STAFF MEETING MINUTES
LANCASTER COUNTY BOARD OF COMMISSIONERS
COUNTY-CITY BUILDING, ROOM 113
THURSDAY, APRIL 4, 2013
8:30 A.M.

Commissioners Present: Larry Hudkins, Chair
Brent Smoyer, Vice Chair
Deb Schorr
Jane Raybould
Roma Amundson

Others Present: Kerry Eagan, Chief Administrative Officer
Gwen Thorpe, Deputy Chief Administrative Officer
Dan Nolte, County Clerk
Cori Beattie, Deputy County Clerk
Ann Taylor, County Clerk's Office

Advance public notice of the Board of Commissioners Staff Meeting was posted on the County-City Building bulletin board and the Lancaster County, Nebraska, web site and provided to the media on April 3, 2013

The Chair noted the location of the Open Meetings Act and opened the meeting at 8:32 a.m.

AGENDA ITEM

1 APPROVAL OF THE STAFF MEETING MINUTES OF THURSDAY, MARCH 28, 2013

MOTION: Amundson moved and Raybould seconded approval of the minutes of the March 28, 2013 Staff Meeting. Raybould, Amundson, Schorr, Smoyer and Hudkins voted aye. Motion carried 5-0.

2 ADDITIONS TO THE AGENDA

A Lincoln-Lancaster County Ecological Advisory Committee Appointment (Eric S. Zach) (Exhibit A)

MOTION: Smoyer moved and Schorr seconded approval of the addition to the agenda. Schorr, Smoyer, Amundson, Raybould and Hudkins voted aye. Motion carried 5-0.

3 LEGISLATIVE UPDATE - Gordon Kissel and Joe Kohout, Kissel/E&S Associates (Legislative Consultants)

Joe Kohout, Kissel/E&S Associates, presented a legislative update and a bills of interest report (Exhibits B and C). He also reported that Senator Chambers has filed a motion to pull Legislative Bill (LB) 266 (Eliminate provisions relating to increases in local option sales tax rates) from the Revenue Committee.

4 TIME AND ATTENDANCE CONTRACT ADDENDUM - Dennis Meyer, Budget and Fiscal Officer

Dennis Meyer, Budget and Fiscal Officer, said an addendum to the contract with Empower (formerly Tesseract) will be scheduled on the April 9, 2013 County Board of Commissioners Meeting agenda. This will allow the County to move forward with a time and attendance monitoring system module that will interface with the Empower payroll system. He said the annual cost to the County will be $10,000, rather than the $2,500 per month monthly subscription cost that would cover both the City and County that was initially quoted. There will be additional expenses for different components such as employee badges, badge readers, mobile applications, etc.

ADDITIONS TO THE AGENDA

A Lincoln-Lancaster County Ecological Advisory Committee Appointment (Eric S. Zach) (Exhibit A)

The Board scheduled the appointment on the April 9, 2013 County Board of Commissioners Meeting agenda.

ADMINISTRATIVE OFFICER REPORT

A. Lincoln-Lancaster County Consolidation Task Force

Schorr disseminated a transcript of discussion at the January 15, 2013 City-County Common Meeting regarding the Lincoln-Lancaster County Consolidation Task Force (Exhibit D). She noted it was decided the City Council and County Board would each appoint citizen representatives to serve on the Consolidation Task Force. Schorr said she was surprised to learn that Commissioner Raybould has been attending and participating in the meetings, although she was not appointed. Raybould acknowledged that she has been participating in the Task Force's discussions. She said she intends to participate by attending the Task Force meetings but will no longer sit at the table or offer comments.

B. General Assistance (GA) Burials

Schorr felt an article in the Lincoln Journal Star Newspaper regarding General Assistance (GA) burials was somewhat misleading and said Gary Chalupa, Veterans Service Officer/General Assistance Director, is preparing a response.

C. Clerk of the District Court Vacancy

The Board scheduled an item on the April 9, 2013 County Board of Commissioners Meeting agenda to accept the resignation of Sue Kirkland, Clerk of the District Court, and establish a procedure and timeline for appointing a replacement to fill the vacancy.

D. Agenda Items for April 11, 2013 Management Team Meeting

The following items were suggested: 1) Time and Attendance System; 2) Prudential Retirement Education Program; 3) Active Shooter Training; and 4) Health Care Dependent Eligibility Audit.

E. Nebraska Association of County Officials (NACO) Salary Survey

Schorr reported that the Nebraska Association of County Officials (NACO) Salary Survey Committee will be comprised of representatives of NACO's districts and affiliate groups. She said Lancaster County can submit the name of a Commissioner to represent the Southeast District. Raybould said she is interested in serving and has submitted her name to NACO.

F. Nebraska Association of County Officials (NACO) "Walk for Your Life" Challenge (June 3-September 1, 2013)

Board consensus was to have the County participate in NACO's "Walk for Your Life" Challenge.

5 RAILROAD TRANSPORTATION SAFETY DISTRICT (RTSD) BUDGET AND PROJECTS - Roger Figard, City Engineer and Executive Director of the Railroad Transportation Safety District (RTSD)

Roger Figard, City Engineer and Executive Director of the Railroad Transportation Safety District (RTSD), gave an overview of the RTSD, noting the following (Exhibit E):

- Origin and History
- Mission
- Authority

- Accomplishments
- Benefits
- Funding
- Future Projects
  - South Beltway
  - Grade Separation Project at 33rd Street/35th Street/Adams Street
  - Highway 2 Corridor
  - 70th Street/Cotner Boulevard/Cornhusker Highway
  - 27th Street and Saltillo Road
  - Burlington Northern/Santa Fe (BNSF) Railway South Corridor
  - 148th Street and Highway 6 (Waverly)
- At-Grade Crossings in the County

In response to a question from Hudkins, Figard explained that the City has a 20% local share requirement for the South Beltway Project. He said the RTSD has authority to provide funding to address two railroad track crossings, on the west and east ends of the South Beltway, which could count towards the local share. The estimated cost of those crossings is $14,000,000. Figard noted that the State will relinquish Highway 2 when the South Beltway is built.

Figard also presented information regarding the Southwest 40th Street overpass project (Exhibit F). Raybould asked that an update on this project also be provided to the West "A" Street Neighborhood.

Figard noted uncertainty regarding the RTSD levy. **NOTE:** The County Board reduced the RTSD's tax levy from 2.6 cents to 1.0 cent in 2012, which reduced the RTSD's revenue from $5,000,000 to $2,000,000. He discussed charts showing a 12-year cash flow for the RTSD, with varying levies (see Exhibit E).

Hudkins asked the current balance for the RTSD. Figard said it is less than $10,000,000 and said by the time the Hickman and Waverly "quiet zones" are finished, it will be under $7,000,000. **NOTE:** A "quiet zone" is a railroad grade crossing at which trains are prohibited from sounding their horns in order to decrease the noise level for nearby residential communities.

Hudkins questioned the number of fatalities in recent years at 33rd Street/35th Street/Cornhusker Highway. Figard said he will have to check and will forward the information to the County Commissioners Office.

Raybould asked how the City is preparing for the South Beltway. Figard said it is shown in the City's long-range transportation plan. It will also be included in the City's Six-Year Capital Improvement Program (CIP).

6 HICKMAN ONE-MILE ZONING JURISDICTION - Brittany Behrens, Deputy County Attorney, Sara Hartzell, Planner; Silas Clarke, Hickman City Administrator

Brittany Behrens, Deputy County Attorney, discussed the City of Hickman's plans to reduce their one-mile zoning jurisdiction, which is permitted under provisions in Nebraska Revised Statute §17-1002(1). The statute gives cities of the second class the authority to choose only "a portion of the territory located within one mile of the corporate limits...within which the designating city or village will exercise the powers and duties granted..."

Silas Clarke, Hickman City Administrator, explained that Hickman is trying to make it easier for individuals who are trying to change zoning or develop a plat where there is split jurisdiction with the County.

Sara Hartzell, Planner, said the County's Zoning Resolution states whenever any lands are ceded to the County's jurisdiction, they automatically go to Agricultural (AG) zoning. She disseminated a map showing the Hickman extra territorial jurisdiction (ETJ) changes (Exhibit G) and said three parcels were identified that might require a zoning change. Hartzell recommended that the parcel highlighted in the northeast portion of the map be changed to Agricultural Residential (AGR) as it has already been platted and is situated between AGR zoning (County jurisdiction) and R1 (Hickman's acreage zoning equivalent). She said the sliver of land highlighted in the northwest portion of the map is currently zoned AGR and is part of a larger area that underwent a zoning change to AGR in 1993. It was later changed to AGX (Hickman's agricultural zoning equivalent) as Hickman's ETJ moved north. Hartzell said there has been no move towards developing the land and recommended leaving it AGR and contacting the owner to determine whether a zoning change is desired. The third parcel, located in the southwest portion of the map, is a five-acre parcel and was zoned R1. She said the change to AG won't affect their ability to use it as an acreage because it is a "grandfathered" (exempted from provisions) parcel.

Behrens said the County's Zoning Resolution also requires the County to re-look at the zoning designations, within a reasonable time following the default action, and amend the districts, boundaries, mapping and any other corresponding language that only reference a one-mile zoning jurisdiction.

Schorr reported that the Village of Roca is also considering reducing its one-mile jurisdiction.

7 HEALTH INSURANCE DISCUSSION - Tracy Krause, AON Risk Solutions; Bill Kostner, City Risk Manager; Doug McDaniel, Personnel Director; Paula Lueders, Benefits Specialist, Personnel Department

Tracy Krause, AON Risk Solutions, gave an overview of Health Care Reform and how it will impact Lancaster County, noting the following (Exhibit H):

- Current Provisions Regarding the Patient Protection and Affordable Care Act

The County will have to pay a Patient Centered Outcomes Research Institute (PCORI) fee of $1.00 for 2012 average members (covered individuals). That fee is due July 31, 2013.

- 2014 Provisions

The County will have to pay a transitional reinsurance fee of $63 for each 2013 average member.

- Employer Penalty Scenarios
- Determining Who is a Full-Time Employee (FTE)

Doug McDaniel, Personnel Director, said the County will need to take a "hard look" at the use of temporary employees. Krause explained the County will be required to perform a "look back audit" and determine how many individuals were employed an average of at least 30 hours per week and not offered coverage. The County will have to offer them coverage for the same amount of time as the measurement period, regardless of whether they are still working 30 hours or more. She said monitoring use of temporary, seasonal and part-time going forward will be critical because the County could be required to provide them with coverage.

- Compliance Timeline

McDaniel noted an excise tax on high-cost coverage will take effect in 2018. He said explained there will be a 40% tax if the total plan costs exceed a certain threshold on both single and family coverage. Krause said plan costs relate to claims, not premiums.

Gwen Thorpe, Deputy Chief Administrative Officer, asked whether having an on-site clinic would help. McDaniel said it would, as long as costs didn't run through the health plan.

Schorr exited the meeting at 10:29 a.m.

8 CRISIS CENTER PLANNING - Ron Sorensen, Community Mental Health Center (CMHC) Executive Director; Scott Etherton, Crisis Center Program Manager; Doug McDaniel, Personnel Director; Richard Grabow, Deputy County Attorney

Richard Grabow, Deputy County Attorney, asked whether it is the Board's intent to have the Crisis Center, which is currently under the Community Mental Health Center (CMHC), become a separate department. He said if that is the case, he will prepare a resolution, noting there are several issues that will need to be resolved such designating an interim director.

Raybould suggested the need for a cost benefit analysis of placing the Crisis Center under an existing department or making it a stand-alone operation.

Grabow said moving it under an existing department would probably result in a smoother transition.

Schorr returned to the meeting at 10:32 a.m.

Ron Sorensen, CMHC Executive Director, felt it should be organized based on consumer needs. He noted it is part of a critical system, that involves providers, the hospitals and the Lincoln Regional Center (LRC), and felt it should be separated out.

Raybould asked Sorensen how he sees CMHC and the Crisis Center disengaging from one another going forward through the process to transition CMHC to another provider. Sorensen said they will probably move 1.5 combined FTE's to the Crisis Center. He added they have expertise in-house to help the Crisis Center set up a records system, manage Medicaid claims, etc.

Raybould asked Sorensen if they could present budget scenarios. Sorensen said they have already started the process and are preparing separate budgets for next year.

Kerry Eagan, Chief Administrative Officer, suggested a hybrid system in which the Crisis Center would be a stand-alone department but would have an agreement with another department to assist with administrative functions. Sorensen said that would be workable.

C. J. Johnson, Region V Systems Administrator, appeared and said a significant portion of the Crisis Center's funding is through the Nebraska Department of Health and Human Services (DHHS) Division of Behavioral Health and cautioned there could be

"political kickback" if it were moved under a correctional department. He said he supports making it a separate department, adding it will be easier to identify costs if there is a decision to privatize the Crisis Center in the future.

Scott Etherton, Crisis Center Program Manager, said he is not sure whether merging the Crisis Center with a correctional department could affect accreditation.

There was consensus to make the Crisis Center a stand-along facility, as of July 1, 2013, and to request more specifics regarding the timeline for separation and how administrative services could be provided.

9 MIDTOWN CENTER DISCUSSION - Ron Sorensen, Community Mental Health Center (CMHC) Executive Director

Ron Sorensen, Community Mental Health Center (CMHC) Executive Director, recommended the County enter into an agreement with Mary Sullivan, a licensed clinical social worker, to assist in the provision of psychiatric services at the Midtown Center, up to 20 hours per week.

The Board will take action on the agreement at the April 9, 2013 County Board of Commissioners Meeting.

ADMINISTRATIVE OFFICER REPORT

G. Claim for Review: Payment Voucher No. PV394376, County Grants to Jason Brownell, Lincoln Police Department (LPD), for $539.94 for Expenses Incurred While Providing the "Why Try" Program (Beyond the 90-Day Time Period)

MOTION: Smoyer moved and Raybould seconded to handle the claim through the regular claims process. Smoyer, Schorr, Amundson, Raybould and Hudkins voted aye. Motion carried 5-0.

H. CenterPointe Request to Post Notice at Community Mental Health Center (CMHC) Seeking Input from Clients

Eagan suggested it would be more appropriate to have those submitting a proposal to meet with the clients at the same time so they all receive the same information.

C. J. Johnson, Region V Systems Administrator, appeared and suggested it be structured similar to the CMHC Planning Committee's focus groups.

Thorpe questioned what would be gained, noting consumers already relayed their concerns through the focus groups.

Johnson felt it would be better to allow the Request for Proposal (RFP) process to continue and wait until an entity or entities are selected before seeking input from the clients. He suggested those conversations focus on the transition.

Board consensus was to deny the request.

10 COMMUNITY MENTAL HEALTH CENTER (CMHC) INVITATION TO NEGOTIATE (ITN) COMMITTEE REVIEW OF REGION V CMHC REQUEST FOR PROPOSAL (RFP) RESPONSES - Ron Sorensen, Community Mental Health Center (CMHC) Executive Director; C. J. Johnson, Region V Systems Administrator

C. J. Johnson, Region V Systems Administrator, disseminated copies of Community Mental Health Center (CMHC) Questions/Decision Points (Exhibit I). He said the Request for Proposal (RFP) for community behavioral health services was issued last Thursday. Five entities have indicated an interest in providing all, or at least one, of he four components. Johnson said the RFP is weighted, with two areas given the most weight : 1) Logistics (transition plan); and 2) Qualitative (how does the entity look at recovery issues, primary care integration, consumer involvement, etc.). He said he made it very clear that they cannot count on any start-up dollars.

Raybould asked Johnson whether he envisions a role for members of the Invitation to Negotiate (ITN) Committee who would like to participate in the review process. Johnson said Region V will not publicly reveal who will be on the RFP Review Committee, but said they have sought out individuals who have experience with RFP's, have been a part of the behavioral health system in the past, have a good fiduciary background, and understand Medicaid. He said there will be consumer involvement as well, noting they have considered seeking consumers from outside the Region V area who may be more objective. Johnson said some of individuals who served on the ITN Committee will be asked to serve on the RFP Review Committee, others have a clear conflict of interest. Sorensen noted one member of the ITN Committee has asked to be considered for overseeing the transition process.

Raybould said the CMHC Advisory Committee wants to make sure there is consistency and that none of the consumers "fall through the cracks." Johnson noted there are at least four consumers on the Behavioral Health Advisory Committee (BHAC) and said BHAC will receive updates throughout the transition.

Johnson noted the RFP's will be evaluated by May 10th and said the entity or entities that are recommended for selection could be asked to give an oral presentation to the Board.

11 ACTION ITEMS

There were no action items.

12 CONSENT ITEMS

There were no consent items.

13 ADMINISTRATIVE OFFICER REPORT

A. Lincoln-Lancaster County Consolidation Task Force
B. General Assistance (GA) Burials
C. Clerk of the District Court Vacancy
D. Agenda Items for April 11, 2013 Management Team Meeting
E. Nebraska Association of County Officials (NACO) Salary Survey
F. Nebraska Association of County Officials (NACO) "Walk for Your Life" Challenge (June 3-September 1, 2013)
G. Claim for Review: Payment Voucher No. PV394376, County Grants to Jason Brownell, Lincoln Police Department (LPD), for $539.94 for Expenses Incurred While Providing the "Why Try" Program (Beyond the 90-Day Time Period)
H. CenterPointe Request to Post Notice at Community Mental Health Center (CMHC) Seeking Input from Clients

Items A-H were moved forward on the agenda.

14 PENDING

There were no pending items.

RETURNING TO ITEM 13B

Schorr noted the Board has received a number of inquires and comments in response to the article in the Lincoln Journal Star Newspaper regarding General Assistance (GA) burials and said the Board has an obligation to make sure the facts are presented.

Gary Chalupa, Veterans Service Officer/General Assistance (GA) Director, appeared and presented a draft letter of response to the article (Exhibit J). He said the article was not representative of the situation and how the decisions regarding GA burials came about.

Eagan felt it should be emphasized that only unclaimed cremains are placed in the ossuary at Wyuka Cemetery. Chalupa said that is correct. He said it is possible to retrieve cremains placed in the ossuary, but not practical, i.e. the crypt would have to be dug up. If a family wished to recover the cremains, it would be at their expense.

In response to a question from Raybould, Chalupa said the cremains are placed in a separate container and are cataloged. Wyuka Cemetery maintains the list, which is not for public display. He said Wyuka has informed him that fewer than 50 cremains have been placed in the ossuary since 2001. Cynthia Covert, GA Deputy Director, said nine have been place in the ossurary since 2009, primarily due to an increase in unclaimed remains.

Raybould inquired about death notices for someone who is indigent. Chalupa said the funeral home notifies the newspaper of the death. A one-time death notice, which includes the deceased name and date of death, is published by the newspaper at no cost. Family may request an obituary or additional information to be published, but it will be at their cost.

Schorr asked that the letter be revised to indicate a list of cremains placed in the ossuary is maintained, the ashes are not commingled, and there is a possibility of family recovering the cremains, at their own expense. She suggested Chalupa submit the letter as an op-ed piece.

15 DISCUSSION OF BOARD MEMBER MEETINGS

A. Lincoln Independent Business Association (LIBA) Budget Monitoring Committee - Smoyer

Smoyer said discussion was focused on the new Lancaster County Adult Detention Facility (LCADF).

B. Public Building Commission (PBC) Chair's Meeting with Mayor - Hudkins

Hudkins said possible litigation was discussed.

C. Chair/Vice Chair's Meeting with Mayor - Hudkins, Smoyer

Smoyer said they discussed the proposal to have the Keno Prevention Fund principal funds invested with the Community Health Endowment (CHE), which is a public endowment.

D. Chamber Coffee - Smoyer, Amundson

Smoyer said they discussed the new LCADF and the Lincoln-Lancaster County Consolidation Task Force.

16 EMERGENCY ITEMS AND OTHER BUSINESS

There were no emergency items or other business.

17 ADJOURNMENT

MOTION: Schorr moved and Raybould seconded to adjourn the meeting at 11:49 a.m. Smoyer, Raybould, Amundson, Schorr and Hudkins voted aye. Motion carried 5-0.

Dan Nolte
Lancaster County Clerk

Lincoln/Lancaster County Ecological Advisory Committee

c/o Lincoln Parks and Recreation Department
2740 "A" Street
Lincoln, NE 68502

EXHIBIT
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RECEIVED
APR 03 2013
LANCASTER COUNTY BOARD

April 2, 2013

Commissioner Larry Hudkins, Chair
Lancaster County Commissioners
555 South 10th Street
Lincoln, NE 68508

Dear Commissioner Hudkins,

The Lincoln/Lancaster County Ecological Advisory Committee would like to recommend the appointment of Eric S. Zach to the Committee. His bio is attached. This will be a one year appointment with a 3 year renewal next year. This is to stagger the number of members whose terms will be up for renewal each year. There is still room for more members if you are aware of anyone you think might be interested in being on this committee.

Sincerely,

Dave Wedin, Chair
LLEAC

ERIC S. ZACH

3001 South 74th Street
Lincoln, NE 68506

eszach12@hotmail.com
Phone: (402) 318-2024

PROFILE

Wildlife Biologist possessing 15 years of experience with wildlife management methods, principles, and concepts in a variety of governmental and non-governmental organizations. My work experiences reflect a demonstrated competence working with the public as well as multi-disciplined partners on a variety of natural resource issues.

PROFESSIONAL EXPERIENCE

- **Ag Program Manager**, Nebraska Game and Parks Commission (2011-present)
  - Ag policy and program analysis, legislative contact, Association of Fish and Wildlife Agencies Bioenergy Working Group Chair, Central Basins Conservation Reserve Enhancement Program Coordinator
- **Highway Environmental Biologist**, Nebraska Department of Roads (2006-2011)
  - Endangered Species Act consultation for transportation projects, interagency team lead, technical assistance to field staff, wildlife monitoring
- **Fish and Wildlife Biologist**, Nebraska Game and Parks Commission (2003-2006)
  - Habitat management and manipulation on publicly owned lands, prescribed burn boss, community outreach, stakeholder relations, wildlife population monitoring
- **Wildlife Biologist**, Pheasants Forever (2002-2003)
  - Implement federal and state conservation programs with private landowners, interface with federal, state, and non-governmental organizations
- **Wildlife Specialist**, USDA-APHIS-Wildlife Services (2001-2002)
  - Wildlife management for the protection of human health and safety in aviation
- **Wildlife Technician**, Nebraska Game and Parks Commission (1997-2001)
  - Habitat management and manipulation, wildlife population monitoring

PROFESSIONAL CERTIFICATIONS

- Nebraska Water Leaders Academy Graduate 2013
- Interagency Consultation for Endangered Species
- S130/S190 Wildlland Firefighter Certified (expired)
- Certified Pesticide Applicator
- Certified Erosion Control Designer and Inspector

EDUCATION

University of Nebraska-Lincoln December 1998

BS in Natural Resource Sciences

Major: Forestry, Fisheries, and Wildlife Minor: Biological Sciences

INTERESTS

- Pheasants Forever member and volunteer
- Exec Board Member and Programs Committee Chair for The Wildlife Society-NE chapter
- Ducks Unlimited member
- Nebraska Sportsmen's Council

KISSEL/E&S
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EXHIBIT
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B

MEMORANDUM

TO: Lancaster County Board of Commissioners

FROM: Gordon Kissel
Joseph D. Kohout

DATE: April 4, 2013

RE: Weekly Update on the 2013 Legislature

Please accept this as the eighth weekly report for the 2013 Legislative Session. This week saw the true beginning of all-day debate with an announcement by the Speaker that the Legislature would remain in session until 6 or 6:30pm each night. Debate focused this week on two bills so far – Senator Tyson Larson's bill dealing with the environmental trust and Senator Lautenbaugh's LB271 which Mr. Shively appeared in support of.

