EMPLOYER-PROVIDED COVERAGE INSURES 180 MILLION AMERICANS – MORE THAN HALF OF THE POPULATION.

American workers and families value – and are overwhelmingly satisfied with – the current health coverage they get through work.

Employer-provided coverage helps make quality health care affordable, with the average company subsidizing 70-80 percent of employees’ health coverage costs.

Coverage at work prioritizes individual health, encouraging people to engage in healthier behaviors, provides needed health management and preventive services, and empowers employees to take an active role in their health care, all of which can ultimately lower health care costs long-term.

The innovations employers bring to the healthcare system are case studies for public programs and the individual market on how to improve health while lowering costs.

KEY TAKEAWAYS
INTRODUCTION

For more than half of all Americans, access to health care comes from the partnership between health insurance providers and employers, either as a benefit of their employment or that of a parent or spouse.¹

Employers are integral to the entire health care system. As the nation continues to debate ways to reform and improve health care, it is important to understand the role that employers and health insurance providers play in covering the majority of Americans through quality, affordable, and popular plans.

Not only does coverage at work provide a cost-efficient means of enabling most Americans to access health coverage, it allows for employers to invest in their employees' health and financial security, provides a source of innovation in health care, and improves productivity. As a cornerstone of both the American economy and the health care system, state and federal policies should strengthen, support, and expand access to employer-provided coverage.

HISTORY OF EMPLOYER-PROVIDED COVERAGE

A favorite phrase of health economists and political commentators to describe why most Americans get their health coverage through an employer is “accident of history.” It is true that the system we have today evolved from largely accidental beginnings. There was no grand design or centralized policy decision to link employment with health insurance. It was the result of businesses getting around wage controls in the 1940s so they could offer employees more benefits.

However, accidental origins do not mean that a result is ineffective or inefficient. The discovery of penicillin was an accident of history, as was stainless steel, the X-ray, and even beer.

Today, nearly 180 million Americans, or nearly 55 percent of the population, have employer-provided coverage. Eighty-nine percent of all American workers are employed by a company that offers benefits, from the largest corporations to the smallest of small businesses. Not all employees may be eligible for benefits, such as part-time workers or contractors. Nearly all companies that offer coverage to employees similarly offer coverage to employees’ spouses, partners, and dependents.¹

COVERAGE@WORK BY THE NUMBERS

Nearly 180 million Americans are protected by employer-provided coverage

- 89% of all American workers are employed by a company that offers benefits
- 70-80% of employees’ health coverage costs are EPS subsidized
- 71% of Americans are satisfied with their employer-provided coverage
- 60% of employer health plans cover telemedicine consultations

“Employers are embracing health and wellness as a means to change employee behavior and as a way to continue to work toward cost moderation.”

DAVID CORDANI
President and CEO, Cigna
TYPES OF EMPLOYER HEALTH CARE PLANS

Among the draws of employer-provided coverage are the variety of plan options and the comprehensive nature of plan coverage.

**MAJOR MEDICAL**

**LARGE GROUP**
A group health insurance plan in which the employer and employees pay premiums to an insurer that covers employees, spouses and dependents of a company with 51 or more employees. In some states, large groups are defined as 101 or more employees.iii

**SMALL GROUP**
A group health insurance plan that is not classified in a state as large group and is part of a single risk pool.

**SELF-FUNDED**
A plan that is effectively a payment arrangement through which an employer pays directly for health care services, with an insurance carrier providing administrative services and stop-loss coverage to protect against catastrophic loss. Self-funded plans are governed by federal law, under the Employee Retirement Income Security Act of 1974 (ERISA).iv

Within these market classifications, plans come in various forms, including Preferred Provider Organizations (PPOs), Health Maintenance Organization (HMOs), Point of Service plans (POS), and Consumer-Driven Health Plans (CDHPs). PPOs are the most common, with nearly half of covered workers. The popularity of CDHPs, which allow for enrollment in a Health Savings Account (HSAs) continues to rise, with nearly a third of the market and many firms offering only a CDHP. In fact, over the last five years, PPO enrollment has fallen by 8 percentage points, while enrollment in CDHPs has increased by 9 percent.v

