



CRASH COURSE

Selecting your company's health care plan

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Let's get started.

Congratulations! Your company is on the verge of launching health benefits, and your employees' lives are about to get a whole lot easier. But now you have to select a the plan, and you have no idea where to start.

That's where we come in. With this guide, you can say goodbye to all that government garble and hello to clear explanations of exactly what you need to know as an employer. So sit back and relax — you're about to uncover the perfect health plan for you and your team.

First off, what am I supposed to do?

WHY SHOULD I PROVIDE HEALTH CARE TO MY EMPLOYEES?

Taking care of your team is an amazing thing. Countless studies have shown that healthy employees are not only happier, they're also more productive. In fact, the CDC [found](#) that adults who make preventive care a priority actually accomplish more at work. The inverse is also true — personal productivity is lowered by \$200 to \$440 annually for every person who struggles with a preventable disease. Studies aside, many small business owners also find that providing health benefits is simply the right thing to do.

We know you care deeply about your employees, so we want to make sure you can protect them AND stay compliant.

The main change under the Affordable Care Act (ACA) — which you may also see written as Obamacare — is something called the “employer mandate.” The mandate is just a new requirement that specifies which types of businesses should offer health insurance or face a government penalty. Here's how to know if the mandate applies to you:

IF YOU HAVE...

49 or less full-time equivalent (FTE) employees: Nope, the mandate doesn't apply, (but you can still offer health care).

Have 24 or less FTE employees? If you answer “yes” to the following questions, you may be eligible for the [Small Business Health Care Tax Credit](#), which covers up to half of your

TRIVIA

Back in 1900, health insurance wasn't even a thing. Since Americans only spent \$5 a year on health care (around \$100 today), there was no need to get insurance for something so darn cheap.

contribution toward your team's premiums (and up to 35% if you're tax-exempt).

- Do you pay at least 50% of your employees' premiums?
- Is your average employee salary \$50k a year or less?
- Do you provide health insurance through the SHOP Marketplace?

50-99 FTE employees: Yep! You'll need to start insuring your full-time workers by 2016. At least 70% of your full-timers need to be covered by 2015, and 95% need to be covered by 2016.

100 or more FTE employees: Yep! Because you're considered a large employer the ACA requires you to offer insurance for all employees and their dependents.



POP QUIZ

How many FTE employees do you have? A full-time employee is someone who works at least 30 hours per week or 130 hours per month. Your total number of full-time equivalent (FTE) employees includes both full-timers and part-timers who count as full-time only for calculation purposes.

Fill out this short quiz to find out how many FTE workers you have on staff:

1. Add up all the hours your part-time employees worked in a single month: _____
2. Take that number and divide it by 120: _____
3. Add in the number of full-time employees you have: _____
4. Woohoo! You now know your FTE employee number. GOLD STAR!

WHAT IS MY RESPONSIBILITY AS AN EMPLOYER?

Stay responsible, friends.

To make sure you're complying with the ACA, you first need to wrap your head around two concepts: employer shared responsibility and minimum essential value.

- **Employer shared responsibility:** This is an ACA provision that tells you whether or not you have to offer health insurance to your employees, and if so, what that plan should look like. Your responsibility is based on how many FTE employees are on your team.
- **Minimum essential value:** Under the employer shared responsibility provision, companies can't just offer insurance willy-nilly — health care must be considered affordable and provide minimum essential value. In other words, plans must cover at least 60 percent of the total cost of essential benefits. These are services that are absolutely necessary, like ambulance rides and prescription drug services.

PRO TIP

To see if you're subject to employer shared responsibility for a given calendar year, look at the size of your staff in the previous calendar year.

NOTE

If companies do not provide valuable and affordable plans, they have to pay the IRS something called a "shared responsibility payment."

What kinds of health plans can I choose from?

Know what your health care requirements are? High five. This section will now walk you through the types of plans that are available to your team.

A health plan is your team's ticket to health care. Plans provide medical care and pay for some of the cost of that care. There's a grab bag of plans out there, which you can purchase either as an employer or on your own. Here are two of the most popular ones:

- Health Maintenance Organization (HMO) insurance: With HMOs, you have to use in-network health care providers to receive coverage, except in an emergency. Also, your primary care physician must give you a referral before you can stroll into a specialist's office.
- Preferred Provider Organization (PPO) insurance: PPO plans cover both in- and out-of-network providers, however, more of the cost is covered when you use providers that are in-network. PPO plans offer a wider selection of practitioners, but HMO plans are generally cheaper.

