

# Small Business Health Insurance Buyers Guide

Employees usually rank health care coverage as the most important of all their benefits. Not surprisingly, U.S. businesses spend hundreds of billions of dollars on group health insurance programs every year.

The three most popular types of health care plans offered to employees today are HMOs, PPOs, and point of service plans (POSs). The landscape has changed considerably in the last few years - traditional indemnity plans have almost vanished entirely, and new consumer-driven plans are starting to take hold. Some businesses offer only one option, while others - particularly those with a large, diverse group of employees - offer two or more.

Which type of plan is best for your company? There is no easy answer. Premiums change every year, your employee base may change considerably, and state and federal rules can affect costs and coverage in unpredictable ways. Many companies make it a point to reevaluate their health care options every year. Because it is one of the most important benefits to your employees and a huge expense for your business, it is worth taking the time to make sure you make the right choice.

The SBHI.NET (Small Business Health Insurance Network) Buyer's Guide will walk you through the various types of coverage, describe how to shop for a plan, and give you some tips on getting the most out of your health coverage. When you're ready, we can put you in touch with health insurance vendors or brokers in your area – for free. [Compare Group Health Insurance Quotes](#)

## Types of Health Insurance Plans

In the last fifteen years, there has been a dramatic shift in employer-sponsored health care. Increased options and cost savings for employers have led the shift away from traditional plans and towards HMO and PPO alternatives.

Here is a rundown of the main types of plans.

### Traditional

The biggest advantage of traditional health insurance is the flexibility it provides employees. Also known as indemnity coverage, traditional health insurance allows individuals to visit any doctor or hospital they want and receive coverage for any treatment covered under the policy. Plan members can go to any specialist without a referral, and the insurance company has no say as to whether or not the visit is necessary. Unfortunately for people who prefer this flexibility, few employers offer traditional health insurance plans any more.

The reason they are so rare these days is cost. Because there are few oversight or cost-saving measures, premiums for traditional insurance tend to be higher than for other kinds of plans, which raises costs for both employers and employees. Traditional insurance also carries more out-of-pocket expenses, since most plans require costly deductibles (the amount the insured has

to pay before the provider starts paying) and co-insurance (the provider pays the majority of the bill, but the insured is responsible for 5%, 10% or 20% of each charge).

## **HMO**

Health maintenance organizations (HMOs) were the first alternatives to traditional insurance. By creating a network of doctors and hospitals and implementing cost-saving measures, HMOs are able to control costs better than other plans. Overall, HMO premiums are the lowest of any type of plan.

However, HMOs are also the least flexible type of health care plan: they require members to choose a primary care physician who performs basic health checkups and approves visits to other physicians. These plans also generally only cover the expense of member visits to doctors and hospitals that are part of the network. Visits to nonparticipating doctors must be paid directly by the employee.

This gatekeeper system represents both the best and the worst of HMOs. While this structure helps minimize costs for employers, it can be unpopular with some employees who currently use doctors outside the HMO network, since they must switch physicians to receive coverage. Also, employees who want more control over their medical care can find it annoying to jump through the gatekeeper hoop to see specialists.

## **PPO**

Preferred provider organizations, or PPOs, are now the most popular choice for employer-sponsored health care. A PPO is a collection of physicians and hospitals that agree to provide health care at a reduced cost to PPO members. With this setup, they can limit health care costs without the restrictions of an HMO.

Most PPOs are quite similar to traditional health insurance policies, with the exception that there are two different levels of coverage depending on which providers you use. For visits to doctors and hospitals that are affiliated with the PPO, patients pay a low deductible and little or no co-insurance. Visits to doctors and hospitals outside the network are not as fully covered, requiring higher payments from the patient.

This structure is designed to encourage PPO members to use specific doctors and hospitals that have been designated by the organization as preferred providers. These doctors and hospitals agree to provide health care to PPO members at lower rates, which allows the PPO to reduce overall health care costs.

## **POS**

Also known as an open-ended HMOs, point of service (POS) plans combine elements of both HMOs and PPOs. As with an HMO, members choose a primary care physician who will provide referrals when needed. However, they are also free to visit out-of-network providers if they desire, with or without a referral - and the plan will still cover the expense, to some degree. However,

members who use services outside the network must pay more than they would for in-network services. This increased cost typically involves deductibles and coinsurance, much like traditional fee-for-service plans.

POS plans are popular with some employees because they provide much of the cost savings of HMOs, but still include some coverage if the member wants to choose a specific doctor.

Finally, a new type of health plan that is rapidly gaining popularity is the consumer-driven health plan - read on for more.

### **Consumer-Driven Health Care**

Consumer-driven health care (CDHC) is based on a basic belief that individuals should play more of a direct role in managing the costs of their own health care, which should help them make wiser decisions about their use of the health care system. This idea has been slowly gaining acceptance for several years, in part due to the escalating costs to employers of other forms of health insurance. So far it is more common in very large companies, but it will likely trickle down to smaller companies over time.

