

**Benefits Focus Group Minutes  
(4-11-13)**

**Note: BFG members who attended are listed; non-members may attend but are not always listed.**

<u>Regular Members</u>	<u>Alternate Members</u>	<u>Staff Advisors</u>	<u>Recorder</u>
Al Woodle		Stacie Mason	PJ Hahn
Janice Cox		April Bryan	
John Glanden			
Bill Culver			
Cindy Maszak			
Dolly Gamble			
Peggy Sawyer			
Kathy King			
Tony Becich			
Stacey Monroe			
Jan Thornburg			
Ed Whitehead			
			<b>Members and Advisors Present = 14</b>

**Call to Order – Chairperson**

Al Woodle called the meeting to order at 1:00 pm, Thursday, April 11, 2013.

**Approval of Minutes from 2/14/13**

Al Woodle called for and received approval of the minutes from the previous meeting on 2/14/13.

**Monthly Costs Update – Stacie Mason**

- Six months into the budget March report.
  - Group Medical and Dental:
    - Investment earnings are down 72%.
    - Active claims and judgments running even with last year at \$2 million.
    - Fund balance is \$3.7 million.
  - OPEB Trust Fund:
    - Investments are down compared to last year.
    - Retiree claims were 5% lower than the same period last year. Last year’s claims were \$3.1 million compared to \$2.9 million this year.
    - Fund balance is \$29 million.

**Review of Health Care Reform Act – Gehring Group**

- Anna Maria Studley presented powerpoint handout on Healthcare Reform Planning. Shawn Fleming and Dominic Nigra accompanied her. Presentation is attached.

- There will be light impact for the next couple of years planning for the budget, and more progressive later for the city's plan to be in compliance.
- The following topics were reviewed:
  - What's effective in 2012, 2013, 2014 and 2018
  - Women's wellness initiative
  - What fees to expect in 2013 and 2014
  - Employer shared responsibility provision a.k.a. pay or play
    - ❖ Penalty exposure
    - ❖ Determining affordability
    - ❖ Determining minimum value
    - ❖ Defining a "full-time employee", "dependent" and "maximum waiting period"

### **Analytical Tool for Claims Data – Stacie Mason**

- This agenda item was shelved until the next meeting.

### **Outcome of Retiree Health Fair – Stacie Mason & April Bryan**

- Postcards inviting eligible retirees to the health fair were mailed and reaffirmed with an email.
- Twenty-one retirees attended and three attended that had not been to the health center previously.
- Three groups attended the fair because of their interest in establishing a health center.
  - Hillsborough County Sheriff, Sarasota Sheriff's Office and Pasco County Schools.

### **2013 Wellness Calendar – April Bryan**

- The classes are either well or poorly attended.
- An attendee at the HRT class stated that mostly information presented could have been seen online and there was no time for questions.
- Discussed possibly scheduling classes in the studio and then can be viewed later on granicus.
- In May will be national ride your bike to work day. A raffle ticket to win a bike will be available when we announce this event.

### **Other Business**

- Stacie Mason stated the CareHere pharmacist said the health center can dispense medication for 180 days. It is upon the discretion of the health center provider if the patient obtains 6 months script from their doctor.
  - Al suggested this information be included in the open enrollment documents.

### **Adjournment and Next Meeting**

Al Woodle adjourned the meeting at 2:25 p.m. The next BFG meeting is scheduled for June 13, 2013.

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# Healthcare Reform Planning

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**City of Sarasota  
Thursday, April 11, 2013**

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**Presented by: Anna Maria Studley,  
Managing Director**



# What's Effective In 2012-2013?

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- **Carriers medical loss ratio rebates due by 08/01/2012**  
*(Not applicable to self-funded groups)*
  - Rebates expected to be less than first thought
  - 85% MLR for large group mandated / 80% small and individual market
- **Women's Wellness Initiative will be effective for plan years beginning after 08/01/2012** *(Implemented)*
  - Preliminary Cost to Comply: \$ 1.00 - \$2.00 per member per month
  - Applies to all Fully Insured and Self Insured Plans

# Women's Wellness Initiative

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- The following services must be covered with no cost-sharing in plan years starting on or after August 1, 2012.

Breastfeeding Support and counseling from trained providers, as well as access to breastfeeding supplies (pumps).

