Metal Spectrum Plans Expected to Become the Norm

One of the positive aspects of the Affordable Care Act is that it gives employers the chance to offer a wide range of plans that let workers pick the coverage that’s right for them.

You can do this by offering “metallic spectrum plans,” each of which has different values and costs. Bronze, silver, gold and platinum plans are a way of serving a wide range of employee needs and reducing the potential of your healthiest employees buying more insurance than they may actually need.

Metallic spectrum plans allow employers to stay compliant with the ACA by offering affordable coverage that covers the 10 essential benefits that are required by the health care law.

The most basic plans – bronze plans – have lower upfront costs in terms of premiums, but copays, coinsurance and deductibles are typically higher, compared to the top-tier plans. And the top plans, platinum, have higher upfront premiums, but lower copays, coinsurance and deductibles.

Metal plans feature in-network cost-sharing maximums, after which the insurance covers 100% of medical costs.

Cost-sharing includes deductibles and coinsurance. For example, once an enrollee has met their deductible, the worker would pay a coinsurance fee (usually a percentage of the medical costs, such as 15%). Once they’ve reached their cost-sharing maximum, insurance covers 100% of medical charges.

If you have questions about the different metal plans, or your employees want to know more, feel free to contact us.

Metal Plan Coverage

- Bronze plans cover 60% of an enrollee’s medical costs during the year.
- Silver plans cover 70%.
- Gold plans cover 80%.
- Platinum plans cover 90%.

Contact Us

If you have questions regarding any of the articles in this newsletter or have a question about any of your policies, please call us at:

Fringe Benefit Services, Inc.
79 East Connelly Boulevard
Sharon, Pennsylvania 16146
Phone: 724-981-3300, 800-732-9281
Medicare Comparison

Medicare Advantage Enrollees in Better Health

A new study has found that Medicare Advantage patients are healthier than their peers who are enrolled in traditional Medicare plans.

The reason? They’re getting more benefits both in terms of breadth of services and care choices, which can help in earlier detection of health issues.

Medicare Advantage plans cost more as they have these added benefits, but with that extra cost comes better services, lower out-of-pocket costs and caps on those outlays.

The study by Healthpocket found that 97% of Medicare Advantage plans cover at least one extra insurance benefit, such as vision or dental coverage. If an individual has traditional Medicare, they will have to pay for those services out of pocket.

Vision and dental are important as enrollees grow older. Studies have found that an annual eye exam and regular dental checkups can often detect health problems early – and early intervention typically equates to greater success in treating a medical problem.

Finally, traditional Medicare plans do not cover drugs unless enrollees also buy a separate Part D plan. Part D drug coverage is already included in Medicare Advantage plans.

While Original Medicare (Part A and Part B) covers many health care expenses, it doesn’t cover everything.

If you enroll in a Medicare Advantage plan, you’re still in the Medicare program. But, you’ll get your Medicare benefits through your plan, instead of through the federally administered program.

Traditional Medicare is administered by the federal government, while Medicare Advantage is run by private sector insurance companies that provide Medicare benefits.

Medicare pays a fixed amount for an enrollee’s care each month to the companies offering Medicare Advantage plans.

Each plan charges different out-of-pocket costs and has different rules for how enrollees get services (like whether they need a referral to see a specialist, or if they have to go to only doctors, facilities or suppliers that belong to the plan for non-emergency or non-urgent care).

HMO VS. PPO

There are four main types of Medicare Advantage plans, but health maintenance organization (HMO) plans and preferred provider organization (PPO) plans are the most common.

They differ mainly as follows:

- **HMO plans** require that beneficiaries see health care providers, doctors and hospitals within the plan’s network, except in urgent and emergency situations.
- **PPO plans** do not require that beneficiaries use in-network providers and do not require a referral to see a specialist.
- HMO plans may require that beneficiaries choose a primary care physician.
- PPO plans do not require that beneficiaries choose a primary care physician.
- HMOs require that you receive coverage within that plan’s network, except in urgent and emergency situations. You can still receive health care outside of the plan’s network, but the plan may not pay for these services.
- Both HMO and PPO plans generally include prescription drug coverage through a Medicare Advantage Prescription Drug plan.
- With a PPO plan, an enrollee’s out-of-pocket costs will generally be lower if they use doctors and hospitals in the plan’s preferred provider network. They may also choose to use out-of-network providers, but their copayment and coinsurance costs may be higher.

