AGENDA
CONTRA COSTA COUNTY SCHOOLS INSURANCE GROUP
HEALTH BENEFITS COMMITTEE MEETING
March 13, 2015
10:00 A.M - 12:00 P.M

CCCSIG Conference Room
550 Ellinwood Way
Pleasant Hill, CA 94523
1 (866) 922-2744

I. CALL TO ORDER

II. ROLL CALL & INTRODUCTIONS
Bylaws of the Contra Costa County Schools Insurance Group I.G.4. Quorum. A majority of each Committee membership shall constitute a quorum for the transaction of business except that less than a quorum may adjourn from time to time.

Member Districts = 9
Number required to achieve a quorum = 5

CCCSIG:
Contra Costa County Schools Insurance Group Bridget Moore, Executive Director

MEMBERS:
Brentwood Union School District Margaret Kruse, Committee Chair
Brentwood Union School District Debbie Valladao, Alternate
Byron Union School District Wendy Richard
Byron Union School District Bev Nicolaisen, Alternate
Canyon School District Gloria Faircloth
Castro Valley Unified School District Candi Clark
Castro Valley Unified School District Robin Yearby, Alternate
Lafayette School District Lenee Cadotte, Vice Chair
Lafayette School District Barbara Davis, Alternate
Moraga School District Kathy Bell
Moraga School District Courtney Avellar, Alternate
Oakley Union Elementary School District Michele Gaudinier
Oakley Union Elementary School District Cindy Peterson/Tammi Lauderdale, Alternates
St. Helena Unified School District Vacant
St. Helena Unified School District Jamie Brewer, Alternate
Walnut Creek School District Kevin Collins
Walnut Creek School District Cindy Lannon, Alternate

CONSULTANTS
Keenan & Associates Debra DeSpain
Keenan & Associates Vickie Vales
Keenan & Associates Cecilia Martinez
III. PUBLIC COMMENTS
Comments from the general public will be received and limited to five minutes per person.

IV. APPROVAL OF AGENDA
2015-018
Action
The Committee retains the right to change the order in which agenda items are discussed. Subject to review by the Committee, the agenda is to be approved as presented. Items may be deleted or added for discussion only according to G.C. Section 54954.2.

V. APPROVAL OF MINUTES – February 20, 2015
2015-019
Action
The Committee will review the minutes of the last Committee meeting for any adjustments and adoption.

VI. CORRESPONDENCE
2015-020
Information
Correspondence will be presented and reviewed by the Committee. No action may be taken in response; only referred for action on a subsequent agenda.

VII. UNDERWRITING
2015-021
Information
PREMIUM AND CLAIMS REPORT
The Premium and Claims Reports for the Health & Welfare Program are presented on a quarterly basis.

VIII. ADMINISTRATION/HEALTH BENEFIT PROGRAM ADMINISTRATIVE UPDATE

Medicare Information
2015-022
Information

ACA – Cadillac Tax, Checklists
2015-023
Information

IRS 6055, 6056 Reporting
2015-024
Information

Preliminary 2016 Renewal Discussion
2015-025
Information

Cafeteria Pre-Tax Employee Contribution Requirements
2015-026
Information

IX. INFORMATION

MEMBER COMMENTS
Information
Each member may report about various matters involving the Committee. There will be no Committee discussion except to ask questions, and no action will be taken unless listed on a subsequent agenda.
CONSULTANT COMMENTS

The Consultant will report to the Committee about various matters involving the Committee. There will be no Committee discussion except to ask questions, and no action will be taken unless listed on a subsequent agenda.

LEGISLATIVE UPDATE/BRIEFING

The Consultant will present Legislative Updates/Briefings/Articles of Interest to the Committee.

X. AGENDA ITEMS NEXT MEETING

Members and others may suggest items for consideration at the next meeting tentatively scheduled for April 10, 2015.

XI. ADJOURNMENT

Americans with Disabilities Act:
Contra Costa County Schools Insurance Group conforms to the protections and prohibitions contained in Section 202 of the Americans with Disabilities Act of 1990 and the federal rules and regulations adopted in implementation thereof. A request for disability-related modifications or accommodation, in order to participate in a public meeting of the Contra Costa County Schools Insurance Group, shall be made to: Bridget Moore, Executive Director, Contra Costa County Schools Insurance Group - 550 Ellinwood Way, Pleasant Hill, CA 94523 - 1 (866) 922-2744.
CONTRA COSTA COUNTY SCHOOLS INSURANCE GROUP

HEALTH BENEFITS COMMITTEE MEETING
AGENDA ITEM DETAIL

PRESENTED TO: Health Benefits Committee

DATE: March 13, 2015

SUBJECT: Approval of Agenda

ITEM #: 2015-018

Enclosure: Yes

ACTION

Category: Approval of Agenda

Prepared by: Keenan & Associates

Requested by: Health Benefits Committee

BACKGROUND:

Under California Government Code Section 54950 the “Legislative Body” is required to post an agenda detailing each item of business to be discussed. The Committee posts the agenda in compliance with California Government Code Section 54954.2

STATUS:

Unless items are added to the agenda according to Government Code 54954.2 (b) (1) (2) (3), the agenda is to be approved as posted.

RECOMMENDATION:

Subject to changes or corrections, the agenda is to be approved.
### CONTRA COSTA COUNTY SCHOOLS INSURANCE GROUP

**HEALTH BENEFITS COMMITTEE MEETING**

**AGENDA ITEM DETAIL**

<table>
<thead>
<tr>
<th>PRESENTED TO:</th>
<th>DATE:</th>
<th>March 13, 2015</th>
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<tbody>
<tr>
<td>Health Benefits Committee</td>
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<thead>
<tr>
<th>SUBJECT:</th>
<th>ITEM #:</th>
<th>ACTION</th>
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<tr>
<td>Approval of Minutes – February 20, 2015</td>
<td>2015-019</td>
<td>Enclosure: Yes</td>
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</table>

**Category:** Approval of Minutes

**Prepared by:** Keenan & Associates

**Requested by:** Health Benefits Committee

### BACKGROUND:

As a matter of record and in accordance with the Brown Act, minutes of each meeting are kept and recorded.

### STATUS:

Included in the agenda packet are minutes from the February 20, 2015 meeting, which have not yet been approved.

### RECOMMENDATION:

Subject to changes or corrections, the minutes of the February 20, 2015 meeting are to be approved as submitted.
MINUTES
CONTRA COSTA COUNTY SCHOOLS INSURANCE GROUP
HEALTH BENEFITS COMMITTEE MEETING
February 20, 2015
10:00 A.M - 12:00 P.M

CCCSIG Conference Room
550 Ellinwood Way
Pleasant Hill, CA 94523
1 (866) 922-2744

I. CALL TO ORDER
The meeting was called to order by Margaret Kruse at 10:07 A.M.

II. ROLL CALL & INTRODUCTIONS
Bylaws of the Contra Costa County Schools Insurance Group I.G.4. Quorum. A majority of each Committee membership shall constitute a quorum for the transaction of business except that less than a quorum may adjourn from time to time.

With guest speakers present at today’s meeting, introductions were made.

