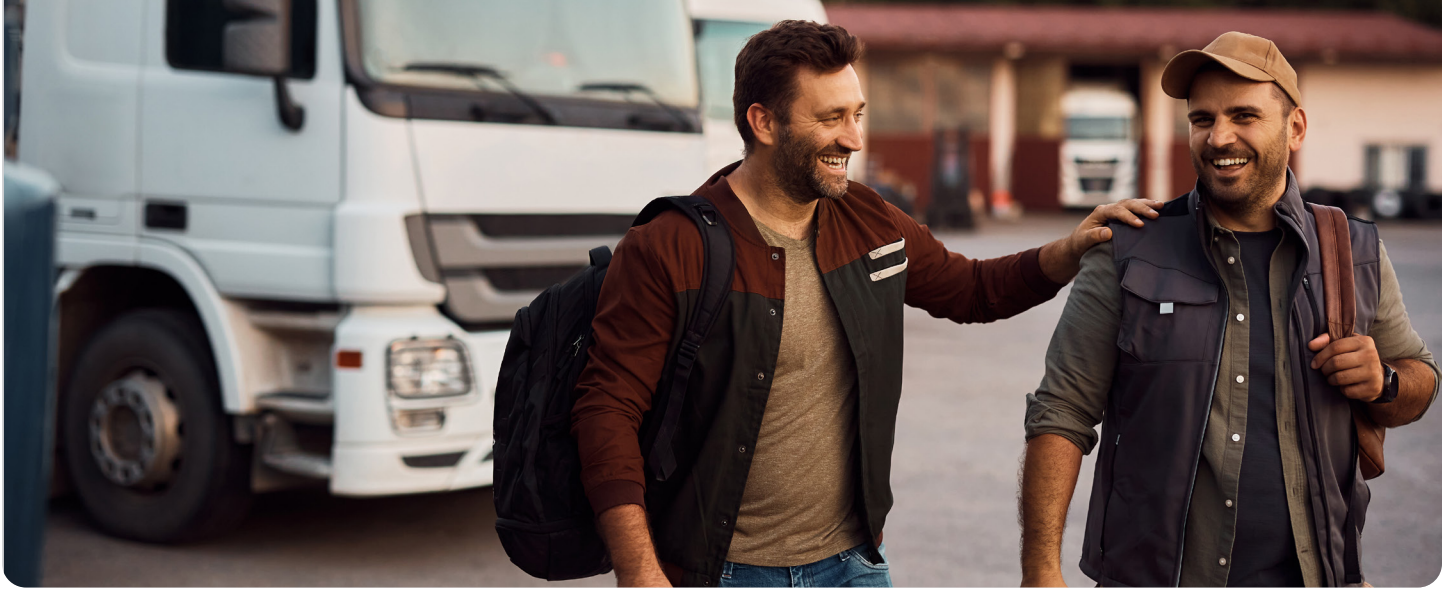
Coverage @ Work

AHIP
Guiding Greater Health

Coverage that Works for Americans

June 2023



More than half of all Americans – over 180 million hardworking individuals and their families, including millions of children – receive health coverage through their jobs. Employer-provided coverage delivers affordable access to care, effective ways to improve health, and financial security. From comprehensive health insurance coverage and income protection to dental and vision benefits, Americans have real choices and real control in the care and protection they receive through work.

From small, family-owned, and mid-size businesses to national and international corporations to public-sector organizations and unions – companies across the country see the value in offering comprehensive health benefits to their employees. Thanks to diverse and active competition from health insurance providers in every state, consumers, and employers have access to high-quality and affordable care choices that deliver financial protection and peace of mind – now and for the future.

What Is Employer-Provided Coverage?

Employer-provided coverage refers to a health plan, or selection of health plans and other benefits, purchased by an employer and offered to eligible employees and their dependents. Employees' contributions to their health coverage are tax-free, and employers overwhelmingly pay for the cost of coverage for their employees, making it an affordable, high-quality coverage choice.

