David Ash – Chip Schutte – Michael Hobert - Sharon Keeler – Dr. Michael Murphy

AGENDA
Joint Administrative Services Board
February 25, 2013 1:00 p.m.
Joint Government Center

1. **Call to Order.**

2. **Approval of Minutes. (January 28 Minutes Attached pg. 2).**

3. **Update from Director:** Joint Technology Plan adopted by Supervisors and School Board. Funding for training and study of Fiber Backbone included in budget requests. Health Insurance deductible creep.

4. **Fraud Tipline Update.** Archana McLaughlin, County Attorney, will discuss her findings into the confidentiality of information provided through a fraud tipline.

5. **Health Insurance Renewal.** Please find the health insurance renewal information attached. This requires the consideration and approval of the Board. The rate increases 7%, but there are no changes to the terms of the agreement. However, Anthem has substituted some underlying vendors for others (mental health, pharmacy, dental, and vision).

6. **Affordable Care Act Issues.** Please find documents attached from Anthem outlining the rollout of the ACA. We are receiving regular correspondence from various sources warning of the need to adjust policies, etc. These include how part-time employees are to be defined, whether employees are free to purchase their insurance from health insurance exchanges, notification requirements, automatic enrollment, etc.

Joint Administrative Services Board

January 28, 2013 Regular Meeting 1:00 pm

At a regular meeting of the Joint Administrative Services Board held on Monday, January 28, 2013 at 1:00 pm in Meeting Room AB, Berryville Clarke County Joint Government Center, 101 Chalmers Court, 2nd Floor, Berryville, Virginia.

Members Present

David Ash [joined 1:09 pm]; Sharon Keeler; Chip Schutte; Michael Murphy; J. Michael Hobert

Members Absent

None

Staff Present

Tom Judge

Others Present

None

1. Call To Order - Determination of Quorum

At 1:02 pm, Tom Judge called the meeting to order having determined that a quorum was present.

Selection of Chairperson

Mr. Judge opened the floor for nominations of Joint Administrative Services Board Chair for 2013.

Chip Schutte nominated Michael Hobert to serve as 2013 Chair.

Michael Hobert, supported by Tom Judge, advised that the Board's practice was to annually alternate between the elected representatives from the School Board and the Board of Supervisors.

In the light of this information, Chip Schutte withdrew his nomination.

Tom Judge, again, opened the floor for nominations.

J. Michael Hobert, seconded by Mike Murphy, moved to nominate and elect Chip Schutte as Chair of the Joint Administrative Services Board for 2013.

With no others names advanced, Tom Judge closed the floor to nominations and called for the vote.

The motion was approved by the following vote:

David Ash	-	Absent
J. Michael Hobert	-	Aye
Sharon Keeler	-	Aye
Michael Murphy	-	Aye
Charles "Chip" Schutte	-	Aye

Following the vote, Tom Judge turned the meeting over to Chairman Schutte.

Selection of Vice-Chairperson

Chairman Schutte called for a motion for nomination of Joint Administrative Services Board Vice Chair for 2013.

Mike Murphy, seconded by Sharon Keeler, moved to nominate and elect J. Michael Hobert as Vice Chair of the Joint Administrative Services Board for 2013.

Being no further nominations, Chairman Schutte called for the vote.

The motion carried by the following vote:

David Ash	-	Absent
J. Michael Hobert	-	Aye
Sharon Keeler	-	Aye
Michael Murphy	-	Aye
Charles "Chip" Schutte	-	Aye

Establishment of meeting calendar

The Board reviewed of the proposed meeting calendar. Highlights include:

- Start time corrected from 12 noon to 1 pm.
- Director evaluation was also added to the October meeting topics.

- January 23, 2014 is a Thursday so as not to conflict with Martin Luther King, Jr. holiday.

David Ash joined the meeting at 1:09 pm.

Mike Murphy, seconded by Michael Hobert, moved to adopt the meeting calendar as noted with the start time being 1:00 PM and the addition of Director evaluation to the October meeting. The motion carried as follows:

David Ash	-	Aye
J. Michael Hobert	-	Aye
Sharon Keeler	-	Aye
Michael Murphy	-	Aye
Charles "Chip" Schutte	-	Aye

2013 Joint Administrative Services Board Meeting Calendar

Date	*Time*	*Location*	*Topic(s)*
02/25/13	1:00 PM	JGC	Health Ins, Budget, Technology
03/18/13	1:00 PM	JGC	Health Insurance, Technology
04/22/13	1:00 PM	JGC	Health Insurance, Technology
05/20/13	1:00 PM	JGC	Health Insurance, Audit, Technology
06/24113	1:00 PM	JGC	TBD
09/23113	1:00 PM	JGC	TBD
10/28113	1:00 PM	JGC	Director Evaluation, TBD
12/16/13	1:00 PM	JGC	Director Evaluation, TBD
01/23/14	1:00 PM	JGC	Organization, Budget

Vice Chairman Hobert requested consideration of amending the bylaws to remove the requirement for a second to lay a motion on the floor.

Chairman Schutte noted that the Joint Administrative Services Board easily met the description of a small board as defined in *Roberts Rules of Order.*

Robert's Rules of Order; Art. IX. Committees and Boards; 50. Boards of Managers or Directors, Boards of Trustees, Executive Committees, etc. . . . .

> *In large boards business is transacted the same as in the society meetings; but in small boards the same formality is not necessary or usual, the informality observed by committees being generally allowed. In a board meeting where there are not more than about a dozen present, for instance, it is not necessary to rise in order to make a motion, nor to wait for recognition by the chair before speaking or making a motion,*

> ***nor for a motion to have a second;*** [emphasis supplied] *nor is there any limit to the number of speeches, nor does the chairman leave the chair when making a motion or discussing a question. The formalities necessary in order to transact business in a large assembly would hinder business in so small a body.*

The Board agreed to carry this matter forward to the February meeting.

2. Approval of Minutes

Mike Murphy, seconded by Michael Hobert, moved to approve the December 17, 2012 meeting minutes as presented. The motion carried as follows:

David Ash	-	Aye
J. Michael Hobert	-	Aye
Sharon Keeler	-	Aye
Michael Murphy	-	Aye
Charles "Chip" Schutte	-	Aye

3. Update from Director

- Joint Technology Plan:
  - Adopted by Supervisors. Supervisor David Weiss requested analysis on return on investment for the different projects.
  - The School Board will consider the plan at its January 28, 2013 meeting.
- Fraud Tip line: FOIA impact of an anonymous tip line is under review by the County Attorney.
- Health Insurance Renewal:
  - No information received as of yet.
  - For now, a 10% increase has been factored into the budget.
  - Last year, the County had a 19% loss.
  - Received a memorandum regarding disability insurance program for persons in the new hybrid program.

4. Zimbra and BoardDocs Pilots

The Government has successfully used Zimbra for email, calendaring, and management of central address databases. The Schools have successfully used BoardDocs to develop and publish board agendas, minutes, and other documents for viewing by the general public. Each organization could potentially benefit by exploring each other's technology solution, and certain synergy benefits such as shared address databases, combined community calendars, shared training and a single source for board and commission documents would result. It is recommended that a limited number of users in

each organization test, or pilot, the application they currently do not use to further discussion of the potential benefits of sharing these applications.

Tom Judge led the discussion. Highlights include:

- Joint Technology Plan speaks to software adoptions and sharing of software that would be beneficial.
- Zimbra:
  - The Schools use Microsoft Outlook but are researching other email programs. Staff would benefit from additional training on how to make the program more efficient.
  - The County uses Zimbra.
  - Joint use could provide a single address database, shared calendars.
  - Gordon Russell suggested piloting the Zimbra program with the schools.
  - Dr. Murphy will identify a select group of power users to pilot the program.
  - Gordon Russell and David Baggett will coordinate.
  - Dr. Murphy would also like to look at the Google exchange product.
- BoardDocs
  - Dr. Murphy would like to demonstrate BoardDocs to County Administration.
  - BoardDocs stores the data in Atlanta, Salt Lake City and one other location.
  - The Schools annual cost is $2,700 through VSBA.
  - The Schools return on investment analysis considered the cost of delivery for 5 packets every 2 weeks, cost of printing, and 20 additional copies.
  - Two search features: search local documents; and search meta documents accessing documents in the sphere.
  - BoardDocs is archived by the vendor for a period of ten years. The content cannot be downloaded as a data file to an external drive. The text of the full or detailed agenda can be viewed but each embedded document must be downloaded and printed separately.
  - Dr. Murphy offered to assist County Administration and create a test meeting of BoardDocs, publish it, put it live on the School's website and email Administration for its review.
  - David Ash offered to test BoardDocs to determine if 1) it presents additional work load; 2) there is benefit from using the same agenda management vendor.

