Health Care Reform

Effects on the Wood County Employee Health Benefits Plan For Plan Year 2013

Employee Health Benefits Committee
October 18, 2012

Health Care Reform (HCR)

- Affordable Care Act (ACA)
  - The Patient Protection and Affordable Care Act (PPACA)
    - H.R. 3590: Public Law No: 111-148 Enacted: March 23, 2010
    - Also known as Obamacare
    - Initial Effective Date: January 1, 2011
    - Eight Year Implementation Timeline: marathon not sprint
    - Collective Bargaining: Bill supersedes negotiations
  - Health Care and Education Reconciliation Act
    - Public Law No. 111-152 Enacted: March 30, 2010
- Public Health Services Act (PHS Act)
  - ACA reorganizes, amends and adds to part A of title XXVII

Amends various federal laws, e.g. Employee Retirement Income Security Act (ERISA) and Internal Revenue Code (Code)

Ongoing Developments

- Supreme Court verdict – June 28, 2012
  - Tax vs. penalty = taxation is permitted
- Federal Agencies providing guidance & developing regulations:
  - Department of Labor (DOL)
  - Health & Human Services (HHS)
  - Treasury Department (including the IRS)
- Ongoing Notices issued

Effective dates were delayed as regulations are developed

How do the regulations apply to the Wood County Employee Health Benefits Plan which is a governmental, self-insured, non-ERISA plan?

Application

- Applies to Health and Prescription coverage only
  - Does not include vision, dental, life
- Mandates Plan to:
  - Alter employee & dependent eligibility rules
  - Alter schedule of benefits
  - Provide affordability using funding ratios
  - Distribution of information
- Does not reduce costs in medical system

Reminder: The Wood County Employee Health Benefits Plan retains Grandfathered Status through January 1, 2014

HCR Timeline - Update

Year	Action	Applies to Grandfathered Status
2010	▪ Change in federal tax definition of dependent to the end of the calendar year in which dependent turns 26	Yes
	▪ Break time/private room for nursing moms	Yes
2011	▪ Dependent coverage to 26 using new definition for eligibility	Yes
	▪ No lifetime dollar limits on essential health benefits	Yes
	▪ Restricted annual dollar limits on essential health benefits	Yes
	▪ No pre-existing condition limitations for children up to age 19	Yes
	▪ No rescissions – 30 day notice required	Yes
	▪ Disclosure of plan data	No
	▪ Appeals process notice	No
	▪ Flexibility in provider choice and emergency room	No
	▪ No charge for certain wellness benefits	No
	▪ Minimum medical loss rule (not for self insured plans)	Yes

Items in bold affect our Plan in 2013

HCR Timeline - Update

Year	Action	Applies to Grandfathered Status
2012	▪ Employers must provide 60-day advance notice of material modifications (notice TBD)	Yes
2013	▪ W-2 reporting for 2012 coverage (originally 2011) ▪ Employers must distribute uniform Summary of Benefits & Coverage (SBC) to participants ▪ Notice of availability of Health Insurance Exchange ▪ Research fees begin	Yes Yes Yes Yes
2014	▪ Automatic Enrollment (originally TBD) ▪ No waiting period over 90 days ▪ Employer Shared Responsibility ▪ Health insurance exchanges ▪ Free-choice vouchers ▪ Additional reporting and disclosure ▪ Dependent coverage to age 26 for any covered employee's child ▪ No annual dollar limits on essential benefits ▪ No pre-existing condition limits ▪ HIPPA wellness limit increases ▪ Annual cost sharing and deductible limits	Yes Yes Yes Yes Yes No Yes Yes Yes No Yes
2018	▪ High Cost Coverage Reporting	

Regulations Affecting 2013 Plan Year

Understand the upcoming Regulations to prepare for increased costs and administration

- Reporting of Plan Costs on W-2
- Summary of Benefits & Coverage (SBC)
- Exchange Notifications
- Research Trust Fund Fee
- Shared Responsibility
- Automatic Enrollment
- 90-Day Waiting Period Limitation

Language used in presentation is directly from federal regulations and official notices designed for use by various types of insurance

