BENEFITS BRIEFING

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Healthcare Reform/Obamacare/Affordable Care Act ***Employer Alert***

Employers must issue Employee Notices of Healthcare Exchanges by *October 1, 2013*

The Affordable Care Act (ACA) requires that employers give their employees notices with information about Healthcare Exchanges (the "Marketplace") not later than October 1, 2013. *(DOL Technical Release 2013-02).* For some employers this will be a very easy process; for other (especially those with more than 50 full-time employees), it will involve significant prerequisite steps.

Why

The state Healthcare Exchanges (or Marketplace) will open for business on October 1, 2013 to provide health insurance for the 2014 calendar year. The federal government wants Americans to know that coverage may be available for them through the Marketplace and that they could be eligible for a tax credit subsidy for such coverage. The government would like employers to help with the communication effort.

What employers are included

- Any employer covered by the Fair Labor Standards Act (FLSA)
- Hospitals, schools and institutions of higher learning
- Governmental employers at the federal, state and local level

Note that there is no specific size requirement. Even employers with fewer than 50 equivalent full-time employees may need to send out the Notice despite the fact that ACA does not require them to provide health.

What does the Notice include

The employee notice must contain the following information:

- The existence of the Marketplace;
- Contact information and description of services offered on the Marketplace;
- A statement that the individual may be eligible for a premium tax credit if the employee purchases a qualified plan on the Marketplace
- A statement that if the employee purchases a qualified plan on the Marketplace, the employee may lose the employer contribution to any health benefit plan offered by the employer and all or a portion of employer contributions may be excluded from federal income.

Who receives the Notice

All full-time and part-time employees. Dependents do not receive a Notice. New employees must receive the Notice within 14 days of hire.

Delivery

By first class mail or electronic delivery (email) following DOL guidelines which essentially require that email delivery is assured.

So how difficult is this?

The DOL has provided model language for two situations; employers with no health plan and employers with a plan. The first case will be quite simple using the DOL model language. The model notice describes the Marketplace and its effect on an employee. The employer with no health plan will just need to add a contact name, phone number and email to the standard wording.

Link for the model wording http://www.dol.gov/ebsa/pdf/FLSAwithoutplans.pdf

The second case of an employer with a health plan requires information about who is covered, dependent coverage, wellness provisions (with the premium rate impact of tobacco use), and premium rates for the 2014 year. The employer is also required to state whether or not the lowest cost health plan offered meets the "***minimum value standard***". This could be a very involved determination.

Link for the model wording http://www.dol.gov/ebsa/pdf/FLSAwithplans.pdf

To meet the minimum value standard the plan's share of the total allowed costs of benefits provided under the plan must be at least 60% of the total cost of a defined comprehensive healthcare program. In comparison with the four plan levels offered by the Marketplace healthcare exchanges, the employer's plan must be at the "bronze" level or higher in relative value.

So in sending out the Notice an employer with 50 or more full-time employees must make the *Pay or Play* decision (i.e., to either provide a sufficient and affordable health plan or pay the penalty tax) and have documentation that their plan meets the Minimum Value test if they choose *Play*.

How does an Employer determine if they meet the Minimum Value Test

The IRS issued proposed regulations on the Minimum Value Test in May. The proposed regs (which can be relied on until final regs are issued) provide options to determine if the Minimum Value Test is met:

Method 1: Use the IRS ***minimum value calculator*** to prove that the 60% value test is met. The calculator has inputs for deductibles, coinsurance, out of pocket limits, benefit provides copays, and drug schedule. If the plan can be modeled with these parameters (possible only for some plans) the model will calclulate the value ratio to see if it is 60% or more. The employer should then keep the calculation input and output to document that the minimum value test is met.

Method 2. Use one of the safe harbor plans provided by the IRS and HHS. The safe harbors issued so far are:

- $3,500 integrated medical and drug deductible, 80 percent cost-sharing, and a $5,000 maximum out-of-pocket limit;
- $4,500 integrated medical and drug deductible, 70 percent cost sharing, a $6,400 maximum out-of-pocket limit, and a $500 employer contribution to an HSA
- $3,500 medical deductible, $0 drug deductible, 60 percent medical cost sharing, a $10/$20/$50 copay tiered drug plan, and a 75 percent coinsurance for specialty drugs.

Safe harbor plans must cover all the essential benefits on the ACA list (just having the deductible/coinsurance amounts is not enough). So the safe harbors may not be helpful to many employers.

Method 3: Have an actuary analyze the plan and determine Whether or not the 60% value test is met. We can provide this actuarial certification if needed.

