

BENEFITS FRINGE MTG.
12.03.2012

ATTENDEE INTRODUCTIONS/THANK YOUS:

Trudy Largent (Vice Chancellor HR/Emp. Relations), Rick Putz (Bus. Rep. Local 39), Bob Frost, HR (Note taker), Jennifer Seibert (Employee and Retiree Benefits Mgr.), Dan Segar, ASCIP (Alliance of Schools for Cooperative Insurance Programs), Rick Putz (Bus.Rep.,Loc. 39), Sara Connors (PFT), Patricia Dudley (PFT), Bruce Jacobs (PRO), Anna Roy (PFT), Laura Leon Maurice, Jerry Herman (PRO), Bruce Jacobs, Abigail Brewer (SEIU).

AGENDA ITEMS:

Jennifer: As you know, since the beginning of this semester we've been exploring JPAs and the thought of joining a JPA as an outgrowth of the spring discussions with the different unions. So after the last meeting in November, several questions came up to me with respect to why we are doing this, so I think this is a nice opportunity to once again remind everyone on:

- (1) Why we are we looking at JPAs
- (2) What is a JPA? We want to understand what a joint powers authority is; what are the different models?

So, I want to take a moment to review the last meeting; please refer to slide #3.

So, why are we considering JPAs? I want to bring this up one more time. We can join a JPA (joint powers of authority) with or without a broker or consultant. We can forego a broker/consultant and join a JPA directly, or we can continue to use a broker/consultant for proper marketing throughout the Peralta population. Currently, the District has independent arrangements with our service providers for medical coverage.

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In the last meeting we discussed the context of the joint powers exploration; let's be sure about the definitions for common understanding. So, this is a review; I don't want to spend too much time on it because we did have the information last time as well. In the scheme of joint powers authority, we may talk about it in one context when the reality is that there is more than one dimension on the concept. For example, when we think of CalPers as a medical provider, that is really not a JPA, that's a joint trust. So, we spent some time last meeting going through some of the features of the different types of joint powers authorities and joint trusts, and we can look at similar features; different relationships. How do you get in? How do you get out? Timing, fiduciary responsibilities, and so forth!

Comment: (Rock Greenspan, PFT) "...So, from my perspective, I think this discussion is unnecessarily complicated, and, from at least the PFT perspective, I think you have to start out with where are we, and one place we are is that we've got a huge number of retirees who are locked into benefit plans with Kaiser and the PPO that cannot be changed. So, that's one thing. The second thing is, as far as the fringe benefits go for current collective bargaining contracts, we have three-year contracts that basically say that the level of benefits is going to stay the same unless the unions agree to change them. And the expectation when we went into it is that we would keep the same level of benefits for three years; and we'd talk how to pay for them.

So, every time this JPA thing comes up, I've yet to hear any discussion that would actually come to a place of how the JPA will save us money if we keep the same benefits and the same level of benefits that we have now. Every time we talk about the JPA it seems like they say, well we have this plan, we have that plan, we have this possibility, that possibility, I don't think we can do this, I don't think we can do that! And so, what I'd like to do is throw it back to the benefits coordinator and your guys and to Trudy, and whatever, and Peter, and just see if there is a way you come back to this committee and say: this will save us money and still allow us to keep the plans we have. Then, I think we would say that

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sounds really great! But if what's going to come back to this committee is only things that say "...the only way to save us money with a JPA is to cut this from the plan and that from the plan, that's not very different then what we went through the last round of negotiations which is how to save Peralta money by cutting this from the plan and cutting that from the plan.

We know how to negotiate that stuff; we've done all that stuff before. So then the JPA could definitely be thrown into that mix. But my understanding is that the reason we were talking about it was to see if we could save money with a JPA and keep the level of benefits the same as they are now.

Trudy: Let's take stroll down memory lane, ok. Last year when we were in negotiations we talked about different ways for the District to save money through the negotiations without changing some of the benefit levels. But during that discussion, and primarily the discussion came up because of the Kaiser unexpected huge increase, where we all, as a group decided: Why don't we look at, explore, the possibility of a JPA? Ok! So that's step one – to explore the possibility of a JPA. And then the next step would then be to see; we have a three-year contract, we're locked into that unless we agree as the District and the union to change any of those terms, and we're locked into that. So then the next step after exploring it, because I heard last year that the subject of a JPA never came before this health benefits committee, and so you wanted to know some more about the JPA. So that's what Jennifer has been doing. She has been bringing vendors in. The next step to that is then, ok now we know what a JPA, generally speaking, can or cannot do. Is there a JPA out there that, who, given our special configuration and our union contracts and all the things we're obligated to do, is there someone out there who can fit, drop us in as we are, into the JPA? So, slow your roll because we'll get there!

