LEHB HEALTHCARE REFORM ACT
MANDATED NOTICE
OCTOBER 1, 2013

LEHB is required to notify all members of the following:

- The "Health Insurance Marketplace" also known as the "Healthcare Exchange" begins open enrollment on October 1, 2013 for coverage starting as early as January 1, 2014.
  - Information found on www.healthcare.gov

- Healthcare Exchanges cost sharing options, Metals Levels:
  - Platinum Plan 90% Coverage
  - Gold Plan 80% Coverage
  - Silver Plan 70% Coverage
  - Bronze Plan 60% Coverage

- Minimum Value Plan
  - Affordable Healthcare defines minimum value plan when the plans share of total cost of benefits is at least 60% of those costs

- The value of the Plan provided through LEHB is above the Platinum level.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 11-30-2013)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution –as well as your employee contribution to employer-offered coverage– is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact _____.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name		4. Employer Identification Number (EIN)
CITY OF PHILADELPHIA		
5. Employer address		6. Employer phone number
PHILADELPHIA CITY HALL		
7. City	8. State	9. ZIP code
PHILADELPHIA	PA	19107
10. Who can we contact about employee health coverage at this job?		
LEHB 2233 SPRING GARDEN STREET, PHILADELPHIA, PA 19130		
11. Phone number (if different from above)	12. Email address	
215-763-8290	Q&A@LEHB.ORG	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - ☐ All employees.
  - ☑ Some employees. Eligible employees are:

    POLICE OFFICERS, SHERIFFS, COUNTY DETECTIVES

- With respect to dependents:
  - ☑ We do offer coverage. Eligible dependents are:

    SPOUSE, DEPENDENT CHILDREN

  - ☐ We do not offer coverage.

☑ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☑ **Yes** (Continue)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____ (mm/dd/yyyy) (Continue)

☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
☑ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* offered **only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much will the employee have to pay in premiums for that plan? $
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

Date of change (mm/dd/yyyy):

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

United States Department of Labor
Employee Benefits Security Administration
FAQs about the Affordable Care Act Implementation Part XVI

Printer Friendly Version

September 4, 2013

Set out below are additional Frequently Asked Questions (FAQs) regarding implementation of various provisions of the Affordable Care Act. These FAQs have been prepared jointly by the Departments of Labor, Health and Human Services (HHS), and the Treasury (collectively, the Departments). Like previously issued FAQs (available at http://www.dol.gov/ebsa/healthreform/ and http://www.cms.gov/cciio/resources/fact-sheets-and-faqs/index.html), these FAQs answer questions from stakeholders to help people understand the new law and benefit from it, as intended.

Notice of Coverage Options Available Through the Exchanges

Section 18B of the Fair Labor Standards Act (FLSA), as added by section 1512 of the Affordable Care Act, generally provides that, in accordance with regulations promulgated by the Secretary of Labor, employers must provide each employee notice of coverage options available through a Health Insurance Marketplace (also referred to as an Exchange). On May 8, 2013, the Department of Labor issued Technical Release 2013-02 provided temporary guidance on FLSA section 18B, as well as model notices.[1]

Q1: Is it permissible for another entity (such as an issuer, multiemployer plan, or third-party administrator) to send the Notice of Coverage Options on behalf of an employer to satisfy the employer's obligations under FLSA section 18B?

Yes, an employer will have satisfied its obligation to provide the notice with respect to an individual if another party provides a timely and complete notice. The Department of Labor notes that, as explained in Technical Release 2013-02, FLSA section 18B requires employers to provide notice to all employees, regardless of whether an employee is enrolled in, or eligible for, coverage under a group health plan. Accordingly, an employer is not relieved of its statutory obligation to provide notice under FLSA section 18B if another entity sends the notice to only participants enrolled in the plan, if some employees are not enrolled in the plan. When providing notices on behalf of employers, multiemployer plans, issuers, and third party administrators should take proper steps to ensure that a notice is provided to all employees regardless of plan enrollment, or communicate clearly to employers that the plan, issuer, or third party administrator will provide notice only to a subset of employees (e.g., employees enrolled in the plan) and advise of the residual obligations of employers with respect to other employees (e.g., employees who are not enrolled in the plan).

