AGENDA

CONTRA COSTA COUNTY SCHOOLS INSURANCE GROUP
HEALTH BENEFITS COMMITTEE MEETING
January 13, 2017
10:00 A.M - 12:00 P.M

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

Teleconference Locations:
Arcohe School District, 11755 Ivie Road, Herald, CA 95638

Call-In Instructions
Call-In Number: 1-800-531-3045, Access Code: 5871616#
Operator will ask if you are entering as Host – at this point Press # and stay on the line until your call is connected
*NOTE – for those members calling in, the location must be accessible to the public and the agenda page must be posted at your teleconference location (outside of main entrance and outside your teleconference location [office door])

I. CALL TO ORDER

II. ROLL CALL & INTRODUCTIONS

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

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

CCCSIG:

Contra Costa County Schools Insurance Group	Bridget Moore, Executive Director

MEMBERS:

Arcohe Union School District	Dr. Jim Shock
Arcohe Union School District	Troy Miller, Alternate
Brentwood Union School District	Roxane Jablonski-Liu
Brentwood Union School District	Debbie Valladao, Alternate
Byron Union School District	Lisa Williams
Byron Union School District	Tina Pedersen, Alternate
Canyon School District	Gloria Faircloth
Castro Valley Unified School District	Candi Clark
Castro Valley Unified School District	Robin Yearby, Chair
Moraga School District	Daniela Parasidis
Moraga School District	Courtney Avellar, Alternate
Oakley Union Elementary School District	Maria de la Luz Bordanaro
Oakley Union Elementary School District	Cindy Peterson/Tammi Lauderdale, Alternates
Travis Unified School District	Jamie Metcalf
Travis Unified School District	Sara Smith, Alternate
Walnut Creek School District	Audrey Katzman
Walnut Creek School District	Griselda Barraza, Alternate

GUEST:

Sutter Health Plus	Alicia Aguilera, Account Manager

CONSULTANTS

Keenan & Associates	Debra DeSpain
Keenan & Associates	Vickie Vales

III. PUBLIC COMMENTS

Comments from the general public will be received and limited to five minutes per person.

IV. APPROVAL OF AGENDA — 2017-001 Action

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

V. APPROVAL OF MINUTES – November 18, 2016 — 2017-002 Action

The Committee will review the minutes of the last Committee meeting for any adjustments and adoption.

VI. CORRESPONDENCE — 2017-003 Information

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

VII. ADMINISTRATION/HEALTH BENEFIT PROGRAM ADMINISTRATIVE UPDATE

Sutter Health Plus Account Manager Introduction — **2017-004 Information**

2016 CCCSIG Health Benefits Committee Member Survey — **2017-005 Action**

2017 Open Enrollment Migration Report — **2017-006 Information**

CCCSIG Health Benefits Committee Eligibility Policy — **2017-007 Information**

VIII. INFORMATION

MEMBER COMMENTS — **Information**

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

CONSULTANT COMMENTS **Information**

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

LEGISLATIVE UPDATE/BRIEFING **2017-008**
Information

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

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1. AGENDA ITEMS NEXT MEETING **Information**

Members and others may suggest items for consideration at the next meeting tentatively scheduled for February 10, 2017.

X. ADJOURNMENT

Americans with Disabilities Act:

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

CONTRA COSTA COUNTY SCHOOLS INSURANCE GROUP

HEALTH BENEFITS COMMITTEE MEETING
AGENDA ITEM DETAIL

PRESENTED TO:		DATE:	January 13, 2017
Health Benefits Committee			
SUBJECT:		ITEM #:	2017-001 **ACTION**
Approval of Agenda		Enclosure:	Yes

Category: Approval of Agenda

Prepared by: Keenan & Associates

Requested by: Health Benefits Committee

BACKGROUND:

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

STATUS:

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

RECOMMENDATION:

Subject to changes or corrections, the agenda is to be approved.

CONTRA COSTA COUNTY SCHOOLS INSURANCE GROUP

HEALTH BENEFITS COMMITTEE MEETING
AGENDA ITEM DETAIL

PRESENTED TO:		DATE:	January 13, 2017
Health Benefits Committee			
SUBJECT:		ITEM #:	2017-002
			ACTION
Approval of Minutes – November 18, 2016		Enclosure:	Yes

Category: Approval of Minutes

Prepared by: Keenan & Associates

Requested by: Health Benefits Committee

BACKGROUND:

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

STATUS:

Included in the agenda packet are minutes from the November 18, 2016, meeting, which have not yet been approved.

RECOMMENDATION:

Subject to changes or corrections, the minutes of the November 18, 2016, meeting is to be approved as submitted.

MINUTES

CONTRA COSTA COUNTY SCHOOLS INSURANCE GROUP
HEALTH BENEFITS COMMITTEE MEETING
November 18, 2016
10:00 A.M - 12:00 P.M

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

I. CALL TO ORDER

The meeting was called to order by Robin Yearby at 10:02 AM. Introductions were made.

II. ROLL CALL & INTRODUCTIONS

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

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

Those in attendance were:

CCCSIG:

Contra Costa County Schools Insurance Group	Bridget Moore, Executive Director

MEMBERS:

Arcohe Union School District	Dr. Jim Shock
Brentwood Union School District	Roxane Jablonski-Liu
Byron Union School District	Lisa Williams
Castro Valley Unified School District	Robin Yearby, Vice Chair (Alternate)
Moraga School District	Courtney Avellar, Alternate
Oakley Union Elementary School District	Maria de la Luz Bordanara, Cindy Peterson
Travis Unified School District	Jamie Metcalf
Walnut Creek School District	Audrey Katzman

CONSULTANTS

Keenan & Associates	Debra DeSpain
Keenan & Associates	Vickie Vales

ABSENT:

Canyon School District	Gloria Faircloth

III. PUBLIC COMMENTS

There were no public comments.

