



Health Benefits Fringe Committee Meeting

November 8, 2012

Board Room



Agenda

1. JPA Exploration-A continued Discussion, Keenan
 1. Keenan
 2. Benefits Bridge

(10:00-10:30)

2. State of the Post Prop 30 District Budget & Five Year Review of benefit costs, Vice Chancellor Gerhardt

(10:40-10:50)

4. Communications:

(10:50 – 11:00)

 1. Flexible Benefits Open Enrollment November 1 – 30
 2. Benefits Mini-Fair Thursday, November 15
 3. Peralta Benefits Everyone October 31
 1. Medicare D Required Notice and Annual Distribution
 2. W-2's for actives AND retired will include value of health insurance
 3. Flexible Benefits Plan online enrollment, remain on the calendar year
 4. Notes on the website now!
 5. How do you communicate with your constituents?
 - 1.

5. Issues in Self-Funding (PSW Benefits Resources & PCCD Benefits Office)

11:00 – 12:00

 1. Enrollment Census (PCCD Benefits Office)
 2. Process for changes to the Summary Plan Description language (Benefits Office)
 3. Out-of-Network Claims Experience (PSW)
 4. Update of Non-California network options (PSW)
 5. Review of Post-election Health Care Reform Considerations for Peralta (PSW)
 6. JPA Exploration Considerations

Agenda Items for next meeting Monday 12/3/12

1. Next Meeting dates for the semester
2. Review of Medicare Coordination Notices to retirees and to union
3. More Discussion on JPA Exploration
4. Buy in options for separated or non-benefit eligible employees
5. Other Topics?



JPA Different Models

- We can join a JPA with or without broker or consultant representation.
- We can forgo a broker/consultant and join a JPA directly.
- We can continue to use a broker/consultant for proper marketing of the Peralta population.



JPA Exploration

Joint Trust vs. JPA Comparison

| | Joint Trusts (ex: CVT, VEBA) | JPAs (ex: SISC, PACE) |
|---|---|--|
| Employee Involvement | <ul style="list-style-type: none"> • Governing Board • District Insurance Committee | <ul style="list-style-type: none"> • District Insurance Committee • Potential Governing Board and Advisory Committee |
| Final Decision on District Benefits | Joint Trust determines benefit design and offerings | JPA determines benefit design and offerings |
| Unilateral Benefit Change | Yes | Yes |
| Legal Structure | Private entity | Public entity |
| Subject to Brown Act | No | Yes |
| Financial Disclosure | <ul style="list-style-type: none"> • ERISA | <ul style="list-style-type: none"> • GASB • AB1200 • Various Government Codes |
| Investment Guidelines | None | Investments limited by government code |
| Fiduciary Responsibility | Shared by Trustees | District and JPA |
| Accreditation Standards | None | Adheres to strict standards if CAJPA accredited |
| Withdrawal | Set forth in document | Set forth in document |
| Geographical Area | Many counties | Many counties |
| Asset Ownership | Assets must be used to benefit trust participants | Member districts own JPA assets |
| Financial Liability upon Dissolution | Trust can default | JPAs must satisfy financial obligations |

Prepared by: Keenan & Associates
2012



Benefits Bridge

- Emerging Technologies
 1. Address changes
 2. Enrollment update
 3. Accuracy of data

State of the Budget-Vice Chancellor Gerhardt



Communications- Benefits Office



Benefits & Medical Information - Windows Internet Explorer

http://web.peralta.edu/benefits/

File Edit View Favorites Tools Help

Home Feeds (1) Read Mail Print Page Safety Help

Benefits & Medical Information

PERALTA COMMUNITY COLLEGE DISTRICT

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Quick Links

- Change of Address Form

Contact Information

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Benefits & Medical Information Home

Where can I find current benefits information, downloads, links and resources?

For 24-hour access to benefit resources and

- if you are an active employee, [click here](#) if you want to view or download resources.
- if you are a retired employee [click here](#) if you want to view or download resources related to your retirement status with Peralta.

