BENEFIT FRINGE MTG.
01/10/2013

WELCOME ATTENDEES/and INTRODUCTION OF NEWCOMERS:

Jennifer Seibert (Benefits/Admin.)

David Betts (HR/ Admin.)

Brenda Johnson (Admin.)

Roxanne Epstein (Administrator)

Rick Greenspan (PFT)

Ava Lee-Pang (SEIU 1021)

Debra Weintraub (PRO)

Matthew Goldstein (Pres., PFT)

Jerry Herman (PRO)

Marybeth Benvenutti (Admin.)

Anna Roy (PFT)

Connie Willis (Admin.)

Peter Wantuch (PSW), Rick Putz (Local 39)

Romeo Garcia (Peralta College Fund)

Helane Carpenter (Admin./Note taker)

AGENDA:

Jennifer: The purpose of this committee is to make recommendations to the District Benefits Office on behalf of a cross-section of constituents regarding the efficient delivery of services to Peralta active and retired employees as well as their dependents. Collective bargaining agreements state that we have a cross-section of representation (classified, admin., faculty) as committee members. The reason we introduce new faces into membership is because we want to fully represent our client base and more fully understand the needs of our audiences.

Recap of "Peralta Benefits – Everyone, January, 2013" Newsletter topics. Note: prior Benefit Fringe Meeting Notes, as well as today's notes, can be found at the web.peralta.edu website home page. The January, 2013 newsletter captures snapshot issues:

(1) Tax Deferred 403(b) Plan update – new limits for 2013 to $17,500. Re-emphasis that MidAmerica is the third-party vendor for voluntary contributions to 403(b) and APPLE Program for part time, limited service employees, and retirees. We are required to announce plan increase changes annually or as frequently as they occur. The District sponsors the Plan; MidAmerica is the third-party administrator.

(2) Compliance Corner announcing Health Care Reform 2013 update that medical premium costs will be reflected on W-2's issued by Peralta in 2013 for 2012 earnings.

(3) Fiscal Cliff update and the direct impact to Peralta employees. New regulations increase employee monthly contribution to the pre-tax commuting plan under IRS Code 132 to $240 on a pre-tax basis. The limit was $125 in 2012. The enrollment form can be downloaded from the website and submitted to Benefits by January 15, 2013. There are currently about 100 participants. Late breaking developments allow some flexibility for late enrollment beyond January 15, 2013 deadline; effective February payroll.

From 1964 until 2012, the District only offered two plans: self-funded and HMO. The District introduced a third plan in July, 2012. The purpose of **Table I** is to identify how people opted for the third plan. **Table II** identifies retiree distribution by retirement date and average age. **Table III** discusses how participation in the Medicare Drug Subsidy Program has yielded approximately $1.5 million in subsidies over the past six years of participation.

Website: PSW tracts Benefits Information Center hits on a monthly basis. Cycles tend to be higher during enrollment periods. BIC hits have gone up approximately 20% over the past year (2012); information is available 24/7.

Marybeth Comment/Question: What is the efficiency of the outside mailing of "Peralta Benefits – Everyone" newsletter in addition to campus mailing and email distribution to active and retiree populations? Is this a possible "overkill of effort," and could possible cost savings be realized by discontinuing outside mailings? Suggestion that only newsletter be mailed to retirees to save the District money.

Jennifer: Transition to electronic communication infrastructure will occur gradually over time based on established infrastructure, policy, compliance, and what provides comprehensive access to employees. Note: Cost savings are actually achieved through mailings when mail is returned from the U.S> Postal service indicating that the recipient is deceased resulting in an unintended, yet cost effective, consequence.

David Betts: The majority of Local 39 comprised of custodians, grounds engineers, etc. who typically don't use email communication within the scope of daily work.