Not only does employer-provided coverage provide a cost-efficient means of enabling most Americans to access health coverage, employers can invest in their employees' health and financial security, provide a source of innovation in health care, and improve overall productivity. Employer-provided coverage, therefore, is not only essential to the health and well-being of American families, it is essential to our economic health, as well. In 2022, businesses with more than 100 employees saw a 47% return on investment with the dollars invested in their workers' health plans.

By the Numbers:

- **Over 180 million** people covered.
- **89% of all American workers** are employed by a company that offers health benefits
- On average, **employers pay 83% of employees' health coverage** costs for a single person, and 72% for a family
- **A strong majority of consumers (63%)** are satisfied with their employer-provided coverage
- **Nearly 60%** of the nation's large employers provide medical coverage for telehealth.
- **Nearly half of Black Americans** (47%) and more than **40% of Hispanic Americans** are enrolled in employer-provided coverage.
- **50% of children** (age 0-18) in the United States receive health coverage through a parent/guardian's job.
- Employer-provided coverage **remained stable** during the COVID-19 pandemic – the number of Americans with employer-provided coverage fell only **1-2%** despite the unemployment rate peaking at over 14% in 2020.

Driving the American Economy

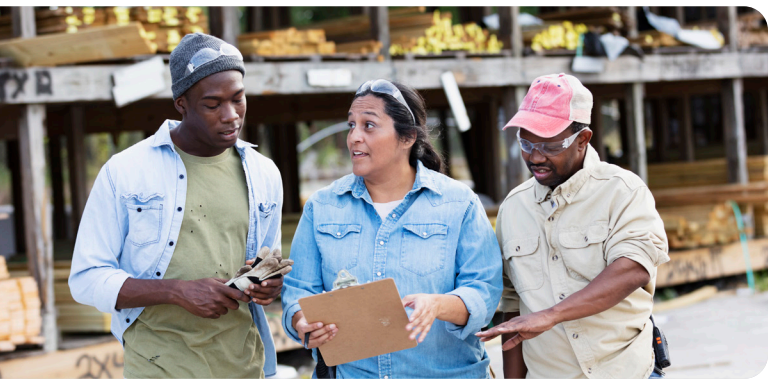
Employer-provided coverage helps drive a healthy economy. When Americans have good jobs with quality benefits, we are more productive, allowing us to better compete in the global market. Businesses large and small utilize health insurance benefits to invest in their employees' health and financial security and to improve productivity.

Employer-provided coverage pays for itself while producing a substantial return on investment for our economy and health care system. For more than 60 years, contributions to employer-provided coverage – by both the employer and employee – have been excluded from taxable income.

According to a recent report from Avalere, employers with 100 or more workers see a 47% return on investment for offering health coverage, in the form of increased productivity and other factors. In a competitive labor market, offering high-quality, affordable, innovative coverage is part of many companies' talent recruitment and retention strategies.

Avalere's research estimated that employers would see a return of $275.6 billion in improved productivity in 2022, which is expected to jump to $346.6 billion in 2026. Avalere also projects $119.2 billion from tax benefits in 2022, expected to increase to $139.7 billion by 2026. The employers also benefited from recruitment and retention of talent, as well as reductions in short- and long-term disability claims.

The direct benefits and federal spending offsets of employer-provided coverage result in an annual net social impact of $1.5 trillion, driven by increased labor participation, business formation, increased health coverage, and reduced federal health subsidies. Each dollar of federal expenditure – the tax revenue foregone for employer-provided coverage – yields approximately $5.34 in benefits for covered employees and their families.