90-day Waiting Period Limitation

PHS Act section 2708 provides that a group health plan or health insurance issuer offering group health insurance coverage shall not apply any waiting period that exceeds 90 days. Section 2704(b)(4) of the PHS Act, section 701(b)(4) of ERISA, and section 9801(b)(4) of the Code define a waiting period to be the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the plan.

On February 9, 2012, the Departments issued guidance outlining various approaches under consideration with respect to PHS Act section 2708 and solicited comments. After reviewing those comments, the Departments provided temporary guidance on August 31, 2012, to remain in effect at least through the end of 2014, regarding the 90-day waiting period limitation. This guidance also solicited comments. After consideration of all of the comments received in response to the February 2012 and August 2012 guidance, the Departments published proposed regulations on March 21, 2013.

The proposed regulations generally provide that a group health plan or health insurance issuer offering group health insurance coverage may not impose a waiting period that exceeds 90 days. The proposed rules also provide that a waiting period is the period 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. For this purpose, being otherwise eligible to enroll in a plan generally means having met the plan's substantive eligibility conditions (such as being in an eligible job classification or achieving job-related licensure requirements specified in the plan's terms). However, eligibility conditions based solely on the lapse of time are permissible for no more than 90 days. Other conditions for eligibility under a plan are generally permissible unless the condition is designed to avoid compliance with the 90-day waiting period limitation. The proposed regulations provide several illustrations of how to apply this rule.[2]

The preamble to the proposed regulations stated that, in the Departments' view, the proposed rules were consistent with, and no more restrictive on employers than, the August 2012 guidance.[3] Therefore, the Departments stated they will consider compliance with the proposed rules as compliance with PHS Act section 2708 at least through 2014.[4]

Q2: Will the Departments be issuing final regulations under PHS Act section 2708 that give plans and issuers sufficient time to comply with the waiting period limitation?

Yes. As stated in the proposed rules, plans and issuers can rely on guidance provided in the March 2013 proposed rules at least through 2014. To the extent final regulations are more restrictive on plans or issuers than the proposed regulations, they will not be effective prior to January 1, 2015 and the Departments expect they will give plans and issuers sufficient time to comply.[5]

Under the proposed rules, to the extent plans and issuers impose substantive eligibility requirements not based solely on the lapse of time, these eligibility provisions are permitted if they are not designed to avoid compliance with the 90-day waiting period limitation. Therefore, for example, if a multiemployer plan operating pursuant to an arms-length collective bargaining agreement has an eligibility provision that allows employees to become eligible for coverage by working hours of covered employment across multiple contributing employers (which often aggregates hours by calendar quarter and then permits coverage to extend for the next full calendar quarter, regardless of whether an employee has terminated employment), the Departments would consider that provision designed to accommodate a unique operating structure, (and, therefore, not designed to avoid compliance with the 90-day waiting period limitation).

Footnotes

1. *See* Technical Release 2013-02, model notice for employers who offer a health plan to some or all employees, and model notice for employers who do not offer a health plan, available at http://www.dol.gov/ebsa/healthreform/.

2. *See* paragraph (c)(3)(i) and (ii) of the proposed regulations, addressing the application of plan provisions requiring certain hours-of-service per period to variable hour employees and cumulative service requirements.

of services by enrollees, the prices of health care services negotiated by the insurer, and how the plan controls the services its enrollees use.

In addition to these four levels of coverage, some individuals will be able to purchase catastrophic plans with an even lower actuarial value. Catastrophic plans will cover essential health benefits (http://101.communitycatalyst.org/aca_provisions/essential_benefit_package) but have high deductibles. Only young adults under 30 and individuals exempted from the individual mandate (http://www.communitycatalyst.org/resources/glossary?entry=individual-mandate) because they cannot find affordable insurance are allowed to purchase catastrophic plans.

How do these plan levels work with insurance subsidies (http://101.communitycatalyst.org/aca_provisions/subsidies) for low- and moderate-income people?

Starting in 2014, the ACA provides assistance to low- and moderate-income people up to 400 percent of the federal poverty level (FPL) (about $88,000 per year for a family of four) who need help paying insurance premiums and out-of-pocket expenses. The amount of premium assistance each individual or family receives is related to the coverage tiers. The subsidy is based on the premium for the second lowest-cost silver plan (http://www.cbpp.org/cms/index.cfm?fa=view&id=3190) available. A silver plan will cover 70 percent of the average costs, with the enrollee paying, on average, 30 percent. However, if an individual decides to purchase a gold or platinum plan, he or she will need to pay the difference between the premium credit amount and the cost of the more expensive plan. This may be a good choice, since the person will get a more generous level of coverage of, on average, 80 percent of costs.

