Employee Benefits Committee
Standard Operating Procedures

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Introduction

In every conversation we have, every initiative we explore, and every action we take, we must hold them up against the PRISM Mission, Vision and Core Values. Together, the Mission, Vision and Core Values are our strategic framework and clarify why PRISM exists and what we aim to be. As you review this document, please keep these in mind:

Mission:

PRISM is a member-directed risk sharing pool of public agencies committed to providing risk coverage programs and risk management services, which drive member stability, efficiency, and best practices.

Vision:

PRISM will continue to be internationally recognized as a leading risk sharing pool for its member-directed operating philosophy and commitment to member fiscal sustainability. PRISM will continue to influence and shape the future of the risk management profession.

Core Values:

PRISM is dedicated to preserving a member-directed culture, defining standards for quality and performance throughout the industry, and ensuring programs and services are:

- **C**ompetitive in scope and price over the long term
- **A**daptable and customized to meet member needs, based on high-quality standards
- **R**esolute in delivering timely solutions that address present and emerging risks
- **E**quitable in allocating costs and services between various members in a fair and consistent manner
- **S**table in supporting cost-effective, fiscally prudent operations *and* long-term solvency, and in building long-term relationships with members and program/service partners.

Composition

The Committee is comprised of 9 members that participate in the Employee Benefits Programs, of which 7 are voting members and 2 are alternates who are eligible to vote at any meeting where a voting member is absent. One of the voting seats is designated for a Public Entity representative. The majority of the Committee members must participate in the Dental Program.

Reference: Committee Composition

Roles

Committee:

Pursuant to the Bylaws, the Employee Benefits Committee is responsible for all matters pertaining to the Miscellaneous Employee Benefits Programs, which consist of Vision, Life Insurance, Disability Insurance, and Employee Assistance Program (EAP). Pursuant to the Dental Program Memorandum of Understanding (MOU), the Employee Benefits Committee is responsible for all matters affecting the Dental Program. This includes but is not limited to approval of renewals, premium allocations and new member applications. The Committee reports their activities to the Executive Committee and Board of Directors for informational purposes.

From time to time, the Committee may consider contracting with outside parties for services. PRISM's Executive Committee has adopted a Service Provider Contracting Policy which outlines the process for competitive bidding as well as protocols and authorities for entering into such contracts. The Employee Benefits Committee is responsible for determining whether a competitive selection process should be used for procurement of any new member service offerings or a new service provider for an existing member service in excess of $50,000. Any renewal contract must go to the Committee for approval of the vendor and the amount to be expended.

The Employee Benefits Committee has oversight of the following contracts:

- Alliant Dental Scope of Services - Addendum to the Alliant Agreement
- Miscellaneous Scope of Tasks - Addendum to the Alliant Agreement
- Ameritas – Dental Service Provider
- Delta Dental of California - Dental Service Provider
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- Benefit Coordinators Corporation (BCC) – Dental and Vision TPA
- EyeMed – Vision Service Provider
- Vision Service Plan (VSP) - Vision Service Provider
- Lincoln Financial - Life and Disability Service Provider
- Voya Financial - Life and Disability Service Provider
- Anthem - EAP Provider
- Concern – EAP Provider
- Turner Consulting - Dental Actuarial Services

Reference: Service Provider Contracting Policy

Chair:

- Call/authorize meeting to be scheduled
  - Staff will contact Chair to arrange date, time, location (in-person or WebEx)
  - Once authorized, staff will notify the Committee members via e-mail
- Call the meeting to order
- Orchestrate agenda items
- Recognize members to facilitate orderly debate
- Preside over voting
- Enforce rules of the group
- Expedite the business of the group
- Declare meeting adjournment
- Attend the PRISM's Annual Strategic Planning Retreat
- Conduct meetings according to Robert's Rules of Order and the Brown Act

Vice Chair:

- Assume the responsibilities of the Chair in their absence.

Staff:

- Assist Chair in facilitating meeting, preparing agenda, taking minutes, summarizing meetings for those not in attendance
- Advisory to the Committee
- Will make recommendations to assist Committee
- Execute Committee's directions
- Sidney DiDomenico is the staff liaison for the Employee Benefits Committee.