Reporting of Plan Costs on W-2

Designed to provide useful and comparable consumer information to employees on health & prescription premium only

- Self Insured plans may calculate costs using Actuarial Method or Past Cost Method
- Calendar year costs reported on or before January 31 of succeeding year (2012 coverage reported on W-2 provided in 2013)
  - Reported in box 12 using DD code
- Includes the total annual cost of coverage
  - Employer and employee contributions (pre & post taxed)
  - Accounts for changes; e.g. single to family, family to single, new or termination
  - Health & prescription coverage only (not deductibles or co-insurance)
  - Includes wellness & administration expenses

Effective: January 2013

Employers with 250 W-2

Report 2012 plan costs

As required by: IRS 6051(a)(14)
Notice 2012-9

Reporting of Plan Costs on W-2

- Federal government views Wood County Government (same tax id no.) as one employer
  - Wood Lane has separate insurance
- Multiemployer healthcare plans are exempt from reporting
  - Legal Research pending
- Implementation meetings held with Auditor's staff, NWSD & Wood Lane
- Software changes required to track annual costs on enrollee basis
  - Current software tracks via funding codes not by enrollee
- Required to advise terminated employees that they may request W-2 at time of separation
  - If requested prior to January 2 it must be provided within 30 days

"Will not cause otherwise excludable employer-provided health care coverage to become taxable."

Summary of Benefits and Coverage (SBC)

Designed to help plans and individuals better understand their coverage & used to compare against other plans

- The document is federally standardized to:
  - Accurately describes the benefits and coverage. Must include:
    - Description of coverage including cost sharing such as deductibles, coinsurance and co-payments
    - Info regarding any exceptions, reduction or limitations
    - Provide two standardized examples
  - Provides standard definitions of terms: Uniform Glossary of Health Coverage and Medical Terms

Effective: Open Enrollments on or after Sept. 23, 2012

As required by: Section 2715 of the Public Health Services Act
Updates ERISA, IRS & HHS

SBC Content

- Must include exact language and format
  - Cannot exceed four double-sided pages
  - Not include print smaller than 12 font
- Must insert our plan design into standardized format and provide examples for cost of care (not cost of coverage) and why it matters
- May be a stand-alone document or in combination with Summary Plan Description (SPD)
  - If combined with SPD must be first portion of document
- Permits online access to communicate additional information on networks, prescription formularies, etc.

Federal Departments estimate annualized cost of $73 million

Must provide free of charge to all applicants and enrollees. Wood County will provide paper copy for 2013 followed by electronic format in subsequent years.

SBC Distribution

- Provide to all Applicants and Enrollees by Plan Sponsor (Wood County) or designated administrator (Meritain/PDMI)
- May be a stand-alone document or in combination with Summary Plan Description (SPD)
    - If combined with SPD must be first portion of document
- Group Health Plans are encouraged to distribute electronically
- Safe harbor for method of distribution
    - Provide electronically if format is readily accessible, and
    - Paper copy is provided free of charge upon request
- If Internet posting must provide via postcard or email that the documents are available on the Internet, address and how to request paper copy
- Final regulations remove the “acknowledge receipt” requirement

Failure to Provide Fine: Not more than $1,000 for each failure (enrollee), plus additional penalties for each affected individual by Secretary of HHS for non-Federal governmental plans

SBC Distribution Timeframes

Provide To:	Timeframe:
"Applicants" and "Enrollees" defined as participants & beneficiaries	Anti-duplication rule permits a single SBC unless known separate address
1. Annually, if written application……. required to reenroll	1. No later than the date materials are distributed
2. Annually, if Automatic Renewal…… (no application required)	2. No later than 30 days prior to the first day of the new plan year
3. Late enrollees……	3. No later than the first date participant is eligible to enroll
4. Newly eligible……	4. No later than the first date participant is eligible to enroll
5. Special enrollees……	5. 90 days from enrollment as required by ERISA
6. Upon request……	6. No later than seven business days following receipt of request
7. Change in SBC……	7. By first date of change in coverage

