

# Small Business Group Health Insurance

## Frequently Asked Questions

Prepared by [Solid Health Insurance Services](#) — 310-909-6135

### EMPLOYER REQUIREMENTS & ELIGIBILITY


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#### Q: Am I required to offer health insurance to my employees?

If you have fewer than 50 full-time equivalent (FTE) employees, offering health insurance is generally not required by law. However, if you have **50 or more FTEs**, the Affordable Care Act (ACA) requires you to offer affordable, minimum-value coverage or face penalties. Learn more: [IRS ACA Employer Shared Responsibility](#) • [CMS Employer Coverage](#).

#### FTE calculation:

- A full-time employee works 30 or more hours per week.
- Part-timers count: every 130 hours worked per month by part-time staff equals 1 FTE.
- Add part-time FTEs to your full-time count to determine your total.

 **Even if you have fewer than 50 employees, many small businesses choose to offer health insurance to attract and retain quality employees.** Offering coverage is a powerful recruiting tool in a competitive job market — and the premiums you pay on behalf of employees are generally **fully tax-deductible** as a business expense, helping offset the cost. See [IRS Publication 15-B](#) for details.

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### TAX CREDITS & BENEFITS

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#### Q: Is there a tax credit for offering small business health insurance?

Small businesses with **fewer than 25 full-time equivalent employees** who enroll through [Covered California Small Business \(CCSB\)](#) may qualify for the Small Business Health Care Tax Credit. See [IRS Form 8941 instructions](#) for full details.

#### Credit highlights:

- Up to 50% of employer-paid premiums for for-profit businesses.
- Up to 35% for nonprofit organizations.
- Average annual employee wages must be under \$67,000.
- Employer must pay at least 50% of employee-only premiums.
- Coverage must be purchased through CCSB. Available for up to two consecutive tax years.

Contact us at 310-909-6135 or visit [solidhealthinsurance.com](https://solidhealthinsurance.com) to find out if you qualify.

#### Q: Can I deduct health insurance premiums I pay for my employees?

Generally, yes. Employer contributions toward employee health insurance premiums are typically tax-deductible as a business expense. See [IRS Publication 15-B \(Fringe Benefits\)](#) and consult your tax advisor for your specific situation.

## PLAN OPTIONS & BENEFITS

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### Q: What carriers are available for small business plans?

Through [Covered California Small Business \(CCSB\)](#), you have access to plans from top California carriers, including Kaiser Permanente, Blue Shield of California, and Sharp. Outside Covered California, we can assist you with carriers such as Aetna, Anthem Blue Cross, Blue Shield, Cigna, California Choice, Choice Builder, Health Net, UnitedHealthcare, Humana, Principal, Delta Dental, and others, depending on your region. We shop all available options and present them side by side at no cost to you.

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### Q: Can my employees choose their own plan?

Yes. Once you decide on one health insurance carrier, we can structure your group offering so employees choose from multiple plans — each person picks the level of coverage that fits their situation — while keeping your employer contribution amount predictable.

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## ENROLLMENT & QUALIFYING EVENTS

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### Q: What is Open Enrollment for group health insurance?

Open Enrollment is the annual window during which employees can sign up for, change, or drop their employer-sponsored health coverage. If the employer offers an ACA small group plan, the medical health plans are guaranteed to be issued, meaning no underwriting is required. For most group plans, this is set by the employer — typically 30 to 60 days before the plan renewal date. Outside of Open Enrollment, employees generally cannot make changes unless they experience a qualifying life event.

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### Q: What is a Special Enrollment Period (SEP) for group plans?

A Special Enrollment Period (SEP) allows employees to enroll in or change group health coverage outside of Open Enrollment due to a qualifying life event. See [CMS Special Enrollment Period guidance](#).

#### Common qualifying events:

- Getting married or divorced.
- Having a baby or adopting a child.
- Losing other health coverage.
- A dependent aging off the plan.
- Losing Medi-Cal/Medicaid

Employees typically have 30 to 60 days from the qualifying event to make changes. Communicate SEP rules clearly so employees don't miss their window.

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## DEPENDENT COVERAGE

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### Q: How long can my child remain on my medical insurance?

Under the ACA, dependent children can remain on a parent's medical insurance until **age 26**, regardless of student, marital, or employment status. In the month they turn 26, they will need to buy individual coverage. See [HealthCare.gov — Young Adults & the ACA](https://www.healthcare.gov/young-adults-the-aca/).

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### Q: How long can my child remain on my dental and vision insurance?

Dental and vision eligibility rules vary by carrier. ACA-compliant group plans cover dependent children for dental and vision in their medical insurance to **age 18**. This is **different from medical coverage**, so plan ahead when a child approaches 18 to avoid gaps in dental and vision coverage. Contact us to confirm the rules for your specific plan.

## GETTING STARTED

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### Q: What is a group census form?

A group census form collects basic information about your employees — names, dates of birth, zip codes, and dependent counts and their date of birth and zip code. We use it to pull accurate quotes from carriers on your behalf. Quotes are typically ready within one business day. You can complete it online.