IV. APPROVAL OF AGENDA

2016-067
Action

A motion was made by Audrey Katzman, seconded by Courtney Avellar and unanimously carried to approve the Agenda as presented. Votes:

Arcohe - Aye	Brentwood – Aye
Byron – Aye	Canyon – Absent
Castro Valley – Aye	Moraga - Aye
Oakley – Aye	Travis - Aye
Walnut Creek – Aye	

V. APPROVAL OF MINUTES – August 12, 2016

2016-068
Action

A motion was made by Courtney Avellar, seconded by Cindy Peterson and unanimously carried to approve the Minutes as presented**.** Votes:

Arcohe - Aye	Brentwood – Aye
Byron – Aye	Canyon – Absent
Castro Valley – Aye	Moraga - Aye
Oakley – Aye	Travis - Aye
Walnut Creek – Aye	

VI. CORRESPONDENCE

2016-069
Information

Debra DeSpain reviewed the correspondence received with new HBC appointments from Moraga, Byron, Arcohe and Walnut Creek. CORRECTION: Daniela Parasidis is replacing Kathy Bell.

VII. ADMINISTRATION/HEALTH BENEFIT PROGRAM ADMINISTRATIVE UPDATE

Chair Election

2016-070
Action

Bridget Moore reviewed the chair and vice chair election rules under the Bylaws. An interest email was distributed to the existing members to see if anyone was interested in volunteering to fill the Chair position. Robin Yearby volunteered to fill the Chair position. Since there are so many new members, it was suggested to leave the Vice Chair position open for now as no one expressed interest. If the Chair is unable to attend a specific meeting, one of the other members would be asked to volunteer to chair individual meetings.

A motion was made by Audrey Katzman, seconded by Courtney Avellar and unanimously carried to accept Robin Yearby as chair and leave the vice chair open as a volunteer option when needed**.** Votes:

Arcohe - Aye	Brentwood – Aye
Byron – Aye	Canyon – Absent
Castro Valley – Aye	Moraga - Aye
Oakley – Aye	Travis - Aye
Walnut Creek – Aye	

Broker Agreement

2016-071
Information

Bridget Moore reviewed the existing Consultant/Broker Agreement highlighting the services Keenan provides the Health Benefits Program. She explained that the HBP is a smaller insured program of the JPA, with the Workers Compensation Program being CCCSIG's core risk program. The Broker agreement will be

up for renewal 1/1/2018 and needs to be brought to the Executive Board for approval. Prior to the renewal date (probably August/September 2017), the agreement will be reviewed with the HBP Committee for any additions/changes. At such time a recommendation will be made by the HBP Committee to have the Executive Committee consider approval of the agreement.

The Business Associate Agreement was also provided. This is the document which details Keenan's handling/protecting of the personal health information of your employees.

Debra also reviewed the Broker fee breakdown by district. Plus, she reminded the committee that any overrides or bonuses Keenan receives from the carriers are passed back to the HBC. These funds have been placed in the HBP's wellness fund. Keenan also audits commission payments made by the carriers to ensure we are not overpaid based on the contract. In the past, Keenan has been overpaid by Kaiser as they cannot facilitate a flat amount in their accounting process. Kaiser uses a percentage and this can at times produce overpayments. These funds have historically been returned to each district based upon percentage of Kaiser enrollment.

2017 Health Benefits Committee Meeting Schedule **2016-072**
Action

Debra DeSpain reviewed the proposed 2017 meeting schedule. There are a few months needing discussion, April and November 2017. The members were surveyed for those months and April 14, 2017 was determined to be acceptable. The November date will be changed to November 3, 2017.

Vickie Vales will send out calendar invites for the 2017 meetings.

A motion was made by Audrey Katzman, seconded by Cindy Peterson and unanimously carried to accept the 2017 meeting scheduled as presented changing the November date from November 10th to November 3rd**.**
Votes:

Arcohe - Aye
Byron – Aye
Castro Valley – Aye
Oakley – Aye
Walnut Creek – Aye
Brentwood – Aye
Canyon – Absent
Moraga - Aye
Travis - Aye

Anthem Blue Cross/Sutter Health Plus Employee Meetings **2016-073**
Information

Debra DeSpain reviewed the employee meetings held at Brentwood, Byron, Moraga, Oakley and Walnut Creek for the existing Anthem Blue Cross members. Most of the meetings seemed to go well. We understand that Sutter Health Plus is not the best option for everyone and are continuing to look for alternatives. Debra has had discussions with United HealthCare as they have some new options. If there is an option that would be an alternative, Debra will provide updates when available.

Debra reminded the committee to be sure they are receiving employee signatures when they opt out/waive coverage. She mentioned there has never been formal JPA eligibility rules established that would assist the districts when employees ask about enrollment/eligibility, etc. Debra offered, and everyone agreed, that it would be helpful to the districts to have an enrollment/eligibility policy. Debra will draft rules and bring to the January 2017 meeting.

The Committee was also reminded to change the vendor information for the insurance premium payment for the 2017 year.

VIII. INFORMATION

MEMBER COMMENTS — Information

There were no additional member comments.

