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How will Health Care Law affect *your business*?

Mr. John Q. Sample
Title or Benefits Manager
XYZ Company [Direct]
1234 Any Road
Anytown, US 12345



The answers are inside ...



Mr. John Q. Sample
Title or Benefits Manager
XYZ Company [Direct]
1234 Any Road
Anytown, US 12345

Customer ID: 0000000



Month, XX 2013

Independence Blue Cross is your partner in Health Care Law

Dear John Q. Sample,

As the Health Care Law becomes effective, it's important for small businesses to be aware of how the law will affect the way you provide health care benefits to your employees.

Fortunately, as a current **Independence Blue Cross** customer, you'll have access to our resources to help guide you through the challenges of providing health care benefits to your employees.

We'll help guide you through the changes, step-by-step.

Over the next few weeks, we'll be providing you with clear, detailed information. These resources will take you through everything you need to know and do in order to help secure the best health care benefits for your employees.

There's nothing for you to do right now.

You don't need to take any action just yet. Simply review the enclosed booklet — it will help you understand the impacts the Health Care Law will have on your business. It will also help you answer any questions your employees will have, as they experience coverage changes. More helpful information is on the way, so keep an eye on the mail as you near your renewal date.

As always, if you have any questions, we'll be happy to help. Contact your broker, ABC Broker Company at XXX-XXX-XXXX or call us directly at 215-241-3400.

Thank you for choosing Independence Blue Cross.

Best regards,

A handwritten signature in black ink that reads "Brett A. Mayfield". The signature is fluid and cursive, with the first name "Brett" being the most prominent.

Brett Mayfield
Vice President of Sales

P.S. As your 2014 renewal approaches, you'll be receiving information that details the specific changes to the coverage you currently offer to your employees. This will be extremely helpful when explaining their plan options.



The Small Business Guide to Health Care Law

How new changes in health care law will affect you and your employees

Independence 

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Introduction

As an employer or benefits manager, health insurance is one of the most important things you can provide for your employees and their families. However, many things about health insurance are *changing*.

Independence Blue Cross (IBC) created this ***Small Business Guide to Health Care Law*** to help you understand how the health care law (officially called the **Patient Protection and Affordable Care Act**) will affect the way you provide health care benefits to your employees.

This Guide is full of information and tools that will help you and your business prepare for the changes ahead as some key parts of the law are implemented. It includes:

- an outline of the upcoming health care law changes
- helpful charts that detail new plan requirements and tier structures
- step-by-step instructions for calculating eligible employees
- tips to help you understand and properly claim your tax credits
- a glossary that explains common health care terms

Independence Blue Cross is here to help you navigate through your health care choices during this transition. Please feel free to contact us with any questions you may have. We'll be happy to help.

This Guide has been prepared by Independence Blue Cross as a general reference source for your use. The Guide is not intended to provide legal and/or tax advice. Please consult with your legal and/or tax advisor regarding your particular circumstances.

Part I: A General Overview of Health Care Law

How does the new Health Care Law affect Small Businesses?

The provisions that make up the Health Care Law will affect virtually everyone — including small businesses. Here is a list of some of the upcoming things that will change with the new health care law:

- Everyone will be required to have health insurance
- Individual and Small Group health plans must include 10 core benefits, which are referred to as essential health benefits
- Employees must work at least 30 hours per week to be considered full-time
- Many single people and working families who purchase their coverage on their own may get assistance from the government to help pay their health care coverage costs. This includes many people who the government does not currently help.
- Many state Medical Assistance programs, also known as Medicaid, are expanding by offering health plans to more people who are uninsured*
- There will also be a new alternative to buy health insurance: the Health Insurance Marketplace
- Rates for individual and small group plans (up to 50 employees) will be based on who will be covered under the health plan, their age, where they live, whether they smoke, and the health plan selected

*At this time, the Commonwealth of Pennsylvania is undecided about whether it will expand Medicaid coverage. If this changes, it will affect eligibility for Medicaid and tax credits/subsidies.