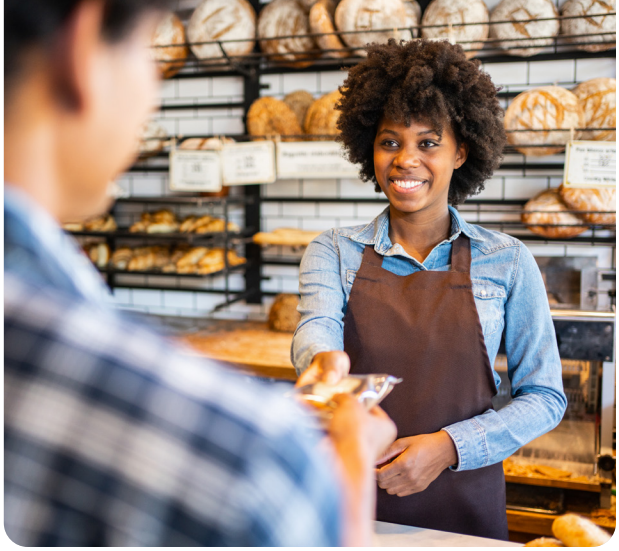
Types of Plans

By Market:

- **Large group:** a group health plan that covers employees of an employer that has 51 or more employees. In some states, large groups are defined as 101 employees or more. 84% of covered workers are enrolled in large group health plans. Over ninety percent (93%) of firms with 50 or more workers offered health benefits in 2022.
- **Small group:** a group health plan that covers employees of an employer that has up to 50 employees. In some states, small groups are defined as up to 100 employees. About **10 million people are enrolled in small group health insurance coverage.**
- **Self-funded (employer-paid claims):** 65% of covered workers – including 20% of covered workers in small firms and 82% in large firms – are enrolled in plans that are self-funded (defined below).

By Network Type:

- **PPO (Preferred Provider Organization):** A health plan where members pay less when they use providers in the plan's network. Patients with PPO plans may receive care from doctors, hospitals, and providers outside of the network without a referral for an additional cost.
- **HMO (Health Maintenance Organization):** A health insurance plan that usually limits coverage to care from doctors who work for or contract with the HMO in order to provide integrated care and focus on prevention and wellness. It generally won't cover out-of-network care except in an emergency.
- **POS (Point of Service):** A health plan where members pay less if they use doctors, hospitals, and other health care providers that belong to the plan's network. POS plans require members to get a referral from their primary care doctor in order to see a specialist.
- **CDHP – HSA Eligible (Consumer-Directed Health Plan/ Health Savings Account-eligible):** A health plan with a deductible coupled with tax-advantaged personal health spending accounts that encourage consumer accountability for their health care spending. Health savings accounts allow enrollees to set aside money on a pre-tax basis for eligible health care expenses, including copayments and deductibles but not premiums.



Funding Types:

- **Self-funded plans:** A plan that is effectively a payment arrangement through which an employer assumes financial risk and pays directly for health care services. In most circumstances, a health insurance provider delivers 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). Most oversight is conducted by the U.S. Department of Labor's Employee Benefits Security Administration (EBSA), with some by the Centers for Medicare & Medicaid Services (CMS) and Internal Revenue Service (IRS).
- **Fully insured plans:** A health insurance contract where an employer purchases coverage from a health insurance issuer who assumes the financial risk for medical claims incurred by plan members, including employees, spouses, and dependents. Fully insured plans are governed by state insurance laws, with some regulation at the federal level by the Centers for Medicare & Medicaid Services (CMS) as a result of laws including the Health Insurance Portability and Accountability Act (HIPAA) and the Affordable Care Act (ACA).
- **Level-Funded plans:** A hybrid form of self-funded and fully insured plans, increasing in popularity, in which an employer pay a set monthly payment to a health insurance provider to cover the estimated cost for expected claims, administrative costs, and stop-loss insurance premiums. If actual claims are lower than expected, the employer receives a refund for unused dollars at the end of the plan year. If actual claim costs are higher, the carrier makes an end-of-year adjustment to increase the premium on the employer's stop-loss insurance.

Coverage That's Comprehensive

Employer-provided coverage gives Americans affordable access to many doctors and providers, comprehensive coverage, and quality benefits – such as preventive care, prescription drugs, and emergency care.