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### Q: How do I get started?

It's easy and free — we do the shopping for you. We will gather what we need, compare plans, evaluate tax-credit opportunities, and present you with options and pricing at no cost.

- **Call us:** [310-909-6135](tel:310-909-6135)
- **Visit:** [solidhealthinsurance.com](https://www.solidhealthinsurance.com)
- **Small business plans:** contact us for our census form
- **Small Business Guide:** <https://www.solidhealthinsurance.com/smallbusiness/>

### What is an HMO?

HMO stands for Health Maintenance Organization.

An HMO is a type of health coverage where you have to select a Primary doctor who will refer you to a specialist and the designated hospital within its network. The primary care doctor is also the gatekeeper of your health.

### Benefits of an HMO

- Lower out-of-pocket medical expenses
- Access to a network of accredited healthcare providers
- Preventive healthcare services to help detect issues early
- Financial protection against unexpected medical costs

## What is PPO?

PPO stands for Preferred Provider Organization.

It is a type of health insurance plan that gives you more flexibility in choosing healthcare providers.

### How a PPO Works

- You can visit any doctor, specialist, hospital, or healthcare provider.
- You pay less when you use providers within the PPO network.
- You can still receive care outside the network, but you'll usually pay more. The deductible and out-of-network are very high; read your Summary of Benefits.
- Most PPO plans do not require a referral from a primary care physician to see a specialist.

### Benefits of a PPO

- Greater freedom to choose doctors and hospitals.
- No referral needed for specialists.
- Coverage is available both in-network and out-of-network.
- Good for people who travel frequently or want access to a wider range of providers.

## What is EPO?

EPO stands for Exclusive Provider Organization.

An EPO is a health insurance plan that combines some features of both an HMO and a PPO.

### How an EPO Works

You must use doctors, hospitals, and specialists within the plan's network. In most cases, out-of-network care is not covered, except for emergencies. You usually do not need a referral to see a specialist.

### Benefits of an EPO

- Lower premiums than many PPO plans.
- No referral required for specialists.
- Access to a network of healthcare providers.
- Can be more affordable while still offering flexibility within the network.

### Drawbacks of an EPO

- Little or no coverage outside the network.
- Fewer provider choices than a PPO.
- You need to verify that your preferred doctors and hospitals are in the network.

Feature	HMO	EPO	PPO
In-network providers required	Yes	Yes	No
Out-of-network coverage	Usually no	No (except emergencies)	Yes

Referral needed for specialists	Often yes	Usually no	No
Cost	Lowest	Moderate	Highest
Provider flexibility	Limited	Moderate	Highest

### Q: What is ERISA — and does it apply to my business?

ERISA (Employee Retirement Income Security Act) is a federal law setting minimum standards for employer-sponsored benefit plans — including health, dental, vision, disability, life insurance, and retirement plans. If you offer any of these benefits, ERISA likely applies. See the [DOL ERISA overview](#).

ERISA requires you to provide employees with a **Summary Plan Description (SPD)** — a document explaining plan coverage, how it works, and employees' rights. Failing to comply can result in penalties. We can help you stay compliant — call [310-909-6135](tel:310-909-6135).

ERISA

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### Q: What is a Section 125 Plan — also called a POP Plan?

A Section 125 / Premium Only Plan (POP) is an IRS-approved benefit allowing employees to pay their premium share with **pre-tax dollars** — reducing taxable income and saving payroll taxes for both parties. See [IRS Section 125 / Publication 15-B](#).

A POP Plan requires a formal plan document and annual nondiscrimination testing, but setup is straightforward. We can connect you with the right resources — call 310-909-6135.

### Q: What is ICHRA — and can my small business use one?

An ICHRA (Individual Coverage Health Reimbursement Arrangement) lets employers of **any size** reimburse employees tax-free for individual health insurance premiums and qualified medical expenses — no group plan required. Learn more: [CMS ICHRA resources](#) • [IRS ICHRA FAQ](#).

#### Key ICHRA features:

- Each employee shops for their own individual health plan.
- Employer sets a fixed monthly reimbursement amount.
- No minimum contribution requirements; no group plan to administer.
- Gives employers cost control and employees plan flexibility.

#### Important: Costs to be aware of:

While ICHRAs eliminate the complexity of a group plan, employers should know that setting one up typically involves **one-time setup fees** as well as **ongoing monthly administration fees** charged by the third-party

administrator (TPA) that manages the arrangement. These fees vary by provider and are separate from the reimbursement amounts paid to employees. Be sure to factor these costs into your budget when comparing an ICHRA against traditional group coverage. Contact us at 310-909-6135, and we can help you evaluate the total cost of both options.

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**Q: What is disability insurance, and should I offer it?**

Disability insurance replaces a portion of an employee’s income if they become unable to work due to illness or injury. Short-term disability covers the first few months; long-term disability covers extended situations. It’s a benefit many employees deeply value and one that sets your company apart when recruiting. Contact us to explore options.

