Your Guide to

Small Business Health Insurance

healthmarkets

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Contents

Employee Benefits for Small Businesses Made Easy

Don’t stress over employee benefits. We’re here to help.

Employee benefits are frequently a deciding factor for many talented individuals in today’s job market, and this isn’t just the case for people looking to work for large corporations. Now more than ever, as a small business owner you are under pressure to provide benefits to attract the kind of employees who will help you grow your business. To do this, you need to learn about your options. But when even the most well-trained and experienced HR managers struggle to understand the plethora of available employee benefits, it’s not surprising that small business owners can quickly feel overwhelmed.

Your business depends on your ability to make profitable returns on your investments. Like updating your technology and equipment, investing in employee benefits allows you to maintain your team and add talented staff. However, studies show that employee benefits are the fourth largest budget expense for small businesses. Is that expense truly worth it? In many cases, it absolutely is. We will show you why throughout the course of this guide.

Who Is This Guide For?

This guide is designed for small business owners—meaning those with fewer than 50 full-time equivalent employees—looking for ways to better manage the cost of their current benefits programs as well as those who are considering offering employee health insurance benefits for first time. *We’ll describe full-time equivalent employees in detail later in the guide.*

What Is in This Guide?

With healthcare premiums soaring, many small businesses are asking employees to shoulder more of the financial responsibility or cutting benefits entirely. While this may work in the short term, employees who have healthcare benefits are more satisfied and healthier—and more likely to help your business grow. That's why HealthMarkets has created this guide to provide small business owners with information you need to make informed decisions on the complicated topic of employee benefits. Use this guide as a source of information and a starting point, when you consider offering, or changing, your health insurance benefits. This guide will describe the following small business health insurance topics:

- Health insurance's economic and industry environment
- Small business health insurance laws
- Reasons to consider providing health insurance benefits
- Types of health insurance plans available to small businesses
- Voluntary benefits available for small business employees
- Ways HealthMarkets can help you

Small Businesses, the Economy, and Healthcare

Small businesses are directly tied to the economic health of the U.S., as their employees make up more than half of the total workforce.

To put the importance of small businesses into perspective:

- There are 28.8 million small businesses in the United States.
- Of those 28.8 million, 5.8 million small businesses have an average of 23.2 paid employees.
- There are only 18,600 large businesses in the United States.

It's clear that small businesses are the cornerstone of our economy. And, health insurance is the leading benefit among companies of all sizes and one of the most talked-about social policy issues of our time. So, it's important you have as much information as possible as you consider your employee health benefits.

Premium rates for group plans have seen a dramatic increase over the past several years, going up 4.8 times higher than inflation. While no one likes to receive rate increases, these added costs are particularly hard for small businesses to absorb. Many small business owners will see an 8% rate increase, if not more, when they renew their plans. But when faced with the choice of a large rate increase or having to search for another plan, many small business owners accept the rate increase or ask their employees to shoulder more of the financial burden for the same plan. While this may work in the near-term, this is not always the best solution.

So, why is it that so many business owners stay with their current plans? There are obviously many reasons; however, one that we hear most often is that there isn't enough time for business owners to

focus on choosing new, more affordable benefits. Most employee benefit plans start at the beginning of the calendar year, which means that business owners must make decisions on what benefits to offer their employees during the fourth quarter. As you are trying to meet holiday demands on your business and juggle employee vacations while finishing out your fourth quarter strong, you are also asked to choose employee health insurance benefits from the myriad of options. Who has time to do all of this on their own? Through our clients, we've learned:

- Nearly half of businesses with fewer than 50 employees believe there are not enough resources to help small businesses navigate Affordable Care Act (ACA) requirements.
- More than half of businesses currently using group coverage indicated that health insurance costs them too much money.
- Nearly half of businesses currently using group coverage indicated that it costs their employees too much money.

And for small business owners who haven't offered benefits in the past, creating a new employee benefit program can be even more overwhelming.

Fortunately, HealthMarkets has solutions for small business owners. Our licensed agents can break down the information you need to know and provide you with options that meet the unique needs of your small business. In fact, more than half of business owners who have used the help of insurance agents feel confident in their understanding of the ACA.

BELOW: An infographic displays the current state of small businesses in the U.S. and how they are affected by healthcare.

Which Laws Apply to Me?

With new healthcare reform proposals underway, you are probably wondering what changes could affect small business.

Congress has had ongoing discussions about healthcare and its requirements, but for now, here's the current law.

There's a lot to know, but all the information may not apply to you. The majority of businesses in the U.S. are not required to comply with the health insurance employer mandate. That's because 5.8 million of the 6 million businesses in America have fewer than 50 employees.

