These notes from our meeting as transcribed are delivered in narrative form and have been transcribed from an audio tape. ( ) = parts of the audio tape that were inaudible.

Health Benefits Fringe Committee Meeting Oct. 11, 2012

Present:

Helane Carpenter (Benefits Office), Bruce Jacobs (VP of the Peralta Retirees Organization), Ava Lee (District), Connie Willis (Business Manager, Laney College), David Betts (HR), Jennifer Seibert (Benefits), Rick Putz (Local 39), Rick Greenspan (PFT), Bob Frost (Notes), Ruby Andrews (Confidentials), Ron Gerhard (Vice Chancellor – Finance), Trudy Largent (Vice Chancellor.

Jennifer: Introductory remarks. Overview of agenda. We have three meetings this semester purpose and make-up of committee. I took material for this from 1021 contract. We want to make more of an effort to get recommendations from committee. Fall Newsletter targeted for distribution in a couple of weeks. Discussion of contents. New to this newsletter: glossary of terms. Newsletter includes recent accomplishments of Benefits Office: long term care introduction, Medicare subsidy recovery, workshops, introduction of a third medical plans.

Rick: Can you mail us numbers on how many people are in each plan?

Jennifer: Yes. Probably in November.

A couple of bullets on health care reform in the newsletter especially as it affects retirees and anyone who has left Peralta employment. We are required to report the value of insurance on W2 in 2013 for work done in 2012, this is new. Cadillac tax.

Connie: You used retirees as example for new reporting requirement. But that applies to everyone?

Jennifer: Correct, anyone who has left Peralta employment (etc.).

Connie: Applies also to active employees?

Jennifer: Let me double-check on that. I thought we were already recording that. I'm not entirely clear but I'll ask.

Bruce: Retirees who do not work for district will not see W2 showing value of health care?

Jennifer: Correct, we're not required to do that at this time. And I have a timeline for health care reform we may want to revisit. It's an issue we need to be technologically prepared for. There was voluntary compliance this year.

Bruce: I am concerned about Medicare D as it relates to Kaiser. If someone's income sufficiently high, then there is Medicare D premium. If you're enrolled in Kaiser, and enrolled in Senior Advantage as

required, and income is of that level, then – first Kaiser enrolls you in Part D. Very confusing to people. (Continued.)

Jennifer: Please forward question to me. I think some of what you say is not exactly correct. (Discussion.) Medicare D does require annual notice. Some retirees for personal reasons may buy product outside of district. But only one entity will get subsidy.

Bruce: Subsidy is not issue. Issue is that Kaiser, as part of Senior Advantage, actually enrolls the retiree in Medicare D. And then the retiree gets a bill for Medicare D.

Jennifer: Please send email to me on this.

Bruce: Will do.

Ava: Question on Open Enrollment. Confusion – can you explain more. What is total now.

Jennifer: We just finished our Open Enrollment for medical and dental plans. Alignment. We didn't have Open Enrollment , for medical reimbursement plan, because under rules. So in order to bring our Flexible Benefits Plan in alignment with medical plan, employees have opportunity to enroll (). But rather than for 12 month period, the employee will be planning for a six-month period, Jan. to June. And then the Flex Plan will be in alignment with (). Another re-enrollment to cover the fiscal year.

Ava: Are you saying this is one time only?

Jennifer: This is one time only. I have attached in here the actual plan description that shows timeline. Question: For this one time only, if I enrolled this October, if I want to change, I can change it in July?

Jennifer: That's correct. In November you'll be submitting forms for expenses January to June. In May of next year, you'll do another form to cover from July 2013 through June 2014.

The form itself will state what the duration of the coverage is.

(Discussion and elaboration.)

Jennifer: There is an announcement which states that in order to bring a Flexible Benefits Plan to alignment you'll have the two enrollment periods.

(Discussion of potential problems.)

Jennifer: We will do two mailings. The form itself will specify the window of coverage.

Ava: Six months. Confusion by some people over this period of time. Potential for people forgetting to take appropriate actions in specified period of time.