CONSULTANT COMMENTS — Information

Vickie provided an update on the HBC flu clinics. They were all successful. Travis and Walnut Creek commented there was some confusion about the payment for the vaccinations for non-enrolled members. Vickie confirmed Maxim is given the information that the fee is to be made payable to the district, but a few nurses did not understand that was the process. With that said, having the payments made directly to Maxim would alleviate any additional billing to the districts on behalf of CCCSIG. Maxim is still closing out their clinic records. The final log sheets and invoice will be available soon.

Debra stated Brentwood received a request from CMS for pharmacy information, which we were able to gather from Anthem Blue Cross and Kaiser. She will forward a copy of the request and the required information to the other districts for reference purposes.

Debra also queried the districts as to the Kaiser posters. We will be ordering them again for 2017 and adding in Travis USD and Arcohe Union School District under the CCCSIG logo.

Lastly, Keenan is keeping a close watch on what will be happening with health care reform now that the election is over. It is expected that some parts of ACA will be reformed, but doubt it will be repealed all together.

LEGISLATIVE UPDATE/BRIEFING — 2016-074 Information

Debra DeSpain reviewed the briefing included in the meeting material:

Health Care Reform: IRS Provides Clarification on Solicitation Requirements for Missing SSNs/TINs – does not apply to this group as it

IX. AGENDA ITEMS NEXT MEETING — Information

Since the agenda items for the next meeting are not critical, it was decided to cancel the December 9, 2016 meeting. The next meeting will be January 13, 2017. Agenda items are:

1. 2016 Broker Satisfaction Survey
2. 2017 Enrollment Migration Report
3. Health Benefits Committee Eligibility Rules - Draft

X. ADJOURNMENT

A motion was made by Roxanne Jablonski-Liu, seconded by Cindy Peterson and unanimously carried to adjourn at 11:10 A.M**.** Votes:

Arcohe - Aye	Brentwood – Aye
Byron – Aye	Canyon – Absent
Castro Valley – Aye	Moraga - Aye
Oakley – Aye	Travis - Aye
Walnut Creek – Aye	

Americans with Disabilities Act:

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CONTRA COSTA COUNTY SCHOOLS INSURANCE GROUP

HEALTH BENEFITS COMMITTEE MEETING
AGENDA ITEM DETAIL

PRESENTED TO:		DATE:	January 13, 2017
Health Benefits Committee			
SUBJECT:		ITEM #:	2017-003
			INFORMATION
Correspondence		Enclosure:	No

Category: Correspondence

Prepared by: Keenan & Associates

Requested by: Health Benefits Committee

BACKGROUND:

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

STATUS:

There was no correspondence received for this meeting.

RECOMMENDATION:

For review and information only.

CONTRA COSTA COUNTY SCHOOLS INSURANCE GROUP

HEALTH BENEFITS COMMITTEE MEETING
AGENDA ITEM DETAIL

PRESENTED TO:	DATE:	January 13, 2017
Health Benefits Committee		
SUBJECT:	ITEM #:	2017-004
		INFORMATION
Sutter Health Plus Account Manager Introduction	Enclosure	Handout

Category: Administration/Health Benefit Program Administrative Update

Prepared by: Keenan & Associates

Requested by: Health Benefits Committee

BACKGROUND:

Sutter Health Plus, the new HBP carrier partner, effective January 1, 2017 will be in attendance.

STATUS:

Alicia Aguilera, Account Manager, Sutter Health Plus, will be introduced to the HBP.

RECOMMENDATION:

For review and discussion.

CONTRA COSTA COUNTY SCHOOLS INSURANCE GROUP

HEALTH BENEFITS COMMITTEE MEETING
AGENDA ITEM DETAIL

PRESENTED TO:	DATE:	January 13, 2017
Health Benefits Committee		
SUBJECT:	ITEM #:	2017-005 **ACTION**
HBP Committee Member Survey	Enclosure:	No

Category: Administration/Health Benefit Program Administrative Update

Prepared by: Keenan & Associates

Requested by: Health Benefits Committee

BACKGROUND:

For the past few years the Health Benefits Committee has utilized an online survey for member districts. The intent of the survey is to evaluate the Broker service activities in relationship to the Program's directives and identify opportunities for the Committee to focus on in the upcoming year.

STATUS:

The proposed questions for the Committee to consider for the 2016 Health Benefits Program survey are:

Rate the following questions using your experience as part of the CCCSIG Health Benefits Program Committee (HBPC).

- Coordinates wellness activities (e.g. flu shots; Kaiser Wellness Posters) that are easy for Districts to implement
- Provides appropriate care and planning in preparation of HBPC agendas to ensure Committee members are well-informed on agenda topics in order to discuss/make decisions on agenda action items
- Minutes of HBPC meetings are complete and accurate
- Identifies trends and needs of the HBP and makes appropriate recommendations for HBPC consideration
- Evaluates options to reduce costs for Districts and their subscribers (e.g. alternative options for District offering such as a high deductible plan to meet Affordability of Health Care Reform)
- Keeps HBPC advised of changes in laws and regulations (e.g. Briefings; Webinars) pertaining to health benefit programs
- Provides general education to HBPC and districts when appropriate and/or requested
- Affordable Health Care Act
    1. Has provided HBPC and Districts sufficient ACA information and direction within the limits of information released by ACA to date

2. Provides ACA information and education timely and as requested
3. Provides ACA related materials timely and as requested when available
4. Identifies needs related ACA and makes appropriate recommendations

- Understands directions provided by the HBPC and follows projects through to completion when assigned
- Written materials are clear, concise, understandable and accurate
- Shows objectivity in making recommendations and presents all sides of an issue for HBPC discussion/ consideration
- Meets established deadlines
- As the Program liaison with the carriers, effectively negotiates renewals and promptly and accurately negotiates contract revisions as required by District benefit changes (e.g. renewal options for 2017)
- Available and accessible when needed for individual District meetings (e.g. for plan overview, workshops, in-service activities, open enrollment, HBPC orientation for new members and Benefit Bridge Training), handling employee questions, problems and complaints in a professional and timely manner
- Please provide suggestions for HBPC consideration and discussion for Program goals and opportunities for 2017

Once approved, the survey will be sent to Committee members next week with the results reported at the February 10, 2017 HBPC meeting and from which any defined Program objectives for the Committee and Broker for 2017 will be established.