WHAT IS THE DIFFERENCE BETWEEN IN-NETWORK AND OUT-OF-NETWORK?

- In-network means that the health care provider and the insurance company have teamed up so you can pay less.
- Out-of-network means that your provider and carrier have no mutual agreement and you will most likely have to spend more out of pocket.

TRIVIA

In 1929, a guy from Baylor University decided he wanted to make health care as cheap as a tube of lipstick. Justin Ford Kimball piloted an insurance program for Dallas schoolteachers, offering them up to 21 days of hospitalization for 50 cents a month. Kimball's idea wasn't just lip service — it went on to become the first-ever Blue Cross plan.

The detailed breakdown

EVERYTHING YOU EVER WANTED TO KNOW ABOUT A HEALTH MAINTENANCE ORGANIZATION (HMO)

What is an HMO?

An HMO is an insurance plan that requires you to use specific health providers unless there's an emergency. With an HMO, your primary care doctor coordinates your care, and must give a referral if you need services they can't provide.

What are the benefits of an HMO?

HMO diehards love the lower monthly premiums and having everything contained within one network. There's also generally less paperwork.

What's the difference between a full and select HMO network?

A full HMO network has more doctors and clinicians in-network. However, even a full HMO network has fewer doctors than a full PPO network. A select HMO network often has a lower premium, yet fewer in-network practitioners.

EVERYTHING YOU EVER WANTED TO KNOW ABOUT A PREFERRED PROVIDER ORGANIZATION (PPO)

What is a PPO?

A PPO is an insurance plan that lets you see any doctor from your carrier's network without a referral. Most PPO plans also allow you to see out-of-network providers without a referral at an extra charge.

TRIVIA

When your MO is an HMO: Sidney Garfield and Henry J. Kaiser created the Kaiser Permanente Health care Program in 1933 in the tiny town of Desert Center, California. While the insurance company had HMO-like qualities, it wasn't an official HMO until much later.

PRO TIP

Did you know health care facilities are also considered providers? Imagine that you pull up to a hospital that isn't in your network. There's a good chance you'll have to pony up some money for that visit. To put the kibosh on any unexpected charges, make sure you find facilities that are always within your network.

What are the benefits of a PPO?

PPO devotees like the freedom of visiting in-network physicians or health care providers without having to pick up a note from their primary doctor.

What is the difference between a full and select PPO network?

A full PPO network has a wider group of doctors that are considered in-network. A select PPO network often has lower premiums, but fewer in-network practitioners.

TRIVIA

Here's a mnemonic device: PPOs are PPO-pular. In 1990, PPO enrollment surpassed HMO enrollment at 38.1 million people.

HMO OR PPO.... WHAT SHOULD I PICK?

HMOs are a solid choice if your team is...

- Is comfortable with a smaller network
- Doesn't mind getting referrals
- Wants to trade flexibility for lower premiums

PPOs are a solid choice if your team is...

- Wants a larger selection of doctors and hospitals
- Doesn't want to deal with referrals
- Is comfortable shelling out more on premiums

WHAT MATTERS MOST TO MY TEAM?

This chart will give you a quick idea about whether your company is more suited for an HMO or PPO plan.

	HMO	PPO
A larger network of providers?		✓
Keeping insurance costs as low as possible?	✓	
Not dealing with referrals?		✓

HOORAY, I FOUND A PLAN! WHAT DO I NEED FOR ONBOARDING?

Ahoy, matey. When you sign up for health insurance, you'll need to have the following pieces of information by your side:

- Company tax information (Federal EIN)
- Current and appropriate levels of workers' comp coverage
- North American Industry Classification (NAICS) code
- Proof of payroll
- Number of employees eligible for health insurance
- Details for each employee: name, address, age, and number of dependents to insure

Additional benefits

Not the PPO or HMO type? Don't fret. Here are some additional benefit payment plans and types for your business.

What is a High-Deductible Health Plan (HDHP)?

Hey, high roller: an HDHP is an insurance plan with a lower premium and higher deductible than an HMO or PPO. In order to get a health savings account (HSA), you need an HDHP first.

With an HDHP, you will pay 100% of your health care costs until you've met your deductible. The only exception to this rule is preventive care, which are services that are covered even before you reach your cap. Once you hit that limit, your insurance provider will start paying for part of your services.

