City of Pataskala Finance Department

James M. Nicholson, Finance Director

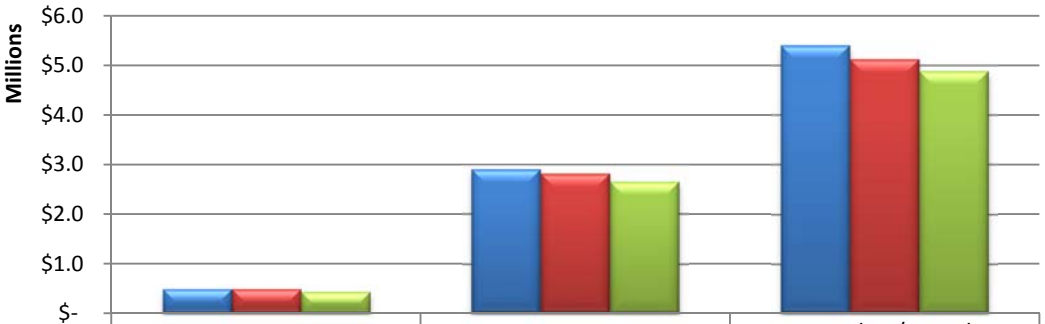
Finance Director's Report to Council

Current Projects & Issues

- **June 2017** – We are just finalizing the June month-end entries, and are in the process of reconciling the account and fund balances. I would anticipate closing the month by early-next week, and I plan to have the monthly financial report prepared and distributed with the next Finance Director's Report to Council. At this point in time, however, I am able to update Council on the status of June's income tax collections.

  - ***Income Tax Revenue*** - Collections for the month of June were $487,525 and are approximately equal to June 2016 collections. On a year to-date basis, total collections are $2,896,005 and are $84,433 (3.0%) higher than last year. This amount equates to 54.37% of the full-year budget, above the 50% straight-line rate if revenues were collected evenly throughout the year. In 2016, the June year to-date collections amount equated to 54.89% of full-year collections, and the rate was 54.22% in 2015. After reaching the mid-point of the budget year and based upon the current collections rate, it would appear that collections are maintaining a trend that is in line with expectations. We will continue monitor this trend closely over the next few months, however, to ensure that collections do not fall off as we go into the 2018 budget season.

Income Tax Collections - All Funds



	June	June YTD	FY Budget/ Actual
FY2017	$487,525	$2,896,005	$5,402,006
FY2016	$487,834	$2,811,572	$5,122,450
FY2015	$434,693	$2,646,521	$4,880,226

- **Employee Health Insurance** – On Monday, June 26th the city's health insurance co-op (OPEC-HC) unilaterally voted to terminate its' relationship with the plan administrator, the Jefferson Health Plan (JHP) effective on July 1st. Benefits under the plan for the past 2-years was provided through the Medical Mutual of Ohio PPO network. In its' place they approved a network of 3rd parties which would effectively serve the same role. The new network approved by the OPEC-HC is not a comparable network, as it is a 'referenced-based pricing arrangement' which does not included

agreed-upon pricing for medical procedures and services. Instead, the plan would pay the Medicaid-reimbursement rate plus a factor (e.g., 20%, 25%, etc. – but currently unknown to us at this point), and the employees would then be 'balance billed' by their healthcare providers. Employees would then be responsible for submitting those balance bills to another 3rd provider who would negotiate them down directly with the providers. It is unclear what would happen to the employees in the event a provider was unwilling to negotiate. Even if the provider agreed to accept a reduced amount, it is quite likely the delay in receiving payment would cause many of these claims to be sent to collections for handling. Unlike the PPO plan, it appeared that the employee would ultimately be responsible for the outstanding amount – a situation that the city was unwilling to impose on our employees and their families.

We believe that this change was inappropriate, and in violation of our agreement with OPEC-HC, Ohio public meeting laws and Federal law. The board met in executive session just prior to the vote, and came out of executive session and proceeded to vote without any discussion on this significant change. A letter was then sent to the membership following the vote (see attached letter) notifying them of the last-minute change. Provisions of the Affordable Care Act (ACA) require a 60-day advance notice of material plan modification to the employees covered by the plan. I've attached a copy of an analysis of this requirement by Anthem Healthcare, although I found a large number of such notices. This requirement applies to any changes made during the plan year – not during open enrollment, and the employer can be subject to a $1,000 fine for each failure. Of note, each covered individual would equate to a separate offense, which could potentially open up the city to a fine of up to $50,000.