RECOMMENDATION:

Committee to approve final survey with any modifications discussed for distribution to member districts.

CONTRA COSTA COUNTY SCHOOLS INSURANCE GROUP

HEALTH BENEFITS COMMITTEE MEETING
AGENDA ITEM DETAIL

PRESENTED TO:		DATE:	January 13, 2017
Health Benefits Committee			
SUBJECT:		ITEM #:	2017-006
			INFORMATION
2017 Open Enrollment Migration Report		Enclosure	Yes

Category: Administration/Health Benefit Program Administrative Update

Prepared by: Keenan & Associates

Requested by: Health Benefits Committee

BACKGROUND:

The open enrollment migration report is compiled from BenefitBridge using enrollment statistics by district for December 2016 and January 2017.

STATUS:

Keenan will present the 2017 open enrollment migration report on the Kaiser Anthem Blue Cross/Sutter Health Plus plans to the committee for review.

RECOMMENDATION:

For review and discussion, as necessary.

Keenan & Associates

Contra Costa County Schools Insurance Group 2017 Open Enrollment Migration Report

KAISER				ANTHEM BLUE CROSS			SUTTER HEALTH PLUS	
District	Plan	December 2016	January 2017	Plan	December 2016	January 2017	Plan	January 2017
Arcohe	High Plan - $20 Copay	10	11	N/A			N/A	
	Low Plan - $30 Copay	15	14					
	HSA Plan - $2000	5	5					
Total		***30***	***30***					
Brentwood	High Plan - $5 Copay	221	238	$15 copay	18		ML30-$10 Copay	4
	Mid Plan - $15 Copay	55	61	PPO - $15 Copay	2		ML34-$20 Copay	2
	DHMO - $10 Copay	68	72				ML24-DHMO	0
Total		***344***	***371***		***20***	***Termed***		***6***
Byron	$10 Copay	107	117	$10 Copay	4		ML30-$10 Copay	2
Total		***107***	***117***		***4***	***Termed***		***2***
Canyon	$15 Copay	5	5	N/A			N/A	
Total		***5***	***5***					
Castro Valley	High Plan - $0 Copay	164	160	N/A			N/A	
	Low Plan - $10 Copay	139	141					
	DHMO - $20 Copay	36	42					
	HSA - $2700	27	32					
	Senior Advantage	109	108					
Total		***475***	***483***					
Moraga	High Plan - $5 Copay	31	33	$20 Copay	16		ML34-$20 Copay	14
	Mid Plan - $15 Copay	59	64					
	DHMO - $20 Copay	9	7					
	Senior Advantage	14	14					
Total		***113***	***118***		***16***	***Termed***		***14***
Oakley	High Plan - $15 Copay	191	195	$15 copay	20		ML30-$10 Copay	8
	Mid Plan - $20 Copay	18	21				ML34-$20 Copay	4
	DHMO - $10 Copay	20	24				ML24-DHMO	2
	Senior Advantage	10	10					
Total		***239***	***250***		***20***	***Termed***		***14***
Travis	High Plan - $10 Copay	36	38	N/A			N/A	
	Low Plan - $20 Copay	70	67					
	DHMO - $10 Copay	37	35					
	HSA - $1800	98	108					
Total		***241***	***248***					
Walnut Creek	Certificated - $10 Copay	25	29	Certificated - $15 copay	10		ML30-$10 Copay	2
	Classified - $20 Copay	15	19	Classified - $15 copay	3		ML34-$20 Copay	2
	DHMO - $10 Copay	136	138	PPO - $15 Copay	0		ML24-DHMO	***0***
Total		***176***	***186***		***13***	***Termed***		***4***
CCCSIG TOTAL		***1,730***	***1,808***		***73***	***0***		***40***
Change			***78***			***(73)***		***40***

CONTRA COSTA COUNTY SCHOOLS INSURANCE GROUP

HEALTH BENEFITS COMMITTEE MEETING
AGENDA ITEM DETAIL

PRESENTED TO:		DATE:	January 13, 2017
Health Benefits Committee			
SUBJECT:		ITEM #:	2017-007
			INFORMATION
CCCSIG Health Benefits Committee Eligibility Policy		Enclosure:	Handout

Category:	Administration/Health Benefit Program Administrative Update
Prepared by:	Keenan & Associates
Requested by:	Health Benefits Committee

BACKGROUND:

At the November 18, 2016 meeting it was agreed that an HBP eligibility policy would be helpful for the member districts. The HBP requested Keenan to prepare a draft eligibility policy for review.

STATUS:

Keenan will present Draft 1 of the CCCSIG HBP Eligibility Policy.

RECOMMENDATION:

The committee should review and discuss draft rules; recommending changes/edits as needed.