- **86% of employers** offering health benefits are satisfied with their choice or provider networks, and a majority are satisfied with the cost of provider networks.
- Health insurance providers are pioneering **innovative programs to improve the behavioral health of their members** in addition to providing mental health benefits that are on par with medical and surgical benefits.
- **Nearly 1 in 4 Americans – 41 million people – accessed affordable mental health support**, ranging from therapy to medication management and substance use disorder treatment – through their employer-provided coverage in 2020. This included **6 million children**.
- **68% of employers are satisfied or very satisfied with access to behavioral health care** in their health plans for enrollees who need it, with large employers more likely to be very satisfied.
- **4 out of 5 employers** offer employee-assistance programs (EAP) as a benefit to **support mental health** and assist with non-medical issues that impact work and home life, including therapy or counseling sessions at no cost to the employee or dependent.

The 10 Essential Health Benefits (EHB) defined by the ACA are covered with no annual or lifetime dollar limits. Those benefits include:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance abuse disorder services (including behavioral health treatment)
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

Benefit Offerings: Other Product Types

- **Disability Income Protection:** Disability income protection is a crucial means for approximately 60 million Americans to protect their career, their income, and their family when they need it most. It 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. There is short- and long-term disability insurance. Short-term coverage generally covers periods lasting less than 6 months, while long-term policies last for the duration of the disability or until retirement.
- **Long-Term Care Insurance:** Long-term care insurance provides coverage for chronic illnesses and disabilities that require care not generally covered by health insurance, such as care with a home health worker or in a nursing home. About 25% of large employers who offer health insurance also offer long-term care coverage to employees. Long-term care insurance empowers more than 7 million people and their families with the freedom and flexibility to choose the long-term services and supports that work best for them.
- **Dental Insurance:** Coverage of dental care is often included in benefits packages, with two-thirds of small employers and nearly all large employers providing dental coverage to employees. From regular checkups to preventive services, to combating tooth decay and gum disease, more than 172 million Americans benefit from high-quality dental care. And around 80% of people report that their benefits give them access to high-quality care.
- **Vision Insurance:** Vision coverage not only helps Americans see better with prescription glasses and contact lenses, but it also 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 employers and 83% of large employers offering vision benefits to employees.

Resilience and Access During the COVID-19 Pandemic

Employers have been at the forefront of responding to the COVID-19 crisis, working to keep millions of Americans covered even when furloughed, supporting access to care throughout the pandemic with rapid plan modifications like increased telehealth, and delivering access to vaccinations.

Employer-provided coverage proved its resilience during the COVID-19 crisis. Three-quarters of adults with employer-provided coverage (75%) report that their coverage was important to maintaining the health and financial security of them and their families during the pandemic. Additionally, 68% of consumers consider it important for plans to cover telehealth services, and 73% believe it's important for the federal government to maintain the pandemic-era telehealth flexibilities for patients.

During 2020, the number of people with employer-provided coverage fell only 1-2% despite the unemployment rate peaking at more than 14%. Congress acknowledged and understood the importance of maintaining quality, affordable coverage at work by subsidizing COBRA coverage for those who did lose their jobs.

Employer-Provided Coverage Works

All Americans deserve more choice and control over their health care needs. Employer-provided coverage delivers affordable access to care, effective ways to improve health, and financial security for over 180 million Americans every day.