Responsibilities of Employers and Employees

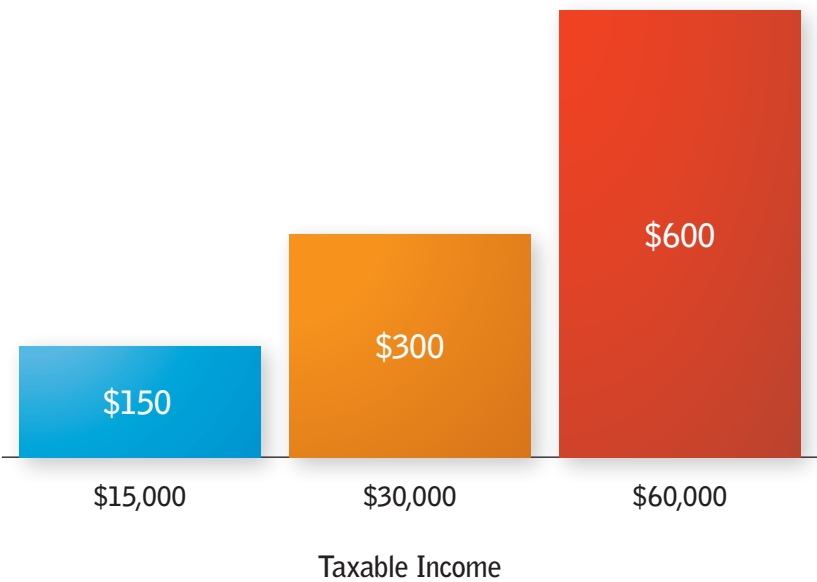
As of January 1, 2014, most individuals will need to enroll in health care coverage or be subject to government penalties. This provision is known as the **individual mandate**. One of the ways an individual can obtain health coverage is through a group health plan provided by an employer.

Groups **up to 50 employees** do not have to offer health care coverage, although the **Individual Mandate** for health coverage still applies to their employees.

As of January 1, 2015, groups with 50 or more full-time or full-time equivalent employees will be required to offer health care coverage to all their full-time employees or face a penalty. This is referred to as the Employer Shared Responsibility rule.

If you have questions regarding the penalties that could impact groups with 50 or more employees, please contact your IBC account representative or independent broker.







2014 Sample Penalty for Individuals Without a Health Plan







New Plan Requirements

Beginning January 1, 2014, all health plans offered to individuals who purchase their own health insurance, and to small businesses (up to 50 employees) must include a core set of **essential health benefits**.

There are no annual or lifetime limits on the amount your health plan spends on these core services for your employees and their families. Essential health benefits include these categories of services:

Essential Health Benefit	Example
 Preventive, wellness and disease management services	Yearly physical, flu shot, gynecological exam, birth control
 Emergency care	Treatment for broken bones, heart attacks and more at a hospital emergency room
 Ambulatory services	Minor surgeries, X-rays
 Hospitalization	Treatment at a hospital for a condition that requires you to stay overnight or multiple days
 Maternity and newborn services	Care through the course of a pregnancy, delivery of the baby and checkups after the baby is born
 Pediatric services, including dental and vision	Well visits, shots to prevent serious health conditions, teeth cleanings, braces, exams, glasses and contact lenses

Essential Health Benefit	Example
 Prescription drugs	High blood pressure medicine, insulin, antibiotics, birth control pills
 Laboratory services	Blood test
 Mental health and substance abuse services, including behavioral health treatment	Getting help to deal with conditions like depression, alcohol abuse, and drug abuse
 Rehabilitation and habilitation services	Physical therapy, speech therapy, occupational therapy

More changes are on the way

While this section of your guide outlines many of the upcoming changes of Health Care Law, not all provisions will take effect by January 1, 2014. In addition to rating restrictions and limits on deductibles and waiting periods, small groups will have other changes to consider. Not to worry — as these changes unfold, Independence Blue Cross will help keep you prepared and informed, with all the facts and tools you need to help you make the best decisions for your business and your employees.





