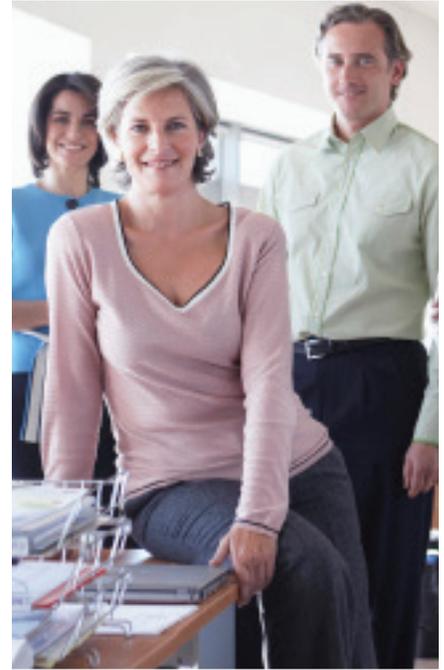


Employer's Guide To Health Care Reform



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Excellus BlueCross BlueShield

has been serving the Upstate New York community for over 70 years. During life's surprises the best resource is a trusted guide to make complex decisions simple. Having assembled a dedicated team of experts specializing entirely on the Health Care Reform legislation, it is our job to work through the laws and regulations to reveal how they impact you as an employer in the real world. This Resource Guide covers many Frequently Asked Questions (FAQs), including the options you have, information you will need, and questions to consider along the path to ensure you and your company are protected.

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Starting Point For All Employers



Change is coming, and you have choices! The most important thing for employers to know is that Health Care Reform may bring with it some changes to health insurance and healthcare, but not everyone will be affected by these changes. More importantly, there are many options for both employers and their employees.

The first step in learning about these choices is to assess an employer's current insurance coverage and requirements under Health Care Reform, also known as the Affordable Care Act (ACA).

- ▶ **Step 1: Determine requirements for employers.** Only employers with 50 or more full-time equivalent employees are required to provide insurance by 2015 or risk having to pay a penalty. See page 4 for assistance with determining your company size under the new regulations.
- ▶ **Step 2: Determine if your benefits will change.** Employers can continue to purchase coverage as they do today, either directly from an insurance company or through a broker. Most plans (for employer groups as well as families and individuals) must cover certain standard benefits (including a number of preventive benefits) in order to be offered in 2014 and beyond, called Essential Health Benefits.
- ▶ **Step 3: Find out where to purchase health insurance.** Employers have the option to purchase insurance coverage the same way they do today: either directly from a health insurance carrier or through a broker. Starting in 2014, some smaller-sized companies have the added option to buy insurance on the SHOP Exchange – a marketplace designed exclusively for businesses with fewer than 50 employees. See page 10 for more information about insurance options for small employers and page 15 for information directed at large employers.

Determine Impact To Your Company

One of the largest changes with Health Care Reform is the rule requiring some employers to provide insurance to their employees or pay a penalty, also known as the “Employer Mandate” or “Play or Pay” provision of the law. The penalty and associated reporting has been delayed until January 1, 2015. The size of your company will determine the impacts of the Employer Mandate and the options available to you. The following chart shows how “small size” and “large size” businesses are impacted by Health Care Reform.

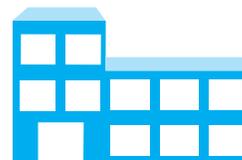
How Employers Are Impacted By Health Care Reform

Small Size Businesses



Less than 50 employees

Large Size Businesses



50 or more employees

	Small Size Businesses Less than 50 employees	Large Size Businesses 50 or more employees
Required to provide insurance	No	Yes, only to full-time employees* OR pay a penalty
Coverage requirements?	If the employer has a plan already, it must cover certain Essential Health Benefits and meet one of the “Metal Levels” of coverage (60%, 70%, 80% or 90% of the Actuarial Value of the plan).	Plans must have a minimum value of a least 60% and not cost employees more than 9.5% of their income.
Where to buy insurance?	If employers have insurance today, the plan’s benefits may change to ensure it meets all the coverage requirements. Employers can continue to buy insurance as they do today (either directly from an insurance company or through a broker) or purchase from the SHOP Exchange.	If employers have insurance today, it is likely they can keep the same plan with just a few modifications to bring it into compliance under Health Care Reform. If they need coverage, they can buy insurance the same way they would today, either through an insurance company directly or a broker.

*Full-time is defined as those working an average of 30 or more hours per week.

Large Employers

Today, large group employers are typically defined as those with 50 or more eligible employees. These employers will be required to offer minimum, affordable health insurance to their full-time employees beginning in 2015 or pay a penalty. "Full time" is defined as anyone working an average of 30 hours or more per week. If the employer already offers coverage, there are two things that should be reviewed to determine whether the coverage offered is sufficient to avoid penalties in 2015:

Does the coverage provide minimum value benefits? Minimum value requirements mean that the insurance pays, on average, at least 60% of covered health care expenses for the member/customer population.

Can employees afford the coverage? A plan is considered affordable as long as full-time employees do not spend more than 9.5% of their taxable household income¹ on the monthly premiums.

If the employer's coverage meets the minimum value and affordability requirements, it is very likely the employer will not have to pay a penalty. Keep in mind while the employer penalties are delayed until 2015, if an employer does not offer minimum, affordable health insurance in 2014, affected employees are still eligible to receive subsidized coverage on the health insurance exchange.

Starting in 2015, large employers will be required to report information on the health insurance they offer to the Internal Revenue Service (IRS), including:

- Number of full-time employees
- If coverage was offered to full-time employees and dependents
- The employees and their dependents who are enrolled in the plan(s)
- Employee's contribution to the premium

Employers are required to report the cost of health insurance starting January 2013 on their employees' W-2 forms filed for the 2012 tax year². Employers must report "applicable employer-sponsored coverage", including most tax-free health insurance coverage available to employees. Employers may report the total insurance premium cost charged by the health plan, or they may report costs determined by calculating the COBRA applicable premium (or a modified version), including:

- The cost of the health insurance provided, even if offering a self-funded or grandfathered plan (it is not necessary to report the cost of health insurance coverage for terminated employees who request their W-2 before the end of the tax year)

Employers have the option to choose how to report the cost of terminated employees' health insurance coverage, as long as the chosen method is reasonable and is used consistently for all affected employees.

These reporting requirements do not include: long term care coverage; accident, disability, and liability coverage; standalone dental or vision coverage; contributions to HSAs or Archer MSAs; or an employee's salary reductions for FSAs (however, employer contributions to an FSA should be included).