Jennifer: Thank you Trudy. The other part to this is that you don't always get the other questions that come to me via email from other committee members that say, again, why are we doing this, which is why I quote, here, from the union agreement "...to conduct a feasibility study." To jump to a conclusion

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isn't a study. Part of the explicit part of the successor agreements is for us to conduct a feasibility study of post 2004 hires buying into Peralta's retiree benefits. At no cost to the District after the District becomes part of the JPA for Kaiser. So to look at the sum total of the charge requires that we go through this exercise. So, it's a two-part issue. That's what the agreement says ..."after District becomes part of the JPA." We've got to explore it. So with that said, and so that we can maximize the understanding of ... Again, we can jump to a conclusion without the exploration, but that's not the diligence that, I think, this committee expects.

So today we have with us Dan Segar from ASCIP (Alliance of Schools for Cooperative Insurance Programs), and again, this is the third installment of our exploration. ASCIP also has an existing relationship with the District. They handle our workers compensation, I believe? So, with that said, I'll turn over the podium to Dan, and we have handouts, so make sure we pass those out, but they are also on the projector. Did you want to function from up here, Dan? Thank you for coming.

Dan: Sure, thank you for having me. I absolutely do understand your concerns.

Jennifer: Can you speak a little louder?

Dan: We offer on the medical side Anthem Blue Shield, UHC, Kaiser. We have HMOs, PPOs; we offer on a self-funded, fully insured basis. Self-funded meaning we pay the claims, we set the premiums. If the premiums are higher than the claims, then the premium calculation is higher than expected. That would create a deficiency in equity in the pool design. If we were conservative, that equity in the pool increases. That equity is used for future programs.

On the dental side we have Delta, we have VSP for vision, and we have ING for life/disability, and MetLife for our Social Security alternative plans.

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On the next slide we are about \$120M in revenue; we have about a 10% equity balance which is very healthy. The JPA fees are about half a percent to a point and half on medical.

We have about 40,000 covered employees; 70 Districts (community college districts) are listed there. We have an October and January enroll dates so our very first consideration would be your July. So we could write an 18-month contract that you would have to renew on your October for January. Or we could write an extended contract the first time. There are no hang ups if you want to get out because you're unhappy or it's not working for you. All we require is a 90-day written verification, 90 days prior to your next regularly scheduled enroll date.

On the HMO side, last year was 4% -9.5%; this year 5% -9,5%, better rate trends. The advantage as was said earlier are based on lower administrative fees; we piggy back on

Bruce: I need for you to go back to the pool trends...

Dan: Sure

Jennifer: Please speak a little louder too ...

Bruce: I'm asking you if you would you go back to the pool trends for just a second. I don't quite understand why the range 4% - 9.5%

Dan: That's a great question. So the way it works, in the second half of the second slide there is a shared risk model. Sometimes there are good years, and sometimes there are bad years, but then we take that range, then we narrow it down, and then we release that range early in all of our districts so that they can budget early. The whole reason is when the district experiences running cold, so that if you're a good risk having a bad year, you're not going to get hammered with your claims. We're going to chalk that up to, ok, this is a bad year.

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So there are advantages to that; it stabilizes your rate. It's a narrow range. We take a longer term view.

The other nice benefit is that we can share claims. Because the rate increases are at least related to type trend over time, we can show you how; we want to show you how you rate; we want you to be comfortable. Without mutual trust, there is no way it's going to work long term.

And the other, of course, is that if there is cost management efforts by the district, if you're managing your eligibility well, or your people are in wellness programs and its reduced your trends, you will enjoy a reduced premium range.....

On the next slide, as I said before, excess premiums are used for rate stabilization and to develop new programs . The decisions around how to spend that equity, and the decisions around the rate change each year are made by a thirteen member executive committee comprised of current district representatives.

So that's all the good news. The considerations, as were voiced in the beginning – and I want to be absolutely up front about these because they're real, they're there – there are limited benefit designs. What drives the carriers crazy is having to make a lot of little adjustments and having to try to manage a thousand and one claims. So, we have a broad, but limited set; the ID cards are out accurately, the claims are paid more accurately – it's much easier to manage, but there is no EPO

Jennifer: What is an EPO, again?