Member Districts = 9
Number required to achieve a quorum = 5

Those in attendance were:

CCCSIG:
Contra Costa County Schools Insurance Group Bridget Moore, Executive Director

MEMBERS:
Brentwood Union School District Margaret Kruse, Committee Chair
Byron Union School District Wendy Richard
Castro Valley Unified School District Robin Yearby, Alternate
Lafayette School District Barbara Davis, Alternate
Moraga School District Kathy Bell
Oakley Union Elementary School District Cindy Peterson, Alternate
Walnut Creek School District Kevin Collins/Cindy Lannon

ABSENT:
Canyon School District Gloria Faircloth
St. Helena Unified School District Jamie Brewer, Alternate

CONSULTANTS
Keenan & Associates Debra DeSpain
Keenan & Associates Vickie Vales
Keenan & Associates Cecilia Martinez
III. PUBLIC COMMENTS
There were no public comments.

IV. APPROVAL OF AGENDA

A motion was made by Kathy Bell, seconded by Robin Yearby and unanimously carried to approve the Agenda as presented. Votes:

- Brentwood – Aye
- Byron – Aye
- Canyon – Absent
- Castro Valley – Aye
- Lafayette – Aye
- Moraga – Aye
- Oakley – Aye
- St. Helena - Absent
- Walnut Creek – Aye

V. APPROVAL OF MINUTES – January 9, 2015

A motion was made by Kevin Collins, seconded by Kathy Bell and unanimously carried to approve the minutes as presented. Votes:

- Brentwood – Aye
- Byron – Aye
- Canyon – Absent
- Castro Valley – Aye
- Lafayette – Aye
- Moraga - Aye
- Oakley - Aye
- St. Helena - Absent
- Walnut Creek – Aye

Kevin asked about the question presented at the January meeting regarding the requirements for a quorum/vote on the minutes. Bridget Moore had researched Brown Act and Roberts Rules and found as long as there is a quorum for the meeting, the voting members do not have to have been in attendance at the previous meeting to approve the minutes.

Debra DeSpain confirmed she checked with Keenan’s legal staff and received the same information.

VI. CORRESPONDENCE

There was no correspondence received for this meeting.

VII. UNDERWRITING

PREMIUM AND CLAIMS REPORT

This was not applicable for this meeting.

VIII. ADMINISTRATION/HEALTH BENEFIT PROGRAM ADMINISTRATIVE UPDATE

Kaiser Permanente Periodic Utilization Report

Jason Douglass, Senior Account Manager – Public Sector, reviewed the Periodic Utilization Report for the period 10/1/2013 – 9/30/2014 as compared to 10/1/2012 – 9/30/13.
Jason highlighted the group’s inpatient, outpatient and pharmacy data. The overview of the total per member per month (pmpm) was a 9.9% increase with 10/12-9/13 pmpm of $405.02 to 10/13-9/13 pmpm of $445.14. In addition, Jason reviewed the top 10 DRG (Diagnosis Related Group) inpatient claims and inpatient claims by MDC (Medical Diagnostic Category). The outpatient overview shows a 13.1% increase in outpatient pmpm primarily due to outpatient surgical procedures. There was also an increase of 19.1% in emergency room visits. Jason provided two (2) flyers to the committee – My Health Manager and Telephonic Appointments - that the committee members can submit to their Kaiser members to provide additional options to reach out for care. Keenan will forward these flyers to the committee members in soft copy.

Jason pointed out there has been a large decrease in the brand non-formulary and generic non-formulary drug categories. Reasons for this could be:

1. Non-formulary drugs moving into the formulary category
2. Members changing to a formulary drug
3. Members no longer using a specific non-formulary drug

Jason also pointed out there is continued use of a very strong pain medication, Oxycontin. He wanted to let the committee know that even though this is a severe drug, there are strict protocols in prescribing the medication and for refills.

Jason also reviewed the High Cost Claimant list. The JPA has a $240,000 pooling point. This means that when incurred claims go over the pooling point, the amount over the pooling point is credited back to the group at renewal and not counted against the total claims. Jason checked on the status of high cost claimants and found claimant #1 has had no further claims incurred since November 2014. Claims for the next few members are ongoing; however, total claims are decreasing.

Jason stated that he discussed the upcoming 2016 renewal with the Kaiser underwriter to get a sense/opinion of the renewal. The trend factors used for the 2015 renewal were 3% for medical and 3.5% for pharmacy. Kaiser expects their trends to continue in that range for future renewals. The dates of service used for the renewal will be the 2014 calendar year. Per Jason and the underwriter, it would most likely not be a decrease for 2016, but should be very favorable.

Kevin Collins asked why the JPA statistics are higher than Kaiser’s overall statistics. Both Jason and Debra replied it could be for several reasons, i.e., age, gender and utilization. School districts typically have more female employees, older workers, etc. In addition, this is a comparison of the CCCSIG JPA utilization to Kaiser’s entire book of business which includes public and private sector clients.

**Anthem Blue Cross – Wellness Website, Time Well Spent 2015-015 Information**

Therese Nielsen provided an update and information relating to the cyber attack. She reviewed the protection services Anthem is providing to all potentially affected members through All Clear. The services will include Identity Theft Monitoring, Lost Wallet Protection, Identify Theft Insurance, Credit Monitoring, and Child Scan Monitoring for a period of 2 years.

Therese also provided a demonstration of their Time Well Spent website and Employer Quick Connect tools.
Debra suggested we look at some of the tools Anthem can provide and discuss how they can best be used by the districts.

2014 CCCSIG HBC Member Survey Results

Bridget Moore reviewed the Member Survey results with the members noting all the results were positive. There was one (1) positive comment of appreciation to Debra. The questions around health care reform were rated very well at 4.40 out of 5.00.

In response to the request for additional information on healthcare reform, Debra recommended to include as an ongoing agenda item.

A motion was made by Wendy Richard, seconded by Cindy Lannon and unanimously carried to approve the Broker Survey as presented. Votes:

- Brentwood – Aye
- Byron – Aye
- Canyon – Absent
- Castro Valley – Aye
- Lafayette – Aye
- Moraga - Aye
- Oakley - Aye
- St. Helena - Absent
- Walnut Creek – Aye

IX. INFORMATION

MEMBER COMMENTS

Oakley, Brentwood and Byron all provided opinions of their recent CECHCR trainings. The first day was very good and full of good information. However, the second day was very sales pitchy and made the attendees uncomfortable. Margaret Kruse sent CECHCR a lengthy email about how uncomfortable everyone was with the second day and the sales pitch.

Barbara Davis, Lafayette, has informed the committee they have signed a three-year contract for the Second Opinion program. The formal proposal is due to Lafayette approximately June 2015.

Kevin Collins asked about the requirements for districts to have employees sign a form every year about their pre-tax contributions. AFA is telling them this is mandatory and they can do it for them but will have to meet with each employee. It was agreed to discuss this further at the next Committee meeting.

CONSULTANT COMMENTS

Debra informed the committee Keenan has started the renewal process. Vickie has requested a census file from everyone and if not completed to please return it as soon as possible.

In light of the Anthem Blue Cross cyber attack, Debra informed the committee that Keenan has examined their security protocols and are confident there is good security and data protection.

Debra has been working on a Medicare readiness document for Walnut Creek. She asked if the group would be interested in having additional education around Medicare. The committee agreed they would be interested. This will be added to a future agenda.
Debra reminded the Committee that the Keenan Annual Summit is coming up next month. She stated that last year’s Annual Summit was well received and this year’s Summit should be very informative. Debra also let the Committee know that Union members and benefit committee members are also welcome.