¹ The total income may be found on Box 1 of an employee's W-2 form. This amount is the total taxable income before taxes, and in some cases may include certain salary reductions.

² Employers with less than 250 W-2s for the 2011 tax year will be exempt.

Small Employers

Today, small group employers are typically defined as those with fewer than 50 eligible employees. Under Health Care Reform, this definition will still apply when a small group purchases health insurance coverage as it does today (either directly from an insurance company or from a broker). However, for purposes of determining whether an employer is subject to the Employer Mandate (whether the employer must offer minimum value, affordable coverage or risk paying a penalty) the number of full-time equivalent employees must be calculated.

Full-time “equivalent” employees include full-time employees plus all non-full-time employees to determine your total number of full-time “equivalent” employees. Employers can use the calculator below to determine their company size under Health Care Reform for purposes of the Pay or Play mandate:

Company Size Calculator

Complete the form below to calculate the employer's company size.

<input type="text"/>	÷	120	+	<input type="text"/>	=	Total is 50 or more = Large Employer Total is less than 50 = Small Employer
Total number of monthly hours worked by part-time employees (those working less than 30 hours per week)				Number of employees working more than 30 hours per week		

An employer may have 50 or more employees but not be considered a “Large Employer” and therefore subject to the Employer Mandate (penalty regulations) if they meet the following conditions, also called the “seasonal employee exception”:

- The entire staff works less than 120 days during the calendar year; OR
- Employees in excess of 50 who were employed during that 120-day (or less) period were seasonal workers.

Options For Individuals & Families



Health Care Reform requires most Americans to have a qualified plan by January 1, 2014. The law makes purchasing insurance easier and more affordable for people by providing three different ways to get insurance coverage:



Option 1

Get insurance from your employer or your spouse's health insurance plan if available.



Option 2

Buy insurance on the Exchange Marketplace designed for individuals and families



Option 3

Buy insurance directly from an insurance carrier or broker as you would today.

The remainder of this section will focus on Option #2: Individual "Exchange" or Marketplace.

Plans On The Individual Exchange

Starting October 1, 2013, individuals and family members will be able to research, compare and purchase health insurance coverage through the Individual Exchange or Marketplace. This marketplace will be available online, in-person and by phone or mail.

The Individual Exchange will have four different plan types: **bronze**, **silver**, **gold** and **platinum**. These are oftentimes simply referred to as "Metal Levels". Each of these plans must cover the same set of Essential Health Benefits and differ by the amount of covered out-of-pocket expenses, such as copays and deductibles. Health insurance carriers are required to offer at least one plan in each metal level on the Exchange.

The chart on the next page shows the amount, on average, that the Health Plan is responsible for paying and the rest that the customer or member pays.

	Monthly Premium	Cost-Share
PLATINUM	90%	10%
GOLD	80%	20%
SILVER	70%	30%
BRONZE	60%	40%

This chart shows that platinum plans will be the most generous, meaning that the Health Plan will pay on average about 90% of the costs for covered services like hospitalization, doctor visits and prescription drug coverage, and the member would have to pay the remaining 10%. In comparison, the Health Plan would pay less for those expenses on a bronze plan (60%) and the member would pay the remaining 40% for those services covered under the insurance. These percentages (also referred to as “Actuarial Values”) are just averages, so actual costs may be higher or lower. Visit the Actuarial Value Calculator at www.cciio.cms.gov for more information.

It is important to note that there is a limit on how much a plan can charge for out-of-pocket costs, including copays, coinsurance and deductibles. This is sometimes referred to as an “out-of-pocket maximum”. However, the amount a person pays for their monthly coverage (called a premium) may be higher or lower depending on which health insurance carrier they choose.

In addition to the four metal levels, some individuals can purchase catastrophic coverage, which covers Essential Health Benefits and three visits to a primary care doctor per year. These plans typically cost less per month (lower monthly premiums) but usually have higher out-of-pocket costs for things like deductibles and coinsurance. Catastrophic coverage is only available to people aged 30 or younger OR adults over 30 who cannot find a plan that is 8% or less of their income. It is also important to note that if catastrophic coverage is selected (regardless of the person’s income), the person would not be eligible for financial help paying for the insurance in the form of a tax credit or cost-sharing assistance.

Buying Coverage On The Exchange

Exchanges will be open for business starting October 1, 2013 and closing on March 31, 2014³. This is known as an Annual Election Period and is the time to shop for plans and determine whether the person can get help paying for their plans or the cost of their benefits. It is important to note that if insurance is needed by January 1, 2014, a plan must be purchased by December 15, 2013 so that it is effective in time to meet that deadline.

A person or family will be eligible to buy coverage on the New York State Exchange if they are:

- An American citizen, national or non-citizen lawfully present in the United States;
- Living legally and permanently in New York State (if you reside in another state, you would purchase from that state’s Exchange);
- Not eligible for Medicaid; and,
- Not incarcerated (except pending disposition of charges).

³ This annual enrollment period lasts six (6) months for one year only. After 2014, the annual election period will run from October 15 – December 7 of each year.

Only people with special circumstances (called a “qualifying event”) can buy or change their health insurance after the March 31, 2014 deadline. Typical qualifying events include:⁴

- Giving birth to a child, adopting a child or placing a child up for adoption
- Gaining a child through marriage
- No longer receiving insurance through their employer
- No longer have the minimum necessary coverage through their employer’s insurance to meet the requirements of what is called “minimum value” (benefits that must be included as part of an employer’s plan)
- Lose health insurance coverage or minimum value of coverage (unless it’s because premiums were not paid, or if there was intentional fraud or misrepresentation of material fact)
- Becoming a U.S. citizen, national, or recently lawfully present
- Moving to a region outside of their health insurance coverage area
- Experienced a change in income that would make him/her eligible or ineligible for certain financial help
- The Health Plan violates their contract with the member in some way
- Either was enrolled or not enrolled on a plan due to an error by the Exchange
- Is Native American or Alaskan Native (these individuals can purchase and change their insurance up to once per month, regardless of any other qualifying events or circumstance).

Employers do not need to purchase coverage on the Exchange, and can continue to purchase insurance as they do today, directly from the carrier or through a broker. Certain smaller businesses with less than 50 employees have the option to buy insurance on the SHOP Exchange, which is similar to the Individual Exchange, and by 2016, the SHOP will expand to include employers with less than 100 employees. See page 11 for more information about the SHOP Exchange.



⁴ Please note that this is not a complete list and New York State may allow a special enrollment period for individuals with exceptional circumstances.

