American Academy of Actuaries

Issue Brief

Considering Employee Benefits for Health Policy Development

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Key Points

- Actuaries play a key role in supporting the pricing, cost expectations, development of "premium equivalents," and other additional support beyond pricing, for employee benefits.
- Employers offer benefits to their employees and dependents for many reasons that vary by industry, location, and competitive environment. Employer decisions around health benefits often demonstrate some combination of cost sensitivity and support for employees to get access to appropriate care when they need it.
- Employer-sponsored health benefits may be provided in the form of fully insured plans, regulated by the states and the federal government, or self-funded coverage regulated by the federal government under the Employee Retirement Income Security Act of 1974 (ERISA) and other applicable laws.
- Small employers offering insured health benefits have fewer options and more requirements for coverage under the Affordable Care Act (ACA), while large employers often tailor the benefits they offer.

Nearly 159 million people are covered by employer-sponsored health benefits in the United States.[1] Employer-sponsored health benefits may be provided in the form of fully insured plans, regulated by the states and the federal government, or self-funded coverage regulated by the federal government under the Employee Retirement Income Security Act of 1974 (ERISA) and other applicable laws. Small employers offering insured health benefits have fewer options and more requirements for coverage under the Affordable Care Act (ACA), while large employers often tailor the benefits they offer.

Employers make strategic decisions about the level of cost-sharing for health care services, how they will share the cost of coverage with their employees and dependents via premiums and cost-sharing, and the role of health benefits in the context of their total employee benefits program. This issue brief provides an overview of employer-sponsored coverage, including the reasons employers offer coverage, the characteristics of that coverage, and how group coverage differs from coverage purchased in the individual market.

Why do employers offer benefits?

Employers offer benefits to their employees and dependents for many reasons that vary by industry, location, and competitive environment. However, some common reasons for employers to offer benefits include:

- To support employees and dependents, fostering a resilient, loyal, productive, and healthy workforce, which is expected to improve company performance and achieve business objectives.

1 "2022 Employer Health Benefits Survey"; Kaiser Family Foundation (KFF); October 27, 2022.

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- To attract and retain employees in a competitive labor market.
- To provide a comprehensive total compensation package for employees and support the needs of employees and their families.
- To increase engagement and a sense of belonging to the employer that isn't accomplished by wages alone.
- To ensure compliance with U.S. legislative and regulatory requirements, such as ACA mandates (e.g., employer shared responsibility payments) or certain state or local requirements.

What do employee benefits typically include?

Just as the reasons for offering employee benefits can vary, so do the exact type and design of benefits offered. Employer-sponsored benefits in the U.S. typically break into the following coverage categories:

- Medical and prescription drug
- Dental
- Vision
- Flexible Spending Accounts/Health Savings Accounts
- Life
- Disability
- Retirement
- Paid leave
- Employee assistance programs
- Other (e.g., long-term care, legal assistance, pet insurance, etc.)

Most employers providing employee benefits offer some form of medical and prescription drug coverage to their employees. Employers that do not offer these benefits tend to be small. For example, two-thirds of firms with 10 to 199 employers offer health benefits to at least some of their workers, while just 39% of firms with three to nine workers do so.[2] When the ACA was enacted, some experts expressed concern that employers would

2 KFF 2022 Survey, Fig. 2.2.

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shift their employees to the public exchanges for medical and prescription drug coverage, but the shift has been less than anticipated so far. Eleven percent of firms offering health benefits offer funds to some portion of employees to purchase non-group coverage, such as that offered on the ACA marketplaces, and just 7% of firms not offering health benefits provide this funding. These funds may be provided through Individual Coverage Health Reimbursement Arrangements (ICHRAs) to provide tax-preferred support for employees.[3]

Employers most frequently offer a broad network (preferred provider organization [PPO]) plan, which provides coverage for both in-network providers as well as providers who are out-of-network without requirements to designate or visit a particular primary care provider (PCP) before seeking services. In-network coverage includes lower cost-sharing for patients than out-of-network. Other types of network designs that are less common include:

- Health maintenance organizations (HMOs) provide coverage for in-network providers (and non-network providers only in case of emergency) and require patients to select a PCP and receive referrals to specialist providers.
- Point-of-service designs function like PPOs, but typically require patients to receive referrals to see specialist providers to receive the highest level of coverage.
- Exclusive provider organizations function like PPOs but without coverage for non-network providers, except in an emergency.