5. Bright and RDA Upgrade Situations.

Both Bright and RDA are recommending upgrades, which it is expected will be mandatory in the near future. Neither would be necessary with the ERP system implementation, though the implementation timing could be tricky. Without the ERP the RDA code compliance will, at a minimum be required.

A. Bright: Pay $1,700 by January 31, or pay $2,500 plus $250 per user annually after January 31. Would gain a third party graphical interface to existing system.

B. RDA: Pay $32,000 for code compliance, graphical interface, and some increased functionality or pay $4,000 for code compliance only.

Highlights of Board discussion include:

- Bright and RDA are pressing for upgrades.
  - The Bright system is used by the Treasurer and the Commissioner of the Revenue.
  - The RDA system is by Joint Administrative Services for payroll, finance, purchasing and utilities.
- Both are trying to provide a graphical interface and asking customers to pay for the graphic overlay.
- The upgrades are intended to make the systems more user friendly without adding great deal of functionality.
- Bright:
  - Dropped its price to $750 by January 31.
  - Bright is making its change to facilitate the addition of other business partners.
  - Gordon Russell opined that the add-on piece was unnecessary barring anything more compelling from the vendor.
  - Sharon Keeler stated that the add-on piece for the Commissioner of the Revenue has not yet been developed.
- RDA:
  - $32,000 would provide the new graphical interface added to its existing code.
  - This amount would be in addition to the current an annual maintenance fee.
  - Some added functionality such as enabling employees to change their addresses.
  - The $4,000 option would give code compliance but would not include any new functionality or graphical interface.
- The Board of Supervisors at its January 15, 2013 meeting agreed with the concept of the Technology Plan; however the Supervisors did set forth funds for an ERP.
- It was agreed that members of the Board would press the importance of implementing an ERP to their respective bodies.
- The Board agreed to hold payments for the upgrades.

6. Response to John Staelin's Questions Regarding ERP System

Please find responses to John Staelin's questions and concerns regarding the procurement of an ERP system which he presented to the JAS Board at this time last year.

TO: Joint Administrative Services Board
FR: Thomas J. Judge, Director
DT: 12/17/2012
RE: Responses to Matters Raised by John Staelin

Attached is John Staelin's memo from March 25 stating concerns over implementation of an ERP system in Clarke County. The purpose of the memo is to respond to these concerns where possible, while not ignoring that fact that the implementation of an ERP system contains risks which must be carefully managed to bring about the desired results.

1. *We do not know what an ERP system would ultimately cost. An industry vendor has since provided a quotation for the ERP system configuration described in the GFOA report. The quotation for software licensing, installation, data conversion, and training is $550,309. The IT departments believe that no additional hardware would be required, but the Joint Technology plan includes $50,000 as a contingency for hardware needs.*

2. *The payback is unclear. A weakness of the GFOA report is that it makes a strong case for return on investment, while remaining mute on precisely where the savings would occur. Consultants frequently infer on sensitive subjects such as position eliminations to preserve their reputation for future clients. It is more "politically correct" for a consultant to note that productivity improvements will mean that fewer additional positions will be required in the future, rather than pointing to specific positions in the future. That said; the payback is a risk that must be managed. The report states that an additional IT staff will be required, but the reference to "two to four positions" could not be located under the recommended alternative.*

3. *We do not know who the winners and losers will be in the ERP Industry. There has been a great deal of consolidation of local government ERP vendors. The major Tier II local government firms are Tyler Technologies (10,000 clients), New World Systems (1,000 clients), and Sungard Public Sector (1,500 clients).*

4. *Technology is changing rapidly. Purchasing software that is not "future-proofed" is another risk that must be managed. Access by handheld devices, citizen access, cloud vs. server, open source vs. proprietary, best practices methods, are all issues that must be addressed. Also, as Mr. Staelin says, options must be kept open. Certain of our current systems are examples of software applications that have lagged behind widely adopted improvements. It is hoped that Joe May's effort to provide Clarke County assistance with this complex task is successful, and recent communications provide confidence that it will be.*

5. *Clarke is too small to be a leader in the ERP area. The obstacles mentioned at the VACO/VML meetings last year, and again during a survey of surrounding communities' plans, all revolve around the institutional resistance of Schools vs. Government, or Constitutional Officer independence, as the primary impediments to implementation of an ERP system. This led the IT Director of a large community to our east to state that Clarke County was far ahead of their community in achieving the political groundwork necessary to move forward. Apparently, size is a disadvantage in this regard. Clarke County's efforts at cooperation have, over many years, made it unusually qualified to take advantage of the benefits of an ERP system. There are issues of data ownership and access to be worked out, and there are policies and procedures that must be improved across organizational boundaries, but in general we can manage this situation more nimbly than larger communities, and may therefore become a leader in the area.*

Tom Judge summarized his memorandum dated 12/17/2012.

Highlights of Board discussion include:

- The governing bodies must make the long-term commitment necessary for successful implementation.
- Additional personnel may be needed to implement and train.
- The Board authorized Tom Judge to provide his response to John Staelin as reviewed.

7. Response to David Weiss's Questions Regarding the Return on Investment of Joint Technology Plan Projects (to be presented at the meeting).

ROI

ERP System Implementation — 12/17/12

Source: Joint Administrative Services

Assumptions:

1. Costs are the average of low and high from page 34 of the GFOA Report. Assumes applications on local server.
2. Total hours estimated to be saved from ERP implementation is 4500 annually (mid range GFOA Study, pg. 35)
3. 4150 hours have been eliminated through Treasurer and Commissioner, leaving an additional 350 still to be saved.

	YEAR 1	2	3	4	5	6	Total
DIRECT COST OF NEW ERP							
Software License (HR, GL, Revenue, Documents)	185,065						
Professional Services	265,282						
Project Contingency	63,078						
Maintenance and Support	32,777	32,777	32,777	32,777	32,777	32,777	
Travel	82,532						
TOTAL	608,734	32,777	32,777	32,777	32,777	32,777	772,620
COST AVOIDANCE (costs incurred if no ERP)							
Commissioner Position*	42,195	42,195	42,195	42,195	42,195	42,195	
Treasurer Position*	36,810	36,810	36,810	36,810	36,810	36,810	
Additional Hours Estimated in GFOA Study	13,713	13,713	13,713	13,713	13,713	13,713	
Bright and XPERT Maintenance		18,250	36,500	36,500	36,500	36,500	
Revenue Modules to XPERT	60,000						
Forced XPERT Front-End Upgrade		15,000					
XPERT Module to Archive Finance Documents			15,000				
Personnel Module Training and Applicant Tracking	30,000						
TOTAL	182,718	125,968	144,218	129,218	129,218	129,218	840,560

ROI in approximately 5.5 years.

Notes:

*These positions have been eliminated, but would need to be replaced when activity increases, unless technology is introduced that offers productivity improvements. XPERT offers some productivity improvement, but is not sufficient, and requires greater training and internal technical support.

**It should also be noted that extension of XPERT does not include the breadth of modules, or technical capabilities (such as on-line payments, and time and attendance) available from the ERP System.

***There is much debate about how much Software as a Service, aka SaaS or Cloud, would save. Studies reviewed indicate that over 5 years the costs of SaaS are approximately 75% of maintaining the software locally. This factor is expected to continue to decline, making SaaS progressively cheaper relative to local server operations. However, it has yet to be determined whether this option is feasible for Clarke County.

Tom Judge included review of his analysis of return on equity with Item 6 - Response to John Staelin's Questions Regarding ERP System.

8. JAS FY 14 Budget.

Please find a proposal attached. This may be discussed, modified, and adopted for inclusion in the Board of Supervisors FY 14 Budget.