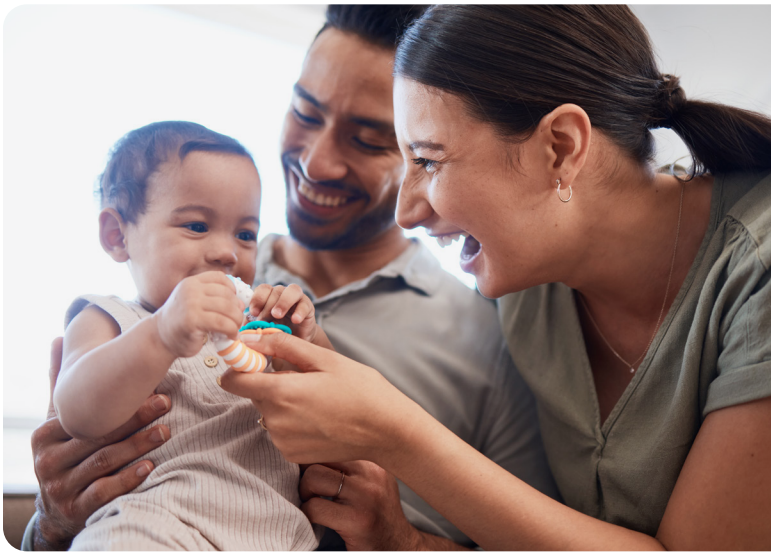
Providing coverage through work is one of the most efficient means we have of enrolling individuals and families in affordable coverage. And because employers have a vested interest in the health and financial security of their employees, employer-provided coverage continues to be a bedrock of our entire health care system.

Through access to strong provider networks, comprehensive benefits, and quality services at an affordable cost, employer-provided coverage helps give hardworking Americans the peace of mind they deserve – now and in the future.

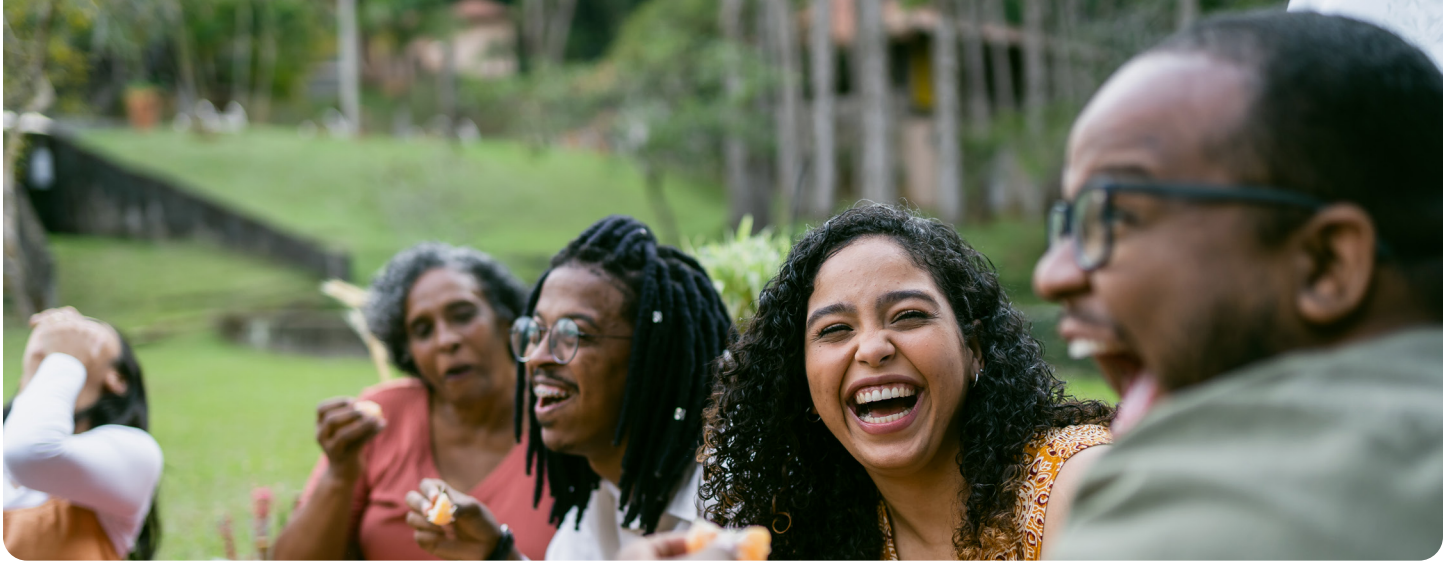
Building on What Works Going Forward

As policymakers consider the future of health care, let's build on the strength, stability, and success of employer-provided coverage. Together, we can ensure that Americans have access to the affordable, high-quality care they deserve.

