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Benefit Plans for Small Businesses

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If you own a small business, you may be finding it increasingly necessary to implement a benefit program to attract and retain employees. For small businesses, benefit plans generally consist of some of the major insurance benefits, discussed here, as well as employer-sponsored retirement plans.

Group health insurance and health care reform

Health insurance is by far the most common benefit offered by employers, and the one most requested by employees. Employers are generally not required to offer coverage, but those that don't may be subject to a penalty tax. In 2020, the penalty tax applies to employers with 50 or more full-time equivalent employees (FTE) who do not offer qualifying health coverage to at least 95% of their FTEs and dependent children up to age 26 (spouses are not considered dependents and coverage does not have to be offered to spouses of FTEs). The penalty is assessed to eligible employers that do not offer coverage if at least one FTE receives a federal premium tax credit or cost-sharing subsidy for coverage purchased through a health insurance Marketplace. In 2020, the employer penalty is $2,320 per FTE divided by 12, excluding the first 30 FTEs.

In addition, if an eligible employer offers health insurance that is not considered affordable or does not provide minimum value, the penalty for each month is $3,480 divided by 12, for each FTE receiving a premium tax credit, up to a maximum of $2,570 per FTE, excluding the first 30 FTEs, divided by 12. Health insurance provides minimum value if it pays for at least 60% of covered health care expenses for a standard population. Health insurance is affordable when the cost of coverage is no more than 9.56% of an employee's family income.

Employers with more than 200 full-time employees that offer health insurance must automatically enroll new full-time employees, subject to a waiting period of no longer than 90 days.

Traditional health insurance plans

Under a traditional plan (also known as a fee-for-service or indemnity plan), you, as the employer, contract with an insurer to provide health insurance benefits for you and your employees (and often for your employees' dependents as well). A typical plan will reimburse claims as a percentage of the normal and customary charge for a given procedure in a particular region. The plan typically pays either the medical provider directly, or reimburses the employee after he or she pays for the medical service.

A covered employee generally must pay a deductible before benefits become payable by the insurer. The higher the initial deductible, the lower the insurance premium. This is because the covered employees are taking on a larger portion of the insurance risk by paying the higher amount, and saving the insurance company the costs of processing smaller claims.

HDHPs

HDHPs are plans that require employees to cover a greater share of their service provider costs in return for lower premiums. HDHPs are often paired with a tax-advantaged savings option, such as a health savings account or health reimbursement account, to help employees manage the higher out-of-pocket costs.

Preferred provider organizations (PPOs)

A PPO is actually a network of doctors and/or hospitals that agree to provide medical services for specified fees. The PPO may be sponsored by a particular insurance company, by one or more employers, or by some other type of organization. PPO physicians provide medical services to the policyholders, employees, or members of the sponsor(s) at discounted rates. In return, the sponsor(s) attempts to increase patient volume by creating an incentive for employees or policyholders to use the physicians and facilities within the PPO network.

Point-of-service plans

A point-of-service plan combines elements of both a traditional plan and a PPO. The employee can choose whether to see an in- or out-of-network service provider; however, should he or she choose to go outside of the network, higher costs will typically apply.

Health maintenance organizations

HMOs generally will offer a lower-cost option for you, the employer, as well as for your employees. Costs are reduced because the HMO typically restricts the doctors a patient can see to those within its provider network. A primary care physician coordinates care for the patient among other participating providers. However, in limited circumstances--as set out by the HMO--participants can generally go out of the provider network, and the HMO may still pick up the cost.

HMO doctors are typically paid a set fee per patient. This fee is paid whether a patient actually seeks treatment or not. Doctors in the HMO network handle all procedures and tests. Thus, the HMO is able to control the entire spectrum of tasks necessary to keep a patient well. In theory, the HMO is also able to control costs by giving doctors incentives to keep costs low. A doctor has no financial incentive to conduct unnecessary tests (the doctor will receive the preset fee and no more), so it is up to the doctor to help control patient costs.

Dental insurance

This benefit has grown in popularity among small businesses. Dental insurance is really more of a co-payment plan than an actual insurance plan. This is because, typically, there are annual limits of a few thousand dollars on the amount of benefits an individual may receive under the plan (unlike health insurance, which may have a lifetime limit of several hundred thousand to millions of dollars for benefits paid).

Nonetheless, dental insurance is highly valued by employees, because dental procedures are often among the most expensive medical charges an individual will incur in a given year.

