

Benefits Fringe Meeting  
Thursday, November 08, 2012

Present:

Helane Carpenter (Benefits Offc.)  
Lee-Pang, Eva (Loc. 1021)  
Connie Wills (Bus. Mgr.), Laney College  
David Betts (HR)  
Jennifer Seibert (Benefits)  
Rick Greenspan (PFT)  
Ruby Andrews (Confidential)  
Ron Gerhard (Vice Chancellor – Finance)  
Trudy Largent (Vice Chancellor-Human Resources & Employee Relations)  
Bob Schoenherr (Keenan)  
Jerry Herman (PRO, Laura Leon Maurice (Confidential))  
Bruce Jacobs (VP of the Peralta Retirees Org.)  
Sara Connor (PFT)

Jennifer: Introduction: JPA discussion continued; recap of meeting Agenda items (See Agenda).  
Question posed: "How do you communicate with your constituents", will add self-funding/in and out of network, briefing on passage of Prop. 30 and impacts to Peralta. We will also spend some time talking about the issues of self-funding, the enrollment census, process for changes, out of network claims experience, update on use of non-California network options, review of post-election healthcare reform considerations, and other thing to be considered is the joint powers of authority exploration as an outgrowth of our negotiations in the spring. There other things that need to be added to the agenda for our upcoming meeting on December 3<sup>rd</sup>, but there is the laundry list of things we don't want to lose sight of.

Just a recap, last meeting, in October, we spoke about a JPA, or started to collectively educate ourselves on the notion of joint powers of authority, JPA. Just so that we're clear, the District can join a JPA with or without a broker or consultant's representation. We were speaking about how we would become engaged in a JPA . Basically, it's where we pool our enrollment with another group for the benefit of more stable rates and predictability. We can use a broker to shop our employee rates for the right JPA, or we can continue as we are, and just to operate without joining a joint powers of authority; it may be more cost efficient, but these are all options.

The reason why we have Keenan here today is to help us determine or identify or explain different terms that are used when we think of JPAs. As a group, I think we tend to think of JPA as a generic term; there are different types of joint powers of authority. For example, Calipers is not JPA, Calipers is a joint trust. I will turn it over to our long time business partner who helps us with other programs here in the District, Bob Schoenherr.

Bob Schoenherr (Keenan): Thanks Jennifer. I've got a packet of information on some other things that we do for the District. What I'd like to do is take a few minutes, stick within my half-hour timeframe, and talk about some things we're doing for the District, talk about JPAs brokers/ consultants – that type of thing – and what's going on out there in the industry.

Keenan and Associates is a school specialist, we have over 800 school district and community college clients in California. We have four divisions: property and liability division, workers compensation, Keenan Financial Services (of which the District is a client), the Apple Program is a Keenan made plan, and employee benefits. I am the employee benefits part of the company. I'm the community college team leader in Northern California for Keenan. So the 34 community colleges that are in Northern are my responsibility. There are two products that the District is currently working with: (1) Benefits Bridge Program – this is our web-based resource for human resources. So the benefits group program is one that is being implemented at this time, and it is management tool for the District to keep track of all benefit programs and all employee programs in one place, and it is also an employee resource that can be used to gather information and used for online open enrollment and other employee resources.

So, this is a tremendous tool; we've got this in place for 400,000 employees at around 180 school districts and other entities throughout the State. So, it's a tremendous management tool that the District is working on implementing right now – that's the Benefits Bridge Program.

The other employee benefit program the District is doing is called BenElect, and I've included a flyer in your packets which describes the BenElect. BenElect is a medical/dental program for adjunct faculty or part-time employees, whether they're classified, or certificated, or student employees. It's completely web-based, web-enrolled, and paid for through the internet, so there's no District administration involved other than the District informing employees that this plan is available. So it is a limited benefits medical plan – low benefit, low cost, designed to provide basic coverage for individuals who might not be able to afford to remain on the District Program even if eligible. So, it a completely optional program that we've put together sponsored by the American Association of Community Colleges; we market it through individual Districts and also through the California Part-time Faculty Association, and through the Faculty Association of California Community Colleges. We're board members of those groups; one thing about Keenan is that because we're community college specialist, we attend all --- anything that has a "C" in it – any type of conference that has a "C" in it ---ACBO, FAB, or CPFA – it really doesn't make any difference, that's our business.

Well, what we're going to talk about now are things like JPAs, but I prefer to use the term "risk pool," and I think that might be an important thing to think about: ...What risk pool does the District want to belong to? Currently you belong to a pool – your own because you're on your own experience! Your own claims experience dictates what your rates will be going forward. On your self-funded plan, your claims experience will indicate what rates will be next year. With the Kaiser program, which is

experience rated, your claims experience indicates what your costs will be next year. So, you're in your own, Peralta Community College District, risk pool. There are a lot of other risk pools; this chart shows a couple of them: joint trust versus JPAs.

Joint trust, for example, is a California value trust; that is a joint trust. VIVA (sp) in San Diego, is a joint trust. What joint trust means is that they're jointly managed by labor and management. Labor has input into the benefit process and is a joint manager of that program.

JPAs physically have labor input, but through committees, not necessarily on the management side. So JPAs are typically management controlled, management oriented versus joint trusts which are designed to be half and half, half labor and half management. So that is the key difference in the type management or administration of those types of programs.

Now, what is Calipers? Where does Calipers fall under this? Calipers is probably described as a group purchase program. It looks like a JPA because the managers of Calipers manage it, but it is more of a group purchase, and it is the largest group purchase program in California, and some say it is the largest group purchase program in the Nation. But, it is really not a true JPA. A JPA has to have approval from the Secretary of State; it has to file and operate under the Brown Act, etc., etc.

So, there are differences in how those programs have to be managed, but it is a difference risk pool. So, when you want to analyze risk pools, how does anyone know the type of risk pool you're entering into, how is it managed, what kind of programs are offered, what are the rates, what is the rate history? So, you have to determine if it is going to be beneficial for you to join that JPA or to join that other risk pool.