Defining Small Businesses

While the law may be changing, the ACA separates small businesses into three categories:

- Self-employed (no employees)
- Fewer than 25 full-time equivalent (FTE) employees
- 25-49 FTEs

Businesses with fewer than 50 FTEs are *not usually* required to offer health insurance to their employees. However, if businesses with fewer than 25 FTEs offer health insurance to their employees, these businesses may be eligible for healthcare tax credits—if they pay average wages of less than $50,000 a year per FTE and purchase coverage through the Small Business Health Options Program (SHOP) marketplace.

Businesses with 50 or more FTEs are considered applicable large employers (ALEs), not small businesses. ALEs are usually required to offer health insurance to their employees.

The Employer Mandate

The mandate is part of the ACA's Employer Shared Responsibility Provision, which requires that employers with 50 or more FTE employees offer health insurance to at least 95% (as of 2016) of full-time staff and their dependents up to age 26 or pay a fee. The ACA recognizes dependents as natural-born or legally adopted children. Spouses,

stepchildren, and foster children are not considered dependents. Complying with the employer mandate also means that businesses must offer coverage that is affordable and meets the minimum value.

Defining Full-Time Equivalents (FTEs)

FTEs are not the same as full-time employees. Full-time equivalents include those who work part-time or variable hours. A full-time employee is anyone who works 30 or more hours a week or 130 hours per month for more than 120 days in a year. An FTE, however, is a non-full-time employee who has worked for at least 30 hours in a week during a specific time frame. Whenever a non-full-time employee works 30 hours, he or she amounts to one FTE. However, a part-time employee who has not worked 30 hours may count as a percentage of an FTE.

So, one full-time employee may equate to one FTE employee, but two part-time employees may also equate to one FTE employee. It all depends on the hours worked per employee during a given period of time. Employers can use a measurement period that looks back to the previous 3 to 12 months to determine which employees qualify as FTEs.

Calculating Full-Time Equivalent Employees

To determine your full-time equivalent employees, add up the number of hours your employees work collectively, and divide by 2,080. That number represents FTEs. For example, you have 5 full-time employees who each worked 2,080 hours over the last year, plus 3 part-time employees who each worked 1,040 hours over the last year. The total hours worked would equal 13,520 (5 x 2,080 plus 3 x 1,040). Your FTEs would equal 6 (13,520 / 2080 = 6.5, rounded to the next lowest whole number).

Can Benefits Help Small Businesses Flourish?

Employees are the engine that keeps your business going.

So, it makes sense to keep them happy and let them know that you care for their well-being.

The Value of Benefits

A Social Market Foundation study of more than 700 employees revealed that happy employees are 12% more productive on average. More productive employees could mean better business performance, which could then lead to more revenue. With more revenue, you may be able to hire and retain more top talent. We like to call it the "Virtuous Circle."

In short, yes. Offering benefits will help your small business. How? It will help retain and attract talent, increase job satisfaction and productivity, and reduce employee absenteeism.

Boosting Employee Retention

Employees who are satisfied with their jobs are more likely to stay twice as long with your company, according to an iOpener Institute for People & Performance study. When you add group health insurance to the mix, they're more inclined to put off looking for a new job in the next 12 months if they're satisfied with their coverage. Of course, companies of all sizes want to increase employee retention. But keeping employees longer may be more vital for small business owners who have 1-4 employees on average. If just one employee were to quit to take a job that offers access to health plans, this may leave your business with no one to perform vital tasks until you find and train a replacement, or put more work load on other staff members or yourself. Plus, the loss of productivity and costs to hire and train someone else could be a big expense.

Attracting New Employees

When it comes to a company's ability to attract the best talent by offering health insurance, larger businesses with 200 or more employees may have an advantage. An overwhelming 98% of these businesses offer health benefits, compared to 56% of smaller businesses with 3-199 employees. You may be able to better compete with larger businesses without burdening your budget by adding voluntary benefits—such as dental, vision, life, etc.—to your health benefits package.

If you think of group health insurance as a cake, voluntary benefits are the icing—the goal is to make a great-tasting cake (attractive health insurance plan) and then make it even better with icing (voluntary benefits coverage).

Statistics on Attracting and Retaining Employees

Small business owners often perform several roles, which may create a greater need to find and keep the right candidates to take on some of those roles. So, it's no surprise that 87% of small employers say offering health insurance is very important for recruiting and retention. A Global Benefit Attitudes Survey from Towers Watson revealed that employees chose health insurance over retirement benefits as the main reason why they joined and have stayed with their current company. This chart shows the percentage rate at which employees value these benefits throughout different years that the survey was conducted.