- **Make Telehealth Services More Affordable and Accessible,** including proposals that allow permanent telehealth coverage on a pre-deductible basis in Consumer Directed Health Plans. Simplified licensing requirements would ensure telehealth providers can deliver services to patients across state lines and allow health plans to better adapt telehealth offerings to meet rising demand and changing environments. Policymakers should support patients' choice of telehealth, when clinically appropriate, as a less costly and more convenient method of care by removing government impediments, modernizing network adequacy regulations, and guarding against regulatory structures that reduce the competitive benefits of this option.
- **Protect Employee Benefits from New Taxes.** Quality health benefits for full-time workers are a key part of the social and economic compact in the United States, worth protecting in our tax code. 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% 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 taxpayers.



- **Build a Mental Health Care System That Leaves No One Behind.** Policymakers can improve access to behavioral health services by implementing policies to expand the workforce of behavioral health clinicians, supporting research for evidence-based behavioral health care, and promoting coordination among an integrated care team of physical and behavioral health providers.
- **Pass the *Chronic Disease Management Act*.** With more than 32 million Americans in HSA-eligible Consumer Directed Health Plans, the *Chronic Disease Management Act* would give employers and health insurance providers greater ability to cover care – including telehealth services – before the deductible. Passing this legislation would make health care more affordable and accessible for millions, and build on the current limited regulatory flexibility of health plans and employers to reduce or eliminate cost-sharing for critical medications and treatment services, such as for chronic health conditions.



- **Promote Choice and Competition to Improve Affordability.** A set of common-sense checks and balances is critical to ensuring every patient and community has access to high-quality care and control over their health care choices. More oversight of anticompetitive hospital mergers is needed, as well as increased enforcement by federal agencies on hospitals' abuse of their market power, and other actionable remedies to ensure increased competition and lower health care prices for every American. Congress should pass the *Healthy Competition for Better Care Act* to crack down on anti-competitive hospitals that abuse their market power by requiring certain contract terms.
- **Create More Opportunity for Small Businesses to Offer Coverage.** Congress should enact a simpler and more accessible Small Business Health Insurance Tax Credit that would enable more small businesses to purchase coverage for employees. The credit is complex, limited in the number of years it can be claimed, difficult to apply for, and unlikely to keep up with medical inflation. We recommend Congress broaden the terms of eligibility to strengthen the effectiveness of the subsidies. The tax credit should be flexible to ensure small businesses have a choice on where to purchase their insurance and expanded to cover all employers with less than 100 employees.
- **Advance and Protect the Principle of Site-Neutral Payments to Avoid Overnight Price Increases.** While Medicare has minimized unwarranted payment differentials through its site-neutral payment policies, more must be done to discourage consolidation and ensure commercial health insurance providers can implement comparable consumer protections. Congress should require separate national provider identifier enumeration for provider-based, off-campus hospital outpatient departments and prohibit the assessment of facility fees unless a special exception applies.
- **Lower Out-of-Control Prescription Drug Costs and Hold Pharmaceutical Companies Accountable.** Drugmakers create life-saving treatments and breakthrough cures. But Big Pharma continues to price gouge sick Americans by taking advantage of a broken system – drastically increasing prices and blocking affordable generic or biosimilar competition, which impacts the affordability of employer-provided coverage. Congress and federal regulators should take action to **stop drug manufacturers from abusing the patent system** to maintain monopoly profits, **accelerate the availability of biosimilars** to increase access to innovative treatments for more consumers, **reform the system for provider-acquired drugs** that results in unfair mark-ups and increased patient costs, and **address the ways drug manufacturers abuse charitable structures** to protect their monopolies rather than help patients.

ABOUT COVERAGE@WORK

Coverage@Work (C@W) is a campaign to educate policymakers and the public about the value employer-provided coverage delivers to over 180 million Americans. C@W supports and advocates for market-based solutions that advance health, choice, affordability, and value for every American. **Learn more at AHIP.org/CoverageAtWork**