Now, let me ask you a question: If your rates are higher than the rates of that risk pool, would you want to join that pool? Think about it. If your rates now are higher than the rates of one of these risk pools, would you want to join that pool? Yes. Would they want you? No. (and vice versa) So, one of the things in looking at analogy in looking at these programs is what are the entry requirements, what are the exit requirements, are there any penalties, are there any subsidies, how are you going to be treated moving forward? Those are all part of the analysis in looking at these other types of programs. Another one is: What degree of control does the District wish to retain over its own benefits programs? What degree of control would you say you have over your current benefit programs today in terms of benefit design? Very high, correct? In your self-funded program if you want to put in the deductible \$77.63, you could. All you would do is tell your administrator this is the deductible we want. Now how about these other risk pools? How about a joint trust? How about a JPA? How about Calipers? Can you modify the benefit programs that you want to offer your employees? The answer is no because they have standardized programs that they've developed, and those are the programs that are going to be offered. So, it's kind of their way or the highway in terms of benefits and costs and typically they are based on geographical locations as well. Calipers, for example has a north rate and a south rate; not surprising, north is higher. The other JPAs and trust have regional rates, not surprising the Bay Area is higher. They will set up standard plans and standard rates, those are the plans that need to be offered to your staff. If they want to make changes, they can make them unilaterally; individual employers have very little, if any, input into what programs will or will not be offered.

So, the decisions of looking at these alternatives are financial, they're benefits, they're management, they're flexibility of the benefits going forward. So, these are some of the things that groups in your position will face as you look for other alternative going forward.

Any questions on the concept of risk pool, joint trusts versus JPAs, etc. ?

Comment/Question : Bruce Jacobs (Peralta Retiree) -- "I just want to be sure I understand. The District has a legacy contract with retirees that guarantees the range of benefits, co-pays, and deductibles established on the date of their retirement, guaranteed. There is no way that the JPA or joint trust would accommodate? How do these joint trust and JPAs handle legacy obligations on the part of the District to people who are guaranteed a particular level of benefits and range of benefits at the date of their retirement?

Bob -Response: It's unlikely. When you have these large organizations -- Calipers has thousands of clients.....There is a way to handle that in some cases. If the legacy benefits are higher than the benefits offered by the pool, you self-fund the difference. Administratively a "pain in the rear," additional liability is unknown, but it's a way to handle that contract.

Comment/Question: Rick Greenspan (PFT) -- The reason we originally got into this issue was because we got hit with an 18% (threatened) increase in Kaiser rates. And when we started looking at those kinds of issues, it turned out that our self-funded plan is actually is among the cheapest in the Bay Area among community colleges self funded plan is among the cheapest in Bay Area for Community colleges precisely because there is no overhead. We don't have any stockholders, etc., and so the self-funded plan wasn't really the issue as much as it was Kaiser. My understanding is that Kaiser doesn't give you their claims experience, they're not public? So then the issue would be just on the Kaiser plan. Can you do it half way? Can this be done just on the Kaiser and not on the self-funded?

Response: Bob....Well, carriers have rules too about entry and exit into other pools. For example, Blue Cross has what's called the Blue on Blue Rule and you can't go from one Blue Cross Plan to another Blue Cross Plan without staying out of the network, without staying out of Blue Cross for a year. The reason for that is, let's suppose Blue Cross is available in five different risk pools, which one are you going to choose? The cheapest one! Is that the right one? No, not necessarily, but Blue Cross protects its "trusts," (if you will) its risk pools by having the Blue on Blue Rule. Kaiser has a similar rule. Kaiser will not let you go to another risk pool and enjoy a lower Kaiser rate than the Kaiser rate you should have.

Comment/Question: Rick Greenspan (PFT)...Yes, so my understanding of what that means is that for one year we would be trying to join this JPA, and the following year we could, or something...with Kaiser?

Bob Schoenherr (Keenan): Kaiser's rule isn't quite as stringent as Blue on Blue and the only exception to the Blue on Blue Rule is Calipers. So probably the only risk pool you could join and possibly get lower than the Kaiser rates would be Calipers. If you join Calipers, you have to join Calipers for all benefits, you can't join it just for Kaiser. So, it's going to be difficult to find another trust or JPA and go there for lower Kaiser rates and keep your self-funded plan. That's going to be difficult; that would have to be part of a marketing strategy, and that is what I was going to get into in the next topic.

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In terms of looking for alternatives, I feel you need a consultant. A broker receiving a commission as opposed to consulting fees from the District, it could be a conflict of interest because he'd want to be protecting his turf. A paid consultant who either works on a project basis or on an ongoing basis, wouldn't care what venue you go to; there wouldn't be any conflict of interest.

So, what I think...in one of the slides that Jennifer had was, you can go to a JPA or a trust with or without a broker, with or without a consultant. Some of these don't work with consultants; they don't pay them, and they don't pay brokers. So, that is another part of the evaluation, you would want to do to decide what kind of brokerage work you would need with a JPA or trust, what kind of consulting work would you need ongoing with a JPA or trust, and, that really gets into more long term planning. What is the goal of the District in the long term as opposed to the short term to just try to reduce your Kaiser rate? Buying business means low-balling a rate and then increasing it to where it should be after a year or two. The marketplace doesn't do that. Everybody wants your business, but they want your business at the right price. So, quotes you're going to get are going to be realistic based on your claims experience. It's up to the consultant to provide you with all of the nuisances and subtleties of how these plans work and what are their differences. And if there is any commercial involved in my presentation today, that would be the piece of business that I applied for, and so I provided a consulting brochure of the things that Keenan does.

So we work with over 30 benefits community colleges, over 50 property liability community colleges. I'm not sure if you've seen it or not. Jennifer, have you shared the employee benefits survey that we've done with the committee?

Jennifer Response: ...not recently.

Bob Schoenherr (Keenan): We do an employee benefit survey each year of all the community colleges in the State, and so I felt that, personally, from the 34 Northern California Districts, I know what's going on out there, who's doing what, where they are, what are the subtleties and nuisances of your peers on the community college side. But the request for proposal part, that's the part that your consultant is supposed to do. We just did a consulting job for Gavalin (sp) for example. They're with Calipers. They wanted alternatives to Calipers, and so we went to the marketplace and provided them with an extensive report of what alternatives might be available out there. We're undergoing a similar project right now for San Joaquin Delta College and finding some very competitive alternatives for their retiree program, and they're in a trust. They're in the CDT Trust. So, you want someone who is going to research the marketplace for you, show you the pros and cons and subtleties of all of these different programs.