Increasing Job Satisfaction and Productivity

You may be surprised to know just how much health benefits can impact job satisfaction. According to a study on employee benefit trends, job satisfaction is likely to be as high as 96% among employees who are happy with their group health insurance. Having a more satisfied or happy team also has positive effects on productivity. These include:

- Being twice as productive
- Having 6 times more energy
- Spending 80% (amounts to 4 work days) of time on job tasks

In contrast, unhappy employees only spend 40% (amounts to 2 work days) of their time on work-related tasks. This results in a loss of productivity, which costs employers money.

The iOpener Institute for People & Performance, which provided these statistics, also noted that companies lose about 3.5 months of productivity for each unhappy employee. While offering or not offering group health benefits isn't the only thing that can make employees happy or not so happy with their jobs, these statistics provide some insight into the importance of job satisfaction. Making group health coverage available to employees is one of the ways you can help maintain a more satisfied and productive workforce.

Reducing Absenteeism

According to research from the U.S. Department of Health and Human Services, employees who have group health coverage are "significantly less likely to miss work than uninsured workers." This makes sense because employees who receive health benefits may have more incentive to seek preventive care and get medical treatment early to prevent conditions from getting worse. This may result in better overall health, which could also lead to increased job satisfaction and productivity at work. Studies show that satisfied workers take one-tenth of the sick days that their unhappy coworkers take.

On the flip side, people without health insurance are less likely to get preventive care and are twice as likely to put off getting necessary healthcare because they're worried about high medical bills. They're also more likely to be admitted to the hospital for health conditions that could have been avoided.

As a small business owner, you may have a few questions...

What if I just renewed our group health plan?

No problem. By law, group health insurance can be changed any month of the year. Sometimes, the savings are significant enough that it doesn't makes sense to wait until next renewal season.

What if I don't offer any benefits?

There are no-cost voluntary programs that can help you attract and retain employees and improve productivity without impacting your budget.

What if I really like my broker?

Would you consider another broker if he or she could deliver more value to you and your employees?

What if I don't have a lot of time?

That's certainly understandable, but taking a little time now to meet with an agent who can show you options can potentially save your business significant amounts of money.

Easing Medical Debt and Financial Stress

Medical debt is one of the main causes of personal bankruptcies for many Americans. A survey on medical bills from the Kaiser Family Foundation revealed that 53% of Americans without health insurance had trouble paying medical bills in the past 12 months whereas only 19% of those with employer-sponsored health insurance reported this problem. Financial problems are the number one cause of stress for Americans, and those with high amounts of debt have stress-related conditions, like ulcers, anxiety, and heart attacks. Why should you be concerned about this as an employer? Because the burden of medical debt and the stress that comes along with it could affect your employees to a greater degree if they don't have access to group health benefits. The snowball effect of employees being more prone to certain illnesses because of financial stress can lead to situations such as more missed days, decreased job performance, and less engagement at work. By offering health coverage, you can help employees manage their medical expenses to minimize these outcomes.

Gives Employees' Spouses and Kids Access to Health Coverage

Making it easier for employees' spouses and dependents to have access to affordable health insurance is another way to help maintain employee satisfaction. But with running a small business, you may be faced with the dilemma of wanting to do what's best for employees while still being mindful of how you spend money on business expenses like health insurance.

A middle ground approach you may want to consider when it comes to providing family health insurance is to not offer benefits to employees' spouses who are eligible for coverage through their own jobs. This is an option that even some large companies are using to help reduce costs. This method means that you would

provide coverage for employees' spouses who are not provided healthcare coverage by their own employers. If an employee's spouse *does* have coverage through his or her own job, this method means that you will not need to provide health insurance for that spouse.

For dependent coverage, the employer mandate requires that companies with 50 or more full-time equivalent employees provide health benefits to dependents up to 26 years old or be subject to a fee. If you have fewer than 50 employees, you can still provide benefits to dependents through a group health plan. It may be the right decision.

It's Convenient

The majority of people under 65 still get their health insurance through an employer-sponsored plan. Getting health benefits at work provides more convenience to employees because they don't have to search for a qualified health plan on their own or deal with whether or not they qualify for subsidies to buy coverage through the Marketplace.

Health Insurance Options for Small Businesses

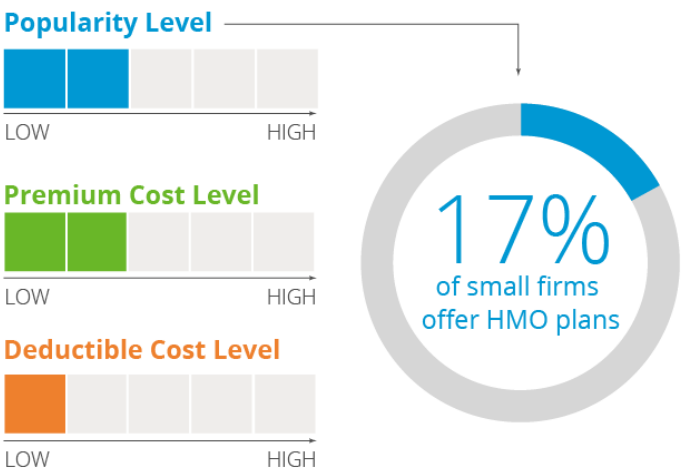
As a small business owner, you aren't limited in your choice of health insurance options.

