EMPLOYER-SPONSORED COVERAGE

An overview

The employer-sponsored system is the cornerstone of the U.S. health care system, covering more than half of all Americans.

For approximately 180 million individuals, access to health coverage comes through employers, either as a benefit of their employment or a parent's or spouse's employment. Employers partner with payers and providers to design coverage that invests in their employees' well-being and financial security. Because employers are afforded more flexibility than is characteristic in public programs or on the public Marketplaces (Exchanges), they can design plans that best fit their needs.

As the nation continues debating ways to enhance or improve health care, it is important to understand the unique role employers play in covering the majority of Americans through high-quality, affordable plans. Any new state or federal policies should strengthen, support and expand access to employer-provided coverage.

CIGNA BY THE NUMBERS

Cigna has 165 million customer and patient relationships around the world, including:

17 million global medical customers

Together, all the way.®

Cigna®

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What is employer-sponsored coverage?

The health benefits that employees, their spouses and/or dependents receive through their employers include a suite of paid and complementary products and services (e.g., voluntary or supplemental insurance). These offerings are all customized by employers to maximize health outcomes, manage costs and maintain productivity.

What are the benefits of employer-sponsored coverage?

Health coverage is consistently ranked as the most valued employee benefit, but its value extends beyond providing general peace of mind and financial security for employees. For both employers and employees, there are tax advantages to health coverage. Employers pay lower payroll taxes and can deduct their annual contributions when calculating their income taxes. Premiums for most health care benefits are paid with pretax dollars, making a dollar of health coverage worth more than a dollar of taxable compensation. Taxpayers derive value from this policy because each dollar of forgone tax revenue allows employers to provide $4.45 in health benefits.

Employers are not just significant payers of health care, they are also 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.[1] Employers are acutely aware of health care's impact on the success of their business, which motivates them to actively manage health care costs, innovate new ways to reduce costs, and drive value for this investment in their workforce. These innovations (e.g., wellness programs) can benefit the health care system overall by driving cost savings while helping to keep their working population healthy.

EMPLOYER-SPONSORED COVERAGE BENEFITS THE AMERICAN TAXPAYER

For every $1 of forgone tax revenue attributable to employer-sponsored coverage in 2016, employers spent $4.45 for health benefits.

American Benefits Council, "American Benefits Legacy: The Unique Value of Employer Sponsorship," Oct. 2018.

Americans are overwhelmingly satisfied with the health coverage they get through work.

71% satisfied with coverage

75% feel their coverage protects them from the majority of medical costs

https://www.ahip.org/esi-survey/

How do employers finance employee health coverage?

The method by which an employer pays for employee benefits varies. Employers can purchase insurance that covers claims and other expenses, known as fully insured funding, or they can self-fund their plan, which means the employer pays an administrator to manage the plan, but the employer assumes all risk for the health claims expenses and pays those bills directly. In 2018, 61% of covered workers were enrolled in plans that were either partially or completely self-funded.[2] The amount of costs employees bear – in the form of copays or deductibles, for example – is a decision made by each employer based on what is affordable for their business and workforce.

CIGNA NOTE – Approximately 85% of Cigna's commercial medical customers are in employer self-insured funding arrangements.

These arrangements can sometimes be best understood by comparing them with bills that most consumers pay:

- **Fully insured** is like a cable bill – no matter how many times you turn it on, or how many hours you watch, you pay the same amount each month and you know what you owe.
- **Self-funding** is more like an electric bill – you pay for what you use.
  - Employers with self-funded plans, also called Administrative Services Only (ASO) plans, often purchase stop-loss coverage to protect against catastrophic costs. Adding stop-loss coverage allows employers to keep the medical coverage premiums lower while protecting themselves from unexpected health events and associated large expenses.
- **Individual stop-loss** limits the employer's liability on each individual for each policy year to a set dollar amount. Individual stop-loss has no impact on the individual employee's coverage, just the employer's liability.
- **Aggregate stop-loss** helps protect an employer's liability from an unexpected increase in overall benefit utilization.