So the question when you prepare the proposal is: Who should the proposal go to? If you want to stand on your own, then you can look at other self-funded vendors, or you can look at insurance companies. Blue Cross would quote on you on a fully insured basis, but as you pointed out, cost would probably go up because their overhead is high.

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Self-funded is the most economical way to deliver benefits in the long term because you don't have that overhead, you don't have risk charges, you don't have overhead charges; you can set your own trend which is more appropriate than what the carrier might set, etc. But, it is also riskier and you're smaller; you're not in a large risk pool so you can be more subject to ups and downs. So that's a pro and con thing that you need to weigh as the employer and where you want to be going forward.

Jennifer: In the ten minutes remaining, I'd like to open it up to more dialogue and discussion; and I'd like to back track just for a few seconds about the BenElect Program. We do have participants in this plan. The District manages five open enrollment periods; we need to become a little bit more electronic about it. Hopefully by open enrollment in May, we'll have everything all there. With that said, any questions from the back? David, Connie...about this whole concept? This is our second installment meeting on JPAs. We had been using the term JPA with the Joint Trusts interchangeably....Bob has brought us some very interesting concepts and I just want to make sure that we're clear, Bob, that as Rick was mentioning, if we're were to join a trust or a JPA, we'd have to send the whole business of active employees –how does that part work, Bob?

Bob Schoenherr (Keenan): Calipers absolutely requires that you would join Calipers for all programs – PPO, HMO, retirees. The other trusts also have that requirement although they always make an exception; you could request an exception, but that's not likely. So, there might be worth looking at other alternatives within Kaiser. There are a lot of moving parts. I would say generally speaking, the chances are if you just wanted to move your Kaiser plan to another pool and try to obtain lower rates; that the chances of success are slim.

Trudy (comment): We just negotiated successful agreements with all three unions and included in that were some defined benefit issues aside from the agreements we have with retirees; we're talking active employees. And so, to be part of the JPA, would we be able to move what we've agreed to over to over to and fit into, or would have to accept whatever the JPAs different level of benefits are?

Bob Schoenherr (Keenan): Typically, if you're in one of these Organized JPAs such as CVP or CIPS (and those two seem to be the largest joint trusts other than Calipers ) if you moved into those, you do not have benefit flexibility. They have standardized pooled programs and standardized rates that are set by geographic area. Now, if there was a smaller JPA or you wanted to create a JPA, and you wanted to get another partner District to share benefits with you on a self-funded basis, PPO, on a fully insured basis for Kaiser (because Kaiser doesn't self-fund) you could do that. In that case, it would be your own JPA; District would become 50% managers of it, and you could create your own benefits within it. What would be the advantage of that? The advantage of that is that you would have your own risk pool; you could share in risk losses – is the other guy better or worse than you – what you would accomplish is better economies of scale joining together instead of having 500 lives in Kaiser, for example, you could go to two groups with 1,000 lives. So you would have more stable rates by joining those groups together. The possibility exists of creating another JPA with other community colleges.

I tried it 10 years ago, it resulted in a dental/vision JPA that exists today because we couldn't get medical off the ground. Why couldn't we get medical off the ground? Because every District had different

benefits, a different administrator, a different pricing combination, and it was just impossible to reach commonality on the medical side. It's much easier on dental and vision because you have Delta Dental and VSP and they're everywhere. So we go a JPA that's in existence for dental and vision, but not for medical. But if there were a partnership relationship that could be established, or you could put together a JPA or you could put together your own joint trust. There was a joint trust in the Bay Area years ago that, unfortunately, fell through the cracks. It was called the Basic JPA, and it's no longer in existence. But, you could find a partner to have economies of scale and have a broader risk pool, you could find another District or two to join together. It's a challenge to do that; very much so.

Question - Jerry Herman (PRO): How does joining a JPA effect administration of Core Source and Kaiser? Isn't there an override? Would they be eliminated?

Bob Schoenherr (Keenan): You'd eliminate them as they exist and you'd join programs offered with the JPA or joint trust, or Calipers or whatever entity it is that you join.

Question - Jerry Herman (PRO): So we'd no longer be offered something called Kaiser; CoreSource would then no longer be ....?

Bob Schoenherr (Keenan): Well, I presume that Kaiser is available in all these other entities, so Kaiser is a given. But your self-funded plan would have to convert to whatever carrier plan the other plan offered. For example, Calipers has Blue Cross PPOs and Kaiser and Blue Shield HMOs. CDT(sp) has Blue Cross and Kaiser, CST (sp) Blue Cross and Blue Shield and Kaiser and HealthNet. So the different entities have different carriers and different benefits which they offer. The only way to find these out is to go out and solicit bids from them.

Question - Jerry Herman (PRO): Would we retain the broker?

Jennifer: It depends on what the JPA's rules are. Just as Bob said earlier, some joint powers of trust don't require a consultant or a broker. So, we as the District could make the decision to forego a consultant or broker and join a JPA or Joint Trust. So it's a partnership. There would be different combinations. As said earlier, Peralta could go in with or without a consultant with other community colleges in a partnership relationship.

Question: Jerry Herman: So, where does your (Keenan) fit in? I assume there is a cost. Tell us what your companies like you would do.

Response: Bob Schoenherr (Keenan): Well, for example, Gavalon is the most recent consulting venue that we've had. We provided a quotation to marketplace, we know the results of that marketplace – a two-part consulting project that was Pt. 1. Pt. 2 would be to work with the Employee Benefits Committee and work with the District to see whether any of those options educate the Committee to a further extent.

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Jennifer: And just to let you know, this is our second meeting, and we're just trying to build understanding. Last meeting we had SISC and Alliant, I think in one way, we're spoon feeding ourselves and level setting with the concept and objectives of our explorative efforts.

Thank you graciously, Bob, for coming, and we need to also benefit from the wisdom of our Vice Chancellor who will give us an update on the post-Prop. 30 impact to the PCCD Budget

Bob Schoenherr (Keenan): Just one more second Jennifer, on the rate side of your packet there are three pages. One is just a summary of health care reform, and one thing I noticed from the District's perspective which should be in your long term planning (because you need to talk about short, intermediate and long term planning as a Committee), the last issue on the right, 2018 Cadillac Tax: If premium costs to an employer per employee are over certain limits in 2018, there is a 40% surtax on those excess premiums.