Jennifer: Explanation of need for realignment; adherence to calendar.
Jennifer: In answer to your question, Ava, the employee would need to carefully weigh if they want to participate.

Ron may be on conference call.

We will have a Benefits Fair on 15th of November after mailing. Throughout year we're approached by people who want to provide things like health club memberships and voluntary supplemental programs, etc. Every year Costco comes. Based on employee surveys, the topics will include estate planning, etc., how to protect my assets, how choose financial planner.

The Benefits Office receives many calls from caretakers. (Discussion.)

Employee Assistance Plan.

All are invited to Benefits Fair.

Next thing to talk about – health care reform we'll save – also in your attachments we're going to give the summary of the self-funded plan changes that have occurred from 2006 to 2008. This is part of an on-going discussion. There was a request for an outline of plan changes. I direct your attention to three-page summary in the packet. This is leftover from spring and summer, list of changes for self-funded plan. Many changes have to do either with change of partnership or compliance or administrative. This is a work in progress. We will go back to 2004. We will discuss at next meeting mechanism by which changes occur.

Other items left over from the spring. Explanation of how survivor rates are determined. That came up. Medicare coordination for retirees. (Discussion.) We knew when plans changed that we would have six-month period for which no (). (Discussion.) I'm pretty sure by end of December we'll have (). Provide union with list as a communication that are going out to retirees who are eligible for Medicare A and B but have not signed up.

Another issue from spring – Local 39 and PFT – wanting to pursue, if you have a variety of employee classifications, some people may not be in position that allows them to have benefits. But they're willing to buy into benefits. What can we do there.

Exploration of network options for non-California retirees. Currently as mentioned in newsletter – the issue came up on how provide max coverage for, or provide a network, for those who are in PPO Lite but moved out of California. (Discussion.)

Rick: Issue is not whether PHCS works for retirees out of California. Issue is that under the Lite plan, if someone not in network, there's no out of network reimbursement.

Jennifer: There would be.

Rick: So if you are in Lite plan and are in Bay Area, and you go out of Blue Cross network, you get no out of network coverage. So now you're a retiree, you're in Oregon. So currently if you're retiree, year 2000, in Oregon, and you go to doctor, doctor not in PHCS network. You submit out of network claim and PHCS, or Peralta, or somebody, pays the 80 percent. If you retire now, today, and you're in Lite plan, and move to Oregon.

Jennifer: You would still have coverage.

Rick: Now you go to same doctor, who is not in PHCS network, you submit claim, you're out of network because you're not in PHCS network, then you get zero coverage. We want you to go through the claims that are non California, PHCS claims, what is dollar value of ones that were reimbursed in 80 percent of usual and customary, and which ones reimbursed at 100 percent. The ones at 100 percent still covered at 100 percent, no difference, but ones at 80 percent covered at zero.

Jennifer: Would be covered at 80 percent.

Rick: No, zero, because there's no out of network coverage anymore.

(Discussion.)

Jennifer: We do have an out of network plan. PHCS. The Lite plan is affiliated in Oregon with PHCS.

Rick: There are few doctors in Oregon who say they're part of PHCS network. Retirees living outside of California - they're submitting claims to PHCS and PHCS paying 80 percent. So the point is under new Lite plan if you go out of network you get zero. Not 80 percent; zero.

We were going to look at claims, PHCS, and see dollar value and percentage, what percentage paid at 80 percent and what paid at 100 percent. The 80 percent ones are not within the PHCS network. What's going to happen when Lite people do start to retire and move to Oregon or anywhere else. That's what we want to find out. The difference between PHCS Oregon and Bay Area with Blue Cross was night and day, a quantum leap.

We haven't had complaints. So something is working.

(Discussion.)

Bruce: People have problems – they can't find providers in-network.

Jennifer: We do offer – this isn't new – we have mechanisms – PSW. Who wants to do where to go. Customer service that help.