As you may recall, we previously notified OPEC-HC of our decision to leave the program as of January 1st which was after the satisfactory completion of our initial contract term with OPEC-HC. Shortly after the board meeting and in response to it, the JHP sent a letter to all members effected by this change (a copy is attached to this report). In the letter, they offered to allow any member who wished: (1) member employees would remain on the MMO network; (2) maintain their current deductibles and deductible monitoring; and (3) retain their group and member identification numbers – all at the current monthly premiums. On Friday, June 30th, we formally notified JHP of our acceptance of their offer through December 31, 2017 to which they confirmed acceptance. In the correspondence, we recognized that they (JHP) are free to offer new health insurance program alternatives for 2018 but that we were under no obligation to accept any offers and were free to leave JHP on or after January 1, 2018. Although not an easy decision, we believe that it was in the best interests of the city and its' employees. At the same time, we also notified OPEC-HC through their broker, Frank Harmon (Ohio Insurance Services) of our decision to retain JHP as our plan administrator. Due to the late notice given by OPEC-HC of the change, we previously sent our July premium of $59,657 to them, and requested a refund of our July premium. Mr. Harmon responded in the affirmative, and (hopefully) we'll see those charges refunded. For now, we are planning to continue to use OIS as the broker/administrator for our dental, vision and life programs, but we'll be evaluating those items as a part of the 2018 open enrollment program.

The events of last week were quite troubling for the Administrator and myself, and created a tremendous amount of upheaval and uncertainty for all member governments and their employees. Based upon all of the email correspondence going back and forth between all of the parties involved, this is most likely not the last we've heard of this issue. We would anticipate that legal action will likely be taken by either or both OPEC-HC and JHP in the future, and the city

may possibly be named as a defendant in the litigation.

- **2017-2020 Audit Contract** – The conclusion of the 2016 audit also concluded our initial contract with the city's auditors, Julian & Grube. We have been very pleased with the level of support and communication received from J&G, and we requested that the Auditor of State's office authorize the optional 3-year contract renewal. The AOS has agreed to our request, and we'll be maintining continuity of audit for the next three years. The significant benefit to a longer tenure is the reduced amount of time required by city staff to educate the front-line auditors on the city's finances and fund structure. We have prepared Resolution 2017-047 requesting Council authorization to enter into the extension agreement.
- **Collective Bargaining** – We reached tentative agreement with the FOP on all issues, including wages and benefits. The FOP members have voted on the agreement, and approved it as presented. The proposal will be presented to Council (Res. 2017-049) at Monday's Council meeting for ratification. Here are some of highlights of the proposed contract:
    - Calls for 3.25% wage increase in 2017, 3.25% in 2018 and 3.0% in 2018
    - Increases uniform allowance from $700 in 2016 to $1,000 by 2019.
    - Standardizes a number of payroll-related items that have been inconsistent between the city's collectively-bargained employees and the non-union (e.g. minimum use of comp time, etc.)
    - Eliminates the ability of Police officers to advance unearned vacation leave into January for use prior to it being earned. This item has created a number of payroll and recordkeeping issues for the city.
    - Employee contributions toward the health care insurance premiums will remain at 10% for 2017 and 2018, but are subject to a reopener for 2019.
    - The grievance process has been streamlined, eliminating a verbal step in the process.
    - Expanded language has been added to the agreement which spells out how an injured employee is to be treated once they have exhausted all injury leave, sick leave, compensatory time and vacation leave.
    - Added language formally addressing the city's K9 program. Previously, we recognized the designated handlers, and provided them with 4 hours of paid time, which they can convert to compensatory time. This has been the existing practice, although the contract did not explicitly discuss it.
    - Standardized definitions of 'immediate family' and 'extended family' when applying for bereavement leave.
- **Police Station Construction Project** – Bids on the construction of the new Police facility are scheduled to be opened on Thursday, July 6th. At that time, we'll have a much clearer picture of the total funding required for the project. This will allow us to tailor the offering to eliminate the risk of any under- or over-funding. The city's financial advisor and underwriter have distributed requests for bids to a number of banks, including Park National and the Pataskala Banking Company, to determine interest/appetite for our debt, as well as the pricing (e.g. interest rate) for the proposed $5.0 million issuance. Proposals are due back to them on or before July 11th, and we have a conference call scheduled for July 13th to review the responses and select the

winning bidder for the project. The issuance is set to close on or before August 8th – well in time for contract award.