Contraception: Approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs

Domestic and interpersonal violence screening and counseling for all women

Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes

Human Immunodeficiency Virus (HIV) screening and counseling for sexually active women

Human Papillomavirus (HPV) DNA Test: high risk HPV DNA testing every three years for women with normal cytology results who are 30 or older

Sexually Transmitted Infections (STI) counseling for sexually active women

Well-woman visits

# What's Effective In 2012-2013?

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- **Eliminate Annual Plan Limit Maximums** *(Implemented)*
  - Plans may not impose lifetime benefit limits
  - Plans may not impose unreasonable annual limits on the dollar value of essential health benefits
- **Summary of Benefits & Coverage (SBC)** *(Implemented)*
  - Effective for all plans renewing or effective after 9/23/2012
  - Applies to group health plans and individual plans regardless of grandfather status

# Insurance Company 1: Plan Option 1

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2013 – 12/31/2013

Coverage for: Individual + Spouse | Plan Type: PPO



**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.\[insert\]](#) or by calling 1-800-[insert].

Important Questions	Answers	Why this Matters:
What is the overall <b>deductible</b> ?	<b>\$500</b> person / <b>\$1,000</b> family Doesn't apply to preventive care	You must pay all the costs up to the <b>deductible</b> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <b>deductible</b> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <b>deductible</b> .
Are there other <b>deductibles</b> for specific services?	Yes. <b>\$300</b> for prescription drug coverage. There are no other specific <b>deductibles</b> .	You must pay all of the costs for these services up to the specific <b>deductible</b> amount before this plan begins to pay for these services.
Is there an <b>out-of-pocket limit</b> on my expenses?	Yes. For participating providers <b>\$2,500</b> person / <b>\$5,000</b> family For non-participating providers <b>\$4,000</b> person / <b>\$8,000</b> family	The <b>out-of-pocket limit</b> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <b>out-of-pocket limit</b> ?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <b>out-of-pocket limit</b> .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a <b>network of providers</b> ?	Yes. See <a href="#">www.[insert].com</a> or call 1-800-[insert] for a list of participating providers.	If you use an <b>in-network</b> doctor or other health care <b>provider</b> , this plan will pay some or all of the costs of covered services. Be aware, your <b>in-network</b> doctor or hospital may use an <b>out-of-network provider</b> for some services. Plans use the term <b>in-network, preferred, or participating for providers</b> in their <b>network</b> . See the chart starting on page 2 for how this plan pays different kinds of <b>providers</b> .
Do I need a referral to see a <b>specialist</b> ?	No. You don't need a referral to see a specialist.	You can see the <b>specialist</b> you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about <b>excluded services</b> .

**Questions:** Call 1-800-[insert] or visit us at [www.\[insert\].com](#).

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at [www.\[insert\]](#) or call 1-800-[insert] to request a copy.

OMB Control Numbers 1545-2229,  
1210-0147, and 0938-1146

# What's Effective In 2013?

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- **New notification requirements for employers (*Delayed*)**
  - Notice to employees of State Exchange/Marketplace
  - Notice of material coverage changes “off anniversary” no less than 60 days in advance of plan effective date
- **Cost of benefits reported on employees W-2**
- **FSA's will have annual limits of \$2,500**
- **Investment income and Medicare tax increase**
  - Additional 0.9% Medicare tax to high earners
- **CLASS (long term care) program implementation has been eliminated**

# What Fees to Expect in 2013/2014?

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- **Patient-Centered Outcomes Research Institute Fee** – Fee helps to fund research on the comparative effectiveness of medical treatments. The 2012 payment must be received by July 2013 on IRS Form 720.
  - **2012 Fee = \$1 PMPY**
  - **2013 & 2014 Fee = \$2 PMPY**
- **Transitional Reinsurance Fee** – Fee on insured and self-insured plans, which is to be submitted by TPA, to finance reinsurance payments for individual market coverage. *States are permitted to increase at their discretion.* Awaiting final guidance from government on timing of payments.
  - **2014 Fee Estimate \$63 PMPY**

# What Fees to Expect in 2013/2014?

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- **Health Insurance Industry Fee** (*Not applicable to self-funded groups*)
  - Fee to assist the government in subsidizing coverage for lower income individuals and families
  - Paid by the carrier providing fully insured plans
  - Fee is ongoing (no planned end)

Year	Fee
2014	\$8 billion
2015 & 2016	\$11.3 billion
2017	\$13.9 billion
2018	\$14.3 billion
Years after 2018	Prior year amount indexed by rate of annual premium growth

- Result = premium increase of 1.6 – 3.5% for 2014

# What's Effective In 2014?

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- **Individual coverage requirement**
  - Penalty phased in - \$695 by 2016
- **Health Insurance Exchange/Marketplace is established**
- **Limits on rating plans based on age**
- **Tax credits available for individuals and small business tax credits expanded**
- **Pre-existing condition exclusions are prohibited**
- **Multi-state qualified health plans are created and offered through the Exchange/Marketplace**
- **Coverage for approved clinical trials is mandated for non-grandfathered plans**
- **Guaranteed issue and renewal**