You have a plan that is already over the limit. The limit for a family is \$27,200.00, Your highest self-funded plan is over that amount. In four or five more years, think of what is going to be! You have a significant issue in what is called a "Cadillac Benefit Plan."

Jennifer: Who pays that tax?

Bob Schoenherr (Keenan): If it's insured, it's the insurance company. If it's self-insured, the entity pays. If the insurance company pays do you think they're going to pay it? No, they're going to pass it through. The other thing I want to mention very briefly, I know you're talking about retirees. The concept of a Medicare Exchange, are national Medicare networks available to retirees that can be added either as a replacement to your current plan or as an option to your current plan. There are very significant savings available out there in the individual Medicare supplement market that we've seen in working with other community colleges.

Finally, there is a webinar that Keenan is putting together next Wednesday on the effects of health care with the new legislation and there's a little flyer in there; if you went to Keenan.com you could register for that program.

Chancellor Gerhard: What I've been asked to share with you today is kind of a history of expenses/ expenditures related to medical, but I've taken the liberty to share with you a broader picture from a 5-year historical perspective of not only increases in health benefits, but also decreases in other areas of the State Budget.

To take a step back, we adopted (The Board) a budget in September, 2011 that took into consideration the parcel tax spending. In June voters approved our Measure B parcel tax that we're projecting bringing in \$27.5, plus or minus, million dollars per year for eight-year period. The budget that the Board approved at that September 11<sup>th</sup> meeting factored in the parcel tax money, but what it factored out is – it assumed that Prop. 30 would fail, and it passed! So, essentially what that means is that we have revenue that was previously unbudgeted for or unanticipated, that will be coming into our unrestricted general fund budget this fiscal year. So, in terms of the agenda item of "what does Prop. 30



for us?" – that's specifically what it means. It means that we're projecting about \$5.5 million dollars in additional revenue to the unrestricted general fund that previously was not incorporated into the unrestricted general fund. Now, how that will be allocated, and what particularly it will be used for, I can't say today because I don't know. But, we have budget and planning processes both at a District and global level that will be used to allocate and divert them to the highest and best use deemed by those planning processes. So, unless there are questions on Prop. 30, that is the dollar magnitude that it will have.

Bruce: That's ongoing money, not one-time money?

Gerhardt: That is on-going money. Part of Prop. 30 was staving off a workload reduction that would have had a magnitude of a \$5.5 million dollar reduction. But, the Governor's primary use of that additional state-wide revenues related to increasing the state tax on wealthier income earners, is also a sales tax increase. His initial push was to use that additional revenue to buy down our deference. Right now we get IOUs from January through the end of the fiscal year in June we get IOUs from the State basically saying: "We know we owe you approximately \$5.0 million per month, but we only have revenues to give you \$3.0 million per month." So, what that forces us to do is go out and borrow money in the open market to meet our obligations, so that our vendors and employees should not have to accept IOUs.

The Governor has been using that additional revenue to buy down our deferral accounts. Prior to Prop. 30, system wide for community colleges, that deferral amount was about \$960 million dollars. Per Peralta, it amounted to approximately \$18.0 million dollars per year. Putting it in context, we receive approximately \$65 million dollars of State apportionment, so \$18 million is a "chunk," over 20%. But other advocacy constituent groups were lobbying requesting the Governor to do some kind of King Solomon approach and use some of it to buy down deferrals and use the other part to fund additional access.

Initially, the thought was that perhaps as a system out of 72 Districts, of the additional revenue we'd get, maybe, \$50 million in additional access to students. Peralta's share of \$50M split 72 ways proportionately is about \$500,000, or a little over 100 FTS. So, it's not substantial; it's marginal. The greater focus is at least the Governor is planning to buy down debt, but we'll see what happens. I'm not sure I answered your questions.

Bruce: Money that comes in from the State, there are two types: one time rolls over year after year; and one type is one-time only money where you can't count on getting it the next year. So we're just asking what kind of money is this?

Gerhardt: It's ongoing. It would be ongoing for that sliver is "loaf money" that increases access to students. The other piece that he uses to buy down deferrals, basically, doesn't translate into any new dollars.

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But, the biggest fear in the folks that were lobbying against Prop. 30, mainly the Howard Jarvis Tax Payer Association, is that they're claim was that it was political roulette, threatening education at the expense of all the other sectors and recent.

With passage of Prop. 30, if it failed the Governor said he would cut community colleges in excess of 7.5% from the general fund. So it wasn't so much that we're getting additional dollars, it's that we not getting cut!

Jennifer: My question is: .what's that? Column 9, "Fringe Benefits...?"

Gerhardt: I'm going to walk you through this spreadsheet. So if you have a question on the spreadsheet, give me a moment to walk you folks through it.

D.Betts: Could you blow it up a little bit t more for the visually impaired?

Gerhard: Visually impaired. Yes, absolutely.

So, what this spreadsheet does is give a five year history going back to 2008 audited, actual numbers going through the current year, 2012-13 budget numbers. Now the caveat in understanding is the 2012 – this column right here – the 2012-13 budget numbers do not reflect the passage of prop. 30, in fact the opposite, it reflects what would have been workload reduction, or the cuts. So that number right there, that \$60,259,454.00M is State revenue....., and now, State revenue will now go up by approximately \$5.5 million dollars. The primary purpose of the spreadsheet I'm sharing with you isn't so much in looking at the revenues, even though that will change the expenditures in order to have a balanced budget, but to look at the expense downside.

So, in 2008, fiscal year 2007-08, here are the expenditures, the audited expenditures of the unrestricted general fund. Now, also in that year, too, keep in mind the District has vastly different accounting practices that have since changed. So when I say 2007-08, the District actually had two unrestricted general funds. For those who are familiar with it, there was Fund 4 and Fund 01. Since then, we've collapsed Fund4 and Fund01 into one, so it's easier and a little more transparent, and for budgeting purposes it's easier to discern if we have a balanced budget.