LANCASTER COUNTY PRIORITIES:

1. **Oppose Elimination of the inheritance tax.** As we have reported previously no bills were introduced to eliminate the inheritance tax. Senator Wightman's LB600 – the bill that would lower rates of taxation – was heard on Wednesday, February 27, 2013 before the Revenue Committee and Chairman Hudkins testified in opposition. The bill has not advanced and was not prioritized. We believe that there will be some component of review of the inheritance tax under the LB613 review.
2. **Support Expansion of Medicaid under the Affordable Care Act.** LB577 was heard on February 28, 2013, before the Health and Human Services Committee. Over 20 individuals and groups appeared in support of this bill with only two appearing in opposition. The bill has advanced, unamended, from the Committee and has been declared to be Senator Campbell's priority bill. Indications from the Speaker this week were that LB577 would be the debated on April 16, 2013.
3. **Eliminate Responsibility of Counties to Pay HHS Rent.** LB632 was referred to the Government, Military and Veterans Affairs Committee and public hearing was held on Wednesday, March 6, 2013. Mr. Eagan appeared in support along with NACO. The Department appeared in opposition through Kerry Winterer. The Committee did conduct an executive session on the bill last week. There has been no further movement on the bill.

4. **Modify Right to Court Appointed Attorney in Juvenile Court.** LB342 was referred to the Judiciary Committee and public hearing held on March 6, 2013. Liz Neely appeared on behalf of the county along with NACO. There was no opposition. We are pleased to report that the bill has been advanced by the Judiciary Committee and will be placed on the Consent Calendar agenda.
5. **Definition and Oversight for Staff Secure Juvenile Detention Facilities.** LB86 was referred to the Judiciary Committee and hearing held on March 7, 2013. Sheli Schindler appeared on behalf of the county along with NACO and Sarpy County. In the first amendment to LB561, the language from this bill was included.

OTHER LEGISLATION:

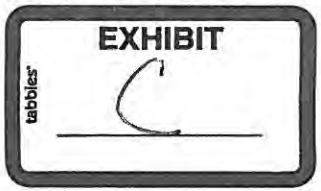
1. **LB63 (Schilz) Change distribution of certain sales and use tax revenue.** *NO POSITION.* Brent Meyer recommends that we support this legislation because it will provide additional funding for aquatic invasive plants. It diverts ½ of the sales tax and registrations fees from motorboats to create a special fund. It was heard on March 14, 2013 before the Revenue Committee and there was a significant amount of support with no opposition. We do not expect this bill to advance.
2. **LB123 (Lautenbaugh) Change distribution of indigent defense fees.** *OPPOSE.* This hearing was held on January 25, 2013 before the Judiciary Committee. This bill was indefinitely postponed by the Judiciary Committee.
3. **LB215 (Schilz) Change provisions relating to use of the County Visitors Promotion Fund.** *OPPOSE/NEUTRAL WITH AMENDMENT.* As previously reported, an amendment was offered to the committee during the hearing February 13, 2013 that addressed the concerns raised by Lancaster County. The bill has advanced with the amendment agreed to by Lancaster County. Please note that this bill was not prioritized.
4. **LB284 (Conrad) Change provisions of the Political Subdivisions Tort Claims Act relating to actions and amounts recoverable.** *OPPOSE.* Referred to the Judiciary Committee, the hearing was on February 13, 2013. Lancaster County submitted a letter in opposition to the bill. We expect the bill to advance from that committee but has not yet. Please note that this bill was not prioritized.
5. **LB317 (Price) Change a duty of county assessors relating to real property valuation.** *OPPOSE.* This bill was heard by the Revenue Committee on March 21, 2013 and both NACO and Douglas County appeared in opposition. Mr. Agena indicated during a previous meeting that he may need an additional 8 people and $700,000 to comply with this legislation. While this bill was not prioritized, Senator Price expressed some desire to address the issue presented under LB317 as part of the discussion on LB97 – the land bank bill.
6. **LB348 (Harr) Change provisions relating to the assessment of certain rent-restricted housing projects.** *NO POSITION.* The hearing was held on March 1, 2013. As you will recall, we indicated that we would not oppose this legislation. The bill has advanced and was declared a speaker priority.

7. **LB381 (Janssen) Require photographic identification to vote.** *NO POSITION.* Introduced by Senator Charlie Janssen, the bill was referred to the Government Committee and hearing was held on March 7, 2013. Please note that this bill was not prioritized.
8. **LB483 (Bolz) Provide for a reentry planning program in adult correctional facilities.** *SUPPORT.* This measure was heard before the Judiciary Committee on Friday, February 22, 2013. A letter of support was submitted to the Committee. It has been declared a speaker priority.
9. **LB613 (Schumacher) Create the Tax Modernization Commission.** *NO POSITION.* This bill was heard by the Executive Board of the Legislative Council on February 19, 2013. It was prioritized by Senator McCoy and will be amended to allow for the Revenue Committee chairman to serve as chair of that Committee. The bill has been the subject of a filibuster by Senator Chambers for several days and cloture was invoked yesterday. The study will move forward. An amendment has been filed by Senator Krist that would place a moratorium on both occupation taxes enacted by cities and on the additional one-half cent of sales tax that was passed last year. We expect this bill to come up next week.
10. **LB636 (Wallman) Provide restrictions for application of certain herbicides.** *OPPOSE.* This legislation was heard on March 5, 2013 before the Agriculture Committee. We do not expect this bill to move. Please note that this bill was not prioritized.
11. **LB246 (Larson) Provide for a health care copayment for jail and prison inmates.** *NO POSITION.* The hearing was held on February 7, 2013 before the Judiciary Committee. We do not expect this bill to move. Please note that this bill was not prioritized.
12. **LB531 (Conrad) Change distribution of sales and use tax revenue and repeal the Build Nebraska Act.** *NO POSITION.* The hearing was held on February 27, 2013 before the Revenue Committee with significant opposition. Please note that this bill was not prioritized.
13. **LB561 (Ashford) State findings and intent for changes to the juvenile justice system and a funding mechanism.** *NO POSITION.* The hearing on this bill was held on March 7, 2013 before the Judiciary Committee and is the Judiciary Committee priority bill. As previously mentioned, we have been working with Mr. Eagan, Ms. Thorpe and Ms. Schindler to develop concepts that would address Lancaster County's concerns with the original amendments thereto. We received an amendment on Thursday of last week and conducted a meeting to discuss said amendment on Monday. The Judiciary Committee took up the amendment during the executive session on Wednesday but there are significant questions and the committee did not advance it. Joe did meet with Katie Zulkoski who represents those interests who are supporting the bill. We have answers to many of the questions raised during the Monday meeting. Some of our suggestions will be incorporated; other concerns will be addressed with clarifying language. I did not sense any effort to minimize our concerns.

We are also attaching your spreadsheet. Please do not hesitate to contact us with any questions you might have.

Kissel/ES Associates
Bills of Interest Report
Client: LC

4/3/2013 5:20 PM



LB/LR	Sponsor	Priority	One-Liner	Committee	Hearing Date	Status	LC	*LC Position*	*NACO*	NACO Position
LB8	Krist		Provide for coverage of children's day services under medicaid and social services	Health and Human Services	2.20.13		x			
LB11	Krist		Change provisions relating to surcharges for 911 service	Transportation and Telecommunications	2.25.13		x		x	Support
LB28	Hadley		Change a late filing penalty relating to personal property tax	Revenue	1.25.13	General File; Select File 2/8; Final Reading 2/25; Passed on Final Reading 46-0-3; Approved	x		x	Support
LB29	Hadley		Provide a duty for county treasurers relating to recording tax assessments and collections	Revenue	1.25.13	General File; Select File w/ER9; Final Reading 2/25;Passed on Final Reading 45-0-4; Approved	x		x	Support

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LB/LR	Sponsor	Priority	One-Liner	Committee	Hearing Date	Status	LC	*LC Position*	*NACO*	NACO Position
LB30	Hadley		Change distribution of motor vehicle certificate of title fees	Transportation and Telecommunications	1.22.13	General File; Select File 1/28; Final Reading 2/5; Passed on Final Reading 49-0-0; Approved 2/15	x			
LB34	Hadley	Speaker	Change provisions of the Nebraska Advantage Act	Revenue	1.23.13	General File w/AM650 3/18;	x			
LB36	Wightman		Change an exemption to the documentary stamp tax	Revenue	1.25.13	General File w/AM42; Select File w/ER10; Final Reading 2/25; Passed on Final Reading w/ Emergency Clause 45-0-4; Approved	x			
LB37	Wightman		Change provisions relating to powers of personal representative with respect to a decedent's Internet sites	Judiciary	1.24.13		x			

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Bills of Interest Report
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LB/LR	Sponsor	Priority	One-Liner	Committee	Hearing Date	Status	LC	*LC Position*	*NACO*	NACO Position
LB41	Cook		Provide for permanent early voting request list and return of early voting ballots to polling places	Government, Military and Veterans Affairs	1.23.13		x		x	Neutral
LB43	Cook		Change provisions relating to a property tax exemption	Revenue	3.1.13		x		x	Oppose
LB46	Ashford		Provide for consolidation and coordination of crime laboratories	Judiciary	1.31.13	General File w/AM398	x		x	Oppose
LB55	Wightman	Speaker	Change provisions relating to reassumption of assessment function by counties	Revenue	2.28.13	General File	x		x	Support
LB56	Larson		Provide for automatic nomination of certain county officers	Government, Military and Veterans Affairs		General File w/AM226	x		x	Neutral
LB62	Schilz		Change levy provisions for rural and suburban fire protection districts	Revenue	3.21.13		x		x	Support

Kissel/ES Associates
Bills of Interest Report
Client: LC

LB/LR	Sponsor	Priority	One-Liner	Committee	Hearing Date	Status	LC	*LC Position*	*NACO*	NACO Position
LB63	Schilz		Change distribution of certain sales and use tax revenue	Revenue	3.14.13		x			
LB65	Schilz		Authorize counties to set sheriff's fees and commissions	Government, Military and Veterans Affairs	1.30.13		x		x	Support
LB76	Nordquist		Adopt the Health Care Transparency Act	Health and Human Services	2.22.13	General File	x			
LB82	Schumacher	Schumacher	Adopt the Taxpayer Investment Program	Revenue	2.21.13 (Cancelled) 3.5.13	General File w/ AM693 3/19;	x			
LB86	McGill		Authorize inspection and regulation of staff secure juvenile facilities	Judiciary	3.7.13		x		x	Support
LB97	Mello	Mello	Adopt the Nebraska Municipal Land Bank Act and authorize land banks to acquire tax-delinquent properties	Revenue	2.13.13	General File w/AM572; Chambers FA39 Filed; Smith FA40 Filed	x		x	Watch
LB98	Mello		Change provisions relating to administrative rules	Government, Military and Veterans Affairs	2.8.13	General File w/AM331	x			
LB101	Watermeier		Change valuation of agricultural land and horticultural land	Revenue	2.28.13		x		x	Oppose

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LB/LR	Sponsor	Priority	One-Liner	Committee	Hearing Date	Status	LC	*LC Position*	*NACO*	NACO Position
LB108	Karpisek		Prohibit counties, cities, and villages from imposing credentialing requirements	Government, Military and Veterans Affairs	1.30.13		x			
LB110	McGill		Change the eligibility determination for homestead exemptions	Revenue	3.1.13		x		x	Oppose
LB115	Lautenbaugh	Speaker	Change provisions relating to homicide	Judiciary	2.7.13		x			
LB119	Cook		State intent relating to appropriations for Public Health Aid	Appropriations	3.25.13		x			
LB123	Lautenbaugh		Change distribution of indigent defense fees	Judiciary	1.25.13	Indefinitely Postponed	x		x	Oppose
LB127	McGill		Provide for preregistration to vote for 16 and 17 year olds	Government, Military and Veterans Affairs	2.7.13		x		x	Watch
LB128	Coash		Create the offense of disarming a peace officer	Judiciary	1.23.13	General File w/AM238	x			
LB134	Avery		Provide for inheritance by issue conceived after death	Judiciary	1.30.13		x			

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LB/LR	Sponsor	Priority	One-Liner	Committee	Hearing Date	Status	LC	*LC Position*	*NACO*	NACO Position
LB139	Krist		Change vital statistics information relating to annulment and dissolution of marriage	Health and Human Services	1.23.13		x		x	Oppose
LB142	Lathrop		Provide that probation records are not subject to disclosure as prescribed	Judiciary	1.23.13		x			
LB144	Brasch		Provide for write-in candidacy by defeated candidate	Government, Military and Veterans Affairs	1.23.13	General File 3/19;	x		x	Neutral
LB145	Brasch		Change valuation of agricultural land and horticultural land	Revenue	2.28.13		x		x	Oppose
LB148	Ashford		Include ammunition in certain offenses involving firearms	Judiciary	1.23.13		x			
LB149	Pirsch		Provide for biennial reviews of state agency programs and services	Executive Board	1.28.13	Indefinitely Postponed	x			
LB151	Seiler		Provide a hearsay exception for certain documents and data kept in the regular course of business	Judiciary	1.25.13		x			

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Bills of Interest Report
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LB/LR	Sponsor	Priority	One-Liner	Committee	Hearing Date	Status	LC	*LC Position*	*NACO*	NACO Position
LB157	Cook		State intent relating to the appropriation of funds in support of dental services	Appropriations	3.25.13		x			
LB158	Seiler	Transportation and Telecommunications	Change provisions relating to eligibility for and use of ignition interlock devices	Transportation and Telecommunications	2.19.13	General File w/AM470; Seiler AM827 Filed	x			
LB160	Schumacher		Provide for electronic signatures on recall, initiative, and referendum petitions	Government, Military and Veterans Affairs	1.31.13		x		x	Neutral
LB169	Gloor		Change provisions relating to jury commissioners	Judiciary	2.13.13	General File w/AM232	x		x	Support
LB171	Bloomfield		Provide for an expedited concealed handgun permit process for applicants who are victims of domestic violence	Judiciary	3.21.13		x			
LB182	Avery	Speaker	Change paternity provisions for a child conceived as a result of sexual assault	Judiciary	2.6.13	Indefinitely Postponed	x			

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LB/LR	Sponsor	Priority	One-Liner	Committee	Hearing Date	Status	LC	*LC Position*	*NACO*	NACO Position
LB183	Karpisek		Provide for county board appointment of election commissioners	Government, Military and Veterans Affairs	1.31.13		x		x	Neutral
LB188	Karpisek		Require legislative approval of gubernatorially appointed election commissioners	Government, Military and Veterans Affairs	1.31.13	General File w/AM 188 3/19;	x		x	Neutral
LB192	Karpisek		Change provisions relating to requests for information by the Auditor of Public Accounts	Government, Military and Veterans Affairs	2.13.13	General File	x			
LB194	Speaker Adams		Provide for deficit appropriations	Appropriations	2.25.13		x			
LB195	Speaker Adams		Appropriate funds for state government expenses	Appropriations	2.25.13		x			
LB196	Speaker Adams		Appropriate funds for salaries of members of the Legislature	Appropriations	2.25.13		x			
LB197	Speaker Adams		Appropriate funds for salaries of constitutional officers	Appropriations	2.25.13		x			

LB/LR	Sponsor	Priority	One-Liner	Committee	Hearing Date	Status	LC	*LC Position*	*NACO*	NACO Position
LB198	Speaker Adams		Appropriate funds for capital construction and property acquisition	Appropriations	2.25.13		x			
LB199	Speaker Adams		Provide fund transfers, create funds, and authorize the sale of land	Appropriations	2.25.13		x			
LB200	Speaker Adams		Provide for transfers from the Cash Reserve Fund	Appropriations	2.25.13		x			
LB202	Coash		Change provisions relating to DNA collection	Judiciary	2.8.13		x			
LB206	Schumacher		Require secret-ballot envelopes for mailed ballots	Government, Military and Veterans Affairs	2.7.13		x		x	Oppose
LB207 A	McCoy		Change motor vehicle registration provisions	Transportation and Telecommunications	1.28.13	General File; Select File 2/5; Select File 2/7; Final Reading 2/25; Passed on Final Reading 45-1-3; Approved	x		x	Support

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LB/LR	Sponsor	Priority	One-Liner	Committee	Hearing Date	Status	LC	*LC Position*	*NACO*	NACO Position
LB209	Harr		Change provisions relating to publication of trade names	Banking, Commerce and Insurance	1.29.13	General File; Select File 2/5; Final Reading 2/25; Passed on Final Reading 46-0-3; Approved	x			
LB215	Schilz		Change provisions relating to use of the County Visitors Promotion Fund	Government, Military and Veterans Affairs	2.13.13	General File w/AM156	x		x	Oppose
LB218	Avery		Require insurance coverage for certain food formulas as prescribed	Banking, Commerce and Insurance	2.26.13		x			
LB224	Janssen	Pirsch	Provide veterans preference for public contracts as prescribed	Government, Military and Veterans Affairs	2.1.13	General File w/AM711 3/21;	x			
LB226	Smith		Regulate dealers in the business of purchasing and reselling precious items	Judiciary	1.31.13		x		x	Watch
LB229	Nordquist		Change the Nebraska Retirement Fund for Judges fee	Nebraska Retirement Systems	2.12.13	General File	x			
LB232	Lathrop	Speaker	Change judges' salaries	Judiciary	2.1.13	General File w/AM200	x			

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LB/LR	Sponsor	Priority	One-Liner	Committee	Hearing Date	Status	LC	*LC Position*	*NACO*	NACO Position
LB235	Howard		Change precinct size requirements and procedures for drawing political subdivision boundaries and changing polling places and provide for election advisory committees	Government, Military and Veterans Affairs	2.14.13	Indefinitely Postponed	x		x	Oppose
LB237	Karpisek		Change provisions relating to a property tax exemption	Revenue	3.1.13		x		x	Oppose
LB241	Sullivan		Authorize voters to change election of county offices from partisan to nonpartisan	Government, Military and Veterans Affairs	2.7.13		x		x	Neutral
LB246	Larson		Provide for a health care copayment for jail and prison inmates	Judicary	2.7.13		x		x	Support
LB247	Larson		Change Nebraska Juvenile Code provisions relating to reimbursement by parents for costs of care and treatment	Judiciary	3.15.13		x			

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LB/LR	Sponsor	Priority	One-Liner	Committee	Hearing Date	Status	LC	*LC Position*	*NACO*	NACO Position
LB255	McGill	Speaker	Change provisions relating to hearsay, child abuse, and offenses relating to morals	Judiciary	2.20.13		x		x	Support
LB257	McCoy		Change provisions relating to creation of municipal counties	Government, Military and Veterans Affairs	1.30.13		x		x	Support
LB260	Gloor		Change requirements for a data and information system under the Nebraska Behavioral Health Services Act	Health and Human Services	2.14.13	General File 3/21;	x			
LB266	Chambers		Eliminate provisions relating to increases in local option sales tax rates	Revenue	2.27.13	Chamber MO29 to place on General File Filed	x			
LB267	Chambers		Prohibit persons on parole, probation, or work release from acting as undercover agents or employees of law enforcement and prohibit admissibility of certain evidence	Judiciary	2.7.13	General File	x			

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LB/LR	Sponsor	Priority	One-Liner	Committee	Hearing Date	Status	LC	*LC Position*	*NACO*	NACO Position
LB271	Lautenbaugh	Government, Military and Veterans Affairs	Change provisions relating to early voting	Government, Military and Veterans Affairs	2.14.13	General File	x		x	Support
LB284	Conrad		Change provisions of the Political Subdivisions Tort Claims Act relating to limits on actions and amounts recoverable	Judiciary	2.13.13		x		x	Oppose
LB286	Conrad		Provide for Cash Reserve Fund transfers for affordable housing, homeless shelter assistance, and legal aid	Appropriations	2.25.13		x			
LB292	Karpisek		Change population restrictions for conducting elections by mail	Government, Military and Veterans Affairs	2.21.13 (Cancelled)		x		x	Support
LB293	Kintner	Kintner	Prohibit disclosure of any applicant or permitholder information regarding firearms registration, possession, sale, or use as prescribed	Judiciary	3.20.13	AM687 Filed 3/19;	x			

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LB/LR	Sponsor	Priority	One-Liner	Committee	Hearing Date	Status	LC	*LC Position*	*NACO*	NACO Position
LB294	Seiler		Change provisions relating to use of public resources by public officials and public employees	Government, Military and Veterans Affairs	2.22.13		x		x	Support
LB297	Bolz		Change mental injuries and mental illness compensation under the Nebraska Workers' Compensation Act	Business and Labor	1.28.13		x			
LB299	Seiler	Seiler	Change political subdivision election provisions	Government, Military and Veterans Affairs	2.21.13 (Cancelled)	General File 3/19; Select File 4/3	x		x	Neutral
LB311	Scheer		Change filing requirements for official bonds and oaths	Government, Military and Veterans Affairs	1.30.13	General File; Select File w/ER16; Final Reading 2/26; Passed on Final Reading 47-0-2; Approved	x		x	Support
LB317	Price		Change a duty of county assessors relating to real property valuation	Revenue	3.21.13		x	Oppose	x	Oppose

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LB/LR	Sponsor	Priority	One-Liner	Committee	Hearing Date	Status	LC	*LC Position*	*NACO*	NACO Position
LB318	McGill		Change duties of law enforcement officers and agencies relating to the taking and distribution of fingerprints	Judiciary	2.8.13		x			
LB324	Lautenbaugh		Change provisions of the Nebraska Workers' Compensation Act	Business and Labor	3.18.13		x			
LB326	Howard	Speaker	Change provisions of Pharmacy Practice Act and Automated Medication Systems Act	Health and Human Services	2.1.13	General File w/AM434; Howard AM456 Filed	x			
LB341	Wightman	Revenue	Change tax sale procedures	Revenue	2.13.13	General File w/AM564	x		x	Support
LB342	Coash		Change right to counsel provisions under the Nebraska Juvenile Code	Judiciary	3.6.13	General File w/AM490	x		x	Support
LB345	Wightman		Change transfer on death deed requirements and filings	Judiciary	2.1.13	General File w/AM350	x		x	Support

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LB/LR	Sponsor	Priority	One-Liner	Committee	Hearing Date	Status	LC	*LC Position*	*NACO*	NACO Position
LB348	Harr	Speaker	Change provisions relating to the assessment of certain rent-restricted housing projects	Revenue	3.1.13	General File w/ AM642 3/18	x	Monitor		
LB350	Murante		Add members to the Nebraska Police Standards Advisory Council	Judiciary	2.7.13		x			
LB351	Harms		Require cognitive tests for persons eighty years of age or older obtaining motor vehicle operator's licenses	Transportation and Telecommunications	2.5.13		x		x	
LB355	Larson		Change the age of majority and certain age requirements	Judiciary	3.15.13		x		x	Support
LB360	Karpisek		Change court fees, sheriff's fees, identification inspection fees, and handgun certificate fees	Judiciary	2.8.13	Withdrawn	x		x	Cond. Support
LB363	Avery		Change provisions relating to access to public records	Government, Military and Veterans Affairs	2.6.13	General File w/ AM389(Withdrawn)& AM166; Select File w/ER22	x	Monitor		

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LB/LR	Sponsor	Priority	One-Liner	Committee	Hearing Date	Status	LC	*LC Position*	*NACO*	NACO Position
LB364	Avery		Permit government bodies to set limits on certain contracts	Government, Military and Veterans Affairs	2.22.13		x		x	Cond. Support
LB370	Lathrop		Create the County Property Tax Assistance Program and the Municipal Property Tax Assistance Program	Revenue	2.27.13		x		x	Neutral
LB377	Johnson		Change provisions relating to annexation of a county road by a city or village	Urban Affairs	2.5.13		x			
LB378	Smith		Eliminate fees for the issuance of certain license plates	Transportation and Telecommunications	3.4.13		x		x	Neutral
LB381	Janssen		Require photographic identification to vote	Government, Military and Veterans Affairs	3.7.13		x		x	Cond. Support
LB386	Christensen		Require notice of road maintenance by counties as prescribed	Transportation and Telecommunications	2.19.13	General File w/AM275	x		x	Oppose

