SMBSD General Membership Meetings
Summary of Questions and Answers

On May 22 and 23 of 2017 a general membership meeting was scheduled at the request of the Employee Benefits Committee to provide all participants in the Santa Maria-Bonita School District Employee Benefits Plan the opportunity to hear directly from our Broker/Advisor from Beneflex, Lesa Caputo. During that meeting, many questions were asked. This document summarizes the answers to the questions that were written on index cards and passed along to Lesa. Also, a short glossary of terms in included at the end for reference.

PLAN DESIGN

1. If everything is doubled (e.g. co-pay) what are the expenses?

As illustrated for the Employee Benefits Committee, one of the plan design changes that was priced out for us by Self Insured Schools of California (SISC), the Joint Powers Authority that manages insurance programs for many schools in California, would have the have the following impacts to benefits and funding.

Santa Maria Bonita School District

SISC Medical Plan Options

	Active & Early Retiree Employee Enrollment	Current Funding 2016-2017	Projected Funding 2017-2018	2017-2018 Downgrade Options 2-6
Composite Rates PEPM 12thly	1383	$1,194.00	$1,338.00	$1,212.00
Required 10thly EE Contribution		$220.00	$391.92	$240.72
10thly EE $ Increase		$0.00	$171.92	$20.72
Total Annual Cost		$19,815,624.00	$22,205,448.00	$20,114,352.00
$ Difference v. Current		n/a	$2,389,824.00	$298,728.00
% Difference v. Current		n/a	12.1%	1.5%
$ Difference v. Renewal		N/A	N/A	-$2,091,096.00
% Difference v. Renewal				-9.4%
Plan Design				
Deductible		$250	$250	$1,000
OOP Max In/Out		$1250/$3000	$1250/$3000	$2000/$6000
Coinsurance		90/70	90/70	80/60
Office Visit PCP/Specialist		$20/$20	$20/$20	$20/$40
Rx		$7/$25	$7/$25	$9/$35

2. If there are 7 options being presented by Lesa to the Benefits Committee, will there be additional meetings to include union members with votes to the options? Options are presented, discussed and evaluated by the Employee Benefits Committee (EBC). The EBC is comprised of members of CSEA, SMEEA and AIMS with Beneflex serving as Broker/advisor. After reviewing the options the members of the committee form a recommendation for any plan design changes. The recommended plan design then goes to the negotiating table for approval. Once approved at the negotiating table, it goes to the bargaining unit for ratification.

3. Can we see the different options and how much it brings down the premiums?

Santa Maria Bonita School District

SISC Medical Plan Options

	Projected Funding 2017-2018	2017-2018 Downgrade Option 1	2017-2018 Downgrade Option 2	2017-2018 Downgrade Option 3
Composite Rates PEPM 12thly	$1,338.00	$1,320.00	$1,289.00	$1,308.00
Required 10thly EE Contribution	$391.92	$370.32	$333.12	$355.92
10thly EE $ Increase	$171.92	$150.32	$113.12	$135.92
Total Annual Cost	$22,205,448.00	$21,906,720.00	$21,392,244.00	$21,707,568.00
$ Difference v. Current	$2,389,824.00	$2,091,096.00	$1,576,620.00	$1,891,944.00
% Difference v. Current	12.1%	10.6%	8.0%	9.5%
$ Difference v. Renewal	N/A	-$298,728.00	-$813,204.00	-$497,880.00
% Difference v. Renewal		-1.3%	-3.7%	-2.2%
Plan Design				
Deductible	$250	$500	$1,000	$250
OOP Max In/Out	$1250/$3000	$1250/$3000	$1250/$3000	$2000/$6000
Coinsurance	90/70	90/70	90/70	90/70
Office Visit PCP/Specialist	$20/$20	$20/$20	$20/$20	$20/$20
Rx	$7/$25	$7/$25	$7/$25	$7/$25

