WELLS FARGO INSURANCE

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Legislative update

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DOL releases model exchange notice with October 1, 2013, effective date

The Patient Protection and Affordable Care Act (ACA) requires all employers subject to the Fair Labor Standards Act (FLSA) to notify employees of their right to access health insurance coverage from a Health Insurance Marketplace (Marketplace), also referred to as a public exchange. Public exchanges are scheduled to have their first open enrollment period on October 1, 2013, with coverage becoming effective on January 1, 2014. As we reported in our January 2013 Legislative Update, regulators delayed the original notice effective date of March 1, 2013, subject to subsequent regulatory guidance.

On May 8, 2013, the Employee Benefits Security Administration of the U.S. Department of Labor (DOL) issued Technical Release No. 2013-12 announcing "Guidance on the Notice to Employees of Coverage Options," along with two model notices for employers to use to satisfy the notice requirement (one for employers not offering employees a health plan, and another for employers who offer a plan to some or all employees). The notice must be provided to all employees – seasonal, part-time and full-time – regardless of plan enrollment status and regardless of whether the employer offers coverage or not. The notice must be provided to all new employees at the time of hiring beginning on October 1, 2013, (within 14 days of an employee's start date), and provided to all current employees the notice must be provided not later than October 1, 2013. Employers are not required to provide the notice to dependents or other non-employee who might otherwise be eligible for coverage.

Employers are not required to use the model notice, but any notice must:

- Include information regarding the existence of a new Health Insurance Marketplace as well as contact information and description of the services provided by the Marketplace
- Inform the employee that he or she may be eligible for a premium tax credit under section 36B of the Internal Revenue Code if the employee purchases a qualified health plan through the Marketplace
- Inform the employee that if he or she purchases a qualified health plan through the Marketplace, the employee may lose the employer contribution (if any) to any health benefits plan offered by the employer and that all or a portion of such contribution may be excludable from income for federal income tax purposes.

While most employers are subject to the FLSA, and this notice requirement, there are some exceptions. An employer is subject to the FLSA if the employer has one or more employees who produce goods for interstate commerce and have annual revenues of no less than $500,000. The notification requirement also applies to hospitals, schools and institutions of higher education, and federal, state, and local government agencies. Employers can visit the DOL website to determine whether they are subject to the FLSA and this new notification requirement at http://www.dol.gov/elaws/esa/flsa/scope/screen24.asp.

In the model notice for employers who offer coverage, employers are required to provide some customized information with respect to whom coverage is offered and whether coverage offered meets the "minimum value standard" (i.e., a plan option pays at least 60% of eligible claim expenses or has a 60% actuarial value). At their option, employers can also provide information in the notice with respect to other aspects of offered coverage, including employees' cost for coverage and whether any prospective changes to coverage are contemplated.

SBC template updated for second year of use

On April 23, 2013, the Departments of Labor, Health and Human Services, and Department of the Treasury (collectively, the "Departments") released additional frequently asked questions (FAQs) regarding implementation of the Patient Protection and Affordable Care Act (ACA). This set of FAQs, set XIV, addresses changes to the Summary of Benefits and Coverage (SBC) template for its second year of use.

An updated SBC template and sample completed SBC are available at www.cciio.cms.gov and www.dol.gov/ebsa/healthreform. SBCs should be provided with open enrollment materials for periods of coverage beginning on or after January 1, 2014, and before January 1, 2015. Note that SBCs must also be provided upon request to special enrollees and new hires.

The only change to the SBC template is the addition of statements indicating whether the plan provides minimum essential coverage and whether the plan meets the minimum value (MV) requirements. Minimum essential coverage is loosely defined as coverage provided under a government-sponsored program, an eligible employer-sponsored plan, a plan offered in the individual market, a grandfathered health plan, or other health benefits coverage recognized by the Department of Health and Human Services. A tax penalty is assessed against any non-exempt individuals who do not have minimum essential coverage in 2014 and beyond (the individual mandate). Minimum value requirements relate to employer sponsored plans and play or pay penalties. Specifically, a full-time employee may qualify for the premium tax credit and possibly trigger a penalty for his or her employer if the plan they are offered does not have an actuarial value at least 60%. These additions to the SBC template are shown on page 4 of the SBC template and on page 6 of the sample completed SBC.

