Health Insurance Basics For Small Business Owners

THE COMPLETE GUIDE

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CONTENT

1 THE BASICS

Managing health insurance for a business is complex, especially if you're unfamiliar with group health plans. Once you obtain a better understanding of healthcare coverage, you'll quickly find that not all health insurance plans work the same way.

Instead of getting overwhelmed, start with the basics. Let's go over what you must know about group health insurance before you begin offering plans to your employees.

What's the difference between group health insurance and other types of insurance plans?

A group health insurance plan is a plan that provides healthcare coverage to a select group of people. As an employer, this is the type of plan that you would typically offer your employees as one of their major benefits.

However, people can also opt for an individual health insurance policy. In this case, a person can purchase an individual health insurance policy that covers one person or that individual's family. Nonetheless, these employees can choose to be covered by their employer's group health plan, if it's offered by the employer.

HEALTH INSURANCE REQUIREMENTS

Take a look at our blog post regarding requirements for small businesses.

Another key difference between group health insurance and individual plans is how an insurer will determine your premium. Individual plan premiums are based on the medical history of an individual or a family. Group health insurance operates with a much larger group of individuals, which means they will balance the risk factors of the entire group to determine your premium.

There are also different types of group plans, such as fully-insured group health plans and self-insured plans, also known as self-funded plans. A fully-insured plan is a more traditional option, where the insurer sets premium rates for the year, collects those premiums, and pays for claims based on your plan. A self-insured plan allows a business to be in control of its own plan.

Self-funding can be risky for small business owners worried about potential losses from claims; however, it can help them save money by eliminating the additional fees that insurance companies apply to their premiums. One way to protect your business from potential losses is by investing in a stop-loss policy that allows you to evaluate savings and exposure.

Do I have to offer group health coverage?

Depending on your business, you may have to offer group health coverage. The Affordable Care Act (ACA) mandates that Americans have health insurance and can penalize those without coverage. However, small businesses with fewer than 50 full-time equivalent employees aren't necessarily required to provide health insurance to their employees.

43%

of employees left their job in 2021 because they wanted an overall better benefits package.*

According to the 2022 Employee Benefits Survey by the Society for Human Resource Management (SHRM), 88 percent of HR professionals named health-related benefits the most important benefit to offer employees. Quality healthcare coverage can serve as a great tool to retain talented members of your team and attract other skilled workers.

*Source: Pew Research Center

What are my responsibilities if I offer group health insurance?

If you offer group health insurance to your employees, you're going to have to follow a few rules set by the ACA. To start, if you decide to offer a group health insurance plan to your full-time employees, you must offer it to every single one of them. You can't pick and choose who gets coverage and who doesn't, and you can't deny coverage to employees with pre-existing conditions. Offering coverage to part-time employees is an option as well. Keep in mind that your employees also have the option to extend their benefits to their families. Of course, there are also financial responsibilities attached to offering health care coverage.

Other responsibilities include:

Covering the essential health benefits in the group health insurance plan

Offering health insurance to new employees within 90 days of their start date

Providing employees with a Summary of Benefits and Coverage

2 TYPES OF PLANS

Health insurance is one of the most sought-after benefits, but not all plans work the same way. There are several different types of group health insurance that differs in terms of how the insurance is purchased and how it affects the group's premiums and plan options.

While all these plans have advantages and disadvantages, it's up to you to decide which makes the most sense for your needs. The following are common types of group health insurance options available for small businesses.

1. Fully-insured plans

Amongst all types of group health insurance, the fully-insured plan is a more traditional option. With a fully-insured plan, the insurance company takes on the medical costs and charges your business an annual premium. Employees are partly responsible for paying the premiums.

The insurer uses a variety of factors used to calculate group health insurance premiums, including:

- Size and health of the group
- Average age of the group
- The employer's claims history
- Types of occupation
- Level of coverage and add-on benefits

2. Self-funded plans

While the insurance company covers the expense of employee health costs in a fully-insured plan, self-funded plans place that burden on the employer. This can often lead to more affordable rates and more control over a plan, with the trade off of your business accepting the risk of having to pay for catastrophic claims.