And the expenses to the right – the columns are labeled: the 8-9 budget, then to the right of that is the 8-9, to the right of that are the 8-9 actuals where we end the in comparison with the budget. So the 9-10 budget actual, 10-11 budget actual, and then 12-13. What I've done for the purpose of the abbreviated time here, is highlighted the percentage change from the 7-8 actuals to where we currently have the 11-12 budget. Keep in mind that the 11-12 budget will change with the passage of Prop. 30, but we don't know what that is going to translate into yet until everything goes through our shared planning and governing processes. But, in looking at it and focusing on the topic of this committee or discussion today is, fringe benefits at large. Now fringe benefits incorporate a lot. It's not just medical benefits, dental or anything like that or just that. It includes your PERS, STRS, your pension benefits for current employees, but it also includes your employer required taxes. You've got FICA for classified folks who have PERS, people who are in STRS are exempt from that. You also have unemployment insurance,

So that's incorporated into it as well. In addition to that, you have medical, dental benefits included in here. More recently, or at least in the last three fiscal years that you see on the spreadsheet, we have the OPEB charge. That was necessary as a result of our OPEB funding structure, or deficit mainly, within our OPEB Program as a result of not being called up on the stage, a loss or devaluation of our OPEB Trust, and a few other categories.

So, as you can see, looking at this five year picture going back to 2007-08, we've already used up \$113.7 million, we have actual expenditures of \$115, say, round up .1, we got suspended that year by approximately 1.3, almost, 1.4 million dollars. The subsequent year, we had expenditures of \$123, you can see in their respective categories where we actually suspended, approximately 2.5, 2.6 million.

This is fiscal year 09-10 right here. We had significant cuts in 09-10, and that's when really the categorical programs, pretty much across the board, got wacked.

The point is, looking at it across the board, almost every, with the exception of other faculty which are Librarians and Counselors, and transfers out related to OPEB, we have significant reductions, but the largest area of increase, basically we had to re-divert resources from other major classifications, to fringe benefits to fund that deficit that was most prominently noted in 2009.

The biggest piece of that (I don't have it broken out here, but I can supply if for a future meeting) is the health and welfare benefits. If you think about it, all the other categories that are mentioned, for example PERS and STRS, FICA, unemployment insurance, the statutory benefits required by the State, those are all based upon a percentage of a salary. Now over that five year period, we have (and everyone in here is probably sensitive and very aware of) significant reductions in the number of full time staff, but yet reduction in staff is attributed to, and you see it manifesting in the reductions in full time academic admin., part time academic, and classified – those are all indications that there are reductions in salary. Well, the only way you can really have reductions in salary like that, or either, for example we had furloughs for two years, or you have a reduction in the overall number of positions being funded out of this unrestricted general fund. And you can see that here, but despite that, we had increases in fringe benefits, and the largest factor to that has been the Kaiser coming in and saying 18% last year and negotiating it down to 11 or 13% depending upon what we did with our other plan. That was just one year alone where we had double digits, and was Kaiser, and with CoreSource too we had double digit increases. The year before we had significant increases. It all goes to show that over a period of time, and what it accumulates to; it compounds to over this five year period.

I want to share with you Prop. 30, what it means to the unrestricted general fund, but specifically to the focus of this Committee sharing this transit line with you here. Finance has been working on accreditation reports, and in one of the recommendations they want to know what Peralta, what collectively we've done to address this trend? Obviously, last year was a huge step, thanks in part to the great work of Human Resources and the negotiating units to do that.

Hopefully that, over time, will offset this more recent five year trend of increasing in benefits, namely medical.

D. Betts: I was noticing that even despite of what was negotiated, there appears to be a significant amount budgeted for fringe benefits for the current fiscal year.

Gerhard: Yes, you may recall initially Kaiser was saying you're going to have almost a 20% increase; we're going to increase your rates by 20%; one-fifth! Had we not done what we did, the increase would have been a lot larger, but despite that, we still had approximately a 10% increase, double digit. Because rather than Kaiser saying an 18%, it still, ok at 11%, but it's still over 10%. Similarly, with Anthem Blue Cross, we had a renewal in excess of 10%. We had increases, although not of the same magnitude, but increases in employer contributions for PERS. STRS doesn't fluctuate year to year because that's set by the Legislature; it takes legislative action.

On our re-insurance; every time I hear the term self-insured on our medical, I feel nausea because we are (Bob mentioned it and he's absolutely right) we've got our own benefits, but on the opposite side there are huge risks involved with being self-insured especially with a smaller pool like we have. Because, as you probably know, we're self-insured for Anthem Blue Cross, PPO, so to offset some of that risk, we buy re-insurance, excess insurance, to cover any major, catastrophic claims that have expense over a certain dollar amount. So for example, in prior years that threshold was \$170,000. So if I had a catastrophic injury or issue that caused my medical bills to exceed the \$170,000, Peralta would pay the first \$170,000. But in excess to that, this other insurance carrier would take up the difference to mitigate that risk. Well, that policy alone last year increased in excess of 50%. So rather than paying \$800,000 or \$600,000 for annual premium on the insurance policy, now we're pay \$1.3 million, almost \$1.4 million. That's all a function of, and the risk associated with, being self-insured. So as previously mentioned, there are benefits, but there are significant, at least from a finance side, significant risks associated with it. And that also part of that budget you see in the \$37.5, \$37.6 million dollars in fringe benefits.

Jenifer: Let me ask the Committee: recently, over the last week or so, we did a mailing, and in that mailing we included the statutory benefits that Ron is talking about. It had the holiday schedule as well as the employer and employee paid statutory expenses, so we're all working from the same understanding of what that fringe benefit category is....

Gerhard: And another thing, and this is the point, with the good work that was done through collective bargaining, was inclusion of a Lite middle-tier plan and also certain voluntary payroll deductions for employees. But the major savings in the eyes of the IRS, is the Cadillac Plan, PPO family in excess of \$27,000, well, that's for employee plus family. Well, for the Lite Plan, the annual premium is somewhere around \$25,000. The significant savings that the District would achieve as a result of the efforts of collective bargaining isn't the employee voluntary contribution(s), it isn't necessarily going from 18% to 11% in negotiation, it's how many employees shift in their selection of plans from the PPO to the Lite. Now, in that shift if the employee decides to take the PPO, now their paying the difference between the two, but really, that also has an impact on rates as well and if they go to Kaiser. So, we

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have one plan that is fully insured with the PPO and the Life, but you have Kaiser which is a fully insured program. So their assuming risk in setting their premium.