CIGNA NOTE – To help with cost control strategies, Cigna goes beyond basic fully insured and self-funded arrangements to offer employers more flexibility through experience rating funding arrangements. Experience rating (which means the overall cost of the plan is calculated based on the risk profile and aggregate claims experience or amount paid to providers for services from year to year) allows employers to pay a fixed monthly amount and share in up to 100% of savings when claims are lower than expected. Cigna covers excess claims if they are higher than expected.

How do employees pay their share?

Generally, employers use cafeteria plans to collect an employee's share of coverage costs. Under a cafeteria plan (governed by Internal Revenue Code Section 125), employees contribute a certain amount of their gross income to a designated account or accounts before taxes are calculated.

Employees, on average, contribute **18%–29%** of the premium, depending on coverage type. Employers pay the remainder.

https://www.kff.org/report-section/2018-employer-health-benefits-survey-section-6-worker-and-employer-contributions-for-premiums/

How do the federal and state governments regulate employer-sponsored benefit plans?

Federal law

Most private sector group health plans are governed by a federal law, the Employee Retirement Income Security Act of 1974 (ERISA). ERISA prescribes requirements for employer-sponsored plans including disclosure of plan terms to plan participants, claims appeal process, employer reporting responsibilities, and some benefit mandates (e.g., federal mental health parity, maternity, and some Affordable Care Act (ACA) provisions are incorporated into ERISA). ERISA also includes a provision that preempts all state laws that "relate to" any employee benefit plan.

State insurance regulation

All states regulate insurance companies doing business in the state, and in turn, indirectly affect fully insured employer benefits plans. State insurance regulation encompasses: Benefit mandates, claim handling requirements, oversight/auditing requirements. Self-funded group plans are not subject to state regulations.

Federal and state regulation of "small groups"

Group health plans sponsored by small employers are accorded special treatment under both federal and state law.

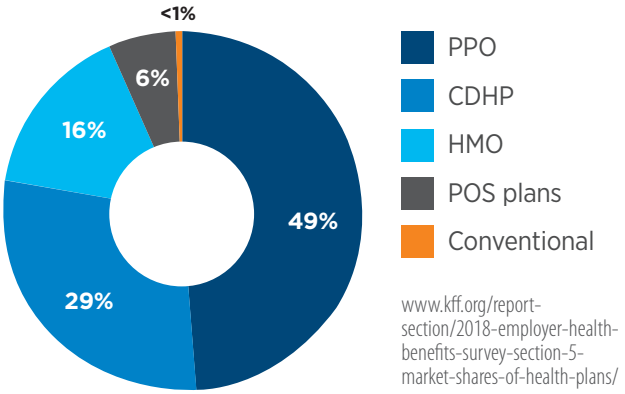
- **Federal law definition of "small employer"**: An employer that employs on average 50 or fewer employees (full-time and part-time).
- **State law definition of "small employer"**: An employer that employs on average 50 (100 in CA, CO, NY and VT) or fewer full-time employees.

Under federal law, only "small group" health plans are subject to certain requirements such as coverage of essential health benefits and community rating. Similarly, under state laws, insurance policies issued to small groups are typically subject to different premium rating requirements and, in some states, only policies with mandated benefit designs can be offered to "small groups."

WHAT TYPES OF COVERAGE DO EMPLOYERS OFFER?

A key component of most employee benefits packages is medical coverage. There are many levers an employer can use to customize medical coverage to best fit the needs of their employees and their business, including plan type, services covered, and cost-sharing (e.g., premiums, deductibles, copays). In addition to the base medical coverage, employers have the choice of offering spending accounts and voluntary insurance.