Individuals and families under 250 percent FPL (about $27,000 for an individual and $55,000 for a family of four) are also eligible for sliding scale cost-sharing credits. This, in addition to premium credits, will help defray any co-payments, co-insurance and deductibles. To get the cost-sharing credits, the individual has to enroll in a silver plan, and would then get assistance (http://www.cbpp.org/cms/index.cfm?fa=view&id=3190) with the out-of-pocket expenses (meaning they would pay less than the average 30 percent of health care expenses).

What are the challenges consumers may face with standardized choices?

For people who have high health care costs there are significant implications for the plan level they choose. Gold and platinum level plans will have lower deductibles, co-payments and co-insurance for health care services, but will likely have higher monthly premiums. Conversely, bronze and silver plans will have lower

monthly premiums, but could expose consumers to significant out-of-pocket costs for each health care service over time.

If people with high medical expenses gravitate to platinum plans because they cover more out-of-pocket costs, and healthy people often choose bronze plans because the premiums are lower, over time the premiums in the platinum plans will increase. Because premiums reflect the cost of providing care, when a health plan attracts sicker people, it drives premium prices higher, causing healthier individuals to seek coverage elsewhere, which add to the problem of increasing premium costs - this is called adverse selection (http://www.communitycatalyst.org/resources/glossary?entry=adverse-selection) . The ACA provides some tools to mitigate this problem, like preventing health plans from charging higher premiums based on a person's health, but it will not completely solve the it. It is likely that insurers will try to find a way to move sicker people to certain health plans, which could drive up premiums.

Another potential challenge is that standardizing benefits based on actuarial value can lead to many variations in the design of health plans. This variation could give insurers room to discourage enrollment of people with costly health conditions.

Brought to you by The Insurance Exchange

Determining "Minimum Value" of Health Plan Coverage

Effective for 2014, a large employer may be liable for a penalty under the Affordable Care Act's (ACA) "pay or play" rules if any of its full-time employees receives a premium tax credit through a state-based health insurance exchange (Exchange). A "large employer" is an employer with at least **50 full-time equivalent employees** during the preceding calendar year.

To qualify for the premium tax credit, an individual cannot be eligible for other minimum essential health coverage, including coverage under an employer-sponsored plan that is affordable to the individual and provides minimum value. Thus, an individual may receive a premium tax credit if his or her employer's group health coverage does not provide minimum value.

MINIMUM VALUE REQUIREMENT

Under ACA, a plan does not provide minimum value if the plan's share of total allowed costs of benefits provided under the plan is less than **60 percent** of those costs.

For employers that offer health coverage that does not meet ACA's minimum value requirement, the monthly penalty amount under ACA for each full-time employee who receives a premium tax credit through an Exchange will be 1/12 of $3,000 for any applicable month. However, the total penalty for the employer would be limited to the total number of the company's full-time employees (minus 30), multiplied by 1/12 of $2,000 for any applicable month.

METHODS FOR DETERMINING MINIMUM VALUE

In May 2012, the Internal Revenue Service (IRS) issued Notice 2012-31 to propose the following approaches for determining whether an employer-sponsored plan provides minimum value.

- ***Approach One: Calculator –*** A minimum value (MV) calculator would be made available by the Department of Health and Human Services (HHS) and the IRS. The calculator would permit an employer-sponsored plan to enter information about the plan's benefits, coverage of services and cost-sharing terms to determine whether the plan provides minimum value.
- ***Approach Two: Checklists –*** HHS and the IRS would provide an array of design-based safe harbors in the form of checklists that employers could use to compare to their plans' coverage. If the employer-sponsored plan's terms are consistent with or more generous than any one of the safe harbor checklists, the plan would be treated as providing minimum value. This method would not involve calculations and could be completed without an actuary. Each safe harbor checklist would describe the cost-sharing attributes of the four core categories of benefits and services: physician and mid-level practitioner care, hospital and emergency room services, pharmacy benefits, and laboratory and imaging services.
- ***Approach Three: Actuarial Certification –*** An actuarial certification approach would be established for plans with nonstandard features that preclude the use of the calculator or checklist methods. Nonstandard features would include quantitative limits (for example, limits on covered hospital days or physician visits) on any of the four core categories of benefits and services. Under this approach, plans would be able to generate an initial value using a calculator and then engage a certified actuary to make appropriate adjustments to take into consideration the nonstandard features.