You can choose from managed care (HMO, PPO, and POS), conventional indemnity—also referred to as fee-for-service (FFS)—and high-deductible health plans.

If you want to know what other small businesses with 3 to 24 employees are offering:

- Just 2% of employees are covered under an FFS plan.
- 16% of employees have HMO coverage.
- 27% of employees are enrolled in a POS plan.
- 23% of employees have an HDHP plan with a savings option.
- 48% of employees have coverage through a PPO.

The Stats on HMO Plans

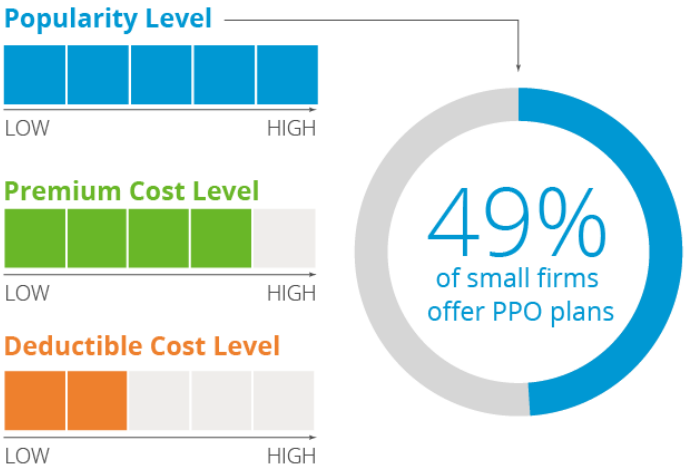


Health Maintenance Organization (HMO)

An HMO plan only covers medical services received at an in-network provider. All care is organized through a primary care physician (PCP). Patients must get a referral from their PCP if a medical condition requires treatment from a specialist. The only exceptions to getting a referral are for emergency room visits and routine, in-network care at an obstetrician or gynecologist.

Because HMO plans are more restricted, premiums and copays are usually lower than some other types of plans, such as a PPO plan. With lower employee premiums, you also put less money toward employer premium contributions.

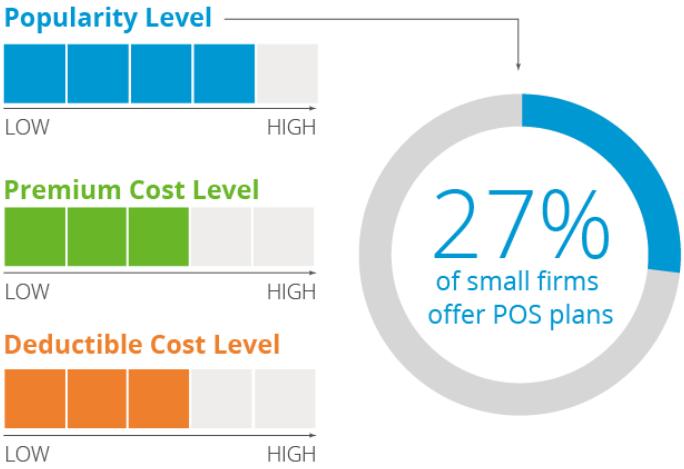
The Stats on PPO Plans



Preferred Provider Organization (PPO)

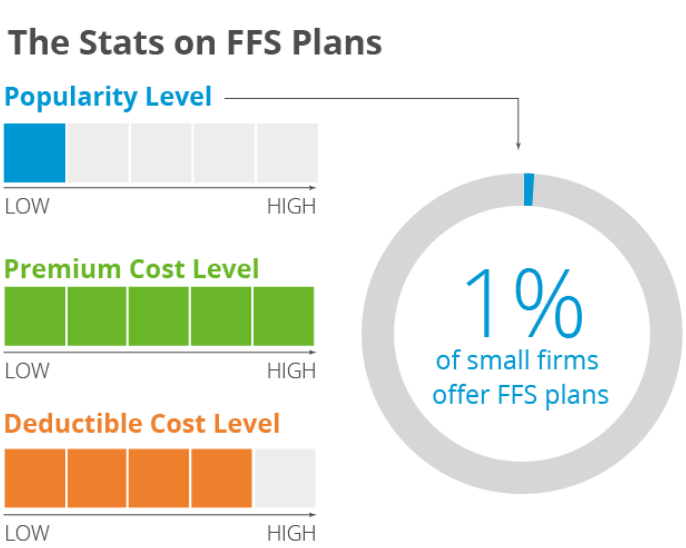
By comparison, a PPO plan provides more flexibility because members can choose to visit an in- or out-of-network provider, and there's no requirement to have a PCP. But the plan provides a lower percentage of coverage for going out of network. In addition to copays, PPO plans usually have coinsurance and annual deductibles. Patients may sometimes have to pay for care received out of network up front and then file a claim with the insurance company to get reimbursed for covered medical services.