Help Paying For Insurance

Financial assistance is available for those who qualify to help pay for premiums (a “premium tax credit”) and to reduce out-of-pocket costs like deductibles and copays (called “cost-sharing reductions”). The chart below, the “2013 Federal Income Guidelines”, lists the income thresholds that would make an individual or family eligible for Medicaid, a cost-sharing reduction or premium tax credit depending on the size of the family⁵.

Get Help Paying for Your Health Insurance 2013 Federal Income Guidelines*			
You may be eligible for help if you have a household income between these limits:	Medicaid	Cost-Sharing Reductions	Premium Tax Credits*
Single person	\$0- \$15,282	\$15,283 - \$28,725	\$15,283 - \$45,960
Family of two	\$0 - \$20,628	\$20,629 - \$38,775	\$20,629 - \$62,040
Family of three	\$0 - \$25,975	\$25,976 - \$48,825	\$25,976 - \$78,120
Family of four	\$0 - \$31,322	\$31,323 - \$58,875	\$31,323 - \$94,200
Family of five	\$0 - \$36,668	\$36,669 - \$68,925	\$36,669 - \$110,280
Family of six	\$0 - \$42,015	\$42,016 - \$78,975	\$42,016 - \$126,360

Source: Department of Health and Human Services. Full calculator available at <http://aspe.hhs.gov/poverty/13poverty.cfm>

* Some individuals and families with household incomes below these limits may qualify for a Premium Tax Credit in certain circumstances where Medicaid is unavailable. Visit the full calculator for more information.

It is also important to mention that if a person or family can get the minimum required coverage through their employer OR if they are eligible for Medicaid, Medicare or another government-sponsored plan, they may not be eligible for financial help.

When a person applies for an Exchange insurance plan, they will be asked to answer questions about their income. One question is what their income is at the time they apply or what they expect their income to be during the year they are applying for coverage. This application will be verified by federal data from the Internal Revenue Service (IRS). As long as that income matches the information that the IRS has OR is no more than 10% below, it would be accepted as proof of income.

For example, if you were a single person who made \$40,000 in 2013 and estimate that you will earn \$36,000 in 2014 – just 10% less than what you made in 2013 – you would be within the guidelines. But if you estimate that in 2014 you would make much less, let’s say \$30,000 (25% less than what you earned the year before) your application might not be approved.

Penalties For Individuals & Families

Those who can afford health insurance but decide not to have it may pay a fine, called the **Individual Penalty**⁶. The penalty varies by income, household size and year that the individual or family was without health insurance:

2014:

Penalty is \$95 per adult and \$47.50 per child (up to \$285 for a family) or 1% of the total household income (whichever is greater).

2015:

Penalty is \$325 per adult and \$162.50 per child (up to \$975 per family) or 2% of the total household income (whichever is greater).

2016 and beyond:

Penalty is \$695 per adult and \$347.50 per child (up to \$2,085 per family) or 2.5% of the total household income (whichever is greater).

Some people may find that they are only insured for part of the year. In this case, the penalty would be calculated (“pro-rated”) based on the number of months the person or family went without health insurance coverage. For example, if the plan started (became effective) on September 1, 2014, the person would pay for the eight (8) months of the year they were without insurance (from January – August). People can go without health insurance up to three (3) consecutive months without facing a penalty.

The Internal Revenue Service (IRS) will collect the penalty on an individual’s or family’s annual federal income taxes for the previous calendar year. *For example, if a person did not have health insurance in 2014, they would pay the penalty when filing their tax return by the April 15, 2015 tax deadline.*

Who Is Exempt from Paying the Penalty? Certain people may be exempt from the Individual Mandate and therefore are not required to have insurance or pay a penalty. This includes:

- People who are exempt from filing annual income taxes;
- Members of certain religious organizations;
- Members of health care sharing ministries;
- Unauthorized aliens;
- Incarcerated individuals;
- U.S. citizens who are living abroad;
- Members of Native American tribes; and,
- Individuals granted hardship exceptions.

⁶ The “Individual Penalty” is not to be confused with the “Employer Penalty” which is the amount select employers would be fined if they do not provide insurance to certain full-time employees.

Options For Small Group Employers



An employer with less than 50 eligible employees is considered a “small employer” today and will continue to purchase coverage as a small employer for 2014. If you are considered a small employer, you have three options when it comes to offering health insurance coverage under health care reform:



Option 1

If it has all the minimum essential benefits, keep the coverage you have today



Option 2

Buy insurance directly from an insurance carrier or broker as you would today



Option 3

Buy insurance on the SHOP Exchange designed exclusively for smaller sized businesses

To verify if you are subject to the Employer Mandate, which requires employers with 50 or more full-time equivalent employees to offer coverage or pay a penalty, calculate the number of full-time equivalent employees as described on page 4. Keep in mind, while penalties do not apply to small employers, if a small employer does not offer minimum, affordable health insurance in 2014, affected employees are still eligible to receive subsidized coverage on the health insurance exchange.

Small Business Coverage for 2014

In 2014, all small group plans will have four different coverage levels: **bronze, silver, gold** and **platinum**. Oftentimes, these plans are simply referred to as “Metal Levels”. Within each metal level there will be multiple plan choices available with different deductibles, coinsurance and copayment options. Each plan must cover the same set of Essential Health Benefits and are different from one another in that they pay for a different amount of the covered out-of-pocket expenses such as copays and deductibles. The chart below shows the amount on average that the health insurance company is responsible for paying and the remainder that the employer would pay.

This chart shows that platinum plans will be the most generous, meaning that the Health Plan will pay on average about 90% of the costs for covered services like hospitalization, doctor visits and prescription drug coverage, and the member would have to pay the remaining 10%. Therefore, platinum plans would have the highest monthly premium cost but lower customer out-of-pocket costs for such things as deductibles, coinsurance and copayments. In comparison, the Health Plan would pay less for those expenses on a bronze plan (60% for expenses) and the member would pay the remaining 40% for those services covered under the insurance.⁷ Therefore, bronze would have the lowest monthly premium cost but higher out-of-pocket costs for deductibles, coinsurance and copayments.

	Monthly Premium	Cost-Share
PLATINUM	90%	10%
GOLD	80%	20%
SILVER	70%	30%
BRONZE	60%	40%

Please note that all Excellus BlueCross BlueShield plans for small groups are changing upon renewal in 2014 to ensure they meet the requirements under Health Care Reform, including meeting the “metal level” standards and covering Essential Health Benefits. Excellus BlueCross BlueShield’s small groups will be notified, in writing, about the coverage changes in the next several months including information about the options available to them well in advance of the coverage deadlines.

