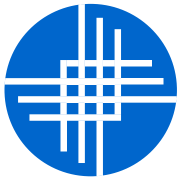

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Reimagining the Future of Employer-Sponsored Health Care to Drive Value: SURVEY INSIGHTS

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About the Milken Institute

The Milken Institute is a nonprofit, nonpartisan think tank focused on accelerating measurable progress on the path to a meaningful life. With a focus on financial, physical, mental, and environmental health, we bring together the best ideas and innovative resourcing to develop blueprints for tackling some of our most critical global issues through the lens of what's pressing now and what's coming next.

About MI Health

MI Health bridges innovation gaps across the health and health-care continuum. We advance whole-person health throughout the life span by improving healthy aging, public health, biomedical science, and food systems.

About Public Health at the Milken Institute

The Public Health team develops research, programs, and initiatives to activate sustainable solutions leading to better health for individuals and communities worldwide. To catalyze policy, system, and environmental change in public health and sustain impact, we approach our work in three interconnected areas: Prevention and Chronic Disease, Mental Health, and Health Equity.

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INTRODUCTION

Employer-sponsored health insurance (ESI) is the most common form of health insurance in the United States, providing coverage for approximately 180 million people, or roughly half of the US population, and accounting for more than $1 trillion in health-care spending annually.[1]

Despite our nation's heavy reliance on ESI, costs have risen steadily. As a result, both employers and employees face issues related to affordability, health outcome improvement, and disparities. According to KFF, in 2023, average annual health insurance premiums increased by 7 percent to $8,435 for single coverage and by nearly one-quarter to $23,968 for family coverage. This represents a 22 percent average increase in family premiums since 2018 and 47 percent since 2013.[2] For 2024, employers project a median increase in health-care costs of 7 percent, a rate that outpaces inflation, according to the International Foundation of Employee Benefit Plans.[3]

Increased ESI spending, unfortunately, has not led to corresponding improvements in health outcomes. Research by the Commonwealth Fund revealed that among high-income nations, the US has the lowest life expectancy at birth, the highest death rates for avoidable or treatable conditions, the highest maternal and infant mortality, and among the highest suicide rates.[4]

In this pivotal moment, employers with US-based workforces seek practical solutions to manage ESI costs while improving employee health. Employers are uniquely positioned to drive value in health-care quality, affordability, and equity through innovation that implements accountable care strategies. Despite the strong case for ESI reform in the US, employer attitudes toward ESI are not widely known or documented, presenting a key knowledge gap worthy of deeper investigation. Further, policymakers need consistent sources of information to identify gaps and opportunities to advance progress in this area. To close this gap, the Milken Institute Public Health team designed and conducted evaluation and measurement research to uncover trends shaping the complex ESI landscape.

This report details responses from the "Milken Institute Public Health Survey: Reimagining the Future of Employer-Sponsored Health Care to Drive Value." The online survey sought to capture insights and attitudes from a representative sample of employers about ESI, accountable care, and approaches to considering benefits for employees and dependents.

KEY SURVEY INSIGHTS

- In the anonymous survey completed by 72 employers across size, sector, and industry types, over one-third of respondents were integrating accountable care strategies that pay for quality over service volume into their ESI. In addition, over one-third of respondents were working to understand the best-fit strategies for their organization, representing an opportunity for peer learning and technical assistance.
- In the context of making health benefit decisions, respondents ranked expanding preventive care, increasing access to primary care, and focusing on whole-person health as the top three tenets of accountable care. However, health system infrastructure limitations and the overall complexity of setting up arrangements were noted as barriers preventing the adoption or scaling of accountable care arrangements. Capacity, bandwidth, geographic limitations, cost, benefit integration complexity, employer size, and an unclear understanding of accountable care were also highlighted.
- Of note, respondents emphasized cost-related considerations, such as the importance of reductions in overall costs. Simultaneously, they acknowledged the importance of a broad network of providers and service options, reflecting a commitment to accessibility. They also recognized the importance of beneficiary affordability, which saves costs for employees.
- A subset of self-funded and jumbo (10,000+ employees) employers reported measuring health outcome disparities annually. However, the majority of respondents were not measuring health outcome disparities.
- Mental health resources are a focus for future enhancements, with greater than 20 percent of respondents intending to primarily enhance these resources in the next few years. Looking at a variety of current benefit offerings, mental health resources, virtual primary care, nurse/advice lines, and maternal health offerings were most frequently offered under health plans. In addition, 63 percent of respondents offered mental health resources through an employee assistance program (EAP), making it the most popular offering through an EAP, with caregiver support and resources following at 36 percent of respondents.

Self-Funded Employer: As a self-funded/self-insured insurance plan sponsor, the employer assumes financial risk for providing health-care benefits to its employees. Self-funded employers pay for medical claims and fees as presented out of revenue instead of paying a predetermined premium to an insurance carrier. With this approach, self-funded employers typically gain more control and freedom over plan design.[5] These employers can contract with a third-party administrator for insurance services such as enrollment, claims processing, and provider networks, or they can be self-administered.