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LB/LR	Sponsor	Priority	One-Liner	Committee	Hearing Date	Status	LC	*LC Position*	*NACO*	NACO Position
LB387	Christensen		Eliminate provisions relating to constructing drainage facilities and taking other control measures on public roads	Transportation and Telecommunications	2.19.13	Indefinitely Postponed	x		x	
LB390	Christensen		Change provisions relating to Governor's powers regarding restrictions on firearms and ammunition under the Emergency Management Act	Judiciary			x			
LB399	Lautenbaugh		Permit members of certain organizations to use flashing amber lights on motor vehicles	Transportation and Telecommunications	2.12.13	General File	x		x	Watch
LB405	McCoy		Eliminate certain sales tax exemptions, corporate and individual income taxes, and the franchise tax and change other tax provisions	Revenue	2.6.13	Indefinitely Postponed	x		x	Watch

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LB/LR	Sponsor	Priority	One-Liner	Committee	Hearing Date	Status	LC	*LC Position*	*NACO*	NACO Position
LB406	McCoy		Change tax provisions	Revenue	2.7.13	Indefinitely Postponed	x		x	Oppose
LB417	Kolowski		Provide for guidelines for election workers	Government, Military and Veterans Affairs	2.21.13 (Cancelled) 3.5.13	General File	x		x	Watch
LB418	Kolowski		Change powers and duties of election commissioners, chief deputy election commissioners, and county boards	Government, Military and Veterans Affairs	2.27.13	Indefinitely Postponed	x			
LB433	Price		Require a report and change administration procedures for ballots at hospitals and nursing homes	Government, Military and Veterans Affairs	2.27.13	General File 3/21	x			
LB434	Price		Provide for emergency management registries for persons with special needs	Government, Military and Veterans Affairs	2.6.13	General File w/AM324; Select File 2/26; Price AM672 Pending 3/18;Passed on Final Reading 43-0-6	x		x	
LB441	Seiler		Change provisions relating to control of dead human remains	Judiciary			x			

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Client: LC

LB/LR	Sponsor	Priority	One-Liner	Committee	Hearing Date	Status	LC	*LC Position*	*NACO*	NACO Position
LB443	Cook		Adopt the Children's Residential Facilities and Placing Licensure Act	Health and Human Services	2.13.13	General File w/ AM552	x			
LB449	Avery		Redefine high elective office for restrictions on multiple office holding	Government, Military and Veterans Affairs	2.27.13	General File	x			
LB450	Avery		Change political party convention and caucus provisions	Government, Military and Veterans Affairs	2.27.13		x		x	Oppose
LB462	Ashford		Change provisions relating to contracts for joint law enforcement services	Judiciary	3.13.13		x			
LB463	Ashford		Change the number of separate juvenile court judges	Judiciary	3.7.13		x			
LB464	Ashford	Ashford	Change court jurisdiction over juveniles and indictment procedures	Judiciary	3.6.13	General File w/AM615; Advanced to Select File 3/21	x			
LB470	Scheer		Adopt the Superintendent Pay Transparency Act	Education	2.5.13	General File w/AM444	x		x	

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LB/LR	Sponsor	Priority	One-Liner	Committee	Hearing Date	Status	LC	*LC Position*	*NACO*	NACO Position
LB473	Bloomfield		Authorize certain residency restrictions near parks under the Sexual Predator Residency Restriction Act	Judiciary	3.13.13		x			
LB482	Kintner		Prohibit the state and political subdivisions from adopting certain policy recommendations	Judiciary	2.13.13		x		x	
LB483	Bolz	Speaker	Provide for a reentry planning program in adult correctional facilities	Judiciary	2.22.13		x	Support		
LB485	Conrad		Prohibit discrimination based upon sexual orientation as prescribed	Judiciary	3.14.13		x		x	
LB503	Coash		Rename the Child Protection Act and provide for alternative response to a report of child abuse or neglect	Judiciary	3.15.13		x		x	Oppose

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LB/LR	Sponsor	Priority	One-Liner	Committee	Hearing Date	Status	LC	*LC Position*	*NACO*	NACO Position
LB531	Conrad		Change distribution of sales and use tax revenue and repeal the Build Nebraska Act	Revenue	2.27.13		x			
LB533	Avery		Require oil and gas pipeline eminent domain condemnors to provide notice to property owners	Judiciary	2.21.13 (Cancelled) 3.5.13		x			
LB535	Lathrop		Adopt Prescription Monitoring Program Act and repeal prescription monitoring provisions	Health and Human Services	3.15.13		x			
LB538	Chambers		Change provisions relating to revocation and suspension of law enforcement training certificates or diplomas	Judiciary	2.22.13	General File w/AM301	x			
LB541	Chambers		Prohibit arbitration of claims involving disciplinary actions against peace officers	Judiciary	2.22.13	General File w/AM491	x			

LB/LR	Sponsor	Priority	One-Liner	Committee	Hearing Date	Status	LC	*LC Position*	*NACO*	NACO Position
LB543	Chambers	Chambers	Change a penalty from death to life imprisonment or life imprisonment without possibility of parole	Judiciary	3.13.13	General File 3/20	x		x	
LB551	Schilz	Schilz	Change recreational liability provisions	Judiciary	2.13.13		x		x	Watch
LB561	Ashford	Judiciary	State findings and intent for changes to the juvenile justice system and a funding mechanism	Judiciary	3.7.13		x		x	Watch
LB562	Ashford		Change provisions of the juvenile justice system	Judiciary	3.6.13		x		x	Oppose
LB565	Nelson	Speaker	Prohibit registering to vote and voting early on the same day	Government, Military and Veterans Affairs	2.28.13	General File w/AM810	x			
LB574	Harr	Speaker	Provide that certain assessments are levied and collected as special assessments	Revenue	2.28.13	General File w/AM446 3/21	x		x	Oppose
LB576	Harr		Require flagging of area near polling places and change restrictions on electioneering	Government, Military and Veterans Affairs	2.28.13	Indefinitely Postponed	x		x	Support

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LB/LR	Sponsor	Priority	One-Liner	Committee	Hearing Date	Status	LC	*LC Position*	*NACO*	NACO Position
LB577	Campbell	Campbell	Change provisions relating to the medical assistance program	Health and Human Services	2.28.13	General File 3/19;	x		x	Support
LB578	Nordquist		Create a fund to provide funding for medicaid services and change distribution of premium tax revenue	Health and Human Services	2.28.13		x		x	
LB580	Johnson		Change certain condemnation procedures	Judiciary	3.15.13		x		x	Support
LB581	Crawford		Change the sales and use tax collection fees	Revenue	3.20.13		x			Support
LB595	Price	Price	Provide for a Public Service Commission study of next-generation 911	Transportation and Telecommunications	2.25.13	General File w/AM695 3/21	x		x	
LB597	Larson		Change provisions relating to county agricultural societies	Agriculture	2.26.13	General File w/AM346	x		x	Oppose
LB600	Wightman		Change inheritance tax rates	Revenue	2.27.13		x			

LB/LR	Sponsor	Priority	One-Liner	Committee	Hearing Date	Status	LC	*LC Position*	*NACO*	NACO Position
LB612	Schumacher	Executive Board	Require the Department of Revenue to present reports to legislative committees	Executive Board	2.19.13	General File w/AM321	x		x	Watch
LB613	Schumacher	Schumacher	Create the Tax Modernization Commission	Executive Board	2.19.13	General File w/AM467; Chambers Ams Pending; Schumacher Motion to Invoke Cloture prevailed 44-2-2-1; Advanced to Select File; Chambers Bracket Motion on Select File Pending; Krist AM744 Pending; Chambers FA37 Pending;	x	Monitor		
LB614	Schumacher		Provide for withholding insurance proceeds for demolition costs	Banking, Commerce and Insurance	2.25.13		x		x	

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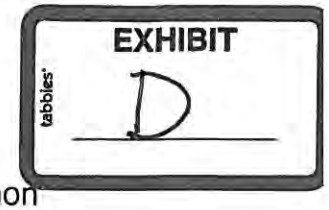
LB/LR	Sponsor	Priority	One-Liner	Committee	Hearing Date	Status	LC	*LC Position*	*NACO*	NACO Position
LB621	Karpisek		Exempt certain information from disclosure under the Intergovernmental Risk Management Act	Banking, Commerce and Insurance	3.4.13		x		x	Support
LB623	Price	Speaker	Change provisions relating to bridge construction and road improvements	Transportation and Telecommunications	2.19.13	General File w/AM518	x		x	Support
LB632	Bolz		Change funding for county offices relating to public assistance programs	Government, Military and Veterans Affairs	3.6.13		x		x	Oppose
LB636	Wallman		Provide restrictions for application of certain herbicides	Agriculture	3.5.13		x	Monitor	x	Support
LB652	Lautenbaugh		Provide procedures for taking grievances by certain county corrections officers to the Civil Service Commission	Business and Labor	3.4.13		x			
LB653	Davis		Change and provide for distribution of the gallonage tax on beer	General Affairs	3.4.13	Indefinitely Postponed	x			



(The following is a verbatim transcript of an excerpt of the City-County Common Meeting held on January 15, 2013 whereby the City-County Consolidation Task Force was discussed. Present were County Commissioners Roma Amundson, Jane Raybould, Deb Schorr and Brent Smoyer; City Council Members Jon Camp, Gene Carroll, Doug Emery, Carl Eskridge, Lloyd Hinkley and DiAnna Schimek; and Ann Taylor, County Clerk's Office.)

RAYBOULD: Next item is number four (4), City-County Consolidation Task Force Focus Group. And I guess I am gonna go ahead and hand out, uh, samples of what was done in the past. Just for your consideration, I would like to propose at this time that we move forward with a joint press release and encourage people that are interested in the community willing to participate on this Task Force to please submit their names to the City Council and to the County Board so that we can make a selection of the Committee. I passed out, um, the recommendations from the Committee that had met in June of 1996 and it looked like they had, uh, about nine (9) people on the task force and they had one facilitator so I guess based on the success of that previous task force, I...I guess

that would be the...the number I would recommend perhaps five (5), uh, rep...names coming through the City Council and five (5) names coming through the County Board so we could, uh, officially get the Task Force up and running. Are there discussion and comment?

CARROLL: I think, I don't know if it was Mr. Camp or somebody had mentioned maybe one (1) name per Council Member, one (1) name per County Board or do you want five (5) and five (5)? It doesn't make any difference to me, uh, whether its...you want it equal between the County and City for the number of people or...

RAYBOULD: I mean, I'm open to all suggestions. That was just throwing it out to get some discussion going.

CAMP: How many total do you want?

HINKLEY: I would think equal representation makes sense.

CARROLL: Okay. What...although you want an odd number for voting purposes versus even.

SCHORR: I believe the Mayor already submitted his name.

CARROLL: Oh...okay. So...

ESKRIDGE: Okay. Alright.

CARROLL: ...then make it five (5) and five (5)? That'd be fine.

RAYBOULD: Okay.

CAMP: Would you have citizens on there, too, that could make up the odd number?

ESKRIDGE: These are citizens.

CARROLL: We're talking...

RAYBOULD: These are...

CAMP: Well...okay...I'm sorry. Okay. I was thinking City Council and County Board Members. Pardon me.

RAYBOULD: Okay, just for clarity, we are going to request five (5) citizen representatives be put forward from the City Council, five (5) citizen representatives put forward from the County Board. We have a representative from the Mayor's Office, as well as one (1) representative from the City Council Members and one (1) representative from the County Board. Did I summarize that correctly? (Inaudible) No? Is that what you said?

SCHORR: They're all gonna be citizens.

CARROLL: Five (5) and five (5) citizens. No...no...no elected officials...

RAYBOULD: Oh...okay...alright...

CARROLL: ...elected officials...

SCHORR: Excuse me.

RAYBOULD: Okay.

CARROLL: ...but should we select a...a facilitator or find somebody to do...because it does work well if you have one (1) person that that's all they do is facilitate the program so...and we can work on that later.

RAYBOULD: Okay.

AMUNDSON: Were you going to have an individual on there from each one of...from the City Council and the Mayor's Office and so forth, in order to answer some questions regarding the, uh, financial sorts of things and to answer questions about the operation?

CARROLL: Usually you assign staff...

AMUNDSON: Okay.

CARROLL: ...to...to the Committee so the staff from the Council, staff from the...the County Board would be able to take to them information.

AMUNDSON: They would be able...they would be on there to answer questions.

CARROLL: Uh huh.

RAYBOULD: Okay. Alright. Does someone want to make a motion to that effect? Do we need a motion to that effect?

CARROLL: We can't make motions.

RAYBOULD: We can't make motions. Okay. Well since that seems to be a consensus here...(inaudible)

CAMP: Would you repeat that?

ESKRIDGE: Repeat exactly...

RAYBOULD: Okay.

ESKRIDGE: ...what you are proposing.

RAYBOULD: To further clarify, we agree that we will have five (5) citizen representatives/candidates put forward from the City Council and five (5) citizen representatives put forward from the County Board and, uh, a yet to be determined facilitator.

SCHIMEK: Plus one (1) from the Mayor's Office.

RAYBOULD: Plus one (1) representative from the Mayor's Office. Okay?

CARROLL: Do you want to set a time and date, uh, to when to get this....to initiate people...

RAYBOULD: Okay.

CARROLL: ...to make their nominations?

SCHORR: Any information about how frequently, uh, this group will meet.

RAYBOULD: Okay. Let's see...

SCHORR: Possible length of time that they will be gathering, uh, so people will have an idea, you know, is this a six (6) month commitment? Is this an eighteen (18) month commitment? Is this for life? (laughter) Um, I think that might be helpful information as people consider whether or not they would like to submit their names and the process and to whom they should submit this information...

RAYBOULD: Okay.

SCHORR: ...would all be helpful things to know, too.

RAYBOULD: I see that our next City-County Common Meeting is February 4th at 12:45 p.m. So is it fair to say, "Please provide your names at that time and we will issue a press release this week?"

ESKRIDGE: Sounds good.

RAYBOULD: Sounds good? Then I guess the term would be probably useful to let people know what they are in for. Should we arbitrarily establish maybe something very brief...a six

(6) month term so that they...

ESKRIDGE: Is that long enough?

SCHORR: Gene?

CARROLL: I'd probably...nine (9)...nine months.

RAYBOULD: Nine (9) months?

CARROLL: Yeah.

RAYBOULD: Okay. Alright.

SCHORR: Have meetings once a month and...

CARROLL: Yeah...

SCHORR: ...additional meetings...

CARROLL: ...and then usually the Committee will decide if they get closer they need to have, yeah, a little bit more but once a month is adequate...

RAYBOULD: Okay...

CARROLL: ...especially up front.

RAYBOULD: ...with the understanding of meeting once a month and a nine (9) month term initially to start with, okay? I...It seems to be the consensus so we'll move forward on that.

SCHIMEK: And would it be fair to say that if the Committee sees a need for a more lengthy time they could always come

back and request...

CARROLL: Sure.

SCHIMEK: ...but this at least would set some parameters for them.

CARROLL: Yes.

RAYBOULD: Okay. Alright. I see no other items of business. Is there a motion to adjourn?

CARROLL: So moved.

AMUNDSON: Second.

RAYBOULD: Okay. All those in favor of adjourning please say aye.

(Camp, Carroll, Emery, Eskridge, Hinkley, Schimek, Amundson, Raybould, Schorr and Smoyer voted aye.)

RAYBOULD: All those opposed. (None.)

RAYBOULD: We are adjourned. Thank you for your time and attention.

(End of transcript.)

EXHIBIT
E

CITY OF LINCOLN NEBRASKA

LANCASTER COUNTY NEBRASKA

Railroad Transportation Safety District (RTSD)

A Future,
Or Not?

Lincoln/Lancaster County RTSD

Origin and History

- 1971 - Nebraska Legislature Authorized RTSD's for 25 years
- 1990 - Lincoln City Engineer named Executive Director
- 1994 - Lincoln PW/U Provides Secretarial/Business Office Functions
- 1995 - Nebraska Legislature Extended RTSD Authority indefinitely.

Lincoln/Lancaster County RTSD

Mission

- It is declared to be the policy of this state to reduce the number of fatalities and injuries caused by collisions between motor vehicles and railroad trains; to eliminate as far as possible unnecessary conflicts between railroad transportation and highway transportation; to improve the movement of both rail and highway traffic by eliminating grade crossings; and to assist in relocation of railroad facilities that bisect the central portions of municipalities, thus hampering the growth of both the municipality and the railroad services; the effect of such policies being to benefit and enhance the community as a whole. These policies shall not be implemented in any manner without just compensation to all damaged parties, including both railroads and shippers, and, where appropriate, alternate routes for affected railroads.
  Neb. Rev. Stat. §74-1301

Lincoln/Lancaster County RTSD

RTSD Authority

- May Purchase Railroad Rights-of-Way/Improvements
- May Acquire Land (Purchase or Eminent Domain) for Railroad Purposes
- May Enter into Contracts and Agreements
- May Bond for Railroad Related Projects
- Must Comply with Regulations of other Government Agencies

Lincoln/Lancaster County RTSD

RTSD Authority

- **Must Examine Costs and Benefits**
- **May Levy Property Tax (through County Board) to Maximum $.026/$100**
- **Raises $5,000,000 per Year in Lancaster County**

DESCRIPTION	TAX RATE	TAX AMOUNT	PREVIOUS
COUNTY	0.262162	393.78	381.44
*CO DBT SER	0.017538	26.34	21.54
PUB BLDG COM	0.017000	25.54	25.54
LINCOLN	0.294980	443.06	436.02
SCHOOL DIST1	1.236094	1856.68	1835.84
*LPS OLD BND	0.037046	55.64	68.40
*LPS 99 BND	0.041008	61.60	54.58
EDU SERV U18	0.014999	22.54	22.50
PLATTE NRD	0.032302	48.52	48.46
RR SAFE DIST	0.026000	39.06	37.26
SE COM COLL	0.065500	98.38	98.40
AGR SOCIETY	0.002008	3.02	4.54
AGR SOC.JPA	0.004180	6.28	6.56
Total Tax Rate	2.050817	3080.44	3041.08

$150,000 Home

DETACH AN

Lincoln/Lancaster County RTSD

Accomplishments

New Viaducts

- "A" Street from 1st to 5th
- Firth Road, West of S. 82nd (Firth, NE)
- 137th Street, North of Highway 6, (Waverly, NE)
- Haymarket Park Pedestrian Overpass
- Van Dorn at Park Blvd.
- "L" Street, West of 9th
- "K" Street, West of 9th
- 27th Street, South of Theresa Street
- US Hwy. 77, South of "O" Street
- 3rd & "F" Street Pedestrian (Underpass)
- Antelope Valley North Leg

Lincoln/Lancaster County RTSD

Accomplishments

Viaduct Replacements

- Harris Overpass – "O" Street from 3rd to 9th
- W. Van Dorn, West of SW 56th Street
- 10th Street, South of Charleston Street
- Havelock, East of Cornhusker Highway

Lincoln/Lancaster County RTSD

Accomplishments

1973 - Agreements established with City and County to provide cooperation at Grade Crossings on:

- New Signals
- New Gates
- Upgrading Signals
- Improving Grade Crossing Surfaces with Permanent Materials (RTSD/RR Partnership)

Lincoln/Lancaster County RTSD

Accomplishments

Quiet Zones

- BNSF Cornhusker Corridor
- BNSF South Lincoln Corridor
- South Salt Creek
- Waverly (In Process)
- Hickman (In Process)

Cornhusker Corridor

South Salt Creek

South Lincoln

Waverly

Lincoln/Lancaster County RTSD

Summary/RTSD Benefits

- **Crossing Exposure Reduced**
- **Number of At-Grade Railroad Crossings reduced in Lincoln Area from 210 in 1970 to 83 in 2007.**
- **Railroad Collisions reduced by 80%**

Time Period	Deaths	Injuries	Property Damage Collisions
1952 - 1967 (16 years)*	55	57	115
1982 - 1997 (16 years)**	6	21	32
2002 - 2009 (8 years)***	3	13	12

* Lincoln Journal - January 10, 1968.

** Nebraska Department of Roads Standard Summary of Nebraska Motor Vehicle Traffic Accidents

*** Federal Railroad Administration Safety Data

Lincoln/Lancaster County RTSD

Summary/RTSD Benefits

- **New Grade Separations Constructed 12 (4 pedestrian)**
- **Grade Separations Rebuilt - 4**
- **New Railroad Track Constructed 5 - 10 miles**
- **At-Grade Crossings Improved - More than 150**
- **At-Grade Crossings Closed - 127***

* Approximately half due to Abandonment
Approximately half due to Consolidation/Grade Separations

Lincoln/Lancaster County RTSD

RTSD Funding

- RTSD Funds Collected Through Levy (1990- 2010) - $ 61,304,270
- Federal Funds Leveraged Prior to 1990 - Over $40.0 million
- Other Funding Received - Railroads

  Nebraska Department of Roads (TMT)

- 1990 - 2010 Total RTSD Expenditures for Safety

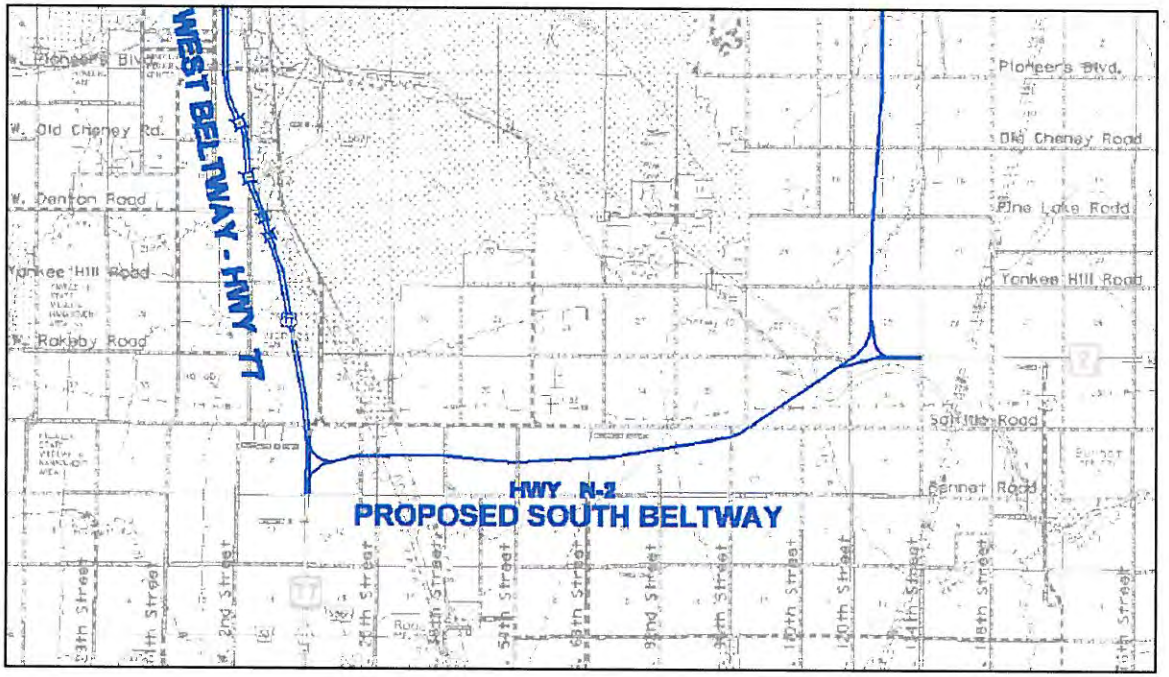
Crossings		$ 2,320,743
Quiet Zones		$ 146,285
Capital Projects		$ 64,693,293
Operating Budget	$ 1,348,595	

Lincoln/Lancaster County RTSD

What's Next?