HHS published revised individual exchange application including employer plan information form

The Department of Health and Human Services (HHS) has published a package of draft applications that will be used by individuals to enroll in public exchanges starting with their initial open enrollment period beginning on October 1, 2013. There are three separate paper applications:

- A short form for single adults who are not eligible for employer-sponsored health coverage and who do not have any dependents and cannot be claimed as a dependent by someone else
- A longer form for families or individuals who are eligible for employer-sponsored coverage
- A form for individuals not seeking to qualify for any affordability programs, including premium tax credits, cost-sharing reductions, and Medicaid

The longer family application includes an Employer Coverage Tool to assist employers in providing the necessary information on employer-sponsored coverage, which will be used to determine whether applicants are eligible for employer-sponsored coverage that meets affordability (the employee portion of the employee-only premium does not exceed 9.5% of the employee's modified adjusted gross income) and minimum value (MV) standards (the plan pays at least 60% of eligible claims). The Employer Coverage Tool is a revised version of the Employer Coverage Form that was included with the earlier draft application. The Employer Coverage Tool contains a new explanation that an employer offering a wellness program is to report the premium that the employee would pay if he or she received the maximum discount for any tobacco cessation programs, but no other discounts based on wellness programs. (See our article on proposed regulations on minimum value below). The information provided on the Employer Coverage Tool is important because an employee who is ineligible for coverage or for whom coverage is not affordable or does not meet MV standards may be eligible to receive a tax credit for exchange-based coverage. Starting in 2014, an employee who is eligible to receive a tax credit for exchange-based coverage could trigger a penalty for the employer under the "play or pay" rules. Employers should review the Employer Coverage Tool and prepare to provide the requested information to employees when public exchange enrollment begins in October. The three draft applications can be found on the Centers for Medicare and Medicaid Services' website:

Family Application including Employer Coverage Tool
http://cciio.cms.gov/resources/other/Files/AttachmentC_042913.pdf

Individuals without employer provided coverage
http://cciio.cms.gov/resources/other/Files/AttachmentB_042913.pdf

Individuals not seeking to qualify for affordability programs
http://cciio.cms.gov/resources/other/Files/AttachmentD_042913.pdf

IRS issues proposed regulations on minimum value, including the effect of wellness incentives on "minimum value" and "affordability" of contributions for employees under the ACA

The Internal Revenue Service (IRS) recently issued proposed regulations, which include proposed guidance on the treatment of wellness incentives in determining a health insurance plan's "minimum value" (MV) or whether employee contributions towards health coverage meets "affordability" thresholds under the Patient Protection and Affordable Care Act (ACA) employer "play or pay" rules. Generally, "applicable large employers" (those with 50 or more full time and full time equivalent employees) must offer all full-time employees medical coverage that meets two key criteria: (a) the coverage provides "minimum value" with the plan paying at least 60% of eligible claims, and (b) an employee's cost for single-only coverage does not exceed 9.5% of the employee's modified adjusted gross household income. Failure to meet both criteria may enable employees to forego employer coverage, purchase exchange coverage, and qualify for federal premium tax credits. Full-time employees who receive such credits may trigger "play or pay" penalties for their respective employers.

Wellness incentives and MV. Wellness incentives can be designed to reduce enrollees' cost-sharing, such as reduced deductibles, co-pays, or maximum out-of-pocket thresholds, when wellness criteria are met. That could effectively increase the plan's actuarial value, which might enable a plan to meet the MV requirement. However, the proposed regulations generally will not allow factoring any such cost-sharing reductions in determining whether a plan meets MV criteria. The one significant exception applies to tobacco use, in which case MV may be calculated if incentives related to tobacco use are earned. In short, a plan can apply the benefit of a tobacco cessation wellness incentive in calculating its MV, but cannot apply any other wellness incentive. Note the transition relief below for plan years prior to 2015.