JAS FY 14 BUDGET PROPOSAL

	FY 11 ACTUAL	FY 12 ACTUAL	FY 13 ADOPTED	FY 14 REQUEST	1/24/2013 VARIANCE	NOTES
FUNC 12240 INDEPENDENT AUDITOR						
3120 PROFESSIONAL SERVICES	30,650	30,650	33,500	34,500	1,000	Held them for years, but new contract.
FUNC 12510 DATA PROCESSING						
3100 PROFESSIONAL SERVICES	1,600				-	
3320 MAINTENANCE SERVICE CONTRACT	23,092	24,181	24,500	26,100	1,600	Held them for years, but no more.
5540 TRAVEL CONVENTION & EDUCATION					-	
6001 OFFICE SUPPLIES	53				-	
8207 EDP EQUIPMENT					-	
12510 DATA PROCESSING	24,745	24,181	24,500	26,100	1,600	
FUNC 12530 FINANCE & PURCHASING						
1100 SALARIES - REGULAR	348,570	343,960	368,036	367,598	(438)	
1300 SALARIES - PART TIME					-	
2100 FICA BENEFITS	26,203	25,555	28,156	28,121	(35)	
2210 VSRS BENEFITS	33,030	38,971	42,913	42,862	(51)	
2300 HEALTH INSURANCE BENEFITS	27,670	26,577	27,895	25,044	(2,851)	10% increase but one dropped coverage
2400 LIFE INSURANCE	970	983	4,380	4,374	(6)	
2750 RETIREE HEALTH CARE CREDIT			4,085	4,080	(5)	
2800 OTHER BENEFITS	4,562	150	-	-	-	
3000 PURCHASED SERVICES	643		-	-	-	
3320 MAINTENANCE SERVICE CONTRACTS	143	-	475		(475)	
3500 PRINTING AND BINDING					-	
3600 ADVERTISING	-	196		200	200	
4300 CENTRAL PURCHASING/STORE	(1,350)	(1,292)			-	
5210 POSTAL SERVICES	2,837	2,688	2,650	2,600	(50)	One cent rate increase, but more EFT
5230 TELECOMMUNICATIONS	1,228	1,309	1,300	1,339	39	
5510 TRAVEL MILEAGE	174	620	100	700	600	
5540 TRAVEL CONVENTION & EDUCATION	821	1,320	800	700	(100)	
5810 DUES & MEMBERSHIPS	544	884	600	900	300	GFOA, IPMA-HR, ACFE, VAGP, Costco
6001 OFFICE SUPPLIES	8,484	2,209	3,000	3,000	-	
6012 BOOKS AND SUBSCRIPTIONS	220	159	230	200	(30)	Star, GAAP Guides
6014 OTHER OPERATING SUPPLIES	13	-			-	
8201 MACHINERY AND EQUIPMENT					-	
12530 FINANCE & PURCHASING	454,751	444,249	484,520	481,920	(2,600)	
TOTAL	510,146	499,080	542,520	542,520	(0)	

Tom Judge briefly reviewed the FY2014 budget.

Mike Murphy moved to approve the Joint Administrative Services FY2014 budget as presented. The motion carried as follows:

David Ash	-	Aye
J. Michael Hobert	-	Aye
Sharon Keeler	-	Aye
Michael Murphy	-	Aye
Charles "Chip" Schutte	-	Aye

9. Next Meeting

The next regularly scheduled meeting of the Joint Administrative Services Board is Monday, February 25, 2013 at 1:00 pm in Meeting Room AB at the Berryville Clarke County Government Center.

Adjournment

At 3:08 pm, Chairman Schutte, hearing no objections, moved that the meeting be adjourned.

Minutes Recorded by Tom Judge and Recording Transcribed by: Lora B. Walburn

FY 14 Monthly Health Benefit Rates

Effective 7/1/2013

Source: Joint Administrative Services

A. Plan Rates	Cost	Employer	Employee	Employer FY 14 Share	Employer FY 13 Share
KA 250 Plan Option					
Regular Full Time					
Single	536.00	456.65	79.35	85%	85%
Dual	992.00	498.02	493.98	50%	50%
Family	1,447.00	727.34	719.66	50%	50%
Transportation, Food Service & Other					
Single	536.00	385.31	150.69	72%	72%
Dual	992.00	420.22	571.78	42%	42%
Family	1,447.00	613.72	833.28	42%	42%
KA 500 Plan Option					
Regular Full Time					
Single	497.00	456.65	40.35	92%	92%
Dual	919.00	498.02	420.98	54%	54%
Family	1,342.00	727.34	614.66	54%	54%
Transportation, Food Service & Other					
Single	497.00	385.31	111.69	78%	78%
Dual	919.00	420.22	498.78	46%	46%
Family	1,342.00	613.72	728.28	46%	46%
TLC High Deductible					
Regular Full Time					
Single	409.00	409.00	.00	100%	100%
Dual	757.00	465.25	291.75	61%	61%
Family	1,104.00	677.56	426.44	61%	61%
Transportation, Food Service & Other					
Single	409.00	345.11	63.89	84%	84%
Dual	757.00	392.57	364.43	52%	52%
Family	1,104.00	571.71	532.29	52%	52%

B. Account Contributions

Regular Full Time	
TLC Health Savings Account Contribution (single)	47.65
TLC Health Savings Account Contribution (dual)	32.77
TLC Health Savings Account Contribution (family)	49.79
Transportation, Food Service & Other	
TLC Health Savings Account Contribution (single)	40.20
TLC Health Savings Account Contribution (dual)	27.65
TLC Health Savings Account Contribution (family)	42.01

C. Total Employer Cost Per Group Health Member

Regular Full Time	
Single Health	456.65
Dual Health	498.02
Family Health	727.34
TLC Single Health & "HSA"	456.65
TLC Dual Health & "HSA"	498.02
TLC Family Health & "HSA"	727.34
Transportation & Food Service	
Single Health	385.31
Dual Health	420.22
Family Health	613.72
TLC Single Health & "HSA"	385.31
TLC Dual Health & "HSA"	420.22
TLC Family Health & "HSA"	613.72

Note: Where two employees are married, and they together opt for either a dual or family option, the employer will pay two times the single employer contribution for the plan option selected.

METHOD:
Force TLC employee single contribution to zero.
Proportion other rates to percentage contributions from prior year.
Force 250 employer contribution to same as 500 contribution.
Force "HSA" contribution so total employer equal across plans.

The Local Choice Health Benefits Program

To: TLC Group Administrators

From: Gene Raney, Director
State and Local Health Benefits Programs

Date: January 2013

Re: The Local Choice Health Benefits Renewal

Thank you for your continuing support of The Local Choice program. We are pleased to enclose The Local Choice (TLC) renewal for fiscal year 2014. TLC will again offer five statewide plans to all local employer groups along with a regional plan in certain geographic areas:

Statewide plans

- Key Advantage With Expanded Benefits
- Key Advantage 250
- Key Advantage 500
- Key Advantage 1000
- TLC High Deductible Health Plan (HDHP) – HSA compatible

Regional plan

- Kaiser Permanente – available in certain service areas

Retiree Plans

- Key Advantage or Regional Plan coverage for retirees not eligible for Medicare
- Advantage 65
- Advantage 65 with Dental/Vision
- Medicare Complementary (Grandfathered for current participants)

The state recently conducted an extensive RFP process to ensure TLC continues to offer you the highest quality and most affordable benefits package available. We are pleased to announce that for the Key Advantage plans, Anthem will administer the medical, behavioral health, outpatient prescription drugs and routine vision benefits for TLC while under a separate agreement with Anthem, Delta Dental will administer the dental portion. The High Deductible Health Plan will continue to be administered by Anthem but with Dental through the Delta Dental arrangement.

All active employee TLC plans include the CommonHealth wellness programs at no cost to your employees. CommonHealth programs feature our *Future Moms* prenatal

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program, our highly acclaimed *Quit For Life* tobacco cessation program, confidential, at work medical screenings plus other health and wellness programs such as nutrition, stress management and fitness programs.

Please note that all employers must choose annually whether or not to extend coverage by one month for dependents of a deceased employee. This benefit is of most value to smaller groups that cannot offer COBRA. If selected, no plan or membership changes will be permitted during the extended month and full premium will be billed.

In 2012-2013, TLC membership grew to 318 groups covering almost 50,000 employees, retirees and dependents, while retaining over 99% of our participating groups. Our size and relationship with the employee benefit plans for Commonwealth of Virginia employees allows TLC to remain well-positioned to assist you during difficult economic times. We offer very competitive plans, rate adjustments below the industry average and value-added features the private sector is unable to match. These advantages, combined with protection through shared risk pools, financial stability and access to the same statewide and regional provider networks available to state employees, are strong incentives to remain with TLC for your group health coverage.

We encourage you to attend a TLC Regional Meeting in March. Walt Norman, TLC's Program Manager, as well as representatives from our program's vendors will present plan highlights, improvements and changes in more detail. The RoadShow meeting schedule for 2013 immediately follows this letter.

Your 2013-2014 renewal notebook includes a Comparison of Benefits brochure outlining the benefits offered under each plan and your rates for all plan options. Together, the statewide Key Advantage plans, High Deductible Health Plan and the Kaiser Permanente HMO fully-insured regional plan (available in certain service areas) offer you a variety of choices with competitive administrative costs and quality coverage.

Our goals are twofold – first, to help you offer a high quality, affordable health benefits package; and second, to assist you in attracting and retaining the highest quality employees. We look forward to your response by April 1, 2013.

Thank you for selecting The Local Choice program.
Sincerely,

Gene Raney
Director, State and Local
Health Benefits Programs

The Local Choice
Table of Contents

Section 1

Fiscal Year 2014 Program Overview

Program Overview and Instructions

The Local Choice (TLC) is pleased to provide your health care program renewal for July 1, 2013 (October 1, 2013 for certain school groups).