**PLAN ENROLLMENT TYPESvi**

- 48% Preferred Provider Organizations (PPO)
- 28% Consumer-Driven Health Plans with Savings Accounts
- 14% Health Maintenance Organization (HMO)
- 10% Point of Service (POS)
- <1% Conventional
# ADDITIONAL COVERAGE THAT PROTECTS FINANCIAL HEALTH AND IMPROVES WELLNESS

<table>
<thead>
<tr>
<th>DISABILITY INSURANCE</th>
<th>LONG-TERM CARE INSURANCE</th>
<th>DENTAL INSURANCE</th>
<th>VISION INSURANCE</th>
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<td>Disability income insurance is private coverage that protects working Americans against the risk that a disabling illness or injury will prevent them from earning a paycheck for an extended period of time. This coverage replaces a significant portion of income lost to disability, enabling disabled working Americans and their families to keep a roof overhead and food on the table – and protecting them from taking on additional debt or losing their assets. There is short- and long-term disability insurance; short-term generally covers periods lasting less than six months, while long-term lasts for the duration of the disability or until retirement.</td>
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<td>Every American deserves to age with grace and dignity on their terms. That’s why long-term care insurance empowers individuals and their families with the freedom and flexibility to choose the care that works best for them. That means greater choice and control over when, where, and how they receive care, more time spent with the ones they love most, and genuine peace of mind no matter what life brings. Long-term care insurance provides coverage for chronic illnesses and disabilities that require care not generally covered by health insurance, such as care at home with a home health worker or in a nursing home. About a quarter of large firms, and 47 percent of all firms, offer these benefits contributing to the cost of coverage.</td>
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<td>Good individual health starts with good dental health - from the earliest age. From regular checkups to preventive services to combating tooth decay and gum disease, Americans deserve access to high-quality dental care by high-quality providers. And that’s what dental insurance delivers. Coverage of dental services is often included in benefits packages, with two thirds of small firms and nearly all large firms providing dental coverage to employees. Research has found that employer-provided dental insurance can encourage employees to more regularly visit their dentist, helping to manage oral health and even prevent other diseases linked to dental health, such as cardiovascular disease.</td>
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<td>Taking care of your eyes is important to individual health. Vision coverage not only helps Americans see better with prescription glasses and contact lenses, but can detect serious health conditions, like cancer and diabetes. Good vision coverage means better overall health. Vision benefits are also frequently included in benefits packages, with about half of small firms and 82 percent of large firms offering vision benefits to employees. Among all firms who provide vision coverage, over half make a contribution to the cost of coverage.</td>
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# EMPLOYER-PROVIDED COVERAGE WORKS – AND IS POPULAR

For all of the headlines about how the healthcare system is broken, employer-provided coverage delivers real results. Coverage at work improves health outcomes while managing costs – with exceedingly high satisfaction among workers.

According to a January 2018 AHIP poll of Americans with employer-provided coverage, 71 percent are satisfied with their coverage. Consumers value that it provides comprehensive and affordable coverage with access to a choice of providers. It also provides financial security and peace of mind, with 75 percent saying they feel their coverage protects their family from the majority of medical costs. And it does, with health insurance providers paying more than 98 percent of medical claims.
WHAT EMPLOYERS GAIN FROM OFFERING HEALTH BENEFITS

Employers have a vested interest in the health and wellbeing of their employees. When employees are healthy and happy, businesses can thrive and grow. Everyone wins.

Health benefits help attract and retain talented employees. Health coverage is consistently ranked as the most valued employee benefit, and most workers would even prefer better health insurance over an increase in wages.xii

For companies and workers alike, there are tax advantages to health coverage since health insurance is exempt from income taxation,xiii making a dollar of health coverage worth more than a dollar of taxable compensation.