- **2018 Budget** - The instructions for the 2018 capital planning process have been prepared and distributed to all of the department heads, along with project printouts from the 2017 program and the planning worksheet templates. The next steps will be: (1) the analysis of 2016 revenue collections and the development of updated 2017-2021 revenue projections; (2) updating the cost-center budget models to include current wage and benefit expectations; and (3) developing the 2018 budget instructions and distribute to the departments along with the cost-center budget planning templates.

June 26, 2017

Re: OPEC-HC Benefits

Dear Member:

The OPEC-HC program is committed to providing exceptional benefits to members. With an ever changing health insurance marketplace the program must evolve to provide timely solutions. Members have found value in OPEC-HC plan designs, service, and cost structure.

July 1st is a very important date for OPEC-HC. It marks the date the program was initially started, the date the initial notice of withdrawal is due (which can be rescinded by September 1st) and it marks the date the program's stop-loss deductible renews.

The OPEC-HC Board of Directors has made a change in administrator effective July 1, 2017. This change was made to address debt position, upcoming renewal, fixed administrative costs, and variable claims cost.

Debt Position: The Board has followed the recommendations of the Jefferson Health Plan (JHP) on the last two rate adjustments (2016 & 2017). Following these recommendations, the position of the OPEC-HC program has not experienced the JHP projected financial results. At this point, the program is in a negative cash position and has an estimated run out liability. Combined, JHP has estimated this equals approximately $6,500 per employee member.

2018 Renewal: JHP failed to provide our members with any 2018 renewal projections. We recognize that our members must be provided renewal options in a timely manner in order to make upcoming renewal decisions. Our new administrator has provided renewal projections which have been voted upon. Groups will be receiving their specific renewal forms shortly. The 2018 renewal will provide your group with two options:

1. Renew as is with a 7% total contribution increase from 2017
2. Opt. out of the 7% renewal and request a custom 2018 renewal

Fixed Administrative Costs: Over the next 18 months we are able to capture $4.8 million of savings that are being charged by our current administrator, the Jefferson Health Plan. Ohio Insurance Services (OIS) has reduced the member services and marketing fee by 20%, providing an additional $604,080 cost reduction. Combined, this will capture fixed cost savings of $5.4 million.

Variable Claims Costs: It has become evident that addressing market changes with renewal increases alone is not a sustainable model. Working with our new administrator we have identified significant market advantages using a transparent pricing model, bill auditing service, and transparent pharmacy benefit manager. These program improvements project savings of more than $7.35 million over the next 18 months when compared to the previous model.

The projected 18 month fixed and variable cost savings of over $12.75 million will better position the OPEC-HC program to address the debt position and future renewals. These program enhancements will allow OPEC-HC to continue to provide exceptional benefits at competitive costs.

OPEC-HC has hired GBQ as the accounting firm to audit the program's income, expenses, debt position and projected run-out liability from July 1, 2014 through June 30, 2017. This is important in order to determine what amount is actually owed to JHP. GBQ will be working with current and prior program partners to establish a complete accounting of program income and expenditures. Once the GBQ final audit has been presented to the OPEC-HC Board all findings will be communicated with membership.

Should you have any questions, please don't hesitate to contact our marketing and service firm, Ohio Insurance Services (800) 989-9095.

