARD OF DIRECTORS

## INFORMATION ITEMS

- A. **Monthly SISC PPO Claims History Through January 2008.** The SISC PPO claims history through January 2008 will be shown at the meeting.
- B. **Update the Board on Phia Recoveries.** The attached two pages show the recovery number for SISC since we began contracting with The Phia Group.
- C. **Update the Board on SISC's Health Improvement Program.** The name of the program is Health Smarts and we are introducing it throughout SISC. Staff will give you a presentation at the Board Meeting.
- D. **Update the Board on the CHCC Presentation given at the December Board Meeting.** As you are aware, Sally Covington, Executive Director of the California Health Care Coalition, CHCC, gave us an update. Two things she mentioned were:
- Doctors Medical Center in Modesto – She mentioned CHCC had obtained a better contract with them than Blue Cross and confirmed SISC had already sent CHCC documentation to have our claims from this facility re-priced. She mentioned at the meeting we should have the results by January or February, but as of now (2/4/08) we haven't seen anything.
  - Catalyst RX – She mentioned that CHCC had put together a committee to explore Pharmacy Based Management, PBM's, and had come up with a PBM by the name of Catalyst RX as the best and wanted SISC to have our claims re-priced by Catalyst RX. Any insurance entity, SISC included, is very reluctant to have another insurance entity know about their discounts. Therefore, we have countered with having Catalyst RX send SISC their pricing components, we would sign a confidentiality/non-disclosure agreement and re-price the claims against the pricing structure we have with Medco. Additionally:
    1. Medco is one of the top 2 or 3 largest PBM's in the U.S. By comparison, Catalyst RX is very small and it is hard to believe they can get the same, or better, discounts.
    2. Medco ranks at the top in customer service.
    3. It appears CHCC and Evergreen have a conflict of interest as it relates to Evergreen providing a no-cost financial comparison of SISC's current PBM contracts to the Catalyst RX contract. If SISC were to decide to implement the Catalyst Rx contract, it is my understanding we would pay \$0.08 PMPM to Evergreen. In addition, we would pay \$0.05 per claim to CHCC. These two payments from SISC would total well over \$200,000 per year.
    4. I recently received e-mails pointing out that Keenan has the best PBM, Paul Johnson with Johnson Rooney Welch told us they have the best PBM, I'm sure PERS thinks they have the best PBM. The person that heads CVT headed the committee that selected Catalyst Rx and they haven't made a move, so we want to do our due diligence but not give anything away in the process.
- E. **Update the Board on the SISC Flex Program.** There are two sheets attached showing employee and district growth in this program since its inception.
- F. **Show the Board a Comparison Between the PERS and SISC GASB 45 Plans.** A law was recently passed that allows PERS to do GASB 45 administration for all governmental entities. That's ok. Here is a comparison between SISC and PERS.
- G. **Mention Blue Cross of California Name Change.** As you are aware, Blue Cross of California is a subsidiary of Wellpoint. The name Wellpoint was kept when Wellpoint and another big insurance company by the name of Anthem merged. The National Headquarters is where the Anthem Headquarters was in Indiana but the merged company took the Wellpoint name. Blue Cross of California is in the process of branding everything because it will have a name change to Anthem Blue Cross. It's possible that new ID cards will be issued at open enrollment. I believe they will start the marketing and information process with commercials on American Idol.

# **SISC III BOARD OF DIRECTORS**

## **INFORMATION ITEMS (Continued)**

- H. **Review an Article from the L.A. Times.** You have probably either seen this in the newspaper, on television or heard it on the radio. The letters were only sent to physicians concerning people that had taken out individual HMO policies (all SISC active and retirees are in the large group market) because there were inconsistencies with what the person was being treated for and what the person had put on the application. This mostly has to do with subscribers not putting down pre-existing conditions.
  
- I. **Comments from the Board of Directors Will Be Heard.** Comments from the Board will be heard at this time.