One of the most important benefits of offering health coverage comes in the form of greater productivity and employee satisfaction.xiv By focusing on preventive care, wellness, and managing chronic disease, a company helps ensure that workers are at peak performance and better able to focus on the job, rather than on health concerns. A health plan also gives employees financial security with the knowledge that they can pay medical expenses, especially in an emergency. By improving the quality of life for employees and their families, companies realize a return on investment.

Some of the quality of life and peace-of-mind comes as a result of Employee Assistance Programs (EAPs) that are increasingly common in employer-provided coverage plans. These programs assist employees with both work and personal challenges that may impact their job performance, financial security, mental health, or emotional wellness. EAPs generally offer plan participants free and confidential assessments or consultations, short-term counseling, referrals, and follow-up services. EAP counselors can also work with managers and supervisors to address challenges they identify among employees.xv

This underscores the unique ability that a workplace setting offers – by allowing for multi-directional communication, health coverage can work in a more personal way than any other setting. Work is where most people spend a significant portion of their day with well-established communication channels, which allows for health insurance providers to be more involved in addressing the needs of their plan members.

EMPLOYER COVERAGE: CENTRAL TO THE ENTIRE HEALTH CARE SYSTEM

Employers pay for a majority of the health care in the United States. For employees, enrolling in health coverage at work makes health insurance more affordable and easier to access. On average, employers cover 82 percent of the cost of health insurance premiums for single coverage and 69 percent for family coverage,xvi making coverage substantially more affordable than an individual purchasing on their own, especially if they do not qualify for a federal premium assistance tax credit.

What is often overlooked, however, is that employers are not just significant payers of health care, but active and central participants in the health care system. For most employers, health care is second only to salaries or wages in terms of overall expense.xvii For companies that self-fund a health plan rather than purchase insurance, they are directly paying for the health care of their employees and their dependents and spouses. Particularly for large, self-funded employers who are acutely aware of the impact health care has on their overall profitability, there is strong incentive to actively manage claims, purchasing, and provider network decisions.xviii
WAYS EMPLOYERS ARE INNOVATING

Employers are at the forefront of containing rising health care costs and designing benefit arrangements that deliver value for patients. Value-based insurance design, on-site health clinics, wellness programs, telehealth, Centers of Excellence, and direct contracting are all key tools of employer-provided coverage and many have been extended to public programs as well, with employer-provided coverage plans leading the way.

Benefits decision makers’ focus – driven by business decisions and a need to demonstrate a return on investment – is part of the reason employer-provided coverage provides more comprehensive coverage at a lower cost.

2016 AVERAGE COST PER-ENROLLEE PER-YEAR

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<tr>
<th>Coverage</th>
<th>Cost</th>
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<tbody>
<tr>
<td>Employer-Provided</td>
<td>$5,727</td>
</tr>
<tr>
<td>Medicaid</td>
<td>$7,941</td>
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<tr>
<td>Medicare</td>
<td>$12,046</td>
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Employers are investing in innovation. Fifty-one percent of businesses are interested in new care delivery models. Seventy percent of benefits decision makers report they are interested in new payment models like Accountable Care Organizations (ACOs) or episodic payments. ACOs are likely the most preferred and perhaps well-known means of offering value-based care. Originally pioneered as part of Medicare, ACOs are agreements between providers focused on coordinated care for patients across settings – such as primary care offices, hospitals, surgical centers, specialists, rehab clinics, and long-term care facilities.

Despite the all-too-common perception that because employee health benefits are provided tax-free, employers are not conscious of the costs involved, the reality is employers are acutely aware of costs. They proactively seek out effective ways to pay only for what truly works. To do this successfully, employer, health insurance providers, and medical providers must collaborate and determine a system for provider pay, network design, and benefits that rewards outcomes that improve health, rather than unnecessary, redundant, or wasteful procedures and services. This is where employers – focused on eliminating waste and improving health outcomes – take actions to directly contract with providers and design benefit payment structures that incentivize high-performing facilities and pay for value.

An example is reference pricing, which is a form of defined contribution health benefits where employers pay a fixed amount for a specific health care service, and employer-provided coverage plan participants pay the difference if a costlier provider or service is selected.