**LEGISLATIVE UPDATE/BRIEFING**

Debra DeSpain reviewed the enclosed briefing, Health Care Reform: Excise Tax On High-Cost Employer Health Plans. Keenan has created a Cadillac tax calculation tool, which will be reviewed at the March meeting.

**X. AGENDA ITEMS NEXT MEETING**

Agenda items for the next meeting scheduled for March 13, 2015:

1. Medicare Information
2. ACA - Cadillac Tax, checklists
3. IRS 6055/6056 Reporting
4. Preliminary Renewal Discussion
5. Cafeteria Pre-Tax Employee Contribution Requirements

**XI. ADJOURNMENT**

Margaret Kruse adjourned the meeting at 12:00 P.M.

**Americans with Disabilities Act:**

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CONTRA COSTA COUNTY SCHOOLS INSURANCE GROUP

HEALTH BENEFITS COMMITTEE MEETING
AGENDA ITEM DETAIL

PRESENTED TO: Health Benefits Committee

DATE: March 13, 2015

SUBJECT: ITEM #: 2015-020
Correspondence

Enclosure: No

INFORMATION

Category: Correspondence
Prepared by: Keenan & Associates
Requested by: Health Benefits Committee

BACKGROUND:

Communications received by, or sent on behalf of, the Committee is presented to the Committee. These communications are normally informational in content and no action is required except to acknowledge receipt.

STATUS:

There was no correspondence received for this meeting.

RECOMMENDATION:

For review and information only.
CONTRA COSTA COUNTY SCHOOLS INSURANCE GROUP

HEALTH BENEFITS COMMITTEE MEETING
AGENDA ITEM DETAIL

PRESENTED TO: Health Benefits Committee

DATE: March 13, 2015

SUBJECT: Premium and Claims Report

ITEM #: 2015-021

INFORMATION

Enclosure: No

Category: Underwriting

Prepared by: Keenan & Associates

Requested by: Health Benefits Committee

BACKGROUND:
The Premium and Claims Reports for the Health & Welfare Program are presented on a quarterly basis.

STATUS:
Not applicable for this meeting.

RECOMMENDATION:
For review and information only.
CONTRA COSTA COUNTY SCHOOLS INSURANCE GROUP

HEALTH BENEFITS COMMITTEE MEETING
AGENDA ITEM DETAIL

PRESENTED TO: Health Benefits Committee

DATE: March 13, 2015

SUBJECT: Medicare Information

ITEM #: 2015-022

INFORMATION

Category: Administration/Health Benefit

Program Administrative Update

Prepared by: Keenan & Associates

Requested by: Health Benefits Committee

BACKGROUND:

Keenan created a Medicare Informational flyer for Walnut Creek School District. During the February 20 HBC meeting, the committee confirmed they would like educational information surrounding Medicare.

STATUS:

Keenan will present an overview of Medicare and the Medicare Readiness document.

RECOMMENDATION:

For review and discussion, as necessary.
CONTRA COSTA COUNTY SCHOOLS INSURANCE GROUP

HEALTH BENEFITS COMMITTEE MEETING
AGENDA ITEM DETAIL

PRESENTED TO: Date: March 13, 2015
Health Benefits Committee

Subject: Item #: 2015-023
ACA – Cadillac Tax, Checklists
Enclosure: Yes

Category: Information

Prepared by: Keenan & Associates

Requested by: Health Benefits Committee

BACKGROUND:
The Health Care Reform Excise Tax on High-Cost Employer Plans (Cadillac Tax) was delayed in 2010 to 2018. To date regulations regarding the Excise tax has not been released.

STATUS:
Keenan will discuss the status of the Excise Tax (Cadillac Tax) as it stands currently. In addition, Keenan will present a Health Care Reform Planning and Implementation Tool.

RECOMMENDATION:
For review and information only.
ONE of the most hotly debated provisions of the Affordable Care Act (ACA) is the addition of Section 4980I to the Internal Revenue Code (IRC), which imposes a 40 percent Excise Tax (also called the “Cadillac Tax”) on high-cost employer health plans. Although the Excise Tax will not be imposed until 2018, it may have a substantial effect on the cost of employer-sponsored health plans; therefore, employers should take steps now to evaluate and minimize the potential impact of the tax on their benefits programs.

To date, the Department of the Treasury has not issued regulations or guidance on IRC Section 4980I and, as a result, there are quite a few open questions about how IRC Section 4980I will apply in practice. This Briefing lays out what we currently know based on the statutory language along with some possible strategies for minimizing the impact of the tax.

BACKGROUND

The purpose of the Excise Tax is threefold: (1) to help fund the costs of the ACA, (2) to assist with slowing the rate of growth of health care costs, and (3) to address the unequal tax treatment of employer-sponsored health coverage. Many proponents of the Excise Tax believe that “rich” benefits shield employees from the true cost of health care and encourage the overutilization of health care services. They also argue that excluding the value of employer-provided health coverage from an employee’s taxable income results in unequal tax treatment that favors higher income employees with high-cost employer plans. This is because employees with higher incomes get a larger tax break than lower income employees with low-cost health plans. It is estimated that the current income tax exclusion for individuals with employer provided health coverage “costs” the government approximately $250 billion annually. Any attempt to eliminate the income tax subsidy would be met with extreme opposition, so the Excise Tax is viewed by the drafters of the ACA as a reasonable compromise. Most affected employers and their employees would probably disagree.

WHO IS LIABLE FOR THE TAX?

The Excise Tax applies to fully insured and self-funded plans for both active employees and retirees. For fully insured plans, the insurer will pay the tax on its share of the “excess benefit.” Although there is no requirement for insurers to pass on the cost of the tax to employers, it is certainly expected that they will do so. For self-funded plans, IRC Section 4980I(c)(2)(c) states that “the person that administers the plan benefits” will be liable for the tax, but the term is not clearly defined. It is likely that it will be the plan sponsor (usually the employer) who is liable for the tax.

Note: The tax is non-deductible for federal income tax purposes.

CALCULATING THE TAX

The Excise Tax is 40 percent of the aggregate cost of health care benefits over certain dollar thresholds (also called the “excess benefit”). The initial thresholds for 2018 are $10,200 for self-only coverage and $27,500 for family coverage (i.e. any coverage tier other than self-only). The Excise Tax applies to the aggregate cost above
the tax thresholds. For example, if the cost for self-only coverage is $12,000, the tax would be 40 percent multiplied by $1,800 ($12,000 – $10,200) or $720 per covered employee.

The plan costs include the core medical benefits, prescription drugs and “carve-out” plans such as Behavioral Health, Employee Assistance Programs, chiropractic, as well as onsite medical clinics that provide significant benefits in the nature of medical care or treatment. The statutory language excludes fully insured stand-alone dental and vision plans but it is unclear whether the exclusion will also extend to self-funded plans. It is anticipated that regulatory guidance will address this question.

The cost of coverage includes employer contributions for medical benefits and employee contributions. In addition, employer and employee contributions to health Flexible Spending Accounts (FSAs), Health Reimbursement Accounts (HRAs) and Health Savings Accounts (HSAs) are included. Deductibles and copays are not included in the cost calculation.