The question came up from Peralta Retirees about how are survivor rates determined. The answers are provided for the self-funded plan and the Kaiser plan. The answers are included. Based on the age of the survivor, and which plan they're enrolled in. We have a written answer that came directly from CoreSource and directly from Kaiser.

Joint Powers of Authority. Another outgrowth of negotiations. The concept may be new. JPA stands for Joint Powers of Authority, entity of two or more public agencies which can operate collectively for purpose of improving buying power; in our case, for health insurance. Why JPA now? Peralta might consider joining a consortium; maybe we can get better pricing. We're already in JPA for dental insurance. Perhaps other issues can be addressed through a JPA. Buying power is basic thing. Last year as part of of our negotiations with Kaiser we faced 18 percent increase with Kaiser HMO plan. We

want to avoid that. We need to stabilize our fluctuations. So with that in mind – I know it came out of PFT – also 1021 – it's a common thing.

Trudy: We all discussed jointly exploring this. That doesn't mean that we're going to be guaranteed anything. JPA has more power if you will to keep rates down. How will changing to JPA potentially impact agreement we already have is a key question.

Jennifer: There are different JPA models. Can go straight to a JPA without a consultant, or use a broker or consultant to find the right JPA. Or continue as we have been. So with that said, one thing we did over the summer, we looked at what JPAs are out there, how easy to join a JPA, timing of doing this, how does this fit our culture, is there minimal duration of commitment, are we contracted for a two year period, a one year period, what do we sacrifice in terms of drug subsidy, what's level of customer service to employees and retirees, how comprehensive are offerings beyond medical, these are among the issues.

I have invited today Lola Nichol from Southern California representing SISC .

Lola: I am from Self-Insured Schools of California. I have handouts.

Jennifer: There may be special enhancements we can achieve with (people who move?)

Lola: I'll go through presentation. (PowerPoint slides; these are in handout.) Who we are. Non profit joint powers authority. We formed in 1978 was with Worker's Compensation program in Kern County. Asbestos containment. 1979 expanded. Fast forward through the years, here we are in 2012, and we are covering over 200,000 people in 380 school districts. We don't have marketing department. We are all personnel of Kern County Office of Education where SISC is based.

We know concept of having to shop for and find solution for health benefits program is miserable situation. People don't want to do this over and over. We are trying to provide something more stable.

SISC has board of directors elected by school districts. We are a school-based entity. We have a high degree of transparency. Board has 12 members. Schools helping schools, core philosophy.

List of our school districts in hand-out. We've got a number of community colleges.

We offer wide range of medical products. One thing to bear in mind, SISC offers wide range and you can customize from our menu but we don't customize our benefits to match yours. You select from a product that is available (). I know a lot of times people when looking at what else out there, ask, "Can you give me what we have now?" Answer probably is "No." We will give you comprehensive package that you can certainly select from. My philosophy is, I want to be a good fit for you and not persuade you that it's something it isn't.

We have strong financial standing. 2012-13: $1.4 billion budget. $272.4 million in net assets. That includes our liabilities. $138 million in reserves.

(Examines results from several years.)

This year we're performing better than was budgeted.

Rick: Are some districts – are they just in with Kaiser, or do you have to go all in, or not at all in?

Lola: It would be subject to underwriting approval.

Rick: So it's possible.

Lola: I don't know that it's possible; when it comes to accepting risk I have to defer to our underwriters. I don't know of any district that participates only in the Kaiser.

Bruce: Retirees have guaranteed benefits based on the benefits we retired on. So in that instance the district would perhaps not be able to include retiree coverage. Can you comment.

Lola: I don't know how to speak to that. We accept the retiree risks along with the active risks. I know that you're self-insuring on one aspect, but on your fully insured, I would be surprised if the fully insured Kaiser would accept the retiree risk without the active risk. If you took the actives out I don't know that Kaiser would continue to insure that population. That would be a question I would ask. Would it be something that we would take the actives without the retirees – absolutely. But that's not something likely to happen. When a district joins SISC we provide materials up front and you have to see how that lines up with prior agreements you have. Lots of districts have joined that have had agreements in the past and have managed to overcome that obstacle.