Santa Maria Bonita School District

SISC Medical Plan Options

	2017-2018 Downgrade Option 4	2017-2018 Downgrade Option 5	2017-2018 Downgrade Option 6	2017-2018 Downgrade Options 2-6
Composite Rates PEPM 12thly	$1,321.00	$1,334.00	$1,312.00	$1,212.00
Required 10thly EE Contribution	$371.52	$387.12	$360.72	$240.72
10thly EE $ Increase	$151.52	$167.12	$140.72	$20.72
Total Annual Cost	$21,923,316.00	$22,139,064.00	$21,773,952.00	$20,114,352.00
$ Difference v. Current	$2,107,692.00	$2,323,440.00	$1,958,328.00	$298,728.00
% Difference v. Current	10.6%	11.7%	9.9%	1.5%
$ Difference v. Renewal	-$282,132.00	-$66,384.00	-$431,496.00	-$2,091,096.00
% Difference v. Renewal	-1.3%	-0.3%	-1.9%	-9.4%
Plan Design				
Deductible	$250	$250	$250	$1,000
OOP Max In/Out	$1250/$3000	$1250/$3000	$1250/$3000	$2000/$6000
Coinsurance	80/60	90/70	90/70	80/60
Office Visit PCP/Specialist	$20/$20	$20/$40	$20/$20	$20/$40
Rx	$7/$25	$7/$25	$9/$35	$9/$35

4. What happens next? Who decides and how does that decision get made as far as downgrades to the plan that can reduce the cost of the premiums? Similar to question 2 above the process goes through the EBC. Options are presented, discussed and evaluated by the EBC. The EBC is comprised of members of CSEA, SMEEA and AIMS with Beneflex serving as Broker/advisor. After reviewing the options the members of the committee form a recommendation for any plan design changes. The recommended plan design then goes to the negotiating table for approval. Once approved at the negotiating table, it goes to the bargaining unit for ratification.

5. Is there a deadline for making the decision on downgrades to the plan to reduce the cost of the premiums? Contract language with both bargaining units requires that unions notify the District of any plan design changes that they wish to make in order to reduce the amount of the premium increase and corresponding increase in the employee payroll deduction by June 1. This provides a window for notice prior to the end of school. There

is a secondary deadline where the District has to notify the Self Insured Schools of California (SISC) of any plan design changes prior to August 1.

6. What are the ACA requirements that have been added into our plan?

Santa Maria Bonita School District
SISC Medical Renewal History

Year	Benefit Plan Changes Made
2010-2011	• applied required enhancements to benefits per ACA/ adopted requirement to use COE's for bariatric/transplant procedures
2014-2015	• per ACA requirement, increased out of pocket maximum (from $1,000) to include annual deductible of $250 (new max OOP $1250/member, three member max per family)
2015-2016	•OOP max added to Rx plan (per ACA req.): $5,350/single and $9,450/family
2017-2018	• adding ACA requirement for transgender surgery to be a covered benefit

7. What are some of our current plan designs (e.g. Maximum Out of Pocket)?

Plan Design	
Deductible	$250
OOP Max In/Out	$1250/$3000
Coinsurance	90/70
Office Visit PCP/Specialist	$20/$20
Rx	$7/$25

8. The ACA requires coverage of Transgender surgery. Who says this surgery is medically necessary? Isn't it an elective surgery? ACA law requires that transgender surgery be covered under all medical plans beginning in 2017. It does not differentiate whether it is an elective or medically necessary surgery.

SMBSD General Membership Meetings
Summary of Questions and Answers

NEGOTIATIONS

9. With current increase is it possible to change the policy of opt out to offset increase? Currently the contracts with both bargaining units do not provide for members to opt out of health coverage and call for all eligible members to be provided with health insurance.

10. Can different options of health plans (more expensive v. less expensive) be offered? It is possible within SISC to have more than one plan. The EBC has historically recommended a single plan design for the members. For a short time SMEEA and CSEA each had their own plan design for their bargaining unit members.

11. How does this 12% increase affect employees that are not full time? I do not know what the charge is for “non-full time” employees on the plan? The contract between the District and both units is similar in that it calls for health coverage for all eligible employees. An eligible employee is on that is a .5 fte position or more. The agreements do not provide for prorating the cost nor the benefits provided based on the fte or hours worked in the eligible position. The potential healthcare cost a member will require is the same regardless of the hours worked. With that in mind, the premium required to fund these benefits is the same regardless of whether a person is a 6.5 hour employee or an 8 hour employee.

12. Why is a 6.5 hour person paying the same as an 8 hour person? Can it change because the net pay is affected? The contract between the District and both units is similar in that it calls for health coverage for all eligible employees. An eligible employee is on that is a .5 fte position or more. The agreements do not provide for prorating the cost nor the benefits provided based on the fte or hours worked in the eligible position. The potential healthcare cost a member will require is the same regardless of the hours worked. With that in mind, the premium required to fund these benefits is the same regardless of whether a person is a 6.5 hour employee or an 8 hour employee.

13. Can the percentage rate be adjusted for 6.5 hour employees vs. 8 hour employees? Any change like this would need to be negotiated.