Part II: New Coverage Levels

New Metallic Tiers

With the Health Care Law, the federal government is creating four new levels of coverage — or metallic tiers — for plans offered to small businesses (up to 50 employees) and individuals that purchase their own insurance.

All new individual and small group plans will be assigned one of these metallic tiers based on how much of the cost of health care services are covered by the health insurance company. These “metallic” categories — bronze, silver, gold and platinum — will make it easier for you to compare health plans among health insurance companies. Regardless of the tier, all products will cover essential health benefits like doctor visits, prescription drugs, X-rays, and hospital stays. The major differences will be in what you pay when you need these services and the monthly cost of the health plan.

Here is how the metallic tiers compare:

				
	Platinum	Gold	Silver	Bronze
Actuarial Value	90%	80%	70%	60%
Monthly Cost	\$\$\$\$	\$\$\$	\$\$	\$
Cost When You Get Care	\$	\$\$	\$\$\$	\$\$\$\$
Good Option If You...	Plan to use a lot of health care services	Want to save on monthly premiums while keeping your out-of-pocket costs low	Need to balance your monthly premium with your out-of-pocket costs	Want a low premium and are willing to pay more for services as they are needed

Understanding Tier Costs

The grouping of health plans by metallic levels will help you compare plans and help your employees to better understand the level of coverage their plan will provide.

As you can see, bronze health plans will have the lowest monthly costs but will likely have higher cost-sharing when you use services. Platinum health plans will cost the most each month, but your costs will probably be lower when actual services are provided.

The metallic levels group plans by **actuarial value**. Actuarial value is the average share of total health spending on essential benefits paid for by the plan. The actuarial value of a plan reflects the cost sharing — deductibles, co-insurance, co-payments and out-of-pocket limits — the consumer is responsible for paying.

For example:

Suppose the average share of total health spending on essential health benefits by a plan is \$6,000 per person and the plan covers \$4,200 of that cost per person, which translates to 70% of the cost of benefits. Therefore, the actuarial value of that plan is 70%, making it a silver plan. Your employees' cost sharing is 30%.

Health insurance companies like Independence Blue Cross will have tools to help determine which health plan will provide the lowest overall cost based on your needs. By answering a few questions about your company's health care needs, you can get an estimate on your monthly premiums and cost-sharing charges for receiving care.

Part III: Changes to Premiums and Eligibility

New Premium Calculation Factors

The Health Care Law also changes the rating methodology used to calculate premiums, or the amount insurance companies charge for a health plan. Currently, laws that vary from state to state determine premiums, and insurance companies can consider a number of factors when calculating premium costs for small groups, such as:

- gender ratio
- pre-existing medical conditions*
- employees' health status over the previous year
- geographic area

However, the factors that can be used in premium calculations will change in 2014.

* IBC has not used pre-existing conditions as a rating factor in small group before, however now it is a federal law that carriers can no longer deny coverage because of a pre-existing condition or charge a higher rate.

Beginning January 1, 2014, rating restrictions limit insurance companies to only four factors for adjusting premiums:

- **individual/family enrollment** determines whether coverage is provided only for an individual or a family. For families with more than three children, the rates are based on the spouses/partners and the oldest three dependents.
- **geographic area** captures differences in the cost of health care services in different parts of a state or region.
- **age** is factored differently for individuals who are younger or older. Individuals up to age 20 are in one age bracket, as are those who are 65 or older. Individuals between 21 and 64 are rated by their specific age.
- **tobacco use** also determines differences in premiums between tobacco users and non-users.