So going through what we have available. We have PPOS, HMOs, dental, vision, etc.

A caveat – regarding fully insured non Kaiser HMOs – just because we offer it doesn't necessarily mean that you all would get it. It's subject to approval. In certain areas they may not want to write that risk.

(Description of various offerings and aspects including pharmacy rebates.)

We contract with Kaiser Permanente. Jennifer mentioned ease of transition. The contentious piece on ease of transition would be Kaiser Permanente. There is what's called a "break in" policy. (Brief explanation of this.)

Delta Dental we would provide through the premiere "Incentive" plans. (Elaboration.)

We're constantly looking at what we can do to create more affordability in our options.

Vision (elaboration). Life (elaboration; mention of booklet).

Living in defined service area. (Discussion.)

Within the PPO we have a number of options. (Discussion.)

I saw you have some pretty rich benefit designs in your current PPO plan. I'm not an expert on your plan – I just noticed difference in area of out-of-network services. We pay them at a non-par fee schedule except for emergencies.

Jennifer: Please elaborate on what "non-par" means.

Lola: "Non participating fee schedule for non network providers." Established by the carrier. I saw that you have a provision I believe in your PPO plan that pays non participating claims at "customary and

reasonable." That scenario that you have in place would only happen in the case of what's defined by the client as a true emergency. Not much problem in California with this. Except in Kern County, a huge hospital not participating with our local insurance. If I were to call 911, ambulance takes me there, I'm treated, this would be paid at customary and reasonable level. Does that protect me from getting a ( ) bill? Absolutely not. There's no ceiling to what a provider can bill. But there's a ceiling to what insurance will pay. If within your self funded plan – I don't know level of autonomy you have to circumvent what that is. Our plan designs are pretty rigid; "customary" – "reasonable" – what is an emergency – but when there's a choice it's a non par fee schedule. What does that look like? It depends on regional pricing for particular providers. What is considered within reason. What I tell my members is, you ought to try to be seeing providers that are in the network unless you want unexpected bills. I don't want to oversell non par fee schedules, because if it's not an emergency it's going to pay a vastly reduced benefit compared to in network.

I saw you have out of pocket maximum on out of network expenses. I don't believe I've seen such a maximum defined as low as yours.

What I have provided in the right side of packet are benefit summaries. I can provide booklets upon request.

Rick: This non par fee schedule. Is that SISC's schedule or is there one for Blue Cross and one for Blue Shield and they keep it internally.

Lola: It's not SISC's. Yes it's for Blue Shield and yes they keep it internally. The fee schedule is proprietary and that's something we don't even see. (Discussion.)

Where you have non network issues is not so much in metro areas.

Rick: On these examples of plans, when a school district joins SISC, they pick – they say, "We want to offer our people an 80 percent plan and a 100 percent plan, but we don't want to offer them a 90 percent plan or an HSA." Or do you have to only go into all one.

Lola: You don't. I have a slide on that that I will show shortly.

"Blue on Blue" – it's an association, an agreement between Blue Cross and Blue Shield – inside of California they're two separate companies, outside of California sometimes they're the same company and you see "BCBSA," Blue Cross Blue Shield Association. But within California you cannot go from an arrangement by which you are directly contracted with Anthem Blue Cross or any kind of arrangement – you can't go from Blue Cross to Blue Cross. Can't go from Blue Shield to Blue Shield. You always have to go into something else. If you're with United or Aetna we have options. (Discussion.) The solution we would be looking for with you would be Blue Shield, they're based in SF, non profit company, I'm quite pleased with some ways they've been operating over the last few years with respect to affordability. (Discussion; mention of "ASO.") ASO – Administrative Services Only.

Outside California. I heard quite a discussion about what happens if you retire and you go outside state. Or what if you're living here but spouse works in Nevada or child going to school somewhere else in the United States. Outside of California you enjoy principally the same in-network benefits as you do inside the state. As long as you access services via Blue Card network; also known as

Blue Cross/Blue Shield Association. We have retirees in every state. Also some outside of U.S. When you go outside of U.S. your coverage limited to emergency services. But inside U.S. you can access same in-network benefits. (Payment processing discussion.)