Determining "Minimum Value" of Health Plan Coverage

On Nov. 26, 2012, HHS issued proposed regulations that address minimum value and generally follow the IRS' approach in Notice 2012-31. In addition, to determine if a plan satisfies the minimum value standard, the proposed regulations would allow employers to take into account:

- All benefits provided under the plan that are included in any essential health benefit (EHB) benchmarks; and
- Employer contributions to a health savings account (HSA) and amounts newly made available under a health reimbursement arrangement (HRA).

Also, if a plan uses the MV calculator and offers an EHB outside of the parameters of the MV calculator, the proposed regulations would allow an actuary to determine the value of the benefit and add it to the result derived from the MV calculator based on generally accepted actuarial principles and methodologies.

AVAILABILITY OF CALCULATOR

In conjunction with the proposed regulations, HHS provided an AV calculator for health insurance issuers to use to determine the "metal" status (that is, bronze, silver, gold or platinum) of non-grandfathered plans in the individual and small group markets. This AV calculator uses assumptions and claims data specific to the individual and small group markets, and does not directly relate to the MV requirement for large employers. However, HHS indicated that the MV calculator that will be provided for large employers to use will be similar to the AV calculator.

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805 words

Wonder how new health insurance law affects you?; It's time to find out: Enrollment begins Oct. 1

Jayne O'Donnell

When it comes to the new health care law, the question on Drew Calloway's mind is: What about me?

The Dumfries, Va., resident thinks the annual premium he pays for his family to be on his employer's health insurance is "abnormally high." He wonders whether he's eligible to buy a new plan through the exchanges set up under the Affordable Care Act.

There's no easy answer for Calloway, who works in the information technology field. Due to what the Kaiser Family Foundation's Karen Pollitz calls a "drafting error," the law only addresses people with self-only plans with annual premiums that exceed 9.5% of their modified adjusted gross income -- not those with family plans. This would rule out most employees other than minimum wage workers.

This kind of convolution is keeping information providers known as navigators and call-center employees hopping. They are rushing to familiarize themselves with the law's nuances so they can guide consumers through the process.

The hotly contested health care reform measure may not help Calloway, but it will make insurance affordable to millions of other Americans who otherwise couldn't pay for it. The uninsured will have a choice of plans available through exchanges run by their states or the federal government (or both in states where the exchanges are operated jointly).

Enrollment begins Oct. 1. Everyone who isn't currently enrolled in a private insurance plan or Medicaid must sign up or face penalties.

It can be hard to see the substance through all the ongoing mudslinging over the law. Here are some of the key questions and answers to keep in mind:

Where do I start?

A: At HealthCare.gov. That's the federal government's portal for the health insurance marketplace, and it will help you find the exchange for your state. You answer questions, plug in your state, and your exchange will tell you whether you can buy insurance this way and if subsidies or tax credits are available. More complicated scenarios can be discussed with call-center employees at the federal exchange, 800-318-2596.

What am I shopping for?

A: Exchanges will offer a selection of plans that are classified as bronze, silver, gold and platinum, representing the different levels of cost-sharing between insurers and consumers. Bronze plans have the highest deductibles; cost-sharing and platinum plans have the lowest.

All insurers participating in an exchange have to offer at least the silver and the gold levels, but most will also offer bronze and possibly platinum plans, Pollitz says. Midlevel silver plans will tend to have deductibles of about $2,000 a year before coverage kicks in.

What's my deadline?

A: The new state-by-state health insurance marketplaces, or "exchanges," will begin enrolling customers Oct. 1.

Coverage begins Jan. 1 for those who sign up by Dec. 15. Pollitz, a senior fellow at the Kaiser Family Foundation, advises consumers to begin looking into their options soon after the Oct. 1 enrollment kickoff, but notes that with six months to decide, there's no need to fret -- yet.

"There's time to go slow, absorb and really understand it," she says.

What happens if I don't sign up?

A: Beginning in 2015 for the 2014 tax year, those who don't have any health insurance (or Medicaid) will be subject to a $95-a-year penalty on their taxes, or 1% of income, whichever is greater.