Broker:

- Advisory to the Committee
- Will make recommendations to assist Committee

Reference: 1/1/18 Alliant Contract – Dental Scope of Tasks
Reference: 1/1/18 Alliant Contract – Misc. Scope of Tasks

Consultants:

PRISM utilizes consultants for various services, including but not limited to actuarial, legal advice, third party claims administration, and underwriting. Their role is:

- Advisory to the Committee
- To offer recommendations to assist Committee

Program Responsibilities

Claims Administration:

The Employee Benefits Committee is responsible for oversight of the program vendors and ensures that claims are being administered properly and efficiently. There is currently 2 approved dental vendors: Ameritas and Delta Dental of California. These vendors were selected due to their ability to offer some of the deepest provider discounts, as well as offering a statewide network. In addition to the California network, Ameritas and Delta Dental are available throughout the United States.

The Committee has no responsibility for claims administration for the Vision, EAP, Life and Disability Programs, as these programs are either fully insured, or the members have a direct self-funded contract with the vendor.

Coverage Matters:

Currently, the vendors are responsible for coverage matters for the members within the programs. The vendors interpret the coverage based on each member's Evidence of Coverage or Plan Summary. If a covered employee or dependent has a dispute with the way a claim was handled, they must file an appeal with the vendor. The vendor must respond to the appeal in a timely manner with either an approval or denial.

Approval of New Members:

There are 3 Dental Program segments in which a member can elect to participate: Fixed-Rate PPO Segment, DHMO Segment and standalone Self-Insured.

The Employee Benefits Committee approves all new members over 250 eligible employee/retiree lives that want to participate in the Fixed-Rate PPO segment. The Employee Benefits Committee works with Alliant and the dental program providers for underwriting services for all prospective members. Alliant and the dental program providers review all of the data provided by the prospective member and provide the Committee with their recommendations for approval into the Fixed-Rate PPO segment.

The Committee has delegated authority to staff to approve all new members under 250 lives into the Fixed-Rate PPO segment, the DHMO segment, and all standalone Self-Funded members. Staff approves all new members for the Vision, EAP, and Life and Disability Programs and provides reports of updated membership to the Employee Benefits Committee.

The Committee has approved the Employee Benefits Underwriting Guidelines for the Dental and Miscellaneous Program members that outlines the general criteria applicable to the approval of new program members and the delegated authority of staff and Alliant.

Reference: Employee Benefits Underwriting Guidelines 2/17/2022

Memorandum of Understanding:

The Employee Benefits Committee oversees the provisions of the Dental Program MOU and will approve changes as needed.

Reference: Dental Program MOU 4/9/19

Coverage Documents:

Each member is responsible for determining their plan designs and the Committee does not approve member specific plan updates/changes. If a member wants to change any provisions to the coverage provided, they request a quote from Alliant. It is then up to the member to determine if they want to make a change.

The program vendors (Ameritas, Delta Dental of California, VSP, Eyemed, Voya, Lincoln Financial, Concern and Anthem) are responsible for issuance of the coverage and plan documents to the members. Alliant works with the program vendors and members to ensure the coverage documents are issued correctly.

The Committee has approved the Employee Benefits Administrative Guidelines for the Dental and Miscellaneous Programs that provide guidance in addressing eligibility, mid-year qualifying events, dependent definitions, and claims. This document is meant to be an outline for Program Administration and will be reviewed by the Committee as needed.

Reference: Employee Benefits Administrative Guidelines 2/17/2022

Premium Allocation Methodologies:

The Committee oversees the provisions of the Dental Program premium allocation methodologies and may approve changes from time to time. Initial premiums upon entry into the Program are set by the dental program providers, in consultation with the Committee, actuaries, and consultants.

The Committee has authority to:

- Approve premium deviations from the standard allocation methodologies
- Declare dividends and assessments
- Direct use of Program Stabilization Funds

At renewal, Alliant reviews claims data in addition to financial information and recommends premium adjustments for the Dental Program. The population

enrolled in the PRISM Dental Program is divided by enrollment into three segments, each underwritten on its own merit:

1. Under 250 participants: Fully pooled renewal where all members are rated together and all receive the same renewal rate change.
2. 250 to 1,000 participants: Partially pooled renewal where all members are rated together, but may receive renewal rate changes different from the pool average based on their own claim experience.
3. 1,000 + participants: Renewal rates based on own claims experience.