3 KFF 2022 Survey, Fig. 2.12.

What is the role of actuaries in employee benefits?

A key role for actuaries is supporting the pricing and cost expectations for employee benefits. For fully insured health coverage, actuaries develop the premiums associated with a given benefit plan, reflecting the services covered, the expected utilization and reimbursement to health care providers, the enrollee cost-sharing, and the carrier's approach to managing care (e.g., prior authorization for certain services). Small-group fully insured ACA plans that are filed with regulators must include a certification by a qualified actuary regarding the adequacy and appropriateness of the premiums. For insured and self-funded plans with customized benefits, actuaries work with carrier underwriters and benefit consultants to price coverage and cost-sharing changes. Actuaries also work with carriers, legislators, and regulators to evaluate the cost of legislated health benefit or program changes, such as new benefit mandates or requirements for how services are provided.

For self-funded ERISA employer groups, stop-loss insurance often is purchased to mitigate the risk of large claims. Actuaries price stop-loss insurance and file stop-loss rates with regulators if required. Actuaries also support development of "premium equivalents"[†] for self-funded employers that are used for budgeting and for determining how employees share in the cost of coverage.

Actuaries may provide additional support for fully insured and self-funded employers beyond pricing, such as evaluating options for sharing premiums or plan costs with employees, projecting the benefits budget, setting and evaluating the health benefits reserves held by self-funded employers, negotiating benefits between employers and labor, supporting review and negotiation of competitive proposals for benefits administrators or carriers, or developing short- and longer-term benefits strategy.

[†] Premium equivalents are used by self-funded groups to represent their expected plan costs per participant, including the cost of health care benefits and the administrative costs of the plan.

Employer plans can vary significantly in terms of specific covered services, deductibles, coverage percentages, copay amounts, and out-of-pocket (OOP) limits, and these differences can vary by firm size. For instance, workers at smaller firms tend to face larger deductibles on average than those at larger firms ($2,543 vs. $1,493 for single coverage).[4] The total monthly premium amounts (paid by either the employer or employee) as well as the portion paid by employees for coverage can also vary significantly by type of plan, design, geography and employee demographics/industry. During 2022, total monthly premiums for single coverage generally ranged from $500 to $900, while family premium ranged from $1,500 to $2,500.[5] Employers typically pay the majority of the premium, although employers usually pay a larger share of single coverage than family coverage, and larger firms generally pay a larger share of premium than smaller firms.[6]

Employers frequently offer multiple plan options at different price points to allow employees to choose the option that best fits their family needs. For example, employers may offer high-deductible health plans (HDHP) that comply with IRS requirements to be offered alongside a health savings account (HSA), providing employees with a tax-advantaged savings opportunity.

In addition to medical and prescription coverage, employers may include other coverage, often as optional, such as:

- Most employers offer dental coverage; some require their employees to pay the full cost of the dental premium. (Small group ACA-insured plans cover pediatric dental and vision regardless of separately selected dental coverage.)
- Many employers provide flexible spending accounts (FSA), which give employees the opportunity to pay for OOP costs with pre-tax dollars. Employees selecting HSA-eligible HDHPs are limited to "limited-purpose FSAs" (dental and vision care).
- Employers frequently offer some form of life insurance coverage, which may be available as a multiple of annual pay or a flat dollar amount.
- Many employers offer short-term disability and/or long-term disability benefits, which typically provide for replacement of a portion of employee income. Employers may subsidize these disability benefits.
- Most employers offer a retirement plan, most commonly a 401(k). Many employers match some amount of employee 401(k) contributions.
- Most employers provide some type of paid leave to employees, such as a combined "paid time off" benefit, or separate vacation and sick leave. Employers also may offer other types of leave, such as parental, bereavement leave, or military service. Certain leave may be required by law.