Fully Insured Employer: As a fully insured insurance plan sponsor, the employer pays a fixed premium to a third-party commercial insurance carrier that covers the medical claims.[6]

Level-Funded Employer: With a level-funded insurance arrangement, the employer makes a set payment each month to a third-party insurance carrier, which funds a reserve account for medical claims, administrative costs, and premiums for stop-loss coverage.[7]

Group Captive Employer: With a group captive insurance arrangement, the employer is part of a collection of employers. Rather than paying a third-party insurance carrier, a group captive employer retains certain risks at lower costs while combining forces with like-minded employers.[8]

SURVEY METHODOLOGY

The Milken Institute Public Health team invited employers across sizes, sectors, and industry types to participate in the "Milken Institute Public Health Survey: Reimagining the Future of Employer-Sponsored Health Care to Drive Value." The team sent the survey questionnaire to 323 organizations, sourced primarily from the Milken Institute network, and oversampled private-sector, jumbo employers to ensure their adequate representation as the population of highest interest. Private-sector, jumbo employers were the population of highest interest because of their power in the health insurance marketplace.

The team requested that individuals in a benefits decision-making or influencing role complete the survey and do so from the perspective of their organization, not their personal point of view. Each organization was limited to one response. The team distributed the anonymous survey via an emailed Survey Monkey link from September 2023 through January 2024.

The 18-item questionnaire incorporated both quantitative and qualitative measures to assess knowledge and attitudes around health benefits decision-making (see Appendix for full questionnaire). Measures included Likert-like scales, ranking, checkbox, and open-response options. The content of the measures was inspired by a literature review of accountable care integration in ESI, emphasizing the often-cited opportunities and barriers employers face. In addition, the questionnaire collected demographic information, including organization size, sector, union representation, and information about how health benefits are currently offered. Respondents from the private sector were asked to indicate their classification according to the Global Industry Classification Standard (GICS). This survey used the 11 high-level sectors and included an "other" option.

SAMPLE DEMOGRAPHICS

Of the 72 responses to the survey, the majority (65 percent) of individuals responding to the survey on behalf of their organization described their role as within benefits, including plan administration, design, employee engagement, and human resource functions. Chief executives comprised 17 percent of survey respondents, with clinical (6 percent), financial (6 percent), investment (1 percent), government affairs (4 percent), and communications (1 percent) roles comprising the remaining respondents' roles.

Table 1 shows the survey respondent demographics by size, based on the number of full-time US-based employees and sector. Of the 72 survey respondents, over one-third were jumbo employers with more than 10,000 employees, 7 percent extra-large, 18 percent large, 19 percent medium, and 18 percent small. Nearly 90 percent of respondents were from the private sector in industries spanning the GICS classifications. Those who marked "other" for overall sector include respondents from federally chartered corporations and other structures where public entities are majority shareholders.

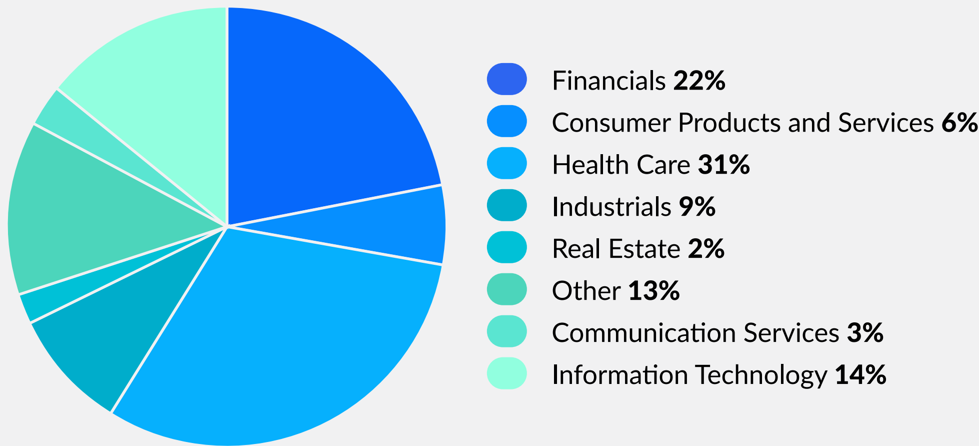
Table 1: Survey Sample Demographics

Organization Description	Number of Survey Takers (Percent of Sample) n=72
Size	
Small (1-99)	13 (18%)
Medium (100-499)	14 (19%)
Large (500-4,999)	13 (18%)
Extra Large (5,000-9,999)	5 (7%)
Jumbo (10,000+)	27 (38%)
Sector	
Private	64 (89%)
Nonprofit	4 (6%)
Other	4 (6%)

Note: *Size based on number of full-time US-based employees*
Source: *Milken Institute (2024)*

Of the 64 private-sector respondents, over one-half were from either health-care or financial industries (see Figure 1). Respondents from the health-care sector range across equipment and supplies, providers and services, and technology. The other respondents included nine from information technology, six from industrials, four from consumer products and services, two from communication services, one from real estate, and eight from other sectors (who did not provide further industry details). Most survey respondents (82 percent) did not have any of their workforce represented by a union. None of the respondents had all of their workforce represented by a union, 6 percent indicated the majority (greater than one-half), and 13 percent indicated some (less than one-half).