CONTRA COSTA COUNTY SCHOOLS INSURANCE GROUP

HEALTH BENEFITS COMMITTEE MEETING
AGENDA ITEM DETAIL

PRESENTED TO:		DATE:	January 13, 2017
Health Benefits Committee			
SUBJECT:		ITEM #:	2017-008
			INFORMATION
Legislative Update/Briefing		Enclosure:	Yes

Category: Information

Prepared by: Keenan & Associates

Requested by: Health Benefits Committee

BACKGROUND:

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

STATUS:

The following briefings are enclosed:

1. AB1386 and AB1745-New Emergency Drug Treatment Options for Schools
2. The Affordable Care Act: Potential Impact of the Presidential Administration Change
3. 2017 Benefit Limits for Health & Welfare Plans
4. Health Care Reform: IRS Extends Due Date for Furnishing IRS Form 1095-C to Employees

RECOMMENDATION:

For review and information only.

AB 1386 AND AB 1748: EFFECTIVE JANUARY 1, 2017 NEW EMERGENCY DRUG TREATMENT OPTIONS FOR SCHOOLS

Two bills signed by Governor Brown in September 2016 will give local educational agencies (LEAs) a greater ability to administer life-saving treatments to students. AB 1386 (Chapter 347, Statutes of 2016) builds on prior legislation, including SB 1266 (Chapter 321, Statutes of 2014), which required LEAs to provide emergency epinephrine auto-injectors (EAIs) to school nurses or trained personnel who had volunteered to administer epinephrine as emergency aid to persons suffering from an anaphylactic reaction. It also builds on SB 738 (Chapter 132, Statutes of 2015) which amended Education Code Section 49414 clarifying physician immunity for providing prescriptions. AB 1748 authorizes school nurses and other trained personnel to use an opioid antagonist to provide emergency aid to persons suffering from an opioid overdose.

AB 1386—EPINEPHRINE AUTO-INJECTORS

This is the second clean-up bill passed after the enactment of SB 1266, which required LEAs to provide EAIs to school nurses and trained volunteers. In 2015, the legislature passed SB 738 (Chapter 132, Statutes of 2015), which expressly exempts physicians from liability, prosecution or professional review for issuing a prescription or order for an EAI, unless the issuance of the prescription or order constitutes gross negligence or willful or malicious conduct.

Effective January 1, 2017, AB 1386 expressly allows pharmacies to furnish EAIs to authorized entities and gives authorized entities greater immunity from civil liability. AB 1386 permits health care providers to issue a prescription for, and a pharmacy to dispense, an epinephrine auto-injector to an authorized entity (including a LEA) if the authorized entity submits evidence it employs at least one person, or utilizes at least one volunteer or agent, who is trained and has a current epinephrine auto-injector certification card issued by the California Emergency Medical Services Authority (EMSA).

The new law also broadens the definition of EAI by eliminating the reference in the statute to a spring-activated needle. Instead, it defines an EAI as a "disposable delivery device designed for automatic injection of a premeasured dose of epinephrine into the human body to prevent or treat a life-threatening allergic reaction."

AB 1386 also requires an authorized entity that possesses and makes available epinephrine auto-injectors to create and maintain on its premises an operations plan that includes:

- The name and contact number for the health care provider who prescribed the EAI.
- Where and how the EAI will be stored.
- The names of the designated employees or agents who have completed the required training program and who are authorized to administer the EAI.
- How and when the EAI will be inspected for an expiration date.

- The process to replace the expired EAI, including the proper disposal of the expired or used EAI in a sharps container.

The law provides authorized entities with immunity from civil liability for damages resulting from any act or omission, other than an act or omission constituting gross negligence or willful or wanton misconduct, connected to the administration of an epinephrine auto-injector by any one of its employees, volunteers, or agents who is a lay rescuer. The law also provides that the failure of an authorized entity to possess or administer an epinephrine auto-injector shall not result in civil liability.

Finally, AB 1386 imposes some additional reporting and recordkeeping requirements on authorized entities. It requires an authorized entity that possesses and makes available EAIs to submit to EMSA a report of each incident involving the use of an EAI, within 30 days after each use. It requires the authorized entity to maintain records regarding the acquisition and disposition of EAIs for three years.

Assisting with Compliance

Through the PRIME program, Keenan developed a resource "EipPen4Schools Program and FAQ" which can be found through this link or on P&C Bridge.

http://www.keenan.com/news/brief/2015/BRF_20150826_SB738EpiPenNewLeg_KA.pdf

AB 1748—Opioid Antagonists

Effective January 1, 2017, this new law authorizes school districts, county offices of education (COEs) and charter schools to provide emergency naxolone hydrochloride (often known by the brand name Narcan) or another opioid antagonist to school nurses or trained personnel who have volunteered. The law allows each public and private school to voluntarily determine whether or not to make opioid antagonists and trained volunteers available at its school. Schools are to take into consideration the response time of emergency medical personnel to their school when making the decision as to whether to stock the drug and make trained volunteers available. Schools choosing to stock the drugs and provide volunteer training must provide the training at no cost to the volunteers and during the volunteers' regular work hours.

AB 1748 allows school nurses or trained personnel to administer an opioid antagonist to provide emergency aid to a person suffering or reasonably believed to be suffering from an opioid overdose. A school cannot grant or withhold a benefit from any individual based on his or her offer to volunteer. Modeled after AB 1266, AB 1748 allows school personnel to volunteer to be trained to administer the drug as emergency first aid. The law also limits the method of administration of this class of drugs to nasal spray or auto-injector, and states that a volunteer should be allowed to administer the drug in the form the volunteer is most comfortable with. Employees who volunteer may rescind their offer to administer emergency opioid antagonists at any time, including after the receipt of training. It is prohibited by the law to retaliate against an individual for rescinding.