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<thead>
<tr>
<th>MEDICARE ADVANTAGE</th>
<th>TRADITIONAL MEDICARE</th>
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<tr>
<td><strong>Cost</strong></td>
<td><strong>Up-front costs are lower, but out-of-pocket costs are not capped, putting enrollees’ futures at risk.</strong></td>
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<tr>
<td><strong>Additional benefits</strong></td>
<td><strong>Dental, vision and hearing benefits are not available.</strong></td>
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<tr>
<td><strong>Drug benefits</strong></td>
<td><strong>Drug benefits are available if enrollees also purchase Part D coverage.</strong></td>
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<tr>
<td><strong>Out-of-pocket cost</strong></td>
<td><strong>Typically there is a 20% out-of-pocket charge for most services covered by Medicare.</strong></td>
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THE AFFORDABLE Care Act is usually quite rigid in its compliance rules, with minimum contribution levels, minimum value and set amounts for employee participation in group plans.

However, there is one little-known nugget that is a gift for small employers. That’s the special enrollment period for small employers (those with 2–100 workers), who don’t meet participation or contribution requirements.

This part of the Affordable Care Act requires health insurance companies to offer this annual one-month special enrollment period from November 15 to December 15 for January effective dates.

This means employers do not have to meet the normal 75% participation requirement or 50% premium contribution rule. So if you have 20 employees and only two want insurance coverage, you can still enroll with no problems during this one-month period.

Also, during this period, you can set up the contribution amount however you want to, but it can be way lower than 50%. And it does need to be the same for each employee.

WHY SHOULD YOU OFFER A GROUP HEALTH PLAN?

- Employer contribution is 100% tax deductible as a business expense and tax free to your employees.
- Employees can pay their portion of premium with pre-tax dollars (if they have a cafeteria plan in place), which saves both employer and employee in taxes. It’s a win-win!
- In most cases, you’ll have more plan choices to offer in the group market.
- Attraction and retention. You want talent and they expect good benefits.

If you hire someone after open enrollment closes, and they need health insurance but don’t have a special enrollment period, and you don’t have a group health plan in place, that talent may go to an employer with a group health plan in place.

So, if you’ve wanted to be that employer of choice and get a group plan in place, but had the dreaded participation or contribution problem, now is your time.

You should call us today so we can work in advance to prepare to enroll your staff during the 30-day window.

Call: 724.981.3300
The U.S. Equal Employment Opportunity Commission has released final regulations for employer-sponsored wellness programs under the Americans with Disabilities Act (ADA) and the Genetic Information Nondiscrimination Act.

The final rules take effect at the start of 2017 and affect all wellness plans for employees and their family members, even those plans that don’t also require enrollment in a health plan.

Here we look at the final rules:

**Incentives**

Under the final rules, you can offer up to a 30% discount on self-only health coverage to employees in wellness plans, but if you offer more than one health care plan, the incentive cannot exceed 30% of the cost of the lowest-priced option.

The final rules also limit spousal incentives to 30% of employee-only coverage.

Under Health Insurance Portability and Accountability Act (HIPAA) regulations, incentives for a wellness program with a smoking-cessation component are not limited to the 30% rule and can be as high as 50%. However, if the program includes biometric screening or any other tests for the presence of nicotine or tobacco, it would be limited to incentives of 30%.

Employers are also permitted to offer in-kind incentives (e.g., employee recognition, parking spot use, relaxed dress code).

**‘Voluntary’ defined**

The final regulations define what is considered “voluntary”:

- Employers must not require employees to participate.
- Employers may not deny health care coverage to employees who do not participate.
- Employers may not take any adverse employment action against or coerce employees who do not participate.

**Notices**

You must provide employees with a written notice that advises them about what medical information will be obtained through the wellness program, how it will be used and restrictions on its use.

**Confidentiality and information protection**

Information obtained under employee wellness programs is still considered protected health information for purposes of HIPAA compliance.

It is important to ensure that all information is kept confidential and that employees handling the information are well trained on their confidentiality obligations. Employers also must ensure that they do not receive the information in a manner that would disclose the identity of specific individuals.

**Non-discrimination**

To ensure that this exception applies, the program must be “reasonably designed to promote health or prevent disease.”

For example, programs that penalize an individual because his or her spouse suffers from a disease or disorder will not meet this standard.

Information collected under the program must actually be used to design services that address the conditions identified in the information collected.

The ADA bars employers from denying access to a particular health plan because an employee does not answer disability-related questions or undergo medical examinations, the EEOC said in a statement.

Under new ADA regulations, employers must offer reasonable accommodations to allow an employee to participate in a wellness program as long as doing so does not constitute an undue burden.

Also, where an employer’s wellness program provides medical care and rewards an individual for meeting a health standard, the employer must provide a reasonable alternative to earning any incentive.

For example, a program that rewards an employee for reaching a certain body mass index must modify that standard for any employee who cannot reach that BMI for medical reasons, such as a thyroid condition. That way the employee could still earn the financial incentive.

**The takeaway**

If you have a wellness program or are considering implementing one, you should talk to us about your options and discuss any concerns you may have regarding compliance with the new regulations.