Dan: EPO is a PPO without the out of network; it's an in network only PPO, so it's fee for service. When you go to the doctor that doctor charges the insurance company, you pay your share or your co-insurance, but you have to go within the network. It's a little bit different than an HMO. HMO is co-pay based, you still have to decide who your provider is ahead of time, not like a PPO or PPO Lite where

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you can go anywhere you want at the time that you get sick or you need care, but you have to go within their network.

Trudy: Following up with Rick's inquiry, could you tell us how it can occur that ASCIP can give us the same agreement that we currently have with our unions under your umbrella?

Dan: We might be able to match the Senior Advantage Plan, but we won't be able to match your existing plans on your commercial PPO population. We will not. And I actually put together , as I figured you'd ask, in the packet is an actual side-by-side of our closest comparison.

So that's the bad news. So the deductibles are higher, the out of pocket costs are higher, basically. But, it sounds worse than it is because when deductibles increase, premiums decrease. So if your employees are paying a share of that cost, then instead of paying per paycheck (increased money per paycheck to go to a richer plan) you're paying per paycheck for that benefit. If you increase your deductible your paycheck deduction goes down because the premium went down, but then you pay all over again at the point of service when you actually go to the doctor. So they get their money one way or another. It's really a two-based two model: either pay per paycheck or you pay when you go. You end up paying the same amount; utilization is utilization.

Question: (speaker not identified) Yes, I wondering with retirees these benefits are locked in; can't change. How does that fit into your plan?

Dan: Early retirees would roll to one of these PPOs, Medicare retirees would roll to the Sr. Advantage Plan. If they're not in Kaiser, then they would also roll to this PPO Plan, we also have a Medicare Supplement Plan called Companion Care they could roll to. But right now Medicare retirees are either in a PPO, or EPO, or, a Sr. Advantage Plan. Is that correct?

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Jennifer: We have three levels of retirees. For the benefit of the group: we have those who retired before 2004, those who retired between 2004 and 2012, and then those who will be retiring from July, 2012 forward. So we have these different populations that we are preparing for.

Comment: (Speaker inaudible) ...we have retirees who have no co-pays, no deductibles and very minimal expenses, and that's not changing. I heard you say higher co-pays....

Dan: Yes, the PPO Plan. Our closest matching PPO Plan has a higher out of pocket cost; higher benefits, higher co-pays – things like that. On the Sr. Advantage Plan, we might be able to match that and preserve what you've got, although I'd have to confirm that. But if there are a lot of retirees in the PPO currently, then we wouldn't be able to offer a zero co-pay or deductible plan. Are they paying premium contributions?

Answer: No.

Dan: So, it would not be attractive to the retirees because there's no premium offset in there. We could potentially explore bringing over non-retirees, retirees from Kaiserbut you're right. It's probably not a good fit.

Jennifer: This is part of the exploration. Again, the questions that come after the meeting are "...why are we looking at this, or why aren't we looking at that?" As we are hearing and asking these questions, we define our population; clarify our population. Yes, we have quite a few pre-04, but then we also have these other segments as well. And if the reality is that there is not match, then there is no match, but at least the questions were asked and answered.

Dan: Exactly. The other consideration is that there is a so-called "Blue on Blue Rule." Have you heard of this one before? Anthem won't compete with itself, even if you're self-funded. So if you're going to change Anthem won't quote so you'd have to change to Blue Shield.

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Then on the Kaiser side, there's a Kaiser break in, break out rule. Have you heard of this one?

Jennifer: "...some of these people, this is their first meeting. As you know Dan, although we've had three installments, for some of the audience, this is the first time they would have heard some of these types of things you're elaborating."

Dan: "...Absolutely! So Kaiser has a break in, break out rule. They know that if an employer is staring down a rate increase from Kaiser, then they can't just jump into a pool that's got a low increase; they'll have a premium deficiency for that year. So what they do is say: ok, when you jump into that pool, if you're looking at a 15% rate increase that year, you jump into a pool that's running at a 5% rate increase every year. The first year you're in that pool, you're still going to get your 15%, but you're not going to get out of that. And then in subsequent years, then you would the blended pool increase. That's the Kaiser break in, break out rule.

So it would potentially work long-term because our Kaiser rate (last year our rate increase) was less than 2%. So it's running very well. But, if you're trying to dodge this year's bullet, it'll be next year's bullet that you dodge.

Question: (speaker unidentified) Do any groups ever come in only to the JPA for Kaiser and continue to self-fund?

Dan: Yeah! So you could go only Anthem only, or Blue Shield only, or Kaiser only. And we have lots of products, dental only. Yeah, you can mix and match a lot.