A lot of people say, "There's never a good time to leave my current arrangement." Bear in mind there's no waiting period, you don't have any limits on preexisting conditions, we have some transition assistance available for people who need it. (Discussion.)

Deductibles.

Outpatient prescription drug coverage. Costco. Walgreen's. (Etc.)

Delta Dental. Networks.

Dental and vision in SISC non-voluntary if you enroll in medical product. (Discussion.)

Value-added services. We have robust health improvement program. Tests of various kinds. Incentives. (Etc.) SISC EAP. Visa card with pre-tax money set-aside. RDS (Retiree Drug Subsidy).

Program options now – you've got that. Participation requirements – I would note that any deviation from SISCO guidelines must be requested in writing from the school district. We are 100 percent participation; any exceptions need to approved through underwriting; we have worked with districts on that.

Retirees. Re-entry issue. A retiree who does not enroll at the initial enrollment can't come back to the plan. Retirees that say "I don't want to do this," if they change their mind, they can't come back after initial enrollment. I always encourage retirees, if they're not sure what to do, always enroll and you can always cancel later. (Discussion of options for retirees.)

Sample rates for this year.

(Other SISC offerings.)

Jennifer: Let's say, our line in the sand, we stop covering at 65. Could we allow our folks who are no longer employed – they don't meet the definition of retiree maybe – but could they buy into supplemental plan?

Lola: We will take risk that is currently insured with you. It is not going to open it up and say "Everybody who ever had employment with Peralta, you have this one-time opportunity." No. It's your current retirees. Or your people who are your future retirees. (Discussion.)

Rick: Jennifer, can you send us this slide package?

Jennifer: Yes.

Rick: Question Number Two, the way our benefits works is that, when someone retires, it freezes their benefits at the rates and coverage they got when they retired. And it doesn't key it back to actives. So we have some people who retired long ago with one dollar co pays. They're still in Kaiser. Kaiser minimum 10-dollar copay. They pay that. Then they submit the bill to the district and district pays them back the other nine dollars. Their contract said one dollar copay. Is there any contractual thing that they couldn't do that, that the district couldn't reimburse people at a higher level when they were covered by this plan?

Lola: In parameters of discussion we're having, what you're saying, the answer is no, there aren't any reasons why the district can't do that. In those parameters. If we're talking about expanding those parameters, so for instance offering a plan with 2500 dollar deductible, because it's a cheaper rate, and then giving the employee 2500 to pay deductible – no. ( ) doesn't like that. But if the district is () on prior agreements by contracting for a third party administrator to adjudicate those claims or whatever ( ) we know some districts have found themselves –

Jennifer: We have to disclose it to you so you know what we're doing.

(Discussion.)

Bruce: The slide that says "All retirees must be enrolled in Medicare A and B."

Lola: If they're not then there's a surcharge.

(Discussion.)

Lola: I should say all retirees who are eligible.

Bruce: And that's also true for dependents.

Lola: Yes. Any person who is Medicare eligible has to enroll in Medicare A and B when they are eligible. If they're retired. If they're active you don't have to get Medicare even if you're 80 and you're working. But we do require it – or the district will be penalized.

Bruce: Could you define eligible.

(Discussion.)

Jennifer: There's age eligibility and there's condition eligibility.

(Discussion.)

Lola: Timing and action items. Just to see what it might look. Our renewal rates go into effect Oct. 1 and stay in effect through Sept. 30. So our renewing districts are going to get their rates in May. Districts can join SISC (timing). We don't care when you join but Kaiser piece will complicate it. (Timing of when to join.) SISC underwriting can provide list of items required for a quote and delivery timeline.