The amount of the penalty will gradually increase each year until you sign up.

How much money will I save?

A: It depends, but most uninsured Americans will be eligible for some form of financial help either through tax credits or increased access to Medicaid. The level and availability of low-cost or free coverage such as Medicaid is based on a state-by-state calculation of where your household income is in relation to the Federal Poverty Level. The Kaiser Family Foundation has a calculator that will tell you the amount of money available to you or your family. If your income is less than 250% of poverty, you may also qualify for cost-sharing subsidies, which would reduce deductibles and co-pays. These are only available with silver plans.

How do I get the money?

A: The tax credits can be sent directly to your insurer to offset your premiums or you can claim them in a lump sum when you file your taxes.

What if I've been denied coverage before?

A: Worry not. Those whose health problems kept them from getting insurance in the past may benefit the most. Studies show one in every two Americans has what could be characterized as a "pre-existing condition." If you have anything from arthritis to cancer or are simply obese, insurers can no longer deny you coverage.

Who's most affected:

1) Those whose employers don't offer insurance.

2) Some who can't afford their employer's coverage.

3) Those who are between jobs.

4) Those whose health problems kept them from getting insurance.

5) The self-employed.

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September 5, 2013

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United States: Notice Of Coverage Options In Exchange Distributable To Employees By October 1, 2013 Under Health Care Reform Act

Last Updated: July 16 2013
Article by **Eugene W. Magee**
Butler, Snow, O'Mara, Stevens & Cannada, PLLC

Update**: On July 2, 2013, the Treasury Department posted a* blog *announcing its intention to delay – until January 1, 2015 – the employer shared responsibility and related requirements of the Health Care Reform Act, and that additional guidance would be issued within a week.* I.R.S. Notice 2013-45 *was issued on July 9, 2013 providing details about the transition relief from the employer shared responsibility and related provisions. However, I.R.S. Notice 2013-45* ***did not *postpone the effective date for distribution of the Notice of Coverage Options In Exchange, which is the subject of the following article.*

One of the "oddities" of the Health Care Reform Act was its several amendments to the Fair Labor Standards Act ("FLSA"). New FLSA §18B requires that ***every employer subject to the FLSA - whether the employer offers a health care plan or not*** - provide each of its employees with a written notice of the coverage options available through the health care exchanges ("Notice"). This Notice was required by FLSA §18B to be given beginning no later than March 1, 2013. However, on January 24, 2013, the Department of Labor ("DOL") issued guidance stating that the Notice requirement would not take effect on March 1, 2013 for various reasons.

The DOL, the Department of Health and Human Services, and the Department of the Treasury (collectively "Tri-Agencies") are working together to develop coordinated regulations with respect to the FLSA §18B requirements, but these regulations are not ready for issuance. Therefore, on May 8, 2013, the DOL issued Technical Release 2013-02 ("Guidance") providing temporary guidance regarding the Notice requirement. The Guidance, which will be effective until regulations or other guidance is issued by the Tri-Agencies, specifies the requirements which much be satisfied in order for an employer to be considered in compliance with FLSA §18B in the interim.

The exchanges – now being referred to in the Guidance as the Health Insurance Marketplace ("Marketplace") – are supposed to be operational on January 1, 2014, with open enrollment for coverage through the Marketplace to begin October 1, 2013. Consequently, the Guidance requires employers to provide the Notice no later than October 1, 2013 to their then current employees. Thereafter, each new employee is required to be provided with the Notice at the time of hiring. (For 2014 - and presumably for the remainder of 2013 - the Notice will be considered to be provided "at the time of hiring" if provided within fourteen (14) days of the employee's start date.)

The Notice must be provided to ***every employee, regardless of whether or not enrolled in a health plan of the employer or whether a part-time or full-time employee***. However, employers are not required to provide separate Notices to dependents or others who are covered or may become eligible for coverage but who are not employees.

The Notice must inform the employee:

(1) of the existence of the Marketplace, the services provided by the Marketplace, and the contact information for assistance at the Marketplace;

(2) that an employee purchasing a qualified health plan through the Marketplace may be eligible for a premium tax credit if the employer plan's share of the total allowed cost of benefits provided under the employer's plan is less than 60% of such costs; and

(3) that an employee purchasing a qualified health plan through the Marketplace may lose the employer contribution, if any, to any employer health plan, all or a portion of which employer contribution may be excludable from income for federal income tax purposes.