The term "CDHC" can include a wide variety of plans. The most common consumer-driven plan pairs a health savings account (HSA) with a high deductible (\$5,000 or more) insurance plan. Employers and employees make pre-tax contributions to the HSA, which can be used to pay for routine and preventative medical care. The insurance provides coverage for catastrophic or high-cost events. Typically, any unused amounts in the savings account can be rolled over and used in subsequent plan years.

Another so-called CDHC plan design offers a broad menu of health care choices with varying contribution levels that an employee can choose from at enrollment. This is more accurately referred to as a defined contribution plan, but it is often described as consumer-driven, since the employer gives each employee a fixed dollar contribution to apply to the available health care options.

Because each employee is responsible for making more of their own decisions around their health care, a key component of successful consumer-driven health care plans is providing a set of tools to assist people in understanding the complex health care system. While the lower overall costs may attract interest from budget-minded benefits managers, employee satisfaction can be seriously affected if workers feel that they are being left on their own.

Due to the small number of companies currently offering true CDHC plans, reliable data on average deductibles and worker contributions is not yet available. However the level of interest shown by many large companies suggests that these plans will quickly become more popular. In fact, some experts predict that CDHC will almost completely replace managed health care plans in just a few years, much like managed health care did to traditional insurance.

### **Finding A Health Insurance Broker**

The first step in choosing health insurance for your company is to find a good broker. A broker is a salesperson who has a state license to sell and service contracts of multiple health plans or insurers. Some states require that you purchase insurance through a broker; others allow you to go directly to insurers if you want. But the benefits of using an insurance broker make it worthwhile in almost any situation.

The majority of group health insurance is "written", or sold, by self-employed agents or brokers who work for agencies. Often, these agencies will handle multiple benefits for your company: health, dental, and vision plans, life insurance, and more. They develop relationships with the providers that let them act more efficiently on your behalf. They can also help your employees process claims or resolve problems: many have "patient advocates" who your employees can contact for assistance.

Your health care costs will be based on your employee demographics, so the quotes you get from any broker are going to be fairly similar. Because of this, you should choose a broker based on the level of service they can provide. Some attributes to look for:

- Flexibility - remember that the broker works for you: they should be able to help you get the best deal and the best plan for your employees.
- Responsive - even during the evaluation process, pay attention to how long it takes the broker to get back in touch with you.
- Multifaceted - by managing several benefits and handling employees' questions, the broker makes themselves more valuable to you.

The broker you choose should be very experienced in dealing with firms of similar size and in the same industry as your own. Interview several candidates and ask questions:

- What services do you offer that I will not be able to get from another broker?
- What types of problems can you solve for my employees?
- Tell me about some problems you have helped other clients' employees resolve.
- Can my employees call you for help 24/7? Do you have a web site or online chat for employees to get help?

Finally, location may or may not be an important issue to you. It may be convenient to have a local broker, but since your employees' interactions with them will be online or on the phone, it is not essential.

### **Watch out!**

While almost all brokers are on the level, some may not present policies fairly. They may offer a computerized search that purports to compare all policies on the market, but favors the broker's pet policies.

As with any business purchase, if you come across a price that is too good to be true, you should be suspicious. Every state has a department that keeps track of all insurance agents and policies:

if you have doubts about the legitimacy of a broker or insurer, you can call and check up on them. Good interviewing and use of referrals should also help you avoid these types of scams.

## **Evaluating Group Health Insurance**

Once you have several plans to evaluate, there are several types of questions you should look into.

### **Policies and reimbursement**

Some policies set artificially low limits on the maximum payment. Make sure the policy you choose offers at least \$1 million of coverage, since costs for treating catastrophic illnesses can easily reach these astronomical amounts.

Also, watch out for low reimbursement levels. Some policies pay a set maximum per procedure, which can be far less than what physicians in your area actually charge. If the claim payment falls short of the bill, the patient can be left paying the difference. To avoid this, you may want to check with a physician to see if reimbursement levels are within the normal billing range.

If you are evaluating PPOs or POSs, avoid overpaying for the flexibility they offer through high deductibles and co-insurance. Be wary of policies that require patients to co-insure more than 25 percent of the cost of treatment or that continue to charge co-insurance for costs in excess of \$10,000.

### **Coverage and features**

Virtually all health plans cover hospital care and emergency care. Most also cover outpatient care, which includes routine exams, lab work, and office visits. But plans can vary significantly in other areas. You may find that some do not include treatments such as prenatal and postpartum maternity care, prescription drugs, and ambulance service, or have very different co-payment or co-insurance fees in these areas.

Pay particular attention to provisions for long-term treatments such as mental health or substance abuse: some plans offer insufficient coverage in these areas. Also check provisions for long-term illnesses and restrictions for pre-existing health conditions (such as diabetes or asthma).

### **Doctors**

The quality of physicians participating in the network can be the most difficult area to assess, although it is arguably the most important.

Inquire about the screening process that is used to sign up physicians. A screening process should ideally include checks of the doctor's background, including analysis of any previous malpractice issues.