Wood County Employee Health Benefits Plan

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

Coverage Period: 1/1/13 – 12/31/13

Coverage for: Single/Family | **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.co.wood.oh.us/employee** or by calling **419.354.9100.** This Plan retains Grandfathered Status until 2014.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$ 150/person or $450/family in-network $300/person or $900/family out-of-network Does not apply to Pre-Admission Testing and Second Surgical Opinion.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** 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 **deductible**. *Coinsurance and copayments do not count toward the deductible. Prescription coverage does not count toward the medical deductible.*
Are there other deductibles for specific services?	$ No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for the other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	$ Yes. $250/person or $450/family in-network; $500/person or $1,500/family out-of-network	The **out-of-pocket limit** 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 out-of-pocket limit?	Premiums, copayments, deductibles, out-of-network, balance-billed charges, and health care this plan does not cover	Even though you pay these expenses, they do not count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	Yes. $2,000,000 on essential services and $1,000,000 on non-essential services	This plan will pay for covered services only up to this limit during each coverage period, even if your own need is greater. You are responsible for all expenses above this limit. The chart starting on page 2 describes *specific* coverage limits, such as limits on the number of office visits.
Does this plan use a network of providers?	Yes. Call 419.354.9100 or see www.co.wood.oh.us/employee for a list of primary and wrap-around network providers and locations.	If you use an in-network doctor or health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.

Questions: Call **419.354.9100** or visit us at **www.co.wood.oh.us/employee.** If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at **www.co.wood.oh.us/employee** or call 419.354.9100 to request a copy.

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

Corrected on May 11, 2012

BCC printing last printed 10/10/2012

Wood County Employee Health Benefits Plan

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

Coverage Period: 1/1/13 – 12/31/13

Coverage for: Single/Family | **Plan Type:** PPO

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	$35 copay + 20% coinsurance	$35 copay, 20% coinsurance + balance billing	Treatment within 72 hours of onset of symptoms for Emergency Medical Care.
	Emergency medical transportation	20% coinsurance	20% coinsurance + balance billing	
	Urgent care	$10 copay + 20% coinsurance	$10 copay + 40% coinsurance + balance billing	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance + balance billing	**Preauthorization** (precertification) required. Semi private room rate.
	Physician/surgeon fee	20% coinsurance	40% coinsurance + balance billing	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$10 copay + 20% coinsurance	$10 copay + 40% coinsurance + balance billing	
	Mental/Behavioral health inpatient services	20% coinsurance	40% coinsurance + balance billing	**Preauthorization** (precertification) required. Semi private room rate.
	Substance use disorder outpatient services	$10 copay + 20% coinsurance	$10 copay + 40% coinsurance + balance billing	
	Substance use disorder inpatient services	20% coinsurance	40% coinsurance + balance billing	**Preauthorization** (precertification) required. Semi private room rate.
If you are pregnant	Prenatal and postnatal care	20% coinsurance	40% coinsurance + balance billing	
	Delivery and all inpatient services	20% coinsurance	40% coinsurance + balance billing	**Preauthorization** (precertification) required. Semi private room rate.

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Wood County Employee Health Benefits Plan

Coverage Examples

Coverage Period: 1/1/13 – 12/31/13

Coverage for: Single/Family | **Plan Type:** PPO

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $7,130
- **Patient pays** $ 410

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$150
Copays	$10
Coinsurance	$250
Limits or exclusions	$0
Total	**$410**

Note: These numbers assume the patient has given notice of her pregnancy to the plan. If you are pregnant and have not given notice of your pregnancy, your costs may be higher. For more information contact: 419.354.9100.

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $4,100
- **Plan pays** $3,380
- **Patient pays** $1,020

Sample care costs:

Prescriptions	$1,500
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$730
Education	$290
Laboratory tests	$140
Vaccines, other preventive	$140
Total	**$4,100**

Patient pays:

Deductibles	$150
Copays	$620
Coinsurance	$250
Limits or exclusions	$0
Total	**$1,020**

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Summary of Benefits and Coverage (SBC)

- Uniform Glossary of Benefits:

Glossary of Health Coverage and Medical Terms

- This glossary has many commonly used terms, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any such case, the policy or plan governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or plan document.)
- **Bold blue** text indicates a term defined in this Glossary.
- See page 4 for an example showing how deductibles, co-insurance and out-of-pocket limits work together in a real life situation.