ADJUSTMENTS TO THE ANNUAL LIMITS

There are several adjustments that may be made to the annual threshold limits. For pre-65 retirees and individuals in high-risk professions (e.g. law enforcement, fire protection and construction), the thresholds are higher. The expected 2018 limits for these individuals are $11,850 for self-only coverage and $30,950 for family coverage. In addition, multi-employer plans (e.g. a Taft-Hartley plan) may apply the $27,500 limit to all tiers, including self-only coverage. This exception does not apply to Joint Powers Authority programs (JPAs) since they are not multi-employer plans as defined under the Employee Retirement Income Security Act of 1974 (ERISA). In addition, the following adjustments will be made either to the initial 2018 thresholds or on an ongoing annual basis:

Health Cost Adjustment – For 2018, the Excise Tax thresholds will be adjusted upwards if the cost of the federal Blue Cross/Blue Shield (BCBS) standard benefit in 2010 increases by more than 55 percent from 2010 to 2018. However, the cost increases for the federal BCBS plan have been minimal since 2010, so it appears unlikely that the 55 percent increase threshold will be met. Therefore, the $10,200 and $27,500 limits are likely to hold for 2018.

Age and Gender Adjustment – For 2018 and beyond, the annual dollar limits will be adjusted to account for age and gender. The adjustment will not be a percentage but rather a dollar amount that will be added to the annual limit. It is anticipated that the Department of the Treasury will provide guidance on this adjustment in the form of tables or formulas.

Consumer Price Index Adjustment – In 2019, the limits will be indexed to the Consumer Price Index-Urban (CPI-U) plus one percent and rounded to the nearest $50. For 2020 and beyond, the annual limit will be indexed to the CPI-U and rounded to the nearest $50. Because the rate of health care inflation is expected to be considerably higher than the CPI-U, the amount subject to the tax is expected to increase significantly over time (assuming employers do not make plan adjustments to avoid the tax).

WHO CALCULATES THE TAX?

Responsibility for calculating the tax falls on the employer. In addition, the employer must determine the share that is attributable to each coverage provider, if there is more than one. After calculating the tax and determining each coverage provider’s share, the employer must report the amount due to each coverage
provider and to the Department of Treasury in a manner that will be determined by future regulatory guidance. For multi-employer plans, the obligation to calculate and report falls on the plan sponsor.

If an employer inaccurately calculates the amount each coverage provider must pay and, as a result, the coverage provider underpays the tax, the coverage provider will not be subject to a penalty but it must pay the additional tax owed. However, the employer who miscalculated the tax will be subject to a penalty equal to 100 percent of the additional tax plus interest.

**EMPLOYER STRATEGIES TO MINIMIZE THE TAX IMPACT**

Although the Excise Tax is not effective until 2018, it is critical for employers to address the potential impact to their benefit programs. The most obvious approach is to reduce plan benefit levels so that the projected plan costs are under the 2018 limits. Deductibles and copays do not count toward the cost of the plan, so increasing these are the “easiest” way to reduce costs; although, with collectively bargained employees, this is easier said than done. Employers should try to maintain bargaining agreements that are flexible enough to accommodate ACA mandates and to make benefit changes that will minimize the impact of the Excise Tax. Employers should also explore alternative plan design options that help lower the overall cost.

The adoption of High-deductible Consumer Directed Health Plans (CDHPs) is another approach many employers are considering. CDHPs hold the promise of lower premiums and lower trend as the consumer is more actively engaged in the management of their own health care than under traditional plans.

Other approaches include implementing narrow-network models, Accountable Care Organizations (ACOs), reference-based pricing for certain procedures and enhanced Population Health Management, including Wellness and Chronic Condition programs. Employers should also examine their tier structure to determine if a reallocation of the tiers may help avoid or reduce the Excise Tax.

**WILL THE TAX BE REPEALED OR MODIFIED?**

Although the Excise Tax is very unpopular with employers and labor, there is currently no legislation pending that proposes to eliminate or modify the tax. There is strong sentiment among employers, labor organizations, and many politicians to change the legislation and we expect there will be attempts to do so over the next year or two; but for now, the Excise Tax is scheduled to go into effect in 2018 and employers should not wait to plan for the tax’s impact.

Please contact your Keenan Account Manager for questions regarding this Briefing or if you require any additional information regarding the Affordable Care Act.
### PART A: §4980H – Evaluate Penalty Exposure

<table>
<thead>
<tr>
<th>Workforce Analysis</th>
<th>Results</th>
<th>Calendar for Discussion or Further Action?</th>
<th>Date Discussed &amp; With Whom?</th>
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<tbody>
<tr>
<td><strong>ALE Status</strong></td>
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<tr>
<td>1) Confirm status as ALE and determine whether ALE has 50-99 FTEs or 100+ FTEs.</td>
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<tr>
<td>a) Use 2015 transition relief for determining ALE status? If yes, what months in 2014 will be used?</td>
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<td><strong>MEC Offered to Required Percentage of FTEs</strong></td>
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<tr>
<td>Is ALE eligible for 2015 transition relief?</td>
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<tr>
<td>1) ALE with 50-99 FTEs:</td>
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<tr>
<td>a) Eligible ALEs not subject to penalty under either §4980H(a) or (b) until first day of 2016 plan year.</td>
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<tr>
<td>b) Ineligible ALEs must satisfy 70% requirement for 2015.</td>
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<td>2) ALE with 100+ FTEs:</td>
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<tr>
<td>a) Must satisfy 70% requirement for 2015.</td>
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<td>3) ALE with non-calendar year plan:</td>
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<tr>
<td>a) Eligible ALEs offering affordable, MV MEC to 70% of FTEs and dependents by first day of 2015 plan year not subject to §4980H penalties from January 1, 2015 through first day of 2015 plan year.</td>
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<tr>
<td>b) Ineligible ALEs subject to §4980H penalties effective January 1, 2015.</td>
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<tr>
<td>4) ALE offers dependent coverage of children to age 26?</td>
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<tr>
<td>a) If no, is ALE taking steps in 2014 and/or 2015 to expand coverage?</td>
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### Workforce Analysis

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<td>1) Has a preliminary workforce analysis been performed?</td>
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<tr>
<td>2) Who performed the analysis? Keenan BUAD, client or other?</td>
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<tr>
<td>3) When was the analysis performed?</td>
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<tr>
<td>4) Will another analysis be performed? If so, when?</td>
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<tr>
<td><strong>Workforce Analysis Results &amp; Penalty Exposure:</strong></td>
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<tr>
<td>1) Are at least 70% of FTEs (and dependents) offered MEC?</td>
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<tr>
<td>2) If no, what is penalty exposure under §4980H(a)?</td>
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<tr>
<td>a) <em>ALE with 100+ FTEs</em> – $2,000 per year per FTE multiplied by entire FTE workforce minus 80 if just one FTE obtains subsidized coverage through the Exchange.</td>
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</tr>
<tr>
<td>a) <em>ALE with 50-99 FTEs</em> – $2,000 per year per FTE multiplied by entire FTE workforce minus 30 if just one FTE obtains subsidized coverage through the Exchange.</td>
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<tr>
<td>3) If at least 70% offered MEC but less than 100%, what is the number of FTEs not offered MEC?</td>
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<tr>
<td>4) For those 30% (or less) not offered MEC, what is the penalty exposure under §4980H(b)?</td>
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<tr>
<td>a) $3,000 per FTE who obtains subsidized coverage through the Exchange.</td>
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</tbody>
</table>
### Workforce Analysis