The Notice must be provided automatically by the employer; free of charge to the employees; in writing; and in a manner calculated to be understood by the average employee. It may be delivered either by first-class mail or electronically, ***if the requirements of the DOL's electronic disclosure safe harbor are satisfied***.

In order to assist employers with providing the Notice, the DOL has posted model Notices on its website. There are two model Notices available – one for employers who do not offer a health plan and another for employers who do offer a health plan. An employer may use one of these model Notices – or a modified version thereof, so long as the modified Notice satisfies the minimum content requirements of the Guidance - to comply with the Notice requirement.

The establishment of the Marketplace will also result in some necessary conforming revisions to the COBRA election notice ("Election Notice"). Under COBRA, upon the happening of a qualifying event, an employer sponsoring a group health plan is required to provide a qualified beneficiary with an Election Notice describing the right to continuation coverage and how to make an election. However, qualified beneficiaries may want to compare COBRA continuation coverage to health coverage alternatives available through the Marketplace. Also, qualified beneficiaries may be eligible for the premium tax credit to help pay for some or all of the cost of coverage offered through the Marketplace.

Therefore, the DOL's model Election Notice has also been revised to make qualified beneficiaries aware of these other coverage alternatives available through the Marketplace, as well as certain other updates. The Guidance provides that use of this revised model Election Notice, appropriately completed, will be considered by DOL to be good faith compliance with the Election Notice content requirements of COBRA. This revised Election Notice is also available on the DOL's website. (Consideration should also be given to any necessary or desirable corresponding changes in the initial notice of COBRA rights distributed to new participants in the employer's health plan at the time of commencement of coverage under the plan).

While there appears to be growing skepticism concerning whether the Marketplace will indeed be operational by January 1, 2014, employers cannot afford to wishfully rely on that possibility and postpone timely preparation for compliance with the Guidance. Otherwise, they may find themselves either hurriedly trying to do last minute compliance, or even being delinquent in compliance, with the Guidance.

Caution: While the DOL has provided these model Notices as a useful "safe-harbor" for meeting the minimum requirements of FLSA §18B and COBRA, care should be taken with respect to merely printing these model Notices and filling in the blanks. In the complicated employee benefits environment, it is an exception rather than the rule that a "one size fits all" approach is appropriate. Generally, some tweaking of these model Notices may be necessary for them to be appropriate for use by many – if not most – health plans.

The content of this article is intended to provide a general guide to the subject matter. Specialist advice should be sought about your specific circumstances.

Health Insurance 101 (http://101.communitycatalyst.org/)

Coverage Tiers

(http://101.communitycatalyst.org/aca_provisions)

Standardizing Health Plans

What does it mean to standardize health insurance plans, and how does it help consumers?

Often people who buy health insurance have difficulty comparing health plans based on different benefits and out-of-pocket costs. In addition, it is often difficult to know, even once a person has a health plan, the entitled benefits and costs of services. One way to address this problem is to standardize the types of benefits and cost-sharing in health plans.

Beginning in 2014, private health insurers will need to meet new requirements for standardizing health insurance plans. Research has found that when people have too many health plans to choose from, it can be confusing. Insurers may also use different benefits in health plans to attract and enroll healthier people and avoid individuals with expensive health conditions. Standardization will help individuals and businesses make better-informed comparisons between different insurance plan options and also help guard against insurance company efforts to cherry pick the healthiest people.

How will health plan standardization work?

Under the Affordable Care Act (ACA) (http://101.communitycatalyst.org/aca_provisions/aca_basics) , insurers will be required to offer plans that fit within four levels of coverage: bronze, silver, gold and platinum (#bronzesilvergold) . Insurers don't have to offer plans in all four levels, but within the health insurance Exchanges (http://101.communitycatalyst.org/aca_provisions/exchanges) , all insurers must offer at least one silver and one gold plan.