Allowed Amount
Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing.)

Appeal
A request for your health insurer or plan to review a decision or a grievance again.

Balance Billing
When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A preferred provider may ***not*** balance bill you for covered services.

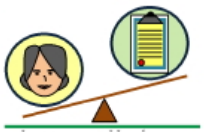
Co-insurance
Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay co-insurance ***plus*** any deductibles you owe. For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your co-insurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.

(See page 4 for a detailed example.)

Complications of Pregnancy
Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section aren't complications of pregnancy.

Co-payment
A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Deductible
The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.



(See page 4 for a detailed example.)

Durable Medical Equipment (DME)
Equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

Emergency Medical Condition
An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm.

Emergency Medical Transportation
Ambulance services for an emergency medical condition.

Emergency Room Care
Emergency services you get in an emergency room.

Emergency Services
Evaluation of an emergency medical condition and treatment to keep the condition from getting worse.

Excluded Services
Health care services that your health insurance or plan doesn't pay for or cover.

Grievance
A complaint that you communicate to your health insurer or plan.

Habilitation Services
Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Insurance
A contract that requires your health insurer to pay some or all of your health care costs in exchange for a premium.

Home Health Care
Health care services a person receives at home.

Hospice Services
Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization
Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

Hospital Outpatient Care
Care in a hospital that usually doesn't require an overnight stay.

In-network Co-insurance
The percent (for example, 20%) you pay of the allowed amount for covered health care services to providers who contract with your health insurance or plan. In-network co-insurance usually costs you less than out-of-network co-insurance.

In-network Co-payment
A fixed amount (for example, $15) you pay for covered health care services to providers who contract with your health insurance or plan. In-network co-payments usually are less than out-of-network co-payments.

Medically Necessary
Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

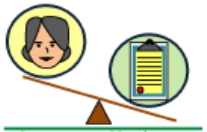
Network
The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

Non-Preferred Provider
A provider who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see a non-preferred provider. Check your policy to see if you can go to all providers who have contracted with your health insurance or plan, or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers.

Out-of-network Co-insurance
The percent (for example, 40%) you pay of the allowed amount for covered health care services to providers who do ***not*** contract with your health insurance or plan. Out-of-network co-insurance usually costs you more than in-network co-insurance.

Out-of-network Co-payment
A fixed amount (for example, $30) you pay for covered health care services from providers who do ***not*** contract with your health insurance or plan. Out-of-network co-payments usually are more than in-network co-payments.

Out-of-Pocket Limit
The most you pay during a policy period (usually a year) before your health insurance or plan begins to pay 100% of the allowed amount. This limit never includes your premium, balance-billed charges or health care your health insurance or plan doesn't cover. Some health insurance or plans don't count all of your co-payments, deductibles, co-insurance payments, out-of-network payments or other expenses toward this limit.



(See page 4 for a detailed example.)

Physician Services
Health care services a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

Exchange Notification

Designed to inform employees about how the Exchanges operate and the circumstances under which an employee may receive coverage

- States are required to develop an insurance exchange to purchase insurance by January 1, 2014 or may opt out and use federal insurance exchange
  - Ohio opted to use federal exchange
- Effective no later than March 1, 2013 for existing employees
  - Beginning March 1, 2013 for new hires
- Regulatory guidance is pending including official notice

Effective: March 2013

As required by: Section 1512 of PPACA

Research Trust Fund

Designed to fund the Patient-Centered Outcomes Research Institute

- Fee paid by employers to a trust fund
- Fee is based on average number of lives covered under the self-insured plan
  - Covered lives may be counted only once if enrolled separately in health and prescription benefits
- Reported and paid one once per year
  - Use IRS Form 720, "Quarterly Federal Excise Tax Return"
  - By July 31 of the calendar year immediately following the last day of the plan year
  - Wood County's 2012 Plan ended December 31, 2012; file by July 31, 2013
  - Plan may file electronically