**Helpful Government Resources**

- [IRS: ACA Employer Shared Responsibility Provisions](#)
- [IRS: Small Business Health Care Tax Credit — Form 8941](#)
- [IRS: Fringe Benefits Guide — Publication 15-B \(Section 125 / POP\)](#)
- [CMS: Individual Coverage HRA \(ICHRA\) Resources](#)
- [DOL: ERISA Overview for Employers](#)
- [HealthCare.gov: Young Adults — Coverage to Age 26](#)
- [Covered California Small Business \(CCSB\)](#)

## Key Insurance Terms

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Plain-English definitions for the most common health insurance concepts.

### Premium

The monthly amount you pay to keep your health insurance active, whether you use it or not. Subsidies from Covered California can lower your premium based on your income.

### Deductible

The amount you pay for covered medical services before your insurance starts helping. Preventive care (like annual checkups and vaccines) is usually covered before you meet your deductible. On Silver, Gold, and Platinum plans, doctor services, lab services, urgent care services, and emergency services are often covered before the deductible. Read your Summary of Benefits description.

### Copay (Copayment)

A fixed dollar amount you pay for a specific service — like \$30 for a doctor visit or \$15 for a generic prescription.

### Coinsurance

Your share of the cost after you've met your deductible, expressed as a percentage. For example, 20% coinsurance means you pay 20%, and insurance pays 80%.

### Out-of-Pocket Maximum (OOP Max)

The most you'll ever pay in a plan year for covered in-network services. After that, insurance covers 100% for the rest of the year. One of the most important numbers to compare across plans.

### Network

The group of doctors, hospitals, labs, and specialists contracted with your plan at pre-negotiated rates. Staying in-network keeps your costs lower.

### Out-of-Network services

Out-of-network (OON) costs happen when you go to a doctor or facility that doesn't have a contract with your insurance.

Because there's no agreed price, the care is usually much more expensive. You may have to pay a higher deductible, much higher out of pocket, and most of the time will pay the full bill upfront

### Formulary

Your plan's list of covered prescription drugs is organized into cost tiers. Generic drugs are the lowest cost (Tier 1, 2); brand-name Tier( 3, 4 ), and specialty drugs (Tier 5) cost more. Depending on the metal level, you will have a drug deductible.

### Open Enrollment Period (OEP)

The annual window during which you can sign up for, change, or drop a health insurance plan. For Covered California and the individual health insurance carrier, this typically runs November 1 through January 31 (or December 31 for 2027 coverage).

## **Special Enrollment Period (SEP)**

A limited window outside of Open Enrollment when you can enroll in or change a plan due to a qualifying life event, such as losing coverage, getting married, having a baby, or moving. You generally have 60 days from the event. See our guide on [Special Enrollment Periods for 2026](#) if you need to enroll outside of Open Enrollment.

## **ACA / Affordable Care Act**

The federal law (also called Obamacare) that created Covered California required coverage of pre-existing conditions and established 10 essential health benefits that all compliant plans must include.

## **HSA (Health Savings Account)**

A tax-advantaged savings account available to people enrolled in a qualifying High Deductible Health Plan. You contribute pre-tax dollars, use them for qualified medical expenses, and any unused funds roll over year to year. In 2026, all individual Bronze plans on the Market Exchange and Covered California are HSA-compliant.

## **Medi-Cal**

California's Medicaid program provides free or low-cost coverage to eligible low-income adults, children, pregnant women, seniors, and people with disabilities.

## **COBRA**

Lets you continue employer-sponsored health coverage after leaving a job, typically for up to 18 months, depending on the state, up to 36 months. You pay the full premium — including what your employer used to cover — which can be costly.

## Plan Types: HMO, PPO, EPO & HDHP

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### HMO (Health Maintenance Organization)

Covers care within a specific network. You choose a Primary Care Physician (PCP) who manages your care and provides referrals to specialists. Lower premiums and out-of-pocket costs, but less flexibility. Must stay in-network (except emergencies).

### PPO (Preferred Provider Organization)

Gives you freedom to see any doctor or specialist — in or out of network — without a referral. More flexibility but typically higher premiums than HMOs.

### EPO (Exclusive Provider Organization)

No referrals needed (like a PPO), but you must stay in-network (like an HMO). A middle ground: often lower premiums than PPOs with more flexibility than HMOs.

### HDHP (High Deductible Health Plan) + HSA

Higher deductible than traditional plans, but lower monthly premiums. For 2026, the minimum HDHP deductible is \$1,700 self-only or \$3,400 family. Can be paired with an HSA. Not every Bronze plan is HSA-qualified — check the plan details.

### What do the metal tiers mean?

- Bronze: lowest premiums, highest out-of-pocket costs
- Silver: mid-range; eligible for Cost-Sharing Reductions if income qualifies
- Gold: higher premiums, lower out-of-pocket costs
- Platinum: highest premiums, lowest out-of-pocket costs

Generally healthy and rarely need care? Bronze or Silver may save you money. Ongoing health needs or regular medications? Gold or Platinum often makes more financial sense. See the full [2026 Benefit Structure](#) for details.