Projects

- **South Beltway**

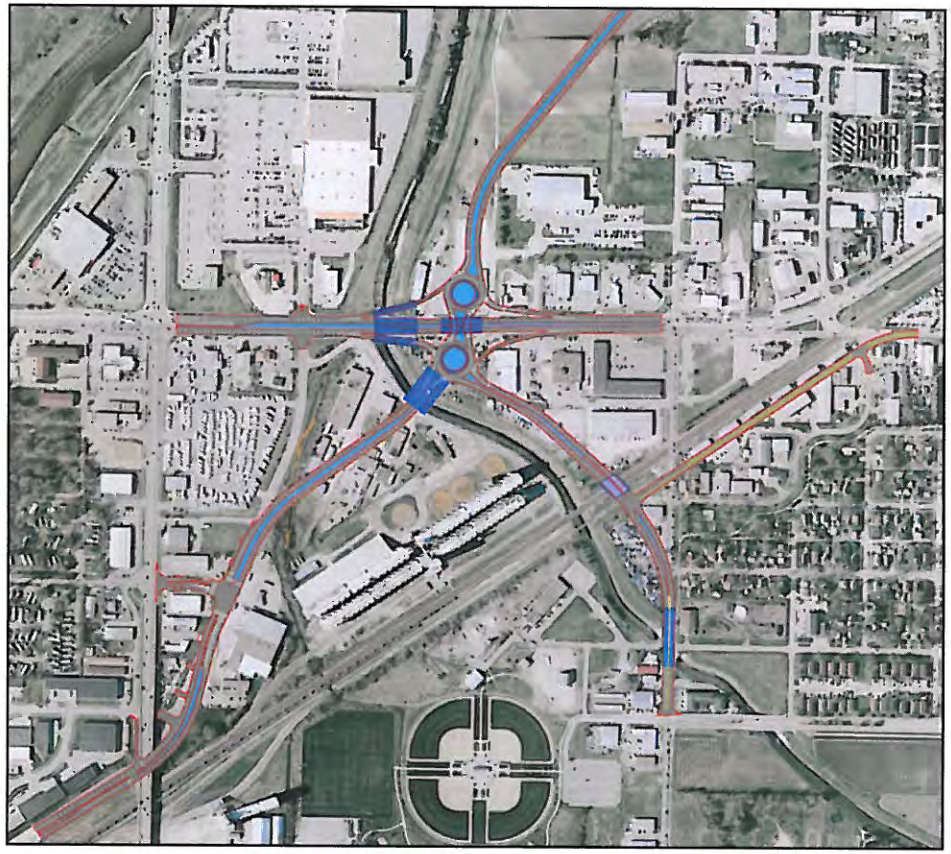


Lincoln/Lancaster County RTSD

What's Next?

Projects

- 33rd/35th/Adams Grade Separation

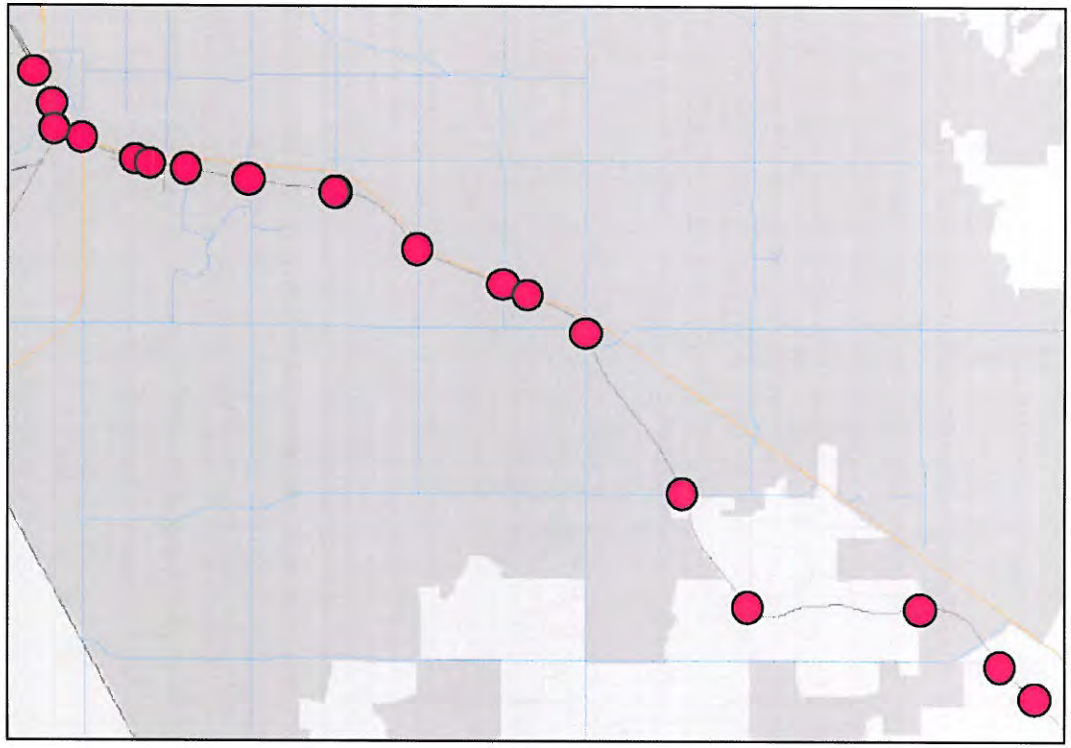


Lincoln/Lancaster County RTSD

What's Next?

Projects

- Highway 2 Corridor (OPPD)



Lincoln/Lancaster County RTSD

What's Next?

Projects

- 70th/Cotner/Cornhusker
- 27th and Saltillo
- BNSF South Corridor
- 148th and Highway 6

70th & Cornhusker

27th & Saltillo

Old Cheney & Warlick

148th and Hwy. 6

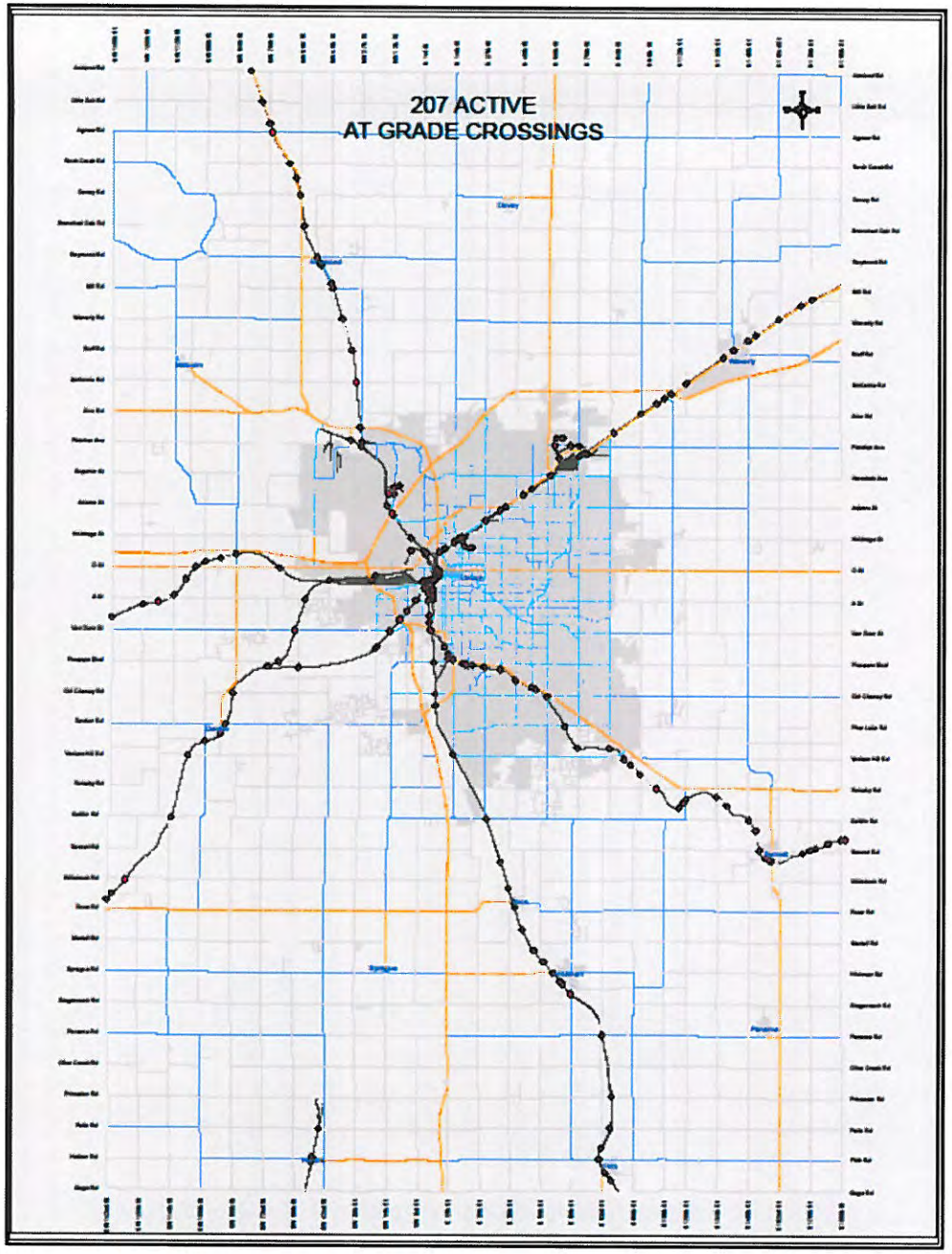
Lincoln/Lancaster County RTSD

What's Next?

- Uncertainty with levy? $0.01/$100 for 2013
- $2 million in funding

- Dedicated source of revenue to improve railroad/car/pedestrian safety

Questions/Discussion


207 ACTIVE
AT GRADE CROSSINGS

SW 40th Viaduct

Water Dept. installing a tapping sleeve and valve.

SW 40th Viaduct

Laying Water Main along SW 40th

SW 40th Viaduct

Van Kirk beginning work at corner of SW 40 & 'O'.

SW 40th Viaduct

Back filling water main along SW 40th Street.

RTSD

12 Year Cash Flow with varying levies

2.6 LEVY ALL YEARS				
Fiscal Year	Total Net Revenues	Operating Expenditures	Capital Project Expenditures	Projected Year-End Cash Balance
FY12-13				10,500,000
FY13-14	5,297,861	(78,538)	(5,025,000)	10,694,323
FY14-15	5,351,104	(80,894)	(1,500,000)	14,464,532
FY15-16	5,422,749	(83,321)	(1,500,000)	18,303,960
FY16-17	5,495,269	(85,821)	(6,500,000)	17,213,408
FY17-18	5,543,671	(88,395)	(7,500,000)	15,168,684
FY18-19	5,587,842	(91,047)	(1,500,000)	19,165,479
FY19-20	5,662,764	(93,778)	(10,600,000)	14,134,464
FY20-21	5,693,096	(96,592)	(11,100,000)	8,630,968
FY21-22	5,721,621	(99,490)	(10,600,000)	3,653,099
FY22-23	5,753,334	(102,474)	(13,148,000)	(3,844,041)
FY23-24	5,792,237	(105,549)	(18,960,000)	(17,117,353)
FY24-25	5,849,978	(108,715)	(500,000)	(11,876,090)

2.6 LEVY ALL YEARS-Alternate Projects Budget				
Fiscal Year	Total Net Revenues	Operating Expenditures	Capital Project Expenditures	Projected Year-End Cash Balance
FY12-13				10,500,000
FY13-14	5,297,861	(78,538)	(5,025,000)	10,694,323
FY14-15	5,351,104	(80,894)	(1,500,000)	14,464,532
FY15-16	5,422,749	(83,321)	(1,500,000)	18,303,960
FY16-17	5,495,269	(85,821)	(6,500,000)	17,213,408
FY17-18	5,543,671	(88,395)	(7,500,000)	15,168,684
FY18-19	5,587,842	(91,047)	(1,500,000)	19,165,479
FY19-20	5,662,764	(93,778)	(6,850,000)	17,884,464
FY20-21	5,711,846	(96,592)	(7,350,000)	16,149,718
FY21-22	5,759,214	(99,490)	(6,850,000)	14,959,443
FY22-23	5,809,866	(102,474)	(9,398,000)	11,268,834
FY23-24	5,848,581	(105,549)	(18,960,000)	(1,948,133)
FY24-25	5,849,978	(108,715)	(500,000)	3,293,130

RTSD

12 Year Cash Flow with varying levies

RAILROAD TRANSPORTATION SAFETY DISTRICT
CASH FLOW PROJECTIONS 04/02/2013

Assumptions:	1% annual valuation growth .5% avg interest rate 3% annual increase in operating expenses

1.0 LEVY ALL YEARS

Fiscal Year	Total Net Revenues	Operating Expenditures	Capital Project Expenditures	Projected Year-End Cash Balance
FY12-13				10,500,000
FY13-14	2,081,146	(78,538)	(5,025,000)	7,477,608
FY14-15	2,086,139	(80,894)	(1,500,000)	7,982,853
FY15-16	2,108,971	(83,321)	(1,500,000)	8,508,503
FY16-17	2,132,107	(85,821)	(6,500,000)	4,054,789
FY17-18	2,130,552	(88,395)	(7,500,000)	(1,403,053)
FY18-19	2,131,199	(91,047)	(1,500,000)	(862,901)
FY19-20	2,152,329	(93,778)	(10,600,000)	(9,404,350)
FY20-21	2,173,671	(96,592)	(11,100,000)	(18,427,271)
FY21-22	2,195,225	(99,490)	(10,600,000)	(26,931,536)
FY22-23	2,216,996	(102,474)	(13,148,000)	(37,965,014)
FY23-24	2,238,984	(105,549)	(18,960,000)	(54,791,579)
FY24-25	2,261,191	(108,715)	(500,000)	(53,139,103)

0.5 LEVY ALL YEARS

Fiscal Year	Total Net Revenues	Operating Expenditures	Capital Project Expenditures	Projected Year-End Cash Balance
FY12-13				10,500,000
FY13-14	1,075,923	(78,538)	(5,025,000)	6,472,385
FY14-15	1,065,837	(80,894)	(1,500,000)	5,957,328
FY15-16	1,073,415	(83,321)	(1,500,000)	5,447,422
FY16-17	1,081,120	(85,821)	(6,500,000)	(57,279)
FY17-18	1,064,239	(88,395)	(7,500,000)	(6,581,435)
FY18-19	1,074,700	(91,047)	(1,500,000)	(7,097,782)
FY19-20	1,085,265	(93,778)	(10,600,000)	(16,706,296)
FY20-21	1,095,935	(96,592)	(11,100,000)	(26,806,953)
FY21-22	1,106,713	(99,490)	(10,600,000)	(36,399,729)
FY22-23	1,117,598	(102,474)	(13,148,000)	(48,532,606)
FY23-24	1,128,592	(105,549)	(18,960,000)	(66,469,563)
FY24-25	1,139,696	(108,715)	(500,000)	(65,938,582)

CITY OF LINCOLN NEBRASKA

EXHIBIT F

SW 40th Overpass
Fast Facts
April 4, 2013

SW 40th Construction:

Prime Contractor:	United Contractors, Inc.
Construction Start Date:	March 25, 2013
Contract Time:	902 Calendar Days
Contract Bid :	$9,399,236.88

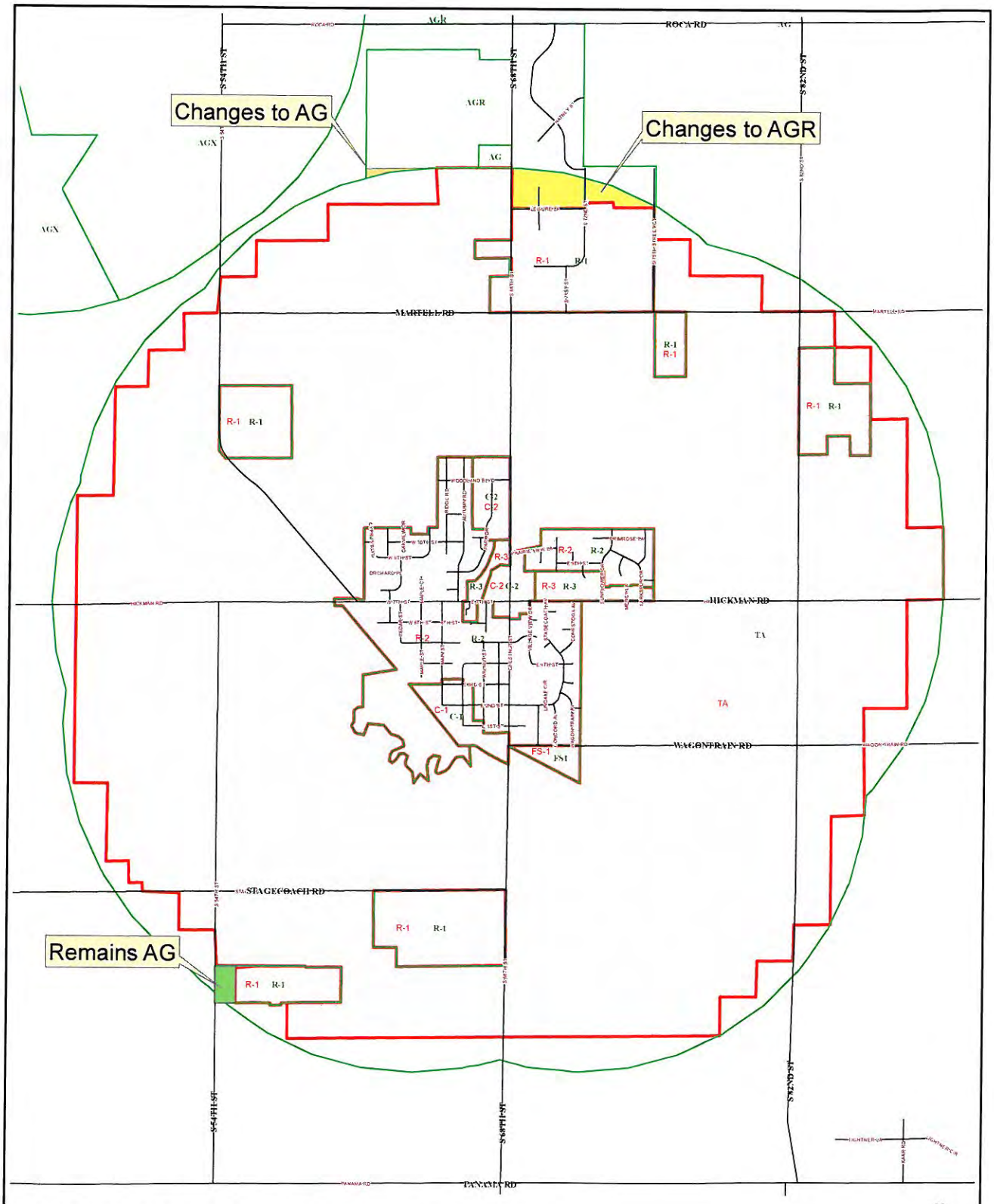
Schedule:

March 25, 2013:	Begin Construction on the 16" water main
July 8, 2013:	Water main construction complete
July 9, 2013	Begin construction of bridge piers
July 22, 2013	Begin construction of wick drain field and placing fill
July 28, 2013:	Abandonment of existing water main complete
Nov. 18, 2013	Begin work on Middle Creek bridge abutments
Dec 1, 2013	Begin work on BNSF bridge abutments
Dec 16, 2013	Begin setting beams on Middle Creek bridge
March 14, 2014	Begin pouring deck, rails and approaches on the Middle Creek bridge
April 14, 2014	Middle Creek Bridge substantially complete
April 28, 2014	Begin setting beams on the BNSF bridge
June 23, 2014	Begin pouring deck, rails and approaches on the BNSF bridge
March 30, 2015	BNSF bridge substantially complete
March 16, 2015	Begin grading roadway on SW40th
April 13, 2015	Begin asphalt and concrete paving
July 7, 2015	Roadway paving complete
August 3, 2015	Roadway open to traffic

*The dates shown are the contractor's best estimate of how the work on SW 40th will progress. The actual dates that certain aspects of construction will occur are dependent upon weather, project phasing, and coordination with BNSF and other projects in the vicinity.

Nebraska Department of Road's Hwy 6 (West 'O' Street) Project.

The Nebraska Department of Roads is working on the design of a project on West 'O' Street at the intersection of SW 40th Street. The extent of construction is limited to the area near the intersection with SW 40th Street. Construction will include adding left and right turn lanes onto SW & NW 40th Streets. Construction is anticipated to begin in spring 2014 and will require coordination between our contractor on SW 40th and NDOR's contractor for the West 'O' Street project.



HICKMAN ETJ CHANGES

N
W E
S

- Planning Dept. Zoning
- Hickman Zoning
- Proposed Hickman ETJ
- Proposed Change to AG
- Proposed Change to AGR
- Remains AG

EXHIBIT

G

tabbies

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April 4, 2013

EXHIBIT
H

Lancaster County

Health Care Reform

April 4, 2013

Presented by:
Tracy Krause Account Executive

AON Hewitt

Lancaster County

Health Care Reform

April 4, 2013

Presented by:
Tracy Krause Account Executive

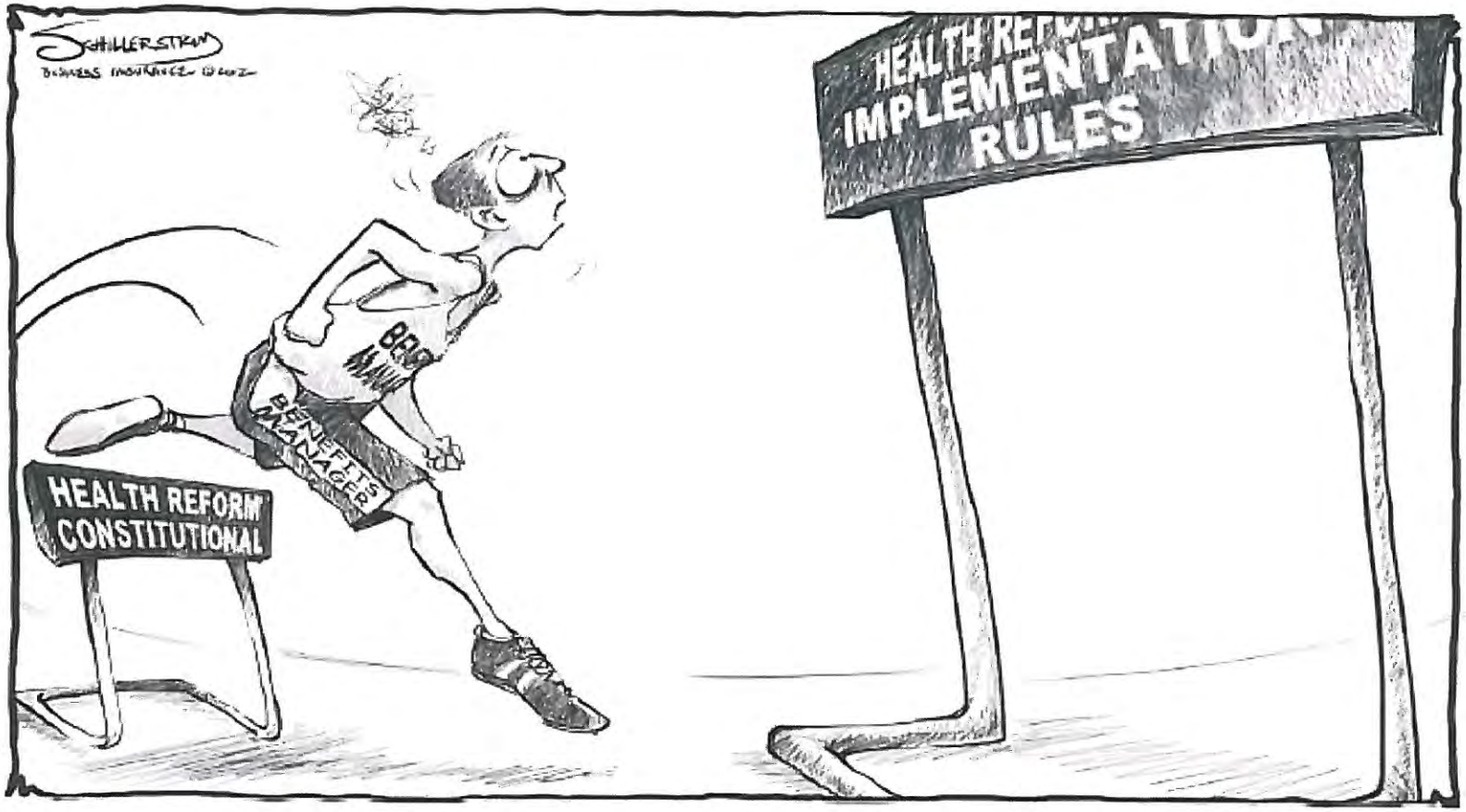
AON Hewitt

Section 1:
ACA Updates

AON Hewitt

What's Next?