Small Business Health Options Program (SHOP)

Beginning October 1, 2013, small business employers can buy insurance from the Small Business Health Options Program (SHOP) Exchange. Employers will choose the plans they want to offer their employees, either from a single carrier or different carriers, as well as the amount they want to pay for that coverage (also called the “employer contribution”). The employees then select the plan that best meets their needs and budget. SHOP products are different from plans available to small groups today, and employers are not required to buy a plan from the SHOP Exchange.

It is important to mention that small employers are not required to purchase insurance on the Exchange and will not face a penalty if they do not offer insurance to their employees.

⁷ These percentages (also referred to as “Actuarial Values”) are just averages, costs may be higher or lower. Visit the Actuarial Value Calculator at www.cciio.cms.gov for more information.

Tax Credit For Some Small Group Employers

For those who qualify, there is a Small Business Tax Credit that will help make health insurance more affordable for small businesses that purchase from the SHOP Marketplace. Employers may be eligible for a tax credit of up to 50% of the businesses' share of their employees' premium (e.g. the employer contribution) in 2014.

To be eligible for the small business tax credit, the employer must:

- Have less than the equivalent of 25 full-time employees; and
- Have an average annual employee wage below \$50,000; and,
- Cover at least 50% of the cost of health insurance coverage.

These tax credits will only be available to small employers for two years, ending in 2016.

Reporting Requirements

Employers are required to report the cost of health insurance starting January 2013 on their employees' W-2 forms filed for the 2012 tax year⁸. Employers must report "applicable employer-sponsored coverage", including most tax-free health insurance coverage available to employees. Employers may report the total insurance premium cost charged by the health plan, or they may report costs determined by calculating the COBRA applicable premium (or a modified version), including:

- The cost of the health insurance provided, even if offering a self-funded or grandfathered plan (it is not necessary to report the cost of health insurance coverage for terminated employees who request their W-2 before the end of the tax year)

Employers have the option to choose how to report the cost of terminated employees' health insurance coverage, as long as the chosen method is reasonable and is used consistently for all affected employees.

These reporting requirements do not include: long term care coverage; accident, disability, and liability coverage; standalone dental or vision coverage; contributions to HSAs or Archer MSAs; or an employee's salary reductions for FSAs (however, employer contributions to an FSA should be included).

⁸ Employers with less than 250 W-2s for the 2011 tax year will be exempt.

Notifying Employees

Employers are required to notify their employees about Health Care Reform's new health insurance Exchanges. The U.S. Department of Labor has issued standard language that all employers (regardless of whether they offer insurance) who are subject to the Fair Labor Standards Act (FLSA) can use to notify employees about the Exchanges. Notices must provide the following information:

1. What Exchanges are, what they provide, and where employees can go to find more information;
2. How tax credits may be available if the employer does not provide minimum essential coverage and the employee purchases health insurance on the Individual Exchange; and,
3. Employees who purchase coverage on the Exchange may lose any employer contributions; these contributions may be excludable from employees' income when they file their Federal income tax.

Employers can write their own notices as long as they include the above three components. The Department of Labor has also provided template notices that employers can use instead of drafting their own.

Employers who offer health insurance should use this notice:

<http://www.dol.gov/ebsa/pdf/FLSAwithplans.pdf>

Employers who do not offer health insurance should use this notice:

<http://www.dol.gov/ebsa/pdf/FLSAwithoutplans.pdf>

Notification must be sent to all current employees by October 1, 2013 and to all new hires beginning October 1, 2013. The notices must be provided, in writing (either by mail or electronically), to all employees, regardless of whether they are eligible for the employer's health insurance coverage.

Answers To Common Questions

Can an employer continue to offer a Healthy New York product? As of January 1, 2014, businesses with 2 – 50 employees can still offer the Healthy New York product. To ensure the program meets the Essential Health Benefit guidelines like other products, Healthy New York will undergo some changes in benefits and fee structure. Although Healthy New York will continue to be available to qualified small businesses, it will no longer be available to self-employed business people (sole proprietors) and people who have Healthy New York as an individual or family (meaning, not through their employer).

What is the waiting or probationary period for a new employee? Starting in 2014, the waiting or probationary period for a new employee to be eligible for coverage cannot exceed 90 days.

Are small business tax credits only available for coverage on the SHOP Exchange? Yes. For plan years beginning on or after January 1, 2014, the small business tax credit is only available to small employers who purchase coverage through the SHOP and who meet all of the eligibility guidelines. It is important to note that these tax credits will only be available through 2016.

How are plans on the SHOP Exchange different from plans available today? Plans on the SHOP Exchange will be similar to small group plans available to small businesses today. For both SHOP and plans offered directly by an insurer, a standard set of benefits (Essential Health Benefits) and meeting one of the four metal levels will be required.

How are plans on the SHOP Exchange different from plans off the SHOP Exchange? All small group plans are available in the form of "metal levels" and carry with them a standard set of benefits. Excellus BlueCross BlueShield plans to offer additional choices of packages for businesses buying directly from us so businesses can continue to purchase coverage as they do today. By purchasing directly from us, businesses will have a broader range of plan options than what is available on the SHOP Marketplace.

Are there maximum deductibles on small group products? As of January 1, 2014, there will be maximum deductibles on all small group products. The maximum deductible limit is \$2,000 for single (individual) coverage and \$4,000 for families. The deductible can be increased if the employer contributes to a Health Savings Account (HSA) or Health Reimbursement Account (HRA). Contributions to a Flexible Spending Account (FSA) are not taken into account when determining the maximum allowable deductible.

Are there maximum out-of-pocket costs on small group plans? Yes, and the maximum out-of-pocket costs are determined annually. Out-of-pocket cost sharing maximums for each benefit will be the same as those for high deductible health plans (HDHPs). For 2014, the maximum out-of-pocket amount for an individual/single plan is \$6,350 or \$12,700 for a family plan.

Can an employee or large business purchase health insurance on the SHOP exchange? No. Only small businesses can buy health insurance through the SHOP Exchange. If an employee of a small business does not have access to affordable coverage through their employer, they may be able to purchase health insurance on the Individual Exchange (see "Individual Exchange", page 5).

When can employers purchase health insurance through the SHOP exchange? Beginning October 1, 2013, small businesses will be able to purchase coverage through the NY State of Health website: <http://nystateofhealth.ny.gov> as well as through their brokers for coverage effective January 1, 2014.

Is assistance available for non-profit businesses? Non-profit employers who meet certain eligibility guidelines may receive credits for 25% (2013) and 35% (2014) of the amount they contribute towards the employees' premium.