# Employer Shared Responsibility Provision a.k.a. Pay or Play

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- **Defining the Employer Shared Responsibility Provision:**  
The ESRP states that large employers must offer coverage that is “affordable” and of “minimum value” to “full-time employees” and their dependents.
- **Employer Shared Responsibility Provision is applicable to all employers with more than 50 employees**
- **ESRP is effective on the first day of the plan year beginning on or after January 1, 2014**
  - Fiscal Year Plan Transition Relief available
  - Penalty is calculated monthly, not annually

# Employer Shared Responsibility Provision Penalty Exposure

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## 1) No Coverage Penalty - \$2,000 / Full-time employee

- Margin of Error Rule: Must offer coverage to substantially all full-time employees and dependents, a.k.a., **the 95% Rule**. Offer coverage to all but greater of 5% of employees or 5 employees.
- Note: If Employer offers coverage under the 95% Safe Harbor, Employer will still be subject to \$3,000 penalty for those full-time employees who receive tax credits/subsidies from the Exchange /Marketplace.
- Also applied if coverage not offered to dependents.

## 2) Inadequate Coverage Penalty - \$3,000 / Full-time employee

- Coverage is unaffordable and employee obtains federally subsidized coverage through an Exchange /Marketplace, OR
- Coverage does not meet “minimum value” requirements and employee obtains federally subsidized coverage through an Exchange /Marketplace.

# Employer Shared Responsibility Provision

## Determining Affordability

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- **Employers may be assessed a penalty for offering coverage to full-time employees that is not “affordable”**
- **Three Affordability Safe Harbors:**
  1. **Form W-2 Safe Harbor – Employee contribution for lowest cost employee only coverage does not exceed 9.5% of employee’s Box 1 W-2 wages for the applicable calendar year.**

Alert: Box 1 amount is reduced by pre-tax payroll deductions for FSA (Medical & Dependent Care), HSA contributions, qualified benefit premiums, qualified retirement contributions (401k, 403b)

# Employer Shared Responsibility Provision

## Determining Affordability

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- **Rate of Pay Safe Harbor – Test using monthly salary at the beginning of the plan year as base. Employee cost 9.5% calculation.**
  - Monthly salary or hourly rate X 130 hours
  - Employee only cost cannot exceed 9.5% of earnings as of the first day of the plan year
  - Monthly test (beware of salary and hourly pay rate reductions)
- **“Federal Poverty Line” (FPL) Safe Harbor – Coverage will be “affordable” if self-only coverage does not exceed 9.5% of Federal Poverty Level for single individual.**
  - Monthly test
  - Current individual FPL is \$11,170 – use most recently published individual FPL guidelines as of first day of plan year

# Employer Shared Responsibility Provision Determining Minimum Value

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- **60% Actuarial Value**
- **Essential Benefits – Large employers**
  - Physician and mid-level practitioner care
  - Hospital and emergency room services
  - Pharmacy benefits
  - Laboratory and imaging services
- **Exchange /Marketplace Bronze equivalent**

# Employer Shared Responsibility Provision

## Defining a “Full-Time Employee”

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- **An employee who is employed on average at least 30 “hours of service” per week or 130 hours per month**
  - Include compensable hours – those worked, also hours paid when no work is performed
  - Special periods of unpaid leave may not be counted against to reduce average hours of service including:
    - FMLA, Military Service, Leave of absence, Jury duty, Vacation, Sick, Personal, Holiday, Incapacity including disability
  - “Employment break periods” – educational institutions
    - Calculate irrespective of break periods subject to 501 hour limit per calendar year
  - Re-hired employees
    - Breaks in service greater than 26 weeks
    - Parity rule for breaks in services less than 26 weeks
- **Qualifying part-time, seasonal and variable employees**

# **Employer Shared Responsibility Provision**

## **Defining a “Dependent” & “Maximum Waiting Period”**

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- **PPACA indicates coverage must be made available to employees and their dependents. Dependents defined through this further guidance as:**
  - Child of an employee who has not attained age 26
  - Spouse coverage not necessary to be offered – if offered, not necessary to be “affordable”
- **New hire waiting period for coverage can be no greater than 90 days (not three months)**

# What's Effective In 2018?

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- **40% excise tax on “Cadillac Plans”**
  - \$10,200 for single coverage (High Risk Employees: \$11,850)
  - \$27,500 for family coverage (High Risk Employees: \$30,950)
  - Excludes dental and vision
  - Includes health plan, FSA, HSA, HRA and supplemental
  - Employers must calculate and report excess value and tax

## PENDING GUIDANCE

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# Questions & Answers