November 2012 Announcements

Save the Date – Thursday, November 15, 2012 Benefits Mini Fair

Open Enrollment for the Flexible Benefits Plan IRS Code 125 is 11/1/12-11/30/12

PERALTA BENEFITS – EVERYONE October 31, 2012

- Review health and welfare benefit offerings
- Access customer service resources
- View medical and dental plan comparisons

Peralta Benefits Everyone Newsletter (October 2012) Supplement with Statutory Contribution Rates 2012-2013

- Employee and Employer Contribution Rates
- Download Holiday Calendar

Benefits Fair Announcement November 2012

- Workshops on Estate Planning, Identity Theft, Choosing a Financial Planner, Retirement Planning
- Invited Guests include our Health & Wellness Benefits Partners:
 - 24 Hour Fitness-Club One-Mariners Square-Kaiser Permanente Wellness Coaches
 - COSTCO-renew your membership
 - Golden State Warriors, enter your name in a raffle

Flexible Benefits Plan Open Enrollment Announcement for 2013

- Section 125 – Flexible Benefit Plan Handbook 2013
- Online enrollment instructions included in this document
- Plan benefits, eligibility criteria are also noted within the Handbook

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Time sent: 2:49:09 PM 11/7/2012

Click here to open the print queue, and then for assistance, click Troubleshooter on the Help menu.

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Issues in Self-funding Peralta Enrollment Census as of October 2012

| | Contract | 50% | 100% | Subtotal | 1021 | 39 | Confidentials | Managers | Total | Grand Total |
|--------------------------------|-----------------|------------|-------------|-----------------|-------------|-----------|----------------------|-----------------|--------------|--------------------|
| Kaiser | | | | | | | | | | |
| Single | 49 | 39 | 3 | 91 | 72 | 20 | 1 | 10 | 194 | |
| 2-party | 39 | 8 | 1 | 48 | 56 | 11 | 7 | 6 | 128 | |
| 3+ | 41 | 3 | 0 | 44 | 55 | 25 | 5 | 8 | 137 | |
| Total | | | | 183 | | | | | 459 | 642 |
| Self Funded Lite | | | | | | | | | | |
| Single | 13 | 1 | 13 | 27 | 17 | 2 | 4 | 5 | 55 | |
| 2-party | 16 | 0 | 16 | 32 | 12 | 2 | 2 | 4 | 52 | |
| 3+ | 31 | 0 | 31 | 62 | 22 | 4 | 3 | 6 | 97 | |
| Total | | | | 121 | | | | | 204 | 325 |
| Self Funded Traditional | | | | | | | | | | |
| Single | 24 | 15 | 0 | 39 | 18 | 1 | 1 | 2 | 61 | |
| 2-party | 24 | 2 | 0 | 26 | 7 | 6 | 1 | 4 | 44 | |
| 3+ | 21 | 0 | 0 | 21 | 5 | 4 | 0 | 1 | 31 | |
| Total | | | | 86 | | | | | 136 | 222 |
| Delta | | | | | | | | | | |
| Single | 82 | 0 | 24 | 106 | 17 | 20 | 1 | 16 | 160 | |
| 2-party | 85 | 0 | 12 | 97 | 20 | 11 | 9 | 16 | 153 | |
| 3+ | 91 | 0 | 2 | 93 | 35 | 25 | 7 | 8 | 168 | |
| Total | | | | 296 | | | | | 481 | 777 |
| United Health Care | | | | | | | | | | |
| Single | 2 | 0 | 11 | 13 | 14 | 1 | 2 | 2 | 32 | |
| 2-party | 1 | 0 | 5 | 6 | 2 | 1 | 1 | 0 | 10 | |
| 3+ | 4 | 0 | 3 | 7 | 5 | 1 | 2 | 7 | 22 | |
| Total | | | | 26 | | | | | 64 | 90 |



- Average age of current Peralta retiree?
- Number of pre 2004 retirees
 - Average Age
- Number of post 2004 retirees
 - Average Age

Issues in Self Funding

Process for changing the Summary Plan Description-see Summary from 10/8/12 meeting