Initial commitment is three years, per the JPA agreement. Never had anyone who asked to withdraw in less than that time period. No penalty for early withdrawal. The only withdrawals we've had recently have been reunifications and they're not really withdrawing. If you do have to withdraw we're strict on dates, you can't withdraw any date except for ( ). If you think you might want to break up with

us Aug. 15 you can send us the letter but you can retract it. I did send electronic copy of JPA agreement and bylaws.

Special attention/support for retirees.

Ease of transition. (More.)

We require every dependent have proof of eligibility, photocopies. (More.)

(Examination of contents of the packet: copy of PowerPoint presentation, sample sheets, etc.)

Can I ask what your renewal date is?

Jennifer: July.

(Break. Transition to Working Lunch.)

Jennifer: Update on state of budget. Vice Chancellor Gerhard here. What's latest word.

Ron: District Website. If you have a bout of insomnia and want to read our budget reports, on left-hand side go to District Office. Then Business Services. Then actual budget documents are listed under Annual Adopted Budget.

This is same presentation provided to Board of Trustees. Pretty much same as Flex Day presentation.

State budget. Review. Coming into year a $16 billion deficit. They ended up with $8.1 billion in cuts. $6 billion in new revenues. $2.5 billion in borrowing and transfers. Also a little less than a billion in reserves. Key figure here is $6 billion in new revenues. That is Proposition 30 on the November ballot. If it passes it will lead to approx. $6 billion in new revenues for the state. If it fails, we have a structural deficit again of $6 billion, six months into our fiscal year.

State budget bill had no new reductions. Unless Prop 30 fails. If it fails, we are looking at $338 million in reductions system-wide. 72 districts. (Etc.)

Last bullet point – should November initiative fail – districts would need to make mid-year cuts to tune of $338 million.

Cautious optimism. Risk. When you look at spectrum of possible outcomes, failure or passage of Prop 30, essentially the total dollar magnitude of opposite end of spectrum, plus or minus $548.5 million. If Prop 30 fails, we're going to have mid year reductions in the system. Peralta, $5.5 million. About a 7 percent reduction. We've built budget numbers based on worst-case assumptions.
If Prop 30 passes that introduces into our budget money we had not counted on.

(Slide.) Here's history of FTS. Primary workload funding driver. Funding model. (Discussion.)

(Slide.) Here is summary of our unrestricted general fund. We have a balanced budget. (Reductions in state funding.) In order to balance budget we've had to cut expenditures.

$37.6 million budget for fringe benefits. Includes everything. Approximately $4 million increase. Had we not had those tentative agreements in place – co-pays, variable rate cap – it would have been much more than $4 million increase.

Total revenues – a history. (Review.) You see that '08'09 was highwater mark in terms of unrestricted general fund revenue of approx. $121 million. Spending in excess of revenues in the past; over last 2 fiscal years we've incorporated fiscal practices that turned that trend around.

Cost centers. (Discussion.) And again this slide is on Website.

Reductions. Chancellor Allen made commitment we would maintain section counts to maintain FTS at that funded FTS amount. We had to budgetarily plan to reduce our part-time faculty budgets from what we generated downward. (More.) District wide we cut discretionary budgets – supply, etc. – second year in a row by 15 percent. Those two items alone make up about 90 percent of that $5.5 million reduction.

The piece left to be done is creating some equity amongst the resource allocations.

Allocation model – development of; implementation of.

This allocation model is huge paradigm shift, it created framework that was somewhat clear and easy. And resembles how we as district are funded from state, following same principles. Important to do this, especially for accreditation.

These next slides go into minutae of allocation model.

OPEB. Debt service. OPEB benefit expenses are what the actuarial firms calls PAGO. Pay as you go. What we're paying on an annual basis for current retirees. Debt service related to OPEB bonds. We sold in 2005 about $153 million in OPEB bonds. Annual debt service payments related to those.

District cost centers and related budgets. Somewhat of a charge-back system. In relation to FTS.

Here's total revenue allocation by college.

Here's the budgets that have been allocated out. (Etc.) Budget allocation model applies here. There are disparities; we're working on disparities. It will happen over the course of a few years.

Ava: Question about usage of allocation model.