SCHILLERSTROM



Source: Business Insurance, July 30, 2012

Current Provisions Regarding PPACA

Provision	Deadline	Lancaster County Status
Coverage of Women's Preventive Health Services (non-grandfathered only)	Effective plan years that begin on or after August 1, 2012	Lancaster County Complies
W-2 Reporting on Cost of Group Health Insurance	Reporting based upon 2012 coverage	Lancaster County Complies
Health FSA $2,500 limit	January 1, 2013	Lancaster County Complies
Patient Centered Outcomes Research Institute (PCORI) fee	Plan years ending on or after 10/1/2012 and before 10/1/2019, Due July 31, *See AonHewitt Bulletin inserts*	Average members for 2012 x $1.00 due July 31, 2013
New taxes—guidance issued 12/2012 applies to those making more than $200,000	January 1, 2013	Consult with Tax Counsel verify HRIS system is setup appropriately
Deductibility of expenses due to RDS payments eliminated (retiree plans)	January 1, 2013	Does not apply to Lancaster County
Quality of Care reporting requirements (non-grandfathered only)	Agencies have not yet issued guidance (deadline was 3/23/2012)	Waiting for additional guidance
Notify all employees about Exchanges, eligibility, services, and contact information	Employer notice for state exchanges due March 2013 (waiting on model notices)	Model notice is delayed and is expected to be released late summer/early fall

Please note: This is not an all inclusive list of PPACA mandates, however, it is a guide to key provisions and dates affecting most employers.

2014 Provisions

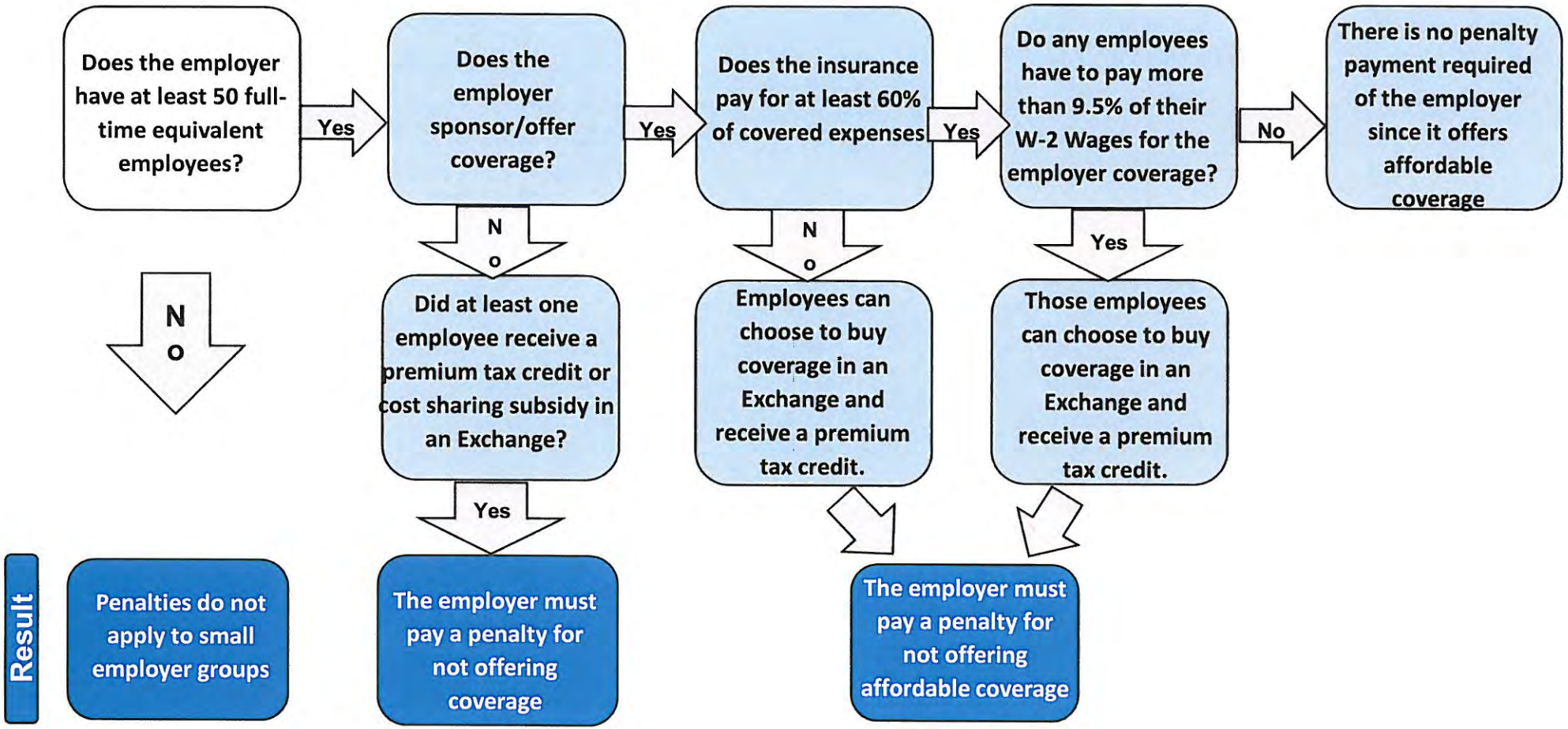
Provision	Deadline	Lancaster County Town Status
State Exchanges Available	1/1/2014	Enrollment for 2014 begins on October 1
Employer Shared Responsibility Provisions and Penalties	1/1/2014	Determine if plan is affordable , provides MEC *, is of minimum value, and is offered to all FTE's and their dependents
Automatic enrollment	Delayed; not expected to be available until 1/1/2014	Awaiting guidance
Maximum 90 day waiting period	1/1/2014	Lancaster County will need to change
Annual dollar limits on Essential Health Benefits and preexisting condition exclusions prohibited	1/1/2014	Lancaster County already complies
Coverage for clinical trials	1/1/2014	Carriers will incorporate into their medical policies
Increased wellness rewards cap	1/1/2014	N/A at this time
Transitional reinsurance fees	1/1/2014- 2016	BCBSNE will handle remitting the payment but Lancaster County has to pay the fee. More details to follow. 2013 Average members x $63
Annual fee on health insurer net premiums based on insurer size and market share (fully insured medical, dental, vision)	2014	N/A- fee imposed on insurance companies
Cost Sharing Limits- Out-of-Pocket Maximum	1/1/2014	Lancaster County currently complies; will need to watch any proposed plan design changes

Please note: This is not an all inclusive list of PPACA mandates; it is a guide to key provisions and dates affecting most employers.

***MEC = minimum essential coverage**

Employer Penalty Scenarios

Penalties for Employers Not Offering Affordable Coverage under the ACA in 2014



Employer Shared Responsibility Provisions – Determining Who is an FTE

- Definition of **Full-Time Employee is complicated**
  - Full-Time Employee is generally defined as an employee who is employed an average of at least 30 hours of service per week with an employer
  - For this purpose, 130 hours of service in a calendar month is treated as the monthly equivalent of at least 30 hours of service per week, provided the employer uses this equivalency rule on a reasonable basis
- For variable-hour or seasonal employees, the government provides the ability to use a **Measurement Period, Stability Period, and Administrative Period**
- **General concept (many details apply)**—if an employer determines that an employee averaged at least 30 hours per week during the measurement period, then the employer treats the employee as an Full-Time Employee during a subsequent stability period, regardless of the employee's number of hours of service during the stability period, so long as he or she remains an employee
- *For details regarding all of the provisions above, please see the AonHewitt Bulletin (January 2013) for more specific descriptions and information*

Employer Shared Responsibility Provisions – "Targeted Penalty"

- Minimum Value
  - Plan fails to provide minimum value if the plan's share of the total allowed costs of benefits provided under the plan is less than 60% of those costs
  - HHS previously proposed guidance on methodologies and intends to propose additional guidance
    - Minimum value calculator
    - Safe harbor checklist
    - Actuarial certification

- Sample Minimum Value Plans:

	Deductible In-Network EE/Family	Out of Pocket Maximum In – Network EE/Family (includes Deductible)	Co-pay In-Network	Rx Coverage In-Network
HSA Eligible	$3,250/$6,700	$6,250/$12,500	70%	70%
Non-HSA Eligible	$3,250/$6,700	$6,250/$12,500	60%	60% Coinsurance with $50/$100/$150 coinsurance maximum

These plans are examples, should Lancaster County want to implement a 60% AV plan, the plan benefits would need to be run by an Actuary for final approval.

Employer Shared Responsibility Provisions – "Targeted Penalty"

- Affordability
  - Plan is affordable if employee's contribution for self-only coverage does not exceed 9.5% of the employee's "household income" for the taxable year
    - Proposed regs permit employer to use a safe harbor, including using an employee's W-2 wages to determine "household income"

- Affordability Safe Harbors *(see Aon Hewitt Bulletin for further details on these provisions)*
  - Three optional affordability safe harbors that would apply only for purposes of determining whether an employee's coverage satisfies the 9.5% affordability test
    - W-2 Safe Harbor
    - Rate of Pay Safe Harbor
    - Federal Poverty Line Safe Harbor (2013 FPL is $11,490)
      - Federal Poverty Line Safe Harbor: 2013 FPL=$11,490 per individual, this amount multiplied by 9.5% leaves an "affordable" premium of $1,091.55 or $90.96 per month. Amounts under this for a minimum value plan will avoid penalties.

Premium Equivalents for 2013 Monthly	
AFSCME-Clerical	$0
AFSCME- Engineer	$0
DFOP 29	$28.28
FOP-Corrections	$39.58
FOP - 77 Youth Services	$0
MSS. C, E X	$0
Retirees	N/A Pay full County Cost

Maximum 90 day Waiting Period

- A waiting period is defined as the period of time that must pass before coverage for an employee or dependent who is otherwise eligible to enroll under the terms of the plan can become effective

- Using an initial measurement period to determine a newly hired employee's eligibility for a plan that complies with the guidance provided in Notice 2012.58 will not be considered a condition designed to avoid compliance with the 90-day waiting period limits if coverage is made effective no later than 13 months from the employee's start date, plus if the employee's start date is not the first day of the calendar month, the time remaining until the first day of the next calendar month

- A waiting period exceeding 90 days that is imposed after the measurement period ends will be considered a violation of this provision.
  - Coverage must begin on the 91st day
  - i.e. a waiting period/effective date of "1st of the month following 90 days" is not acceptable

- *See the AonHewitt Bulletin for additional information*

Transitional Reinsurance Fees

- Imposed on fully-insured and self-insured group health plans providing major medical coverage
  - To help stabilize premiums in the individual insurance market
  - Will fund a reinsurance program to be established in each state by 01/01/2014
  - Program will run from 2014 through 2016
- Total annual fee or "contribution rate" for 2014 is proposed to be $63.00 per capita ($5.25 per month)
  - Per capita means all enrollees in the plan
  - Includes employees, pre-65 retirees, spouses and dependents
- States that opt to establish their own program may impose additional rates on fully-insured plans, but not self-insured plans covered by ERISA
- Proposed rule exclude the following plans:
  - HIPAA-excepted benefits such as stand-alone dental and vision plans and on-site medical clinics
  - Health Savings Accounts
  - Health Reimbursement Arrangements that are integrated with a group health plan
  - Health flexible spending arrangements
  - Employee assistance plans that do not provide major medical coverage
  - Disease management and wellness programs, to the extent they do not provide major medical coverage
  - Stop-loss and indemnity reinsurance policies
  - Plans or coverage provided by an Indian Tribe to Tribal members and their spouses and dependents

Transitional Reinsurance Fees (continued)

- Medicare Secondary Payor Rules apply
  - Plans are liable for payment of the fee with respect to an individual over age 65 if the group health plan is the primary payer of medical expenses under MSP rules (i.e. Medicare eligible, but actively working)
  - Individuals entitled to Medicare due to disability of ESRD should be counted (consistent with the working aged)
- Determining the number of covered lives:
  - Similar to methods used for the PCORI fee: Actual count method, snapshot count method, Form 5500 method
  - To avoid double counting of covered lives, if two or more plans collectively provide major medical coverage for the same covered lives, the plans are treated as a single, self-insured group health plan
- Submit to HHS no later than November 15 an annual enrollment of the average number of covered lives for the calendar year, regardless of the group's **actual benefit** year
- HHS notifies each entity of contribution to be paid within 15 days of the submission of covered lives or by December 15th, whichever is later
- Amounts then due within 30 days after that notification

- 2012 Average members for Lancaster County approximately =1,443 x $63 = $90,950

- *See AonHewitt Bulletin on this subject for more details*

Compliance—Timeline

2011 Plan Year

- Lifetime dollar limits on Essential Health Benefits (EHB) prohibited*
- Preexisting Condition Exclusions Prohibited for Children under 19*
- Overly restrictive annual dollar limits on EHB prohibited*
- Extension of Adult Child Coverage to Age 26*
- Prohibition on Rescissions*
- No Cost Sharing and Coverage for Certain In-Network Preventive Health Services**
- Effective Appeals Process**
- Consumer/patient protections**

2011

- Over-the-Counter Medicines Not Reimbursable Under Health FSA, HRAs, or from HSAs Without a Prescription, Except Insulin
- Public Long-Term Care Option (CLASS Act) –*No Longer Supported by HHS*

2012

- Employer Distribution of Summary of Benefits and Coverage to Participants*
- Comparative Effectiveness Fee - $1.00
- Employer Quality of Care Report**
- Employer Reporting of Health Coverage on Form W-2 (*due January 31, 2013*)
- Medical Loss Ratio rebates (insured plans only)*

2013

- Addition of women's preventive health requirements to No Cost Sharing and Coverage for Certain In-Network Preventive Health Services **
- Limit of Health Care FSA Contributions to $2,500 (Indexed)
- Notice to Inform Employees of Coverage Options in Exchange
- Comparative Effectiveness Fee - $2.00
- Medicare Tax on High Income

2014

- Individual Mandate to Purchase Insurance or Pay Penalty
- State Insurance Exchanges
- Employer Responsibility to Provide Affordable Minimum Essential Health Coverage***
- Annual Dollar Limits on Essential Health Benefits HB Prohibited*
- Automatic Enrollment (likely delayed to 2015)
- Employer Reporting of Health Insurance Information to Government and Participants
- Increased Cap on Rewards for Participation in Wellness Program**
- Cost-sharing limits for all group health plans, not just HDHPs/HSA (OOP maximum)**
- Transitional reinsurance contributions

2018

- Excise Tax on High-Cost Coverage

***Denotes group/insurance market reforms applicable to all group health plans.**

****Denotes group/insurance market reforms not applicable to grandfathered health plans.**

***** This requirement applies to full time employees (e.g., 30 hours per week) and will require coverage that is affordable and satisfies a certain actuarial value to avoid the penalty. Guidance forthcoming.**

Appendix 1: AON Alerts

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IRS Releases Final Regulations Imposing PCORI Fee on Sponsors of Fully Insured and Self-Insured Health Plans

December 2012

The Internal Revenue Service (IRS) issued final regulations on December 5, 2012, requiring health insurance issuers and plan sponsors of self-insured health plans to finance the Patient-Centered Outcomes Research Institute (PCORI) Trust Fund through the payment of an annual fee (the PCORI fee). The Trust Fund, which was implemented as part of the Patient Protection and Affordable Care Act (Affordable Care Act), will fund the Institute's research into the comparative effectiveness of medical treatments.

The PCORI fee is imposed on health insurance issuers and plan sponsors of self-insured health plans for plan or policy years ending on or after October 1, 2012 and before October 1, 2019. The fee imposed is based on the average number of covered lives. For plan or policy years ending on or after October 1, 2012 and before October 1, 2013, the fee is one dollar ($1) multiplied by the average number of covered lives for that plan year. The fee then increases to two dollars ($2) for plan years ending on or after October 1, 2013. For plan years ending on or after October 1, 2014, the fee increases are based on a formula that includes increases in the projected per capita amount of National Health Expenditures provided by the Department of Health and Human Services (HHS).

The final regulations apply to plan or policy years ending on and after October 1, 2012 and before October 1, 2019.

Fully Insured Health Plans and the PCORI Fee

Health insurance issuers are responsible for the PCORI fee for policy years ending on or after October 1, 2012, and before October 1, 2019. The PCORI fee applies to any accident or health policy (including a policy under a group health plan) issued with respect to individuals residing in the U.S., including any prepaid health care coverage arrangements such as health maintenance organizations (HMOs). The PCORI fee applies to any policy that provides accident and health coverage to active employees, former employees (including COBRA coverage and retirees), or qualifying beneficiaries. The PCORI fee does not apply to:

- Any insurance policy if substantially all of its coverage is of excepted benefits, such as stand-alone vision or dental plans;
- Any group policy issued to an employer where the facts and circumstances show that the group policy was designed and issued specifically to cover primarily employees who are working and residing outside of the U.S.;
- Any stop-loss or indemnity reinsurance policy; or
- Any insurance policy to the extent it provides an employee assistance program, disease management program, or wellness program if the program does not provide significant benefits in the nature of medical care or treatment.

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Calculating Covered Lives in a Fully Insured Plan

To determine the average number of lives covered under a health insurance policy during a policy year, an issuer must use one of the following methods:

- **Actual Count Method**—An issuer adds the total number of lives covered for each day of the policy year and divides that total by the number of days in the policy year.
- **Snapshot Count Method**—An issuer adds the total number of lives covered on any date during the same corresponding month in each of the first three quarters of the policy year and divides that total by the number of dates on which a count was made.
- **Member Months Method**—An issuer may determine the average number of lives covered under all policies in effect for a calendar year based on the member months (an amount that equals the sum of the totals of lives covered on pre-specified days in each month of the reporting period) reported on the National Association of Insurance Commissioners (NAIC) Supplemental Health Care Exhibit filed for that calendar year.
- **State Form Method**—An issuer that is not required to file NAIC annual financial statements may determine the number of lives covered under all policies in effect for the calendar year using a form that is filed with the issuer's state and a method similar to the "member months" method.

An issuer must use the same method of calculating the average number of lives covered under a policy consistently for the duration of the year. In addition, for all policies for which a liability is reported on a Form 720, "Quarterly Federal Excise Tax Return," for a particular year, the issuer must use the same method of computing lives covered.

Self-Insured Health Plans and the PCORI Fee

The PCORI fee is imposed on the plan sponsor of an applicable self-insured health plan, which includes a plan established or maintained by a plan sponsor (generally, the employer) for the benefit of employees, former employees (including retirees), or other eligible individuals to provide accident or health coverage if any portion of the coverage is provided other than through an insurance policy. An applicable self-insured health plan includes a retiree-only plan and COBRA continuation coverage. Since the PCORI fee is imposed on the plan sponsor and not the plan, the Department of Labor (DOL) does not consider the fee to be a plan expense under Title I of ERISA.

Multiple self-insured arrangements established and maintained by the same plan sponsor with the same plan year may be treated as a single self-insured health plan for purposes of calculating the fee. As a result, the same life covered under each arrangement would count as only one covered life for purposes of calculating the fee. For example:

- A plan sponsor maintains one self-insured arrangement providing medical benefits and another providing prescription drug benefits with the same plan year. The two arrangements may be treated as one self-insured health plan for purposes of the fee.
- A health reimbursement arrangement (HRA) is integrated with another applicable self-insured health plan that provides major medical coverage. The HRA and the major medical plan may be treated as one self-insured health plan. Note, however, that an HRA integrated with an insured group health plan is subject to the fee as an applicable self-insured health plan. In that case, the issuer of the insured group health plan would also be subject to the fee.

If a group health plan offers both fully insured and self-insured options, a plan sponsor may disregard the lives that are covered solely under the fully insured options for purposes of calculating the fee on its self-insured options.

Under the final regulations, the PCORI fee does not apply to:

- HIPAA-excepted benefits, such as stand-alone dental and vision plans and on-site medical clinics;
- Health savings accounts (HSAs);
- HRAs that are integrated with a self-insured group health plan;
- Health flexible spending arrangements (FSAs);
- Employee assistance plans, disease management programs, and wellness programs, to the extent they do not provide significant medical benefits;
- A plan that, as demonstrated by the facts and circumstances surrounding the adoption and operation of the plan, was designed specifically to cover primarily employees who are working and residing outside the U.S.;
- Stop-loss and indemnity reinsurance policies; and
- Plans or coverage provided by an Indian tribe to tribal members and their spouses and dependents (and other persons of Indian descent closely affiliated with the tribe).

Calculating Covered Lives in a Self-Insured Plan

The average number of lives covered under an applicable self-insured health plan for a plan year can be calculated by any one of three different methods:

- **Actual Count Method**—A plan sponsor adds the total number of lives covered by the plan for each day of the plan year and divides the total by the number of days in the plan year.
- **Snapshot Method (using the snapshot count or snapshot factor)**—The "snapshot" calculation method involves adding the totals of lives covered on one date in each quarter, or more dates if an equal number of dates are used for each quarter, and dividing that total by the number of dates on which a count was made. The date or dates used for each quarter must be the same (e.g., first day of the quarter, last day of the quarter, first day of the month). When using the snapshot method, the number of lives covered on a date is equal to either: 1) the actual number of lives covered on the designated date ("snapshot count" method); or 2) the sum of the number of participants with self-only coverage on that date, plus the product of the number of participants with coverage other than self-only coverage on the designated date and 2.35 ("snapshot factor" method).
- **Form 5500 Method**—A plan sponsor may also use the Form 5500 method to calculate the average number of lives for a plan year based on the number of reportable participants for the Form 5500, "Annual Return/Report of Employee Benefit Plan," filed for the applicable self-insured health plan. For an applicable self-insured health plan offering self-only and other coverage (e.g., employee plus spouse, employee plus children, family), the average number of lives equals the sum of total participants covered at the beginning and the end of the plan year, as reported on the Form 5500 filed for the plan. For an applicable self-insured health plan offering only self-only coverage, the average number of lives covered equals the sum of the total participants covered at the beginning and the end of the plan year, reported on the Form 5500, divided by two.

A plan sponsor must use a single method for calculating the average number of covered lives for an entire plan year, but a different method may be used from one plan year to the next. Examples of each calculation method are included in the final regulations.

If a plan sponsor only maintains a health FSA (that is not an excepted benefit) or HRA, the plan sponsor may treat each participant's health FSA or HRA as covering a single covered life (and not include any spouse, dependent, or other beneficiary of the participant). If a plan sponsor maintains a health FSA or HRA and another applicable self-insured health plan (other than a health FSA or HRA), the plan sponsor may treat the two arrangements as a single plan. In this case, the special counting rule (i.e., treating each participant's health FSA or HRA as covering a single covered life) applies only to participants in the health FSA or HRA that do not participate in the other applicable self-insured health plan. If such individuals also participate in the other applicable self-insured health plan, they will be counted under one of the methods, described above, used by the plan sponsor.

For plan years beginning before July 11, 2012, and ending on or after October 1, 2012, a plan sponsor may use any reasonable method for determining the average number of lives covered under the plan for the plan year.

Reporting and Payment of Fees on IRS Form 720

Health insurance issuers and plan sponsors will report and pay the fees only once per year on IRS Form 720, "Quarterly Federal Excise Tax Return," by July 31 of the calendar year immediately following the last day of the plan year. A Form 720 return generally covers plan years that end during the preceding calendar year. Full payment of the fee is due annually by the July 31 due date. The first potential due date for reporting and filing the fee on Form 720 is July 31, 2013.

Form 720 may be filed electronically and is available at: www.irs.gov/efile. Any claim for a refund of the fees must be filed on Form 8849, "Claim for Refund of Excise Taxes," or Form 720X, "Amended Quarterly Federal Excise Tax Return."