Jerry: I'm going to be leaving for the annual PRO Membership Meeting, so I'd like you to give me the message to take to them of the status of retiree benefits.

Gerhard: The status of the retiree benefits – it's funded, we have a planned funding mechanism in place to ensure that it's funded for the future. Are we solvent, are we funded? And the answer is yes.

Rick: This has to do with time, we now have this extra money from the State and the self-funded plan we just kind of keep rolling as far as – we can get a projection any time as to how much it's gone up compared to the year earlier or a month earlier – whatever we want, we get those figures anytime? But Kaiser only negotiates those rates once for the fiscal, so when was it that all this stuff happened with the 18%, 12%. I'm just trying to figure out when this coming spring we're going to have to sit down and figure all this stuff out with Kaiser in terms of the JPA option, the continuing paying as we go with Kaiser. When will the numbers come in from Kaiser? Maybe Peter knows more about Kaiser....

Gerhard: From a budgetary impact, as you know sitting on the PBC Committee, more recently the PBC in terms of our budget planning and assumptions from the Board, we've adopted, or incorporated a model going on three years. What we've built unto the budget assumptions, for example, for the next fiscal year that we're getting ready to talk about this month for fiscal year 2013-14, we're assuming a cost increase, a premium increase for medical of a three-year rolling average. So, right now I think it's between 8.5 and 9.0% that we're projecting an increase for next fiscal year. Now, we don't want the carrier to know that because we actually want a reduction, but I'll let Peter speak to the time of the negotiations.

Peter: You must be sitting at my desk! Because tomorrow morning, at 10:00 a.m., I'll have my first meeting with Joe, remember the gentleman from Kaiser! He's literally going to be at my desk at 10:00 a.m. talking in preliminary about your specific renewals. You must have actually been sitting at my desk to know that meeting is coming....

I've heard off the top, I don't know if it's true or not, but I've heard the experience is running a little better than expected with Kaiser. We still have a period of time to go. Just in case anybody want to know, the CoreSource experience is looking a little better this year than in the past. So what does that mean in translation? I don't know. What will Kaiser try to do tomorrow? I don't know, I don't even know if they're going to come in with numbers or just want to talk about....

All I know is that I've said to them and I've pressed on it because this wonderful lady behind me is saying: Peter, we need this renewal done early.

Trudy: ...because last year we got it really kind of late in our estimation based on the negotiations. I know you did the best you could do. But now that we're having this discussion – the JPA, etc., -- from Rick's there is a timeline that we need to have honored, and right now we're exploring JPA, and that's why we're having people come in and talk about that concept, but we need to firm up our timeline and

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look forward to making a change, if we're going to make a change. It would be helpful if we could get anything by Christmas. The thing I don't want to have happen with Kaiser and Joe is to have that conversation with Joe again.

Peter: I'm very, very clear about this conversation, and that's I did request, and we've actually talked once before, and I asked for the meeting tomorrow, and they're going to come in and start talking about it. So, I'll know more tomorrow morning than I do now and able to report the timeline and where we are, but pressing for time considerations.

Jennifer I (comment): Our next meeting is December 3<sup>rd</sup> so we can see how far these developments have gone.

Gerhard: So, unless I have any questions, I'm going to transition over....

Sara Connor (PFT) Question: Could you explain...(speaker inaudible)

Gerhard: Biggest piece of that debt service on OPEB bond service.

Question: DSPS transfer out...?

Gerhardt: That is the debt service; the other piece of that is the transfer out annually to DSPS as an unrestricted match or contribution. But, other than that \$1.1 million, the rest of it debt service on the OPEB Bonds.

Connor: So if .....(speaker inaudible)

Gerhard: Well the DSPS transfer is approximately \$1.1 million, so the cell that's selected there, 4.7, that would indicate then the expected debt service payment on the OPEB Bonds for fiscal year 1213. It's going to be in the area of 3.6 million dollars based upon their debt schedule. Now one thing to note too is in October, 2011, we refinanced those bonds – it's kind of a side notation – but had we not refinanced that debt, those bonds, rather than 4.7 it would be towards 8.5. Million. So, that was a significant piece in balancing our budget for this fiscal year, and again, reducing the cuts that otherwise would have had to been made.

Connor: (inaudible)

Gerhard: ....again the column, the 1213 budget, was with the assumption that Prop. 30 was going to fail, so compared to the 11-12 budget, our funded FTS from the State was approximately 17,800 FTS. So, if Prop. 30 had of failed, we would have had a workload reduction going from \$17,800 funded FTS down to

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16,600, a 1,200 FTS reduction. That quantified in terms of dollars a little in excess of 5.5 million dollars. So, in planning for that, at least in this unrestricted general fund budget, we built the budget as funding or serving 16,600 FTS for students. But with the passage of the parcel tax, there is a separate fund that is not incorporated in these numbers that we used to backfill pretty much, for the most part, with backfilling that with parcel tax dollars.

So once again, this is only unrestricted general funds. But when you're focusing specifically on part-time faculty, you're only looking at probably two-thirds of the picture. The other one-third of picture is in a separate fund that is not displayed here. And with regard to the percentage, is that, yeah, in dollars – there's time value in money here, but a finance professor would say, well, this five year history is a lot more than 2.47% because over this five year period, you had inflation, you increases in purchasing that are reflected in a consumer price index. And so as I presented to the Board sometime last summer and we were discussing the tentative budget, I provided a real, true cost of these cuts over a five year period, factoring in time, value and money; factoring inflation and CPI. And really, it's not 2.47% or, on a dollar magnitude \$112.2 million versus \$115. Really, that reduction, when you factor in those other considerations, is to the tune of excess of 10%, in excess of \$116 million dollars.

Connor: (inaudible)

Gerhard: Yes, the retirees in the first year were included as well. The difference is that in the first year, 2007-8, the invoices that was coming in and was being paid for the District for retirees, was lumped into one pot, the same pot that the same invoices for active employees were being paid from. So, it's still under; it's not a reclassification in terms of this major category of fringe benefits. Now if you were to drill down at a four-digit account number level, there were reclassifications, for example, from 3411 and 3421 to 39, but within the major classifications of fringe benefits, it's still the same number. So, for the purposes of the aggregate numbers that you've seen here by major classification, there are no reclassifications.