Thank you,

OPEC-HC Board of Directors

June 28, 2017
Ohio Public Entity Consortium Healthcare Cooperative ("OPEC-HC")

Dear OPEC-HC Member:

You are receiving this letter because your political subdivision is a member of the Ohio Public Entity Consortium Healthcare Cooperative ("OPEC-HC"). The OPEC-HC Agreement, which your organization signed when joining OPEC-HC, designates the Jefferson Health Plan as the Administrator of OPEC-HC. As the Administrator, and on behalf of the Jefferson Health Plan's 50,000 participating member lives, the Jefferson Health Plan has negotiated rates with the vendors utilized by OPEC-HC members to provide significant network discounts, claims payment, and prescription drug management. Vendors include Medical Mutual of Ohio ("MMO"), UMR (which provides access to the UnitedHealthcare Network), the Health Plan, and CVS Caremark.

As you may or may not be aware, the Board of Directors of OPEC-HC held a special meeting on June 26, 2017. During the meeting, the Board took action to terminate the Jefferson Health Plan as OPEC-HC's administrator, effective July 1, 2017. Thereafter, the OPEC-HC Board approved contracts with Benovation to serve as the new administrator of OPEC-HC and Appro-Rx for prescription drug coverage. This means that the Jefferson Health Plan's vendors will no longer pay claims for your plan participants beyond June 30, 2017, even if those claims were incurred before June 30, 2017, and that your large claims will not be protected through the Jefferson Health Plan for pooling or stop-loss coverage. Additionally, prescription drug coverage through CVS Caremark will also cease. The healthcare provider networks and discounts delivered by OPEC-HC will, therefore, differ due to these changes. This may have potential ramifications for members with employees covered by collective bargaining units due to the change in network and the potential loss of providers contracted in your new network(s).

The Jefferson Health Plan is, naturally, unhappy with this unilateral decision of OPEC-HC's Board. We also understand that you may not be happy with this decision, as it may adversely affect the cost of your plan, since you will be losing the discounts available through your current health care provider network. Although it is our understanding that OPEC-HC, through Mr. Harmon, has arranged for another claims administrator using a different provider network to handle claim payments for your plan participants after June 30, 2017, that claims administrator probably does not have deductible and out of pocket information available to it for claims processed before July 1, 2017. This certainly will result in claims administration problems for your plan participants, and may also increase your costs. Under this new provider network, as we understand it, claims will also be administered for your program under a reference based pricing arrangement, which means that your plan participants may face balance billing issues when their claims are paid by the new administrator. Needless to say, these changes will result in claims disruptions for your plan participants.

The literature distributed by Ohio Insurance Services ("OIS") notifying the OPEC-HC membership of this last-minute change also provides misinformation. OIS quotes that they will create $4.8 million in savings for members during the upcoming 18 months by leaving the Jefferson Health Plan and moving to this new administrator. The Jefferson Health Plan's net annual fees for OPEC-HC for all of 2016 totaled only

$2,083,800. Thus, simple math shows that by simply removing the Jefferson Health Plan as administrator $4.8 million cannot be saved over 18 months. Further, the OPEC-HC membership also would lose the significant discounts it gains by using the Jefferson Health Plan's vendors.

You should be aware that the Jefferson Health Plan considers the actions of OPEC-HC's Board: (1) non-compliant with the Ohio Open Meetings Act, O.R.C. §121.22; and (2) beyond the scope of the authority delegated to the OPEC-HC Board in the OPEC-HC membership agreement.

Under the Open Meetings Act, when a public body like OPEC-HC holds a special meeting, the public body must identify the specific purpose for the meeting and the topics to be discussed at the meeting. A public body is confined to discussing or taking action only on the topics identified in the notice. OPEC-HC's special meeting notice for the June 26, 2017 meeting listed only the following topics: "(1) pending and potential litigation; (2) program costs and performance; (3) upcoming renewal (4) an update regarding the audit; (5) the market environment; and (6) discussion on innovative options to change/improve the program." Notably, there is no mention in the special meeting notice of a stated purpose to terminate the Jefferson Health Plan as administrator of the program or the hiring of a new administrator. Moreover, it is believed that OPEC-HC did not properly publish notification of its meeting with local media and improper deliberations among OPEC-HC Board Members discussing the potential termination of the JHP as the Administrator occurred prior to the public meeting.