Causes

1. Change in business partnership
Change from Blue Cross, Interplan, Anthem, Spectera, CVS Caremark
2. Clarification
addition of reference to PHCS as a network for non-California residents
3. Conformity
preservation of past practice
4. Correction
union name change from 790 to 1021
5. Compliance
coverage of dependents to age 26, elimination of pre-existing conditions

Work Order for Change

1. Cause triggers a work order to our TPA, currently CoreSource
2. Then amendment is published or otherwise distributed in the revised SPD

Codification for claims administration with business partner

Issues in self-funding Out of network claims review (PSW Benefit Resources)



Successor Agreements:

“ Year 1 (2012-2013): Status quo (current) coverage for eligible dependent or people who retire AND move out of California

Years 2 and 3: Revisit out-of-state networks...shall work together to make every reasonable effort to attempt to provide out-of-state retirees a network similar to the California Anthem BlueCross network, beginning in Year 2.

Issues in self-funding Out of Network Claims Experience-PSW



PERALTA COMMUNITY COLLEGE DISTRICT --- NETWORK SAVINGS ANALYSIS

CLAIMS PAID BETWEEN OCTOBER 1, 2011 AND SEPTEMBER 30, 2012

In-Network / Out-of-Network Analysis

| Network | Total | | | | | |
|-------------------------------------|---------------------|---------------------|--------------------|-----------------------|--------------------|------------|
| | Claims Billed | Claims Allowed | Claims Paid | Employee Contribution | Network Discount | % Discount |
| BCCA-PRUDENT BUYER MEDICAL PROVIDER | \$36,147,352 | \$9,852,679 | \$6,970,424 | \$98,518 | \$5,899,069 | 46% |
| PHCS-PPO PRODUCT | \$2,787,784 | \$738,607 | \$349,655 | \$2,752 | \$205,869 | 37% |
| OUT OF NETWORK | \$780,278 | \$283,536 | \$174,787 | \$751 | \$0 | |
| MULTIPLAN-MP | \$75,055 | \$40,606 | \$37,989 | \$271 | \$17,690 | 32% |
| MULTIPLAN NEGOTIATION | \$15,246 | \$10,207 | \$10,034 | \$173 | \$3,769 | 27% |
| NATIONAL CARE NETWORK | \$10,984 | \$9,141 | \$9,001 | \$140 | \$1,656 | 16% |
| All Other Par (In Network) | \$0 | \$0 | \$0 | \$0 | \$0 | |
| All Non-Par (Out of Network) | \$2,683,938 | \$1,322,803 | \$897,259 | \$171,409 | \$80,818 | 8% |
| Total | \$42,500,638 | \$12,257,580 | \$8,449,149 | \$274,015 | \$6,208,870 | 42% |

Update of Non-California network options, PSW Benefit Resources



- Changes in the network landscape

Health Care Reform – How has the Peralta Community Benefited?



Disclosure Form

Health Care Reform Changes

Because of the recent health care reform law (formally known as the Patient Protection and Affordable Care Act or “PPACA”), we are updating some information you may see in this booklet. These changes are for Plan years beginning on or after September 23, 2010. You’ll find more details in your *Evidence of Coverage* or *Certificate of Insurance*.

Preventive services

Please refer to the “Benefit Highlights” section for the cost sharing that applies for preventive services. If your coverage is not a “grandfathered health plan” under PPACA, or if your group has purchased the preventive package for non-grandfathered coverage, there will be no copayments, coinsurance, or deductibles for any of the preventive services that are specified in the health care reform law, or that are mandated by state law.

Coverage for adult children

Under new federal law, dependent children may stay on their family’s plan until they turn 26. If you have children who will be younger than 26 at the start of the next Plan year, you will be able to enroll them, subject to your group’s eligibility rules, even if they previously lost or were unable to get coverage because of their age.

Grandfathered coverage

If your group’s coverage is a “grandfathered health plan” under PPACA, some of these mandates may not apply. To find out whether your coverage is grandfathered, or for other questions about grandfathered coverage, please ask your group.