If an employer purchases a plan on the SHOP exchange one year, can they purchase from a broker or health insurance plan in the future? Yes. Small businesses, just like individuals, are given the opportunity to evaluate their options when it comes to health insurance every year and make a decision based on their needs. The SHOP Exchange only requires employers to follow a 12-month plan year, following that, they can decide to continue on the SHOP Exchange or purchase coverage elsewhere.

In what state does an employer purchase coverage if some branches of the businesses are located in different states? If you have 50 or more employees, you can continue to offer group health insurance the same way you do today even if you have branches located in other states. If you do not offer coverage, keep in mind that your employees may purchase insurance coverage through the Individual Exchange in their location.

Options For Large Group Employers



The Health Care Reform's "Employer Mandate" requires employers with 50 or more full-time equivalent employees to pay a penalty if they don't provide minimum value, affordable health insurance to their full-time employees and dependent children in 2015. **Under Health Care Reform, "full time" is defined as an employee who works on average 30 hours or more per week.** Those who do not offer coverage must pay a penalty of \$2,000 per full-time employee (not including the first 30 employees). If the employer has never offered health insurance to their employees in the past, they will be required to offer insurance or pay the penalty.

If an employer of 50 or more full-time equivalent employees does not offer affordable health coverage that provides a minimum level of benefits, they may be subject to a \$3,000 penalty for each employee who does not take the employer-sponsored plan and instead applies for coverage on the Individual Exchange and receives financial assistance for purchasing that coverage. Assistance is only available if minimum value, affordable coverage is not being offered to them through their employer, if they are not qualified for OR currently receiving Medicaid or Medicare, OR if affordable coverage is not available through their spouse's employer.

Employers will not be assessed a penalty if they offer minimum essential coverage to all but 5% or 5 full-time employees, whichever is greater.

Minimum Value Requirements

If an employer has coverage for their employees today, it is important to ensure that coverage meets the minimum amount of benefits. **Minimum Value (MV)** is the amount the Health Plan expects to pay versus the amount that the member would pay for things like deductibles and coinsurance. The employer's plan must have an MV of at least 60%, which means the plan covers at least 60% of the total allowed cost of benefits that are expected to be incurred under the plan.

Those currently receiving coverage through an Excellus BlueCross BlueShield plan will be notified if their coverage does not meet the 60% threshold to determine which alternative plan options best meet their needs. To check if a plan meets minimum value, please visit www.cciio.cms.gov for the minimum value calculator.

On an Excellus BlueCross BlueShield plan? Many of Excellus BlueCross BlueShield's plans for employers are already at or above the minimum value requirement of 60% MV required by Health Care Reform. Excellus BlueCross BlueShield is currently reviewing all products to ensure they meet the minimum value guidelines. If an employer's current plan is found to not meet the minimum value requirement, Excellus BlueCross BlueShield will assist groups to find insurance coverage that works best for them and meets the Health Care Reform guidelines.

Affordability Requirements

Affordability refers to the amount an employee has to pay for the insurance plan if they were to buy coverage for themselves only. If any employee has to pay more than 9.5% of their annual household income for the company's health insurance, the coverage is not considered affordable. In general, there are three ways employers can determine affordability.

Employers can use any or all of these methods:

- The employee's share of self-only coverage does not exceed wages reported on Box 1 of IRS Form W-2
- The employee's share of self-only coverage does not exceed 9.5% of the employee's rate of pay multiplied by 130 hours
- The employee's share of self-only coverage does not exceed 9.5% of the Federal poverty line (FPL) for one person.

As an example, the insurance would not be considered "affordable" if it costs more than \$238 per month for an employee earning \$30,000 annually or more than \$396 per month for an employee whose salary is \$50,000.

When an employer offers multiple plans to choose from, the affordability test applies to the lowest-cost plan option available to the employee. It is important to note that when testing for the minimum value of the plan, the plan selected must have the minimum level of benefits included.

Employer Look Back Process

Many employers may have employees that are not hired as full-time workers but who work a variable number of hours throughout a month. An employer most likely would not offer coverage to these employees. If, however, that employee actually worked on average 30 hours or more per week, under Health Care Reform, they should have been offered coverage just like a full-time employee.

Due to the existence of these types of employees, Health Care Reform created an Employer Look Back Process where variable hour employees work as they normally do, and then, later in the year, employers "look back" to see if they actually worked 30 hours or more per week. If any employees actually worked 30 hours or more, coverage will need to be offered to those employees on a go forward basis.

How the look-back period works:

Choose measurement period: Select a previous time period of between 3 – 12 months to measure the actual number of hours the employee worked

Calculate employee hours: Determine the employees who, during that period of time, worked more than 30 hours per week on average

Determine mandatory insurance requirements: Which of those employees were not offered health insurance coverage for the same period of time? Those employees must be offered health insurance coverage for either 6 continuous months or the same period you used to measure in your measurement period for Step #1 (whichever time period is greater). The employer has a 90-day administrative period to enroll the identified employees.

Reporting Requirements

Starting in 2015, large employers will be required to report information on health insurance coverage to the Internal Revenue Service (IRS), including:

- Number of full-time employees
- If coverage was offered to full-time employees and dependents
- The employees and their dependents who are enrolled in the plan(s)
- Employee's contribution to the premium

Employers are required to report the cost of health insurance starting January 2013 on their employees' W-2 forms filed for the 2012 tax year⁹. Employers must report "applicable employer-sponsored coverage", including most tax-free health insurance coverage available to employees. Employers may report the total insurance premium cost charged by the health plan, or they may report costs determined by calculating the COBRA applicable premium (or a modified version), including:

- The cost of the health insurance provided, even if offering a self-funded or grandfathered plan (it is not necessary to report the cost of health insurance coverage for terminated employees who request their W-2 before the end of the tax year)

Employers have the option to choose how to report the cost of terminated employees' health insurance coverage, as long as the chosen method is reasonable and is used consistently for all affected employees.

These reporting requirements do not include: long term care coverage; accident, disability, and liability coverage; standalone dental or vision coverage; contributions to HSAs or Archer MSAs; or an employee's salary reductions for FSAs (however, employer contributions to an FSA should be included).

Notifying Employees

Employers are required to notify their employees about Health Care Reform's new health insurance Exchanges. The U.S. Department of Labor has issued standard language that all employers (regardless of whether they offer insurance) who are subject to the Fair Labor Standards Act (FLSA) can use to notify employees about the Exchanges. Notices must provide the following information:

- What Exchanges are, what they provide, and where employees can go to find more information;
- How tax credits may be available if the employer does not provide minimum essential coverage and the employee purchases health insurance on the Individual Exchange; and,
- Employees who purchase coverage on the Exchange may lose any employer contributions; these contributions may be excludable from employees' income when they file their Federal income tax.