4 KFF 2022 Survey, Fig. 7.6.
5 Gallagher 2022 Survey; 2022.
6 KFF 2022 Survey, Fig. 6.2.

How do employers make decisions about health benefits?

Employer decisions around health benefits often demonstrate some combination of cost sensitivity and support for employees to get access to appropriate care when they need it. Typically, decision-making starts with "What is necessary?" before moving to "What would be preferred?" and limited by "What can the company afford?" The decision process often includes the following steps:

1. Assess health benefits offered in the industry, including the level of coverage and cost-sharing, and how competitors vary their benefit offerings and employer financial responsibility across employee groups (hourly vs. salary, executive benefits, etc.). Employers generally strive to provide benefits similar to or better than their competitors for less cost.
2. Consider benefits meaningful to employees through employee surveys or analysis of workforce demographics.
3. Consider what is affordable for the company as a total compensation package, and what additional benefits may offer value to both the employer's benefits budget and to their employees and other plan participants, such as employee assistance programs, onsite clinics, wellness programs, health navigators, etc.). Covered benefits align with what the company is willing and able to spend.

It's important to note that larger employers typically provide more and different health coverage than small employers, especially regarding new benefit programs, plan features, or networks. This is partly driven by economies of scale as well as their ability to customize solutions for their population. In addition, large employers usually are self-funded ERISA plans that are not subject to state insurance regulation, and therefore have more control over how to design and fund health benefits.

What are the key priorities for employers when deciding which health benefits to offer?

When considering health benefits to offer to employees and their families, an employer's key priorities typically align with the following goals:

- Promote a healthy and productive workforce, with large employers often tailoring coverage based upon the underlying demographics of their workforces.
- Offer a competitive total compensation package for attraction and retention of employees, consistent with their industry norms around health benefits.
- Manage costs, especially for those with high-cost conditions and services.
- Maintain/expand affordability and access to health care.
- Support workforce diversity, equity, and inclusion ("DEI") efforts.

When do employers stop offering health benefits?

Employers may decide to eliminate or reduce health benefits for their employees due to either a lack of utilization/perceived value by employees and/or a need to reduce employer benefit costs. It is less common to terminate core benefits such as medical and prescription insurance for all employees. More frequently, benefits may be reduced for all employees or eliminated for certain classes of employees (e.g., seasonal or part-time employees). Sometimes alternative sources of coverage may be available to employees on more favorable terms than what the employer could provide; for example, if the employer does not offer coverage or that coverage doesn't meet certain ACA requirements, some low-wage earners may be eligible for subsidized coverage on the ACA public exchanges.

How does group-sponsored health coverage differ from consumer-purchased health insurance coverage?

Health coverage offered by insurance carriers and purchased by consumers differs from group-sponsored coverage in several ways, as described below. Many of these differences are also true for other types of coverage and employee benefits.