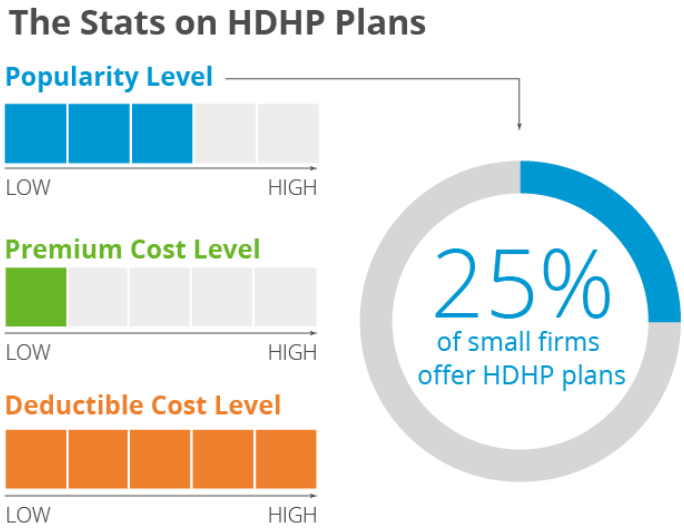
The Stats on POS Plans



Point of Service (POS)

This type of plan is a cross between an HMO and a PPO. The HMO aspect requires that patients first see their PCP to receive care and get a referral in some cases. The PPO element allows patients to receive some covered services at a provider outside the plan's network, but this may require a referral from the PCP. With a POS plan, some medical services may not be covered out of network, and members may have to file all claims forms themselves.





Fee for Service (FFS)

An FFS plan, also known as indemnity health insurance, lets members visit any physician, specialist, and hospital they choose. But this flexibility comes with higher out-of-pocket costs. The plan may pay healthcare providers directly or reimburse members for covered services after a claim has been submitted. An FFS plan can include a PPO option depending on the plan's service area. By using a PPO provider, members typically have lower out-of-pocket costs, and they usually don't have to file claims.

High Deductible Health Plan (HDHP)

As the name reveals, members pay a high annual deductible for having this plan. To compensate for the high deductible, this type of plan usually has a lower monthly premium than other plan types. An HDHP in a small group health insurance benefits package is usually paired with a health savings account (HSA). An HSA is funded through pretax dollars that are automatically deducted from employees' paychecks. Employees can use funds from the account to pay for out-of-pocket healthcare expenses.

Medicare

Medicare is a federally facilitated health plan for individuals who are 65 or older, have End Stage Renal Disease, or have certain disabilities. It comes in several segments: Medicare Part A and Part B (Original Medicare), Medicare Advantage, and Medigap (Medicare Supplement plans). Business owners as well as employees can become eligible for Medicare, and a licensed agent can help transition individuals into Medicare.

THE SMALL BUSINESS HEALTH CARE RELIEF ACT

SBHRA

Small business owners are now able to offer penalty-free qualified small health reimbursement arrangements (HRAs) on individual health plans to employees to help pay for their out-of-pocket medical expenses, including premiums.

This is thanks to the Small Business Health Care Relief Act (SBHRA), a former bill that became a provision within the 21st Century Cures Act that President Obama signed into law in December 2016.

To be eligible for qualified HRAs, you must have fewer than 50 full-time equivalent (FTE) employees and not offer group health plans to your employees. If you are eligible and you decide to offer qualified HRAs, the plan must be provided on the same terms to all eligible employees and be funded solely by you (the employer). The plan must also provide payment or reimbursement for medical expenses only after the employee provides proof of coverage.

Lastly, the plan must limit annual payments and reimbursements to specified dollar amounts.

The small business provision of the 21st Century Cures Act caps HRAs at $4,950 per single employee and $10,000 per employee with dependents. Double dipping of benefits is not allowed and will result in a fee. This means that if you are providing qualified HRAs to your employees, in most cases they cannot also receive ACA premium tax credits (though there are exceptions) or other qualifying HRAs.

Keep up to date with the latest healthcare reform news at HealthMarkets.com/Resources.

Voluntary benefits have become increasingly important as the cost of health insurance has risen.

hMany small businesses use voluntary benefits as a way to offer employees an added layer of protection, regardless of the level of health insurance being offered (if any). These benefits are called "voluntary" because they are optional benefits that employees may choose to add to their coverage package if an employer makes them available. Small business owners can choose to contribute to the cost of an employee's voluntary benefits, but it is not required. Another option would be to **offer voluntary benefits at no cost to the employer** and deduct the premium from employees' paychecks if they choose to enroll.