Resources

The full text of the final regulations is available at: http://www.gpo.gov/fdsys/pkg/FR-2012-12-06/pdf/2012-29325.pdf

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IRS Issues Rules on New Taxes Imposed by the Affordable Care Act

December 2012

The Internal Revenue Service (IRS) released guidance implementing three new federal taxes under the Patient Protection and Affordable Care Act (Affordable Care Act) beginning January 1, 2013:

- A proposed rule imposing an 0.9% additional Medicare tax on high-income earners;
- A proposed rule implementing a 3.8% net investment tax on certain investment income for high-income earners; and
- Final rules implementing a 2.3% excise tax on medical devices.

Although the rules on the additional Medicare tax and the net investment income tax are in proposed form, the IRS stated that taxpayers may rely on the proposed rules beginning January 1, 2013. Any changes made in the final rules will only apply after publication of the final rules. This Aon Hewitt bulletin describes the rules for each of the new taxes.

Additional Medicare Tax on High-Income Earners

The Affordable Care Act imposes an additional Medicare tax on an individual's wages that exceed $250,000 (for married taxpayers filing jointly), $125,000 (for married taxpayers filing separately), and $200,000 for all other taxpayers. The additional tax, which applies in tax years beginning after December 31, 2012, applies only to the employee portion of the Medicare tax and does not affect the portion of the Medicare tax paid by employers.

Employer and Payroll Responsibilities

An employer is responsible for withholding the additional 0.9% Medicare tax from wages or compensation it pays to an employee in excess of $200,000 beginning January 1, 2013, without regard to the individual's filing status or wages paid by another employer. Any additional withheld Medicare tax will be credited against an individual's total tax liability shown on his or her individual income tax return.

An employer that fails to withhold the additional 0.9% Medicare tax is liable for the tax unless the employee actually pays the tax. If errors in withholding are discovered, they may be corrected through an interest-free adjustment provided in the proposed rule, but only in the same calendar year in which wages are paid. Further, an employer is subject to all other applicable penalties for failing to properly withhold the additional Medicare tax.

The additional 0.9% Medicare tax applies only to wages paid to an employee in excess of $200,000 in a calendar year. If an employee receives wages from an employer in excess of $200,000 and the wages include taxable noncash fringe benefits, the employer calculates wages for purposes of withholding the additional 0.9% Medicare tax in the same way that it calculates wages for withholding the existing Medicare tax—i.e., the value of the taxable noncash fringe benefits must be included in wages and the

employer must withhold the applicable additional 0.9% Medicare tax and deposit the tax under the rules for employment tax withholding and deposits that apply to taxable noncash fringe benefits.

Similarly, the same rules regarding sick pay from a third party and the calculation of wages from a nonqualified deferred compensation plan apply in determining wages subject to the additional 0.9% Medicare tax.

Reliance on Proposed Rule

As stated above, although these proposed rules will not be finalized before the tax becomes applicable on January 1, 2013, taxpayers must comply with the law as of that date and may rely on these proposed rules. If any requirements change in the final rules, taxpayers will only be responsible for complying with the new requirements from the date the final rules are published.

Net Investment Income Tax

For a tax year beginning on or after Janaury 1, 2013, the Affordable Care Act will impose a 3.8% net investment income tax on individuals, estates, and trusts with investment income above a certain threshold amount. The amount of the tax on individuals is equal to 3.8% of the lesser of:

- An individual's net investment income for such taxable year; or
- The excess, if any, of 1) the individual's modified adjusted gross income for such taxable year, over 2) the threshold amount.

Individuals will owe the tax if they have net investment income and also have modified adusted gross income above $250,000 (if married filing jointly), $125,000 (if married filing separately), and $200,000 (if single). These threshold amounts are not indexed for inflation. For example:

> **Facts**—Taxpayer, a single filer, has $180,000 of wages. Taxpayer also received $90,000 from a passive partnership interest, which is considered net investment income. Taxpayer's modified adjusted gross income is $270,000. Taxpayer's modified adjusted gross income exceeds the threshold of $200,000 for single taxpayers by $70,000. Taxpayer's net investment income is $90,000.
>
> **Result**—The net investment income tax is based on the lesser of $70,000 (the amount that Taxpayer's modified adjusted gross income exceeds the $200,000 threshold) or $90,000 (Taxpayer's net investment income). Taxpayer owes net investment income tax of $2,660 ($70,000 x 3.8%).

What Is Investment Income?

Under the proposed rule, in general, investment income includes, but is not limited to: interest, dividends, capital gains, rental and royalty income, non-qualified annuities, income from businesses involved in trading of financial instruments or commodities, and businesses that are passive activities to the taxpayer. Net investment income also includes any interest, dividends, and capital gains of an individual's children that are included on an individual's income tax return.

Examples of gains taken into account in calculating net investment income (to the extent not otherwise offset by capital losses) include gains from the sale of stocks, bonds, and mutual funds; capital gain distributions from mutual funds; and gains from the sale of investment real estate (including gains from the sale of a second home that is not a primary residence).

What Is Not Investment Income?

Income that is not considered net investment income includes wages, unemployment compensation, operating income from a nonpassive business, Social Security benefits, alimony, tax-exempt interest, self-employment income, and distributions from certain qualified plans (401(a), 403(a), 403(b), 408, 408A, or 457(b)).

Estates and Trusts Subject to Net Investment Income Tax

Estates and trusts will be subject to the net investment income tax if they have undistributed net investment income and also have adjusted gross income over the dollar amount at which the highest tax bracket for an estate or trust begins for such taxable year (for tax year 2012, this threshold amount is $11,650).

Trusts Not Subject to the Net Investment Income Tax

Trusts that are **not** subject to the net investment income tax include: trusts that are exempt from income taxes, such as charitable trusts and qualified retirement plan trusts exempt from tax under Code Section 501; a trust in which all of the unexpired interests are devoted to trusts and operated exclusively for religious, charitable, scientific, literary, or educational purposes, or to foster national or international amateur sports competition (but only if no part of its activities involve the provision of athletic facilities or equipment), or for the prevention of cruelty to children or animals; trusts that are classified as "grantor trusts"; and trusts that are not classified as "trusts" for federal income tax purposes (e.g., Real Estate Investment Trusts and Common Trust Funds).

Applicability to U.S. Territories

According to the proposed rule, the net investment income tax will apply to individuals living in American Samoa and Puerto Rico because they are still subject to U.S. federal income tax laws. The only exception is if individuals residing in these territories are nonresident aliens with respect to the U.S.

Guam, the Northern Mariana Islands, and the U.S. Virgin Islands have a tax code that is generally identical to the U.S. tax code and therefore, the net investment income tax does not apply to individuals living in these territories because they have no income tax obligation to the U.S. provided that they comply with the tax laws of the relevant territory.

Reliance on Proposed Rule

Similar to the additional Medicare tax, taxpayers may rely on the proposed rule for determining the net investment income tax during 2013.

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Advanced Medical Device Tax

The IRS issued final regulations to implement a new 2.3% excise tax to be imposed on manufacturers and importers on the sales of certain advanced medical devices beginning January 1, 2013. Also on December 5, 2012, the IRS released Notice 2012-77 to provide transitional relief during the first three quarters of 2013 regarding the determination of sale price and other issues related to the tax.

Industry commentators note that the tax applies mostly to devices used and implanted by medical professionals, ranging from pacemakers and knee replacements to surgical sutures and tongue depressors. Commentators have raised concerns that manufacturers will pass through the cost of the tax to purchasers of medical devices, such as providers and health care plans.

The final regulations define a "taxable medical device" as a device that is listed as a device with the Food and Drug Administration (FDA). If a device is not listed as a device with the FDA but the FDA determines that the device should have been listed as a device, the device will be deemed to be listed as a device with the FDA as of the date the FDA notifies the manufacturer or importer in writing that corrective action with respect to listing is required.

The new tax does not apply to the sale of eyeglasses, contact lenses, hearing aids, and any other devices that are of a type generally purchased by the general public at retail for individual use (the retail exemption). A facts and circumstances approach is used to evaluate whether a type of device qualifies for the retail exemption. The final rule suggests factors to consider in the evaluation and is a non-exhaustive list. However, the final rule provides that several categories of medical devices qualify for the retail exemption safe harbor, including: devices in the FDA's online in-vitro diagnostics (IVD) Home Use Lab Tests (Over-the-Counter Tests) database; devices that the FDA describes as "over the counter" in certain official FDA classification or product code headings or descriptors; and a number of devices that qualify as durable medical equipment, prosthetics, orthotics, or supplies for which payment is available on a purchase basis under the Medicare Part B payment rules.

Payment of the tax is made quarterly, and the first quarterly return for the medical device excise tax is due April 30, 2013, for the months of January, February, and March 2013. Manufacturers and importers of taxable medical devices also must make semimonthly deposits of tax. The first semimonthly deposit for the medical device excise tax, which covers the first 15 days of January, is due January 29, 2013.

Next Steps

Comments on the proposed rules regarding the additional Medicare tax and the net investment income tax are due by March 5, 2013. Comments on IRS Notice 2012-77 are due March 29, 2013.

More Information

The additional Medicare tax proposed rule is available at: http://www.gpo.gov/fdsys/pkg/FR-2012-12-05/pdf/2012-29237.pdf

The IRS's additional Medicare tax FAQs are available at: http://www.irs.gov/Businesses/Small-Businesses-&-Self-Employed/Questions-and-Answers-for-the-Additional-Medicare-Tax

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IRS Proposes Rules on Employer Shared Responsibility Payment

January 2013

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IRS Proposes Rules on Employer Shared Responsibility Payment

The Department of the Treasury and the Internal Revenue Service (IRS) issued proposed rules December 28, 2012 on the employer shared responsibility provisions under the Patient Protection and Affordable Care Act (Affordable Care Act) that may be assessed on applicable large employers.[1] These proposed rules outline what is arguably the most significant change under health care reform for employers—a penalty tax that may be assessed on employers beginning in 2014.

This penalty is referred to as the "assessable payment" and the amount of the penalty depends on whether the employer: 1) fails to "offer" coverage to its full-time employees (and their dependents); or 2) "offers" coverage but that coverage is unaffordable or does not provide minimum value. A large employer could be subject to an assessable payment in one of two situations:

- **"Failure to Offer" Penalty**—If a large employer fails to offer its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage (MEC) under an eligible employer-sponsored plan and any full-time employee is certified to the employer as having received a premium tax credit or cost-sharing reduction, then the employer will be subject to a monthly penalty equal to 1/12 of $2,000 times the total number of full-time employees minus the first 30 full-time employees.
- **Targeted Penalty**—If a large employer offers its full-time employees (and their dependents) the opportunity to enroll in MEC under an eligible employer-sponsored plan and one or more full-time employee(s) is certified to the employer as having received an applicable premium tax credit or cost-sharing reduction because the employer coverage is either unaffordable or does not provide minimum value, then the employer will be subject to a monthly penalty equal to 1/12 of $3,000 times the number of full-time employees that receive the tax credit or cost-sharing reduction. This penalty may not exceed the amount of the "Failure to Offer" Penalty above.

This Aon Hewitt bulletin provides an overview of the proposed rules for determining: whether an employer is an "applicable large employer"; whether an employer is liable for any assessable payments under the two scenarios described above; which employees are full-time employees; and the administration and assessment of such payments.

Determining an Applicable Large Employer

The assessable payment provisions only apply to large employers. In determining which employers are large employers for this purpose, the proposed rules address the application of aggregation rules for employees of a controlled group, as well as employees who work outside the U.S.

[1] For purposes of determining whether the shared responsibility penalty will apply, a large employer is generally defined as an employer that employed an average of at least 50 full-time employees (including full-time equivalent employees) on business days during the preceding calendar year.

Aggregation Rules

The Affordable Care Act provides that for counting the number of full-time employees and full-time equivalent[2] employees in order to determine whether an employer is a large employer, all entities with a "common owner," or who are otherwise related, are treated as a single employer. Using these "controlled group and affiliated service group rules" is common practice with other tax and employee benefit rules. An example in the proposed rules provides:

> **Facts**—For 2015 and 2016, corporation P owns 100% of all classes of stock of corporation S and corporation T. Corporation P has no employees at any time in 2015. For every calendar month in 2015, S has 40 full-time employees and T has 60 full-time employees. P, S, and T are a controlled group of corporations.
>
> **Conclusion**—Because corporations P, S, and T have a combined total of 100 full-time employees during 2015, each of P, S, and T is an applicable large employer for 2016.

However, the proposed rules clarify that for a calendar year during which an employer is an applicable large employer, the determination of liability for, and amount of, any assessable penalty applies separately to ***each member*** of the controlled group (i.e., each large employer member). Each member of the controlled group is liable for its own assessable payment, and is not liable for the assessable payment of any other entity in the controlled group.

Services Performed Outside the U.S.

The proposed rules provide that employees working outside the U.S. will not qualify as full-time employees for purposes of determining an employer's status as a large employer or for purposes of determining and calculating any potential liability under the employer shared responsibility provisions, if the compensation for those hours of service is considered foreign source income consistent with federal tax law. Hours of service generally do not include hours worked outside of the U.S.; however, hours of service that an individual receives as U.S. source income are considered hours of service for purposes of the employer shared responsibility provisions.

The proposed rules also provide a bit more context, not all conclusive, regarding how a successor (and predecessor) employer, a new employer, seasonal workers, full-time employees, and full-time equivalents figure into the determination of whether an employer is an applicable large employer and subject to the shared responsibility provisions.

"Failure to Offer" Penalty

If an employer offers MEC under an eligible employer-sponsored plan to its full-time employees (and their dependents), it will not be subject to the "Failure to Offer" Penalty regardless of whether the coverage it offers is affordable to these employees or provides minimum value.

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[2] A full-time equivalent employee is defined as a combination of employees, each of whom individually is not treated as a full-time employee because the individual does not work on average at least 30 hours of service per week but, when added together, are counted as the equivalent of a full-time employee solely for the purpose of determining whether an employer is a large employer.

Minimum Essential Coverage (MEC)

As stated above, an applicable large employer must offer its full-time employees (and their dependents) the opportunity to enroll in MEC, to avoid the "Failure to Offer" Penalty. The Affordable Care Act provides that MEC includes coverage under an eligible employer-sponsored group health plan, but it remains unclear what standard, if any, that an employer plan would have to meet to be considered MEC. The IRS has indicated that it will provide further guidance on the definition of MEC and eligible employer-sponsored plans.

Dependents

The proposed rules clarify that an employer must offer coverage to the dependents of all full-time employees, and defines a dependent as an employee's child (i.e., biological or adopted son or daughter, stepson, stepdaughter, a child placed for legal adoption, or an eligible foster child as defined in Internal Revenue Code Section 152(f)(1)) who is under 26 years of age. This definition does not include an employee's spouse.

Offer of Coverage

Under the proposed rules, an employee must have an effective opportunity to accept coverage, or to decline an offer of coverage that is not affordable or does not meet minimum value. If a large employer does not offer coverage to a full-time employee for any day of a calendar month during which the employee was employed, the employee is treated as not being offered coverage for that entire month. If a full-time employee terminates employment in a month and the employee would have been offered coverage for the entire month if employed for that entire month, the employee will be treated as having been offered coverage for the entire month.

In the case of nonpayment or late payment of premiums by an employee, the proposed rules generally adopt the COBRA continuation coverage rules, which generally provide a 30-day grace period for payment and also provide rules regarding timely payments that are not significantly less than the amount required to be paid. If an employee does not meet these requirements and fails to pay the premium on a timely basis, the employer is not required to provide coverage for the period for which the premium is not timely paid, and the employer is treated as having offered coverage for the remainder of the coverage period (typically the remainder of the plan year).

Offer of Coverage and the 95% Standard

The proposed rules allow for a margin of error to recognize potential inadvertent errors in the offer of coverage. An employer will be treated as offering coverage to its full-time employees (and their dependents) for a calendar month if, for that month, it offers coverage to 95%[3] of its full-time employees (and their dependents), thereby avoiding the "Failure to Offer" Penalty. This "margin of error" is permitted regardless of whether the failure to offer is inadvertent.

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[3] In any case, the employer cannot offer coverage to fewer than five full-time employees (and applicable dependents).

Assessable Penalty

If an employer does not offer health coverage to its full-time employees in a particular month, and any full-time employee is certified to the employer as having received a premium tax credit or cost-sharing reduction for such month, then the employer will be subject to a monthly penalty equal to 1/12 of $2,000 times the total number of full-time employees minus the first 30 full-time employees. The assessable payment is not tax deductible.

30-Employee Reduction

For purposes of calculating the "Failure to Offer" Penalty, the total number of full-time individuals employed by an employer for any month is reduced by 30. In the case of a controlled group, only one 30-employee reduction is allowed across the controlled group, and the reduction must be allocated ratably based on the number of full-time employees employed by each member of the controlled group. If there are more than 30 members of the controlled group and the ratable allocation would result in more than zero but less than one full-time employee, the proposed rules would allow each member's share to be rounded up to one full-time employee. The preamble recognizes that this may lead to an overall reduction to all members of the controlled group of more than 30 employees.

Targeted Penalty

A large employer is at risk of incurring the Targeted Penalty if the employer coverage offered either does not meet minimum value or is not affordable. The Targeted Penalty is also triggered if an employer offers MEC to at least 95% of its full-time employees (and their dependents), and any one or more of these full-time employees who is not offered coverage is certified to the employer as having received a tax credit or cost-sharing reduction.

Minimum Value

A plan fails to provide minimum value if the plan's share of the total allowed costs of benefits provided under the plan is less than 60% of those costs. The Department of Health and Human Services (HHS) issued prior proposed regulations providing guidance on methodologies (minimum value calculator; safe harbor checklist; actuarial certification) for determining minimum value, and the agencies intend to propose additional guidance with respect to this issue.

Affordability

An employer-sponsored plan is affordable if the employee's required contribution for self-only coverage does not exceed 9.5% of the employee's "household income" for the taxable year. However, large employers typically do not maintain (and would find it difficult to obtain) "household income" of its full-time employees. As a result, the proposed regulations permit employers to use a safe harbor, including using an employee's Form W-2 wages in lieu of "household" wages to determine affordability, as described in more detail below.

Assessable Penalty

If one or more full-time employees is certified to the employer as having received an applicable premium tax credit or cost-sharing reduction for a particular month because the employer coverage is either unaffordable or does not provide minimum value, then the employer will be subject to a monthly penalty equal to 1/12 of $3,000 times the number of full-time employees who receive the tax credit or cost-sharing reduction for that month. This penalty will never exceed the amount of the "Failure to Offer" Penalty. The assessable payment is not tax deductible.

Affordability Safe Harbors

The proposed rules provide three optional affordability safe harbors that would apply only for purposes of determining whether an employer's coverage satisfies the 9.5% affordability test. An employer may use the affordability safe harbors only if the employer offers its full-time employees (and their dependents) the opportunity to enroll in MEC that provides minimum value with respect to self-only coverage offered to the employee. An employer may choose to use one or more of these safe harbors for all its employees or for any reasonable category of employees, if used on a uniform and consistent basis for all employees in a category

Aon Hewitt Comment: *Note that all three safe harbors focus on the employee's share of the cost for self-only coverage under the employer's plan when determining affordability, even if an employee selects another coverage tier (e.g., family coverage).*

Form W-2 Wages Safe Harbor

The safe harbor generally requires that a full-time employee's required contribution for self-only coverage not exceed 9.5% of Form W-2 wages for a calendar year. Of course, the coverage must be MEC and meet minimum value as well. Wages for this purpose would be the total amount of wages, which is the amount required to be reported in Box 1 of Form W-2. Box 1 excludes the employee's pre-tax salary reduction contributions to a retirement savings plan (such as a 401(k) or 403(b) plan) or cafeteria plan.

Application of this safe harbor is determined after the end of the calendar year and on an employee-by-employee basis, taking into account the employee's Form W-2 wages from the employer and the employee contribution. So, for example, the employer determines whether it met the Form W-2 safe harbor for 2014 for an employee by looking at that employee's 2014 Form W-2 wages (generally furnished to the employee in January 2015) and comparing 9.5% of that amount to the employee's 2014 employee contribution. The safe harbor may also be used prospectively. At the beginning of the year, an employer could set the employee contribution at a level so that the employee contribution for each employee would not exceed 9.5% of that employee's Form W-2 wages for that year (for example, by automatically deducting 9.5%, or a lower percentage, from an employee's Form W-2 wages for each pay period).

Employees Who Are Employed Less Than a Full Year (New Hires, Terminations)/Employees Not Offered Coverage for the Entire Calendar Year

For an employee who was not a full-time employee for the entire calendar year, an employer would apply the Form W-2 safe harbor by adjusting the employee's Form W-2 wages to reflect the period when the

employee was offered coverage, and then comparing those adjusted wages to the employee share of the premium during that period.

> **Example:** Employee worked 8 months of a calendar year. Employer offered coverage to employee for 5 of these 8 months. Employee's Form W-2 reflects $24,000 in wages. Adjusted wages are $24,000 multiplied by 5/8 (months coverage was offered/months employee was employed) = $15,000. Affordability determination for 5 months of coverage uses $15,000 in adjusted Form W-2 wages.

Rate of Pay Safe Harbor

This is a design-based safe harbor, where an employer takes the hourly rate of pay for each hourly employee who is eligible to participate in the health plan as of the beginning of the plan year and multiplies that rate by 130 hours per month. The employer then determines affordability based on this resulting monthly wage amount. The employee's monthly contribution amount (for the self-only premium of the employer's lowest cost coverage that provides minimum value) is affordable if it is equal to or lower than 9.5% of the computed monthly wages (the employee's applicable hourly rate of pay x 130 hours). For salaried employees, an employer would use monthly salary instead of hourly salary multiplied by 130.

An employer may use this safe harbor only if, with respect to the employees for whom the employer applies the safe harbor, the employer did not reduce the hourly wages (hourly employees) or the monthly wages (salaried employees) during the year.

Federal Poverty Line (FPL) Safe Harbor

This is a design-based safe harbor, where employer-provided coverage offered to an employee is affordable if the employee's cost for self-only coverage under the plan does not exceed 9.5% of the FPL for a single individual. For households with families, the amount that is considered to be below the poverty line is higher, so using the amount for a single individual ensures that the employee contribution for affordable coverage is minimized. Employers may use the most recently published poverty guidelines as of the first day of the plan year of the applicable large employer member's health plan.

Determining Who Is a Full-Time Employee

Determining whether an employee is a full-time employee is a key factor in determining liability under the employer shared responsibility provisions. The Affordable Care Act defines a full-time employee as an employee who was employed on average at least 30 hours of service per week, with respect to any month. The IRS, in 2011 and 2012, published several Notices[4] (Notice 2011-36, Notice 2012-17, and Notice 2012-58) that outlined potential approaches for determining who is a full-time employee. The proposed rules generally adopt the approaches outlined in Notice 2011-36 and Notice 2012-58 but with modifications based on comments received.

[4] For more information, see the Aon Hewitt bulletins written on these Notices. Links appear at the end of the document.

Hours of Service

Hours of service are used in determining whether an employee is a full-time employee for purposes of the employer shared responsibility provisions. Under the proposed rules, an employee's hours of service include:

- Each hour for which an employee is paid, or entitled to payment, for the performance of duties for the employer; and
- Each hour for which an employee is paid, or entitled to payment, by the employer on account of a period of time during which no duties are performed due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty, or leave of absence.

The proposed rules consider 130 hours of service in a calendar month as the monthly equivalent of 30 hours of service per week.

If an employee is paid on an hourly basis, the employer must calculate actual hours of service from records of hours worked and hours for which payment is made or due. In contrast, for employees who are not paid on an hourly basis, the proposed rules allow employers to calculate the number of hours of service using one of three methods:

- Counting actual hours of service, similar to hourly workers;
- Using a days-worked equivalency method that would credit an employee with eight hours of service for each day the employee would be required to be credited with at least one hour of service; or
- Using a weeks-worked equivalency of 40 hours of service per week for each week the employee would be required to be credited with at least one hour of service.