Also ask how many physicians in the network the American Board of Medical Specialties has certified. To be certified, a physician must demonstrate competency in a specialty by passing tests or meeting training requirements. Ideally, 85 percent or more of the physicians should be board-certified.

Though it is not unusual for HMO and PPO networks to be enormous, some plans sign up doctors simply to boost their numbers. To get a better sense of the actual availability of doctors in the network, ask what percentage of the doctors actually accept new patients.

A final statistic to evaluate is the physician turnover rate. This can give you a good indication of the likelihood that you will be forced to switch doctors. The turnover rate can also indicate how satisfied physicians are with the rules for treatment and reimbursement within the network. Better programs usually have a turnover rate of 3 percent to 5 percent.

### **Grievances**

Save your employees many potential problems by researching how the insurers resolve grievances from plan members. Quality organizations should have a set procedure in place for airing disagreements before a grievance board. A clearly outlined appeals process gives members a way to protest unfair reimbursement levels or other problems.

Consulting the state department of insurance, which keeps records of patient complaints, may shed some light regarding patient satisfaction. If there are a lot of outstanding grievances from current plan members, a warning flag should go up.

### **Health Insurance Pricing**

Employers' costs keep rising. According to the Kaiser Family Foundation/HERT Employer Health Benefits 2004 Annual Survey, the costs for providing health insurance increased by an average of 11.2% in 2004, the fourth straight year of double-digit premium increases. For the first time, the average cost of a family PPO plan went above \$10,000 a year. Fortunately for employees, employers pick up most of the costs: in 2003, on average, employers picked up 84% of premium costs for single coverage and 73% of the premium for families. Larger companies tend to pay more of the costs: large firms paid on average 76% of family coverage premium costs, compared to smaller companies' 64%.

Generally, traditional health insurance tends to be the most expensive kind of health insurance program for individuals, followed by PPOs, POSs, then HMOs. For families, PPOs are the most expensive, with HMOs the cheapest.

### **Traditional indemnity insurance**

According to the Kaiser study, the average annual premium for an individual in a traditional health plan is now \$3,820, with employer's contribution averaging \$3,352.

Out-of-pocket costs for traditional health insurance can vary depending on how you structure the policy. Employees typically pay deductibles from \$200 to \$1,000, and co-insurance is usually about 20 percent for the first \$2,000 to \$10,000.

## **HMO**

HMOs are the lowest cost option for health insurance, with total premiums averaging \$3,458 and employer contributions averaging \$2,906.

Besides monthly premiums, out-of-pocket costs for employees include low co-payments for visits to physicians within the network and for prescription drugs. These co-payments generally range from \$5 to \$25. And visits to physicians outside the network are generally not covered at all.

As with most plans, employees pay up to a deductible each calendar year (typically between \$250 and \$1,000) as benefits are provided, then around 10 to 20 percent co-insurance of any additional charges.

## **PPO**

PPOs cost employers an average of \$3,235 per covered employee, with total premiums averaging \$3,808. While almost as expensive as traditional health plans, they are much more popular with employees and employers alike because of their greater flexibility.

In terms of patient out-of-pocket costs, PPOs can vary tremendously. Some networks require members to pay only a small deductible with each visit, much like an HMO. Most have deductibles and co-payments similar to HMOs, and most will require members to pay significant co-insurance on out-of-network visits.

## **POS**

Average costs for POS plans are slightly higher than HMOs: total premiums average \$3,627 with employer contributions averaging \$3,085.

POS plans keep out-of-pocket expenses low with easy co-payments for visits within their networks and for referrals. Employees who choose to go outside the network, however, will pay much more in co-insurance.

## **Broker fees**

Health insurance agents and brokers are paid by the insurer, based on the value of the policies you purchase. If you contract your broker to provide other HR services, such as life insurance or handling COBRA administration, you may have to pay additional fees accordingly.

## **Health Care Buying Tips Finding insurance for small businesses**

Small businesses that have difficulty finding coverage directly from insurers may want to contact their state department of insurance to learn about small business group health providers in their area. As an alternative, small businesses can join an association that offers group benefits for their members. Companies should be careful to scrutinize the operations of such organizations to ensure that all funds are handled appropriately.

### **Types of policies to avoid**

Watch out for hospital indemnity policies and dread disease policies. Hospital indemnity policies pay for each day you are in the hospital. Unfortunately, most do not provide enough coverage to even cover the typical daily cost of a hospital stay. Dread disease policies cover particular illnesses but tend to be far more expensive than the likelihood of contracting one of these diseases would suggest.

### **Let employees choose**

In 2004, only 14% of companies with fewer than 200 employees offered more than one health care option. However 57% of companies with 200 to 1000 employees offered multiple options, and 76% of companies with 1000+. Offering more than one plan gives your employees the freedom to choose the plan best suited for them. There is little additional cost to you, so it can really improve employee satisfaction and make your small business seem a little bigger.

### **Know the law**

If you decide to create your own health care plan, make sure you do enough research to understand the requirements you have to meet. There are many laws and regulations that govern health care, and many states have their own regulations, too.

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