While dental and vision insurance may be the first insurance options to come to mind, life and disability policies are also important to consider when offering a well-rounded benefits package.

Dental and Vision Insurance

Twenty-six percent of small businesses offer dental coverage, and 14% of small businesses offer vision coverage. In a Glassdoor survey, dental and vision coverage are the health benefits that employees value the most. This may be because regular dental and eye checkups are important in detecting serious medical conditions. In fact, a 2014 health benefits study conducted by a major vision insurance provider and risk management firm, HCMS Group, found that employees who receive stand-alone vision benefits have less long-term healthcare costs, which saved business owners $5.8 billion over a four-year period.

This is because employees who find out about major health problems through comprehensive eye exams are less likely to visit the emergency room and be admitted to the hospital. That's less money businesses can lose from employee turnover and decreased productivity. This may be all the more reason to make vision as well as dental benefits available to your employees.

Life Insurance

Among small businesses with less than 50 employees, just 36% offer life insurance. This provides an opportunity to be more competitive in the job market by providing workers access to the financial protection that a life insurance policy can provide. Your company usually needs just 2 employees to offer group life insurance. But many business owners offer coverage only when they have at least 10 employees.

The type of life insurance that's typically offered by companies is group term life. Term insurance provides coverage for a specific number of years, usually 5-30 years, and is often used as income replacement when a primary income earner dies. You decide the amount of coverage you want to offer employees, such as 1 or 2 times their annual salary or a flat amount like $50,000. Premiums for group term policies are a tax-deductible business expense, which offers more incentive to provide this benefit.

Disability Insurance

Twenty-six percent of small businesses offer short-term disability coverage, and 20% offer long-term disability coverage to their employees. A handful of states require disability insurance, another option available for small businesses to offer employees. There are two types of coverage: short-term disability (STD) and long-term disability (LTD). Both types of insurance pay income directly to employees if they're unable to work due a disabling accident, injury, or illness. STD benefits can last from 6 months to 2 years, while LTD benefits are paid out for 2 to 10 years, or until the age of retirement, depending on the policy that's chosen. Disability insurance is a very important benefit for employees because most disabilities are not work-related and wouldn't be covered under workers' compensation, according to the Council for Disability Awareness. Without the replacement income that a disability plan provides, many employees may have a hard time paying for everyday living expenses.

Critical Illness and Cancer Insurance

As we just mentioned, most disabilities are not work-related. And according to WebMD, critical illnesses like cancer and stroke are some of the main causes of disability that lead to missing work. While more and more people are surviving a cancer diagnosis and progress is being made against the disease, cancer rates still continue to increase, so it's likely that someone on your staff could be affected during their employment. By including critical illness or cancer insurance in your employee benefit package, you get the satisfaction of knowing that you're providing a voluntary health benefit that's relevant to what's taking place in society, and your employees get added financial protection by receiving a cash benefit for a qualified illness.

Gap Insurance

Supplemental gap plans help cover out-of-pocket costs, like deductibles, coinsurance, and copayments. While they don't cover any specific conditions, they can come in handy with high-deductible or high out-of-pocket-cost plans.

HealthMarkets is here to help your small business thrive.

Our agents are trained and licensed, doing things the right way the first time. HealthMarkets agents are available year-round, not just when it's time to renew or enroll in next year's plan. You can always rely on us. Plus, our best price guarantee means you are getting the best deal for the plans we offer.*

Why HealthMarkets

Why choose to work with HealthMarkets for your benefit needs? Our employer-specialized insurance agents are trained to understand the unique needs of your business and provide solutions to help you reach your goals. An agent can help you find the right solution by:

- Showing you innovative cost-saving solutions that other agents and brokers may not tell you about; these alternatives can help manage your expenses and avoid costly loss of productivity and turnovers
- Providing communication and on-site support for a smooth transition to a potentially new plan, so there are fewer disruptions to running your business
- Being available to help with answering employee benefit questions, enrolling new employees, and more; an agent can take these time-consuming tasks off your plate so you can focus on growing your business—not on benefits administration

Once you and your agent have decided which solution best meets your needs, he or she will work with you to communicate to your employees in a way they can easily understand.

Your HealthMarkets agent will even meet with each of your employees to create a personalized solution that provides the coverage they need at a price they can afford.

BEST PRICE GUARANTEE

** Your State Department of Insurance regulates the insurance products that we offer in your state and corresponding premium rates. The premiums charged by a carrier for a particular insurance product must be consistent regardless of whether you buy it from HealthMarkets Insurance Agency, from a competing agency, or directly from the insurance company.*

Helpful Terms to Know

Affordability In order to meet affordability guidelines, the cost of a company's least expensive health plan cannot exceed 9.69% of any employee's income.