Ron: Tentatively we would use it in terms of when new money becomes available, determining which college ( ).

Jennifer: Thank you Ron. Can you speak briefly at high level on OPEB process again.

Ron: ( ) requires us, requires gov. agencies such as us, to report within our financial statements on our balance sheet the liability related to these benefits. Medical benefits. Now it doesn't require us to fund them, but there are consequences if we decide not to fund them. Pay as you go – PAGO – pay that annual amount and don't set aside money for future. Rating agencies have issues with that and it costs district every time we go out and issue debt, and accreditation committee sensitive to this. The last actuarial study we obtained put our liability at $121 million. We issued those bonds. We issued $153 million bonds. Plan was, proceeds of those bonds would be invested and we would generate money or accumulate wealth, I guess on the spread between what our rate of return on investments would be, versus our annual costs. Stock market took hit in 2008 and derailed that. There were a few other assumptions in there as well: that we would continue to get COLA from state. And that medical benefit premium increases would be single digits. 2010-11 OPEB charge implemented. We're in process now of getting new actuarial study done. I was told by firm we could expect it by end of November. Based on that, I would expect future discussions in this body. This impacts every budget in which permanent personnel are paid out of.

Connie: How long has GASB (Government Accounting Standards Board) been around?

Ron: GASB 45 was introduced 2000-2004. (Details on what it does.) We had to implement it in 2006. That's why my predecessor issued those bonds in 2005. We're about in Year Seven of GASB 45.

Connie:

Ron: And you're on board of Retirement Board.

Jennifer: Thank you Ron.

So now we'll have in Hour Three, Alliant. Not a JPA. Reason why invited, we are part of them already for dental plan. So we want to explore other possibilities.

We can go direct to JPA. We can go to consultant and choose a JPA that way. With that said, we have invited Alliant, the largest public entity benefits consultant in California. Christine Kerns and Erin Sanders.

Christine: Handout. We're familiar with Peralta. I've been meeting with Jennifer. We've studied your benefits. We have some suggestions and ideas, very high level today.

Tab One. P. 4: We see ourselves as brokers and consultants. Broker – gets best financial deal, oriented to contract and rates. Consultant – helping throughout year, where you are today, where you want to go. P. 6: How Alliant different. Leverage our size; kind of the Costco concept.

P. 7. These are some of programs available.

Your dental program – there are opportunities for you to save some money. We'll go over those.

P. 8 – List of some clients. Cabrillo College for six years. City College of San Francisco. Etc. We work with a number of counties and cities in the Bay Area. And other public agencies.

We see ourselves as helping our clients obtain and secure best benefit package. That's different for each client. I think opportunities for you to get benefits you have today at lower price. We understand joint labor-management process.

P. 10. We see ourselves as advocates. We're passionate about education.

P. 11. Impact of health care reform. Compliance – we look at all your contracts. Wellness program. Employee Awareness meetings – how you become a better consumer of plan you're signed up for.

Making sure plans you offer have long-term stability. From our vantage point, on outside looking in, that's what we're most concerned about.

Section 4. Some ideas we see we can help you explore. One things – Joint Powers Authority. Alliant is the key broker for SISC. We have a lot of experience with SISC. Some districts that we work with have plans outside SISC.

We believe savings potential for you in pharmacy benefit ( ). Alliant has best contract available with (pharmacy company). Also savings available in stop-loss program. Your costs here are very high, that's where your retirees are. About 50 percent of those covered retirees. Super-expensive. Kaiser vs. self-funded. How spread risk ( ).

PHCS for network. That network does not provide as steep a discount as what's available in marketplace. Blue Cross Blue Card.

Consider JPAs. Our job is to take information and help paint a picture with SISC if that's where you want to go; what plan looks like today; what plan would look like in future.

Jennifer: You can shop us around yes, not just tied to SISC.

