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"Minimum Essential" and "Affordable" Coverage: What Do These Terms Mean?

Starting in 2014, the Affordable Care Act (ACA) will require every American to have "minimum essential coverage" or make a "shared responsibility payment" when filing their federal income tax return. The law allows certain exemptions and will not require shared responsibility payments from individuals who cannot find "affordable" coverage. What do all these terms mean?

"Minimum Essential Coverage"

Health plans that meet the "minimum essential coverage" standards include:

- Individual health insurance plans (including qualified health plans in the Affordable Insurance Exchange)
- Eligible employer-sponsored plans, including COBRA
- Government-sponsored coverage such as Medicare, Medicaid, the Children's Health Insurance Program, TRICARE, and veterans' health care.

Minimum essential coverage does not include certain specialized coverages, such as insurance that covers only a specific disease or condition, including cancer or critical illness insurance, or limited-benefit plans, such as hospital indemnity plans.

If you do not have qualifying coverage, you'll be able to buy coverage on the insurance exchanges created by the ACA. For individuals and small groups, plans will be segmented into four levels of coverage, based on the percentage of covered costs they pay:

- Bronze: 60 percent
- Silver: 70 percent
- Gold: 80 percent
- Platinum: 90 percent

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This Just In…

Study proves provider networks control costs. Out-of-network claims account for only a small portion of paid insurance claims—approximately 12 percent—reported America's Health Insurance Plans (AHIP), a trade association. That's fortunate for consumers, because providers can charge whatever they want for out-of-network services.

AHIP studied maximum billed charges for out-of-network paid claims for specific procedures in the 30 most populous states. Researchers used the applicable Medicare fee as a benchmark, computing billed charges as a percentage of the applicable Medicare fee for the region.

In one data set (claims for the first 30-74 minutes of critical care), researchers found eight of the states studied had maximum billed charge-to-Medicare fee ratios under 1,000 percent of Medicare; 16 states had ratios between 1,000 and 3,000 percent; and six states had billings at more than 3,000 percent of Medicare. The highest paid claim, for $12,000, was 64 times the Medicare payment of $187 for the same service.

AHIP says, "…the cost can be enormous" when physicians "balance bill," or bill patients for any balance remaining after the insurer pays the claim. Insurers' contracts with their network providers generally prohibit this practice.

The moral? Use in-network providers whenever possible.

Protect Your Earning Ability with Disability Insurance

Disability can be more disastrous financially than death. If you are disabled, you lose your earning power, but you still have living expenses and often huge expenses for medical care. Disability insurance can help your family maintain its standard of living while you recover.

Disabilities are more common than you might think. According to U.S. Census data, some 10.5 percent of Americans of working age have at least one disability. Although many disabilities don't prevent a person from working, people with disabilities have a far lower employment rate than any other group tracked by the U.S. Bureau of Labor Statistics, said Sen. Tom Harkin. As he reported to Congress last year, only 37 percent of working age adults with a disability participated in the workforce before the recession. Since then, the participation rate shrank by more than 10 percent.

If you suffered a disability that affected your ability to earn a living, how would you make ends meet?

- **Savings?** Yes, if you have planned ahead. However, only about a quarter of Americans (24 percent) have enough savings to cover six months' worth of lost wages. Another 24 percent have no emergency savings at all.
- **Social Security?** Unlikely. Qualifying for Social Security disability benefits is more difficult than qualifying for benefits under a private insurance plan. Social Security has a very stringent definition of disability. And benefits are low—in 2011, the monthly benefit averaged $1,237 for a disabled man and only $972 for a disabled woman, due to their generally lower pre-disability earnings. Could you maintain your standard of living on that?
- **Employer-provided disability insurance?** Possibly. Employer-sponsored plans can provide basic disability coverage on a group basis—which can be important for people whose health would disqualify them from individual coverage. However, only 39 percent of private industry workers had access to employer-sponsored short-term disability insurance, while only 33 percent had access to employer-sponsored long-term disability insurance.
- **Individual disability insurance?** Individual disability insurance provides portable coverage that you can take with you, even if you leave your employer. And if you buy a noncancellable policy, you can have coverage for life, even if your health status changes, as long as you continue to pay premiums.

Those who have employer-provided disability income insurance can use an individual policy to supplement benefits under the employer's group plan. All disability insurance policies replace only a portion of your pre-disability earnings; some group plans replace as little as 50 percent. Individual plans might replace as much as 80 percent of pre-disability earnings.

If your employer pays the premiums on a group plan, income taxes will further reduce your monthly income. When you buy an individual policy, you pay premiums with taxable dollars, but receive any benefits tax-free.

There are two types of disability policies: Short-term disability policies pay benefits for a maximum of two years, while long-term disability policies pay benefits until either age 65 or life. (Most policies that pay lifetime benefits will reduce your benefits once you reach age 65.)