Paying insurance premiums

Whatever type of health plan(s) you select, it's fairly typical for an employer to pay a portion (or all) of the employee cost of the plan. If an employee also wants to cover his or her family, the additional cost is often paid for entirely by the employee.

Group term life insurance

Group term life (GTL) insurance is another popular benefit offered by more and more small businesses.

Typical GTL plans offer employees insurance in either a set amount (e.g., all employees receive $10,000 of insurance, regardless of income level) or an amount based on their salary level (e.g., each employee receives insurance equal to two times current salary).

GTL benefits are tax free up to $50,000 of coverage (assuming that the benefits are provided under a policy that qualifies as GTL insurance for tax purposes). If you provide employees with more than that amount of coverage under a qualifying GTL policy, your employees must pay taxes on the amount of the premium attributable to insurance coverage in excess of $50,000. However, the amount of additional income recognized by employees as a result of employer-provided GTL coverage in excess of $50,000 is typically very small (especially for younger employees). Therefore, the additional taxable income should not, by itself, be a disincentive for providing higher amounts of GTL coverage for your employees if you're so inclined.

Short-term and long-term group disability insurance

A disability plan is designed to provide an employee with an income stream should he or she become disabled.

Short-term disability plans provide benefits (usually a fixed percentage of the employee's salary) for a set number of days (typically 180). After that period of time, assuming the employee is still disabled, long-term disability insurance (if available) kicks

in, and the employee receives benefits under that program until he or she is no longer disabled.

Typically, under a group plan, these benefits are fixed and not adjusted for inflation (in contrast, individual policies often offer an inflation rider). And if an employer pays all or a portion of the premium for disability coverage, then the portion of the benefits paid to employees that is attributable to the employer's contribution is considered taxable income.

Note: *Currently, you're required to purchase disability insurance if your employees are located in California, Hawaii, New Jersey, New York, Puerto Rico, or Rhode Island (Source: SBA.gov).*

Cafeteria plans

Though not an insurance plan per se, a cafeteria plan can offer employees a way to pay their portion of insurance premiums with pretax dollars. If you implement a cafeteria plan as part of your business's benefits program and the plan satisfies certain requirements, employees can elect to forgo a portion of their salary and have that money instead go to pay for their premium payments, without the amount being included in their taxable income.

Employees save money because their taxable income is reduced, yet benefits remain the same. The employer's payroll taxes are reduced as well, because the employees are receiving lower salaries than they were before the cafeteria plan was implemented.

In order for a plan to qualify as a cafeteria plan under the Internal Revenue Code, it must satisfy certain requirements. In addition, an employer that has established a cafeteria plan is required to annually file a Form 5500 tax return for the plan.

Required employee benefits*

All employers must pay in whole or in part for certain legally-mandated benefits and insurance coverage including:

- As an employer, you must pay Social Security taxes at the same rate paid by employees (the current rate for Social Security is 6.2% for employer and employee, plus an additional 1.45 percent each for Medicare). High-income employees (single filers who earn more than $200,000 and joint filers who earn more than $250,000 per year) have to pay an additional 0.9% Medicare tax. Unlike the regular Medicare tax, employers will not need to match this additional amount.
- Employers generally must also pay unemployment tax to help fund the Federal-State Unemployment Insurance Program. This program provides unemployment insurance benefits to eligible employees who lose their job through no fault of their own. States administer their own laws to determine worker eligibility. Depending on your state regulations, you may owe just a federal unemployment tax, a state unemployment tax, or both. For more information, visit the Department of Labor Employment and Training Administration web site, www.doleta.gov . That site also provides a list of links to state unemployment tax agencies.
- Workers' compensation insurance, which pays a benefit to employees who are injured at work or get sick from job-related causes, is governed by the individual states. For more information, visit your state's Division of Workers' Compensation. You can see a list of state divisions at the Department of Labor's web site.
- While regular vacation leave is not a required benefit, private employers with 50 or more employees and all public employers are required to provide leave under the Family and Medical Leave Act (FMLA). This provides 12 weeks of job-protected, unpaid leave during any 12-month period to eligible, covered employees for reasons including birth and childcare, immediate family care, or care for the employee's own health condition.
- Companies who had 20 or more employees on more than 50 percent of its typical business days in the previous calendar year are subject to COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985). COBRA provides continuation of health coverage at group rates for former employees, retirees, spouses, former spouses, and dependent children.

*Source: SBA.gov

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