⁹ Employers with less than 250 W-2s for the 2011 tax year will be exempt.

Employers can write their own notices as long as they include the above three components. The Department of Labor has also provided template notices that employers can use instead of drafting their own.

Employers who offer health insurance should use this notice:

<http://www.dol.gov/ebsa/pdf/FLSAwithplans.pdf>

Employers who do not offer health insurance should use this notice:

<http://www.dol.gov/ebsa/pdf/FLSAwithoutplans.pdf>

Notification must be sent to all current employees by October 1, 2013 and to all new hires beginning October 1, 2013. The notices must be provided, in writing (either by mail or electronically), to all employees, regardless of whether they are eligible for the employer's health insurance coverage.

ANSWERS TO COMMON QUESTIONS

Do employers have to offer insurance to part-time or contract (1099) employees? No. Employers who have to provide insurance due to the Employer Mandate are only required to offer insurance to their full-time employees and their dependent children, not spouses, part-time, seasonal or contract (1099) employees. However, the employer must keep track of an employee's hours worked and if they work 30 or more hours per week, the employer will be required to offer them coverage on a go forward basis or pay a penalty. This is called the Employer Look Back Process (see above).

Is assistance available for large businesses? At this time there is no assistance available for large employers with 50 or more employees; large employers will continue to purchase group coverage as they do today.

Do employers pay a penalty if the employee starts a new job and is not eligible for coverage until 90 days after they are hired? The employer will not have to pay a penalty as long as they offer minimum affordable coverage after the 90-day waiting period. In addition, the employee will not have to pay a penalty as long as they maintain insurance for the rest of the year.

Can an employee enroll in coverage from a carrier or on the Individual Exchange while they are waiting for coverage through their employer? Yes, a person can enroll in a plan through the Individual Exchange while they are waiting for their employer-sponsored coverage to begin.

What if an employer offers coverage, but not all employees can afford it? If coverage is not considered affordable for full-time employees, the employer will be subject to the penalty for each full-time employee who goes to the Exchange and is found eligible for an income-based subsidy. For example, let's say the John Smith Company has two employees who cannot "afford" the company's insurance plan because it costs more than 9.5% of their income. The John Smith Company decides that they do not want to increase their contribution to the plan, thus making it more affordable for these two employees. In this example, the two employees can buy coverage from the Individual Exchange and because their income falls below a certain threshold, they will qualify for financial help paying for that Individual Exchange plan. When this happens, the John Smith Company is charged a \$3,000 penalty for each employee because they are able to get financial assistance for their insurance for a total penalty of \$6,000 for 2015. It is important to note that this penalty (\$3,000/employee) is for 2015 only and increases every year.

If the employer offers coverage to part-time employees, does it matter if the coverage is “affordable”? Penalties are only applied to full-time employees. The employer will not have to pay a penalty for coverage offered to part-time employees.

How do employers who offer a wellness program determine if the plan is affordable? Employers will calculate affordability based on the employee’s share of the premium before wellness incentives are applied unless it is a tobacco-related wellness program. For example, if an employer provides a premium discount to employees who do not smoke, that discount can be used to determine affordability.

Does affordability also apply to prescription drug coverage or just medical coverage? The affordability guidelines apply to the combined medical and prescription drug coverage, regardless of whether the employer has one or more insurance companies or managed care organizations offering those plans.

What is the waiting or probationary period for a new employee? Starting in 2014, the waiting or probationary period for a new employee to be offered coverage cannot exceed 90 days.

How does an employer calculate affordability with full-time employees who work variable hours? For hourly employees, the 9.5% contribution is based on the actual hours worked. For example, an employer can look at the actual number of hours worked within a month and determine the employee’s income versus the employee’s premium contribution to determine if the contribution is less than 9.5% of the employee’s income. There are a few methods for determining hours if the employee is not paid hourly: 1) they can count actual hours worked, 2) they can consider the employee to have worked eight hours for each day they work at least one hour, or 3) they can consider the employee to have worked 40 hours per week for each week worked.

Employer Penalties



Beginning January 1, 2015, employers with 50 or more full-time equivalent employees will be required to pay a penalty if they do not provide minimum value, affordable coverage.

WHAT IS THE PENALTY?

In 2014, the penalty for not offering coverage is \$2,000 a year for each full-time employee. The first 30 full-time employees are not counted. This means that if an employer has 100 employees, the penalty of \$2,000 would apply to 70 employees (totaling \$140,000 in penalties for 2014).

The penalty for offering coverage that an employee cannot afford (meaning it does not meet the minimum affordability guidelines) is \$3,000 for each employee that receives assistance for exchange coverage.

It is important to note that these penalties will increase in amount each year.

Penalties are determined on a monthly basis and calculated based on the number of months coverage was not offered or did not meet the minimum requirements. For example, if an employer offers the necessary coverage for five months out of the year, the penalty would only apply to the seven months when the employer **did not** offer coverage.¹⁰

Penalty Triggers

Employers will learn that they owe a penalty if at least one of their full-time employees purchases insurance from the Individual Exchange and is eligible for help paying their monthly premiums (a “premium tax credit”). The premium tax credit is available for individuals who fall below certain income thresholds. Once this occurs, the employer will receive notification and have an opportunity to respond to the Internal Revenue Service (IRS) before they have to pay the penalty.

If an employee declines employer-sponsored coverage and enrolls in a health plan on the Individual Exchange, the employer would only be charged a penalty if that employee becomes eligible for help paying for the Individual Exchange insurance. Therefore, as long as the employer offers affordable coverage that meets the guidelines, the employee would not be able to receive a premium tax credit on the Individual Exchange, and therefore the employer would not pay a penalty.

It is also important to note that employers who send employees to the individual market Exchange with an HRA, HSA, or FSA contribution may be subject to the Employer Shared Responsibility penalty if their employees receive a federal subsidy to help them pay for their insurance.

Companies Under Common Law Ownership

A company is considered a large employer when any one company under common owner exceeds 50 full-time equivalent employees. For example, if there are 50 or more total full-time equivalent employees within **any one common law company**, that company may be subject to the Employer Mandate and pay a penalty. If there are 50 or more total full-time equivalent employees within **all companies under a common owner combined**, each company would be subject to the Employer Mandate, although each of those companies would be assessed a penalty on its own.

For example, if the John Smith Corporation owns Employer A and Employer B, and the number of employees under the John Smith Corporation totals 75, each organization will be subject to the employer responsibility provision. If Employer A offers health insurance coverage that meets federal requirements but Employer B does not, only Employer B will be subject to the penalty. When calculating the penalty, the reduction of the first 30 full-time equivalent employees will be divided among all companies under common ownership that do not offer health insurance coverage, based on their total number of employees.