Effective: Plan years ending on or after October 1, 2012

As required by: Department of Treasury and IRS

Research Fee Calculation Methods -
Employer may select one of three methods:

Actual count method - Total lives covered by the plan for each day of the year, divided by the no. of days in the plan year

Snapshot method -

1) **Snapshot count**: actual number of lives on a designated date
2) **Snapshot factor**: sum of number of participants with self-only coverage on that date, plus the product of the number of participants with coverage other than self-only on the designated date and 2.35

Form 5500 method - Wood County is not required to file

A different method may be used from one plan year to the next

Research Trust Fund

Financial Impact: Wood County elects the Snapshot Factor as of August 2012 = $1,328

2012 Plan Year - $1 per life
2013 Plan Year - $2 per life
2014 Plan Year – fee increases based on a formula that includes increases in the projected per capita amount of National Health Expenditures by HHS

Regulations apply to plan years ending before October 1, 2019

Shared Responsibility Payment

Designed to encourage large employers to provide group health plan coverage for their employees (and dependents)

- If an employee is eligible for insurance coverage through a state or federal health care exchange through a premium tax credit or cost sharing reduction, then
- Government may impose "pay or play" requirements called "shared responsibility payment" penalties if the employer fails to pass Shared Responsibility Criteria

Effective: January 2014

Employers with 50 full-time equivalent employees

As required by: Code section 4980H

DOL, HHS, IRS

Notice 2012-28 *(issued 8/31/12)*

Notice 2012-58 (issued 8/31/12)

Notice 2012-59 (issued 9/20/12)

Shared Responsibility Payment

- Payment is based on Shared Responsibility Criteria:
  1) Employer does not offer to full-time employees (& dependents) minimum essential coverage, or
  2) Employer's coverage is either unaffordable relative to an employee's household income or does not provide minimum value

What does that mean?

1) Full-time employees
2) Unaffordable relative to an employee's household income

Shared Responsibility - Offering

1) Employer does not offer to full-time employees (dependents) minimum essential coverage

- Federal definition of "Full-time Employee" is an employee who is employed on average at least 30 hours per week
  - Wood County's current definition is 40 hr
- Notice 2012-58 provides Safe Harbor for calculating of hours worked
  - **Measurement Period** – determines eligibility
  - **Administrative Period** – perform calculations & inform staff
  - **Stability Period** – period of eligibility

Penalty Test - Part 1

Determining Full-time Status

- Employer establishes timeframes used to determine eligibility, but must be consistent in application
- Differences are permitted for:
  - Bargaining/non-bargaining
  - Salaried/hourly
  - Different entities
  - Different states

Shared Responsibility Offering

Measurement Period

Lookback period of 3 to 12 consecutive calendar months to check if ongoing or newly hired variable-hour or seasonal employees are full-time.

Hours worked include all hours actually worked in addition to any vacation, sick leave, holidays, etc.

Shared Responsibility Offering

Measurement Period

Lookback period of 3 to 12 consecutive calendar months to check if ongoing or newly hired variable-hour or seasonal employees are full-time.

Hours worked include all hours actually worked in addition to any vacation, sick leave, holidays, etc.

2012 - 2013

Oct 15 (Year 1) to Oct 14 (Year 2)

Working avg of 30 hrs per week?

Shared Responsibility Offering

Measurement Period

Lookback period of 3 to 12 consecutive calendar months to check if ongoing or newly hired variable-hour or seasonal employees are full-time.

Hours worked include all hours actually worked in addition to any vacation, sick leave, holidays, etc.

Administrative Period

Maximum of a 90 day period between the Measurement and Stability periods to perform administration and communicate with employees

2012 - 2013

Oct 15 (Year 1) to Oct 14 (Year 2)

Working avg of 30 hrs per week?

Shared Responsibility Offering

Measurement Period

Lookback period of 3 to 12 consecutive calendar months to check if ongoing or newly hired variable-hour or seasonal employees are full-time.

Hours worked include all hours actually worked in addition to any vacation, sick leave, holidays, etc.

Administrative Period

Maximum of a 90 day period between the Measurement and Stability periods to perform administration and communicate with employees

Recommended Timeline for Wood County

2012 - 2013

Oct 15 (Year 1) to Oct 14 (Year 2)

Working avg of 30 hrs per week?