In addition, Fixed-Rate PPO program members of any size who have Legacy Premium Stabilization funds on account are rated separately from the main renewal pool until these reserves have been completely exhausted. The Committee has adopted a policy statement, referenced below, that defines and outlines the use of the Dental Program Premium Stabilization funds.

Reference: Dental Program Premium Stabilization Fund Policy 12/18/19

In addition to the Dental Program, the Committee also oversees the premium allocation for the EAP and Life and Disability Programs. The Committee is responsible for making decisions related to the use of the stabilization funds, if available.

Reference: Life and LTD Stabilization Fund Policy Statement 4/30/07

Dental Financials:

Throughout the year, the Committee reviews the Dental Income Statement of the Fixed-Rate pooled segment of the Dental Program. This financial report includes a review of revenue and expense related to the program with an account for unrestricted equity, if applicable. This is done in order to monitor program performance and review potential premium surplus primarily related to the Fixed-Rate PPO program segment.

In 2014, the Committee requested an actuarial study be conducted in order to set an appropriate program Incurred but Not Reported (IBNR) liability and incorporate a Claims Fluctuation Margin (CFM) into the financials. In doing so, the Committee created and adopted the Target Funding Guidelines, referenced below, that would ensure that there is a sufficient portion of program equity being allocated to program liabilities and reserves, with the remaining portion being referred to as program surplus. The Committee has established within the guidelines the methodology for determining surplus and mandated that the IBNR and CFM be updated on a biannual basis.

Reference: PRISM Dental Target Funding Guidelines 12/18/19

Program Services & Administrative Costs for Dental Program:

The Committee is responsible for overseeing the administrative expenses of the Dental Program and determines how the costs will be allocated amongst the

members. They also evaluate and approve the TPA fees and contract terms and develop program budget policies that outline the long and short term goals of the Employee Benefits programs. The following are the current administrative costs (or fixed costs) associated with the Program:

Eligibility TPA Services:

The Program currently contracts with 1 eligibility vendors (BCC). The current fees for BCC is $1.60 per employee, per month for pooled members, and $.75 per employee, per month for self-funded members.

Carrier Provider Services:

The Program currently contracts with 2 carriers (Ameritas and Delta Dental of California). These dental program providers provide the following basic services: provider network, adjudication of all dental claims, and coverage documents. The current Delta Dental fee is set at 6.7% of total claims incurred and the Ameritas fee structure is as follows:

Enrolled Lives	Fee per Covered Person per month
50-250	$4.75
251-999	$3.80
1000+	$3.00

Alliant Fee:

Alliant charges a fee based upon the size of the member entity and the program in which the member participates. For members that are self-funded, Alliant's compensation is capped at 3%. For pooled members, the commission is capped at 7%.

The Committee is also responsible for overseeing the administrative expenses of the Program and determining how those costs will be allocated amongst the members. Budget Policies are annually reviewed by the Committee in advance of the budget being developed for adoption by the Board. The Committee may make changes from time to time.

Reference: 2023 Employee Benefits Program Budget Policies
Reference: 2023 Miscellaneous Program Budget Policies

Meetings

Scheduling:

The Employee Benefits Committee schedules tentative meeting dates at the beginning of each calendar year. Those dates can be changed or additional meetings can be called by the Chair. Below are generally when the Committee will meet to address certain matters:

- **February/May**
  - Program Renewals
  - Member Statistics
  - New Member Applications
- **July/September**
  - General Business
  - New Member Applications
- **October/December**
  - New Member Applications
  - Strategic Planning

Quorum

Pursuant to the Bylaws, a quorum consisting of a majority of the Committee (at least 4 members) must be present in order to conduct a meeting.

Voting Requirements

Pursuant to the Bylaws, the voting requirement is a majority of the Committee (at least 4 members) for all actions of the Employee Benefits Committee.

Code of Conduct/Ethics Policy:

The Board has adopted a Code of Conduct which is applicable to all members, staff, Committees, and the Board.

Reference: Code of Conduct

Conflicts

Pertinent PRISM Code of Conduct Provisions:

1. We are committed to the concepts of democratic, effective and efficient governance by responsible, knowledgeable members of the Board of Directors and Committees with an understanding that official decisions made and actions taken by PRISM are always made in the best interests of PRISM's membership, as opposed to the interests of PRISM's staff, service providers, or other outside interests.