Definition of Tobacco User

As you'll notice from the new premium calculation factors, your employees' tobacco usage now contributes toward the cost of your premium. Under the Affordable Care Act (ACA) you may be able to reduce your premium if you have employees who:

- don't use, or limit the use of tobacco products, or
- have committed to reducing or eliminating the use of tobacco products through a certified tobacco cessation program

The Health Care Law defines "tobacco use" as the use of any tobacco product four or more times a week on average within the last six months. This does not apply to anyone who uses tobacco products for religious or ceremonial use.

Limits on Waiting Periods

Employers sometimes have certain requirements before their employees become eligible for benefits. These requirements can vary — an employer might decide new employees must work a certain number of hours, or work for the company a certain number of days after the hire date before they are eligible for the company's health plan.

Starting on January 1, 2014, Health Care Law will limit the maximum waiting period for a new employee to become eligible for health care benefits to no more than 90 days.



Part IV: Group Size Validation

How to determine group size

To determine your group size, you first need to calculate the number of hours worked by your full-time and full-time equivalent employees.

Determine your full-time employees by identifying all employees who work 30 or more hours per week. Add to that amount, the number of your full-time equivalent employees.

You must also account for part-time workers, by calculating full-time equivalents as follows:

-  Add up the total hours worked by part-time employees per month and divide this number by 120.
-  Add this number to your total number of full-time employees – this will give you your group size.




Seasonal workers may also contribute to your overall group size.

For more details on how to determine your group's size, please refer to the [IRS website](#) or consult your legal or accounting professional for assistance.

Definition of hours of service

An employee's hours of service include each hour for which he or she is paid, or entitled to payment, during the tax year. You must also add each hour of paid leave (no more than 160 hours of service are required to be counted for an employee).

Here are 3 ways to determine hours of service per employee:

-  Determine actual hours of service from records of hours worked and hours for which payment of wages is made or due, including hours for paid leave;
-  Use a days-worked equivalency which credits the employee with 8 hours of service for each day payment of wages is made or due, including days of paid leave; or
-  Use a weeks-worked equivalency which credits the employee with 40 hours of service for each week payment of wages is made or due, including weeks of paid leave.

To calculate your group size:

Once you have determined each employee's accurate hours of service, add up the total hours of service you pay wages to your employees during the year (but not more than 2,080 hours for any employee). Divide by 2,080. If the result is not a whole number, round it to the next lowest whole number. If the result is less than one, round up to one.

Seasonal workers are generally not covered unless they work more than 120 days per year. However, premiums you pay on behalf of seasonal employees may be counted in to determine the amount of your credit.

Part V: Tax Credits

Tax Credits for Small Employers

Tax credits became available in 2010 for small groups that provide health insurance to their employees. In 2014, these small group tax credits will be available only for small group health coverage purchased on the Small Group Marketplace Exchange — known as the Small Business Health Options Program, or SHOP.

To understand how small groups will be affected by the new tax provisions, you need to look at what tax credits are available to the small group market and the criteria you must meet to qualify for tax credits. You should consult with your tax advisor.

What is currently available to help small groups?

Health Care legislation made some tax credits available to small groups beginning January 1, 2010. The small business tax credits occur in two phases.

Phase 1: 2010 – 2013

Employers with 25 or fewer employees can claim up to 35% of their health care costs as a tax credit.