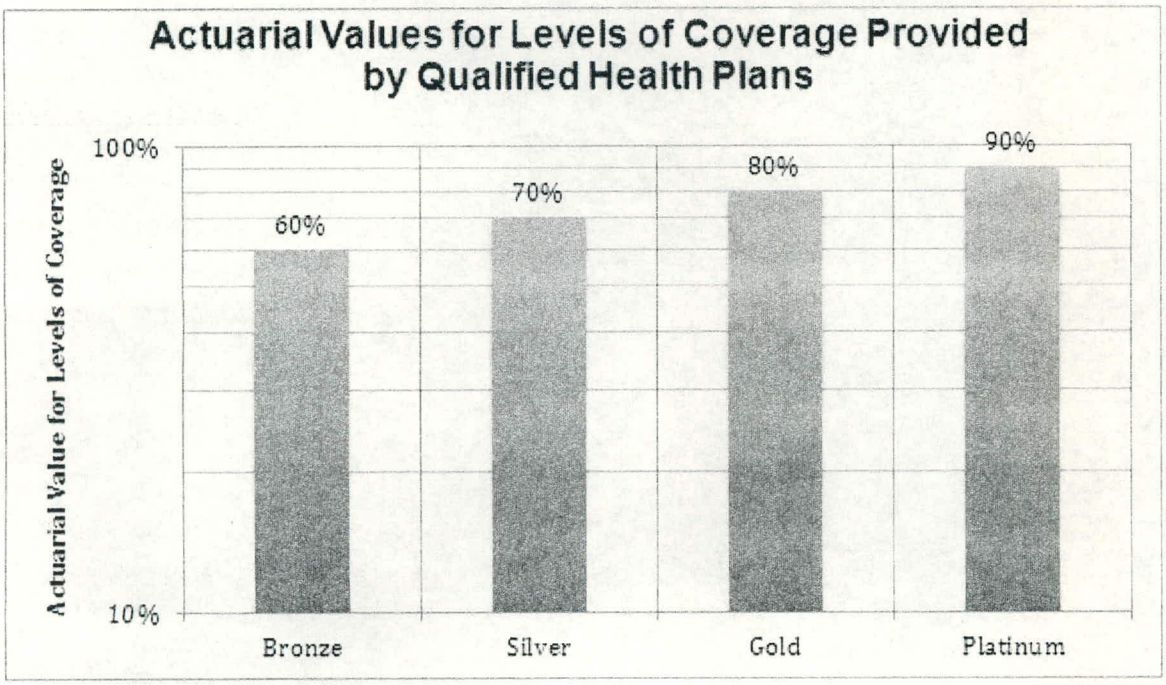
Each plan level must cover the same set of minimum essential health benefits (http://101.communitycatalyst.org/aca_provisions/essential_benefit_package) - greater detail on these benefits will be determined by the Department of Health and Human Services (HHS). But while the *scope* of benefits will be the same among the plans, the *value* of those benefits will vary across the bronze, silver, gold and platinum levels. This means the amount of cost-sharing required will differ in those tiers. Bronze plans will have the least generous coverage with more out-of-pocket costs for enrollees, and platinum plans will have the most generous benefits.

However, no health plan will be allowed to charge cost-sharing - including deductibles, co-payments or co-insurance - greater than the limits for high-deductible plans (in 2010, the limit was $5,950 for an individual

and $11,900 for a family). And health plans for small businesses are barred from charging deductibles greater than $2,000 per year for individual coverage or $4,000 per year for family coverage (this amount will be annually adjusted for inflation). No health plan can apply a deductible or any cost-sharing for certain preventive health services (http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm) .

How will the levels of coverage differ?

The four levels of coverage - bronze, silver, gold and platinum - are based on actuarial value (http://www.communitycatalyst.org/resources/glossary?entry=actuarial-value) , a measure of the level of financial protection a health insurance policy offers. It indicates the percentage of health costs that a health plan would pay for an average person. The four levels provided in the ACA are illustrated in the chart below.



For a bronze plan, the insurance would cover 60 percent of all health care costs for an average person. Enrollees, on average, would be responsible for paying 40 percent of the costs. For a platinum plan, an average individual would pay 10 percent out-of-pocket for their covered benefits and the insurer would pay 90 percent. However, individuals with high-cost health conditions could end up paying significantly more than the average person. For an example of how actuarial value will look on the Federal Employee Health Benefit Plan, see here (http://www.nationalhealthcouncil.org/NHC_Files/files/EHB_ActuarialAnalysis.pdf) .

Actuarial value (http://www.communitycatalyst.org/resources/glossary?entry=actuarial-value) is different from the premium (http://www.communitycatalyst.org/resources/glossary?entry=premium) for the health plan. Premiums for different plans at the same level will vary from one insurer to another, based on the overall use