Christine: Correct, we're independent consultant. We have access to entire marketplace. The biggest challenge is making sure you have viable non-Kaiser plans. The way your contributions are structured, a lot of people want Kaiser, we need self-funded to have healthy population as well. You may want to consider emerging plans offered on group basis, sponsored by AARP and United, through college, available to individuals that are less expensive than what it costs for retirees to stay on your plans. $170 vs. over $300. I don't have silver bullet but we'd love to go through analysis with you.

Dental plans. (Reviews subtle semantics and nomenclature of Delta Dental.)

There's a huge opportunity here. (Further discussion of the dentistry marketplace and how dentists attract patients.) If we were your broker, we could go to Delta Dental on your behalf and say, "We want Peralta to be PPO plus Premiere," etc.

Erin: (More on dental subtleties.)

Christine: Delta has 94 percent of dentists. (Etc.) Fee schedules.

Other pieces. Vision. Currently you have Kaiser and United. Maybe something to explore; easier to use, etc. PSP is super-popular (etc.). (Discussion.)

P. 18. Life and disability. You have ING for employer-paid life. CIGNA for supplemental life. Usually it's one carrier; typically lower costs to be had if working with one. Consolidation. Lower costs. Maybe better contract provisions. There's a JPA that Alliant works with specifically for schools that helps provide discounts for life and disability: National Joint Powers Authority.

Employee Assistance Program. (Discussion.)

Jennifer: Questions?

Christine: Again, we're independent consultant. Anthem plans are self-funded. We would do benefit analysis, network analysis, cost analysis. Benefit analysis – we understand your benefits are bargained. We would say, "We need to keep them the same." SISC – they're all standard plans, about 100 different combinations. We would say, "Here are three plans Peralta offers, here are SISC plans that most closely match." Maybe we'd say we can't exactly match this plan so maybe do a high low – a high low Anthem and a high low Kaiser. (Etc.) SISC is just one option; they're big; financial stability remarkable. Medical is SISC's focus.

Christine: Apples and oranges question. We're consultant; they're JPA. Alliant – we can save you money on component costs. Strategically: look at how you are offering your programs. SISC might be one of options to explore in terms of options to your program. I don't know if SISC is going to save you money.

Connie: I was going to ask, would SISC always save us money?

Christine: I would say nine times out of 10 SISC offerings cost less. But it's all in how you look at it. Monterey Peninsula College example (discussion of). Stability vs. rolling the dice.

Jennifer: Alliant didn't know SISC was here and SISC didn't know Alliant was here. They didn't know; objectivity.

There are other JPAs out there. Worker's comp etc. Lots of them.

Christine: Not a lot of JPAs have successful medical plans. It's very hard to do because of risk pool. It's possible that SISC would say "No thank you" to you because you have a lot of Kaiser and a lot of retirees.

Bruce: Question ( ). Cost to older retirees almost non-existent. Given that situation ( ), older retiree rich benefit plan, how does that play into ( )?

Christine: Fifty percent of my clients have ( ). I understand collective bargaining process and one of most important things to you is exactly what you said, price of the plan, out-of-pocket for retirees, and what the plan covers – I get it. One of the reasons for this committee is to preserve this as much as possible. All I'm saying is ( ) immediate feedback on our ability to outline what the issues are and what costs are and if they are viable options. So maybe there aren't. But have you done due diligence to determine if there are. Especially based on budget information we had today. So yes it's by contract. For those who have it covered it by 100 percent, they don't have any incentive to look at something less expensive. But are there retirees who are paying some who would want to look at something different that would maybe cost them less. That helps you at the same time. Risk pool. Impacting actives. Can you maintain a viable non-Kaiser plan?

Trudy: This was very valuable. This is an on-going dialogue.

Jennifer: End of meeting.

Summary of Action Items from October 2012 to review/discuss/calri in the November 2012 Meeting

Enrollment Demographic Information

Clarification of Medicare D coordination with Kaiser

Flexible Benefit Plan Open Enrollment Clarification

Disclosure of W-2 reporting requirements for health insurance for active and retirees

Non-California claims expenses incurred through PHCS

Continued Exploration of JPA Concept

Self-funded plan development-How do changes occur