This path is often seen as an option for large businesses, but small groups can also take advantage of self-funded plans. Small groups can opt for a partially self-funded plan with stop-loss insurance. This option limits your risk so that you can still reap some of the benefits of self-funding without taking on the entire burden in case a catastrophic claim occurs.

3. Health-Maintenance Organization (HMO)

An HMO is a group coverage setup where members pay for specific health services through monthly premiums. Through an HMO, you'll have access to a network of healthcare providers and locations, but services will be limited to those that fall under that network. This arrangement allows HMOs to be more affordable than other group plans; however, seeing any doctor or facility not included in your HMO network can result in a group member having to pay the entire bill out-of-pocket.

4. Preferred Provider Organization (PPO)

PPO plans are similar to HMO plans, except with more flexibility. PPOs also feature a network of healthcare providers and facilities, but group members have the option to go to doctors or locations without being completely on the hook for the entire bill. Instead, these visits will result in higher copays and additional service costs, giving members more freedom than HMO plans.

5. High-Deductible Health Plan with a Savings Option (HDHP/SO)

An HDHP plan is based on lower premiums and higher deductibles for group members. Members of these plans will have to pay more out of pocket before the plan pays for its share. However, this route lowers monthly premiums making it a good option for employees who don't use many medical services.

In addition, HDHP plans can be paired with savings options like a health savings account. These accounts allow members to contribute pre-taxed dollars to an account which is used to pay for health costs ranging from copays to major medical services.

Health reimbursement accounts are another potential savings option. These accounts are similar to health savings accounts, except that you contribute to them as opposed to your employees.

3 REQUIREMENTS FOR BUSINESSES OFFERING HEALTH INSURANCE

With all the uncertainty surrounding healthcare, it's understandable that small business owners may be unsure of what the future holds. It's important to recognize what they need to do to ensure their business doesn't violate any legal requirements.

These requirements can depend on the size of your business and if you offer healthcare coverage. To start, small businesses with 50 or fewer full-time equivalent employees are not required to offer health coverage. However, these businesses are still required to provide healthcare information reports to employees. This report should cover certain information about the marketplace, such as what it is and how employees can contact the marketplace.

Despite it not being mandatory, many small businesses with less than 50 full-time equivalent employees still make the choice to provide workers with health insurance because quality healthcare coverage can help businesses attract and retain top talent. This decision can be very beneficial, but it means that small business owners will need to take on a few new responsibilities.

Essential health benefits

When you offer your employees health insurance, certain elements must be included. All plans are required to have a set of 10 different categories of services that the government considers essential health benefits.

These benefits include:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Pregnancy, maternity, and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Laboratory services
- Pediatric services, including oral and vision care
  Note: adult dental and vision coverage aren't considered essential health benefits
- Preventive and wellness services and chronic disease management

Employee coverage

Small businesses that offer health insurance are required to provide coverage for all full-time equivalent employees. Full-time equivalence requires an average of 30 hours of work per week for a calendar month or at least 130 hours of work in a month.

An employer may not discriminate between employees when offering insurance. If you offer insurance to some full-time employees, you must offer it to every employee. Also, you must then provide health insurance to each employee's dependents. You can also choose to offer health coverage to your part-time employees who do not meet full-time equivalence however, only full-time employees are required.

90-day maximum waiting period

When an eligible employee is hired by a business that offers health insurance, that employee must be offered health insurance within 90 days of his or her employment start date. Employers may institute a waiting period for insurance coverage, setting a specific period of time that employees must wait before they become eligible to enroll in the company's health insurance plan. However, this waiting period may not exceed 90 days. A small business owner may also decide to waive this waiting period and allow employees to enroll as soon as possible.

Summary of Benefits and Coverage (SBC) Disclosure

To help employees understand their options, employers are required to provide eligible workers with an SBC form. This form explains what an employer's plan covers and what it costs the employees. This includes breakdowns of specific costs, such as deductibles and out-of-pocket costs for varying medical events. The Department of Labor provides an online SBC template and other resources for any owners who provide health coverage.

4 ABOUT GMS

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