Removal of annual or lifetime limits

We’re removing all lifetime and annual dollar limits on essential health benefits. Members who exceeded these limits before will now be covered for these services, going forward.

More information

For more information about these or other benefit changes, please contact our Member Service Call Center, weekdays from 7 a.m. to 7 p.m. and weekends from 7 a.m. to 3 p.m. (except holidays), at **1-800-464-4000** or **1-800-777-1370** (TTY for the deaf, hard of hearing, or speech impaired).

For more information on health care reform and how we’re responding to it, please visit kp.org/reform.

Health Care Reform-An update/Review



1. Our broker's perspective



November 6, 2012

Health Care Reform Timeline 2012 - 2018

PSW Benefit Resources and Insurance Services is providing this timeline of the implementation of key reform provisions that affect employers and individuals. Please read below for more information and contact PSW Benefit Resources and Insurance Services with any questions about how you can prepare for any of the health care reform requirements.

2012

HEALTH PLAN ADMINISTRATION

- **Uniform Summary of Benefits and Coverage.** All non-grandfathered and grandfathered health plans will be required to provide a uniform summary of the plan's benefits and coverage to participants. The summary will have to be written in easily understood language and will be limited to four pages. Any mid-year changes to the information contained in the summary will have to be provided to participants 60 days in advance. The health care reform law indicated that plans would be required to start providing the summary by March 23, 2012.

Note: On Nov. 17, 2011, the Department of Labor (DOL) issued guidance that delayed the deadline for plans to begin providing the summary until after the release of final regulations. On Feb. 9, 2012, HHS, the DOL and the Treasury Department issued final regulations on the summary of benefits and coverage requirement.

The final guidance provides that plans and issuers must start providing the summary by the following deadlines:

- Issuers must provide the summary to health plans effective **Sept. 23, 2012**;
- Plans and issuers must provide the summary to participants and beneficiaries who enroll or re-enroll during an open enrollment period starting with the first day of the first **open enrollment period** that begins on or after **Sept. 23, 2012**;
- Plans and issuers must provide the summary to participants who enroll for coverage other than through an open enrollment period (for example, newly eligible individuals and special enrollees) starting with the first day of the first **plan year** that begins on or after **Sept. 23, 2012**.

The Department of Labor's basic approach to ACA implementation is: "to work together with employers, issuers, States, providers and other stakeholders to help them come into compliance with the new law and to work with families and individuals to help them understand the new law and benefit from it, as intended. Compliance assistance is a high priority for the Department of Labor. Their approach to implementation is and will continue to be marked by an emphasis on assisting (rather than imposing penalties on) plans, issuers and others that are **working diligently and in good faith** to understand and come into compliance with the new law." Accordingly, consistent with this guidance,



- **Reporting Health Coverage Costs on Form W-2.** Employers will be required to disclose the value of the health coverage provided by the employer to each employee on the employee's annual Form W-2.

Fees and taxes

- **Comparative Effectiveness Research (CER) Fees.** Effective for **plan years ending on or after Oct. 1, 2012**, issuers and sponsors of self-insured health plans must pay CER fees to fund health care research. The CER fees do not apply for plan years ending on or after Oct. 1, 2019. Thus, for calendar year plans, the CER fees will be effective for the 2012 through 2018 plan years. For plan years ending before Oct. 1, 2013 (that is, 2012 for calendar year plans), the research fee is **\$1** multiplied by the average number of lives covered under the plan. The fee goes up to **\$2** for plan years ending on or after Oct. 1, 2013 and before Oct. 1, 2014, and will be indexed for future years. CER fees must be reported and paid by July 31 of each year, and will generally cover plan years that end during the preceding calendar year. The first possible due date for paying CER fees is **July 31, 2013**.