Connie: Quick question. I don't know if you've already said this. The salary that's in the parcel tax fund, are benefit costs associated with those salaries also in that fund?

Gerhard: They are. Now I'll transition over to Jennifer. She has a few slides of additional information that she'd like to share with you.

Jennifer: Well I wanted to share them because, actually Trudy has asked me the question, and these are like "icebreakers"...we're looking at numbers. We know how much, but how many kinds of questions. Ron, thank you so much. That was very in depth, very thorough, and I appreciate the time you've taken to deliver the information to us.

In your packets...

Average age of the current Peralta Retiree? Any guesses here?

The answer is 73. That's the average age of all Peralta retirees.

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The number of pre- 2004 retirees?

The answer is 437.

And, the average age of that group?

78 – Ruby gets a prize.

The number of post-2004 retirees? Those who retired after the benefit changed from lifetime benefit coverage to age 65. How many are in that group?

The answer is about 240. We almost did 50 during the VERIP (Voluntary Early Retirement Incentive Program) of 2011. So there about 240 who have retired post-2004 with co-pays of \$10.00.

And what is the average age of the post-2004 retiree?

The answer is 65.

So, one more time, the average age of the current Peralta retiree is about 73. The number of pre-2004 retirees (and this is the group that has the \$1.00 co-pays) that's 437, just the retiree, not the dependents. The average age of that retiree is 78. The number of post-2004 retirees is 243, and the average age of those retirees is about 65.

Average age 78

Jennifer: So, that's "fodder," but the Benefits Office is beginning to engage with finance to develop the information for the OPEB funding. So as I stride down this journey, I start thinking – we have total retirees of about, what, 600...

Gerhard: So Jennifer, in your infinite wisdom, why are those nuggets of interesting pieces of information; what does that mean for us in the budget? Does that mean that we are more predisposed in the future to having annual renewals being larger as opposed to being smaller in peer Districts?

Jennifer: Well, what it means, and I haven't had time to prepare, I would look at the numbers pre-2004 retirees a year ago, and if that number was higher, then what we would start looking at is, hopefully, a decrease in the population. But, ....(laughter) The average age is 78 right now, and the life expectancy is, let's say, is 100, those are considerations to speak about....

Gerhard: Not to offend some of our esteemed PRO folks, but recalling back to the last actuarial study, I think the life expectancy, based upon financial projections is, I think, 84.

Peter: First of all, I understand we're talking from the budgetary; we all need to understand the fact that 70% of all medical bills for everybody's entire life, on average, will be in the last six months of one's life. Seventy percentage of all the medical bills of your whole life in dollars, is going to be in the last six months of your life. The point is will your costs be higher than other peer colleges? The answer would be yes, if they don't have that retiree liability; it's just a logical answer.



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Bruce: We need to know how many are on Medicare because the fact is that Medicare will pay a huge chunk of their bill if they are on Medicare. From what I understand we are below...

Peter: We are below ...

Jennifer: Going back to the issue that Ron brought up earlier on the stop loss, the first \$170K that incur on self-funded that we pay, there's a Medicare one. So when there's no Medicare, we absorb not that first \$200K, but anything over that. So as we're bringing those numbers, the reality is that people are retiring at an earlier age.... If we had a 50% stop loss experience, our stop loss carrier would be shopping every year. The question on the table is: Will we require all of our retirees in Medicare? The answer is "yes" or "no". So, I just wanted to reemphasize and illustrate the point, stop loss is a component in our expenses, yes the non-coordinated population numbers are down, but not down to zero.

Peter: We did have a claim last year of over 1M; you can say, yes, non-coordinated Medicare, and it was over \$1M. You can say that the District has specific stop loss that covers a claim over \$170, now \$200K, and so the District only had that risk, but the re-insurers are starting to scream that the risk of their getting, and that in fact Peralta is one of the only Districts that they have on the books, that allows non-coordinated Medicare, and that's causing a tremendous problem in the re-insurance market.

Jennifer: And even if we go to a JPA or trust, they could ask us the same question, and the answer is either "yes" or "no".

Peter: And the biggest issue you need to understand in a JPA that we could walk over to, whether it's PERS or any number of others, is you have to cancel out your self-insured program because all of these JPA programs are fully insured. So you're going to have to run out of --the total group is like \$2.2million dollars, the actives are about half of that, \$1.1. But if you just move the actives to the JPA, ok -- this is really important to understand -- if you move the actives only to a JPA you've got to fund the run out, so the District would have to come up within 60 day, \$1.1 million to put into an account to fund the run out of claims that were incurred or paid after the contract. Retirees probably cannot be moved over to a JPA because of the benefit design that the JPA is not set up to absorb, and they have a contract that says we've got to maintain those benefits. Then going back out into the re-insurance market and saying to the re-insurance market, do you want just these retirees? And some of them are not coordinated by Medicare, I don't know what the market would say. That would be a question for me to pursue. But the fact is that I'm concerned about how they would view that given the fact of the potential for large claims and the number of people not coordinated through Medicare.

So, that's an issue that I have.

Thank you again, Ron.

Jennifer: Issues of self-funding. We're going to hit several topics in this component, not only the enrollment census, but the processes for changing summary plan descriptions, out of network claims

experience, an update to the non-California Network options, and other JPA considerations moving forward. So, you can review this at your leisure. We'll probably update it once, and definitely in December. But, the way this census data on pg. 8 is laid out, basically we take each employee group (this is only for active), but for the purpose of this meeting the numbers shake out like this.

So the structure of this table basically outlines the coverage level and the union affiliation for our population, actives only. So for example, if you want to know how many contract faculty on the faculty side are in Kaiser, at the single party rate, the answer would be 49. Those who are in the part-time 50-50 Plan, the answer is, single party coverage 39, those paying the premium at the single party rate there are 3 people enrolled.

So, in the PFT example, we break them down by different levels of coverage as well as the subdivisions within the ranks to arrive at the subtotal for that group. Does that make sense? So if you follow the letters you could do that for the right, but then we look at each benefit plan, we look at Kaiser HMO, then we look at self-funded Lite, then the Traditional at each coverage level, then Delta Dental followed by the United Health care Plan. So, those are the major components which were contained in the fringe benefit categories Ron used in his previous slide. So just in terms of numbers, not costs, just numbers and distribution of enrollment, in terms of total population in Kaiser that are active – those 642---there are 325 people, just employees who opted enrollment to the Lite Plan, and 222 opted to stay with the Traditional. So combined enrollment for the self-funded plan is 547. Relative to Kaiser enrollment of 642 actives...and then we look at the general enrollment –777 in Delta Dental, and 90 opted enrollment to United Healthcare Plan. So we will update and include in the combined total in the next...something's wrong about that total....