2013

Oct 15 (Year 2) to Dec 31 (Year 2)

Review hours worked to determine eligibility

Shared Responsibility Offering

Measurement Period

Lookback period of 3 to 12 consecutive calendar months to check if ongoing or newly hired variable-hour or seasonal employees are full-time.

Hours worked include all hours actually worked in addition to any vacation, sick leave, holidays, etc.

Administrative Period

Maximum of a 90 day period between the Measurement and Stability periods to perform administration and communicate with employees

Stability Period

At least 6 consecutive calendar months that follows and not shorter in duration than the Measurement period. May not exceed Measurement period if employee does not qualify during the Measurement Period.

Recommended Timeline for Wood County

2012 - 2013

Oct 15 (Year 1) to Oct 14 (Year 2)

Working avg of 30 hrs per week?

2013

Oct 15 (Year 2) to Dec 31 (Year 2)

Review hours worked to determine eligibility

Shared Responsibility Offering

Measurement Period

Lookback period of 3 to 12 consecutive calendar months to check if ongoing or newly hired variable-hour or seasonal employees are full-time.

Hours worked include all hours actually worked in addition to any vacation, sick leave, holidays, etc.

Administrative Period

Maximum of a 90 day period between the Measurement and Stability periods to perform administration and communicate with employees

Stability Period

At least 6 consecutive calendar months that follows and not shorter in duration than the Measurement period. May not exceed Measurement period if employee does not qualify during the Measurement Period.

Recommended Timeline for Wood County

2012 - 2013
Oct 15 (Year 1) to Oct 14 (Year 2)
Working avg of 30 hrs per week?

2013
Oct 15 (Year 2) to Dec 31 (Year 2)
Review hours worked to determine eligibility

2014
Jan 1 (Year 3) to Dec 31 (Year 3)
Coverage eligible

Shared Responsibility - Offering

Federal Example: An employer utilizes a 12-month stability period that begins January 1 and a 12-month standard measurement period that begins October 15.

Employee A was employed for the entire measurement period and works on average 30 hours per week from October 15 of Year 1 to October 14 of Year 2.

Employee A must be provided coverage during the entire Year 3 stability period, including Year 3 administrative period.

Consequences

- Employee does not need to work 30 hours per week in Year 3 to be eligible for insurance coverage in Year 3. Employee is eligible regardless of the number of hours worked
- If employee does not work 30 hours in Year 3 measurement period they will not be eligible for benefits in Year 4 even if they work 40 hours in Year 4
- Will the employee have sufficient wages to collect monthly premium via payroll deduction
- This may increase administrative costs for departments with Variable Hour Employees

Shared Responsibility - Offering

- Initial Measurement Period – used for variable hour employees between 3 and 12 months
- Standard Measurement Period – annual measurement period used for ongoing employees
  - Ongoing Employee – employed for one complete standard measurement period

Treatment of employees who experience changes in employment status are expected to be covered in future federal notices or guidance

Shared Responsibility - Affordability

2) Employers coverage is either unaffordable relative to an employee's household income or does not provide minimum value

- Minimum Essential Value based on:
  - Inadequate - less than 60% of the total allowed costs of benefits
  - Unaffordable – if the employee's share of the premium (lowest single) is more than 9.5% of the employee's household income
- Notice 2012-58 provides a Safe Harbor for calculating the "employee's household income" to the employee's Form W-2 wages as reported in Box 1: Wages minus
  - Section 125 (POP) Insurance Premiums
  - Employees' OPERS contributions (10%)
  - Deferred Comp contributions (varies)
  - Other Pre-taxed deductions, e.g. AFLAC

Penalty Test - Part 2

Example using worse case using 2012 rates:

Wage (state min.)	$7.70
Full-time (30 hrs/wk)	x 1,560
	$12,012
Minus OPERS	($ 1,201)
2012 Family Ins. Ded.	($ 1,715)
Deferred Comp ??	($ 260)
Annual W-2 Wages	**$ 8,836**
Lowest Single Rate	**$ 715**