When purchasing disability insurance, ask:

- **How does the policy define disability?** Some policies consider you disabled if you are unable to perform the duties of any job. Better plans pay benefits if you are unable to do the usual duties of your own occupation.
- **When do benefits begin?** Most plans have a waiting period after an illness before payments begin. A short-term disability policy might begin to pay benefits immediately for a disability resulting from a non-work accident and within a week for one resulting from illness. However, more commonly you'll find policies with waiting periods of two weeks to one month.
- **How long do benefits last?** After the waiting period, payments are usually available until you reach age 65, though shorter or longer terms are also available.
- **What will the policy pay?** In addition to looking at the percentage of income a policy will replace, make sure you understand any offsets. Will your insurer reduce benefits by Social Security disability and workers' compensation payments? Will your benefits increase with inflation? Will the policy sponsor continue making

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Under a bronze plan, your insurer would pay for 60 percent of any covered services after deductibles; you would be responsible for the remaining 40 percent. Assuming you had met your plan's deductible and your doctor charged you $200 for an office visit, your plan would pay $120 and you would pay the remaining $80. You'll pay higher premiums for a plan that pays a higher percentage of covered costs, but your out-of-pocket expenses will be less whenever you use healthcare services.

Exchanges also have the option of offering a catastrophic plan to individuals who are under age 30, who are exempt from the individual responsibility requirement because coverage is unaffordable to them, or who have a hardship. A catastrophic plan must cover essential health benefits and at least three primary care visits.

"Shared Responsibility Payments"

First, the law grants exemptions from the coverage requirement for certain people:

- Individuals who cannot afford coverage;
- Taxpayers with income below the filing threshold;
- Members of Indian tribes;
- Individuals with specific hardships;
- Individuals who experience short coverage gaps (generally less than a month).
- Those who object to health insurance for religious reasons;
- Members of a health care sharing ministry;
- Incarcerated individuals; and
- Individuals who are not lawfully present.

Anyone else must have at least "minimum essential coverage" or pay the penalties.

Starting in 2015, individuals filing a tax return for the previous tax year will indicate which members of their family (including themselves) are exempt from the provision. For family members who are not exempt, the taxpayer will indicate whether they had insurance coverage. For each non-exempt family member who doesn't have coverage, the taxpayer will owe a payment.

Those who can afford to purchase health insurance coverage but do not will face a penalty of the greater of $95 or one percent of income in 2014, $325 or two percent of income in 2015 and $695 or 2.5 percent of income in 2016, up to a cap of the average premium for a "bronze plan," or the least expensive type of health plan available on the insurance exchanges. Families will pay half the amount for children up to a cap of $2,250 for the entire family. After 2016, dollar amounts will increase by the annual cost of living adjustment.

"Affordable"

The ACA makes provisions for those who cannot afford coverage. It expanded access to Medicaid, generally allowing people with a family income up to 138 percent of the federal poverty level to qualify for coverage starting in 2014. (In 2013, the poverty level equals $32,499 or less for a family of four.) However, the Supreme Court's 2012 decision on the Affordable Care Act made this provision optional for the states; some states have opted not to expand Medicaid coverage.

The ACA also creates a subsidy program to help people whose incomes are too high for Medicaid buy private insurance coverage. Individuals with family incomes between 100 and 400 percent of the poverty level will qualify for a "premium assistance tax credit." Individuals not eligible for an employer health plan or a government plan will be able to use these credits to buy health insurance on an insurance exchange. The credit amount will be based on the cost of the second lowest-cost "silver" plan available on the insurance exchange in the individual's area. Calculations for premium assistance credits do not take into account benefits above the "essential health benefits" mandated by the states.

Employees offered employer-sponsored coverage will be eligible for premium credits if their employer plan pays for less than 60 percent of covered benefits or if the employee's share of premiums exceed 9.8 percent of the employee's income. However, in January, the IRS determined that "affordability" would depend on the premiums for single-only coverage, not for family coverage. Since many employers charge more for dependent coverage than for employee-only coverage, it is conceivable that an employee could find affordable coverage for himself/herself, but not dependents. However, those dependents would not be eligible for a subsidy.

For information on how the ACA will affect your coverage, or finding coverage for yourself and/or your family members, please contact us.

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contributions to your pension plan so you have retirement benefits when the disability coverage ends?

We can help you review your disability preparedness plan and make recommendations for appropriate insurance coverages. For more information, please contact us.