Under Method 1 the *minimum value calculator* uses a standard distribution of employees to determine the value of benefits for hospital, physician, rehab, x-ray/lab, imaging, skilled nursing, drugs and other ACA listed benefits. In theory an employer can used the calculator themselves, but they may prefer to get help with this or to have independent documentation of the minimum value test. To help you gauge the level of plan design information needed for the MV calculator, here is the input section (grayed out areas change depending on plan input):

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☑
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Grandfathered Plan?	☐

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$2,500.00			
Coinsurance (%, Insurer's Cost Share)			80.00%			
OOP Maximum ($)			$5,000.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

	Tier 1				Tier 2				Service Not Covered?	
Type of Benefit	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Tier 1	Tier 2
Medical	☑ All	☑ All			☑ All	☑ All				
Emergency Room Services	☑	☑			☑	☑			☐	☐
All Inpatient Hospital Services (inc. MHSA)	☑	☑		$100.00	☑	☑			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Well Baby, Preventive, and X-rays)	☑	☑			☑	☑			☐	☐
Specialist Visit	☑	☑			☑	☑			☐	☐
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑			☐	☐
Rehabilitative Speech Therapy	☑	☑			☑	☑			☐	☐
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00	☐	☐
Laboratory Outpatient and Professional Services	☑	☑			☑	☑			☐	☐
X-rays and Diagnostic Imaging	☑	☑			☑	☑			☐	☐
Skilled Nursing Facility	☑	☑			☑	☑			☐	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑			☐	☐
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑			☐	☐
Drugs	☑ All	☑ All			☑ All	☑ All				
Generics	☑	☑		$25.00	☑	☑			☐	☐
Preferred Brand Drugs	☑	☑		$45.00	☑	☑			☐	☐
Non-Preferred Brand Drugs	☑	☑		$75.00	☑	☑			☐	☐
Specialty High-Cost Drugs	☑	☑		$100.00	☑	☑			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

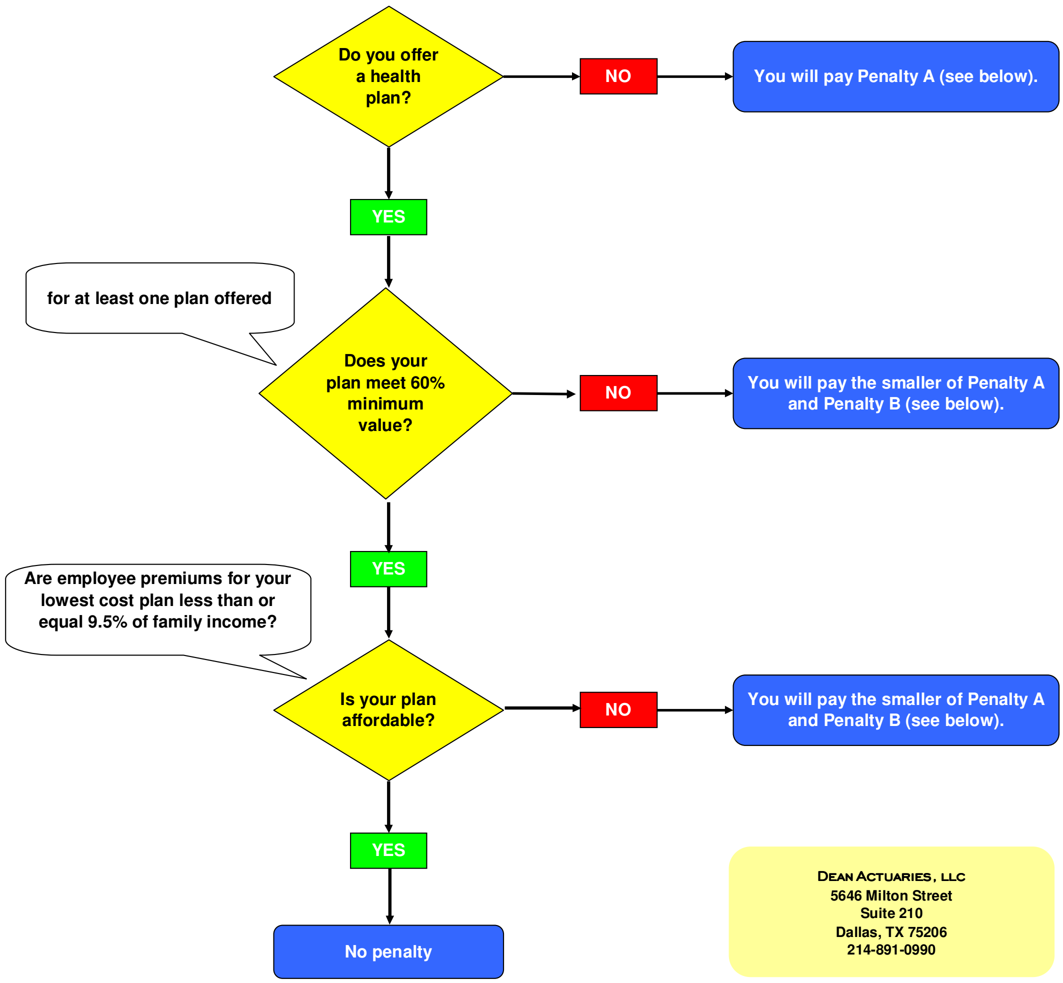
Next Issue: ***Employer Pay or Play and Related Strategies***

For the advanced student: See if you can follow the decision chart below.
Questions:

- *Is Pay or Play all or nothing or are there intermediate strategies?*
- *How large are the type A and B penalties?*
- *How are dependents treated?*

Employer *Pay or Play* Decision Chart

(Employers with 50 or more equivalent full-time employees)



FTE is number of full time employees.

Penalty A is $2,000 x (FTE - 30)

Penalty B is $3,000 x (FTEs receiving tax credit for premiums)

A full time employee is eligible for tax credits if that employee is paying more than 9.5% of their family income in premiums.