The following plans will be offered.

- Key Advantage Expanded
- Key Advantage 250
- Key Advantage 500
- Key Advantage 1000
- TLC HDHP (HSA compatible High Deductible Health Plan)
- Kaiser Permanente HMO (in certain service areas)
- Advantage 65 – Medical only
- Advantage 65 with Dental/Vision
- Medicare Complementary (grandfathered plan)

Key Advantage Plans (statewide)

- Claims are administered by:
  a) Medical, Behavioral Health, Outpatient Prescription Drugs and Routine Vision: Anthem Blue Cross and Blue Shield
  b) Dental: Delta Dental of Virginia

TLC HDHP (statewide)

- All claims administered by Anthem
- While this is an HSA (Health Spending Account) compatible plan, TLC does not provide the HSA account.
- Routine vision benefits are not available under this plan.
- Dental coverage is provided with a separate deductible.

Kaiser Permanente HMO (regional)

- A fully insured HMO is available in Fredericksburg, Northern Virginia, Washington D.C. and parts of Maryland.

Medicare Eligible Plans

- **Medical and vision claims are administered by Anthem. Dental is administered by Delta Dental of Virginia.**

Choice of Plans – Statewide and Regional

Most employers may select a combination of plans.

- Groups with 25 or fewer eligible employees may offer only one benefit plan.
- Groups with 26 to 100 eligible employees may offer two plan options.
- Groups with more than 100 eligible employees may offer two Key Advantage plans plus the HDHP and/or the Regional plan (if available).

At renewal, an employer may change the definition of eligible employees and retirees so long as the change coincides with their published personnel practices. Written request of any changes must be submitted to the Department of Human Resource Management (DHRM) with your Renewal Employer Data Sheet (located in Section 3). DHRM will review the changes for compliance with state regulations.

Following is a high level description of the plans offered by TLC. More details are available in the Comparison of Benefits brochure found later in this renewal.

Key Advantage – Statewide Plans:

Administered by Anthem

Comprehensive medical and routine vision benefits (through Blue View Vision) are covered in all Key Advantage plans.

While members receive the highest level of benefits when visiting an in-network provider, Key Advantage plans also provide out-of-network coverage for covered medical services with additional deductibles and/or coinsurance.

These plans also allow for medical care when traveling outside Virginia through the Blue Card program.

Behavioral Health Services

As with medical services, members receive the highest level of benefits when visiting an in-network provider for behavioral health services. All Key Advantage plans offer out-of-network behavioral health services with additional deductibles and/or coinsurance.

Prior authorization of benefits is not required but is highly recommended. Members should contact Anthem to confirm medical necessity and avoid deductibles and coinsurance for services received outside the network.

Under the Employee Assistance Program (EAP), members receive up to four visits per incident at no cost. The EAP is only available in-network through Anthem. Prior to receiving behavioral health or EAP services, members should contact Anthem.

Outpatient Prescription Drug

Our plan is a mandatory generic drug program through Anthem. If members receive a brand name drug when a generic equivalent is available they are responsible for the applicable copayment plus the difference between the allowable charge for the generic equivalent and the brand name drug.

Prescription drugs are divided into three co-payment tiers, depending upon the type of drug.

- First Tier – Typically generic drugs - $10 co-pay for up to a 34 day supply
- Second Tier – Lower cost brand drugs - $20 co-pay for up to a 34 day supply
- Third Tier – Higher cost brand drugs - $35 co-pay for up to a 34 day supply

Home Delivery is available through the outpatient prescription drug benefit. Up to a 90-day supply is available through home delivery at two times the 34-day supply co-pay.

Dental Services from Delta Dental of Virginia

Preventive, primary and major restorative dental benefits with orthodontia are provided through Delta Dental of Virginia. You are not required to use an in-network provider for dental. However, members pay less when using an in-network dentist. Non-network providers may balance bill members for charges in excess of the negotiated discounts.

High Deductible Health Plan HDHP) – Statewide Plan:

Administered by Anthem

Preventive medical care is covered with no deductible or coinsurance. All other covered medical, behavioral health and prescription services are subject to the $1,500 employee and $3,000 family, plan year deductible and 80/20 coinsurance. Note that the fourth quarter deductible carry over is not available with HDHP.

The HDHP provides only in-network coverage except in the event of a life-threatening emergency.

Kaiser Permanente HMO – Regional Plan:

Kaiser Permanente offers a regional HMO plan in Northern Virginia, Fredericksburg, Washington D.C., and parts of Maryland and is available only in those areas. Kaiser information is only in the renewal notebooks of groups that are eligible for Kaiser coverage.

A detailed outline of the service area and benefits may be found in the Kaiser HMO benefits summary. Mental illness and substance abuse, EAP, prescription drug and dental coverage are included in the Kaiser plan.

The Regional plan offers only blended rates to Retirees Not Eligible for Medicare. Coverage for Retirees Eligible for Medicare or Medicare eligible dependents of retirees is not available. Groups must offer a Key Advantage plan if they wish to provide the TLC Medicare supplement. Coverage must be offered to Retirees Not Eligible for Medicare in order for a group to offer coverage to Retirees Eligible for Medicare.

Coverage for Retirees Not Eligible for Medicare:

Retiree coverage is available but not automatically provided. All groups in our 49 and under pool receive rates that automatically incorporate blended premiums. In a blended program, Active Employees and Retirees Not Eligible for Medicare will have the same rates. If a local employer, with 50 or more participating employees, offers coverage to Retirees Not Eligible for Medicare, they may blend that premium with the Active Employee premium or elect Stand-Alone rates. With Stand-Alone rates, Retirees Not Eligible for Medicare will pay two times the Active Employee rates. The TLC Local Administrative Manual states that once a premium is blended, it may not revert to Stand-Alone status. Blended rates are only available at plan anniversary. Although allowed, no employer contribution is required for retiree coverage.

Medicare-Eligible Supplemental Plans for Retirees:

A group must offer coverage to Retirees Not Eligible for Medicare if they wish to provide coverage for retirees Eligible for Medicare. A local employer may add retiree coverage by submitting a written request to DHRM along with an approved resolution from their Board or Governing Body.

For groups currently offering coverage to Retirees Eligible for Medicare, the Medicare Complementary, Advantage 65-Medical Only and Advantage 65 with Dental/Vision plans continue to be available. However, Medicare Complementary is not available unless you currently offer that option. It may not be added. Medical and routine vision benefits are administered by Anthem, and dental benefits by Delta Dental.

Groups adding retiree benefits to their program for the first time may offer only Advantage 65-Medical Only or Advantage 65 with Dental/Vision.

A local employer may also add Dental/Vision coverage to a current Advantage 65 contract. Once added, however, it may not be removed.

Prescription drug coverage is not available in any of the Medicare-Eligible plans.

It is important to remember that a local employer may select only one plan for Retirees Eligible for Medicare.

These plans are available only if your Active Employees are enrolled in a statewide self-funded plan and you elect to offer coverage to both Retirees Not Eligible for Medicare and Retirees Eligible for Medicare.

To prevent claims denial and/or retraction of claims, it is imperative that you communicate the following information to all covered participants, whether active or retired.

Coverage under a Key Advantage plan, the HDHP or a Regional plan (if available) is only for:

- Active Employees and their Dependents
- Retirees not eligible for Medicare and their Dependents Not Eligible for Medicare, and/or
- Dependents of Medicare eligible retirees who are not Medicare eligible.

Retirees Eligible for Medicare and the Medicare eligible dependents of any retiree, whether Medicare eligible or otherwise, may not enroll or remain in a Key Advantage or Regional plan. If coverage is offered to Retirees Eligible for Medicare and their Medicare eligible dependents, it must be obtained through one of our Medicare Supplemental contracts. They require participation in both Parts A and B of Medicare to receive maximum benefits. Outpatient Prescription Drug coverage is not offered in our Medicare Supplemental contracts so obtaining Medicare Part D is extremely important.

See Tab 7 (Medicare Eligibility Memo) of this renewal binder for additional detail.

Advantage 65-Medical Only

Advantage 65 provides supplemental medical benefits for your Retirees Eligible for Medicare and the Medicare eligible dependents of any covered retiree. It does not provide benefits for outpatient prescription drugs. Anthem administers the plan.

Advantage 65 with Dental/Vision As a group option, you may elect to add Dental/Vision coverage to Advantage 65-Medical Only. This product provides Advantage 65 medical coverage plus dental and vision coverage.

Dental: The plan, administered by Delta Dental, pays 100% of the Allowable Charge (AC) for diagnostic and preventive services, 80% of AC for basic dental services and 5% of AC for major dental care. Up to $1500 per member per plan year is payable.