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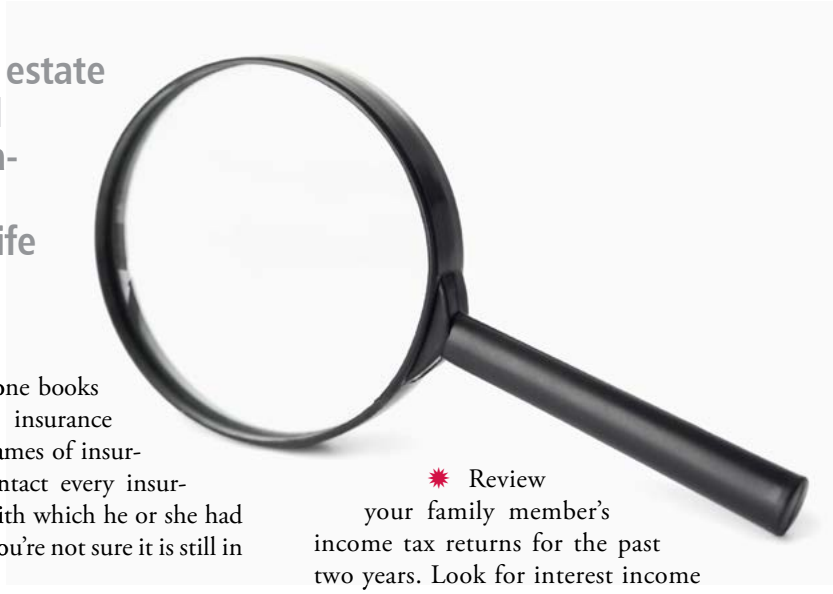
insurance companies licensed to do business in its state.

If your search fails to turn up a policy, the ACLI recommends contacting MIB Solutions, an insurance industry-owned corporation that provides statistical and other information for insurers. For a fee of $75, MIB can check the decedent's name against its database of more than 150 million records on individually underwritten life insurance applications. However, MIB's database does not include coverage issued under a group plan or policies written more than 12 years ago. If you are looking for an older policy and suspect it might have a high death benefit, you might wish to contract for a manual search.

How to Locate a Missing Life Insurance Policy

Maybe you've been named executor of the estate of your very wealthy but very disorganized uncle. Or maybe your relative's valuable papers have been destroyed or lost in a fire, flood or move. In either case, you know a life insurance policy exists somewhere but you can't find it. What can you do?



Every state has laws that "escheat" unclaimed assets to the state— in other words, if the owner of a bank account or policy beneficiary cannot be found, those funds revert to the state for safekeeping until the owner can be found. The National Association of Unclaimed Property Administrators estimates that state treasuries and other agencies are safeguarding at least $58 billion in unclaimed funds. That includes bank accounts, life insurance policies and other financial accounts.

Although states are required to attempt to find owners of these unclaimed assets, their efforts might be limited to publishing a name in a list. If you believe a family member had a life insurance policy that might benefit you, don't rely on the state to find you.

The American Council of Life Insurers (ACLI) recommends taking these first steps to find a missing life insurance policy:

- Check your family member's papers, address and telephone books to look for life insurance policies or the names of insurance agents. Contact every insurance company with which he or she had a policy, even if you're not sure it is still in force.
- Check with the employee benefits office at their latest and previous places of employment. Or, check with the union welfare office.
- Check bank books and canceled checks for the last few years to see if any checks may have been written to pay life insurance premiums.
- Check the mail for a year after the death for premium notices, which usually are sent annually. If a policy has been paid up, there will not be any notice of premium payments due. However, the company may still send an annual notice regarding the status of the policy or it may pay or send notice of a dividend.
- Review your family member's income tax returns for the past two years. Look for interest income from and interest expenses paid to life insurance companies. Life insurance companies pay interest on accumulations on permanent policies and charge interest on policy loans.
- Check with the state's unclaimed property office to see if any unclaimed money from life insurance policies may have been turned over to the state. If, after a number of years, an insurance company holding the unclaimed money cannot find the rightful owner, it turns the money over to the state.
- Contact life insurance companies directly to see if a policy exists. Each state insurance department has a listing of life

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How Will the ACA Affect Covered Benefits?

Starting in 2014, the Affordable Care Act (ACA) requires all non-grandfathered health plans offered to individuals and small groups to include a core package of items and services known as "essential health benefits" (EHBs). What are these EHBs?

EHBs must include items and services within the following 10 categories:

1. **Ambulatory patient services**
2. **Emergency services**
3. **Hospitalization**
4. **Maternity and newborn care**
5. **Mental health and substance use disorder services, including behavioral health treatment**
6. **Prescription drugs**
7. **Rehabilitative and habilitative services and devices**
8. **Laboratory services**
9. **Preventive and wellness services and chronic disease management**
10. **Pediatric services, including oral and vision care**

The ACA requires these EHBs to be equal in scope to benefits offered by a "typical employer plan."

Because each state regulates health insurance plans sold within its borders, and because insurance costs depend largely on regional medical costs, the U.S. Department of Health and Human Services has proposed a rule that would allow every state to define EHBs using a state-specific benchmark plan. This will allow plans to reflect current markets in the various states. In the event a state does not make a selection, HHS will select as the default benchmark the largest small group plan in the state.

Insurance industry observers are concerned that requiring plans to cover these EHBs will make health insurance even more expensive than it is already.

In addition, every state has laws that require health insurance policies to cover certain services. The National Conference of State Legislatures reported that some 1,600 to 1,800 state laws defined treatments and services that health insurance policies must cover. It says, "States continue to debate whether such mandates actually ensure adequate protection for their constituents or further increase their health care costs." Whether a state includes mandated benefits over and above the EHBs in its benchmark plan could greatly affect affordability of coverage in that state.

We can help you compare health insurance policies in terms of coverage and cost. Please contact us for information. ■