Benefit & Coverage Changes



Grandfathered Plan

If a plan is “grandfathered” it generally means that it was available before March 23, 2010, the date that the health reform law was enacted and therefore is exempt from complying with some parts of the health reform law. As long as the plan’s benefits and cost-sharing amounts were not significantly changed, it is likely the employer can continue to offer their grandfathered plans.

In 2014, grandfathered plans will **not** be required to:

- Offer Essential Health Benefits
- Offer “Metal Level” coverage (e.g. Bronze, Silver, Gold and Platinum plan designs)
- Limit deductibles to \$2,000 (single) or \$4,000 (family)
- Remove cost-sharing on preventive services
- Offer clinical trial coverage

In 2014, grandfathered plans must:

- Remove any limits on annual (or lifetime) dollar amounts on Essential Health Benefits (if they are offered already)
- Limit waiting periods to 90 days
- Remove any exclusions on pre-existing conditions

It is important to note that grandfathered plans must be recertified each year and they are exempt from some, but not all, of the 2014 Health Care Reform rules.¹¹

Summary Of Benefits

A Summary of Benefits and Coverage (SBC) is a description of services and benefits associated with a health insurance plan. The purpose of the SBC is to provide employers and their employees a clear and easy way to compare plans to make an informed decision about which plan to buy. SBCs include a standard list of common terms and two examples of coverage to determine how the plan works in everyday life. The goal is to ensure that this documentation is written in plain language so that members are aware of what exactly is covered under their insurance plan.

Employers will be provided an SBC for each health insurance plan they offer. Employers must give an SBC to employees who are eligible for coverage in the following instances:

1. During the open enrollment period;
2. When an employee first becomes eligible for health insurance; and,
3. Within seven days of getting a request for an SBC.

Preventive Benefits

Health Care Reform includes a number of provisions that have been in effect since 2010, including a requirement to cover certain preventive services. The regulations provide that certain preventive services come at no cost to members, including:¹²

- Diagnostic tests, including breast cancer and colon cancer screenings, cholesterol and blood pressure screenings and diabetes tests
- Immunizations
- Preventive care and screenings for infants, children and adolescents
- Health education counseling services like smoking cessation and weight management

In addition to the above preventive services, the following lists additional women's preventive services that must be made available at no cost:

- Well-woman visits, including pre-natal visits
- Gestational diabetes screening
- Humana Papillomavirus (HPV) testing
- Counseling for sexually transmitted diseases
- Contraceptives and contraceptive counseling
- Breastfeeding support, supplies, and counseling
- Domestic violence screening and counseling

This is not a complete list, and additional no-cost preventive services, such as coverage for obesity related conditions, may be covered in the future. Members will be able to have other preventive services but may have to pay a copay or coinsurance to receive them.

Wellness programs are used to boost the health of members. Wellness programs can include rewards or penalties for adhering or not adhering to a certain health-related behavior. In most situations, rewards and penalties cannot be more than 30% of the cost for that coverage, or up to 50% for smoking cessation or smoking prevention programs. These incentives must be based on and have the goal of improving or maintaining members' health. Please note that these wellness rules take effect for plan years beginning on or after January 1, 2014.

¹² To receive these preventive benefits, services must be obtained through an in-network provider (e.g. doctor, hospital, or clinic that participants in the Health Plans Exchange network). There may be limits on how frequently these preventive services may be used.

BROKERS & OTHER INTEREST GROUPS



Broker Program

Brokers have been invited to sell Individual and SHOP insurance coverage on the Exchange, providing another resource to individuals, families and businesses requiring assistance determining their options. Much like others selling products on the Exchange, brokers must sign agreements with the state Exchange and complete all required training and education, including SHOP education requirements.

Brokers will be paid the same commission rates for individual and small group sales on and off the Exchange. The Health Plan will pay these commissions directly to the broker.

Navigator Program

The Navigator program was established to provide education and assistance with applications and enrollment to individuals who want to buy health insurance on the Exchange. Navigators are not allowed to receive any form of compensation from a health insurance carrier for sales on or off the Exchange. For this reason, brokers are not eligible to be Navigators if they wish to continue their current role. New York State's Navigator Program will be in place by October 2013.

In-Person Assistor Program

Similar to the Navigator Program, the In-Person Assistor (IPA) program was created to provide education, help with applications, and provide enrollment assistance to individuals who want to buy health insurance on the Exchange. New York State's In-Person Assistor program will be in place by October 2013. In-Person Assistors are not allowed to receive any form of compensation from a health insurance carrier. For this reason, brokers are not eligible to be In-Person Assistors if they wish to continue in their current role.

Certified Application Counselor Program

Certified Application Counselors provide another source of education and assistance for individuals and employees who want to buy health insurance on the Exchange. Certified Application Counselors will undergo the same training as Navigators and In-Person Assistors.



Taxes & Fees



Health Care Reform introduces a number of taxes and fees that may affect the cost of premiums. The new taxes and fees will affect employers differently, based on factors like how many employees they have, what coverage they have, and how much they contribute to those plans.

		Amount	What it pays
For Health Insurance Companies	Excise tax	\$8 billion (2014) - \$14.3 billion (2018)	Helps fund premium tax credits for individuals and families
	Transitional Reinsurance Fee	\$5.25 per person enrolled per month	Helps stabilize the health insurance industry during the first years of Health Care Reform
	Risk Adjustment Fee	\$1 per person enrolled per year (estimated)	Helps stabilize individual, family and small business health insurance markets during the first year of Health Care Reform
	Exchange User Fee	Exact amount to be determined	Allows the Health Plan to offer their products on the Exchange
	PCORI Fee	\$1 (2012 - 2013) \$2 (2013 - 2014) TBD: After 2014	Helps fund research to improve health care decisions and delivery
For Employers	Cadillac Tax	Exact amount to be determined	Tax on employers who offer high cost health insurance beginning in 2018
	Transitional Reinsurance Fee (for self-funded plans)	\$5.25 per person enrolled per month	Helps stabilize the health insurance industry during the first years of Health Care Reform
	PCORI Fee (for Self-Funded, HRA and HSA Plans only)	\$1 (2012 - 2013) \$2 (2013 - 2014) TBD: After 2014	Helps fund research to improve health care decisions and delivery
For Individuals	Medicare Surcharge	0.9% gross income	Supports the Medicare program and only applies to those earning more than \$200,000 (single) and \$250,000 (married)

Common Terms

Actuarial Value: The amount the health plan pays for covered benefits compared to the amount the member pays out-of-pocket.