The law also requires LEAs to ensure in writing that each employee who volunteers is provided a defense and indemnification from civil liability, as well as prohibiting a person who has been trained and administers an opioid antagonist in good faith and not for compensation from being subject to civil liability, criminal prosecution or professional review, except in cases of gross negligence or willful and wanton misconduct.

With regard to acquisition of an opioid anatagonist, the law authorizes pharmacies to provide the drugs to LEAs without a prescription in the State of California. CVS and Walgreens will sell Narcan without a prescription in their stores in California. The LEA must maintain records of the acquisition and disposition of the opioid antagonist for at least three years. The LEA is required to monitor the supply of opioid antagonist and ensure the destruction of expired drugs. LEAs who elect to stock an opioid antagonist must, at least once every school year, distribute a notice to all staff describing the volunteer request and the training volunteers will receive, stating the right of an employee to rescind the offer to volunteer, and stating that no benefit will be granted or withheld in connection with volunteering and no retaliation will be made for rescinding the offer to volunteer.

The law directs the Superintendent of Public Instruction to consult with experts in establishing minimum standards for the training and to review these standards every five years. The minimum standards will include training on recognizing the symptoms of opioid overdose, procedures for storage and emergency use of opioid antagonists, and basic emergency follow-up procedures after administering the drug. It also requires the California Department of Education to include on its website a clearinghouse for best practices in training non-medical personnel to administer opioid antagonists.

For questions regarding this *Briefing*, please contact your Keenan Account Manager.

THE AFFORDABLE CARE ACT: POTENTIAL IMPACT OF THE PRESIDENTIAL ADMINISTRATION CHANGE

Barely a week in the rearview mirror, the election of 2016 has brought monumental uncertainty to health benefit plans. President-elect Donald Trump stated unequivocally during the campaign that he would "get rid of Obamacare" and with Republican majorities in both the House of Representatives and the Senate, he appears to have the legislative support to do so. Moreover, opposition to and the promise to repeal the Affordable Care Act (ACA) has been a mainstay of Republican campaigns since 2010. There have been more than 60 attempts to repeal all or part of the ACA in the last seven years. The voters who elected an outspoken new President and Republican majorities in both houses of Congress will expect results.

In this new political environment, benefits managers are understandably asking many questions about the future of the ACA: Will the entire law be repealed? How quickly will that happen? What else is likely to be enacted in its place? What does this mean for employers in California? Right now, there are no certain answers, except that once again, health care reform is likely to be the first order of business of a new administration that is committed to sweeping change. Below is an analysis of what that change may look like and what the challenges will be for lawmakers. Our analysis is broken into three parts: Repeal, Replace, and California.

REPEAL

Complete repeal of the law will be challenging, if not impossible, for two reasons: (1) Republicans do not have a filibuster proof majority in the Senate, and (2) there are parts of the law that have proven popular. Moreover, President-elect Trump has made comments in recent days that he would like to keep intact at least two of the most popular aspects of the ACA.

Since any efforts for complete repeal are unlikely to make it through the Senate, it is more likely that parts of the ACA could be repealed through the budget reconciliation process, which requires a simple majority of 51. This is the process that was used to pass the ACA in 2010; it was also the process House and Senate Republicans used in 2015 to pass legislation that repealed key parts of the ACA. There are also limits to what can be enacted or repealed through budget reconciliation; the provisions must be related to revenue. Congress would not be able to repeal provisions unrelated to revenue.

What might this look like? The 2015 legislation vetoed by President Obama provides what policymakers in the Capitol believe will likely be the baseline for "repeal" legislation. H.R. 3762 would have:

- Phased out funding for subsidies to help individuals afford insurance purchased through the exchanges;
- Eliminated the tax penalties for individuals who do not purchase health insurance and employers with 50 or more employees who do not provide health coverage to employees;
- Eliminated the medical device tax and health insurance providers fee;
- Eliminated the "Cadillac tax" on higher-cost employer-provided health benefits; and

- Phased out the ACA expansion of Medicaid over a two-year period.

As noted above, there are provisions of the ACA that are not related to revenue and some of these provisions have had broad public support. Congress is unlikely to repeal provisions extending coverage of dependent children to age 26, the prohibition against annual and lifetime dollar limits, or the prohibition against pre-existing condition exclusions.

Finally, although Congress would not be able to repeal non-revenue related provisions through the budget reconciliation process, there could still be significant changes to these provisions through regulatory and sub-regulatory guidance from the executive branch agencies. For example, under the Trump administration, the U.S. Department of Health and Human Services could potentially revisit its definition of "preventive care" as it relates to birth control, which has been a contentious issue since enactment.

REPLACE

This is where predictions become somewhat more difficult. To date, critics of the ACA have not coalesced around a single plan. President-elect Trump's campaign proposals touching on health care reform have been brief. He has endorsed expanding the use of Health Savings Accounts (HSAs), allowing the purchase of insurance coverage across state lines, making the cost of individual health coverage premiums tax deductible, price transparency in medicine, block-granting Medicaid and allowing prescription drug imports.