So, with that said, more issues in self-funding, one issue that has come up...the question comes up what is the process for changing the summary plan description? And, at the last meeting I prepared a summary, which was online, and....

Rick (Question/Comment) ...my question is about this thing which is – there was somebody who went in for a colonoscopy and at the clinic they brought in an anesthesiologist who was not in network, and Core Source charged that person for the anesthesiologist as an out of network procedure. The people at PSW worked it all out and they got it knocked off. What I want to know is what do (PSW) in the SPD or that something that you do out of the niceness of your heart?

Jennifer: Let me answer that because it's not their question. The answer is yes.

Jennifer: Regarding changes to plan language: if any business partners change we have to update SPD description to clarify. Another trigger event is to preserve past practices; SPD when corrections occur, or compliance. Fundamental benefits don't change, but triggering events mandate amendments to recodify for compliance for proper claims administration with our business partners. We need to update our summary plan description when there is a correction. For example, when Local 790 became Local 1021, guess what, we had to update the summary plan description which requires an Amendment. Or, there is an issue of compliance, so while the fundamental benefits hasn't changed, these are

triggering issues that require a re-write, for example, due to healthcare reform. We are externally required to cover dependents to age 26. There is another elimination of pre-existing condition. We have to re-write or amend the summary plan description.

So these are all triggering events that will require the District or trigger a work order to make sure we are in compliance and that our third-party administrator, currently CoreSource knows how to codify these changes. The District then will amend and business partners will amend the initial amendments and update the website, send out announcement, or revise the entire summary plan description. But what we really also need to do as part of the language intent and satisfy the compliance requirement, we need to codify our changes for proper claims administration with our business partners.

Bruce (Ques.'Comment) Routine changes in language should come to this committee and I say that because we recently had experience where the language was changed in the SPD, but the change actually resulted in a reduction in benefits. Recent language change actually resulted in a reduction in benefits. When that happens it can go completely un-noticed until services are affected. Retirees are guaranteed a level of benefit that's attributable to the SPD on retire. If the District makes a later than that applies to that group of people, then those people need to be notified that there is going to be a change in the SPD, and here's what the change is – the old language versus the new language, and give them an opportunity to say – wait that represents a reduction in my benefits.

Trudy: Your point is duly noted; we agree and we recognize.

Jennifer: At this point, I'll turn it over to PSW; it's in the context of the out of network issue which came out of the successor agreement negotiations that in year one with our self-funded plan, we would remain status quo in terms of paying for out of network benefits for eligible dependents for people who retired and moved out of California. In years 2 and 3, the District would visit out of state networks and shall work together to make every reasonable effort to attempt to provide out of state retirees a network similar to California, Anthem Blue Cross in year 2.

So, Peter, Kimberly, PSW, take it away!

Introductions: Peter, Kimberly

Peter: (See Pg. 12) In-Network/Out-of-Network Analysis

In starting off we're looking at claims billed, allowed, paid... So on the first line we're looking from the in network claims billed, allowed, paid, employee contributions, what the discounts were. Moving down there was a question on a separate line on PHCS the PPO product – that would be the out of State, what those claims were.

The next areas the out of network, the multi plan, the multi plan negotiation, the national care network – all of those were out of network expenses that were paid as in network for some over riding reason – some emergency, some situation that caused them to be paid as in network.

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Second to the bottom line, the bottom line obviously being totals are all the non-participating out of network, is the non-network side of all the claims. So we're looking at in network and then the out of network being the 8%. That represents all of the non-network claims.

So there was a question posed as far as how are our claims being in or out of network, so those top areas, really we call those in network all the down to the bottom line which we be the non-participating out of network claims.

Jennifer: So there were \$897,000 worth of claims paid through the PSD network?

Peter: That is correct.

Jennifer: How much do we spend in out of network claims? That would be almost \$900K?

Peter: That's correct. So of the claims allowed, we have actually paid \$900K.

Peter: Misperception that Blue Cross and Blue Shield the same; they are like franchises and the only thing that actually brings them together is the Blue Shield Association out of Chicago. They have now gotten together to network together for greater cost effectiveness to re-price for California (JAA) to reprise all California claims for the same providers with 10% claims cost. That triggers a look at Blue Cross/Blue Shield across the nation; that would be better for Peralta, takes about 3-4 months, first implementation of this network 01/2013. Requires all subscribers to have new cards; looking at what could be done in advance. This process allows us (PSW) to look at the landscape.

Peter: Brokers perspective see Healthcare Reform moving forward based on election, Health Care Reform Timeline 2012-2010 a standing issue on-going.

Peter: Moving forward based on election results; States had been dragging

See Pg. 17 ( ) Fees & Taxes (See) Filing mandated by Peralta Form 720; monthly reporting required for self-funding programs. Tracking CoreSource enrollments.

Peter: Feasibility Study JPA Exploration: JPA Considerations: rates higher or lower, experience (See Pg. 21)

Renewal date: self-funded, JPA

Administration: JPA more structured. Self-funded more flexibility.

Cost consideration. Both Kaiser and CoreSource would need to move to the JPA with the possible exception of retirees. Will current retiree program be allowed to be sustained? Will the re-insurance program be available?

Jennifer (Question) Why claims within the run out period?

Peter: Explanation of Jennifer's question –

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Jennifer: Can we sustain financially paying old claims and current premium costs?

D.Betts: Isn't that what we're doing now?

Peter: We designed the traditional and Lite PPO Plans; there is plan design flexibility with Kaiser but the JPA limited flexibility with plan design. How would change effect retirees? Funding? Currently self-funded. Stop loss? Is that available? Affordable Care Act how would that impact? Would be later determined.

#### MEETING CONCLUSION

Next Meetings December and January; continued topics; Kaiser renewal status KAISER RENEWAL STAUS.

Meeting notes as well a presentation are on the Benefits website.

OPEN TO QUESTIONS:

END