14. Can part time employees (6.5 hours or less) pay less premium than an 8 hour (full time) employee? Any change like this would need to be negotiated.

15. Why no increase in funding coming from the District? Any change to the District contribution for Health Benefits (Cap) would need to be negotiated.

16. If the deadline (to notify the District of plan design changes to mitigate the cost of the increase) is June 1. Do SMEEA and CSEA need to immediately determine from its members what cost shifting options best meet their needs? And will these options be in place by October 2017? SMEEA and CSEA will need to determine the timeline for their communications with their members. Any approved plan design changes, communicated

to the District from the bargaining units within the deadline will be in place prior to October 1.

17. Can we choose not to have insurance? Currently the contracts with both bargaining units do not provide for members to opt out of health coverage and call for all eligible members to be provided with health insurance.

18. How do we choose our options? Options are presented, discussed and evaluated by the Employee Benefits Committee (EBC). The EBC is comprised of members of CSEA, SMEEA and AIMS with Beneflex serving as Broker/advisor. After reviewing the options the members of the committee form a recommendation for any plan design changes. The recommended plan design then goes to the negotiating table for approval. Once approved at the negotiating table, it goes to the bargaining unit for ratification.

19. Classified make less than Certificated. How is it fair to raise the classified the same? The amount of the premiums being charged for employee health benefits is based on the projected costs for the next plan year. Because the medical cost a person may incur in the coming year is not connected to their earnings, the premium cost per eligible member is not different for an eligible member who makes more vs an eligible member who makes less. So the total potential plan costs for the year are then divided evenly across all eligible members when calculating the premiums.

20. Will the 12% increase only affect teachers or will the District absorb some of the increase? The 12.1% increase will affect not only teachers but classified and administrators as well. Under the terms of the contract the increase can be mitigated by plan design changes to reduce the employee contribution. The District contribution to the employee benefits plan is limited to $13,060 based on the negotiated cap.

21. Why isn't there an option to cover just the employee, the employee plus one dependent or the employee plus two dependents, like there is for the dental and vision plans? There have been discussions between the District and the bargaining units during the Employee Benefits Committee meetings about options involving tiered rates as a way to provide single members more affordable health benefits. This conversation has been a part of the renewal process for each of the last three renewal cycles, including this one for 2017-18. The committee has not recommended offering a tiered rate option to this point. MB

22. Why does a single individual pay the same as someone with many children? There have been discussions between the District and the bargaining units during the Employee Benefits Committee meetings about options involving tiered rates as a way to provide single members more affordable health benefits and shifting more of the premium costs to members who also cover other dependents. This conversation has been a part of the

renewal process for each of the last three renewal cycles, including this one for 2017-18. The committee has not recommended offering a tiered rate option to this point. MB

23. Why doesn't Beneflex offer several plans with differing benefits allowing individuals to make an informed decision based on their individual needs? Beneflex is an advisor and broker for SMBSD. SMBSD through the EBC makes the decisions related to the plan design to be provided to eligible members and not Beneflex.

PLAN ADMINISTRATION

24. Why do we pay Beneflex at all? Why can't we work directly with SISC? Beneflex providers broker advisory services to SMBSD to identify the best cost options in the marketplace, facilitate employee benefits committee meetings throughout the year, provide reporting on plan performance and employee advocacy services to members. There is the option to work with SISC directly without a broker. However, SISC does not provide advisory services that are targeted to the needs of SMBSD. SISC represents hundreds of Districts and has loyalty only to the pool. They do not provide services across multiple lines of the District's benefits package like Dental, Vision and Long Term Disability as Beneflex does. They would not market our plan to other providers to determine if better rates were available on the open market because it might cost them a customer. We pay Beneflex because they provide an independent, well informed and experienced review and analysis of our plan activity and help to inform the actions and activities of the EBC in ways that SISC would be unable or unwilling to do.

25. Who covers CalTrans? The Prison Systems? LAUSD? And who is their broker? Are they using SISC as a JPA? JPA's are usually specific to a particular industry. SISC works exclusively with school districts. It appears that both the California Department of Corrections and Rehabilitation both use CalPERS for health benefits. The leaders of both bargaining units met with representatives from CalPERS last year during the renewal cycle. No change to CalPers was made or requested last year after this investigation. It is unclear where LAUSD gets it coverage. They offer HealthNet HMO, Kaiser HMO, Anthem Blue Cross Select HMO and Anthem Blue Cross EPO.

