HEALTH CARE 101 | SMALL BUSINESS

7 things every small business owner should know about health coverage

Ask anyone who runs a company with just a handful of employees and they'll tell you the same thing: **There are no small decisions at a small business.**

The fewer employees you have, the more likely it is that your workforce is made up of spouses, best friends, and brothers and sisters. That means health care is more than a line item — it's a lifeline to the people you depend on every day.

This ebook gives you an overview of employer-sponsored coverage—from why you should offer it to what kinds of plans make sense for your business to understanding the confusing language of health care.

Whether you're buying coverage for the first time or looking for a better plan, the next few pages will put you on the path to making an informed decision.

7 things every small business owner should know about health coverage

1. Why should I offer health coverage to my employees?
2. What is group coverage? How is it different from individual coverage?
3. What are my plan options?
4. How much should I spend?
5. What other coverage issues do I need to consider?
6. How do I choose a company for coverage?
7. What if I still have questions?

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Why should I offer health coverage to my employees?

If you run a business with 50 or fewer full-time employees, you may not be required to offer coverage. But there are a lot of reasons why you should.

The most basic reason is that your employees want it. After paid time off, health and medical coverage is viewed by employees as the most important benefit you can offer.* It can increase job satisfaction—and it makes your company more attractive to potential candidates.

In addition to helping improve workforce morale, the right benefits program can be an asset at tax time. Learn about small business tax credits in the **costs section** of this ebook.

What coverage means to your workforce – by the numbers

- 90% of employees say benefits programs **improve work culture**
- 78% say coverage makes them **feel more productive**
- 63% say coverage makes them **feel engaged and loyal** to their company

Source: Virgin Pulse, 2016.

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What is group coverage? How is it different from individual coverage?

If you've ever bought coverage for yourself or your family, then you know the amount of money you pay each month (also known as your **premium**) is based on personal information like your age and where you live.

Group coverage for small businesses is similar, except that instead of having one policy for each individual (or family), **you have a single policy for all your covered employees.** And your premiums are calculated based on the ages and health risks of the entire group.

Here's what group coverage allows you to do:

- Provide coverage for your employees and their **dependents**
- Potentially negotiate more favorable premiums than your employees could find individually
- Pay for some or all of your employee's monthly premiums

Always included: 10 essential health benefits

Even though premiums are based on health risks, no one can be denied coverage because of a pre-existing health condition. Additionally, the **Affordable Care Act** (ACA) requires all qualified health plans to cover these 10 essential health benefits:

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

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What are my plan options?

When you get down to the nitty gritty, you have many plan options under group coverage. But look at the big picture and you'll see three basic plan types you should be aware of: health maintenance organization (HMO), preferred provider organization (PPO), and point-of-service (POS) plans. Here's a quick description of each and what they mean for you.

HMO	PPO	POS
• A pre-paid health plan with predictable costs and doctors who work inside a closed network • Great for groups who want a connected health care experience with lower out-of-pocket costs and care coordinated by a primary care physician	• A plan that allows members to see any provider that accepts their coverage • An option for groups who want more choice of doctors without needing referrals	• In some ways, a mix of HMO and PPO • An option for groups who want some benefits of an HMO but need to go out of network or let their employees keep their current doctor

Additional options

There are more choices for coverage than just your plan type. From cost-sharing to health payment accounts, there are lots of additional features you can include in your plan to get the most out of your health care dollars. For more information on those features and others, check out the final section of this book.

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How much should I spend?

It depends. As you learned earlier, your premiums are calculated in part by the health risks of your group. But there's more to cost than just the monthly premium.

ACA-qualified health plans are rated on a "metal" scale: bronze, silver, gold, and platinum. Bronze and silver plans tend to have lower monthly premiums and higher **out-of-pocket** costs. They can be good if you have lots of young, healthy employees with no or few chronic conditions.

Gold and platinum plans tend to have higher premiums and lower out-of-pocket costs. That means they cost more up front but potentially less overall for high-utilizers, such as older people with chronic conditions or people with families. (Kids are spectacularly good at finding their way into unscheduled emergency room visits.)
Ask yourself: Am I getting the right value for what I'm spending?

Tip

Learn more about other contributors to cost in the back section of this book.

Doug's lumber yard

Finding a cost-effective plan

A few years ago, Doug purchased a policy for himself and the 22 employees at his lumber yard and distribution site. Cost was top of mind, and he didn't have much time to spend looking for plans. So he selected the cheapest bronze plan available and didn't think about it again.

Everything was fine until his employees started complaining that they couldn't find doctors in the area who accepted the coverage. And those who did complained about high deductibles and pricey emergency room visits.

So this year, Doug is working with a broker to find a more cost-effective plan—something that works for his bottom line without putting most of the cost on his employees' shoulders.

Calculating your tax credit

To determine how many full-time-equivalent workers you have:

1. Take the number of full-time employees who work at least 40 hours a week.

0	full-time employees

2. Calculate the number of full-time-equivalent employees by dividing the total annual hours of your part-time employees by 2,080.

0	total annual hours for part-time employees
2,080	

3. Add these two numbers together to get your total number of full-time-equivalent employees.

0

You can also calculate your eligibility using the **IRS Small Business Health Care Credit Estimator**.

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What other coverage issues do I need to consider?