<table>
<thead>
<tr>
<th>Affordability</th>
<th>Results</th>
<th>Calendar for Discussion or Further Action?</th>
<th>Date Discussed &amp; With Whom?</th>
</tr>
</thead>
</table>
| 1) Are employee contributions for the lowest cost self-only coverage that provides MV equal to or less than 9.5% of employee household income?  
  a) Was an affordability safe harbor used to make this determination? If so, which one?  
  2) For those FTEs offered unaffordable coverage, what is the penalty exposure under §4980H(b)?  
    a) $3,000 per FTE who obtains subsidized coverage through the Exchange. | | | |
| Minimum Value | Results | Calendar for Discussion or Further Action? | Date Discussed & With Whom? |
| 1) Does the plan pay at least 60% of the total allowed costs of benefits?  
  a) Was determination made using MV calculator, a safe harbor or actuarial certification?  
  2) For those FTEs offered coverage that does not provide MV, what is the penalty exposure under §4980H(b)?  
    a) $3,000 per FTE who obtains subsidized coverage through the Exchange. | | | |

Note, if coverage is both unaffordable and does not provide MV for an FTE who purchases subsidized coverage through the Exchange, the penalty under §4980H(b) is $3,000.
### PART B: §4980H – Planning & Implementation

<table>
<thead>
<tr>
<th>2014 Client Action Items</th>
<th>Notes &amp; Comments</th>
<th>Calendar for Discussion or Further Action?</th>
<th>Date Discussed &amp; With Whom?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Review Eligibility Rules</strong></td>
<td></td>
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<tr>
<td>1) Review current plan document to identify gaps in coverage relative to 30 hours per week.</td>
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<tr>
<td>2) Evaluate whether there are any Union/CBA considerations related to changing eligibility.</td>
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<tr>
<td><strong>Evaluate &amp; Choose Strategic Options</strong></td>
<td></td>
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<tr>
<td>Depending on the level and nature of the tax exposure, consider the following:</td>
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<tr>
<td>1) Maintain the status quo; or</td>
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<tr>
<td>2) Make changes to:</td>
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</tr>
<tr>
<td>a) <strong>Address offers of MEC to FTEs:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>i) Make changes to eligibility:</td>
<td></td>
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</tr>
<tr>
<td>(1) Change eligibility rules relative to 30 hours per week.</td>
<td></td>
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<tr>
<td>(2) Expand Bronze level plan to all employees with option of cash-in-lieu waiver.</td>
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<tr>
<td>(3) Expand Bronze level plan to all employees with option of voluntary benefits rather than cash-in-lieu waiver.</td>
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<tr>
<td>(4) Expand offer for the lowest-cost plan to all employees and children but exclude spouses or add spousal surcharge.</td>
<td></td>
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<tr>
<td>ii) Make changes to benefit portfolio:</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>(1) Add Bronze level plan.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>(2) Offer plans by class of employees but consider potential discrimination issues.</td>
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</tbody>
</table>
### Evaluate & Choose Strategic Options

**iii) Make changes to staffing and workforce management:**

1. Manage workforce hours relative to 30 hours per week for part-time and variable hour employees.
2. Shift hiring/staffing policies:
   - a) To NFTE to avoid offering benefits.
   - b) To FTE to limit need to track hours.
   - c) To leased employees to outsource responsibility for benefits.

**b) Address affordability:**

i) Review employer contribution strategy.

ii) For composite rates (e.g., family/single or medical/dental) – consider unbundling lowest cost plan.

iii) Use one of the three safe harbors (W-2, Rate of Pay or FPL).

**c) Address MV:**

i) Add Bronze level plan.

**d) Offset costs:**

i) Review spousal coverage – surcharge or exclude from coverage?

ii) Do not offer coverage to NFTE employees.
### 2014 Client Action Items

<table>
<thead>
<tr>
<th>Choose Method for Determining FTE Status &amp; Implement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Considerations When Choosing Method:</td>
</tr>
<tr>
<td>1) Who has authority to make the decision about which method will be used?</td>
</tr>
<tr>
<td>2) If authority to make the decision will be delegated, to whom will it be delegated?</td>
</tr>
<tr>
<td>3) Recommend client documents decisions for their records.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Implementation Issues Common to Both Methods:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify Common Law Employees</td>
</tr>
<tr>
<td>1) Identify all common law employees, excluding independent contractors and leased employees.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Counting Hours of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Methods for counting hours of service for common law employees:</td>
</tr>
<tr>
<td>a) Hourly employees – actual hours worked;</td>
</tr>
<tr>
<td>b) Non-hourly employees – actual hours worked, days-worked equivalency or weeks-worked equivalency; and</td>
</tr>
<tr>
<td>c) Employees whose hours are not tracked (e.g., adjunct faculty) – a reasonable method for crediting hours of service.</td>
</tr>
<tr>
<td>2) Recommend client documents policies and procedures for counting hours of service.</td>
</tr>
<tr>
<td>2014 Client Action Items</td>
</tr>
<tr>
<td>--------------------------</td>
</tr>
<tr>
<td><strong>Choose Method for Determining FTE Status &amp; Implement</strong></td>
</tr>
<tr>
<td><strong>Implement Monthly Method:</strong></td>
</tr>
<tr>
<td>1) Develop written policies and procedures for carrying out monthly method:</td>
</tr>
<tr>
<td>a) Tracking when employees are first otherwise eligible for an offer of coverage.</td>
</tr>
<tr>
<td>b) If weekly periods will be used, define how it will be used.</td>
</tr>
<tr>
<td>c) Tracking breaks-in service to determine if rehired employee should be treated as a continuing or new employee.</td>
</tr>
<tr>
<td><strong>Implement Look-Back Method:</strong></td>
</tr>
<tr>
<td>1) Who has authority to make decisions about the length of the SMP/IMP, AP, and SP?</td>
</tr>
<tr>
<td>a) If authority to make decisions will be delegated, who will it be delegated to?</td>
</tr>
<tr>
<td>2) Are there any Union/CBA considerations related to choosing the length of SMP/IMP, AP, and SP?</td>
</tr>
<tr>
<td><strong>Ongoing Employees</strong></td>
</tr>
<tr>
<td>1) Choose length of SMP, AP, and SP for ongoing employees.</td>
</tr>
<tr>
<td>a) Recommend 12-month SMP, 2-month AP, and 12-month SP.</td>
</tr>
<tr>
<td>b) Recommend SP align with plan year.</td>
</tr>
</tbody>
</table>
### Choose Method for Determining FTE Status & Implement

2) Recommend client documents decisions about length of SMP, AP, and SP plus its policies and procedures for handling ongoing employees.

**New Employees**

1) Identify and categorize new employees as:
   a) Reasonably expected to be FTE on start date;
   b) Reasonably expected to be part-time on start date;
   c) Variable hour; or
   d) Seasonal.

2) Develop written policy and procedure for handling new hires who are reasonably expected to be FTE at start date.
   a) Offer MEC by first day of fourth calendar month from start date.
   b) Must use monthly measurement method until start of next ongoing SMP.