Medicare Enrollment Drive 2013

Over the past five years, we have been stepping up our outreach efforts to increase Medicare enrollments for eligible members. The District saves money when members coordinate coverage with Medicare. As the primary carrier, Medicare pays the larger portion of the monthly premium thus reducing PCCD costs. The District saves money when an eligible member coordinates with Medicare. When eligible members and dependents turn 65, Medicare then becomes the primary carrier and pays

the larger percentage of the monthly premium and claims. Example: if an eligible member over sixty five experiences a broken arm and the cost is, say, $1,000, Medicare will pay $800 of the expense leaving only$200 of the expense to be paid by the District. However, if you are age 64 and not coordinated with Medicare, the District would pay the entire $1,000 claim. That's the underlying operational concept with Medicare.

In 2011 we decreased the non-coordinated population of retirees and dependents by half with Kaiser.

Peter: We've gone from 85 to 34. There were claims of excess of $2M dollars above, the stop loss of Kaiser, for large claims of retirees over sixty-five, who did not have Medicare as primary. That number will impact the renewal in some way, and that experience does continue to be a drag on the rates of Kaiser and CoreSource.

Jennifer: We have about a 90-day window in which to do our outreach and the current window starts in January. In past drives we have identified some of the reasons why eligible members and their dependents do not enroll in Medicare:

1. Because the District allows employees and retirees to cover eligible dependents, the eligible dependent doesn't necessarily have to be a retiree and may still be working. So we have two conditions where we have a PCCD retiree who is over 65 and eligible for Medicare, but has a dependent that may not be 65, is still working and may have coverage under another plan. So, while the retiree is eligible for Medicare, the dependent is not, and because we are still paying for the dependent, the District incurs the higher premium cost.
2. The requirement for Medicare coordination does not exist.
3. If someone is a Kaiser subscriber, Medicare may not offer out of service area providers/facilities that are in the Kaiser network.
4. Collective Bargaining Agreements are silent on the issue and./or do not outline consequence of non-conformance

Peter: There are about 34 subscribers with "special circumstances" who have not switched to Medicare. People go in and out of Medicare; the numbers fluctuate.

Announcement (Medicare Enrollment Drive) sent to retirees in the January, 2013 Peralta Benefits Everyone Newsletter. Information is provided on when to enroll, criterion for enrolling, etc. This information is provided annually to active employees and the guidance is provided upon retirement as well. It's on the website as well as mailed. Specific guidance is provided on the entire Medicare enrollment process.

FAQ's and answers:

(1) When does an eligible retiree enroll?

(2) When do dependents enroll?

(3) Who do I contact to enroll?

(4) Does Kaiser assess a penalty?

(5) What are the benefits of enrolling in Kaiser Sr. Advantage?

(6) To whom are Medicare premiums paid?

(7) Who is eligible for reimbursement? (District reimburses the premium for retirees only)

(8) What if I'm on the self-funded plan?

Jennifer: Scenarios vary. At some point it was decided that Medicare, Social Security, Kaiser, etc. all come and participate in the Medicare Workshop and answer questions across the board.

Debra: PRO will conduct telephone outreach to facilitate increased Medicare coordination with retirees who are eligible but have not yet switched over to Medicare. There are no legal mandates that force retirees to switch. We'll just keep trying to get another ten or twelve to go along with the program and save money for the District.

Jennifer: Quarterly purge of records helps identify who is or isn't eligible; we go through mailings and use an interactive database of Social Security records to identify if an individual is still living.

Jerry: First of all, we're only dealing with pre-2004 retirees, right? After 2004, eligible retirees having reached age 65 are mandated to enroll in Medicare. The good news is that we're dealing with a number that will continuously go down over time.

Jennifer: Keep in mind that even in the 2004 group, we have members with spouses who may not be eligible. In any event, the District/Benefits will continue its outreach to bring those numbers down.

Brenda: Something could be developed to give clear guidance on Medicare enrollment scenarios, to demystify the process, point out cost saving benefits to the District, and make clear the benefits to subscribers.