Category	Consumer-purchased health insurance coverage	Group-sponsored health coverage
Funding: insured vs. self-funded	All products on the individual market are insured by officially licensed insurance carriers.	Can either be insured or self-funded. The financial risk for insured coverage is borne by the carrier, while the employer bears the risk for self-funded. Self-funded employers may purchase stop-loss coverage to protect against high-cost claims.
Regulating authority	All plans on the individual market are subject to both federal and state regulation. There are many constraints on plan designs, rate increases, premium setting, among other items and plans and rates must be filed and approved by regulators.	Self-funded coverage is governed by ERISA and not state-level regulation. Insured coverage is subject to both federal (ERISA) and state regulation, though large groups generally have more flexibility than small groups. As in the individual market, plans for small groups of 1-50 employees have many constraints on plan designs, rate increases, premium setting, among other items, and plans and rates must be filed and approved by regulators.
Plan options and minimum requirements	The ACA marketplace is more robust now than at its inception in 2014, with many states offering three or more carriers, each with multiple plan designs. These designs must be designated with a "metal" rating to indicate the level of member cost-sharing to the consumer, from rich, low cost-sharing options (platinum or gold), to medium (silver), to lean (bronze), facilitating comparability. HSA-eligible high-deductible health plans may be available.	The level of choice (carrier, plans, and health care networks) is up to the employer and their benefits strategy. Employers often offer at least two options, a richer plan at a higher premium and a leaner plan at a lower premium. Employers may offer an HSA-eligible high-deductible health plan to allow participants to save for future health care expenses on a tax-favored basis. Group plans have regulated affordability and minimum value benefit requirements. Self-funded plans have more flexibility around benefits offered.
Enrollee cost-sharing approach	Richer plans with lower cost-sharing may be preferred when financial resources are available and higher service use is expected. Higher cost-sharing plans are generally chosen due to their lower premiums and lower expected use of services.	Employers seek to offer competitive packages to attract employees, so will generally offer richer benefits (in terms of services covered, wider availability of providers, and lower cost-sharing) if resources are available.

Network and access to providers	Often narrow, possibly value-based provider networks to reduce premiums and manage costs.	Broad network options are frequently offered, possibly alongside a smaller, lower-cost high-value network. Large employers may develop group-specific provider arrangements.
Premium-setting methodology	Premiums for plans in the individual marketplace reflect the characteristics of all enrollees in the marketplace (e.g., the single risk pool) as well as the plan features (e.g., provider network). Within each state, risk adjustment programs transfer funds among participating plans to reflect the relative risk of individuals enrolled in each plan. Rates may vary among individuals to a limited extent based on their age, tobacco use, geography, family size, and geography.	Premiums for small groups of 1-50 employees are developed similarly to individual coverage, using base rates and adjustment factors, with a risk adjustment mechanism like the individual market. For groups larger than 50 employees, premiums (or self-funded premium equivalents) can include the group-specific experience, with experience being a larger factor as group size increases. Within a group, rates may vary by family type and number of family members enrolled.
Who pays premium: employer vs. employee premium share	Income-related premium subsidies are available to eligible individuals, both to reduce premiums and lower out-of-pocket cost-sharing (copays, deductibles, etc.), potentially to zero. Subsidies are not available to individuals eligible for Medicaid or employer coverage meeting certain requirements. Premiums are not tax-deductible, except for self-employed individuals.	Split between employer and employee, usually with the employer paying over 50% of premium for employees. Premiums for dependent coverage are often covered by the employer at a lower percentage, with dependent coverage availability often varying by group size, competitive requirements, and other factors. Cost of coverage typically is tax-advantaged.
Sales and marketing	Individuals can enroll during an annual open enrollment period and at other times if there are special circumstances (e.g., moving to a different area). The federal government and some states run conduct outreach and information campaigns to inform the public of where to go to learn more and enroll. The online marketplaces are set up to facilitate comparison between many different plans to help individuals make the best decision. In addition, health insurance navigators are available to provide enrollment assistance.	Companies generally have an annual open enrollment period where the company or its adviser / agent develop employee education that is ultimately determined by their benefits strategy and resources. Larger employers may host town halls and presentations to explain the benefits and any plan changes to help employees make the best decisions for their specific situation. Smaller employers may have more limited options and receive more limited education.
Underwriting	The ACA prohibits underwriting. Individuals cannot be denied coverage or charged premiums based on health status factors.	Small group coverage is generally managed like individual coverage with the addition of a wellness option. Underwriting for larger groups is usually at the group level rather than review of individual risk, and also may include employment status, hours worked, and possibly a waiting period before coverage begins.
Risk transfer payments	The ACA risk adjustment program transfers payments among insurers based on the relative risk of their plan participants for individual coverage.	The ACA risk adjustment program transfers payments among insurers based on the relative risk of their plan participants for small group. Larger groups generally depend on full-time employment requirements and spreading risk across enough lives to sustain the relative health of their group, with no risk adjustment or payments available.