This is really another way of asking: What do you want your coverage to do? There's no single answer, because no group of people is exactly the same. Before you purchase a plan, try asking your employees if there's anything beyond basic coverage that matters to them. Some areas to consider are:

Dependent coverage – Depending on the age of your team, coverage for family members could make a big difference in attracting and retaining employees.

Dental and vision – These services aren't always included in health plans for adults, but routine dental cleanings and eye exams can keep your team feeling sharp – and potentially prevent costly conditions down the road.

Video visits and other telehealth services – These days everybody cares about easy access to care. And you care about helping your employees avoid time away from work. So the ability to email a doctor, make appointments online, and have phone or video visits are very important. Check to see whether telehealth services are included in your coverage.

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How do I choose a company for coverage?

After you've figured out the health care issues that matter to your workforce, you'll want to find a health plan that can meet those needs. But how do you differentiate between companies offering plans? Here are three tips:

1. **It's all about access.** What good is coverage if you can't find a place to use it? Make sure doctors in your area have convenient locations—and that employees can choose a doctor they like. This is especially important if you live in a rural area with fewer options for care.
2. **Don't forget about quality.** In the same way you might check Yelp before going to a new restaurant, you can learn about quality by checking health plan and hospital ratings. Just pay attention to what the ratings actually measure—member satisfaction, cost effectiveness, and clinical quality are some of the common ratings you might find. And check whether it comes from a credible organization.
3. **Ask about the company's values.** This is especially important if your team is made up of mostly employees under 35, since millennials tend to be a cause-oriented, values-driven crowd. They want to have a positive effect on their communities—and they expect businesses to give back too. But it's not just for millennials. Corporate social responsibility can matter to employees of all ages.

Cupcakes by Claire

Finding a value-based partner

Claire has been a baker her whole life. This year, she finally opened her own bakery—which sells pastries and cakes made from ethically and locally sourced ingredients and uses sustainable packaging materials. Claire's three employees share her values, so when she decided to offer coverage for the first time, it was important to find an insurer who shared them as well. She chose one with a history of high-quality care and community service in her city, knowing her team would appreciate the choice.

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What if I still have questions?

Want to learn more? Here's a list of commonly used terms and concepts in health care—so you can feel confident in your decision making. If you're having trouble making heads or tails of your coverage options, visit the Small Business section of **kp.org/choosebetter**.

Glossary

Tap blue terms to return to previous page.

Affordable Care Act (ACA): The comprehensive federal health care reform law enacted in March 2010. Also known as "Obamacare" or "health care reform."

Coinsurance: The percentage of charges you pay when you receive a covered service. Your health plan coverage pays the rest. Coinsurance amounts vary depending on your plan and the service.

Copayment (copay): The fixed dollar amount you pay when you receive certain covered services or prescriptions. Your health plan coverage pays the rest. Copays vary depending on your plan and the service.

Cost share: The portion of charges for a service or prescription that the member is responsible for paying, such as a copay, coinsurance, or deductible payment.

Deductible: The set amount your employees must pay in a plan (group) or policy (individual) year for certain health care services before their health plan coverage begins to pay.

Dependent: A spouse, child, or domestic partner who's covered under a policyholder or subscriber's plan, depending on applicable law and the plan's terms and conditions.

Flexible spending account (FSA): An FSA is an account you own that your employees can use to pay for qualified medical or dependent-care expenses. They fund the account with pretax contributions from their paychecks. Any unused funds will be forfeited by employees at the end of the FSA plan year.

Health reimbursement arrangement (HRA): An HRA allows your employees to use funds you contribute to pay for qualified medical expenses. Because the money in your employees' HRA accounts isn't considered part of their wages, it's not subject to federal income taxes.

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Glossary *(continued)*

Tap blue terms to return to previous page.

HRA rollover: If your employees have an HRA, you can offer the rollover option, using funds left over from one year to pay for qualified medical expenses the next year, as long as the employees are still members of the same plan. How funds roll over – including how much can roll over from year to year – will depend on your plan details.

Health savings account (HSA): A financial account that employees can fund with pretax contributions from their paychecks or after-tax contributions that are tax deductible. They can use funds in their HSAs to pay for qualified medical expenses now or in the future, even if they change jobs or retire.

Out-of-pocket maximum: The maximum amount individual employees will pay in a calendar year for most services covered by their plan. After they reach this amount, the insurer will provide most covered services at no cost to them for the rest of the calendar year.

Premium: The amount you and your employees pay (usually each month) for health plan coverage.

Preventive care services: Preventive care services are types of routine care intended to help keep you and your employees healthy. A service is considered preventive if you have no symptoms indicating you need diagnostic services or treatment, and if no signs of illness are discovered during the service.

Provider: A doctor, health care professional, or health care facility that's licensed, certified, or accredited to provide health care services and supplies as required by state law.

Workforce health: The practice of encouraging healthy lifestyles at work. It can include offering programs that support healthier behaviors, educating employees about health issues, and making health-related objectives part of your corporate policy. The right workforce health program can help your employees get healthier while strengthening your bottom line.

* *Employee Job Satisfaction and Engagement: Revitalizing a Changing Workforce,* The Society for Human Resource Management, April 18, 2016.

The tax references in this ebook relate to federal income tax only. Consult with your financial or tax advisor for more information about state income tax laws.

Information may have changed since publication.

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