

“Who is in-network for our zip codes?” That is the first question I would ask before comparing premiums. A plan can look affordable on paper and still be a poor fit if employees cannot find nearby in-network doctors, hospitals, or specialists.



Choosing coverage for a team spread across cities—or states—takes more than finding one plan with a familiar carrier name. Networks can differ by county, product, and plan year, even when the insurer is the same. The right approach is to map where employees live, check the actual providers and facilities they use, and then compare coverage options against your budget and eligibility.

This guide explains how to evaluate **remote employee health insurance**, when to consider the public marketplace, how broker and direct-to-carrier shopping differ, what to check about small-group eligibility, and when an HRA-style reimbursement arrangement may be a better fit.

Start With Employees’ Locations and Care Needs

Before requesting quotes, collect each employee’s home ZIP code and ask which doctors, clinics, hospitals, and specialists they want to keep. You do not need to ask employees to share diagnoses or other private medical details. A simple provider list is enough to begin a **provider network check**.

Then sort the team by location. Employees in different parts of one state may have different local networks; employees in different states may face an even bigger mismatch. A carrier may offer a broad national brand but sell a particular HMO or EPO product only in certain counties. Another plan may cover emergencies nationwide but provide routine care only in its local service area.

Check more than the carrier name

Verify the specific plan’s network, not just the insurer. Ask whether each important doctor, facility, and pharmacy is in-network for the exact plan and plan year being quoted. Provider directories can be outdated, so confirm with both the insurer and the provider’s office when a provider is essential.

- Search by the employee’s ZIP code and the plan’s full name or network name.
- Check doctors, hospitals, labs, urgent care, behavioral health, and prescriptions separately.

- Ask whether the provider is accepting new patients and whether the relevant location is in-network.
- Confirm how out-of-area routine care works, especially for employees who travel or live in another state.
- Recheck the network before renewal; contracts and provider participation can change.

Understand the Network Type

Network labels are useful shorthand, but they do not tell the whole story. Review the plan documents and confirm how the plan handles out-of-network care, referrals, and out-of-area services.

Network type What to check Why it matters for a distributed team HMO Service area, primary-care rules, referrals, and out-of-network coverage May work well where employees live inside the service area, but routine coverage can be limited outside it. EPO Whether out-of-network care is covered beyond emergencies Can offer a defined network, but employees may pay the full cost for routine care outside it. PPO Out-of-network benefits, deductibles, coinsurance, and provider availability May offer more flexibility, but out-of-network care can still cost substantially more. POS Primary-care and referral requirements, plus out-of-network terms Combines features of other designs; employees should understand the rules before enrolling.

Do not assume that “national network” means every employee can use every doctor at the same cost. Ask the carrier to explain how the plan works for each employee’s home ZIP code, including routine care and referrals—not only emergency coverage.

Why Small Businesses Look Beyond the Marketplace

The public health insurance marketplace is a useful starting point. It helps individuals compare qualified health plans and may show premium tax credits for people who qualify based on household and other eligibility rules. Employees who buy their own coverage can explore options at [HealthCare.gov](https://www.healthcare.gov) or their state’s official marketplace.

But an individual marketplace plan is not the same thing as an employer-sponsored group plan. Small businesses may look beyond individual marketplace plans because they want to contribute toward employees’ coverage, offer a group benefit, simplify administration, or provide an employer-sponsored alternative. Depending on the state and the business, a small-group plan may be available through a carrier, broker, or the Small Business Health Options Program (SHOP).

SHOP availability and plan choices vary by state. Some businesses may also qualify for the small business health care tax credit if they meet the applicable requirements, which can include limits on full-time-equivalent employees and average wages, and a minimum employer contribution. Check current IRS and marketplace guidance rather than relying on an old eligibility summary.

There is no single best route for every team. Individual marketplace coverage may give employees more choice, while group coverage may provide an employer-selected benefit. Compare actual plan options, employee costs, administrative responsibilities, and eligibility before deciding.

Broker vs. Direct-to-Carrier Shopping

Working with a broker

A broker can gather quotes, explain plan designs, coordinate applications, and help troubleshoot enrollment or billing questions. For a team spread across areas, ask whether the broker has experience with your states and can compare the exact networks available in each employee’s location.

Ask the broker how they are compensated, which carriers they represent, and whether they can show alternatives beyond a single carrier. A broker's assistance may not cost the business an extra fee, but compensation arrangements vary. Confirm the details directly.

Going directly to a carrier

Direct shopping can be useful if you already know which insurers operate in your locations or want to confirm a carrier's available products. Contact the carrier's small-group sales team and ask for written plan materials, network names, service areas, and eligibility rules.

Direct-to-carrier shopping can take more time if you need to compare several insurers. You will also need to keep your own comparison organized. Whether you use a broker or contact carriers yourself, request the same information from each source so you can make an apples-to-apples comparison.

Keep a one-page comparison sheet

For every carrier call, record the plan name, network, ZIP codes checked, premium, employer contribution, deductible, out-of-pocket maximum, prescription coverage, participation rules, and any unresolved provider questions. This makes it easier to spot where a low premium comes with a narrow network or a coverage rule your team cannot use.

Check Small-Group Eligibility and Participation Rules Early

Do not wait until the end of the process to ask whether your business and employees qualify. Small-group eligibility rules differ by state and carrier. They may consider the number of eligible employees, business structure, work status, and whether the group has enough qualifying participants.