Wellness incentives and affordability. Wellness incentives can also be designed to reduce enrollees' premiums when wellness criteria are met. The proposed regulations provide that wellness incentives that reduce premiums will not be considered in determining whether employee premiums for single-only coverage are affordable. The one significant exception is for tobacco cessation wellness programs, where the affordability of a plan will be determined based on the premium paid by individuals who don't use tobacco, or tobacco users who complete a nondiscriminatory wellness program for tobacco use, such as completion of a smoking cessation course. Note the transition relief below for plan years prior to 2015.

Transitional relief. Plan sponsors may benefit from transitional relief for wellness incentive programs in place as of May 3, 2013. Solely for plan years before 2015, employers will not be subject to "play or pay" penalties for any employees who receive a premium tax credit because:

- The offer of coverage was not affordable or did not satisfy MV criteria
- Employer plan coverage offered to the employee would have been affordable, or would have satisfied MV criteria based on the total required employee premium
- Cost-sharing for that plan that would have applied to the employee if the employee satisfied the requirements of any wellness program in place as of May 3, 2013, including a tobacco-related wellness program

In addition to the effect of wellness programs on minimum value, the proposed regulations provide that a plan's MV may be calculated using the Department of Health and Human Services' (HHS) MV calculator, a safe harbor yet to be formally developed by HHS and the IRS, or an actuarial certification from a member of the American Academy of Actuaries for plans with nonstandard plan designs. With respect to the safe harbor method, the proposed regulations outline and request comment on the following three MV safe harbors for plans that cover all benefits included in the MV calculator:

- A plan with a $3,500 integrated medical and drug deductible, 80% cost-sharing, and a $5,000 maximum out-of-pocket limit
- A plan with a $4,500 integrated medical and drug deductible, 70% cost-sharing, a $6,400 maximum out-of-pocket limit, and a $500 employer contribution to a health savings account (HSA)
- A plan with a $3,500 medical deductible, $0 drug deductible, 60% medical cost-sharing, a $10/$20/$50 co-pay tiered drug plan, and a 75% coinsurance for specialty drugs

The proposed regulations also address the effect of employer contributions to an HSA or a health reimbursement arrangement (HRA) on MV, providing that all employer contributions for the current plan year to an HSA should be taken into account in determining the plan's share of costs for MV. Employer current-year contributions to HRAs integrated into the group health plan are also taken into account for determining the plan's MV, but only if those funds can only be used for cost-sharing and not for premiums.

With respect to the effect on the affordability of the plan, the proposed regulations provide that amounts made newly available under an HRA for a current plan year that can either be used only for premium payment or that can be used either for premiums or for cost-sharing reduction can be considered as available to increase the affordability of employee coverage. This is a relatively uncommon approach, but if an employer allows an employee to pay for premium from an HRA, those funds factor into the affordability of the coverage.

The proposed regulations specifically reject the idea of a de minimis exception to the 60% MV requirement, noting that a plan that falls below 60% by any amount does not provide MV. In addition, the preamble to the proposed regulations discusses a situation in which an employer offers a 50% MV plan. While the preamble notes that an employer cannot likely require participation in such a plan, the discussion suggests than an employer might be able to offer such a plan under certain circumstances. Certain carriers have begun to market this type of ACA "play or pay" solution in the form of a self-funded plan that provides only preventive care and wellness. Employers should note, however, that regulators have not yet defined self-funded minimum essential coverage. A plan that covers only preventive care and wellness would very likely not meet 60% actuarial value and could be problematic under any future definition of self-funded minimum essential coverage.

Please contact your Wells Fargo Insurance representative before considering this type of solution, or for any other questions about the proposed minimum value regulations.

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