

**SISC III
HEALTH BENEFITS PROGRAM
BOARD OF DIRECTORS MEETING
SEPTEMBER 26, 2007 - 1:00 P.M.**

A G E N D A

I. CONSENT CALENDAR

- | | | |
|----|---|----------------|
| A. | Approval of Minutes for August 2007 Board of Directors Meeting | Russell Bigler |
| B. | Report of Activity for the Month of August 2007 and ratification of payment as follows: | Russell Bigler |

DELTA DENTAL CLAIMS	6,037,380.15	
SISC ASO	396,052.15	
DENTAL COALITION CLAIMS	1,137,969.17	
DENTAL COALITION ASO	74,650.78	
DELTACARE/PMI PREMIUM	0.00	
TOTAL DENTAL		\$7,646,052.25
VISION SERVICE CLAIMS	1,091,535.09	
VSP ASO	87,348.16	
MES CLAIMS	35,095.06	
MES ASO	4,342.40	
TOTAL VISION		\$1,218,320.71
PACIFICARE/BEHAV HEALTH	443,889.75	
CIGNA BEHAV. HEALTH (MCC SLECT)	17,842.48	
SECURE HORIZONS PREM (PACIFICARE)	8,643.50	
SENIOR ADVANTAGE PREM (KAISER)	31,466.00	
SENIORITY PLUS PREM (HEALTHNET)	71,199.00	
BLUE SHIELD HMO PREMIUM	1,401,962.93	
BLUE SHIELD FULLY INSURED PPO	16,941.74	
HEALTH NET PREMIUM	1,736,327.00	
CALIFORNIA CARE PREMIUM	775,203.00	
KAISER PREMIUM	2,245,954.78	
PACIFICARE PREMIUM	27,075.10	
UNITED HEALTHCARE (FORMERLY PACIFIC UNION DENTAL)	1,895.22	
UNITED HEALTHCARE (LIFE INSURANCE)	103,828.83	
NAT'L BENEFIT RESOURCES (STOP LOSS)	83,481.84	
BLUE CROSS HEALTH CLAIMS	40,806,477.49	
BLUE SHIELD HEALTH CLAIMS	3,937,485.99	
BEHAVIORAL HEALTH CLAIMS	237,661.42	
ITS CLAIMS	1,005,962.02	
COMPANION CARE CLAIMS	215,283.40	
TOTAL BLUE CROSS AND BLUE SHIELD CLAIMS		\$46,202,870.32

**SISC III BOARD MEETING
WEDNESDAY, SEPTEMBER 26, 2007
PAGE 2**

BLUE CROSS NETWORK ASO	1,022,461.35	
FOUNDATION ADJUDICATION ASO	514,384.65	
BLUE SHIELD ASO	122,576.64	
BEHAVIORAL HEALTH ASO	139,748.00	
ITS ASO	88,738.18	
COMPANION CARE ASO	29,296.31	
TOTAL BLUE CROSS AND BLUE SHIELD ADMIN.		\$1,917,205.13
TOTAL BLUE CROSS AND BLUE SHIELD		\$48,120,075.45
MERCK CLAIMS	9,094,452.92	
ASO-COPAY	265,836.74	
CLAIMS - DISCOUNT CARD	75,076.59	
ASO - DISCOUNT CARD	2,888.11	
CLAIMS - MEDICARE PART D	290,960.70	
ASO - MEDICARE PART D	9,735.95	
AHC - CLAIMS	1,936,088.81	
AHC - ASO	74,105.40	
TOTAL RX CLAIMS		\$11,749,145.22
TOTAL BC, BSC AND RX		\$59,869,220.67

II. PUBLIC COMMENT

III. ACTION ITEMS

- | | |
|---|----------------|
| A. Financial Report - Financial Statements For Prior Month Presented For Approval | Cindy Sproles |
| B. Request Approval of the 2007-2008 Budget | Cindy Sproles |
| C. Request Approval to Revise Policy No. 7000.8 | Russell Bigler |

IV. DISCUSSION AND INFORMATION ITEMS

- | | |
|--|---|
| A. Monthly Blue Cross/SISC PPO Trend History Through August 2007 | John Stenerson |
| B. Newspaper Article on Single Payer Health Care | Russell Bigler |
| C. Show the Board an Article on Medical Tourism | Russell Bigler |
| D. Show the Board a Letter Blue Cross sent to it's Members | Russell Bigler |
| E. Show the Board an Article on what is Happening in Sacramento as it Relates to Health Care | Russell Bigler |
| F. Discuss the IRS Changes to 403(b) Regulations | Russell Bigler |
| G. Comments from the Board of Directors Will Be Heard | |
| H. Adjournment | |
| I. Next Meeting: | Wednesday, October 17, 2007
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.

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.

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 copayments 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.

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.