$715 / $8,836 = 8.1%

Considered affordable Using Safe Harbor **8.1%**

It appears that Wood County Employee Health Benefits Plan does provide affordable coverage relative to an employee's full-time hourly rate

Shared Responsibility Payment

- Employer is charged a penalty, aka “Free rider penalty”
  - If at least one full-time employee receives a premium tax credit or cost-sharing reduction
  - Employer Fails Minimum Value Test as defined by the Secretary of Health and Human Services (inadequate or unaffordable)
- Penalty is based on the lesser of:
  - $3,000 for each employee who receives assistance, or
  - $2,000 per full-time employee (not counting the first 30 employees)
- Safe Harbors may be used until the end of 2014

DOL views Wood County Government as one employer sharing the same tax id number

Concern: How is penalty applied for those Plans outside the Wood County Employees Health Benefits Plan (Wood Lane) or a different employer (NWWSD)?

Shared Responsibility Payment

- Requires Wood County to change plan's eligibility rules
  - Must lower hours of eligibility from 40 hours per week to 30 hrs per wk or pay penalty
- Requires administrative changes for determining initial and ongoing eligibility by creating
  - Measurement – Administrative – Stability Periods
- Departments with variable hour employees must track hours and reconsider call-in procedures for part-time staff
  - Plan for increased insurance costs to operating expenses

Automatic Enrollment

Designed to enroll & continue coverage for all new full-time employees

- Directs employers
  - automatically enroll new full-time employees (single contract)
  - Provide adequate notice and the opportunity to opt out of coverage or process to change election
- DOL is postponing implementation due to interaction with other regulations such as Shared Responsibility and 90-Day Waiting Period

Effective: January 2014

Postponed from 2013
FLSA employers with more than 200 full-time employees

As required by: ACA section 1551
modified FLSA Section 18A
Notice 2012-28 (issued 8/31/12)
Notice 2012-59 (issued 9/20/12)

90-Day Waiting Period Limitation

Designed to prevent an otherwise eligible employee (or dependent) from having to wait more than 90 days before coverage becomes effective

- PHS "does not require the employer to offer coverage to any particular employee or class of employees, including part-time employees"
  - May condition on full-time, bona fide job category, receipt of license, specific cumulative number of hours of service with a period
- Waiting Period: period of time that must pass before coverage for an employee or dependent who is otherwise eligible to enroll under the terms of the plan can become effective
  - May use Shared Responsibility Measurement Period to determine Variable Hour employees

Effective: Plan years beginning on or after January 2014

As required by: PHS Act section 2708
Notice 2012-17
Notice 2012-59 (issued 9/20/12)
Technical Release No. 2012-02 (issued 8/31/12)
"guidance in effect at least through the end of 2014"

90-Day Waiting Period Limitation

- Wood County conditions eligibility on the following
  - In active pay status as a permanent full-time employee (not on leave of absence on regularly scheduled day)
  - Completes the employment waiting period of 30 days as a permanent full-time employee in active pay status
  - Coverage becomes effective on the first day of the month following completion of the employment waiting period provided all enrollment requirement of the Plan are satisfied, including making application
- Employers may use Code section 4980H Safe Harbor to determine if a newly hired employee cannot be determined to work full-time initially
  - Variable Hour Employees determined to have worked full-time during the Measurement Period must be enrolled no later than 13 months from the employee's start date (plus the time remaining in the calendar month if not hired the first day of the month)

Full-time employees are within regulation, however, Wood County must develop a process to review those working variable hours

Other Action Items

- Update Plan Document and Summary Plan Description (SPD) for eligibility rules, auto enrollment, etc.
- Update Participation Agreements with Elected Officials and Department Heads
- Meet with Departments who employ variable hour employees
  - Require tracking of hours – creates a challenge for call-in coverage
  - If eligible for coverage and not working sufficient hours must self-pay premium collected via payroll deduction or terminate
- Share information with Wood Lane
- Communicate to Insurance Group Representatives
- Plan for increased for administrative costs: Research Trust Fund and potential penalties

Observation: Nothing in the Affordable Care Act makes the Wood County Health Care Plan more affordable