Catastrophic Coverage: A coverage option with a limited benefit plan design that typically has a lower cost monthly premium but a higher deductible that must be met before benefits begin. Catastrophic coverage is intended to protect individuals against the cost of unforeseen and expensive illnesses or injuries.

Consumer-Driven Health Plans: These health plans seek to increase consumer awareness about health care costs and provide incentives for consumers to consider costs when making health care decisions. These plans usually have a high deductible accompanied by a savings account for health care services. There are two types of savings accounts: Health Savings Accounts (HSAs) and Health Reimbursement Accounts (HRAs).

Cost Sharing: Health plan members are required to pay a portion of the costs of their care. Examples of these costs include copayments, coinsurance and annual deductibles.

Deductible: The dollar amount a plan member must pay for health care services each year before the health insurance company (insurer) begins to reimburse health care services. Beginning in 2014, deductibles for small group insurance plans will be limited to \$2,000 for individual policies and \$4,000 for family policies.

Employer Mandate: Beginning in 2015, employers with 50 or more full-time equivalent employees will be required to offer minimum essential health benefit packages or pay a penalty.

Essential Health Benefits: The health reform law places certain coverage requirements on Essential Health Benefits, and provides a broad set ten benefit categories that would be considered essential to a health benefits package: outpatient services; emergency services; hospitalization; maternity and newborn care; mental health and substance abuse services; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services, including chronic disease management; and pediatric services, including oral and vision care.

Full Time Employee: Under Health Care Reform, "full time" is defined as anyone working an average of 30 or more hours per week.

Grandfathered Plan: A health plan that was in place on March 23, 2010, when the health reform law was enacted, is exempt from complying with some parts of the health reform law, so long as the plan does not make certain changes (such as eliminating or reducing benefits, increasing cost-sharing, or reducing the employer contribution toward the premium). Once a health plan makes such a change, it becomes subject to other health reform provisions (e.g., appeals and cost sharing restrictions on preventive services).

Group Health Plan: Health insurance that is offered by a plan sponsor, typically an employer, on behalf of its employees.

Health Insurance Portability and Accountability Act of 1996 (HIPAA): This law sets standards for the security and privacy of personal health information. In addition, the law makes it easier for individuals to change jobs without the risk of extended waiting periods due to pre-existing conditions.

Health Reimbursement Account (HRA): A tax-exempt account that can be used to pay for qualified health expenses. HRAs are usually paired with a high-deductible health plan and are funded solely by employer contributions.

Health Savings Account (HSA): A tax-exempt savings account that can be used to pay for qualified medical expenses. Individuals can obtain HSAs from most financial institutions or through their employer. Both employers and employees can contribute to the plan. To open an HSA, an individual must have health coverage under an HSA-qualified high-deductible health plan that has deductibles of at least \$1,200 for an individual and \$2,400 for a family in 2010.

High-Deductible Health Plan: These health insurance plans have higher deductibles and lower premiums than traditional insurance plans.

Individual Mandate: The requirement that most individuals have health insurance or pay a penalty beginning in 2014.

Large Group Market: Businesses typically with 50 or more employees, or eligible employees depending on applicable state law, can purchase health insurance for their employees through this market, which is regulated by states.

Mandatory Benefits: A state or federal requirement that health plans provide coverage for certain benefits, treatment or services.

Medical Loss Ratio (MLR): The minimum percentage of premium dollars a commercial insurance company must spend on the reimbursement of certain medical costs. The health reform law requires insurers in the large group market to have an MLR of 85 percent and insurers in the small group and individual markets to have an MLR of 80 percent (with some waivers granted to states to reduce the threshold for certain markets).

Out-of-Pocket Costs: Health care costs that are not covered by insurance, such as deductibles, copayments and coinsurance. Out-of-pocket costs do not include premium costs.

Out-of-Pocket Maximum: An annual limit on the amount of money individuals are required to pay out-of-pocket for health care costs, excluding premiums. The health reform law, beginning in 2014, prevents an employer from imposing cost sharing in amounts greater than the current out-of-pocket limits for high-deductible health plans (\$6,350 for an individual policy or \$12,700 for a family policy in 2014). These amounts are adjusted annually.

Part Time Employee: Under Health Care Reform, “part time” is defined as anyone working less than 30 hours per week on average.

Patient Protection and Affordable Care Act (PPACA): Also referred to as the “health reform law,” this Act begins the implementation of a staged set of rules with an initial effective date of March 23, 2010. The law is intended to increase access to health care for more Americans, and includes many changes that impact the commercial health insurance market, Medicare and Medicaid.

Pay-for-Performance: A payment system where health care providers receive incentives for meeting or exceeding quality and cost benchmarks. Some systems also penalize providers who do not meet established benchmarks. The goal of pay-for-performance programs is to improve the quality of care over time.

Pre-existing Condition: An illness or medical condition for which a person is diagnosed or treated within a specified period of time prior to becoming insured in a new plan. The health reform law prohibits the denial of coverage due to a pre-existing condition for plan and policy years beginning after September 23, 2010, for children younger than 19, and for all others beginning in 2014.

Premium: The amount paid, often on a monthly basis, for health insurance. The cost of the premium may be shared between employers or government purchasers and individuals.

Premium Tax Credit: Financial assistance available for qualified individuals and families with income between 133 percent and 400 percent of the federal poverty level to help pay for premiums.

Preventive Care Services: Health care that emphasizes the early detection and treatment of medical conditions. The health reform law requires certain health plans (excludes grandfathered plans) to provide coverage without member cost-sharing for certain preventive services.

Qualified Health Plan: Insurance plans that are sold through an exchange must have been certified as meeting a minimum benchmark of benefits (i.e., Essential Health Benefits) under the health reform law.

Self-Insured Plan: The employer assumes the financial responsibility of health care benefits for its employees in a self-insured or self-funded plan. Employer-sponsored self-insured plans typically contract with a third-party administrator to provide administrative services for the plan.

Small Business Health Options Program (SHOP): SHOP is a competitive health insurance marketplace where small businesses and their employees will be able to purchase coverage.

Small Business Tax Credit: The health reform law includes a tax credit equal to 50 percent (35 percent in the case of tax-exempt eligible small employers) for qualified small employers that provide health coverage to their employees. The tax credit is available to employers with 25 or fewer employees with average annual wages of less than \$50,000.

Small Group Market: Businesses with typically two to 50 employees, or eligible employees depending on applicable state law, can purchase health insurance for their employees through this market, which is regulated by states.