Jennifer: Medicare coordination primarily applies to retirees. Once a year, Medicare comes here to the District to answer questions which will be part of the Medicare Enrollment Drive in February. Medicare, Social Security, as well as our other vendors will be present to answer questions.

Medicare 5th Annual Drive: Announcement has been sent, scheduled for February 5th, 2013. The workshop will focus on Medicare coordination, emphasize what every surviving spouse should know; Medicare and Social Security representatives will be present as well as other vendors.

Preliminary telephone outreach will be conducted to facilitate participation by Jay Quesada and Linda Japson; enrollments will be effective July 1, 2013. Over the past two years I have observed that people

do come on and off Medicare. This is an annual effort that allows us (the District) to clean up our records and control enrollments.

JOINT POWERS AUTHORITY

Jennifer: Re-visitation of JPA rationale – Why are we doing this? Consideration of the JPA resulted from an outgrowth the collective bargaining and the double-digit increase in Kaiser rates. Successor Agreements from the Spring/PFT Contract language says we are to do a feasibility study. Let's review what have we found during the exploration and what are the considerations involved in a transition to a JPA.

Who can mirror the plan design we currently offer our employees?

Which partnership would mirror the plan design that we currently offer both active employees and retirees?

Is there a designated time (calendar year or fiscal year timeline) in which we are mandated to enter or exit the partnership?

Is there a minimum commitment time given our current three-year commitment?

Which JPA partnership would best serve considering all variables?

What time should PCCD enter into agreement?

What about time commitment?

Who did we look at: Alliant, ASCIP, SISC, Recovery Team (all shared risk pools).

These are the common questions and considerations which have come out of our discussions thus far.

NEGATIVE CONSIDERATIONS:

JPA's can become insolvent; they can become bankrupt.

Will District loose flexibility and control?

Connie: My main concern is that the JPA choice restricts PCCD control and flexibility especially concerning contracts. That's a big concern. Granted there may be cost savings, but would trade off flexibility and control.

Rick: Sounds like the existing PPO system would not fit into the JPA model. Also, retirees would be too expensive. Is it possible to just move active employees into a JPA? Suggestion that a spreadsheet be prepared reflecting cost savings or losses over a five year projection before a decision for JPA model is recommended. Underlying concern is whether retirees can be moved into a JPA without incurring

considerably more cost to the District. Cost of active employee pool would be less costly due to age factor.

Recommend a three-year projection, retaining the same level of benefits where the active and retiree Kaiser group enters a JPA, and given all of the extenuating variables, determine numeric values on whether it will be (hypothetically) cost effective or not cost effective to the District to enter into the JPA model.

Jerry: First of all we have four segments of benefit recipients: active, retirees, PPO, and Kaiser. First we eliminate the PPOs, retirees they're not going to take. So, what we're left with are active employees in Kaiser which are about a quarter of the benefit recipients we're talking about. There seem to be enough problems here; I'd like to see some real, hard, cost savings numbers –is it going to save us (PCCD) money and give us the same benefits?

Peter: Everybody is ignoring the elephant in the china closet – the Affordable Care Act may transform how benefits are done in the United States. It is unfolding in its development throughout 2013 for an effective date of January 1, 2014. Kaiser has announced that , through the Affordable Care Act, an individual can go through his/her employer to purchase benefits. The ACA will allow purchase through their exchanges. Jennifer and I both have documentation that emphatically states that once you enter into a new program, you are locked into that contract for a minimum of 24 months. The escape clause is that you cannot re-enroll or come back into Kaiser in any other form.

My best recommendation is to not lock into anything until after January, 2014 to see what options would be available at that time. So, why lock yourselves into something for 24-months (which Kaiser will hold you to), when everyone in this room, including myself, may be going to an exchange? There will be gold, platinum, bronze exchange plans in California (State run).

As your consultant, I would be charged then (in January, 2014) with an analysis.

Eva: (inaudible) …I would not recommend JPA.