Vision: Benefits are provided once every 12 months through the Anthem Blue View Vision network. Members pay a $20 copayment for a routine eye exam, receive up to a $100 allowance with a 20% discount on the remaining cost for one pair of frames, has a $20 copayment per pair of either single, bifocal or trifocal lenses, and receives up to a $100 allowance then 15% off remaining balance for contact lenses.

Medicare Complementary

Medicare Complementary is a "grandfathered" plan available only to groups who already offer the product. It is not available to any group not currently offering this coverage. It provides supplemental medical benefits, plus dental and vision coverage for Retirees Eligible for Medicare and the Medicare eligible dependents of any covered retiree. Medical benefits are administered by Anthem; vision through Anthem Blue View Vision; and dental through Delta Dental.

Note: In order for Retirees Eligible for Medicare to receive maximum benefits they must have both Parts A and B of Medicare. If prescription drug coverage is desired they should participate in Medicare Part D. ***

CommonHealth

The CommonHealth Wellness Program is a value-added benefit included at no cost to TLC groups. CommonHealth provides medical screenings, health risk appraisals, and several wellness programs including Quit for Life smoking cessation, Future Moms* pre-natal risk management, and stress management.

Since wellness programs often can help control claims costs, we strongly encourage you to take advantage of all that CommonHealth has to offer. Employees and their dependents covered by any TLC program are eligible to participate.

* Key Advantage Expanded and Key Advantage 250 plans include a Future Moms incentive. The maternity inpatient hospital copayment is waived if the member enrolls in the program in the first trimester (14 weeks), has a dental cleaning during pregnancy, and completes the program.

Group Rating

Pooled Rating - Group size of 1 through 49 employees

Experience Rating - Group size of 50 or more. The Credibility Factor applies to medical components only. Behavioral health and substance abuse, prescription drugs, and dental claims are pooled, based on the combined experience of all current TLC groups, regardless of size.

Group Size	Credibility Factor
50 - 99	41% of the group's medical experience
100 - 149	58% of the group's medical experience
150 - 199	71% of the group's medical experience
200 - 249	82% of the group's medical experience
250 - 299	91% of the group's medical experience
300 – and above	100% of the group's medical experience

To protect our employers, TLC provides shared risk protection through medical attachment points (Specific Pooling Points) of $90,000 for groups with fewer than 300 participating employees; $110,000 for groups between 300 and 999 participating employees; $150,000 for groups between 1,000 and 1,499 and $175,000 for groups with 1,500 or more employees.

Monthly rates for employee plus one and family are calculated as a factor of the single employee rate. The relationship between the single, dual, and family rates remain the same as in the current plan year: single = 1, employee plus one = 1.85 X single rate, and family = 2.70 X single rate.

Employer Contribution

In order to allow greater flexibility, most groups may select a combination of our plan offerings but minimum funding will be based on the un-weighted average single rate of the all statewide and regional plans, except the HDHP. For example, if a group offers Key Advantage Expanded and Key Advantage 500, you would add the single rates for each and divide by two. The minimum requirement would then be 80% of the average single rate.

The Code of Virginia-required Key Advantage minimum employer contributions are:

Full Time Employees

- 80% of the average single employee premium rate
- 20% of the average additional dependent cost, if applicable *

Part Time Employees (if coverage is offered)

- 50% of the amount contributed toward active employee coverage (at all membership levels)

***If 75% of all eligible employees enroll, the dependent contribution requirement is waived.**

Minimum employer funding for the HDHP is separate from the Key Advantage and regional plan requirements. If the HDHP is offered, a Local Employer must pay a minimum of 80% of single premium and 20% of the additional dependent premium, regardless of participation percentage. For part time participants the 50% rule above will apply. You may make a higher contribution if you choose.

Regulations Governing the Local Choice Program

The Virginia Administrative Code governing The Local Choice Program can be found at http://virginiageneralassembly.gov. Enter key words "Commonwealth of Virginia Health Benefits Program" or Administrative Code "1VAC55-20-20". Regulations continue through 1VAC55-20-480.

Renewal Acceptance

To renew your coverage with TLC, complete the enclosed Employer Renewal Data Sheet and return it to TLC in the envelope provided.

DHRM must receive the completed Employer Renewal Data Sheet by Monday, April 1, 2013. Once your renewal is approved, you will receive a letter from DHRM confirming your renewal, benefits plans, premiums and employer contribution requirements.

Deadline Extensions

All groups must return the Employer Renewal Data Sheet by April 1, 2013. Please keep in mind that you may be granted an extension upon receipt of your written request. This extension is for the return of your Employer Renewal Data Sheet only. The Code of Virginia does not permit an extension or wavier of the 90-day written termination request if you plan to leave the TLC Program. Please contact Walter Norman, TLC Program Manager at (804) 786-6460, to discuss your options if you cannot comply.

Send your Employer Data Sheet or extension requests to:

The Local Choice Health Benefits Program
Commonwealth of Virginia

Department of Human Resource Management

101 North 14th Street, 13th Floor
Richmond, VA 23

See Section 3 for information on the Renewal Enrollment Process.

Termination

For information on termination, please reference 1 VAC 55-20-160, 1 VAC 55-20-290 and 1 VAC 55-20-300 of the Virginia Administrative Code. According to these regulations, if you choose to terminate participation in The Local Choice Health Benefits program, DHRM must receive written notification at least 90 days prior to the date of termination. Please note that the 90-day notification will not be extended by a request to extend the April 1, 2012 renewal response deadline. The department will notify a terminating local employer of any Adverse Experience Adjustment (AEA)

within six-calendar months of the time the local employer terminates participation in the program. Further the department reserves the right to modify the amount of the experience adjustment applicable to a terminating local employer for a period not to exceed 12 months from the end of the plan year in which such termination occurred. The experience adjustment shall be payable by the local employer in 12 equal monthly installments beginning 30 days after the date of notification by the department. In the event that a terminating local employer requests, in writing, an extension beyond a period of 12 months, the department may approve an extension up to 36 months provided the local employer agrees to pay interest at the statutory rate on any extended payments. Since AEA is an exact look back limit of liability, it cannot be estimated.

The Local Choice Support

You may contact your local Marketing Representative to assist you with the details of your renewal.

If you have questions about eligibility or policy administration, please contact Walter Norman, TLC Program Manager at (804) 786-6460. You may also send inquiries by e-mail to walter.norman@dhrm.virginia.gov.

Thank you for your continued support of The Local Choice program.

Anthem Blue Cross and Blue Shield
Renewal Analysis For:
(Excludes Advantage 65 premiums and claims)
For
Clarke County And Schools
Group #47284
for July 1, 2013 through June 30, 2014

I.	Income at Current Rates (1)	$2,734,956
II.	Projected Medical Claims Related Charges (2)	
A.	Claims Cost (01/01/2012 though 12/31/2012)	$3,891,964
B.	100% Facility Network Savings	($1,349,735)
C.	100% Professional Network Savings	($769,163)
D.	Claims in excess of the $110,000 pooling limit	($40,352)
E.	Subtotal	$1,732,715
F.	Change in Incurred But Not Reported Claims	$17,327
G.	Benefit Adjustment	$0
H.	Enrollment Adjustment	$0
I.	Trend	$159,254
J.	Total Medical Projected Incurred claims	$1,909,296
III.	Projected Reinsurance Charges	$171,837
IV.	Projected Medical Administrative Charges, Network Access Fees, and Affordable Care Act(3)	$142,662
V.	Projected Dental Capitation	$139,339
VI.	Projected Behavioral Health Capitation	$34,974
VII.	Projected Drug Capitation	$652,848
VIII.	TLC Contingency Reserve or Risk Fee(4)	($124,792)
IX.	Total Income Requirements (II.J. + III. + IV. + V. + VI. + VII.+ VIII.)	$2,926,164
	Percent of Current Income	107.0%

[1] Illustrative income is based on current enrollment as follows:

	KA 250	KA 500	HDHP	TOTAL
Single	71	141	11	223
Dual	14	34	5	53
Family	20	34	7	61
TOTAL:	105	209	23	337

[2] There are 2 claims in excess of the $110,000 pooling limit.
Facility and Professional network savings represent 54.4% of medical claims cost.
Medical trends used in the renewal development were 6.% annual.
For a 18 month projection, this equates to 9.1%

[3] Administrative charge as a percent of income requirements is 4.9%

[4] Includes DHRM Program Administration and CommonHealth

The Local Choice Health Benefits Program

Clarke County And Schools

Proposed Rates Effective from
July 1, 2013 through June 30, 2014

	Single	Dual	Family
ACTIVE EMPLOYEES			
Key Advantage Expanded	$577	$1,067	$1,558
* Key Advantage 250	$536	$992	$1,447
* Key Advantage 500	$497	$919	$1,342
Key Advantage 1000	$468	$866	$1,264
* High Deductible Health Plan	$409	$757	$1,104
RETIREES NOT ELIGIBLE FOR MEDICARE			
Key Advantage Expanded	$577	$1,067	$1,558
* Key Advantage 250	$536	$992	$1,447
* Key Advantage 500	$497	$919	$1,342
Key Advantage 1000	$468	$866	$1,264
* High Deductible Health Plan	$409	$757	$1,104
RETIREES WITH MEDICARE			
Advantage 65	$160		
* Advantage 65 and Dental/Vision	$190		

*** Benefit Plans Currently Offered**

Coverage under The Local Choice Key Advantage and HDHP contracts is for:

- Active Employees and their Dependents
- Retirees not eligible for Medicare and their Dependents not eligible for Medicare, and/or
- Dependents of Medicare eligible Retirees who are not Medicare eligible.