Affordable Care Act (ACA) This comprehensive healthcare reform law was enacted in March 2010. The law was enacted in two parts: The Patient Protection and Affordable Care Act was signed into law on March 23, 2010, and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name "Affordable Care Act" is used to refer to the final, amended version of the law, which is also commonly known as Obamacare.

Agent An agent (or broker) is a person who is regulated by states to sell the insurance products the agent is licensed to sell. Typically these individuals receive payments, or commissions, from health insurance companies for enrolling a consumer into their plans. Some agents and brokers may only be able to sell plans from specific health companies.

Applicable Large Employer (ALE) Companies that have 50 or more full-time equivalent employees are considered ALEs and are subject to the employer mandate.

Benefits The healthcare items or services covered under an insurance plan. Covered benefits and excluded services are defined in the insurance plan's coverage documents.

Benefit Level The maximum a health plan will pay for covered benefits.

Benefit Year A year of benefits coverage under a health insurance plan. The benefit year for individual plans bought inside or outside the Marketplace begins January 1 of each year and ends December 31 of the same year. Coverage ends December 31 even if coverage started after January 1. Any changes to benefits or rates are made at the beginning of the calendar year. This is not true for group plans, which can start or end at any time, depending on what an employer chooses.

Claim A request for payment that you or your healthcare provider submits to your health insurance company. Claims are submitted when you receive products or services for medical treatment that may be covered by your plan.

Coinsurance The amount you may be required to pay as your share of the cost for healthcare services or prescriptions after you pay any deductibles. Coinsurance is usually a percentage (for example, 20%).

Copayment The amount you may be required to pay as your share of the cost for healthcare services or products, such as a doctor's visit or prescription drugs.

Deductible The amount you pay for covered healthcare services before your insurance plan starts to pay. With a $2,000 deductible, for example, you pay the first $2,000 of covered services yourself. After you pay your deductible, you usually pay only a copayment or coinsurance for covered services. Your insurance company pays the rest.

Dependent Coverage Insurance coverage for family members of the policyholder, such as spouses or partners and children.

Drug Formulary A list of prescription drugs covered by a prescription drug plan (like Medicare Part D or individual health insurance plans that include prescription drug benefits). Also called a drug list.

Effective Date Unless otherwise specified, enrollments or changes in enrollment become effective on this date.

Employee Contribution The amount an employee pays into a health plan.

Employer Contribution The amount an employer pays into a health plan.

Employer Mandate (Employer Shared Responsibility Payment [ESRP]) The Affordable Care Act (ACA) requires certain employers with at least 50 full-time employees (or 50 FTEs) to offer health insurance coverage to at least 95% of their full-time employees (and their dependent children under age 26). The coverage must meet certain minimum standards set by the ACA or the employer will have to make a tax payment called the ESRP.

Enrollment The process by which a person becomes a member of a healthcare plan.

Exclusions Items or services that a health plan does not cover.

Flexible Spending Account (FSA) An arrangement set up through a health insurance plan for policy holders to pay for out-of-pocket medical expenses with tax-free dollars. These expenses include insurance copayments and deductibles, and qualified prescription drugs, insulin, and medical devices. Policyholders decide how much of their pre-tax wages they want taken out of their paycheck and put into an FSA. Policyholders don't have to pay taxes on this money. Plans set limits on the amount a policyholder can put into an FSA each year. FSA funds that are not spent by the end of the plan year are forfeited and can't be used for expenses in the next year. An exception is if the FSA plan permits the use of unused FSA funds for expenses incurred during a grace period of up to 2.5 months after the end of the FSA plan year. (Note: FSAs are sometimes called Flexible Spending Arrangements.)

Full-Time Equivalent (FTE) The number of full-time equivalent employees is the ratio of average weekly hours per employee. A company's FTEs will be less than the number of its employees on full- and part-time schedules, unless it has no part-time employees. (Note: To find out how to calculate your number of FTEs, see page 6.)

Guaranteed Issue A requirement that health plans must permit you to enroll in their plans regardless of health status, age, gender, or other factors that might predict the use of health services. Except in some states, guaranteed issue doesn't limit how much you can be charged if you enroll.

Health Savings Account (HSA) A medical savings account available to taxpayers who are enrolled in a High Deductible Health Plan. The funds contributed to the account aren't subject to federal income tax at the time of deposit because deposits are made with pre-tax dollars. Funds must be used to pay for qualified medical expenses. Unlike an FSA, funds roll over year to year if you don't spend them, and the funds can be invested.