Among the other, more detailed plans that have been discussed in the wake of the election is the "A Better Way" plan introduced by House Speaker Paul Ryan in June of 2016. Ryan's plan included many elements that have been common to Republican "replace" plans, including:

- Buying insurance across state borders
- Tax credits for individuals to purchase health insurance
- Expanding use of HSAs and Health Reimbursement Arrangements
- Allowing Association health plans and individual health pools
- Medical malpractice reform
- Capping the tax exclusion for employer-sponsored health coverage
- Removing Equal Employment Opportunity Commission restrictions on wellness plans
- Adjusting age rating ratios
- Establishing high risk pools

Ryan's plan also outlined major changes to federal Medicare and Medicaid programs. While the various proposals lay out general ideas, the lack of details make it challenging to predict what a replacement plan would look like. It is also important to remember that even once legislation is passed, the federal agencies will need to implement regulations, which could take several months or longer. The bottom line is that repealing and replacing the ACA is not going to happen overnight. Just as the full enactment of the ACA has taken time, so will the unwinding of it.

California

Since 2010, California has been at the forefront of enacting the ACA at a state level. What that means is that many of the ACA's provisions are enshrined in state law. In some cases, California went even further than the federal law. California has statutes on the books mirroring or enhancing ACA provisions with regard to:

- Essential health benefits and coverage of preventive services,
- Prohibitions on discrimination,
- Annual and lifetime dollar limits on coverage,
- Limits on cost-sharing, including deductibles and out-of-pocket maximums,
- Coverage of emergency services,
- Standardized benefits, and many other provisions.

It remains to be seen whether and how California will unwind this legal tangle, but at least at present, many of these laws will stay on the books until the California legislature acts to repeal or amend them.

There is also the matter of Covered California and whether California will be able to maintain its Exchange. It has been estimated that California receives more than $20 billion a year to subsidize consumers who buy policies on the Exchange and to pay for others who became eligible for free or low-cost care under Medi-Cal. Maintaining that level of subsidized coverage would take a substantial ongoing investment from the state and it is unclear whether purchasers would continue using the Exchange absent the subsidized coverage to which it provides access.

Next Steps: Hold to Existing Law

While we wait to see what the new Administration and Congress will do with the ACA, employers and carriers must continue to administer their plans in full compliance with existing law, unless and until each provision is repealed. This includes the reporting under Internal Revenue Code sections 6055 and 6056 that is due in early 2017. At present, employers subject to the Employer Mandate are still obligated to provide statements to their full-time employees and to report to the Internal Revenue Service by the applicable deadlines.

Keenan has been at the table at a state and national level, talking to clients and policymakers about what is likely to happen. As we have always done, we will continue to advocate for affordable health coverage for our clients. As health care reform proposals coalesce, we will continue to keep you informed and seek your input. Through the coming weeks of uncertainty, you can be certain that Keenan will explain, in real time, what changes are coming your way.

Please contact your Keenan Account Manager for questions regarding this *Briefing.*

2017 BENEFIT LIMITS FOR HEALTH & WELFARE PLANS

Every year, the U.S. Government sets new limits for various benefit programs to reflect inflation and changes in the law. Following are the limits announced for 2017. Employers should review their benefit plans to ensure they reflect these new limits.

Retirement Plans	2016	2017
Limits On Benefits And Contributions:		
o Defined benefit plan, basic limit	$210,000	$215,000
o Defined contribution plan, basic limit	$53,000	$54,000
o 401(k) and 403(b) plans, elective deferrals	$18,000	$18,000
o 457(b) plans, elective deferrals	$18,000	$18,000
o SIMPLE plans, elective deferrals	$12,500	$12,500
o Annual compensation limit	$265,000	$270,000
Catch-Up Contributions		
o 401(k), 403(b) or governmental 457 plans	$6,000	$6,000
o SIMPLE plans	$3,000	$3,000
"Highly Compensated" Definition	$120,000	$120,000
"Officer" Or "Key Employee" Definition	$170,000	$175,000

Health Savings Accounts	2016	2017
Contributions		
o Individual	$3,350	$3,400
o Family	$6,750	$6,750
Minimum Annual Deductible		
o Self-Only	$1,300	$1,300
o Family	$2,600	$2,600
Out-of-Pocket Maximums (OOPM)		
o Self-Only	$6,550	$6,550
o Family	$13,100	$13,100
Post-55 Catch-Up Limit	$1,000	$1,000

Non-HSA Qualified Plans	2016	2017
Out-of-Pocket Maximums (OOPM)		
o Self-Only	$6,850	$7,150
o Other than self-only coverage	$13,700	$14,300

Medicare	2016	2017
Part A (Hospital Insurance):		
o Inpatient deductible	$1,288	$1,316
o Daily Coinsurance, Days 61-90	$322	$329
o Daily Coinsurance, Days 91-150 Lifetime Reserve	$644	$658
o Daily Coinsurance, Skilled Nursing Facility[1].	$161	$164.50
Part B (Supplementary Medical Insurance):		
o Monthly premium	$104.90	$109
o Deductible	$166	$183
Part D (Prescription Drug Benefit):		
o Base Part D Premium	$34.10	$35.63
o Maximum Annual Deductible	$360	$400
o Initial Coverage Limit	$3,310	$3,700
o Annual Out-Of-Pocket Threshold	$4,850	$4,950
o Minimum Copayment For Costs Above The Annual Out-Of-Pocket Threshold	$2.95 generic $7.40 other	$3.30 generic $8.25 other

Medical Savings Accounts	2016	2017
Individual Deductible Range	$2,250 – $3,350	$2,250 – $3,350
Individual Out-Of-Pocket Maximum	$4,450	$4,450
Family Deductible Range	$4,450 – $6,700	$4,500 – $6,750
Family Out-Of-Pocket Maximum	$8,150	$8,250

Long Term Care Insurance Deductible Premiums	2016	2017
Age:		
o 40 or less	$390	$410
o 41-50	$730	$770
o 51-60	$1,460	$1,530
o 61-70	$3,900	$4,090
o Over 70	$4,870	$5,110

[1] For days 21-100. Days 1-20 is $0 for each benefit period.