If coverage is offered to Medicare eligible retirees and their Medicare eligible Dependents, it must be obtained through one of our Medicare Supplemental contracts which require participation in both Parts A and B of Medicare to receive maximum benefits.

THE LOCAL CHOICE
CLARKE COUNTY EMPLOYEES
ACCOUNT CODE: '05875'
MEDICAL PROGRAM EXPENSE REPORT
(INCLUDES HDHP EXCLUDES MEDICARE)
(INCLUDES BLUE VIEW VISION EXPENSE AND SAVINGS)
CLAIMS PROCESSED: '201201' - '201212'

	TOTAL FACILITY & PROFESSIONAL SUBMITTED CHARGES	5,354,634.09
LESS	NON-COVERED/INELIGIBLE AMOUNTS	530,438.15
LESS	MEDICARE COB	524,815.79
LESS	COMMERCIAL COB	26,775.90
EQUALS	COVERED BILLED CHARGES (B)	4,272,604.25
LESS	NETWORK SAVINGS (A)	2,118,897.15
EQUALS	COST OF BENEFITS	2,153,707.10
LESS	MEMBER PAID AMOUNT/PLAN DESIGN (C)	380,639.84
EQUALS	GROUP MEDICAL EXPENSE	1,773,067.26
	% SAVINGS TO PRE BENEFIT DESIGN COVERED CHARGES (CALC A/B)	49.59
	% SAVINGS TO POST BENEFIT DESIGN COVERED CHARGES (CALC A/(B-C))	54.44

STATISTICS PRESENTED REFLECT ALL APPROVED AND DENIED
MEDICAL CLAIMS. CAPITATION, DRUG AND DENTAL CLAIMS
ARE NOT INCLUDED.

EUCTLC.P_MED_PRG_EXP_CTOT
01/17/2013 15.07.23

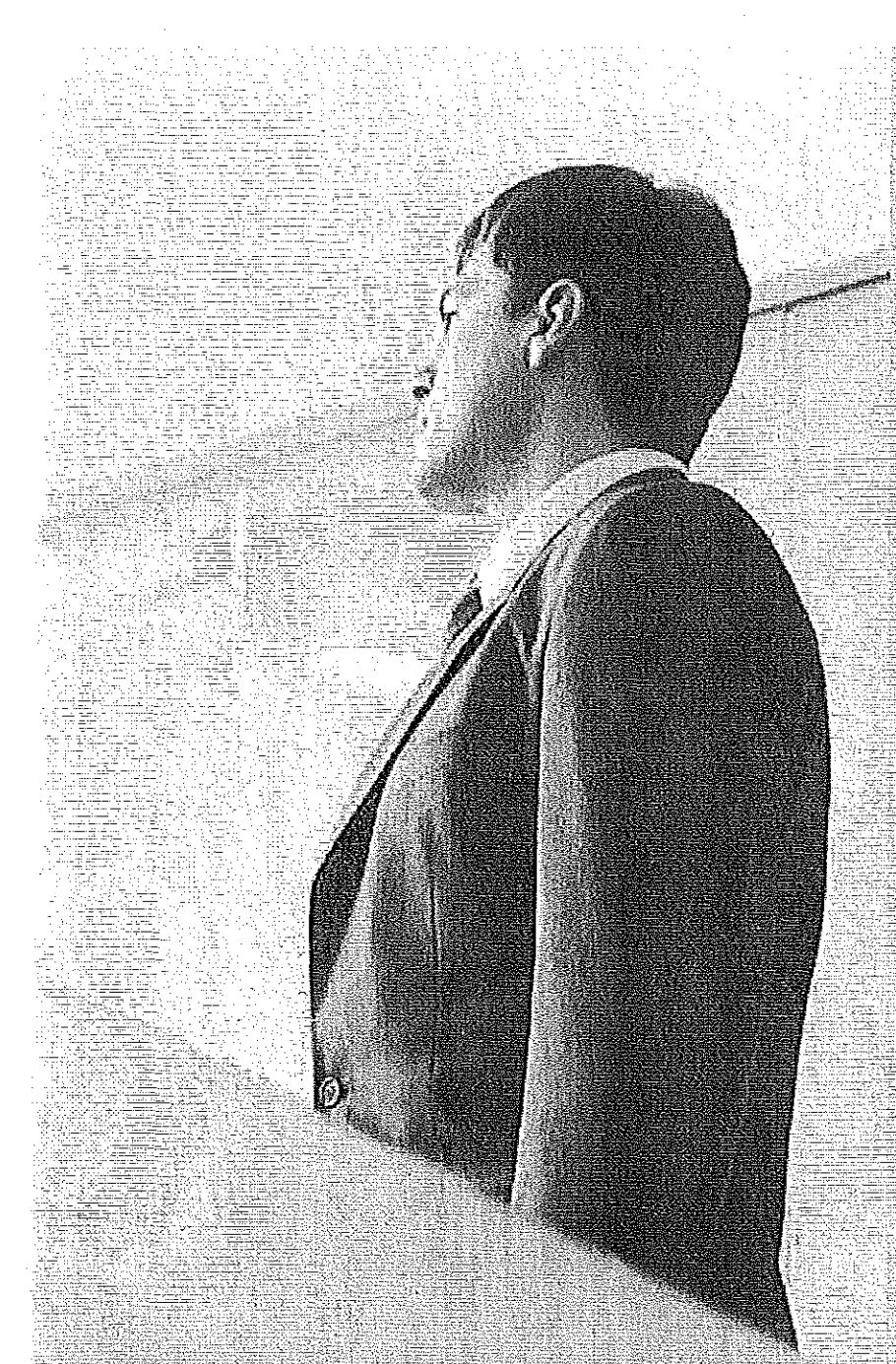
THE LOCAL CHOICE
FOR CLARKE COUNTY EMPLOYEES PAR-PPO GROUPS BETWEEN '47284000' AND '47284999'
PARTICIPANTS WITH LARGE CLAIMS OVER 25000
(INCLUDES HDHP EXCLUDES MEDICARE)
(INCLUDES BLUE VIEW VISION EXPENSE)
CLAIMS PROCESSED: '201201' - '201212'

PRODUCT	SEX REL	EMP CURRENT CVRG STATUS	DIAGNOSIS	MEDICAL EXPENSE
PAR-PPO	4	A	BENIGN NEOPLASMS	137,944.23
PAR-PPO	2	A	CHEMOTHERAPY	122,407.92
PAR-PPO	1	A	GENITOURINARY	69,661.56
PAR-PPO	1	A	HEART DISEASE	60,296.36
PAR-PPO	2	A	GENITOURINARY	51,017.49
PAR-PPO	2	A	MALIGNANT NEOPLASMS	37,458.29
PAR-PPO	1	A	MUSCULOSKELETAL	37,238.32
PAR-PPO	1	A	MUSCULOSKELETAL	26,460.57
PAR-PPO	1	A	HEART DISEASE	26,593.06
PAR-PPO	2	A	MUSCULOSKELETAL	26,474.31
PAR-PPO	3	A	SKIN/SUBCUTANEOUS TISSUE	25,218.07
				620,770.18

SEX REL CODES:
1 MALE EMPLOYEE 2 FEMALE EMPLOYEE
3 MALE SPOUSE 4 FEMALE SPOUSE
5 MALE DEPENDENT 6 FEMALE DEPENDENT
7 MALE DEPENDENT 8 FEMALE DEPENDENT

CVRG STATUS:
A ACTIVE
C CANCELLED

EUCTLC.P_LCLMS_PPO_X
01/14/2013 15.12.11



Anthem BlueCross BlueShield

And Its Affiliate HealthKeepers, Inc.