Secondly, the OPEC-HC membership agreement, which each member employer has signed, states that the Jefferson Health Plan is the administrator of OPEC-HC under Article VII, Section 4:

> *Section 4. Delegated Administration.*
>
> *Member desires that certain aspects of the Joint Self-Insurance Program established herein be administered by the Jefferson Health Plan, a regional council of governments established pursuant to Ohio Revised Code Chapter 167. Pursuant to the Agreement, the Board of Directors shall enter into an Agreement to provide for such Administration.*
>
> *Additionally, the Board of Directors shall provide that the designation of the Administrator pursuant to this Agreement shall be the same as any such designations made pursuant to the Jefferson Health Plan.*

Further, that same membership agreement states in Article XI, Section 8 that:

> *This Agreement may be modified, amended, or supplemented in any respect not prohibited by law upon approval of the modification, amendment or supplement by the written agreement of at least two-thirds (2/3) of the representatives of the Member bodies. The OPEC-HC, through the Board, may require that Members provide written documentation satisfactory to the Board, in its sole judgment, that such Member has the requisite capacity and authority, and has obtained all required approvals, to vote on any matter contemplated by this Section.*

Without having received notice that the Membership has agreed by a 2/3 majority that the Jefferson Health Plan has been removed as the Administrator pursuant to the terms of the Agreement, the Jefferson Health Plan further considers this action of the OPEC-HC Board to be beyond the scope of the OPEC-HC Board's authority with its action to terminate the administration agreement with the Jefferson Health Plan is invalid.

The Jefferson Health Plan agreement executed by the OPEC-HC Board requires OPEC-HC to provide a six month notice of termination. If it fails to issue the required notice, OPEC-HC is obligated to pay to the Jefferson Health Plan an amount for unauthorized withdrawal from the Agreement. The Agreement also requires OPEC-HC to pay any deficit within 90 days of withdrawal from the Jefferson Health Plan, which means that your pro-rata share of the cash deficit owed to the Jefferson Health Plan would be owed by your organization within 90 days. To date, the OPEC-HC membership has been saddled with significant legal expenses, as OPEC-HC currently is engaged in three separate lawsuits with former or current OPEC-HC members. Through this action, the OPEC-HC Board has exposed the membership to additional significant potential liability.

The Jefferson Health Plan has stood behind the OPEC-HC helping over these past three years to fund claims for OPEC-HC when insufficient funds existed to pay the cooperative's claims. The Jefferson Health Plan is willing to continue to administer those OPEC-HC members who wish to retain their coverage, benefits and claims payer affiliations through the conclusion of each member's term of membership with OPEC-HC and beyond. Further, if you decide that you want to notify the Jefferson Health Plan that you wish to continue your relationship with the Jefferson Health Plan, you will not be required to pay your share of OPEC-HC's deficit at this time. The Jefferson Health Plan will help you to fund that debt over time, and will cover your run out claims as an ultimate charge to your organization.

If you wish to continue your relationship with the Jefferson Health Plan, or wish more time to prudently consider the options available to you with more complete information, you may continue to use the Jefferson Health Plan's current vendors to pay claims for your plan participants, and maintain your level of benefits, please send a written notification to us (email or letter) of your desire to retain the Jefferson Health Plan as your plan administrator, and pay your monthly accruals directly to the Jefferson Health Plan. **Following your notification to us of your desire to remain with the Jefferson Health Plan and receipt of your accrual payment to The Jefferson Health Plan, at 2023 Sunset Boulevard, Steubenville, Ohio 43952**, we will notify your claims payer that they can continue to process claims for your plan participants without an interruption in service, at which time your plan participants will be able to continue to use the ID cards for your current claims payer.

We also believe it will be in the best interest of the OPEC-HC membership to develop a new membership agreement for approval by 2/3 of the membership, and would be willing to assist in the facilitation of this process. OPEC-HC members wishing to stay with the Jefferson Health Plan will be able to continue to allow plan participants the use of the ID cards currently in their possession, following your formal written notification to us that you wish to remain with the Jefferson Health Plan. In this transition, we will be happy to work with any broker of your choosing following written confirmation of your desire to use that broker as a representative of your organization with the Jefferson Health Plan.

We are available to meet individually with you and/or your Board at any time to answer any questions or provide any additional information you may require.