The proposed regulations allow an employer to apply different methods for different classifications of non-hourly employees, as long as the classifications are reasonable and consistently applied, and also allow an employer to change the method of calculation for each calendar year. However, the proposed regulations would prohibit use of the days-worked or weeks-worked equivalency method if the result would be to substantially understate an employee's hours of service in a manner that would cause that employee not to be treated as a full-time employee.

Educational Organizations

In response to comments from teachers and other employees of educational organizations, the IRS weighed in on the unique circumstances presented by educational organizations as they typically function on the basis of an academic year, which includes extended periods where such organizations have limited classroom activity or are not in session, and because they often employ adjunct faculty.

For traditional breaks in an academic or school year (winter or spring breaks) that are paid leave periods, an employer must credit employees with hours of service pursuant to the hours of service rules described earlier. Also, as described in further detail below, the proposed rules address these issues by providing an averaging method for employment break periods that generally would result in an employee who works full-time during the active portions of the academic year being treated as a full-time employee. With respect to adjunct faculty members and determining hours of service for such individuals, the preamble invites further comment. Until further guidance is issued, employers must use a reasonable method of crediting hours of service. On this note, the preamble sets out that it is not a reasonable method of

crediting hours to only count an adjunct faculty member's classroom or other instruction time, and not count those hours such as class preparation time that are necessary to perform the employee's duties.

Look-Back Measurement Method

The proposed rules generally incorporate the optional look-back measurement method for determining full-time employees presented in Notice 2012-58, with modification, as described below.

Ongoing Employees

The proposed rules define an ongoing employee as one who has been employed by an employer for at least one standard measurement period. An employer is permitted to determine the full-time status of an ongoing employee by using a measurement period (of at least three but not more than 12 consecutive months) to determine if an employee averaged at least 30 hours of service per week, and if so, to provide coverage during a subsequent stability period as long as the employee remains employed. The stability period must be at least six consecutive calendar months but no shorter in duration than the standard measurement period. The proposed rules also retain the ability of an employer to use an administrative period of up to 90 days between the measurement and stability periods.

Payroll Periods

The proposed rules would allow an employer to begin and end a measurement period with the beginning and ending of regular payroll periods if each of the payroll periods is one week, two weeks, or semimonthly in duration. For example, the proposed rules provide that, an employer using the calendar year as a measurement period could exclude the entire payroll period that included January 1 (the beginning of the year) if it included the entire payroll period that included December 31 (the end of that same year), or, alternatively, could exclude the entire payroll period that included December 31 of a calendar year if it included the entire payroll period that included January 1 of that calendar year.

New Full-Time Employees

If an employee is reasonably expected to be a full-time employee upon hire, then the employer must offer group health plan coverage before the expiration of the employee's initial three full calendar months of employment or the employer could be at risk for an assessable payment.

New Variable Hour and Seasonal Employees

A large employer is permitted to apply an initial measurement period to an employee who is determined to be a variable hour or seasonal employee upon hire. The employer will not be at risk for an assessable payment for failure to offer a new variable hour or seasonal employee group health plan coverage upon hire during an initial measurement period. Of course, if such individual is determined to be a full-time employee during the initial measurement period, then the employer must offer MEC during the subsequent stability period or will be at risk for an assessable payment.

A new employee is considered variable hour or seasonal if, based on the facts and circumstances at the start date, it cannot be determined that the employee is reasonably expected to be employed on average at least 30 hours of service per week. Further, a new employee who is expected to be employed initially at least 30 hours of service per week may be treated as a variable hour employee if, based on the facts and circumstances at the start date, the period of employment at more than 30 hours of service per week is reasonably expected to be of limited duration and it cannot be determined that the employee is

reasonably expected to be employed on average at least 30 hours of service per week over the initial measurement period.

The proposed regulations reserve the definition of seasonal employee, and following Notice 2012-58, provide that employers are permitted, through 2014, to use a reasonable, good faith interpretation of the term seasonal employee for purposes of determining employer liability. However, it will not be a reasonable good faith interpretation to treat an employee of an educational organization, who works during the active portions of the academic year, as a seasonal employee.

The IRS reiterated that an employer may use both an initial measurement period of between three and 12 months (the same as allowed for ongoing employees) and an administrative period of up to 90 days. As long as the employer offers MEC and does not restrict enrollment beyond 13 months and a fraction of a month (i.e., the initial measurement period plus the administrative period may not extend beyond the last day of the first calendar month beginning on or after the one-year anniversary of the employee's start date), it will be in compliance.

> **Example:** Employer B hires Employee Y on May 10, 2015. Employee Y's initial measurement period runs from May 10, 2015 through May 9, 2016. Employee Y has an average of 30 hours of service per week during this initial measurement period. Employer B offers coverage to Employee Y for a stability period that runs from July 1, 2016 through June 30, 2017. Employer B satisfies this rule.

It is important to note that if the new variable hour or new seasonal employee is not a full-time employee during this initial measurement period, the stability period cannot be more than one month longer than the initial measurement period and must not exceed the remainder of the ***standard*** (emphasis added) measurement period (plus any administrative period) in which the initial measurement period ends. The proposed regulations outline examples on this complex topic.

Change in Employment Status

The proposed regulations address the treatment of new variable or seasonal employees who have a change in employment status during the initial measurement period (for example, in the case of a new variable hour employee who is promoted during the initial measurement period to a position in which employees are reasonably expected to be employed on average 30 hours of service per week). A change in employment status is defined as a material change in the position of employment or other employment status that, had the employee begun employment in the new position or status, would have resulted in the employee being reasonably expected to be employed on average at least 30 hours of service per week.

If such a change in employment status occurs during the initial measurement period, the proposed rules would require the employee to be treated as a full-time employee as of the first day of the fourth month following the change in employment status or, if earlier and the employee averages more than 30 hours of service per week during the initial measurement period, the first day of the first month following the end of the initial measurement period (including any optional administrative period applicable to the initial measurement period). The change in employment status rule only applies to new variable hour and seasonal employees. An ongoing employee's change in employment status does not change the employee's status as a full-time employee or non-full-time employee during the stability period.

Employees Rehired After Termination of Employment or Resuming Service After Other Absence

Large employers have two options for determining how to classify an employee who terminates (or has a period of absence) and subsequently incurs an hour or more of service. If an employee goes at least 26 consecutive weeks without an hour of service and then has an hour of service, he or she may be treated as a new employee for purposes of determining whether or not the employee is a full-time employee. The employer may also choose to apply a rule of parity for periods of less than 26 weeks where an employee may be treated as having terminated employment and having been rehired as a new employee if the period with no credited hours of service (of less than 26 weeks) is at least four weeks long and is longer than the employee's period of employment immediately preceding that period with no credited hours of service.

> **Rule of Parity Example:** Employee works three weeks for an applicable large employer, terminates employment, and is rehired by that employer 10 weeks after terminating employment. The rehired employee is treated as a new employee because the 10-week period with no credited hours of service is longer than the immediately preceding three-week period of employment.

This rule applies solely for purposes of determining the full-time employee status for employers using the look-back measurement method and not for any other purpose (including application of the 90-day waiting period limit).

For an employee who is treated as a continuing employee (as opposed to an employee who is treated as terminated and rehired), the measurement and stability period that would have applied to the employee had the employee not experienced the period of no credited hours of service would continue to apply upon the employee's resumption of service. For example, if the continuing employee returns during a stability period in which the employee is treated as a full-time employee, the employee is treated as a full-time employee upon return and through the end of that stability period. For this purpose, the proposed rules provide that a continuing employee treated as a full-time employee will be treated as offered coverage upon resumption of services if the employee is offered coverage as of the first day that employee is credited with an hour of service, or, if later, as soon as administratively practicable.

Special Unpaid Leave

The proposed rules include a method for averaging hours for continuing employees upon the resumption of services when applying the look-back measurement method to measurement periods that include special unpaid leave. Special unpaid leave refers to periods of unpaid leave under the Family and Medical Leave Act (FMLA), the Uniformed Services Employment and Reemployment Rights Act (USERRA), and jury duty. Under this proposed averaging method, the employer either:

- **Option 1:** Determines the average hours of service per week for the employee during the measurement period ***excluding*** the special unpaid leave period and uses that average as the average for the entire measurement period; or
- **Option 2:** Treats employees as credited with hours of service for special unpaid leave at a rate equal to the average weekly rate at which the employee was credited with hours of service during the weeks in the measurement period that are not special unpaid leave.

Break Periods for Employees of Educational Organizations

The proposed rules include additional requirements for employment break periods for employees of an educational organization. The proposed rules define an "employment break period" as a period of at least four consecutive weeks (disregarding special unpaid leave) during which an employee is not credited with an hour of service. Under the proposed rules, an educational organization must apply one of the methods described above ("Special Unpaid Leave") to employment break periods related to or arising out of non-working weeks or months under the academic calendar. However, an educational organization is not required to exclude (option 1 above) or credit (option 2 above) an employee in any calendar year with more than 501 hours of service for any employment break period (although the 501-hour limit does not apply to, or take into account, hours of service required to be credited for special unpaid leave). Note, the employment break period rules described in this paragraph do not apply to employees who are treated as terminated and rehired.

The Treasury and IRS are considering whether to extend the employment break period rules to all employers and requested comments on the issue. Any such extension would not take effect before 2015.

New Short-Term Employees

The preamble notes that there is no employer liability for new employees hired to work for three months or less even if they are hired to work more than 30 hours of service per week. However, the preamble requests comments on whether any special rules should apply where employment is expected to last no more than four or five months.

Temporary Staffing Agencies

Recognizing the particular challenges a temporary staffing agency may face in applying the employer shared responsibility provisions and look-back measurement method (e.g., because of uncertainty as to the likelihood and duration of assignments of its common law employees), the Treasury and IRS have requested comments specific to these entities.

The Treasury and IRS anticipate that the final rules will include an anti-abuse rule to address situations where the employer would purport to employ its employees for only part of a week, such as 20 hours, and then hire those same individuals through a temporary staffing agency or other staffing agency for the remaining hours of the week. In this case, under the anticipated rule, if an individual performs services as an employee of an employer, and also performs the same or similar services for that employer through a temporary staffing agency or other staffing agency, then all hours of service are attributed to the employer for purposes of the employer shared responsibility provisions.

Certification of Subsidy Payment

An applicable large employer member is subject to an assessable payment if at least one full-time employee of that member has been certified to the member as having enrolled in a qualified health plan with respect to which a premium tax credit is allowed or paid. Proposed guidance is expected from HHS that will establish a process under which employees who have enrolled for a month in a qualified health plan and for whom an applicable premium tax credit or cost-sharing reduction is allowed or paid will be certified to the employer. This certification will consist of methods adopted by the IRS to provide this information to an employer as part of its determination of liability.

Transition Rules

The proposed rules provide some transition rules to help employers comply with the new requirements.

Non-Calendar Year Plans

The proposed regulations provide for some transition relief for employers sponsoring plans with plan years ***other than the calendar year*** (referred to in the regulations as "fiscal year" plans). Specifically, for an employer that as of December 27, 2012, already offers health coverage through a plan that operates on a fiscal year (a fiscal year plan), transition relief is available. First, for any employees who are eligible to participate in the plan under its terms as of December 27, 2012 (whether or not they take the coverage), the employer will not be subject to a potential payment until the first day of the fiscal plan year starting in 2014.

Second, if the employer offers coverage to 1) at least one-third of its employees (full-time and part-time) at the most recent annual enrollment or 2) the plan covers at least one-quarter of the employer's employees, then the employer also will not be subject to the employer shared responsibility payment with respect to any of its full-time employees until the first day of the fiscal plan year starting in 2014, provided that those full-time employees are offered affordable coverage that provides minimum value no later than that first day. Questions and answers issued by the IRS on December 28, 2012 address this matter and provide an example.

Employers that use this transition relief will still be subject to the reporting requirements under Code Section 6056 for the entire 2014 calendar year.

Salary Reduction Elections for Accident and Health Plans Provided Through Cafeteria Plans for Cafeteria Plan Years Beginning in 2013

If an employer offers group health plan coverage to employees through a Section 125 cafeteria plan (e.g., by allowing participants to pay for coverage on a before-tax basis), participants are subject to very specific midyear change rules. As a general matter, cafeteria plan elections must be made before the start of the plan year, and are irrevocable during the plan year. However, the cafeteria plan rules allow for very specific midyear changes in elections due to a particular circumstance, such as a change in status event—examples include birth, adoption, and marriage—as long as certain requirements are met.

Because employees of large employers may, as of January 1, 2014, wish to enroll in Exchange coverage and discontinue their employer coverage, or enroll in their employer's coverage for the first time to avoid the individual responsibility payment, the Treasury and IRS are providing transition relief from the cafeteria plan change in status rules with respect to the revocation, modification, or commencement of salary reductions for accident and health coverage offered through a cafeteria plan with a fiscal plan year (presumably, the IRS means a plan year that is not the calendar year) beginning in 2013. This change would not be permitted under the current cafeteria plan midyear change rules without this transition relief. Only specific changes will be permitted and an amendment to the plan is required.

Measurement Periods for Stability Periods Starting in 2014

Solely for purposes of stability periods beginning in 2014, employers may adopt a transition measurement period that is shorter than 12 months but is at least six months and that begins no later than July 1, 2013 and ends no earlier than 90 days before the first day of the plan year beginning on or after January 1, 2014 (90 days being the maximum permissible administrative period).

> **Examples:** An employer with a calendar year plan could use a measurement period from April 15, 2013 through October 14, 2013 (six months), followed by an administrative period ending on December 31, 2013.
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> An employer with a plan with a fiscal plan year beginning April 1 that also elected to implement a 90-day administrative period could use a measurement period from July 1, 2013 through December 31, 2013 (six months), followed by an administrative period ending on March 31, 2014.

However, an employer with a fiscal plan year beginning on July 1, 2014 must use a measurement period that is longer than six months in order to comply with the requirement that the measurement period begin no later than July 1, 2013 and end no earlier than 90 days before the stability period. For example, the employer could have a 10-month measurement period from June 15, 2013 through April 14, 2014, followed by an administrative period from April 15, 2014 through June 30, 2014.

Expanding Coverage to Dependents

Recognizing that some employers currently offer coverage only to their employees and not to dependents, a transition rule is provided so that any employer that takes steps during its plan year that begins in 2014 toward satisfying the requirement to offer coverage to full-time employees' dependents will not be liable for any assessable payment solely on account of a failure to offer coverage to the dependents for that plan year.

Multiemployer Plans

The IRS requested additional comments on how the employer shared responsibility provisions should apply to employers that participate in multiemployer plans. However, the IRS did provide a transition rule through 2014 for contributions made by employers that participate in a multiemployer plan, in order to help these employers comply with the employer shared responsibility provisions. Specifically, an applicable large employer will not be treated as failing to offer MEC to a full-time employee (and their dependents) under the "Failure to Offer" Penalty and will not be subject to the Targeted Penalty for a full-time employee if:

- The employer is required to contribute to a multiemployer plan for a full-time employee under a collective bargaining agreement or an appropriate related participation agreement;
- The multiemployer plan offers coverage to the full-time employee (and his or her dependents); and

- The coverage offered to the full-time employee is affordable and provides minimum value. Regarding affordability, employers participating in a multiemployer plan may use any of the affordability safe harbors described in this bulletin. Coverage under a multiemployer plan will also be considered affordable for a full-time employee if the full-time employee's required contribution toward employee-only coverage does not exceed 9.5% of the wages reported to the qualified multiemployer plan; wages may be determined based on an hourly wage rate under the applicable collective bargaining agreement or on actual wages.

The preamble notes that any waiting period for coverage under the plan must separately comply with the 90-day waiting period limitation, and such limitation will be addressed in further guidance.

Effective Date and Next Steps

Employers may rely on these proposed regulations pending the issuance of final regulations or other guidance. Final regulations will not become effective until at least the date the final regulations are published in the *Federal Register*.

Written comments on these proposed rules must be submitted by March 18, 2013. In addition, interested parties may request to testify at a public hearing on this issue, scheduled for April 23, 2013.

Resources

The IRS proposed regulations are available at: http://www.gpo.gov/fdsys/pkg/FR-2013-01-02/pdf/2012-31269.pdf

The IRS "Questions and Answers on Employer Shared Responsibility Provisions Under the Affordable Care Act" are available at: http://www.irs.gov/uac/Newsroom/Questions-and-Answers-on-Employer-Shared-Responsibility-Provisions-Under-the-Affordable-Care-Act

The Aon Hewitt bulletin on IRS Notice 2012-58, "Agencies Provide Guidance on Determining Full-Time Employees and 90-Day Waiting Period," is available at: http://www.aon.com/human-capital-consulting/thought-leadership/leg_updates/healthcare/reports-pubs_Agencies_Provide_Guidance-on-Determining_FT-Employees_90-Day_Waiting_Period.jsp

The Aon Hewitt bulletin on IRS Notice 2012-17, "Agencies Answer Employer Questions on Automatic Enrollment, Employer Shared Responsibility, and Waiting Periods," is available at: http://www.aon.com/human-capital-consulting/thought-leadership/leg_updates/healthcare/reports-pubs_automatic-enrollment-022012.jsp

The Aon Hewitt bulletin on IRS Notice 2011-36, "IRS Requests Comments on Employer Shared Responsibility Provision of the Affordable Care Act," is available at: http://img.en25.com/Web/AonHewitt/IRS%20Requests%20Comments%20on%20Employer%20Shared%20Responsibility.pdf

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How "Minimum" Is Your Health Insurance Coverage? IRS Proposes Regulations on Offering and Maintaining Minimum Essential Coverage Starting in 2014

February 2013

Proposed regulations issued by the Treasury and Internal Revenue Service (IRS) on February 1, 2013, provide guidance to individuals and employers on what constitutes "minimum essential coverage" (MEC)—the health insurance that employers must offer to employees and the health insurance that most individuals must carry, starting in 2014, to avoid tax penalties under the Patient Protection and Affordable Care Act (Affordable Care Act).

This Aon Hewitt bulletin discusses:

- The definition of MEC, including what types of employer-sponsored group health coverage meet the definition; and
- Individuals who must maintain MEC or pay a shared responsibility payment.

What Is MEC?

MEC includes medical coverage under any of the following:

- A government-sponsored program (including Medicare, Medicaid, CHIP, and TRICARE);
- An eligible employer-sponsored plan;
- A plan in the individual market offered to individuals not in connection with a group health plan, including a qualified health plan offered through an Exchange (also referred to as a marketplace);
- A grandfathered health plan; or
- Other health benefits coverage as recognized by the Department of Health and Human Services (HHS).

Under the proposed regulations, most employer-sponsored group health plans will be considered MEC. This broad definition will help employers satisfy their obligation to offer health care coverage to their full-time employees and dependents, thus avoiding the penalty for failure to offer health insurance under Internal Revenue Code Section 4980H(a). It also will help employees and retirees avoid the shared responsibility payment for not carrying health insurance.

Note: Employers that offer plans that qualify as MEC will still need to design those plans to be affordable and of minimum actuarial value in order to avoid the employer shared responsibility payment under Code Section 4980H(b) for failure to offer affordable MEC of minimum value.

An "eligible employer-sponsored plan" that meets MEC is a group health plan that provides medical care to employees (or former employees) and their dependents, including:

- Governmental plans;
- Grandfathered health plans;
- Insured plans;
- Self-insured plans;
- Retiree health insurance coverage; and
- Continuation coverage under COBRA, but only to the extent that the individual actually enrolls in COBRA coverage.

MEC does **not** include health coverage that consists of "excepted benefits," such as:

- Accidental death and dismemberment coverage, disability insurance, workers' compensation, and coverage for employer-provided on-site medical clinics;
- Limited-scope dental or vision benefits, long-term care, and benefits provided under many health flexibility spending accounts (FSAs);
- Coverage offered for a specified disease or illness (and under a separate policy or contract of insurance) or fixed dollar indemnity insurance; and
- Certain fully insured supplemental policies (also known as Medigap or MedSupp).

Who Must Maintain MEC?

Beginning in 2014, most individuals must either maintain MEC, qualify for an exemption, or pay a penalty (shared responsibility payment).[1] The requirement applies to individuals of all ages, including children. The shared responsibility payment must be paid by the parent(s) who is eligible to claim the child for federal income tax purposes if the child does not have MEC or does not qualify for an exemption.

Who Is Exempt From the Shared Responsibility Payment?

Exempt individuals include members of recognized religious sects or divisions; members of a health care sharing ministry; an individual who is not a citizen or national of the U.S. if he or she is not lawfully present in the U.S. or nonresident aliens; incarcerated individuals; members of an Indian tribe; individuals who qualify for a hardship exemption; and individuals with household income below the applicable return filing threshold.

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[1] The monthly penalty amount is equal to 1/12 of the greater of: 1) a flat dollar amount; or 2) a percentage of income, up to a maximum amount equal to the national average of the annual cost of a bronze level health insurance plan, for the applicable family size, offered through an Exchange. The annual dollar amount is set at $95 for 2014, $325 for 2015, and $695 in 2016, increased by a COLA after 2016 per individual who does not maintain MEC. The amount is half for individuals who have not attained age 18. The flat dollar amount is capped at three times the annual flat dollar amount per year. The percentage of income is calculated as the excess of the individual taxpayer's household income over the taxpayer's federal income tax return filing threshold, multiplied by a percentage as follows: 1% in 2014, 2% in 2015, and 2.5% after 2015. More details on computing the shared responsibility payment are addressed in the proposed regulations.

An individual is also exempt from the shared responsibility payment if the individual does not have access to "affordable" MEC. For this exemption, affordability is determined on the basis of the required contribution for self-only coverage (for an individual) and the required contribution for family coverage (for dependents).

Note: The affordability test for an individual exemption from the shared responsibility payment considers the cost of individual and family coverage. In contrast, the affordability test for determining whether the employer has offered affordable MEC, thus avoiding any Affordable Care Act penalties, considers only the cost of individual coverage.

Affordability for Individuals

For individuals, coverage is not "affordable" if an individual's required annual premium for self-only coverage under the lowest cost plan exceeds 8% of the taxpayer's household income for the taxable year. (For this purpose, household income is increased by the portion of the required contribution made through a salary reduction arrangement and excluded from gross income.)

If two or more members of a family are employed and their respective employers offer self-only and family coverage, each employed individual determines the affordability of coverage using the premium for self-only coverage offered by that individual's employer.

> **Example:** Taxpayer A is an unmarried individual with no dependents. In November 2015, A is eligible to enroll in self-only coverage offered by A's employer for calendar year 2016. If A enrolls in the coverage, A is required to pay $5,000 of the total annual premium. In 2016, A's household income is $60,000. Taxpayer A lacks affordable coverage for 2016 because A's required contribution ($5,000) is greater than 8% of A's household income ($4,800) and A is therefore exempt from the individual shared responsibility payment.

Affordability for Individuals Related to Employees (or Former Employees, Such as Retirees)

If an individual is eligible for an employer-sponsored plan because of a relationship to an employee (or former employee) and a personal exemption is claimed for the individual on the employee's (or former employee's) federal income tax return, the required contribution is the portion of the annual premium the employee would pay (whether through salary reduction or otherwise) for the lowest cost *family* coverage that would cover the employee and all related individuals included in the family. For this rule to apply to former employees who are eligible to elect COBRA, the former employee must actually *enroll* in COBRA.

> **Example:** Taxpayers B and C are married and file a joint return for 2016. B and C have two children, D and E. In November 2015, B is eligible to enroll in self-only coverage under a plan offered by B's employer for calendar year 2016 at a cost of $5,000. C, D, and E are eligible to enroll in family coverage under the same plan for 2016 at a cost of $20,000. B, C, D, and E's household income is $90,000. B has affordable coverage for 2016 because B's required contribution ($5,000) does not exceed 8% of B's household income ($7,200). C, D, and E lack affordable coverage for 2016 because their required contribution for family coverage ($20,000) exceeds 8% of their household income ($7,200).

Affordability for Individuals in Plans With Fiscal Years

In the case of a plan with a fiscal year plan year, affordability is determined separately for each employment period that is less than a full calendar year or for the portions of an employer's plan year that fall in different taxable years of the individual. The annualized required contribution is the required contribution for the part year period multiplied by the number of months in the part year period during the individual's taxable year.