26. My spouse is a teacher in the Santa Maria High School District and having us each pay for insurance is very costly! Why can't both Districts merge? The districts in Santa Maria have explored sharing a pooled plan in the past but it has never been beneficial to both parties to combine our health benefits plans.

27. How much of the increase is because SISC raised its rates? SISC's Administrative fee has not changed since 2002.

28. How much of this increase is because Anthem raised its rates? $2.00 per employee per month

29. How much of this increase is because Beneflex raised its rates? Beneflex has not increased their rates since becoming the broker for SMBSD in 2003.

30. How much of our premium goes to actual medical benefits and how much goes to plan administration and other fixed costs? What is the breakdown? Of the $1,600 premium $$$ goes to? Of the 2017/18 required funding rate per employee per month of $1,605.73, only $64 will go to fixed costs (including plan administration) and the rest will be reserved for actual costs for medical medical services to be paid under the plan.

31. Are any of the fixed costs negotiable? Beneflex fees are negotiated and all others are fixed by the providers.

32. How does Beneflex make money and how much is earned annually from their association with SMBSD? Beneflex is an employee benefits advisor to its clients. It charges a fixed rate per member, per month for the SMBSD plan. They earn their money by providing their experience and expertise to the EBC as it relates to monthly activity analysis, implications of large claims on the plan and our reinsurance, remarketing our plan each year to make sure our rates are the lowest available for our plan design.

33. Has Beneflex shopped the plans with CalPERS? CalPERS does not work with Brokers so Beneflex has not been able to shop the District plan with CalPERS. CalPERS has a standard slate of plan designs that can be selected. The leaders of both bargaining units met with representatives from CalPERS last year during the renewal cycle. No change to CalPers was made or requested last year after this investigation.

34. What standard does Beneflex use when determining which plan is the best? To determine the best provider, Beneflex takes our current plan designs out to test what the premiums would be on the open market using other JPA's like SISC and fully insured providers. The standard as part of this test is simply the cost of the quoted premium. If a competitor's rates are lower than SISC's we would consider them a viable replacement. Generally our experience is that SISC's option is always the least expensive so we have remained at SISC. Related to plan designs, Beneflex takes a set of plan design parameters and requests quote from SISC. These quotes are then shared with the EBC. The EBC then decides if the savings on the premium from the plan design are sufficient to justify a change in the plan design. If so, the EBC would then recommend the plan design changes to the negotiations table. Whether it is the provider or the plan design, it is the resulting savings that is the "standard" that is analyzed by the EBC in determining any changes.

GENERAL

35. What is the amount that will be paid for the increase and/or how is that calculated? SISC does a renewal calculation for all of its districts that includes an analysis of medical trend, pharmacy trend, large claims activity and administrative charges. For SMBSD, this year's increase approximates $173 per employee, tenthly and is comprised of $29.40 per employee, tenthly for pharmacy trend, a reduction of $36.93 per employee, tenthly for the change in large claims activity, $5.12 per employee, tenthly for administrative activities and $175.21 per employee, tenthly for increasing costs of medical services. (Note that large claims are rated separately from the overall medical trend. The decrease of $36.93 reflects a reduction in the overall impact of large claims projected for next year compared to this same projection in 2016-17.)

36. What specifically has led to the increase in the cost? How much can be attributed to the Affordable Care Act (ACA)? For the 2017/18 plan year, only $.54 PEPM is required to pay ACA fees. Anthem has increased their fees $2 PEPM. The remainder of the increase required is for the increased cost of claims estimated to be incurred under the plan (including ACA required benefits).

37. Have we looked into the SBCEO again? In talking with those who work there, it appears their fees and package are more attractive on a monthly basis, with options for opting out, etc. Has this been ruled out? SBCEO employees are covered under their own collective bargaining agreement between the bargaining units and the SBCEO board.

Glossary of Insurance Terms

ACA – Affordable Care Act (aka, Obamacare)

AHCA – American Health Care Act (aka, Trumpcare)

Annual Out-of-Pocket Maximum – The most you have to pay out-of-pocket each calendar year for covered health care services. Your deductible is part of your out-of-pocket maximum.

Coinsurance – Your share of health plan costs (a % of total cost) after meeting your PPO deductible

Copay – A flat fee that you pay for covered services like physician office visits and prescription drugs

Deductible – The amount you pay each calendar year before your PPO plan starts to pay its share of coinsurance

PEPM – Per employee per month

PPO Provider/Facility – A doctor or facility who is in the network; also known as a contracted provider.

Non-PPO Providers – A doctor or facility who is NOT in the network and is NOT contracted