Health Insurance Portability and Accountability Act (HIPAA) The "Standard for Privacy of Individually Identifiable Health Information" (also called the "Privacy Rule") of HIPPA assures your health information is properly protected while allowing the flow of health information needed to provide and promote high-quality healthcare and to protect the public's health and well-being.

Long-Term Disability (LTD) Disability insurance that pays income directly to employees if they're unable to work due a disabling accident, injury, or illness for 2 to 10 years, or until the age of retirement, depending on the policy that's chosen.

Marketplace The federal government operates The Health Insurance Marketplace (also known as the "Marketplace" or "exchange"), available at healthcare.gov, for most states. Some states run their own Marketplaces. It provides health plan shopping and enrollment services for individuals and families needing coverage outside of an employer-provided plan.

Maternity Coverage The coverage of maternity care and childbirth services provided before and after your child is born. Maternity coverage is one of the ACA's 10 essential health benefits, which means all qualified health plans inside and outside the Marketplace must cover maternity care.

Minimum Value Health insurance that's equivalent to the minimum essential coverage and cost-sharing amount (60%) for a bronze plan found on the Marketplace.

Network The facilities, providers, and suppliers your health insurance company or plan has contracted with to provide healthcare services.

Obamacare See Affordable Care Act (ACA).

Open Enrollment Period The yearly period when people can enroll in a health insurance plan.

Out-of-Pocket Costs Expenses for medical care that aren't reimbursed by insurance. Out-of-pocket costs include deductibles, coinsurance, and copayments for covered services plus all costs for services that aren't covered.

Out-of-Pocket Limit/Maximum The most you have to pay for covered services in a plan year. After you spend this amount on deductibles, copayments, and coinsurance, your health plan pays 100% of the costs of covered benefits. The out-of-pocket limit doesn't include your monthly premiums.

Pre-Existing Condition A health problem you had before the date that new health coverage starts.

Premium The amount that must be paid for your health insurance plan. You and your employer usually pay it monthly, quarterly, or yearly.

Preventive Services Routine healthcare that includes screenings, checkups, and patient counseling to prevent illnesses, diseases, or other health problems.

Primary Care Physician A physician—M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine)—who directly provides or coordinates a range of healthcare services for a patient.

Provider A person or organization that's licensed to give healthcare. Doctors, nurses, and hospitals are examples of healthcare providers.

Referral A written order from your primary care physician (or PCP) for you to see a specialist or get certain medical services. In many Health Maintenance Organizations (HMOs), you need to get a referral before you can get medical care from anyone except your primary care doctor. If you don't get a referral first, the plan may not pay for the services.

Schedule C Tax form used to report income or loss from a business you operated or a profession you practiced as a sole proprietor.

Schedule K-1 Tax form used to report your share of the corporation's income (reduced by any tax the corporation paid on the income), deductions, credits, etc.

Small Business Health Options (SHOP) Marketplace The public health insurance exchange for employers, known as the Small Business Health Options (SHOP) Marketplace. Compared to self-employed health insurance coverage outside the SHOP Marketplace, it has been reported that the SHOP has fewer plans. Many states only offer plans from one insurance company, and available plans are usually the more expensive options.

Short-Term Disability (STD) Disability insurance that pays income directly to employees if they're unable to work due a disabling accident, injury, or illness for 6 months to 2 years.

Special Enrollment Period (SEP) A time outside the yearly Open Enrollment Period when you can sign up for health insurance. You qualify for an SEP if you've had certain life events, including losing health coverage because you lost or changed your job, moving, getting married, having a baby, or adopting a child.

Specialist A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of healthcare.

Subsidized Coverage (Subsidy) Subsidized coverage is health insurance available at reduced or no cost for people with incomes below certain levels. Subsidies are only available to people who purchase coverage through the Marketplace and are not available for employer-provided plans. One kind of subsidized coverage, or subsidy, is known as a premium tax credit. Premium tax credits can lower the monthly cost of health insurance premiums. Another type of subsidy, cost-sharing reductions, can lower out-of-pocket costs (like copays and deductibles).

Summary of Benefits Insurance companies and job-based health plans must provide you with a short, plain-language Summary of Benefits and Coverage (SBC)

Underwriting The process that an insurance company uses to decide, based on your medical history, whether to take your application for insurance, whether to add a waiting period for pre-existing conditions (if your state law allows it), and how much to charge you for that insurance.

Voluntary Benefits Services not covered by major medical insurance that enrollees can choose to buy or reject. Enrollees who choose these benefits pay for them directly, usually in the form of premiums and/or copayments or coinsurance. Some employers may choose to cover a portion of these benefits, or employees may pay for the entire cost. These services can be grouped or offered individually and separate from any health plan offered.

Waiting Period The time that must pass before coverage can become effective for an employee or dependent who is otherwise eligible for coverage under a job-based health plan.

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