3) Choose length of IMP, AP, and SP for new part-time, variable hour and seasonal employees.
   a) Recommend 12-month IMP, 1-month AP, and 12-month SP.
   b) Recommend IMP begin on first day of calendar month following employee’s start date.
   c) Consider part-time, variable hour and seasonal employee turnover rate as an indicator of the potential administrative burdens associated with new employees.
### Choose Method for Determining FTE Status & Implement

<table>
<thead>
<tr>
<th>2014 Client Action Items</th>
<th>Notes &amp; Comments</th>
<th>Calendar for Discussion or Further Action?</th>
<th>Date Discussed &amp; With Whom?</th>
</tr>
</thead>
<tbody>
<tr>
<td>d) Develop written policy and procedure for handling changes in employment status for new part-time, variable hour and seasonal employees.</td>
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<tr>
<td>4) Recommend client documents decisions about the length of IMP, AP, and SP plus its policies and procedures for handling all new employees.</td>
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</tbody>
</table>

### Leaves of Absence

| 1) Develop written policy and procedure for counting hours of service for special unpaid LOA (FMLA, USERRA, jury duty). | | | |
| a) Decide on averaging method to be used for calculating hours of service during special unpaid LOA. | | | |
| 2) Develop written policy and procedure for tracking breaks-in-service for other types of LOA. | | | |
| 3) Develop written policy and procedure for tracking breaks-in-service for educational organizations. | | | |
| a) Decide on averaging method that will be used to calculate hours of service during the break-in-service, including whether 501-hour limit will be used. | | | |

### Rehired Employees

| 1) Develop written policy and procedure for tracking breaks-in-service to determine if rehired employee should be treated as ongoing or new employee. | | | |
## Prepare for §§6055 & 6056 Reporting

<table>
<thead>
<tr>
<th>2014 Client Action Items</th>
<th>Notes &amp; Comments</th>
<th>Calendar for Discussion or Further Action?</th>
<th>Date Discussed &amp; With Whom?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evaluate current systems’ capabilities to track data necessary for reporting under IRC §§6055 and 6056. a) Systems should be functional by end of 2014.</td>
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<tr>
<td>Identify who is the responsible entity for reporting and furnishing statements under §§6055 and 6056.</td>
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<tr>
<td>Identify who will do the reporting to the IRS and furnish statements. a) Will another entity or third party be designated?</td>
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<tr>
<td>Determine whether reporting to IRS will be done electronically.</td>
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<tr>
<td>Determine whether furnishing of statements will be done electronically.</td>
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<tr>
<td>Develop and implement process for collecting TINs for all enrolled individuals.</td>
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<tr>
<td>Consider simplified reporting methods available for §6056.</td>
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</tbody>
</table>
### Reporting & Fees

1) File IRS Form 720 and pay PCORI fees by July 31, 2014.
2) Estimate Transitional Reinsurance fees for 2014 and include as part of the plan’s financials.
   a) Submit average number of covered lives to HHS by November 15, 2014.

### Plan Design – Mandated Benefit Changes & Compliance

1) Determine GF status of plan(s).
   a) Were there plan changes that could impact GF status?
2) Ensure required changes applicable to GF & NGF plans are made.
   a) Coverage of dependents up to age 26.
   b) No lifetime and annual limits on the dollar value of EHB.
   c) No preexisting condition exclusions.
   d) No waiting periods exceeding 90 days (60-days for fully-insured in CA).
## 2014 Client Action Items

### Plan Design – Mandated Benefit Changes & Compliance

3) Ensure required changes applicable to NGF plans are made.
   a) Coverage of preventive services without cost-sharing.
   b) OOP maximums for plan years beginning in 2014.
      i) $6,350 for individual; $12,700 for family.
      ii) Ensure new methods for counting expenses toward OOP maximum are implemented (i.e., in-network co-payments, deductibles and coinsurance for EHB vs. out-of-network).
      iii) For plans with multiple service providers (e.g., Rx), consider 2014 transitional rule.
   c) Begin planning for 2015 OOP maximum coordination for plans with multiple service providers.
   d) OOP maximums for plan years beginning in 2015.
      i) $6,600 for individual; $13,200 for family.
   e) Coverage of routine costs of approved clinical trials.
   f) Internal and external appeals processes.

### Cadillac Tax

1) Evaluate impact of tax on current plan(s).
2) Develop 3-year plan to mitigate tax, if necessary.
<table>
<thead>
<tr>
<th>2014 Client Action Items</th>
<th>Notes &amp; Comments</th>
<th>Calendar for Discussion or Further Action?</th>
<th>Date Discussed &amp; With Whom?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Wellness</strong></td>
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<tr>
<td>1) Review wellness programs and make changes as necessary to comply with new regulations.</td>
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<tr>
<td>a) 3 types of programs – participatory, outcomes-based, and activity-only.</td>
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<tr>
<td>b) Maximum reward up to 30% of total cost of coverage and up to 50% if smoking cessation included.</td>
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<tr>
<td><strong>HR Considerations</strong></td>
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<tr>
<td><strong>Communications Strategy:</strong></td>
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<tr>
<td>1) Required</td>
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<tr>
<td>a) Provide Notice of Exchange to new hires within 14 days of their start date.</td>
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<tr>
<td>b) Develop policy and procedure for maintaining records to show compliance with requirement.</td>
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<tr>
<td>2) Optional</td>
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<tr>
<td>a) Develop communications strategy to address employee questions about HCR.</td>
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<tr>
<td>b) Promote Exchange to employees who do not qualify for benefits.</td>
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<tr>
<td>i) Identify contact person for employees (or refer to <a href="http://www.keenandirect.com">www.keenandirect.com</a>).</td>
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<tr>
<td>c) Identify contact person to address inquiries from the Exchange regarding employer plans.</td>
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<tr>
<td><strong>Compliance:</strong></td>
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<tr>
<td>1) Understand ‘Whistleblower’ protections related to the ACA and update HR policies accordingly.</td>
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</table>
### APPENDIX

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>ACA</td>
<td>Affordable Care Act</td>
</tr>
<tr>
<td>ALE</td>
<td>Applicable Large Employer</td>
</tr>
<tr>
<td>AP</td>
<td>Administrative Period</td>
</tr>
<tr>
<td>CBA</td>
<td>Collective Bargaining Agreement</td>
</tr>
<tr>
<td>EHB</td>
<td>Essential Health Benefits</td>
</tr>
<tr>
<td>FMLA</td>
<td>Family and Medical Leave Act</td>
</tr>
<tr>
<td>FPL</td>
<td>Federal Poverty Line</td>
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<tr>
<td>FTE</td>
<td>Full-Time Employee (as defined by ACA)</td>
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<tr>
<td>GF</td>
<td>Grandfathered</td>
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<tr>
<td>HCR</td>
<td>Health Care Reform</td>
</tr>
<tr>
<td>IMP</td>
<td>Initial Measurement Period</td>
</tr>
<tr>
<td>IRC</td>
<td>Internal Revenue Code</td>
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<tr>
<td>IRS</td>
<td>Internal Revenue Service</td>
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<tr>
<td>LOA</td>
<td>Leave of Absence</td>
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<tr>
<td>MEC</td>
<td>Minimum Essential Coverage</td>
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<tr>
<td>MV</td>
<td>Minimum Value</td>
</tr>
<tr>
<td>NFTE</td>
<td>Not Full-Time Employee</td>
</tr>
<tr>
<td>NGF</td>
<td>Non-Grandfathered</td>
</tr>
<tr>
<td>OOP</td>
<td>Out-of-Pocket</td>
</tr>
<tr>
<td>PCORI</td>
<td>Patient-Centered Outcomes Research Institute</td>
</tr>
<tr>
<td>SMP</td>
<td>Standard Measurement Period</td>
</tr>
<tr>
<td>SP</td>
<td>Stability Period</td>
</tr>
<tr>
<td>USERRA</td>
<td>Uniformed Services Employment and Reemployment Rights Act</td>
</tr>
</tbody>
</table>
**CONTRA COSTA COUNTY SCHOOLS INSURANCE GROUP**

**HEALTH BENEFITS COMMITTEE MEETING**

**AGENDA ITEM DETAIL**

<table>
<thead>
<tr>
<th>PRESENTED TO:</th>
<th>DATE:</th>
<th>March 13, 2015</th>
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</thead>
<tbody>
<tr>
<td>Full Board</td>
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</table>

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<thead>
<tr>
<th>SUBJECT:</th>
<th>ITEM #:</th>
<th>2015-024</th>
</tr>
</thead>
<tbody>
<tr>
<td>IRS 6055 &amp; 6056 Reporting</td>
<td>Enclosure:</td>
<td>Yes</td>
</tr>
</tbody>
</table>

**Category:** Administration

**Prepared by:** Keenan & Associates

**Requested by:** Health Benefits Committee

**BACKGROUND:**

The committee has discussed that the Contra Costa County Office of Education (CCCOE) is in the process of preparing the reporting for the IRS 6056 Large Employer Reporting Requirements that are due by March 31, 2016 (filed electronically).