Thank you for your attention to this matter. Further questions regarding this communication can be addressed to Mr. Tom Gee of the Jefferson Health Plan who can be contacted at tgee@burnsconsulting.com or 419-794-7325.

Anthem
National Accounts

Health care reform at-a-glance

60-day notice of material modification

The *Affordable Care Act* (the federal health care reform law) requires plan sponsors or issuers to provide 60 days advance notice to enrollees when making material modifications to the plan.

On February 9, 2012, the Department of Health and Human Services (HHS) released the revised Summary of Benefits and Coverage (SBC) regulation. The regulation included the notice of material modification rule, which states that a notice of modification should be provided when:

- Changes occur at a time other than in connection with a renewal or reissuance of coverage.
- A change to benefits affects the content of the SBC.
- Information is not reflected in the most recent SBC.

In the circumstances listed above, the notice would be required to be provided to enrollees at least 60 days prior to the date that the change will become effective.

If a group changes carriers, we believe this will be considered a material modification. In the case of a carrier change, all responsibility for notifying plan participants is on the group. We will not provide notice to the group administrator in any case of carrier change —whether it is a group leaving us for another carrier, or a new group coming to us from another carrier.

Listed below are the general requirements for the 60-day notice of material modification:

- The requirement takes effect for plan years beginning on or after September 23, 2012.
- The requirement only applies to changes made during the plan year. It does not apply to renewals of coverage or any modifications made as part of the renewal.
- The requirement can be met by providing an updated Summary of Benefits and Coverage if the change is reflected on the summary or by sending a separate written notice describing the material modification.
    - For employer groups, we will update the SBC and provide it to the group administrator. The group administrator will distribute it to plan enrollees.
- Before a material change can be effective, all affected participants must receive at least 60 days advance written notice of the change. The rule's definition of "material modification" is the same as the definition in ERISA Section 102 (explained below).
- Plan issuers or sponsors that willfully (intentionally) fail to provide the notice of material modification are subject to a fine of up to $1,000 for each failure. Each covered individual equates to a separate offense.

According to section 102 of the *Employee Retirement Income Security Act of 1974* (ERISA), a material modification includes:

- Any coverage modification that alone or combined with other changes made at the same time would be considered by "an average participant" to be "an important change in covered benefits or other terms of coverage under the plan or policy."
- An enhancement of covered benefits, services or other more general, plan or policy terms. For example, coverage of previously excluded benefits or reduced cost-sharing.
- A "material reduction in covered services or benefits" or more strict requirements for "receipt of benefits," including:
  - Changes or modifications that reduce or eliminate benefits
  - Increases in cost-sharing
  - Imposing a new referral requirement

ERISA already required plan sponsors or issuers to provide a summary of material modification. However, the health care reform requirements differ from ERISA requirements in several ways, including:

- **Requires notice in advance** — The health care reform law requires plan sponsors or issuers to provide notice to plan participants at least 60 days before the effective date of the material modification. ERISA allowed for notices to be distributed after the effective date of the material modification.
- **Applies to all plans, not just ERISA plans** — The health care reform provision applies to all plan issuers and sponsors, including issuers of individual market health plans, fully insured and self-funded ERISA group plans, and other non-ERISA group plans (i.e., church and governmental groups).

The health care reform law requires plan issuers or sponsors to give plan participants at least 60 days advance written notice of material modifications. This requirement goes into effect September 23, 2012. It does not apply to renewals of coverage or changes made by a self-funded employer at the beginning of the new plan year. The Notice of Material Modification rule can be met by providing a separate notice describing the material modification. Or, it can be met by updating the SBC with the modification and distributing the updated SBC to plan participants. Plan issuers or sponsors that intentionally fail to provide timely notice of material modification are subject to a fine of $1,000 per enrollee.

The 60-day notice of material modification does not apply at the time of renewal. After renewal, the rule is applied differently based on:

- The funding type (fully insured or ASO), and
- Whether a group automatically renews or requires participants to submit an application for each renewal period.
  - A group is considered to "automatically renew" if the plan participants are not required to submit an application for coverage at each renewal. We expect this to be the standard scenario because we do not require applications.