PLAN ENROLLMENT TYPES



www.kff.org/report-section/2018-employer-health-benefits-survey-section-5-market-shares-of-health-plans/

Medical plan types

- **Preferred Provider Organization (PPO)** is a type of health plan that offers a larger network so individuals have more doctors and hospitals to choose from. Out-of-pocket costs and premiums are usually higher with a PPO than with an HMO or EPO plan, but individuals do not need to select a primary care physician (PCP) or seek referrals to see specialists. Individuals can go out-of-network for services, but typically at a higher out-of-pocket cost.
- **Consumer-driven Health Plan (CDHP)** is typically a PPO plan design combined with a qualifying health plan and a health savings account (HSA) or health reimbursement account (HRA) (see Spending Accounts for more information). CDHPs encourage consumer engagement to maximize their health and benefits. These may also be referred to as high-deductible health plans (HDHPs).
- **Exclusive Provider Organization (EPO)** is similar to a PPO plan, except it does not offer coverage for out-of-network services (except in an emergency). Because of the network restriction, an EPO is usually less expensive than a PPO plan.
- **Health Maintenance Organization (HMO)** is a type of health plan that offers a local network of doctors and hospitals. It usually has lower monthly premiums than a PPO or an EPO health plan. Most HMOs exclude out-of-network coverage and require individuals to choose a PCP to coordinate care.
- **Point of Service (POS)** plans provide access to health care services at a lower overall cost, but with fewer choices. Plans vary, but, in general, POS plans are considered a combination of HMO and PPO plans. Individuals can access care from in- or out-of-network providers, but the level of coverage will be better when staying in-network. Most POS plans require the selection of a PCP to coordinate care.
- **Conventional or Indemnity** plans do not have provider networks, nor do they require individuals to select a PCP. These plans reimburse individuals a predetermined amount for health care expenses.

Consumer-driven spending accounts

- **Health Savings Account (HSA)** – Federal rules require an HSA to be paired with a high-deductible health plan (with minimum deductibles determined annually by the IRS). It is an employee-owned, tax-exempt savings account, and contributions can be made with pretax dollars by the employer and the employee, up to the IRS limit each year ($3,550 for individuals/$7,100 for families in 2020). The IRS also determines which health care services are eligible for reimbursement. The account and all contributions remain with the employee even if he/she changes employers or coverage.
- **Health Reimbursement Arrangement (HRA)** – All employer-sponsored medical plans are eligible to be paired with an HRA, which is an employer-owned account to help employees pay for covered costs. Contributions are made by the employer. Employers choose how much to contribute and which costs are eligible for reimbursement. Unused HRA dollars typically roll over to the next plan year, but terms vary by employer.[3]
- **Flexible Spending Account (FSA)** – A tax-exempt spending account funded by employees that can be used for qualified expenses not covered by the health plan. Up to $500 in unused FSA dollars may roll over into the next plan year, depending on the employer's plan.

Supplemental benefits

Voluntary or supplemental benefits include all other types of insurance beyond medical coverage, including dental, vision, life, accident and critical illness coverage. As the name implies, these products are generally voluntary enrollment options for employees. Sometimes vision and/or dental insurance is "bundled" with the medical policy at no extra cost to the employees. When not bundled with medical, the cost of dental benefits is usually still subsidized by the employer. Most other voluntary products require the employee to pay a majority – if not 100% – of the costs, though the cost is usually lower under the group plan than if an employee were to buy it on their own.

Dental insurance, similar to medical insurance, covers both preventive services and treatments. It comes in a variety of plan types, including those that offer lower-cost care through network dentists and those that allow employees to select any dentist. Coverage of dental services is often included in benefits packages, with two-thirds of small firms and nearly all large firms offering dental coverage to employees.[4]

Vision insurance provides coverage for not only vision screenings, prescription glasses and/or contact lenses, but screenings that can also detect serious health conditions, such as cancer and diabetes. Vision benefits are frequently included in benefits packages, with about half of small firms and 82% of large firms offering vision benefits to employees.[4]

Disability insurance can protect employees against the risk that a disabling illness or injury will keep them out of work for an extended period of time. The coverage replaces a significant portion of income lost due to a disability, and provides employees and families with financial protection during these unexpected events. There is short- and long-term disability insurance, with short-term covering periods lasting less than six months, and long-term lasting for the duration of the disability or until retirement.

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.

Critical illness, accidental injury and hospital insurance all provide financial peace of mind for employees who opt to purchase one or all of these coverage options. These types of insurance policies help with out-of-pocket costs from unexpected illness or injury. Employees generally receive a lump sum payment after filing a claim. The money can be used for anything from paying for out-of-pocket costs not covered by insurance, transportation, room and board, or childcare.