Navigating the next phase of health care reform

Health care reform timeline

A year-by-year look at what to expect

2010	◦ Early Retiree Reinsurance Program began ◦ Began closing the Medicare Part D "donut hole"
Beginning on plan year that starts on or after September 23, 2010	◦ Dependent coverage for adult children up to age 26 (or higher if state law mandates it) ◦ No lifetime dollar limits on benefits ◦ Restricted annual dollar limits on essential health benefits ◦ No pre-existing condition exclusions for children ◦ 100% coverage for preventive services in network* ◦ No prior authorization for emergency services or higher cost-sharing for out-of-network emergency services* ◦ No referrals required for OB/GYN services ◦ Any available primary care physician (PCP) accepting new patients may be selected ◦ Pediatrician may be selected as a PCP for children ◦ Revised appeals process and changes to adverse benefit determinations (enforcement of some regulations delayed until detailed guidance is issued)* ◦ No discrimination in favor of highly compensated employees (enforcement delayed until detailed guidance is issued)*
2011	◦ Prescription required for health account reimbursement for over-the-counter medications ◦ 20% tax for nonqualified HSA withdrawals ◦ Medical loss ratio standards go into effect (85% for large group)
2012	◦ Uniform summary of benefits and coverage/60-day notice for material modifications (delayed until final regulations are issued) ◦ Value of employer-sponsored coverage on W-2s for 2012 tax year - meaning W-2s issued in January 2013 (originally required earlier, but the IRS delayed the requirement until the 2012 tax year for large employers and the 2013 tax year for employers who issue fewer than 250 W-2s) ◦ First year medical loss ratio rebates may be issued
2013	◦ Employee notification of exchanges and premium subsidies ◦ Medical flexible spending account contributions limited to $2,500 per year ◦ Annual per-member fee for Patient-Centered Outcomes Research Institute (for fiscal year 2013, which technically begins October 1, 2012) ◦ Elimination of tax exclusion for Medicare Part D retiree drug subsidy payments
2014	◦ Penalties for employers who don't provide minimum coverage to full-time employees (50+ employees) ◦ Employer requirement to auto-enroll employees into health benefits (200+ employees) ◦ 90-day limit on waiting periods for coverage ◦ Small group redefined as 1-100 (states may defer until 2016) ◦ No annual dollar limits on essential health benefits ◦ Individual mandate ◦ Guaranteed issue ◦ 30% incentive cap for wellness programs ◦ Coverage of routine patient costs for clinical trials of life-threatening diseases*
2018	◦ 40% excise tax on high-cost "Cadillac" plans

*Not required for grandfathered group health plans

Benefit changes. Coverage requirements. Automatic enrollment. When it comes to health care reform, there's a lot to know – and a lot to do. The more you understand the law and its provisions, the better you can prepare for change and make strategic decisions that fit your organization and your employees.

On the other hand, too much information can be overwhelming. That's why this guide focuses only on the key provisions that will affect you and the key decisions you need to make. If you want more details, chat with your broker or account representative or visit our website at anthem.com/healthcarereform.

Moving reform forward for the benefit of you and your employees

To minimize disruption for you and your employees, we aim to implement health care reform as quickly and effectively as possible. While unresolved legal and legislative challenges have created uncertainty about the future of health care reform, these challenges will not affect our current implementation efforts. We will continue to implement reform in good faith for the benefit of our customers and members.

Exempted plans

The federal health care reform law will impact many types of plans, but there are exceptions. In general, these plans are exempted from all or some provisions of health care reform:

- Retiree-only plans with no active employees
- HIPAA-excepted benefits (benefits that are not an integral part of a health plan, such as stand-alone dental and vision, life and disability plans)
- Short-term health insurance plans
- Medigap and Medicare Supplement plans
- Long-term care insurance
- Employee assistance plans

Looking back

Employers weigh the pros and cons of grandfathering

For many employers, the big decision in 2010 was whether to grandfather their benefit plans. Under the health care reform law, plans that existed on or before March 23, 2010, and haven't made certain changes since then may be considered grandfathered plans. Grandfathered plans may be exempt from some of the requirements of the health care reform law.

Cost concerns versus benefit implications

So far we have seen muted market interest in retaining grandfathered status. Why? Many employers cited the complexities of remaining grandfathered, as well as a perception that it would offer limited benefit to them. This reflects the difficulty of health care reform for many employers: balancing today's cost concerns with tomorrow's potential benefit implications:

Employers' reasons to not grandfather	Employers' reasons to stay grandfathered
Now (2010-2013): • More flexibility to manage immediate cost concerns through benefit buy-downs and changes to employer contribution levels • Fewer administrative responsibilities such as notices and mandatory language on plan documents • Access to all of the additional benefits the health care reform law requires, such as 100% coverage for in-network preventive care services* Later (2014 and beyond): • To be determined	Now (2010-2013): • Not required to include some benefits, such as 100% coverage for in-network preventive care services* • Able to maintain plan designs that aren't allowed for nongrandfathered plans Later (2014 and beyond): • Not limited to four benefit tiers, all of which must include essential health benefits (small groups only) • Not required to implement community rating requirements and restricted age-based rating factors (small groups only)

Can you grandfather? Should you?

We continue to administer grandfathered plans upon the request of our customers who qualify. To help you decide whether you're eligible to grandfather – and if grandfathering is the right decision for you – we've developed a simple, interactive online tool that offers customized feedback based on your input. Try out the tool at anthem.com/healthcarereform or talk to your account representative.

*While not all health care reform changes are required in grandfathered plans, in some cases our company has decided to adopt health care reform provisions in both grandfathered and nongrandfathered plans. According to the U.S. Department of Health and Human Services (HHS), adoption of these additional provisions has no impact on the grandfathering status of those plans. For specific benefit plan impacts of health care reform, please refer to plan materials provided to you.

Looking back

How we implemented the first round of provisions

Here's an overview of how we implemented some key provisions for group health plans in 2010. These provisions went into effect for plan years beginning on or after September 23, 2010:

Dependent coverage to age 26

For many plans, we implemented this provision early to avoid a coverage gap for spring 2010 graduates. Group plan members were given the opportunity to enroll dependents younger than 26 at their first open enrollment after September 23, 2010. We decided to cover dependents to age 26 for most vision and dental plans as well, even though the health care reform law doesn't apply to these HIPAA-excepted benefits.

No lifetime dollar limits/restricted annual dollar limits on essential health benefits

We removed lifetime dollar limits from plans where required and gave individuals who may have previously reached their lifetime maximum an opportunity to re-enroll at the group's regular open enrollment. We implemented the annual limits provision, removing annual benefit and plan dollar limits. In general, we are not administering restricted annual limits on essential health benefits (also known as transitional annual limits).

No member cost share for in-network preventive care*

We expanded our standard preventive care list and updated nongrandfathered plans to cover these services with no member cost share. We also chose to include this coverage in some grandfathered plans. An updated preventive care list that includes expanded coverage for women's services (including FDA-approved contraception methods) will take effect at the first renewal on or after August 1, 2012.

Patient protections*

We decided to include these provisions in all plans, even though they aren't required for grandfathered plans.

Revised appeals process and adverse benefit determinations*

We created a standard appeal process that complies with health care reform for fully insured and self-insured groups. We have updated adverse benefit determinations (including explanation of benefit forms) to comply with this provision's notice requirements.

No discrimination in favor of highly compensated employees*

In December 2010, the government issued a notice delaying enforcement of this provision until more guidance is available. It is the employer's or group's responsibility to ensure compliance with this provision.

Early Retiree Reinsurance Program

Five billion dollars was set aside to help employers continue to provide coverage to certain retirees. We have helped customers apply for these funds by supplying required reporting and information. Funds for this temporary program had nearly run out by late 2011 – just 18 months after the program began.

*Not required for grandfathered group health plans

Where we are today

Making gradual shifts from 2011 to 2013

From 2011 to 2013, reform focuses less on benefit changes and more on industry regulation and funding reform-related programs. Some key provisions you should be aware of:

Spending account changes

Starting January 1, 2011 (regardless of plan year dates), prescriptions are required for spending account reimbursement of over-the-counter drugs other than insulin. Also on January 1, 2011, the penalty for nonqualified health savings account distributions went up to 20%. Starting in 2013, health care flexible spending account contributions will be limited to $2,500 per year. The limit will be adjusted for the cost of living every year.

Uniform summary of benefits and coverage/ notice of material modification

These rules were scheduled to take effect in March 2012, but they've been delayed until final regulations are issued. Plan summaries must have consistent contents and formatting. For fully insured plans, the plan issuer must provide a compliant paper or electronic summary at certain times in the enrollment process. Also, the plan issuer must provide 60-day notice for material modifications to plan benefits.The notice requirement doesn't apply to renewals.