Like traditional health insurance plans, there is an out-of-pocket maximum, or a cap on how much money you will pay out-of-pocket each year. This cap depends on the type of plan you have. Certain HDHPs can be paired with pre-tax (HSAs) to help minimize your out-of-pocket costs for qualified health expenses.

What are the pros and cons of having an HDHP?

PROS

- Monthly premiums are typically lower
- Pre-tax HSA funds can be used to pay for many out-of-pocket health care expenses, or saved for future eligible medical expenses. Your HSA account is yours, meaning it is portable even if you leave your current plan or employer.

TRIVIA

In 2015, Kaiser predicts that 24 percent of workers were enrolled in an HDHP with a savings account component. And in 2009? That number was only 8 percent.

CONS

- Higher deductibles
- Higher out-of-pocket costs before you meet your deductible
- Not all health care expenses qualify for use of HSA funds
- Health care expenses for the year won't be as predictable as they would be with an HMO or PPO
- Not ideal for individuals with chronic health conditions who require frequent doctor visits or high-cost prescription medications
- Some individuals may delay important services because they can't afford the full cost of a doctor's visit

PRO TIP

Always stash your medical receipts somewhere safe when you have an HSA. Why's that? If the IRS ever asks you to prove an HSA expense is valid, you'll be in the clear.

What is Exclusive Provider Organization (EPO) insurance?

An EPO is a managed care plan that doesn't require you to have a primary care provider. Rates are lower than HMOs and PPOs, but services are only covered if you use providers inside the network.

What is a Health Savings Account (HSA)?

An HSA is a medical savings account available to U.S. taxpayers who are enrolled in a high-deductible health plan, or HDHP. When you squirrel away part of your paycheck to your HSA, that money is not subject to federal income tax at the time of deposit. Funds roll over year to year if you don't spend them, sort of like the health-plan version of a slinky.

TAX ADVANTAGES

- HSA contributions make your taxable income lower
- HSAs earn tax-free interest
- Withdrawals are also tax-free as long as they're used to pay for approved medical expenses

How much money can I put into my HSA?

For 2015, individuals can add up to \$3,350 per year, and families can contribute up to \$6,650. For 2016, that individual amount remains the same, while families can add up to \$6,750. Participants 55 and older can add an extra \$1,000 at both contribution levels in 2015 and 2016.

PRO TIP

Want to save for a rainy day? Take a look at an FSA. You can expect to save between 20 to 40 percent on out-of-pocket medical costs thanks to this thrifty account.

WHAT IS A FLEXIBLE SAVINGS ACCOUNT (FSA)?

Flex your FSA knowledge, folks. A flexible spending account, (also known as a flexible spending arrangement), is a special account you can put your pre-tax dollars into to help pay for out-of-pocket health care costs.

How does it work?

When you have an eligible health care expense, you can take care of it with your FSA payment card, or pay out-of-pocket and request reimbursement from your employer.

What is the tax advantage?

FSA contributions lower your taxable income because the money that you funnel into the account is tax-free.

What Is a dependent care FSA?

A dependent care FSA is a way for you to save money by using pre-tax dollars to pay for your dependent care expenses.

Eligible dependent care expenses include:

- Before and after-school care
- Au pair and nanny services and (qualified) babysitters
- Preschool or nursery school
- Summer day camp
- Extended day programs
- Elderly day care

Hold up. What Is a dependent?

A dependent is quite literally, someone who depends on you. That person could be a child, relative, or spouse that you take care of. Employees may enroll their dependents in their company's group medical plan if they pay the premiums.

What happens to the money that I don't use at the end of the year?

Cue sad music — it disappears. With an FSA, you have to use your money before it expires at year's end. Under the ACA, a plan may allow an employee to carry over up to \$500 into the following year without letting go of the funds. However, this is at the employer's discretion and must be decided before the plan year begins.

NOTE

This guide is intended to help employers of various sizes gather general information about choosing a health plan. Keep in mind that your specific needs may vary. If you'd like to learn more, please get in touch with a licensed broker or contact us at my-benefits@gusto.com.

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Thanks for reading!

While there is no magic health care plan that works for everyone, we hope that this guide was able to point you toward one that is more likely to be a fit. Because when health care becomes a little less fuzzy, you're able to take better care of your incredible team.

Just because you've reached the end of this guide, it doesn't mean our relationship is through. If you have any other questions about benefits, [check out our website](#), [visit our blog](#), and take a look at some of the other [free Framework resources](#) that are just waiting for you to explore.

Ready to get started with benefits?

START YOUR FREE TRIAL →