Jennifer: But we would still have partner with whatever plan design....

Dan: Exactly, and that's what you would have to figure out

Question: Is your Kaiser plan here somewhere?

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Dan: It's in the brochures; I only matched the PPO.

Question: The other question was that, the way the retirees work is that say Kaiser says that their minimum amount of drug co-pay allows \$10.00, and we have a retiree that went out with a \$1.00 co-pay and is guaranteed \$1.00 co-pay for life. What happens if that person goes to Kaiser and pays the \$10.00, keeps the receipts, and on a quarterly basis turns them into our office and gets reimbursed the missing \$9.00? So, my question is whether that type of thing would be possible with the Kaiser plans that you have where the District can make up parts of the plan if it turns out that the co-pays or deductibles, or whatever are higher than what they were contractually obligated to?

Dan: Potentially the deals we have with United Healthcare and Kaiser is that we will run this thing with a limited number of plan designs as administratively and consistently as we can in exchange for a lower admin. rate. If we start asking for one opts (?), they're going to say, wait a minute here, you promised us. We gave us this lower admin. rate....it may be feasible, it may be workable, it may not.

Jennifer: Let me get back to the question to that end. Just so we have command of the facts; we're paying annually, not quarterly? So it was my understanding that when we, for lack of a better term, when we – based on a population and so forth-- when we ignore or implement administrative procedures which alter the usage of plans we're offering (you know because we make up the difference) does it affect the District's relationship with you as our partner?

Dan: Yeah, you're doing the administration; you're doing the work on the back end; we would need to alert underwriting, probably because the co-pay is there, also to make sure (with the left over) is utilized. You're paying a dollar. Underwriting may have a concern than they would have paying \$10.00.

Jennifer: Then there's Jerry who had a question.

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Jerry: Yeah, hum...since what we're looking at here is primarily and exclusively about lowering costs to the District, have you models on the various scenarios that show that Peralta can actually save money?

Dan: The admin fees, as I say, are going to be lower than your Anthem, maybe, but it depends upon what you are able to negotiate through your broker. So, best way; the only way to guarantee to save you money is to look at the bid direct from Anthem; look at the bid from ASCIP and Blue Shield. After that, we'll know. We don't have a control group to say what if you were outside ASCIP versus actually going with ASCIP. We can't actually measure that. But what we can do is bid on you and then you can decide whether those premiums are attractive to you. That's how we would save you money.

Question: (speaker not identified) What if the District coverage includes services such acupuncture; a long list which are very rich. If it's not covered in the standard plan, that same solution does not work? Right, because the people who are administering the benefits want to work from a single SPD?

Dan: Yeah, you're right and that's a great point. You're right. There are two things: one is co-pays and coverage levels; it's what's in the bucket of service levels of coverage? So we would do a more careful comparison of the summary plan description to see what's excluded and what's included. If there are certain things that are afforded to the population, acupuncture, things like that, we would refer them to Kaiser.

Jennifer: Well actually they're not with Kaiser but with our self-funded plan.

Dan: So we would do that side by side to make sure there are no surprises. So only by, because of the way the pool is structured, we rely on the longevity of the District to try to earn that longevity. One of the ways is that we don't low-ball that first year rate. The other way is fully exposed claims; we try and educate the buyers as much as we can....

Jennifer: Rick you have a question?

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Question: Yeah, you said there was a list someplace of the school districts and community colleges that you work with. Can you give it to us today?

Dan: ...there's a list on the first or second slide. I just listed the community colleges.

Jennifer: Other questions? Abby?

Question: Do we have a comparison of what plan design we have now compared to what is being offered?

Dan: That's our closest match; that's your PPO, and that's in your handout. So, this has the most commonly used benefits and services, but the list is really long. That's a lot of reasons. We put the highlights here, but if there are other things that you are interested in then absolutely....

Comment (unidentified speaker)...Question. You, you have, off the top of your head, the number of pre-04 retirees, and number of post-04 retirees?

Jennifer: Not off the top of my head...

(Unidentified speaker)...but you have it?

Jennifer: Right, and actually I'll bring it forward on the next meeting. I'll look at my numbers again, and I think this is the last installment of our (guest) exploration, so now we'll move on to the numbers, our populations and census information.

Dan: So you can talk about an object being, of course, lowering costs. Pooling would help your admin which is great, but it's not the big component of the rate. Blending (sp.?) would help your trends because volatility over time would be smoothed out, but it's really not going to affect your trends because the utilization/underutilization would have to do something about it.

