Employer-Sponsored Insurance

Center Forward Basics

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Overview

Employer-sponsored insurance (ESI) has long been the most common source of healthcare coverage for Americans. Employees may be eligible for employer-sponsored health coverage, which covers a significant portion of the costs of receiving health care. Around 60% of individuals under the age of 65, almost 165 million people, receive their insurance through an employer-sponsored plan.

Employer-sponsored coverage typically does not cover the full cost of coverage. Plan enrollees typically contribute to **premiums** and cost-sharing components, such as **co-pays**, **deductibles**, **out-of-pocket limits** and possibly more. Just like other sources of health insurance, the quality and costs of employer-sponsored plans can vary widely.

Types of Health Plans

Employees with access to employer-sponsored coverage are typically offered either a **fully-insured** plan or **self-funded group health plan**. In a fully insured plan, the employer purchases health insurance coverage from an insurance carrier. The carrier assumes financial risk and establishes plan design. In a self-funded plan, the employer uses its own assets to pay employees' healthcare claims directly and usually uses a third-party administrator for network and administrative services.

Employers may offer different types of health benefit options to employees. These most commonly include **comprehensive major medical**, which cover a large share of the costs of hospital, physician, and prescription care a family might incur in a year. Additional benefits include **ancillary benefits**, such as dental or vision care plans, and **fixed indemnity plans**, which may provide flexibility by offering direct cash payments to enrollees to cover medically associated costs (e.g., hospital indemnity).

Health insurers and third-party administrators contract with providers such as hospitals, pharmacies, and physicians to deliver care to enrollees at a predetermined cost. Generally, these agreements create a **network,** meaning an enrollee receives coverage for care within a group of contracted providers. If an enrollee receives care outside the network, the enrollee may be responsible for higher cost-sharing or the full amount of out-of-network charges.

Legislative Framework

Fully insured plans have historically been regulated primarily at the state level, a structure that continues today despite the introduction of more uniform federal standards. By contrast, self-insured plans are largely governed by the Employee

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Center Forward brings together members of Congress, not-for profits, academic experts, trade associations, corporations and unions to find common ground. Our mission: to give centrist allies the information they need to craft common sense solutions.

Key Definitions:

- **Premium:** The amount that must be paid for an individual or family's health plan, usually paid monthly, quarterly, or yearly
- **Co-pay:** A fixed amount an enrollee pays for a covered health care service, usually when you receive the service
- **Deductible:** An amount an enrollee could owe during a coverage period (usually one year) for covered health care services before your plan begins to pay
- **Out-of-Pocket Limit:** The yearly amount set as the most each individual or family can be required to pay in cost sharing during the plan year for covered, in-network services.
- **Fully-Insured Plan:** A health coverage plan in which the employer purchases health insurance coverage from an insurance carrier. The carrier assumes financial risk and establishes plan design
- **Self-funded Plan:** A health coverage plan in which the employer uses its own assets to pay employees' healthcare claims

Retirement Income Security Act (ERISA), which broadly preempts state insurance laws to ensure the ability to offer consistent, nationwide benefits. ERISA's preemption authority plays a critical role in enabling multi-state employers to administer uniform coverage and avoid a patchwork of varying state requirements.

The Affordable Care Act (ACA) provided a federal legislative framework to divide employers into the small group and large group markets, based on the number of full-time equivalent employees (FTEs). Employers with at least 50 FTEs—considered large employers for ACA purposes—are potentially subject to financial penalties under the ACA if they do not offer health coverage that meets certain minimum requirements to their full-time employees. This is known as the **employer mandate**. Under the ACA, if large group employers do not offer minimum essential coverage to 95% of their full-time employees and their dependent children, they may pay a fine based on the number of employees who were not offered coverage. Employers are also penalized if their coverage is deemed unaffordable or does not provide minimum value, defined as covering 60% or more of a typical population's health spending. For 2025, coverage meets the minimum value standard if the employee premium contribution is less than or equal to slightly more than 9% of household income.

A significant factor contributing to the widespread prevalence of ESI is the current income tax exclusion for employer-provided health benefits. This policy, known as the **income exclusion** allows employer contributions toward health premiums to be excluded from employees' taxable income, resulting in substantial tax savings for the employee and employer. Employees' contributions to their health premiums are usually made pre-tax, reducing their taxable income. Employers benefit by deducting their premium contributions as a business expense, lowering their overall tax liability. This system incentivizes businesses to offer comprehensive health insurance coverage and makes the coverage more affordable for employees.

Look Ahead

Some suggest that employer coverage is becoming less affordable for workers as increasing healthcare costs across the board are being shifted to employees through higher deductibles, coinsurance, and premium contributions. KFF data shows family premiums for Employer Coverage rose 6% in 2025, outpacing both inflation and wage growth. The average total yearly premium for family coverage was nearly $27,000, with just over $20,000 covered by the employer and $6,850 by employee contributions. Data shows annual deductibles have increased from $300 to over $1,500 over the past two decades. Some argue that long-term price increases have resulted in an increase of high-deductible plans, higher coinsurance costs, and more narrow networks, among other effects.

Typically, smaller firms may have more difficulty offering employer-sponsored plans to the majority of their employees. In 2024, 54% of firms offered health benefits to their employees. Approximately 46% of firms with 3-9 employees offer coverage, compared with 56% of firms with 10-24 employees, 68% of firms with 25-49 employees, and 92% of firms with 50-199 employees. Employees at firms that do not offer employer sponsored health coverage may turn to other directly and usually uses a third-party administrator for network and administrative services

- **Group Plan:** Healthcare coverage sponsored through an employer, union or other group sponsor that provides coverage for certain health care costs
- **Comprehensive Major Medical Plan:** A healthcare plan that covers a large share of the cost of hospital, physician and prescription costs that a family might incur during a year
- **Ancillary Benefits:** Supplemental benefits offered by a sponsor, such as dental or vision care plans
- **Fixed Indemnity Plan:** A type of supplemental insurance which may provide a limited additional benefit or direct cash payment to enrollees if certain circumstances occur, such as hospitalization
- **Network:** A group of contracted providers. If an enrollee receives care outside the network, the enrollee may be responsible for higher cost-sharing or the full amount of out-of-network charges
- **Employer Mandate:** Included in the ACA, large employers are potentially subject to financial penalty if they do not offer health insurance coverage meeting certain requirements to their full-time employees
- **Income Exclusion:** This policy allows employer contributions toward employee health insurance premiums to be excluded from employees' taxable income, resulting in substantial tax savings for both parties

Key Statistics:

- Around 60% of individuals under the age of 65, almost 165 million people, receive their insurance through employer-sponsored

sources like the health insurance marketplace, where individuals without an employer-sponsored plan can purchase coverage with federal assistance to help cover premiums. Congress is still deliberating its next steps regarding the much-debated Enhanced Premium Tax Credits which further offset premium costs for marketplace plan participants.

In conclusion, employer-sponsored insurance coverage is likely to remain the most common source of health insurance for the foreseeable future and a cornerstone of the healthcare system.

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Link to Additional Resources

- American Benefits Council: Employer Healthcare Tax Benefits
- Business.com: Employer Health Insurance: Average Employee Health Insurance Cost in 2025
- Employee Benefit Research Institute: Employment-Based Health Benefits: A 2008–2023 Review
- HealthInsurance.org: Employer-Sponsored Health Insurance
- Kaiser Family Foundation: Employer-Sponsored Health Insurance 101
- Kaiser Family Foundation: 2025 Employer Health Benefits Survey
- U.S. Department of Labor: Health Plans and Benefits
- United States Congress: Patient Protection and Affordable Care Act