> **Example:** Taxpayer F is an unmarried individual with no dependents. In June 2015, F is eligible to enroll in self-only coverage under a plan offered by F's employer for the period July 2015 through June 2016 at a cost of $4,750. In June 2016, F is eligible to enroll in self-only coverage under a plan offered by F's employer for the period July 2016 through June 2017 at a cost of $5,000. In 2016, F's household income is $60,000. F's annualized required contribution for the period January 2016 through June 2016 is $4,750 ($2,375 paid for premiums in 2016 x 12/6). F has affordable coverage for January 2016 through June 2016 because F's annualized required contribution ($4,750) does not exceed 8% of F's household income ($4,800). F's annualized required contribution for the period July 2016 to December 2016 is $5,000 ($2,500 paid for premiums in 2016 x 12/6). F lacks affordable coverage for July 2016 through December 2016 because F's annualized required contribution ($5,000) exceeds 8% of F's household income ($4,800).

Next Steps

Comments on the proposed regulations are due by May 2, 2013, and a public hearing is scheduled for May 29, 2013.

Resources

The regulations are available at: http://www.gpo.gov/fdsys/pkg/FR-2013-02-01/pdf/2013-02141.pdf

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HHS Proposes $63 Transitional Reinsurance Fee for Group Health Plans in 2014

December 2012

The Department of Health and Human Services (HHS) issued a proposed rule on November 30, 2012 that will impose a transitional reinsurance fee on fully insured and self-insured group health plans to help stabilize premiums in the individual insurance market. The fee, which is proposed to be $63.00 per capita initially, will fund a reinsurance program to be established in each state by January 1, 2014. The program will operate from 2014 through 2016. The transitional reinsurance fee was implemented as part of the Patient Protection and Affordable Care Act (Affordable Care Act).

Proposed 2014 Contribution Amount

The total annual fee or "contribution rate" for 2014 is proposed to be $63.00 "per capita" for all fully insured and self-insured group health plans providing major medical coverage. As described more fully below, this means that the fee will be applied to all enrollees in the plan, including employees, pre-65 retirees, spouses, and dependents. The estimated per capita contribution rate in 2014 on a monthly basis would be $5.25 per month. For each year, a plan's fee would be calculated by multiplying the average number of covered lives in the plan by the contribution rate for the applicable year.

States that opt to establish their own reinsurance program may impose additional contribution rates on fully insured plans, but not self-insured group health plans covered by the Employee Retirement Income Security Act (ERISA). Therefore, for fully insured group health plans, it is possible that the insurer will be liable for fees in excess of $63.00 per capita. A state must notify HHS within 30 days after the HHS issues its draft notice of benefit and payment parameters whether the state intends to collect additional amounts.

Contribution Responsibility and Collection Methodology

The Affordable Care Act requires health insurance issuers and third-party administrators on behalf of self-insured group health plans to make reinsurance payments from 2014 to 2016. According to the preamble, the self-insured group health plan is ultimately liable for the reinsurance fee, although it may use a third-party administrator or administrative services only contractor to make the payments on behalf of the self-insured plan. A self-insured, self-administered group health plan would make the reinsurance contributions directly to HHS.

HHS proposes that these contributing entities would submit to HHS no later than November 15, an annual enrollment count of the average number of covered lives for each benefit year.[1] Within 15 days of the submission of the annual enrollment count or by December 15, whichever is later, HHS would notify each contributing entity of the reinsurance contribution amounts to be paid. The amounts would then be due

[1] The preamble notes that the reinsurance program operates on a benefit year basis, which is defined as the calendar year, and the applicable counting methods all apply on that basis, regardless of the plan year applicable to particular plans.

within 30 days after that notification. HHS proposes to collect all reinsurance contribution amounts on an annual basis, even if a state establishes its own reinsurance program.

Plans Subject to Transitional Reinsurance Fee

HHS proposes that only plans providing "major medical coverage" will be liable for payment of the transitional reinsurance fee. HHS proposes to define "major medical coverage" as health coverage, which may be subject to reasonable enrollee cost sharing, for a broad range of services and treatments including diagnostic and preventive services, as well as medical and surgical conditions provided in various settings, including inpatient, outpatient, and emergency room settings.

The proposed rule would explicitly exclude the following types of plans from liability for the transitional reinsurance fee:

- HIPAA-excepted benefits, such as stand-alone dental and vision plans and on-site medical clinics;
- Health savings accounts (HSAs);
- Health reimbursement arrangements (HRAs) that are integrated with a group health plan;
- Health flexible spending arrangements (FSAs);
- Employee assistance plans that do not provide major medical coverage;
- Disease management programs and wellness programs, to the extent they do not provide major medical coverage;
- Stop-loss and indemnity reinsurance policies; and
- Plans or coverage provided by an Indian Tribe to Tribal members and their spouses and dependents (and other persons of Indian descent closely affiliated with the Tribe).

Medicare Secondary Payer (MSP) Rules Apply

Under the proposed rule, plans are not liable for payment of the fee with respect to post-65 retirees and their dependents. Plans are liable for payment of the fee with respect to an individual over age 65 if the group health care plan is the primary payer of medical expenses under the MSP rules. Thus, a working 68-year-old employee enrolled in a group health plan where Medicare is the secondary payer would be counted for purposes of reinsurance contributions, while a 68-year-old retiree enrolled in a group health plan where Medicare is the primary payer would not be counted for purposes of reinsurance contributions. The preamble also states that HHS intends that individuals entitled to Medicare because of disability or end-stage renal disease but that have other primary coverage under the MSP rules be treated consistently with the working aged and therefore would be counted.

Determining Number of Covered Lives

The proposed rule provides several methods that health insurance issuers and self-insured group health plans can use to determine the average number of covered lives in a plan. The proposed methods adopt and build on the methods permitted for purposes of determining the fee to fund the Patient-Centered Outcomes Research Institute (PCORI) Trust Fund (PCORTF). If two or more plans collectively provide major medical coverage for the same covered lives, the plans are treated as a single, self-insured group

health plan. According to the preamble, this approach would avoid the double counting of a covered life for major medical coverage offered across multiple plans and would prohibit plan sponsors from attempting to avoid reinsurance contributions by splitting coverage into separate arrangements and claiming that it does not offer major medical coverage.

Counting Methods for Fully Insured Group Health Plans

The proposed rule provides that fully insured group health plans may use the following methods to determine the number of covered lives:

- **Actual Count**—An insurer adds the total number of lives covered in the first nine months of the benefit year and divides by the number of days in the first nine months;
- **Snapshot Count**—An insurer adds the total number of lives covered on any date during the same corresponding month in each of the first three quarters of the benefit year and divides that total by the number of dates on which a count was made; or
- **Member Months or State Form Method**—An insurer multiplies the average number of policies in effect for the first nine months of the benefit year by the ratio of covered lives per policy in effect.

Counting Methods for Self-Insured Group Health Plans

For self-insured group health plans, the proposed rule provides that plans may use the following methods to determine the number of covered lives:

- **Actual Count or Snapshot Count**—Described above;
- **Snapshot Factor**—A plan adds the total number of lives covered on any date during the same corresponding month in each of the first three quarters of the benefit year and divides that total by the number of dates on which a count was made, except that the number of lives covered on a date is calculated by adding the number of participants with self-only coverage to the product of the number of participants with coverage other than self-only coverage and a factor of 2.35; or
- **Form 5500 Method**—A plan uses the number of lives covered for the benefit year calculated based on the Form 5500 for the last applicable time period. The number of covered lives for a plan offering only self-only coverage equals the sum of the total participants covered at the beginning and end of the benefit year as reported on the Form 5500 divided by two. The number of covered lives for a plan offering self-only coverage and coverage other than self-only equals the sum of the total participants covered at the beginning and end of the benefit year as reported on the Form 5500.

Counting Methods for Plans With Self-Insured and Fully Insured Options

If an employer maintains a group health plan that offers both self-insured and fully insured options, the proposed rule would require the plan to use either the actual count or snapshot count method.

Consistency With PCORTF Rule Not Required

Although HHS proposes counting methods similar to the methods used to calculate the PCORI fee, the proposed rule would allow a contributing plan to use a different counting method for purposes of the reinsurance contributions and the PCORI fee. In addition, the preamble to the proposed rule recognizes

that because the time periods and counting methods may differ, the estimates of covered lives may be different.

Tax Deductibility

In a set of frequently asked questions (FAQs) issued on November 30, 2012, the Internal Revenue Service (IRS) stated that reinsurance contributions are deductible by insurers as ordinary and necessary business expenses paid or incurred in carrying on a trade or business. Plan sponsors of self-insured plans may also treat the contributions as ordinary and necessary business expenses, subject to any applicable disallowances or limitations under the Internal Revenue Code. If the self-insured plan is a multiemployer plan or a plan funded through a voluntary employees' beneficiary association (VEBA), the employer or employers contributing to the plan may deduct their contributions to the plan, subject to any applicable disallowances or limitations under the Internal Revenue Code.

Next Steps

In the preamble, HHS has requested comments about, among other issues, whether it has the authority under the Affordable Care Act to defer $2 billion of the reinsurance payments that are to be paid to the U.S. Treasury to partially offset the cost of the Early Retirement Reinsurance Program (ERRP) until 2016. If deferred, this would reduce the 2014 national contribution rate per capita. Comments on the proposed rule must be submitted to HHS by December 31, 2012.

More Information

The proposed rule is available at: http://www.gpo.gov/fdsys/pkg/FR-2012-12-07/pdf/2012-29184.pdf

The IRS FAQs are available at: http://www.irs.gov/uac/Newsroom/ACA-Section-1341-Transitional-Reinsurance-Program-FAQs

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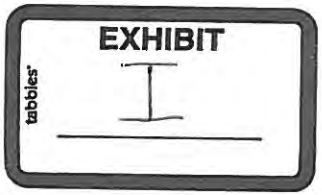

CMHC TRANSITION QUESTIONS/DECISION POINTS
(Revised: 4/2/13)

ADDITIONAL QUESTIONS SUBMITTED POST 3/14/13 MEETING

	Request/Decision Point	Resolution	Requesting Agency
A1	Do you know when we will get the Med Mgt APRN expenses? Are their revenue included in the Revenue sheets (didn't know for sure since the expenses were not listed). 68 hours a week total at $75 an hour totals $265,000 and the contract is only for $202,800—why the difference?	APRN staff are included under, Other Misc Contract, line item for the related expenses. Total contract is $202,800 for the two APRN staff. Contract is for 68 hours a week @ $75 an hour. Revenue is comprehensive of all sources. When budget was submitted we did not have two APRNs and rate was increased also they take time off.	Submitted by BVBH
A2	Can we can get a total number of the staff who are currently using the health and dental insurance (Employee only and number of those with family insurance). I also need to know the dollar amount that the county pays for the employee's share (100%) of both the health and dental.	Single—33 employees $565.56 mo/staff pay $0 2/4—14 employees $1,081.62 mo/staff pay $190.86 Family—9 employees $1,442.06 mo/staff pay $254.49 None—10 employees identified as FT but classified as temporary so no benefits	Submitted by BVBH
A3	What is the amount that the MHC commits to the staff retirement, how is that figured?	6% out of salary; matched 150%. Mandatory after 1 year of employment & 25 yrs of age. Opt in after 6 mo employment & 21 yrs of age.	Submitted by BVBH
A4	Is the rent for the Day Rehab building $3,000? It has "building" listed in the expense sheet but want to make sure that was the rent.	This line item is Building Repair & Maintenance.	Submitted by BVBH
A5	Is there a document for the 2012-2013 budget that includes all the expenses grouped together? There is one for revenue but I didn't see one for expenses (so it would total out all the expenses for Rent, Health Insurance, etc, rather than having to total each from all the different programs)	Posted to the website 3/19/13.	Submitted by BVBH
A6	On page 316 (Expenditures by Program) what program is that referencing? It has expenditures for	The $55,000 budgeted reflects labeled Client Assistance Funds is flexible funding received from	Submitted by BVBH

	$55,000.	Region V. Funds are pooled amongst providers and a specific dollar amount is not specified in the provider contract. Flexible funding reflected is inclusive of funds received for Community Support, Housing, Transition/Homeless.	
A7	Is there no Med Mgt services allocated to Day Tx?	None of the psychiatrist's position is allocated to this progam but a percentage of the psychiatrist's time is specific to that program.	Submitted by BVBH
A8	The MRO revenue is about $500,000 under budget for Community Support through December, which is pretty significant. How come?	CMHC did not submit claims to Medicaid in December. December claims were not submitted until January.	Submitted by BVBH
A9	There are 5 externs, what programs are they in and where are there expenses listed at (don't see them listed)?	Currently, 5 externs are contracted by CMHC each with an annual contract of $16,113. Costs are identified as Other Misc. Contracts in the "Expenditures by Program" as distributed across the Community Support, Psych Res Rehab, Day Rehab and Outpatient programs.	Submitted by BVBH
A10	Has Mike Foley done an audit on the CMHC in the past? If so, could this information be provided for our review?	No State audit in recent history.	Submitted by Premier
A11	Is it possible to get blueprints of the current S 17th CMHC building?	Pending request to the County.	Submitted by Premier
A12	Does CMHC have contracts or arrangements with a pharmacy to fill all prescriptions or a lab for lab work? If so, who are these arrangements with? Do we have permission to contact them?	Crisis Center only.	Submitted by Premier

CMHC TRANSITION QUESTIONS/DECISION POINTS
(Revised: 4/2/13)

A13	The Core Services with R5 funds totals **$1,065,034.** I was looking at what is contracted now with the CMH and this is what I total up. • Day Tx: $116,258 • Outpatient: $251,935 • Med Mgt: 161,258 • Comm. Support: $592, 317 • Total: **$1,121,768** -What is the **$56,000** difference? Can you give the individual breakdown for the 4 programs?	Available funds were based on a 3 year utilization pattern. Adjusted as follows from FY13 budget. Day Treatment ($22,817) OP $56,687 (due to cuts made to this program by CMHC in 2011; we elected to returned funds to original amount) MM ($12,473) CS ($78,131) The unavailable funds are being pooled within Region V to address any potential need for start-up costs (although not guaranteed). It also allows for some flexibility should providers submit innovative ideas above and beyond the scope of dollars currently available through the RFP.	Submitted by BVBH
A14	Where did the **$67,000** of Harvest NFFS funding go, is that available? I know we talked about the Harvest Program not being available, does that mean the funding is gone? If not used with the MHC, where does it go now?	The funding will continue but much like ACT because of the collaborative entities involved in that specific program that contract is being negotiated separately rather than through an RFP process.	Submitted by BVBH
A15	What about the **$18,160** with Medication Support, is that available?	Medication support dollars will still be available. Formula is based on overall funding to the agency.	Submitted by BVBH
A16	I have some budget questions; do I call Ron for those answers? For instance in the Personnel Summary Form, under Med Mgt, there are 2 RN II's listed. Are those APRNs? If they are APRNs where is the listing of just the RNs because I know there is at least one if not two	That represents the 2 RNs. The APRNs are contract staff; we are working with Ron to get the personnel summary of contracted staff. Contract staff is reflected in expenses under Other Misc Contracts.	Submitted by BVBH
A17	The Harvest Program, IDL (Independent Living),	The Harvest Program is Region V funded and as	Submitted by BVBH

	AWARE and the two homeless services are off the table, correct?	indicated will be negotiated with the other collaborative partners involved in that project. The Homeless services receive only the $32,500 from Region V through the PATH grant. Those funds will have to be RFP'ed separately. AWARE as an extension of Day Rehab does not receive specific Region V funding so is not part of the RFP likewise with IDL. That being said, opportunity exists for the prospective providers to start approaching the other funding sources to explore their interest in continuing those projects with the new provider.	
A18	How many hours a week of service do the APRNs provide under contract with CMHC?	2 APRNs 68 hours total a week @ $75 hr	Submitted by Region V
A19	What does the contract with Lancaster Med Society cover? Is that a staff person? Assume this is allocated to Med Services in Other Misc Contract?	The contract with the Medical Society was cancelled. We hired a staff person for same amount as contract to complete applications for free or reduced price medication from pharmaceutical companies.	Submitted by Region V
A20	WAR JAR & Psychologist-Alcohol Counselor—what business unit is this allocated to?	This is Crisis Center only.	Submitted by Region V
A21	CARF accreditation-is this expense allocated across business units? What is the line item?	This was for CMHC CARF accreditation for this year. $0 will be budgeted for next year.	Submitted by Region V
A22	Lincoln Area on Agency-Other than the $67,000 for ERCS what is included under this contract? What is the revenue source? The revenue for 7845 shows only the State 302 funds in amount of $67,692.	This is for 1 case manager for Harvest Project. Revenue is recorded in business unit 7847-Community Support. Revenue sources are Medicaid and Region V. $67,692 is Emergency Community Support.	Submitted by Region V
A23	Is there currently rent expense for Midtown Center?	No, CMHC does not currently pay rent on this facility.	Submitted by BVBH
A24	Under this RFP, would we be permitted to subcontract in order to fulfill certain service requirements?	Yes.	Submitted by LFS
A25	What is the service definition for the 24 hour crisis line?	Posted on the website: www.region5systems.net. Draft; not yet formally approved as part of Title 206.	Submitted by LFS
A26	Where is the 24 hour crisis line currently housed?	CMHC—2001 S. 17th St. location	Submitted by LFS

CMHC TRANSITION QUESTIONS/DECISION POINTS
(Revised: 4/2/13)

A27	Will Partial Hospitalization be a service that will stay with the County or will it also be transitioned to other providers?	The Day Treatment program (an NBHS/Region funded service) at CMHC also meets the definition of Partial Hospitalization for Medicaid. They refer to the program as Partial Hospitalization but it is billed to the Region as Day Treatment and Medicaid as Partial Hospitalization. It will be transitioned and is included in the RFP under the service category of Core Services as it is the expectation that Community Support, Outpatient, Day Treatment and Medication Management all be provided "under the same roof".	Submitted by LFS
A28	Are the phone systems at CMHC and Midtown stand alone systems or are they part of the County's telephone system? If they are stand alone systems, can you identify the manufacturer, model number, age of the system and number of handsets? If they are stand alone systems or not, can you tell us, by location, the number of incoming lines, the number of outgoing lines, do they utilize direct inward dial (DID) lines at either location?	Request submitted to Lancaster County; will be provided should it become available.	Submitted by LFS 4/1/13
A29	Are the existing computers and servers at CMHC to be made available to the new provider of services? If so, is there an inventory of such items?	Servers are linked to the County and will not be available. Some existing computers will be available to the new provider. Request has been submitted to Lancaster County as to the numbers / inventory that will be available.	Submitted by Premier 4/2/13
A30	How is internet service provided, through which carrier?	Not available after transition.	Submitted by Premier
A31	Is the existing telephone system to remain? If so, is an inventory available?	Lines to offices are on a central hub. Lines will need to be addressed between Windstream and new provider.	Submitted by Premier
A32	Is the existing furniture and décor to remain? If so, is an inventory available?	Existing furniture will be made available to the new provider. Décor will not. An inventory request has been submitted to Lancaster County.	Submitted by Premier
A33	What are the plans for the existing vehicles? What program(s) used these?	Request has been submitted to Lancaster County regarding the status of vehicles. The vans have	Submitted by Premier

		primarily used by Midtown. Community Support has primarily used the cars. A van has been utilized, upon need, to transport clients to/from medication management or day treatment.	
A34	Will a digital excel file of patient demographic information be available?	CMHC utilizes Foxbro. A demographic file, including names, will be available in Excel format.	Submitted by Premier
A35	Are patient appointments kept in an electronic format that could be made available?	Appointments are kept in electronic format – Foxbro.	Submitted by Premier
A36	For FY12, were day treatment services billed to Medicaid? If not, what was the reason? (per Medicaid claims data provided)	Medicaid claims receipts for Day Treatment were: $141,079 (FY11) and $125,516 (FY12).	Submitted by Premier
A37	Are any of the expenses for the crisis unit reflected in the core services budgets?	No	Submitted by Premier
A38	Please provide the current allocation of office space, by square footage, for each of the core services.	Space is not broken out by core services – not available.	Submitted by Premier
A39	What are enrollment fees and T-Current Budget $10,000? (Community Support budget as of 12/31/12)	Please clarify page referred to. Enrollment fees and T(training/Continuing Education) are under Support Services budget and expenditures are then assigned to programs.	Submitted by Premier
A40	What are Information Services – Current Budget $53,482? (Community Support budget as of 12/31/12)	Please clarify page referred to. Information services are budgeted under Support Services to support all programs.	Submitted by Premier
A41	What are Other Misc Fees & S – Current Budget $12,500 (Med Management budget as of 12/31/12)	Please clarify page referred to. Miscellaneous Fees & S under Med Management includes charges related to submitting/editing Medicaid claims	Submitted by Premier
A42	What percentage of janitorial, pest control, phones, snow removal and maintenance is allocated to each of the core services? (LC Budget R55CR1007)	Please refer to CMHC budget for allocation by services by which to calculate percentages.	Submitted by Premier
A43	For the organization that is awarded the core services contract, is that organization able to see some of its existing patients at CMHC?	Respondent is encouraged to address this in the Transition Plan.	Submitted by Premier
A44	Are CMHC's operating policies and procedures available for review?	Available upon request in WordPerfect.	Submitted by Premier

A45	Will all patients seen for core services under the new CMHC contract be considered the patients of the organization awarded the core services contract?	Yes, however consumer choice in providers must be respected.	Submitted by Premier

Yellow denotes draft responses to questions received 4/1-2/13 that need final answers approved for formal response and posting.

When addressing indigent burials, state statutes require counties to provide all necessary means for a decent burial of such person. It is the county's responsibility to establish guidelines to address eligibility for these services and to determine the level of services to be provided. State statutes also specify who can be held financially responsible for the costs of burial in the event of a death. By law, it is only the estate of the deceased, a spouse, or a parent of a minor child that can be held financially responsible for payment of funeral and burial expenses. Since 1998, Lancaster County has worked with the local Funeral Homes to standardize services and provide payment for burial of the indigent in Lancaster County.

While still in the early stages of development, the storage of unclaimed cremains became an issue of concern for the local Funeral Homes. To counteract this problem Lancaster County partnered with Wyuka Cemetery to provide an ossuary as a place to provide for a decent burial of unclaimed cremains. At an initial cost to the county of $500 plus an additional fee of $50 per inurnment, this service is offered to all who apply for County General Assistance but was intended to be used only for the proper burial of unclaimed cremains. According to records kept at Wyuka Cemetery, "less than fifty (50)" inurnments have been conducted at Wyuka Cemetery utilizing the ossuary and not all of them were done through the General Assistance program.

In 2007, due to the increasing costs associated with burials, Lancaster County adopted a policy that provided for cremation only. Last year, during discussions with representatives from the various Funeral Homes doing business in Lancaster County, The major complaint involved the costs associated with the preparation of the deceased for a "private family viewing", and the conduct of a "chapel or graveside service". Numerous options were discussed while trying to find a solution to this problem including; a three tiered plan that would provide for payments based upon the level of services provided, raising the authorized payment amount so as not to eliminate any services currently being provided, and to reduce the various services authorized when funded through the General Assistance program and thereby reducing the costs to the county.

After reviewing all the possible options, the equal treatment of all individuals was determined to be a necessity which ruled out the three tiered plan. At that point, the County was left with two choices, increase payments or reduce services. During earlier discussions with the Funeral Homes, a final figure was never reached, however the discussions centered on a proposed rate increase to approximately $1,600 per cremation and keeping all of the currently provided services. Based upon an average of 60 county cremations per year an increase of almost $500 per application would result in an annual budget increase of $30,000. The other option was to reduce the authorized services which would also reduce spending by $18,000 per year.

Taking into consideration what is fair to the funeral homes and to the taxpayers of the county, the decision was made to provide a direct cremation at a cost of $800.00. This solution best fulfills the county's requirement to provide a decent burial for an indigent person and is also fiscally sound.