If a fully insured group that automatically renews wants to make a change to their benefits within the month of their renewal date, we may honor their request, depending on state regulations and market business processes. If the change is allowed, we will give the group administrator an updated SBC that shows the change(s); the group administrator is responsible for giving the updated SBC to the plan participants and may need to reopen open enrollment. Please note, only the group's first request to make changes will be granted without the material modification rule being applied, provided it is within the renewal month. If a group makes a request for additional changes, even if it is within the renewal month, the material modification rule will apply and a 60-day notice to plan participants will be required.

If the change is submitted after the renewal month, the change cannot be effective for at least 60 days after the plan participants have received the updated SBC.

If the group is ASO, or a fully insured group that requires participants to submit an application at renewal, any change made after renewal benefits are submitted, and final open enrollment materials have been issued to the group administrator, is considered a material modification and the 60-day notice requirement applies.

Small and Large Group scenarios

Below are some examples that clarify different scenarios. These scenarios are intended to provide general education only and will not address every instance:

Small Group

- **Example 1:** Small Group ABC has a January 1 renewal date and automatically renews (does not require participants to complete an application). They submit their renewal confirmation on December 31, but decide on January 7 to change to a plan design with a higher deductible. This change is allowed and the 60-day notice of material modification does not apply since the change is requested during their renewal month. The group should work with their sales representative to determine when the change can be implemented and administered. The group is responsible for providing the SBC to the plan enrollees.
- **Example 2:** Small Group FGH has a January 1 renewal date and automatically renews. They submit their renewal confirmation with benefit changes on January 5. We have already provided the group administrator with an SBC for the prior year's benefits since renewal confirmation was not received prior to the renewal date. Upon receipt of the renewal confirmation on January 5, we have seven business days to provide the group administrator a revised SBC that reflects the group's selected plan design(s). This change is allowed and the 60-day notice of material modification does not apply since the change was requested within their renewal month. The group should work with their sales representative to determine when the change can be implemented and administered. The group is responsible for providing the revised SBC to the plan enrollees.
- **Example 3:** A continuation of Example 2, Small Group FGH with a January 1 renewal date that automatically renews, and submitted their renewal confirmation on January 5 with their renewal plan choice. The group then notifies us on January 12 that they want to select a different plan design. We have seven business days from January 12 to provide the group administrator a revised SBC that reflects the group's newly selected plan design(s). This change is allowed and the 60-day notice of material modification does not apply since the change was requested within their renewal month. The group should work with their sales representative to determine when the change can be implemented and administered. The group is responsible for providing the revised SBC to the plan enrollees.

- **Example 4:** A continuation of Example 3, Small Group FGH with a January 1 renewal date that automatically renews changes their mind again. On January 20, they notify us that they want a different plan design than they notified us of on January 12. This change may be allowed, however, the 60-day notice of material modification will apply, even though it is still within their renewal month, since this is the second change they are requesting. The group should work with their sales representative to determine:
  - When the new SBC can be delivered to the group administrator.
  - When the group administrator can distribute the SBC to enrolled plan participants.

  The change will be effective at least 60 days after the plan participants receive the copy of the SBC, depending on the coordination between the group administrator and sales representative.

- **Example 5:** Small Group LMN has a January 1 renewal date. The group decides on February 1 to switch to a plan with a higher deductible. This change may be allowed, however, the 60-day notice of material modification does apply since the change is outside of their renewal month. The group should work with their sales representative to determine:
  - When the new SBC can be delivered to the group administrator.
  - When the group administrator can distribute the SBC to enrolled plan participants.

  The change will be effective at least 60 days after the plan participants receive the copy of the SBC, depending on the coordination between the group administrator and sales representative.

Large Group

- **Example 6:** Group XYZ, which is an ASO group, has a January 1 renewal date. The group wants to make a change on January 5 to increase the deductible. This change may be allowed, however, the 60-day notice of material modification does apply since the group must send their renewal changes in advance of their renewal date. The group should work with their sales representative to determine:
  - When the new SBC can be delivered to the group administrator.
  - When the group administrator can distribute the SBC to enrolled plan participants.

  The change will be effective at least 60 days after the plan participants receive the copy of the SBC, or a date more than 60 days out, depending on the coordination between the group administrator and sales representative.