Flexible Spending Accounts	2016	2017
Dependent Care	$5,000	$5,000
Medical	$2,550	$2,600

Qualified Transportation Fringe Benefit	2016	2017
Parking	$255	$255
Transit Pass/ Commuter Vehicle	$130	$255

Control Employee Definition for Commuting Valuation	2016	2017
Officer Compensation	$105,000	$105,000
Employee Compensation	$215,000	$215,000

Affordable Care Act (ACA)	2016	2017
4980H(a) Penalty	$2,160	$2,260
4980H(b) Penalty	$3,240	$3,390
FPL Affordability Safe Harbors	[2]	[3]
- FPL for Single individual	$11,770	$11,880
- Maximum monthly contribution	$93.18	$95.93
Affordability		
- Affordability threshold under 4980H affordability safe harbors	9.66%	9.69%
- Affordability threshold for eligibility of premium tax credits	9.66%	9.69%
- Affordability threshold under Individual Mandate	8.13%	8.16%

For questions regarding this *Briefing*, please contact your Keenan Account Manager.

[2] Use 2016 poverty guidelines to determine affordability.
[3] Use 2016 poverty guidelines to determine affordability.

HEALTH CARE REFORM: IRS EXTENDS DUE DATE FOR FURNISHING IRS FORM 1095-C TO EMPLOYEES

The Internal Revenue Service (IRS) issued Notice 2016-70 on November 18, 2016 extending the deadline for furnishing Form 1095-C to employees and extending good-faith transition relief to the 2016 reporting year. This *Briefing* outlines these extensions as well as other key points that employers should keep in mind as they prepare for the second year of reporting.

BACKGROUND

Internal Revenue Code (IRC) section 6056 requires each Applicable Large Employer (ALE) subject to the Employer Mandate to file information returns with the IRS and provide statements to their full-time employees about the employer-sponsored health coverage offered. This reporting will assist the IRS with enforcing the Employer Mandate and with administering the premium tax credits. ALEs sponsoring self-insured group health plans are also required to report under IRC section 6055 on everyone enrolled in their self-insured plans. This reporting will assist the IRS with enforcing the Individual Mandate.

ALEs must report under section 6056 using IRS Forms 1094-C and 1095-C, Parts I and II. ALEs offering self-insured plans must also complete Part III on Form 1095-C for everyone enrolled in those plans. Carriers are responsible for the section 6055 reporting for fully-insured plans.

FILING DEADLINES

The IRS has extended the deadline for providing statements to employees from January 31, 2017 to March 2, 2017. No extensions beyond March 2, 2017 will be granted for furnishing statements to employees.

The deadline for filing with the IRS has not been extended. These deadlines remain February 28, 2017, if not filing electronically, or March 31, 2017, if filing electronically. ALEs filing 250 or more forms are required to file electronically. Requests for an automatic 30-day extension can be made by submitting Form 8809 on or before the filing due date. No signature or explanation is required for the extension request. Additional 30-day extensions may be available under certain hardships.

Penalties for failing to meet these deadlines can be up to $260 per statement up to a maximum of $3,193,000 and $260 per return up to an additional maximum of $3,193,000. However, the IRS has extended good-faith transition relief from penalties for the 2016 reporting year. As with the prior transition relief, employers must be able to show they have made good-faith efforts to comply with the reporting requirements and file on time.

Changes and Clarifications to Forms

The IRS issued final versions of Forms 1094-C and 1095-C, along with instructions, for the 2016 reporting year. There are some minor changes and clarifications, including:

- Two new Form 1095-C indicator codes – 1J and 1K – for line 14 added for reporting "conditional" offers of coverage to spouses. A "conditional" offer of coverage is one that is subject to one or more reasonable, objective conditions (e.g., an offer to cover an employee's spouse only if the spouse is not eligible for coverage under Medicare or another employer-sponsored group health plan).

- Clarification that code 1G on line 14 of Form 1095-C applies for the entire calendar year or not at all.

- The affordability safe harbor codes (2F, 2G, 2H) on Form 1095-C line 16 cannot be used if the ALE fails to offer minimum essential coverage to at least 95 percent of its full-time employees and their dependents.

The 2016 instructions provide more detailed guidance than the 2015 instructions and include examples for reporting on COBRA coverage. The instructions also address how to report on retiree coverage. Final versions of Forms 1094-C and 1095-C, along with instructions, are available from the IRS website:

- Form 1094-C – https://www.irs.gov/uac/About-Form-1094-C
- Form 1095-C – https://www.irs.gov/uac/About-Form-1095-C

Soliciting Social Security Numbers

ALEs with self-insured plans must take reasonable steps to solicit the social security numbers of everyone enrolled in those plans. IRS Notice 2016-70 extends the good-faith transition relief to any missing or inaccurate social security numbers and dates of birth. However, ALEs must still be able to show they have made good-faith efforts to solicit the social security numbers. An overview of recent IRS guidance outlining the reasonable steps ALEs must take is available in our October 2016 *Briefing*:

http://www.keenan.com/news/brief/2016/BRF_20161014_HCRClarificationSolicitationSSNTINs_KA.pdf

Please contact your Keenan Account Manager for questions regarding this *Briefing* or if you require any additional information regarding the Affordable Care Act.