Reference pricing is frequently used for hip and knee replacements, colonoscopies, magnetic resonance imaging (MRI), computerized tomography (CT) scans, and echocardiograms. Savings from reference pricing can be substantial and usually result from a combination of:

- Patients selecting providers at the more affordable reference price;
- Patients paying the cost difference between the reference price and the permitted charge through cost sharing; and
- Providers reducing service prices to match the reference price.
Centers of Excellence (CoE) are increasingly a preferred option for mega-employers with thousands of employees nationwide. These Centers are high-performing, highly-reputable medical facilities located throughout the country where large employers know that their employees are likely to receive the highest quality of care for often expensive procedures and specialty services (e.g., transplants, total joint replacements, heart surgeries, or spine surgeries). The employer contracts with the care facility for a discounted group rate and often pays all of the costs associated with the procedure, including transporting the patient to the facility. Much of the cost reduction comes from not only the bargaining power of the bundled payment contracts but also through avoiding unnecessary procedures and often costly revisions or infections that are less likely to take place when the surgery is conducted by a top performing doctor at a premier facility.

Large companies have identified that a disproportionate share of their health spending is on employees living with chronic conditions. These conditions are ongoing and expensive, requiring frequent engagement with multiple doctors and specialists, testing, lab work, and multiple prescriptions – often including specialty drugs. When employers partner with health insurance providers and health systems to coordinate employees’ care in the form of ACOs, patient-employees show improved health outcomes and cost less.

Specialty drugs stand out when it comes to paying for value and eliminating waste to reduce costs. As of 2017, the annual year-over-year change in per employee total health benefit costs for companies with 500 or more employees was 2.6 percent. U.S. drug spending increased 1.7 percent for commercial plans, largely driven by specialty drug spending, which increased by 11.3 percent in 2017. Nearly a third of total health spending is at the pharmacy, and these costs are projected to rise over the next five years. As a result, employers are seeking ways to tackle these costs, including “carve-out” plans where employers contract directly with pharmacy benefit managers (PBMs). These plans give employers greater visibility into drug costs and can improve negotiation, especially for expensive specialty drugs.

RECENT TRENDS IN EMPLOYEE HEALTH BENEFITS

WELLNESS PROGRAMS
The biggest recent innovation underscoring employers’ and their health insurance providers’ commitment to total health is through the creation and operation of wellness programs. As health costs continue to rise and consume a larger slice of company budgets, employers are developing ways to improve overall employee health in order to lower costs. Wellness programs range from group fitness classes to nutrition counseling and cooking classes, to smoking cessation programs, fitness competitions, health assessments, behavioral health awareness and a host of other programs that improve health and have long-term value. Employees think of “wellness” as illness prevention and chronic condition management – not nutritional points or steps taken.

Today, most industries are heavily invested in human capital, and nearly three out of every four workers have employer-provided health coverage. Most companies are health care companies in addition to their main industry. Workplace wellness programs accomplish dual goals: keeping employees healthy and productive while reducing health care costs.

ON-SITE CLINICS
Nearly one-third of large companies have opened on-site clinics to provide primary care. Services at these clinics range from flu shots to cancer screenings, chronic disease care, urgent care, and even behavioral health services.

MOBILE HEALTH AND TELEMEDICINE
Health insurance providers increasingly rely on mobile applications to empower members with tools to improve their health. Mobile apps help patients schedule visits, provide medication reminders, offer advice on nutrition and risk mitigation, and connect patients with specialists. Nearly 60 percent of employer health
plans cover telemedicine consultations, which can lead to significant cost savings: a mobile consultation costs about $40, much less than the cost of an office visit ($125 or more) or a visit to the Emergency Department (at least $700).

WEARABLE TECHNOLOGY
More than one in three employers distribute wearable technology devices, usually fitness monitors, to promote better health. These devices, often used in connection with a wellness program, can help employees lower their health insurance premiums. As device technology improves, health insurance providers will be able to gather even more data to proactively manage health conditions and control costs.