Phase 2: 2014 – 2016

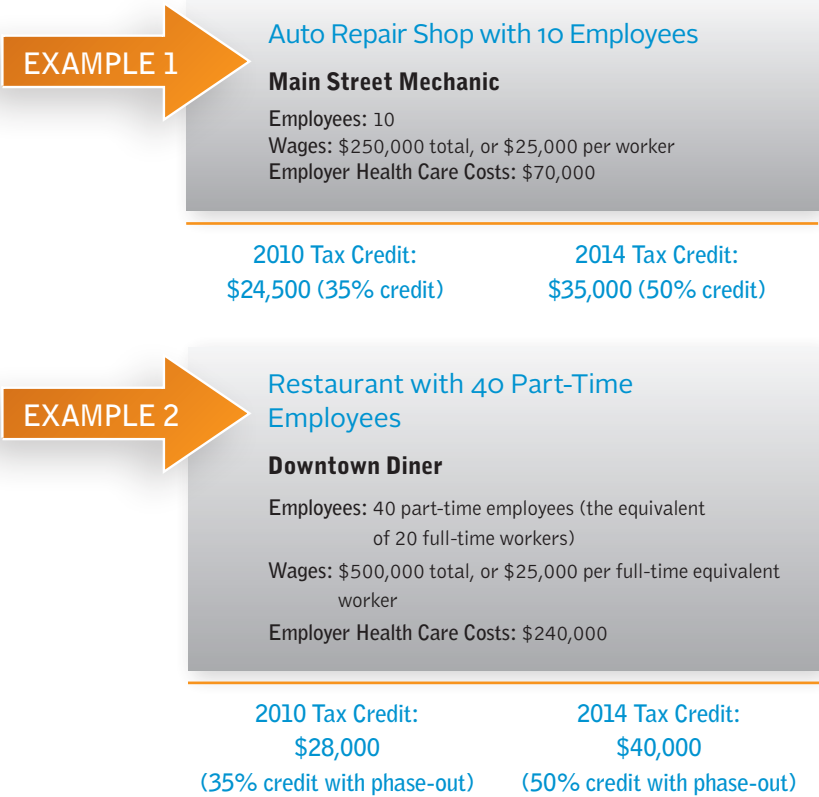
Employers with 25 or fewer employees that purchase health insurance through the SHOP Marketplace may claim up to 50% of their health care costs as a tax credit.

Which companies can claim tax credits?

Right now, your business may be eligible for tax credits up to 35% of your annual premium costs if you meet the following basic criteria:

- You have 25 or fewer full-time employees (not counting owners, family members, partners, shareholders and sole proprietors)
- You pay your employees (not counting owners or family members) average wages of less than \$50,000 per employee
- Your company pays for at least 50% of your employees' total health insurance premium costs (not family premium costs)

Here are some examples* of how tax credits will change in 2014:



*Source: www.whitehouse.gov/the-press-office/fact-sheet-small-business-health-care-tax-credit

Part VI: Glossary

Glossary of Common Health Care Terms

Here are simple definitions of some of the health insurance terms in this guide:

Actuarial Value: Actuarial value is the average share of total health spending on essential health benefits paid for by the plan. The Metallic Tier levels are grouped by Actuarial Value.

Employer Shared Responsibility: A provision of Health Care Law that requires groups with 50 or more full-time or full-time equivalent employees to provide affordable health coverage that provides a minimum level of health care coverage to their employees. If affordable health care coverage that provides a minimum level of health care coverage is not provided and a group member obtains a subsidy from the individual Marketplace, the group will be subject to a government penalty.

Essential Health Benefit: A set of ten (10) core health care service categories that must be covered by individual and small group plans, purchased in 2014. These include doctor office visits, hospitalizations, and prescriptions. Insurance policies must cover these benefits to be certified and offered in exchanges, and all Medicaid plans must cover these services by 2014.

Group Size: The number of full-time and full-time equivalent employees employed by a company. In 2014, the definition of a full-time employee is someone who works at least 30 hours per week.

Health Insurance Marketplace: A state marketplace where consumers and small businesses can shop for health insurance, comparing products and prices. Also known as “Exchanges” and “Small Business Health Options Program (SHOP).”

Individual Mandate: A provision of Health Care Law that requires individuals to have health care coverage by 2014 or the individual may be subject to government penalties.

Metallic Tiers: Four (4) new product levels of health care coverage established by the Health Care Law. These new tiers (Platinum, Gold, Silver and Bronze) will define the costs and coverage of health plans offered to small businesses.

Small Business Health Options Program (SHOP): A state marketplace where small businesses can shop for health insurance coverage. Also known as “Exchanges” or “Marketplace.”



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