Connie: I heard the JPA presentations; I really didn't like them. It has been a pleasure and learning opportunity and I'm pleased to have served on this committee. Passing off Administrator representation to Brenda Johnson and Marybeth Benvenutti; this will be my last meeting. However, I want to go on record that I do not like the JPAs nor would I vote in favor of them.

Jerry: I motion that JPA consideration be tabled until the first meeting of this committee in Jan., 2014 with an understanding that our consultant will have an analysis and perhaps a recommendation for us at that time.

Motion is seconded.

Vote: all in favor; no nays.

Out of California Claims:

Peter Wantuch (PSW Benefit Resources)

Question: Had there been a national Blue Cross Network in existence, how much money would have been saved? About 1.2M could have been saved. It will have one in the next few months, but the question is how was the $1.2M determined? What services were re-priced at a national level, and for what types of claims? (We're) re-visiting the "senior management conversation" on this. This issue would also have a large impact on re-insurance contracts.

Consultant cost analysis (see agenda), inpatient charges of about $300,000, other hospital was another $217,000-$218,000. The professional non-facility was another $500,000 - $900,000 for out of hospital facilities, non-prescription drug claims. So I think that answered the question (Sarah) asked at last month's meeting.

For those people who wanted to know what we have on health care reform, we have very detailed information that everybody should look at. In 2012, a lot had to do with Summary Plan Descriptions and summary plan coverage which had to be provided in succinct, understandable language of only a few pages in length. Also, Peralta had to disclose what the value of the medical and EAP coverage were on 2012 W2s.

Going into 2013, the issue is the Flexible Spending Account which has a maximum calendar limit of $2,500.

Employee Notices of Exchanges: The government in California will start issuing notices. Due to the Affordable Care Act, every state in the Nation will be required and funded to create a State Exchange. Each exchange will be an opportunity for an individual to purchase medical coverage in this platinum, gold, silver, or bronze configuration, and if the employer does not have some sort of plan, they will pay a penalty whereby the employee will be able to go through an exchange. It's rumored that exchange rates will be, on average, lower than employer rates. Rates will be indexed to salary so that it's possible that costs could be as low as 50% of current costs. Employers could then disband group coverage, pay employee the cost of coverage, and allow employees to purchase coverage through the exchange without exclusions of pre-existing conditions, limitations, and all the insurance companies are submitting proposals on what benefits they will offer through these exchanges.

This is the main reason for deferring consideration of the JPA. This is huge and will change the landscape on how medical benefits are purchased.

In 2014: We've talked about mandates, health insurance reform, premium restrictions against subsidies, non-discrimination based on health status, no annual limits, waiting periods will be limited, etc.

Employer Wellness Programs: Credit incentives indexed against salary; while not currently applicable to PCCD, in some cases employers can give up 20% bonuses for employee participation in bone-fide

employer-sponsored wellness programs. Not defined yet, but for example health screenings, smoking cessation programs…..

Jennifer: We will spend some of the remaining time on wellness…

Peter: The controversial one, which is 2018, that if your plan is a "Cadillac Plan, i.e., spending over $10K on an individual per calendar year," those premiums in excess could be taxable. Those premiums could be taxable to the employer for amounts exceeding $10k or $27,500k in 2018. There will be exceptions and relevant to costs in 2018; for the time being nothing to worry about.

Jennifer: One thing I've noticed that in implementing regulations such as this, implementation is graduated and the larger the employer group, the longer the graduation window is for employer compliance.

Peter: Development is still unfolding over 2013; we'll keep you informed as to where things are heading.

What we're going to start doing is tracking the data provided by CoreSource and Kaiser. For example all individuals over the age of 50 (active or retired) need to have a colorectal examine. Our data identifies 74% non-participation results colorectal examination for members over age 50. The norm is 75% participation. This is CoreSource data, we haven't seen Kaiser data yet.

We will continue discussions on health and wellness outreach in our next meeting, Thursday, February 7, 2013.