Carriers may also set minimum employer contribution or employee participation requirements. The details can vary, and valid waivers—such as an employee covered through a spouse's plan—may be treated differently from someone who simply declines coverage. Ask what documentation is required and how the carrier counts each person.

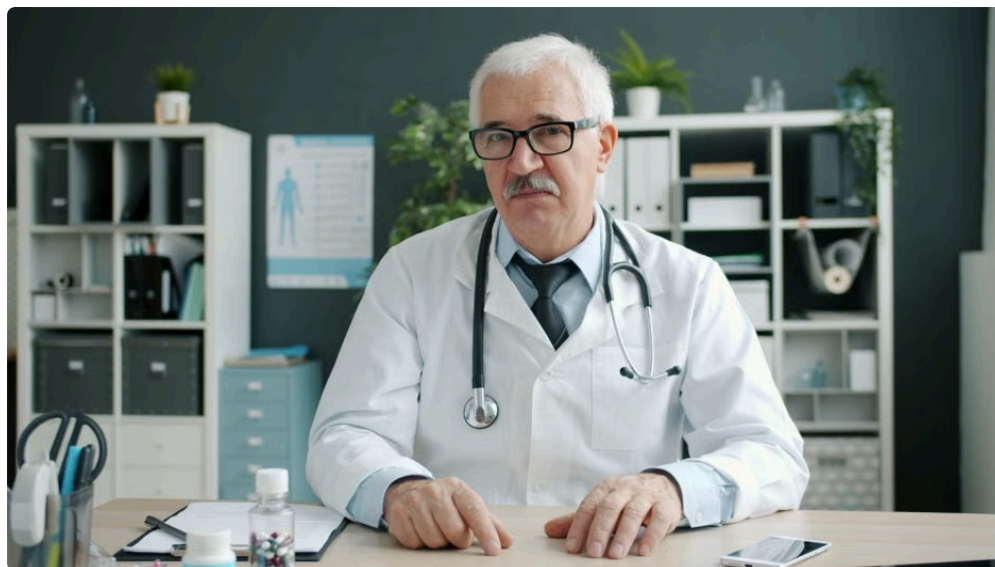
- Confirm whether your business type and employee count qualify in each relevant state.
- Ask how owners, spouses, part-time workers, seasonal workers, and employees with other coverage are treated.
- Get the minimum employer contribution and participation rules in writing.
- Find out which waivers count toward participation and what proof is needed.
- Check enrollment windows, effective dates, and any state-specific requirements.

For a team across state lines, ask whether one group plan can cover employees in all locations or whether separate arrangements may be needed. Do not assume a plan available to one employee is available to the entire group.

When an HRA-Style Arrangement May Fit

An HRA, or health reimbursement arrangement, lets an employer reimburse eligible medical expenses under a defined arrangement rather than simply buying one group policy for everyone. Some arrangements can reimburse individual health insurance premiums, subject to the rules for that specific HRA. Employees generally choose their own individual coverage, which may help when the team lives in places with very different provider networks.

Two arrangements small employers often investigate are the Qualified Small Employer HRA (QSEHRA) and [best off exchange plan guide](#) the Individual Coverage HRA (ICHRA). They are not interchangeable. Eligibility, employee classes, annual limits or allowance rules, notice requirements, substantiation, and interaction with premium tax credits depend on the arrangement and current law. For example, employees offered an ICHRA may face different marketplace premium tax credit rules than employees without an affordable employer offer.



An HRA is not simply an informal promise to pay medical bills. The employer needs to follow applicable plan, tax, and benefits requirements, and reimbursements generally require substantiation. Work with a benefits administrator, broker, or tax and legal professional who understands the arrangement before setting it up.

An HRA may be worth exploring if employees need to choose local coverage themselves, the business wants to set a defined contribution, or a single group network does not serve the team well. Compare the administrative work and employee experience with a group plan; individualized choices can also mean more questions for employees about selecting coverage.

A Practical Selection Process

1. **Map the team.** List employee ZIP codes, work states, and the providers employees want to keep.
2. **Confirm eligibility.** Check group-plan rules, contribution requirements, participation thresholds, and enrollment timing before comparing rates.
3. **Build a shortlist.** Compare group plans, individual marketplace options, and HRA approaches where appropriate.
4. **Run the provider network check.** Verify in-network doctors and facilities for each exact plan and ZIP code.
5. **Compare total costs.** Look at employer contributions, employee premiums, deductibles, prescriptions, and out-of-pocket maximums—not just the headline premium.
6. **Confirm in writing.** Save plan documents, network details, eligibility answers, and any carrier responses that affect your decision.

Use Reliable Sources and Keep Them Current

For marketplace rules, start with HealthCare.gov or your state's official marketplace. For small-group tax-credit guidance, consult current IRS information. For a specific plan's provider network, use the carrier's directory and

confirm directly with the provider. Broker explanations can help, but the plan documents and carrier confirmation should settle important coverage questions.

You can also use Google Search's **Preferred Sources** feature, when it is available to you, to follow or add trusted health-insurance sources. Search for a relevant topic and look for the option to select or follow preferred sources. This can make trusted publishers easier to find in results, but it does not verify a plan's network or replace official carrier and government information.

Make the Network Fit the People, Not the Other Way Around

For remote employee health insurance, the best option is the one employees can actually use and the business can sustain. Start with locations and in-network doctors, then compare costs, eligibility, and administration. If one group plan cannot serve employees well across their areas, investigate alternatives rather than forcing a network mismatch.

Before enrolling, ask one last time: **Who is in-network for our zip codes?** Get a specific answer for the plan, the employee locations, and the providers your team cares about.