W-2 reporting

Employers must start reporting the value of employer-sponsored coverage on W-2 forms for the 2012 tax year – meaning W-2s issued in January 2013. This will be a new, separate entry on the W-2 form. This is a reporting obligation only and does not change the current tax-free nature of the benefit.

Medical loss ratios

Health insurance issuers will report medical loss ratios (the percentage of premiums spent on medical care and quality improvement, as opposed to administrative expenses) to HHS on a calendar-year schedule. This reporting starts with calendar year 2011. Issuers that don't meet the minimum medical loss ratio (85% for large group) during the calendar year will need to pay rebates by August 1 of the following year. The first rebate payments, if any, must be made by August 1, 2012. For group plans, these rebates will be sent to the group. The group can then distribute the rebate to current subscribers or use it to reduce premiums.

Comparative effectiveness research plan fees

For plan/policy years ending after September 30, 2012, and before October 1, 2019, the plan issuer or sponsor will pay a fee to partially support the Patient-Centered Outcomes Research Institute. In the first year, the annual fee will be $1 multiplied by the average number of covered lives. In the second year, it will increase to $2 multiplied by the average number of covered lives.

Notification requirements

Starting in 2013, employers will need to start telling employees about health insurance exchanges and premium subsidies.

What do you need to do?

- If you offer spending accounts, update your employee benefit materials to reflect the new rules.
- Make sure your payroll department or vendor is prepared for W-2 reporting.

Where we are today

Moving to a new health insurance market in 2014

The most significant health care reform requirements start in 2014. These are some of the key requirements that will affect employers:

Employer responsibility to provide coverage

Employers with 50 or more full-time employees must offer minimum coverage to active employees (see sidebar). Employers will be subject to penalties if they don't provide minimum coverage to full-time employees or if they provide coverage that is not "affordable." These penalties will range from $2,000 to $3,000 per employee.

Automatic enrollment

Employers with more than 200 employees must automatically enroll new and existing full-time employees in health insurance plans. Employees may opt out.

Health insurance exchanges

Starting in 2014, people who don't get health insurance at work may be able to shop for it through an exchange run by the state or the federal government. Small businesses also can use exchanges to find insurance for their workers. Starting in 2017, states may permit large groups to purchase coverage through an exchange.

Employers will also be able to purchase coverage outside of the exchanges. Many states have already started setting up their exchanges. During this process, we're encouraging policymakers to design exchange policies that maximize product choice inside the exchange and minimize disruptions to the existing marketplace.

Employer reporting requirements

Employers will be required to report certain information to the IRS annually. This information includes:

- Whether minimum coverage is offered to full-time employees
- Any waiting periods for health coverage
- The monthly premium for the lowest cost option in each enrollment category under the plan
- The employer's share of the total allowed cost of benefits provided under the plan
- Number of full-time employees during each month
- Name, address and taxpayer identification number (or Social Security number) of each full-time employee, and the months each employee was covered under the employer's plan
- Other information that HHS may require (which will likely be refined in later regulations)

Requirements for minimum coverage

To be considered minimum coverage, a plan must:

- Provide 60% actuarial value minimum – basically, this means the plan covers at least 60% of covered health care costs.
- Be "affordable" based on regulations.

Note: Benefit package requirements are not defined; current guidance does not indicate that large group and self-insured plans will need to include the essential health benefits package.

Requirements for exchange plans

To be offered in an exchange, a plan must:

- Include the essential health benefits package.
- Provide 60% actuarial value minimum.
- Comply with one of the four benefit tiers with specified actuarial values (shown on the right).

Plus catastrophic plan offerings for individuals who are younger than 30 or qualify because of financial hardship.

FAQs

Answering common questions about health care reform

Can we increase our deductible a little bit each year and stay grandfathered?

A small increase every year could cause a loss of grandfathered status. That's because grandfathered status is determined by comparing benefits and contributions to the baseline plan in place on March 23, 2010, not the plan in place during the previous plan year. For more details about changes that would cause a loss of grandfathered status, visit our website at anthem.com/healthcarereform. You can also discuss your unique situation with your account representative.

If we make a benefit change that causes us to lose grandfathered status, when do we need to move to a nongrandfathered plan?

If you make a benefit change that causes a loss of grandfathered status, you would need to move to a nongrandfathered plan immediately.

What preventive care services were added for nongrandfathered plans?

Most of the services required by HHS were already included in our preventive care guidelines; however, we did make some modifications:

- We added certain services, including several additional screening tests and certain services associated with previously covered screenings and vaccines.
- We added counseling related to aspirin use, tobacco cessation, obesity and alcohol.
- Some services currently covered as medical/maternity are now considered preventive and covered with no cost share applied.

An updated preventive care list that includes expanded coverage for women's services (including FDA-approved contraception methods) will take effect at the first renewal on or after August 1, 2012.

What services are considered essential health benefits?

Late in 2011, HHS released a bulletin on its approach for essential health benefits. Instead of defining a specific package or rules, HHS will let states choose based on a benchmark plan. If a state chooses not to select a benchmark, HHS suggests that the default benchmark will be the small group plan with the largest enrollment in the state.

We do know that essential health benefits include at least these general categories:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services
- Chronic disease management
- Pediatric services, including oral and vision care

Does the health care reform law require health plans to cover members' costs for clinical trials?

Starting in 2014, nongrandfathered plans must include coverage of routine patient costs for clinical trials of life-threatening diseases.

How does a fully insured plan determine whether it is complying with nondiscrimination tests?

We recommend that the group work with its legal and benefits counselors as we cannot provide legal or tax advice. The health care reform law states that the rules for determining compliance for fully insured plans are similar to the rules that apply for self-insured plans. These rules are outlined in Internal Revenue Code Section 105. In December 2010, the government issued a notice delaying enforcement of this provision until more guidance is issued.

Can an employer impose an eligibility waiting period before enrolling new employees?

Yes, to the extent that the federal health care reform law and state law permits. Starting in 2014, under the federal health care reform law eligibility waiting periods cannot exceed 90 days.

Does the employer mandate provision require employers to offer dependent coverage?

No, dependents do not have to be offered coverage based on the employer mandate.

What is considered a "Cadillac plan"?

The health care reform law defines high-cost coverage (also known as a "Cadillac plan") as a plan that costs more than $10,200 (multiplied by the health cost adjustment percentage) for single coverage or $27,500 (multiplied by the health cost adjustment percentage) for family coverage. The health care reform law imposes a 40% excise tax on these plans starting in 2018. The insurer or employer will be responsible for the tax. The amounts will increase in future years based on factors that will be provided to the insurer or employer.

Find more questions and answers on our website

We're constantly adding new health care reform resources to our website, including answers to common questions. If you have a question about health care reform that isn't answered here, be sure to visit anthem.com/healthcarereform.

Summary

Pulling it all together

Provision	Required for grandfathered plans	Required for nongrandfathered plans
No lifetime benefit dollar limits	✔	✔
Dependent coverage for adult children up to age 26 (or higher if state law mandates it)	✔	✔
No annual dollar limits on certain types of benefits for group plans	✔	✔
100% coverage for preventive care in-network	*	✔
No prior authorization for emergency services or higher cost sharing for out-of-network emergency services	*	✔
No pre-existing limitations for children under the age of 19 for group plans	✔	✔
No discrimination in favor of highly compensated employees		✔
Revised appeals process and changes to adverse benefit determinations	*	✔
Reporting the value of employer-sponsored coverage on W-2s (2012 tax year)	✔	✔
Uniform explanation of coverage (2012)	✔	✔
Pre-enrollment document sent explaining benefits and exclusions (2012)	✔	✔
60-day notice for material modifications to plan benefits (2012)	✔	✔
90-day limit on waiting periods for coverage (2014)	✔	✔
Penalties for 50+ employers who don't provide minimum coverage to full-time employees (2014)	✔	✔
Automatic enrollment in health plan for employers with 200+ employees (2014)	✔	✔
Coverage of routine patient costs for clinical trials of life-threatening diseases (2014)		✔

*In some cases our company has decided to adopt these health care reform provisions in both grandfathered and nongrandfathered plans.

What do you need to do?

- Visit our health care reform website for details about maintaining grandfathered status.
- Update spending account materials to reflect new rules.
- Prepare for W-2 reporting for the 2012 tax year.

Need help making decisions in the complex post-health care reform environment?

We've developed tools to make health care reform information more understandable and customized. Check out our comprehensive online resource for up-to-the-minute information and tools:

- Articles and fact sheets summarize the regulations and answer common questions.
- User-friendly layout makes it easy to find the information you need.

It's all at anthem.com/healthcarereform.

There's a lot to know when it comes to the health care reform law. And there's more to come as this law continues to take shape. For the latest developments, check in at anthem.com/healthcarereform.

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