September 26, 2007

TO: SISC III Board of Directors
FROM: Russell E. Bigler, Chief Executive Officer
SUBJECT: Approval of 2007-2008 Budget

BACKGROUND INFORMATION

The 2007-2008 budget will be presented at the Board Meeting.

ADMINISTRATIVE RECOMMENDATION

It is respectfully requested that the Board approve the budget for the 2007-2008 fiscal year.

REB:clp



September 26, 2007

TO: SISC III Board of Directors
FROM: Russell E. Bigler, Ed.D., Chief Executive Officer
SUBJECT: Revise the Late Premium Payments Policy; Policy No. 7000.8

BACKGROUND INFORMATION

At the March 19, 2003 Board Meeting, Policy No. 7000.8 was adopted to allow the SISC III JPA to annually adopt a budget that would be funded equitably between the member districts. It has helped, but since the premiums are so large and districts can still pay up to two months late before they are penalized, several districts, and not SISC, are earning interest on their premium payments during this two-month period.

Staff charted this for the second quarter and the results speak for themselves. (I will go over these at the meeting.) Since the revision shortens the penalty period from two to one month, we reduced the interest from 1.5 percent to 1.0 percent.

ADMINISTRATIVE RECOMMENDATION

It is respectfully requested that the Board approve the attached revised policy. We will notify districts that the policy will start on January 1, 2008.

REB:clp

LATE PREMIUM PAYMENTS

Paid premiums and interest on reserves represent the funding sources utilized to maintain and operate the Self-Insured Schools of California (SISC), Medical, Dental and Vision Joint Powers Authority (JPA). It is the desire of the Board of Directors and the Administration to establish the annual budget so that it reflects equitably on its member districts.

To set the budget equitably, each member district has to pay its monthly premium within the following guidelines:

2. Premium for health insurance is due by the first of the month for the month covered.

Example: Premium for October coverage is due October 1st. The premium will be considered late if it is not received before the first day of the month immediately following the coverage month. In this case, November 1st.

3. If the premium is not received before the first day of the month immediately following the coverage month, an additional one percent (1.0%) will be attached to the premium.

**Adopted March 19, 2003
Revised September 26, 2007**



MEMORANDUM

Date: September 26, 2007

To: Superintendents
SISC III – Health Benefits Member Districts

From: Russell Bigler, CEO
Self Insured Schools of California (SISC)

Subject: Revised Policy No. 7000.8, Effective January 1, 2007

As a non-profit school-purchasing group, SISC's mission is to keep insurance premiums as low as possible for all California member schools. Late premium payments create a financial burden that affects all SISC members. The SISC III Board of Directors recently revised Policy No. 7000.8, "Late Premium Payments." It reads as follows:

Paid premiums and interest on reserves represent the funding sources utilized to maintain and operate the SISC Medical, Dental, and Vision Joint Powers Authority (JPA). It is the desire of the Board of Directors and the Administration to establish the annual budget so that it reflects equitably on its member districts.

To set the budget equitably, each member district has to pay its monthly premium within the following guidelines:

1. Premium for health insurance is due by the first of the month for the month covered.
Example: Premium for October coverage is due October 1st. The premium will be considered late if it is not received before the first day of the month immediately following the coverage month. In this case, November 1st.
2. If the premium is not received before the first day of the month immediately following the coverage month, an additional one percent (1%) will be attached to the premium.

Thank you in advance for your assistance in this matter, and for helping to maintain a well-funded JPA program on behalf of all member districts. If you have any questions, please feel free to contact Yolanda Villarreal at (661) 636-4412.

SISC III
INFORMATION AND DISCUSSION ITEMS
SEPTEMBER 26, 2007

- A. **Monthly Blue Cross/SISC PPO Trend History Through August 2007.** The monthly Blue Cross/SISC PPO Trend History through August 2007 will be presented.
- B. **Newspaper Article on Single Payer Health Care.** Not that Single Payer is going anywhere, but an interesting article.
- C. **Show the Board an Article on Medical Tourism.** This article shows this new medical term in action.
- D. **Show the Board a Letter Blue Cross sent to it's Members.** Enclosed is a copy of the letter Blue Cross sent to its members showing their revised fee structure. At the last board meeting I showed you a similar letter we sent to SISC member districts.
- E. **Show the Board an Article on what is Happening in Sacramento as it Relates to Health Care.** After reading the article in IV B and reading this article, you can see things starting to take shape in Sacramento concerning health care.
- F. **Discuss the IRS Changes to 403(b) Regulations.** I'm sure you are aware that the IRS has announced changes to 403(b) regulations that will require school districts to have an increased responsibility for administering these retirement savings plans. Just as our GASB 45 and IR 125 Plans, we believe this falls into our mission of Schools Helping Schools and can look into putting together an administrative program, if you want.
- G. **Comments From the Board of Directors.** Comments from members of the Board will be heard at this time.