CIGNA NOTE – In addition to the voluntary options listed above, Cigna Leave Solutions provides employers with a simpler, more coordinated way to effectively manage Family and Medical Leave Act (FMLA), Americans with Disabilities Act (ADA), Paid Family Leaves (PFL) and other types of planned and unplanned absences.

WHAT ARE EXCEPTED BENEFITS?

Some voluntary products are also considered "excepted benefits." To qualify as an excepted benefit, coverage must be elected separately from the medical policy (i.e., not bundled with the medical plan), must often be insured (i.e., not self-funded), and require an additional premium. These benefits are not subject to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) portability rules or ACA market reforms. Common excepted benefits include: Health FSAs (that meet certain design requirements), stand-alone vision and dental plans, and supplemental disability and life insurance coverage.

CIGNA BY THE NUMBERS

Cigna has:

- **17 million** covered by dental globally
- **15 million** covered by group disability and life in the U.S.

How have employer plans evolved?

In addition to standard medical benefits and supplemental insurance offerings, employers are constantly innovating their benefits strategies to help improve their employee's health and well-being, which impacts both workplace productivity and the company's performance.

- **Integrated benefits designs** incorporate medical, pharmacy and behavioral health benefits from the same insurance provider. When integrated, the benefits plan can help connect the various points of health care needs for an individual, allowing a whole-person, holistic approach to care coordination and service delivery. Integration has been shown to lead to higher consumer engagement, improved health outcomes and lower overall medical costs.

CIGNA NOTE – Based on the Cigna 2018 Value of Integration Study, integrating medical, pharmacy and behavioral health benefits saved $193 per member per year (PMPY) and increased participation in health coaching and case management programs by 22%. The savings increased to $645 PMPY for customers with known health improvement opportunities and $9,792 PMPY for customers with specialty medical conditions.

- **Wellness programs** are offered by more than 80% of large companies to support employees and their family members in improving their health.[5] In addition to encouraging a culture of health, these programs are designed to reduce health care costs for both employees and the company. Generally, employers offer incentives to encourage employee participation in the programs. Wellness programs range from onsite fitness classes and nutrition counseling, to smoking cessation programs, health assessments, and a variety of other programs that improve health and have sustainable long-term value.

- **Onsite health clinics** are offered by 10% of large companies to provide primary care services,[6] which range from flu shots to cancer screenings, chronic disease care, urgent care, and even behavioral health services.

CIGNA NOTE – Cigna offers multiple care management and wellness programs, including employee assistance programs, health coaching and chronic care management to assist both employers and employees when addressing health and wellness.

CIGNA'S TAKE: ENHANCE EMPLOYER-SPONSORED COVERAGE

Recent policy changes and proposals pose serious risks to employer-sponsored coverage. Chief among these policy risks are those which place new taxes on, or remove tax advantages from, employer-sponsored health coverage. These threats include the "Cadillac" tax, a 40% excise tax on so-called "high-cost plans" currently scheduled to take effect in 2022; and proposals to eliminate or cap the existing employee tax exclusion, which would be a direct tax increase on workers. Instead of encouraging more businesses to offer health benefits and innovate, these policies could lead to businesses providing fewer benefit options and less comprehensive coverage, while shifting more costs to employees.

The current employer system works for tens of millions of Americans. Rather than considering proposals that would weaken employer-sponsored coverage, there should be more focus on policy solutions that strengthen and support that coverage.

1. http://ww2.cfo.com/health-benefits/2017/11/run-health-care-business-whether-like-not.
2. https://www.kff.org/report-section/2018-employer-health-benefits-survey-summary-of-findings.
3. Proposed rules issued in Oct. 2018 would allow employers to offer employees HRAs that can be used to pay for individual coverage. For more information, visit InformedonReform.com.
4. https://www.kff.org/report-section/ehbs-2017-section-2-health-benefits-offer-rates.
5. https://www.kff.org/report-section/2018-employer-health-benefits-survey-section-12-health-and-wellness-programs.
6. https://www.kff.org/report-section/2018-employer-health-benefits-survey-section-section-14-employer-practices-and-health-plan-networks.