**STATUS:**

Keenan will present a high level overview of the Equifax services as an alternative to the CCCOE reporting.

**RECOMMENDATION:**

For review and information only.
Getting ready: Monthly tracking

To prepare for 2016, applicable large employers need to track information each month in 2015, including:

- Whether you offered full-time employees and their dependents minimum essential coverage that meets the minimum value requirements and is affordable.
- Whether your employees enrolled in the self-insured minimum essential coverage you offered. (See glossary on back.)

You need to track this information because you could be subject to an employer shared responsibility payment if either:

- You offered coverage to fewer than 70% (for 2015; after 2015 this threshold changes to 95%) of your full-time employees and their dependents and at least one full-time employee enrolled in coverage through the Health Insurance Marketplace and receives a premium tax credit, or
- You offered coverage to at least 70% (for 2015) of your full-time employees and their dependents, but at least one full-time employee receives a premium tax credit (because coverage offered was not affordable, did not provide minimum value or the full-time employee was not offered coverage). After 2015, this threshold changes to 95%.

Glossary

Affordable coverage: If the lowest cost self-only only health plan is 9.5% or less of your full-time employee's household income then the coverage is considered affordable. Because you likely will not know your employee's household income, for purposes of the employer shared responsibility provisions, you can determine whether you offered affordable coverage under various safe harbors based on information available to the employer.

Minimum essential coverage: For purposes of reporting by applicable large employers, minimum essential coverage means coverage under an employer-sponsored plan. It does not include fixed indemnity coverage, life insurance or dental or vision coverage.

Minimum value coverage: An employer-sponsored plan provides minimum value if it covers at least 60 percent of the total allowed cost of benefits that are expected to be incurred under the plan.

For additional guidance on whether an employer-sponsored plan provides minimum value if the plan fails to substantially cover in-patient hospitalization services or physician services, see Notice 2014-69. Under existing guidance, employers generally must use a minimum value calculator developed by HHS to determine if a plan with standard features provides minimum value. Plans with nonstandard features are required to obtain an actuarial certification for the nonstandard features. The guidance also describes certain safe harbor plan designs that will satisfy minimum value.

Premium tax credit: A tax credit for eligible individuals and families with low or moderate incomes. The credit offers premium assistance to help them afford health insurance purchased through the Health Insurance Marketplace.

More information

See ACA Frequently Asked Questions for Employers on IRS.gov for detailed information about employer reporting requirements and more.

Learn more about the Affordable Care Act at www.IRS.gov/aca

Affordable Care Act: Reporting Requirements for Applicable Large Employers

Understanding employer reporting requirements of the health care law

Under the Affordable Care Act, applicable large employers – those with 50 or more full-time employees, including full-time equivalent employees – are required to take some new actions. These employers must file information returns with the IRS and also provide statements to full-time employees about health coverage the employer offered or to show the employer didn’t offer coverage.

Information reporting was voluntary for calendar year 2014. All applicable large employers are required to report health coverage information for the first time in early 2016 for calendar year 2015.

To be prepared to report this information to the IRS and issue the new Form 1095-C to employees, you’ll need to:

- Determine if your organization is an applicable large employer.
- Determine the kind of health insurance coverage you offered to full-time employees and their dependents, if any.
- Identify who your full-time employees are for each month and track health coverage information in 2015 to help complete new IRS forms.
Are you an applicable large employer?
Your organization is an applicable large employer if you or other entities that must be combined together with your organization (for instance, other members of an aggregated group) employed an average of at least 50 full-time employees, including full-time equivalent employees, on business days during the preceding calendar year. For example, your 2014 employee count determines if you’ll be required to track employee and health coverage information in 2015 to report in 2016. A special rule applies for 2015 for determining if you are an applicable large employer. Under this special rule you may use any consecutive six-month period during 2014, rather than being required to use all 12 months of 2014.

Reporting requirements apply starting in 2015
Applicable large employers are subject to certain reporting requirements for full-time employees. The reporting requirements apply to all applicable large employers starting in 2015, even to those employers with special circumstances that qualify for transition relief from employer shared responsibility payments for 2015.

Certain reporting requirements also apply to employers that sponsor self-insured coverage, even if the employer is not an applicable large employer.

Which employees count when determining if you’re an applicable large employer
Employers average their number of employees across the months in the year to see whether they will be an applicable large employer for the next year. To determine if your organization is an applicable large employer for a year, count your organization’s full-time employees, full-time equivalent employees and, if you are a member of a combined group, the full-time employees and full-time equivalent employees of all members of the group for each month of the prior year and then average the numbers for the year.

In general:
A full-time employee is an employee who is employed on average, per month, at least 30 hours of service per week (or at least 130 hours of service in a calendar month).
A full-time equivalent employee is a combination of employees, each of whom individually is not a full-time employee (has fewer than 30 hours of service per week), but who, in combination, are equivalent to a full-time employee.
An aggregated group is commonly owned or otherwise related or affiliated employers, which must combine their employees to determine their workforce size.

There are many additional rules on determining who is a full-time employee, including what counts as hours of service. For more information on these rules, see the employer shared responsibility final regulations and related questions and answers on IRS.gov.

Preparing to fill out new IRS forms in 2016

1 Form 1095-C
Employer Provided Health Insurance Offer and Coverage
- Provide to full-time employees to use when filing their tax returns.
- File with the IRS as an information return.
- Reports information about health insurance coverage offered and any safe harbors or other relief available to the employer, or reports that no offer of coverage was made.
- Helps the IRS determine if your organization potentially owes an employer shared responsibility payment to the IRS.
- Helps the IRS determine whether your full-time employees and their dependents are eligible for the premium tax credit.

What you’ll need for Form 1095-C
- Who is a full-time employee for each month.
- Identifying information for employer and employee such as name and address.
- Information about the health coverage offered by month, if any.
- The employee’s share of the monthly premium for lowest-cost self-only minimum value coverage.
- Months the employee was enrolled in your coverage.
- Months the employer met an affordability safe harbor with respect to an employee and whether other relief applies for an employee for a month.
- If the employer offers a self-insured plan, information about the covered individuals enrolled in the plan, by month.

2 Form 1094-C
Transmittal of Employer Provided Health Insurance Offer and Coverage Information Returns
- File with the IRS as a transmittal document for Forms 1095-C, Employer Provided Health Insurance Offer and Coverage.
- Provides a summary to the IRS of aggregate employer-level data.
- Helps the IRS determine whether an employer is subject to an employer shared responsibility payment and the proposed payment amount.

