



What Employers Need to Know Right Now About Health Care Reform

ESSENTIAL HEALTH BENEFITS, MINIMUM ESSENTIAL COVERAGE, MINIMUM VALUE COVERAGE – WHAT’S THE DIFFERENCE?

The Patient Protection and Affordable Care Act (PPACA) uses terms that sound alike for three very different things. Here’s a closer look at these terms, and when they’re used.

Essential Health Benefits

Significantly affects individuals and small employers with a fully insured plan. Has a limited impact on self-funded and large insured plans.

Beginning in 2014, policies in the individual and small group markets* will be required to provide coverage for each of the 10 “essential health benefits” regardless whether the policy is purchased through or outside the exchange. Self-funded plans (regardless of size), large group plans, and grandfathered plans (regardless of size) do not have to cover all 10 essential health benefits, but they will not be allowed to put lifetime or annual dollar limits on an essential health benefit.

Each state will have its own “benchmark” essential health benefits package. The essential health benefit categories are ambulatory/outpatient, emergency, hospitalization, maternity and newborn care, mental health and substance use, prescription drugs, rehabilitative and habilitative services and devices (for example, speech, physical and occupational therapy), laboratory services, preventive and wellness services and chronic disease management, and pediatric services, including pediatric dental and vision care.

Minimum Essential Coverage

Affects most individuals and all employers with 50 or more employees (regardless whether its plan is self-funded or fully insured).

Beginning in 2014, most Americans will be required to have “minimum essential coverage” or pay a penalty with their tax return. (In 2014, the penalty will be the greater of 1 percent of income

or \$95.) A person will have minimum essential coverage if he or she is covered under an eligible employer-sponsored plan, an individual policy (through or outside the exchange), or a government plan (Medicare, Medicaid, CHIP, TRICARE, VA, etc.).

Also beginning in 2014, employers with 50 or more full-time or full-time equivalent employees will be required to offer minimum essential coverage to nearly all of their employees who work 30 or more hours a week, or pay a penalty. (If minimum essential coverage isn't offered to at least 95 percent of full-time employees and their dependent children, a penalty of \$2,000 per year per full-time employee, excluding 30 full-time employees, will apply.)

A clear definition of "minimum essential coverage" for employer-provided benefits has not been provided yet, but it appears that fairly basic medical coverage will be enough. "Eligible employer-sponsored coverage" includes any plan offered in the small or large group market in a state, as well as self-funded plans, unless the plan only provides "excepted benefits." Excepted benefits are those that provide very limited medical coverage, like hospital indemnity, long-term care and cancer plans, on-site medical clinics, disability income and accident plans, and dental- and vision-only coverage. Plans with annual dollar limits on essential health benefits will not be allowed after 2014, so it is unlikely that a standalone HRA will provide minimum essential coverage.

Minimum Value Coverage

Affects employers with 50 or more employees (regardless whether its plan is self-funded or fully insured) and individuals who may be eligible for premium tax credits/subsidies.

Beginning in 2014, employers with 50 or more full-time or full-time equivalent employees that offer coverage that is less than "minimum value" will have to pay a penalty. (The penalty for not providing minimum value, affordable coverage is \$3,000 for each full-time employee who obtains coverage through a public exchange and receives a premium tax credit/subsidy. Individuals will not be eligible for a subsidy if their employer offers them affordable, minimum value coverage.)

Minimum value coverage is coverage with an actuarial value of at least 60 percent – this means that on average the plan is designed to pay at least 60 percent of covered charges. (The employee would be responsible for the other 40 percent through the deductible, copays and coinsurance.) In the self-funded and large markets, employers will be able to use a calculator provided by the government, and possibly safe harbor plan designs, to make sure their plan meets the 60 percent standard. The proposed calculator can be found here (under the "Plan Management" section, look for Feb. 20, 2013 / Minimum Value Calculator): [Regulations and Guidance | cciio.cms.gov](#). According to HHS, 97 percent of the employer-sponsored plans they surveyed already meet the 60 percent requirement.

In the individual and small group markets, a "bronze" policy will have an actuarial value of 60 percent.

In a nutshell, then:

- Essential health benefits are the kinds of care small plans must cover



- Minimum essential coverage is what individuals must have and large employers must offer if they don't want to pay tax penalties
- Minimum value coverage is what large employers must offer to avoid a different tax penalty

* It is still unclear what size makes a plan "large" or "small" under the essential health benefits rules. Clearly, a plan with fewer than 50 employees is "small" and a plan with more than 100 employees is "large." States have the option to consider plans below 100 as "small" until 2016, but it is not clear yet how they make that choice. (It is clear that a plan is "large" under the minimum essential and minimum value requirements if there are 50 or more full-time or full-time equivalent employees in its control group.)

09-Apr-2013



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