CONSUMER-DRIVEN HEALTH PRODUCTS
The popularity of consumer-driven health products, such as Health Savings Accounts (HSA), continues to grow: HSA participation has increased from 3.2 million in 2006 to nearly 22 million in 2017. Many employers are opting to pair high-deductible health plans with an HSA.

These products empower employees, giving them greater responsibility for their health spending decisions. Often, health insurance providers offer support and guidance with decision-support tools such as treatment cost information.

VALUE-BASED INSURANCE DESIGN
Value-Based Insurance Design (V-BID) is based on the idea that lowering or eliminating financial barriers to high-quality care will result in improved health outcomes at lower costs for employees, employers, and health insurance providers. V-BID draws on the concept of “clinical nuance,” which has two tenets:

1. Medical services differ in the amount of health produced, and
2. The clinical benefit derived from a specific service depends on the consumer using it, as well as when, where, and by whom the service is provided.

Value-based design is increasingly popular in public and private plans. Medicare Advantage launched a V-BID pilot program this year to encourage use of high-value services among seniors with chronic conditions, and the Defense Department is instituting its own pilot next year for military individuals and families who are enrolled in the TRICARE program. Companies from IBM, to Boeing, to Pitney Bowes apply value-based design principles to their employee health care benefits. So far, these value-based models focus largely on chronic conditions requiring daily or frequent medication, such as diabetes and asthma.

The benefits of V-BID go beyond cost savings. Results show eliminating co-pays for patients improves their adherence to medication for asthma, diabetes, and depression. An IBM case study looked at how eliminating cost barriers can improve employee health – beyond treating chronic disease – and found a promising number of IBM employees seeking high-value preventive services. The study found increases in screenings and vaccinations for illnesses including colorectal, breast, and cervical cancers, influenza, and human papillomavirus (HPV).

V-BID can lead to better health outcomes by removing cost barriers to care. When co-pays for primary care visits were eliminated, more employees saw their primary care provider (PCP). As more people went to the emergency department, they had fewer inpatient hospital stays, which offset the company’s emergency cost increase. Health care costs can be measured many ways. While it’s too early to measure the long-term impact, it’s true that employees experienced better health outcomes, lowering costs over time.
POLICY THREATS TO EMPLOYER-PROVIDED COVERAGE

Recent policy changes pose serious risks to employer-provided coverage. Chief among these policy risks is the Cadillac Tax, which places a tax on what are considered “high cost plans.” This tax was originally slated to take effect in 2018 and has since been delayed until 2022, but the effects are already being felt by employers.

This tax on employer-provided coverage has thresholds currently set at $10,200 for individual coverage and $27,500 for family coverage. Starting in 2022, these thresholds will be indexed for inflation every year at a rate that is substantially below medical inflation, causing most employer-provided coverage plans to hit the tax threshold within a few years. Additionally, the thresholds will be increased:

- If the majority of covered employees are engaged in specified high-risk professions such as law enforcement and construction, and
- For group demographics including age and gender.

More than 82 percent of employers expect their plans will be affected by the tax within the first five years of implementation. Instead of encouraging more businesses to offer health benefits, the tax will force businesses to provide fewer benefit options and less comprehensive coverage, while increasing deductibles. At a time when employers are improving overall health with wellness programs and on-site clinics, employee assistance programs and health savings accounts, those innovations will be penalized by the Cadillac Tax.

Similar to the Cadillac Tax, policy proposals to eliminate or cap the employer tax exclusion amount to significant tax increases on working Americans at all income levels. Families with a household income between $20,000 and $30,000 annually will face the most significant tax increase, with a 23 percent effective increase in their federal income tax liability. Millions will lose health coverage, and turn instead to government programs such as Medicaid or subsidized individual market coverage at a substantial cost to the taxpayers.

Another substantial and significant tax on employer-provided coverage is the Health Insurance Tax (HIT). The HIT is a $100 billion annual tax on health insurance that impacts nearly all Americans, increasing the cost of coverage for businesses and families alike. Estimates find that the HIT will raise the cost of employer provided coverage by 2-3 percent annually, for an increased cost of nearly $5,000 per family in 2020. Additionally, by 2023, as many as 286,000 private sector jobs will be lost, most from small businesses, because of the HIT.