Remittance of Fees

Insurers and plan sponsors must report and pay these fees annually on IRS Form 720, which will be due by July 31 of each year. The first due date is July 31, 2013. A return will generally cover policy or plan years that end during the preceding calendar year. In other words, fees for a plan year are due by July 31 of the calendar year following the calendar year containing the plan year end. Form 720 may be filed electronically. **The IRS has not yet updated Form 720 to reflect the reporting of these fees.**

2013

HEALTH PLAN ADMINISTRATION

- **Limiting Health Flexible Savings Account Contributions.** The health care law will limit the amount of salary reduction contributions to health FSAs to \$2,500 per year, indexed by CPI for subsequent years.
- **Employee Notice of Exchanges.** Effective **March 1, 2013**, employers must provide a notice to employees regarding the availability of the health care reform insurance exchanges. HHS has indicated that it plans on issuing model exchange notices in the future for employers to use.
- **HIPAA Certification.** By **Dec. 31, 2013**, employers with group health plans must certify that their plans comply with HIPAA's rules on electronic transactions. HHS intends to issue more guidance on this requirement in the future.

FEES AND TAXES

- **Eliminating Deduction for Medicare Part D Subsidy.** Currently, employers that receive the Medicare Part D retiree drug subsidy may take a tax deduction for their prescription drug costs, including costs attributable to the subsidy. The deduction for the retiree drug subsidy will be eliminated in 2013.
- **Increased Threshold for Medical Expense Deductions.** The health care reform law increases the (IRS) income threshold for claiming the itemized deduction for medical expenses from 7.5 percent of income to 10 percent. However, individuals over 65 would be able to claim the itemized deduction for medical expenses at 7.5 percent of adjusted gross income through 2016.
- **Additional Medicare Tax for High Wage Workers.** The new law increases the Medicare tax rate by 0.9 percentage points on wages over \$200,000 for an individual



- **Individual Coverage Mandates.** The health care reform legislation requires most individuals to obtain acceptable health insurance coverage or pay a penalty, beginning in 2014. The penalty will start at \$95 per person for 2014 and increase each year. The penalty amount increases to \$325 in 2015 and to \$695 (or up to 2.5 percent of income) in 2016, up to a cap of the national average bronze plan premium. After 2016, dollar amounts are indexed. Families will pay half the penalty amount for children, up to a cap of \$2,250 per family. Individuals may be eligible for an exemption from the penalty if they cannot obtain affordable coverage.
 - Legal challenges to the health care reform law have focused on whether Congress had the constitutional authority to enact the individual coverage mandate.
 - On June 28, 2012, the U.S. Supreme Court addressed these legal challenges and upheld the individual coverage mandate as constitutional. This means that the mandate will go into effect in 2014 as planned, unless it is repealed by Congress.
- **Employer Coverage Requirements.** Employers with 50 or more employees that do not offer coverage to their employees will be subject to penalties if any employee receives a government subsidy for health coverage. The penalty amount is up to \$2,000 annually for each full-time employee, excluding the first 30 employees. Employers who offer coverage, but whose employees receive tax credits, will be subject to a fine of \$3,000 for each worker receiving a tax credit, up to an aggregate cap of \$2,000 per full-time employee. Employers will be required to report to the federal government on health coverage they provide.

HEALTH INSURANCE EXCHANGES

The health care reform legislation provides for **health insurance exchanges** to be established in each state in 2014. Individuals and small employers will be able to shop for insurance through the exchanges. Small employers are those with no more than 100 employees. If a small employer later grows above 100 employees, it may still be treated as a small employer. However, states may limit employers' participation in the exchanges to businesses with up to 50 employees until 2016. Large employers with over 100 employees are to be allowed into the exchanges in 2017. The health care reform legislation provided that workers who qualified for an affordability exemption to the coverage mandate, but did not qualify for tax credits, could use their employer contribution to join an exchange plan. This requirement is known as the "free choice voucher" provision. The federal appropriations bill signed by President Obama on April 15, 2011, eliminated the free choice voucher provision from health care reform.

HEALTH INSURANCE REFORM

Additional health insurance reform measures will be implemented beginning in 2014.