What you’ll need for Form 1094-C
- Identifying information for your organization.
- Information about whether you offered coverage to 70% of your full-time employees and their dependents in 2015. (After 2015 this threshold changes to 95%.)
- For the authoritative transmittal
  » Total number of Forms 1095-C you issued to employees.
  » Information about members of the aggregated applicable large employer group, if any.
  » Full-time employee counts by month.
  » Total employee counts by month.
  » Whether you are eligible for certain transition relief.

For more information, visit www.IRS.gov/aca
How are you managing the ACA?

Few employers have been impacted by the Affordable Care Act (ACA) as greatly as those in Higher Education. With complexities such as different employee types and multiple campuses, managing the ACA can be perplexing – especially with changes in the regulations and your workforce.

Equifax can help

Our ACA Management Platform relieves you of administrative burdens, helps you determine the ACA’s impact on your institution, and puts compliance on auto-pilot by addressing the intricacies of the ACA:

- **Measuring and tracking eligibility**—The system calculates “hours entitled to payment” for different employee types such as adjunct faculty where a conversion rate based on credit hours must be used. It also tracks all measurement periods for both new and ongoing employees.

- **Deciding to “pay or play”**—The built-in models help you understand the ACA’s impact on your institution and create a sound strategy while identifying potential fines and risks.

- **Communicating eligibility status**—Automated reports can be scheduled for secure, internal distribution to different campuses or offices, notifying them of potential changes in eligibility status.

- **Reporting to the IRS**—The platform gathers, manages, and populates the necessary information to satisfy section 6055 and 6056 reporting requirements.

- **Adapting to changes**—The calculations, models, and reports are updated as new provisions are rolled out, minimizing compliance risks.

“In the case of the Affordable Care Act, [an analytics platform like the ACA Management Platform] may be the only tool that will effectively support employers in their daily need to monitor and manage the complexities of this legislation.”

- Yvette Cameron, Vice President & Principal Analyst Constellation Research, Inc. (May 4, 2013).

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Reduce unemployment costs through claims processing, hearing representation, and reemployment strategies.

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ACA Management Platform

What we deliver
Put simply, there is no other ACA management tool that takes all factors into consideration to maximize compliance and provide end-to-end support. It collects and connects all of the necessary information – no matter the source, location, or system – and takes the guesswork out of the ACA by:

- Tracking eligibility
  Depressing tracking of employee eligibility is the foundation of ACA compliance. Tracking and monitoring the measurement periods for each individual employee is also one of the most challenging parts. Our platform is preconfigured with the necessary calculations, provides real-time access to the data, and allows you to set up automated alerts for important trends or changes in employee eligibility status. It also provides the ability to forecast and view eligibility trends for different departments, locations, demographics, and more.

- Avoiding fines and penalties
  Navigating the ACA is no simple task. It's complicated and even the slightest oversight can subject your organization to severe financial and legal risks. Our models and reports take key factors that influence your ACA strategy into consideration and provide alerts that assist in avoiding financial and legal implications by being proactive rather than reactive.

- Managing compliance and reporting
  As the ACA evolves, managing compliance will become increasingly challenging and will require a significant amount of administrative support. Our platform has built-in reporting features that follow your three leading and ensures strict reporting requirements are met in a timely manner. You can also set up a schedule to distribute reports to management as often as you'd like.

Healthcare reform is here to stay
… and if you’re like most employers, you’re working diligently to understand the evolving legislation and its impact on your business. Although the figure commonly quoted around per employee penalties is $2,000, costs can actually range as high as $18,000 per employee when critical lesser-known factors are considered. Meanwhile, most organizations are struggling to answer even the most basic of questions, such as:

- How will this legislation impact my business and workforce?
- Who is eligible today and who will become eligible tomorrow?
- What tools and resources will ensure my organization maintains compliance?

We are the ACA experts
For the past 113 years, Equifax has been helping employers make critical decisions with greater confidence. That’s why we’ve created an ACA team dedicated to understanding the legislation and its impact on employers.

Through partnerships with government agencies and legal specialists, our team is equipped with the most thorough and current knowledge of ACA provisions. We’ve leveraged this expertise to develop an innovative platform with unparalleled capabilities to support the complete ACA lifecycle so that you can worry less about compliance and focus on growing your business.

ACA Management Platform provides employers with a comprehensive, flexible toolset to model costs and risks of the ACA shared responsibility regulations. A foundational model is delivered that adds value right out of the box. Employers can then easily tailor this model to their organization’s specific strategy. The platform is also designed to quickly accommodate any additional changes in legislation as they occur.

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ACA Management Platform

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- Managing compliance and reporting
As the ACA evolves, managing compliance will become increasingly challenging and will require a significant amount of administrative support. Our platform has built-in reporting features that simplify the burden of extensive reporting requirements and ensure strict reporting requirements are met in a timely manner. You can also set up a schedule to distribute reports to management as often as you like.

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ACA MANAGEMENT PLATFORM
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➤ Who is eligible today and who will become eligible tomorrow?
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➤ Modeling costs and risks
The ACA Management Platform provides employers with a comprehensive, flexible toolset to model costs and risks of the ACA shared responsibility regulations. A foundational model is delivered that adds value right out of the box. Employers can then easily tailor this model to their organization’s specific strategy. The platform is also designed to quickly accommodate any additional changes in legislation as they occur.

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PRESENTED TO: Full Board

DATE: March 13, 2015

SUBJECT: Preliminary Renewal Discussion

ITEM #: 2015-025

Enclosure: Handout

Category: Administration

Prepared by: Keenan & Associates

Requested by: Health Benefits Committee

BACKGROUND:

At the February 20, 2015 Committee meeting, the committee discussed the Impact of CECHERS for Lafayette, Brentwood and Oakley.

STATUS:

Keenan will discuss the following items in preparation for the 2016 renewal:

1. JPA Pooling with the loss of districts
2. Anthem alternatives
   a. Marketing
   b. MCSIG JPA
3. Revisit Standard Plan Designs

RECOMMENDATION:

For review and information only.
CONTRA COSTA COUNTY SCHOOLS INSURANCE GROUP

HEALTH BENEFITS COMMITTEE MEETING
AGENDA ITEM DETAIL

PRESENTED TO: Full Board

DATE: March 13, 2015

SUBJECT: Cafeteria Pre-Tax Employee Contribution Requirements

ITEM #: 2015-026

Enclosure: Handout

Category: Administration

Prepared by: Keenan & Associates

Requested by: Health Benefits Committee

BACKGROUND:

At the February 20, 2015 Committee meeting, Kevin Collins, Walnut Creek Elementary School District, asked about administration of Section 125 plans.

STATUS:

Keenan will provide information on employee signature requirements for pre-tax payroll for plan contributions and other pre-tax benefits.

RECOMMENDATION:

For review and information only.
PRESENTED TO: Health Benefits Committee

DATE: March 13, 2015

SUBJECT: Legislative Update/Briefing

ITEM #: 2015-027

Category: Information

Prepared by: Keenan & Associates

Requested by: Health Benefits Committee

BACKGROUND:

Keenan & Associates provides their clients with updates on current and pending legislation and other items affecting school districts.

STATUS:

There were no Legislative Updates or Briefings published for this meeting.

RECOMMENDATION:

For review and information only.