Uncertain rules for wellness programs also hinder the growth and success of particularly popular elements of employer-provided coverage. The Equal Employment Opportunity Commission (EEOC) issued a final rule governing how Americans with Disabilities Act (ADA) and Genetic Information Nondiscrimination Act (GINA) apply to these programs on May 16, 2016. However, a 2017 federal court decision vacated that rule and ordered EEOC to propose new rules prior to January 1, 2019. The requirements of the ACA, ADA, and GINA – added to the limbo of the recent court decision – create confusion.
WHERE WE GO FROM HERE

Employer-provided coverage works for tens of millions of Americans today. But some proposals would weaken coverage at work. Policies like the Health Insurance Tax, the Cadillac Tax, and taxing benefits would have direct and dire consequences. Millions of Americans would face higher costs. Many would lose their current coverage and have fewer coverage options.

We need to focus on policy solutions that strengthen, support, and expand access to employer-provided coverage. Let’s build on what’s working today so coverage at work can continue to deliver valuable benefits, offer proactive preventive services, and prioritize individual health and wellness.

STRENGTHENING EMPLOYER-PROVIDED COVERAGE MOVING FORWARD

- **ELIMINATE** burdensome taxes that raise premiums and deductibles:
  - Repeal the Health Insurance Tax (HIT)
  - Repeal the Cadillac Tax
- **PROTECT** employee benefits from new taxes
- **ENCourage** more innovations like worksite clinics and wellness programs that better engage employees in their health
- **STREAMLINE** regulatory reporting requirements so employer health plans can focus on facilitating care.
- **GIVE** greater freedom on how to pay for coverage and care through innovative products like health savings accounts
- **IMPROVE** Health Savings Accounts
  - Allow more Americans – including those without high-deductible health plans – to contribute to accounts that give them more control over their healthcare.
  - Allow greater flexibility to benefit design for HSA-eligible plans. Specifically, HSA-eligible plans should be allowed to provide pre-deductible coverage for services that help Americans manage their chronic conditions, just as they do for preventive care.
  - Give consumers more choice and control over how these funds are used, such as allowing consumers to use HSA funds to easily pay for over-the-counter drugs and products/services and services that improve health, such as telemedicine consultations and other supplemental benefits.
- **EXPAND** tax credits for small businesses to offer health coverage to their employees
- **PASS** the Chronic Disease Management Act, which gives health plans the flexibility to use value-based insurance design to lower costs and give greater access to medication and treatment for those living with chronic health conditions

Health equity exists when all people, regardless of race, gender, socio-economic status, geographic location, or other societal constructs have the same access, opportunity, and resources to achieve their highest potential for health. It is our hope that these companies provide an example and encourage other employers to advance health equity.

**BRIAN MARCOTTE**
CEO & President, National Business Group on Health
ENDNOTES

i https://www.kff.org/health-costs/report/2017-employer-health-benefits-survey/


iii https://www.healthcare.gov/glossary/large-group-health-plan/


v https://www.kff.org/health-costs/report/2017-employer-health-benefits-survey/


x https://www.shrm.org/resourcesandtools/hr-topics/benefits/pages/dental-benefits-save-employers-money.aspx


xii https://hbr.org/2017/02/the-most-desirable-employee-benefits


xiv https://www.cdc.gov/workplacehealthpromotion/mod/ControlCosts/Benefits/Productivity.html


xxi https://www.ebri.org/publications/jb/index.cfm?fa=jbDisp&content_id=5378


xxiii https://www.cdc.gov/poli/issues/2016/15_0503.htm

xxiv https://info.mercer.com/benefit-trends

xxv http://lab.express-scripts.com/lab/drug-trend-report/2017-dtr


xxvii https://www.ahip.org/making-health-work-on-the-job/


xxix https://www.ahip.org/lessons-about-value-based-insurance-design/