- **Guaranteed Issue and Renewability.** Health insurance issuers offering health insurance coverage in the individual or group market in a state must accept every employer and individual in the state that applies for coverage and must renew or continue to enforce the coverage at the option of the plan sponsor or the individual.
- **Pre-existing Condition Exclusions.** Effective Jan. 1, 2014, group health plans and health insurance issuers may not impose pre-existing condition exclusions on any covered individual, regardless of the individual's age.
- **Insurance Premium Restrictions.** Health insurance issuers in the individual and small group markets will not be permitted to charge higher rates due to health status, gender or other factors. Premiums will be able to vary based only on age (no more than 3:1), geography, family size and tobacco use. The rating limitations will not apply to health



- ***Nondiscrimination in Health Care.*** Group health plans and health insurance issuers offering group or individual insurance coverage may not discriminate against any provider operating within their scope of practice. However, this provision does not require a plan to contract with any willing provider or prevent tiered networks. It also does not apply to grandfathered plans. Plans and issuers also may not discriminate against individuals based on whether they receive subsidies or cooperate in a Fair Labor Standards Act investigation.
- ***Annual Limits.*** Restricted annual limits will be permitted until 2014. However, in 2014, the plans and issuers may not impose annual limits on the amount of coverage an individual may receive.
- ***Excessive Waiting Periods.*** Group health plans and health insurance issuers offering group or individual health insurance coverage will not be able to require a waiting period of more than 90 days.
- ***Coverage for Clinical Trial Participants.*** Non-grandfathered group health plans and insurance policies will not be able to decline coverage because an individual chooses to participate in a clinical trial for cancer or other life-threatening diseases or deny coverage for routine care that they would otherwise provide just because an individual is enrolled in such a clinical trial.

EMPLOYER WELLNESS PROGRAMS

FEES AND TAXES

- ***Individual Health Care Tax Credits.*** The new law makes premium tax credits available through the exchanges to ensure people can obtain affordable coverage. Credits are available for people with incomes above Medicaid eligibility and below 400 percent of poverty level who are not eligible for or offered other acceptable coverage. The credits apply to both premiums and cost-sharing.

2018

HIGH COST PLAN EXCISE TAX

A 40 percent excise tax is to be imposed on the excess benefit of high cost employer-sponsored health insurance. This tax is also known as a “Cadillac tax.” The annual limit for purposes of calculating the excess benefits is \$10,200 for individuals and \$27,500 for other than individual coverage. Responsibility for the tax is on the “coverage provider” which can be the insurer, the employer, or a third-party administrator. There are a number of exceptions and special rules for high coverage cost states (i.e. California) and different job classifications (not yet defined).



JPA Exploration

...Feasibility study of pos-2004 hires buying into Peralta's retirees benefits at no cost to the District after the District becomes a part of a JPA for Kaiser...

PFT Successor Agreement

JPA Considerations – our broker's perspective



PERALTA COMMUNITY COLLEGE DISTRICT

Considerations While Reviewing Joint Powers Agreement (JPA)
for July 1, 2013 Effective Date

Rates: Higher vs. Lower?

Claims Experience: Shared/Pooled vs. Stand-alone

Renewal Date: Self-determined vs. JPA determined

Administration: Flexible vs. Structured

Claims Run-out Cost: Accrued vs. Required (Total: about \$2,200,000/Actives Only: about \$1,100,000)

Transition Timeline & Costs: ?

Available Benefit Plans: Flexible vs. Structured Options

- **Actives** – Options?
- **Retirees** – required to be maintained at current levels

Carrier Availability: Flexibility vs. Restricted and Bundled Combinations

Funding Availability: Flexible vs. Only Fully Insured

Stop-Loss Coverage if Retirees Only: Available & Stable?

Effects from PPACA or other Federal/State Laws: Unknown/Vague

Prepared by PSW Benefit Resources
November 6, 2012

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Agenda Items for Next Meeting-Monday, 12/3/12 & beyond



1. Recommendations from the Committee on other potential action items?
2. Second Monday in January for next meeting
3. Review of Medicare communications to the unions and to the employees
4. More JPA Exploration
5. Considerations of employee buy in