The other elephant in the room is the claims. That's where the action is. And so, without a strategy to address the claims, cost of payment strategies aren't going to be that effective. So we have been trying to take our equity and develop programs around containment of claims. So there are two buckets really.

1. There's employee wellness, and,
2. There's care delivery alternatives

So there are two real drivers of healthcare trends. One is individual health status which is getting worse, there are higher rates of inactivity, and we eat delicious, terrible food which creates higher levels of obesity, diabetes, cholesterol, high blood pressure. Studies have shown that 50- 85% of all disease is modifiable. So it's our lifestyle that's doing it, and without addressing that, it's going to be difficult to address claims.

The other part of it is the delivery system (for Kaiser) is fragmented. You go to primary care, they send you to specialists, you get prescriptions, you go to emergency room – they bounce you around the venue; whatever, but they're not talking very much to each other. Incentives are based on volume. Every step of the way you're a customer, and they're going to do stuff to you so they can bill your insurance company.

So the most effective strategy is to address both of those. On the next slide – So there are a couple of buckets:

Employee wellness is something that takes time. Changing habits developed over decades, not years, not months, but decades takes time. And most employers start with a wellness committee to start educating their employees as to what their habits are doing to them. One of the resources that we provide is that we offer wellness committee assessment. Most offices when they get together, they get

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very excited, and then they look at each other when it's time to do the work and say, well who's actually going to write this email, etc.

So we actually can help provide legally, interesting content. We have a consultant who's actually very down to earth (who recommends) what cereal to buy, where can you go and buy fast food – educational content email classes, things like that...

On the next slide we are looking at alternative care delivery to stay away from that fragmentation. We introduced to the district a couple of years ago, bold screen vendors. These are big R-Vs with advanced imaging machines inside. So you go in there and you get risk assessments, blood work, but this particular program also has EKG, echo-cardiogram, artery ultrasound and others; the object of the game being early detection. Most chronic diseases, diabetes, heart disease, blood pressure are a-systematic until you are well into your advanced stages. This mobile vehicle costs about one-tenth of the cost of having these tests done at stand alone facilities. The results that we've gotten are horrific as expected. 30% pre-diabetic out of 700 people who had no idea . The expectation is to have blood work done and your cholesterol is elevated; your blood sugar is elevated. You feel fine. You go home and tell the wife "... I forgot to fast that morning, I had French toast for breakfast." But if you have a prior ultra sound and it's 30% occluded, that might just scare enough to change your habits. So that's another thing that we're doing.

On the next slide, we're also highlighting an onsite primary care model where there's a primary care physician onsite at three different school sites and another offsite. She provides the typical health screening for infections, things like that and she available on-call 24/7 even available for house calls.

The thought is that we bring healthcare closer to the participants. You know, you get home, there's soccer practice, homework – all those things – and then you think about the experience. Our primary

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care experience is terrible. You drive 30 minutes to the doctor's office, you wait 40 minutes in the waiting room, and you wait 20 minutes in the exam room. They see you for 7 minutes in the exam room – no wonder you don't want to go back! It's horrible.

This experience is much different. Right down the hall, five minute wait time; a less hurried office visit and the expectation is that you get to build a relationship and really a plan, right? It's not the prescription or referral; it's not the fraud you get in today's world because they don't have the time to give you. What you get is a prescription or a referral. This is a better way of preventing barriers to care because you can get into a conversation about how I can change my habits so that I don't need this medication in the first place.

This is a better way than putting barriers to care; a better utilization.

These are things that we are doing that are in various stages of development. If you were to come onboard with ASCIP we could have thousands of conversations about piloting something like this at some time in the future. Our expectation is, and what the results show so far (we know we're lucky, we don't sure if we're good yet over time) the enhanced primary care is enough to lower the burden of experience in emergency hospital care. The primary care you get is so much better and the access to the doctor is so much better that you don't need to go to emergency care, you don't need to go the hospital because you're getting better treatment up front. Those tertiary (sp) expenses are so high that it actually pays for the primary care! So that's the business model that will actually not only cost you anything, but save the District money.

Jennifer: Jerry, you had a question?

Jerry: Yes, this all sounds good, but how much of this is in the actual development stage, how much of it has actually been experienced for which you can give us actual numbers?

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Dan: We launched the onsite screens two years ago and it actually resulted in a decline. We launched the onsite care model in 2012, and so far it is paying for itself and has lowered trends, but it's a little early to tell. We hope in 2013 to introduce these two programs to a second, larger District. If that works, then we're off to the races to a product solution.