2. We are committed to the principle that conflicts of interest, (defined as situations in which a person has a financial or other interest or the appearance of a conflicting interest that would call into question the person's ability to act in an impartial manner with respect to a matter affecting PRISM) should be avoided, and, where present, shall be fully disclosed. This includes situations when a member of the Board, a Committee, staff, or vendor has personal interests (including those of his/her family) that are contrary to his/her loyalty to PRISM).

Vote on behalf of PRISM or the Entity I Represent?

Attorney General Opinion No. 00-708 dated 12/8/00 concluded that a member of the governing board (in this case the Employee Benefits Committee) of a joint powers agency may cast a valid vote on a matter before the agency that is inconsistent with the position by the legislative body which appointed the member.

Reference: Attorney General Opinion No. 00-708

Voting When Conflict Arises:

According to FPPC:

- Disqualification
  - For financial interest (exception when action required)
- Abstention
  - Conflicting loyalties
  - Perception you can't be fair
  - Ethical dilemmas (exception for necessity to take action)

According to Roberts Rules of Order:

- Duty to vote if you have an opinion
- Right to abstain
- Personal interest - must abstain except
  - Vote for self in an election
  - Vote if other's interests are included in the motion

Glossary of Terms

Administrative Services Only (ASO): An arrangement under which an insurance carrier or an independent organization will handle the administration of claims, benefits, and other administration functions for a self-insured group, but does not assume any financial risk for the payment of benefits.

Balance Bill: Refers to the leftover sum that a provider bills to the patient after insurance has only partially paid the charge that was initially billed.

Calendar Year Deductible: The dollar amount for covered services that must be paid during the calendar year (January 1st – December 31st) by members before any benefits are paid by the plan.

Claim Fluctuation Margin: A reserve meant to manage unfavorable claim years through use of surplus funds set aside for claims fluctuation.

COBRA - Consolidated Omnibus Budget Reconciliation Act of 1986: Federal legislation that includes a requirement for groups with 20 or more employees to offer extended dental insurance coverage, at the member's expense, to members and eligible dependents that leave the group or are otherwise no longer eligible for the group's coverage.

Coinsurance: An arrangement under which the member pays a fixed percentage of the cost of dental care after the deductible has been paid. For example, an insurance plan might pay 80% of the allowable charge, with the member responsible for the remaining 20%, which is then referred to as the coinsurance amount.

Coordination of Benefits (COB): Contractual provision which reduces the benefits under one contract to the extent that those benefits are available under a second contract. The purpose is to prevent double payment for one service.

Deductible: An amount the covered person must pay before payments for covered services begin. The deductible is usually a fixed amount. For example, an insurance plan might require the insured to pay the first $50 of covered expense during a calendar year.

Dependent: Person, (spouse or child), other than the subscriber who is covered under the subscriber’s benefit certificate.

Enrollee: An individual who is enrolled and eligible for coverage under a dental plan contract. Also known as the "insured."

Explanation of Benefits (EOB): A form sent to the covered person after a claim for payment has been processed by the carrier that explains the action taken on that claim. This explanation might include the amount that will be paid, the benefits available, reasons for denying payment, or the claims appeal process.

Incurred but not reported (IBNR): This is an accounting estimate used by dental plans to accrue for care that was provided (“incurred”) in one accounting period, but not paid or “reported” until another accounting period.

In-Network: Refers to the use of providers who participate in the carrier’s provider network. Many benefit plans encourage covered persons to use participating (in- network) providers to reduce the individual’s out of pocket expense.

Non-Participating Provider: A dental provider who has not contracted with a particular dental plan within its participating provider network. The member is responsible for the total charge for services rendered.

Out-Of-Network: The use of dental care providers who have not contracted with the carrier to provide services.

Plan Allowance (Amount of Allowable Charge): The maximum dollar amount a contract allows for services covered, regardless of the provider's actual charge. A provider who participates in the network cannot charge the member more than this amount for any covered service.

Third Party Administrator (TPA): A third party administrator is an organization that processes or manages certain aspects of employee benefits administration, such as, billing, eligibility maintenance and claims processing.