Jennifer: Rick has a question and then Bruce.

Rick: Does this onsite stuff include Kaiser people as well as the PPO?

Dan: Great question. No. In the Kaiser world they're all salaried; so even if all the utilization is going to the onsite doc. (doctor), Kaiser is still paying that doctor the same salary.... We hope that we could show a decline in PPO claims and say: "...do you want to play or not? Because, we are going to advertise this like crazy and peel you membership away. So unless you give us premium credit for implementing this, then we're actively try and pull people out of Kaiser.

Jennifer: Well, let me say this, Kaiser does have a wellness program and....

Dan: ...willing to do all kinds of stuff and it's very integrated. But, I was a Kaiser member for a while and the experience is the same – take a number. Technically it's very integrated, but you do kind of feel like a piece of hamburger....

Jennifer: Bruce, you have a question:

Bruce: I don't quite understand what onsite primary care means. Does that mean that there would be a facility located on premises at a given community college, at the District Office? Half of our retirees who are older, sicker this would be no more convenient than going to the doctor,

Dan: That's a great question. That's actually one of the concerns in our pilot district for retirees there has been a reluctance to actually give up their primary doctor. But, we figured out that the initial

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experience facilitates future optimization of ongoing experience. That initial appointment may be no more convenient, but beyond that the experience of being able to send an email and get an answer to 5 minutes is wonderful.

Dan: The message I want to leave you with is: you've got to focus on employee wellness and alternatives to care delivery. That's where the action is; that's where the cost savings are. If you're thinking about doing employee wellness there's a lot of literature here. There needs to be a shift in the culture from you pay a fee and get taken care of we have to start taking care of ourselves.

Jennifer: Thank you Dan for coming and I appreciate your time, and we'll see how things go.

I just want to share with you that the minutes from this and past minutes are located at benefits committee meetings from the web.peralta.edu website.

The other thing that we talked about at our last meeting and we want to follow up on is benefits for non-benefit eligible people is the BenElect Plan offered through the American Association of Community Colleges offered to non-faculty? The answer is yes, and we currently have participants in the plan. So the participant customizes his or her own options based upon his or her own medical needs. So I confirmed that with Keenan.

The other question that came up from the last meeting was can the District publish the entire rate matrix for active and retired employees? The answer is yes. Refer to the Peralta website for that. Next follow up action from the last meeting is: does the self-funded plan pay out of network on anesthesia when handling the choice of selection for professional services and where is it cited?

So I included the exert that Rich sent to everyone; basically the language is cited from the summary plan description(refers to summary plan language)

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(Unidentified speaker): ...For the record, the letter says that the anesthesiologist they used for this procedure was non-network, and then the reply from PSW was "...that's fine we're going to cover it."

And that's great, it was covered.

Jennifer: No, it had to be re-submitted...

(Unidentified speaker): The citation is that non-preferred anesthesiologist gets covered at the preferred provider rate may not actually cover the cost of the anesthesiologist

Jennifer: They write it off because it's treated as in network...

Un.Spkr.: So write off means that the patient does not receive a bill for the difference, right?

Jennifer: That's correct

UN.Spkr.: And the anesthesiologist does or doesn't get paid

Jennifer: The customer service team works it through....

Other out of network retiree coverage issues, etc. will be addressed by Peter Wontok (sp.)

Peter W.: I get to relate great news today that everyone will be happy about. Most people are not aware that Blue Cross/Blue Shield is a franchise. It's like MacDonald's; it's 46 separate programs. You go to Arkansas, you go to Florida and they call it the same thing. But what's been happening because of this franchise is Blue Cross of New York really didn't talk much to Blue Cross of Florida, or California or anywhere else. That's changing. It's changing not only throughout the entire United States, but it's changing in California. So, we've been watching this for the last several months, and effective for July 1, 2013, we going to be able to discuss two options. The impetus on this conversation is about the out of California, but the meat and potatoes on this is also within California.

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So Blue Cross Blue Shield got together and said this is ridiculous. We need to get all of our doctors together across the country, California included, doctors and hospitals, and we need to get onboard with a more cost effective system before we are left in the dust, so to speak.

Currently, Anthem Blue Cross uses Blue Cross of California network. And you also have the PHCS for non-California. Anthem Blue Cross in it's national network called JAA, which is called joint administrative agreement, went out and took a look and said hey, this is something we could probably do for this California group but before we take a look at non-California, it has to be improved within California and then go out of California.

BENEFITS FRINGE MTG.
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