Figure 1: Survey Sample Private Industry Sectors



Source: *Milken Institute (2024)*

Organizations were asked how their ESI is selected and funded, with more than one selection as a possibility. Two-thirds (43) of respondents reported the insurance as self-funded, 28 (39 percent) as fully insured, and 3 (4 percent) as level-funded. None reported their insurance as group captive or part of a collection of organizations. Thirteen (18 percent) respondents indicated that their insurance was broker-facilitated. Two respondents left comments in the other option: one wrote "fully insured now but moving to self-funded in 2024," and the other wrote "combination but most self-funded."

The majority of jumbo respondents (88 percent) had self-funded ESI. However, one-third of these respondents also noted fully insured or broker-facilitated options. Table 2 shows self-funded respondent demographics. Of the self-funded respondents, 56 percent were jumbo employers, and around one-fifth were large employers. The majority of self-funded respondents were from the private sector, but about 12 percent were from the nonprofit and other sectors.

Table 2: Self-Funded Respondent Demographics

Organization Description	Number of Survey Takers (Percent of Sample) n=43
Size	
Small (1-99)	3 (7%)
Medium (100-499)	3 (7%)
Large (500-4,999)	8 (19%)
Extra Large (5,000-9,999)	5 (12%)
Jumbo (10,000+)	24 (56%)
Sector	
Private	38 (88%)
Nonprofit	2 (5%)
Other	3 (7%)

Note: *Size based on number of full-time US-based employees*
Source: *Milken Institute (2024)*

SURVEY INSIGHTS

Trends in Benefit Offerings

The survey first asked respondents to catalog their current benefit offerings and areas for enhancement in the next few years. Respondents reported offering a variety of health benefits, with nearly all (99 percent) offering health insurance coverage from one or multiple carriers.

Most respondents offered flexible spending accounts (77 percent), health savings accounts (75 percent), and high-deductible plans (70 percent) as options. Health reimbursement arrangements (32 percent) and lower cost, narrow-network option health plans (28 percent) were offered by nearly one-third of respondents. No respondent offered a stand-alone accountable care arrangement, and only two respondents offered an accountable care arrangement embedded within a health plan. The two employers who offered an accountable care arrangement within the plan were jumbo and self-funded.

The next set of questions sought to understand whether organizations offered 11 benefits that support whole-person health, including virtual primary care, expanded substance use disorder (SUD) treatments, maternal health offerings, and caregiving resources. The options for these benefits were not offered, offered under the health plan, offered through an EAP, and/or individually contracted through a separate vendor.

Maternal health offerings, mental health resources, virtual primary care, and nurse or advice lines were most frequently offered under the health plan. Healthy food benefits, fitness benefits, expanded SUD treatments, and caregiver resources were the benefits least frequently offered. Mental health resources and caregiver resources were the most-offered benefits through an EAP, offered by 44 respondents and 25 respondents, respectively. Over one-third of respondents offered caregiving resources and fitness benefits through a vendor.

Whole-person health recognizes that health and wellness are not limited to physical health but are fostered through holistic well-being. Approaches involve addressing the whole person, not separate organs or body systems, and instead of treating a specific condition, focus on restoring health, promoting resilience, and preventing diseases across the lifespan.[9]

Respondents were then asked which of these benefits they plan to enhance in the next two to three years. **Thirteen respondents, or 23 percent, are primarily planning to enhance mental health resources. Of these respondents, half were jumbo and self-funded.** Virtual primary care and caregiver resources were the other benefits identified as the primary area of enhancement by about 20 percent of respondents. Of respondents planning to enhance caregiving resources, 70 percent were self-funded, but more other-sized respondents were planning to enhance than jumbo.

Trends in Attitudes about Health Benefit Decisions

The survey asked a series of questions about the factors that drive decision-making around health benefit offerings. In the context of their organization's health benefit decisions, respondents were asked to rank tenets of accountable care in order of importance (see Figure 2).

Expanding preventive care was ranked as the most important tenet, with increasing access to primary care and focusing on whole-person health as the second and third most important. Reducing health outcome disparities and increasing access to digital care were ranked lowest. The ranking between overall responses and self-funded employers did not differ. However, jumbo employers ranked "increasing access to primary care" as the number one tenet with "expanding preventive care" as second and "integrates behavioral health care" and "pays for quality, not volume of services" equally as third.

Figure 2: Respondents' Ranking of Tenets of Accountable Care, in Order of Importance

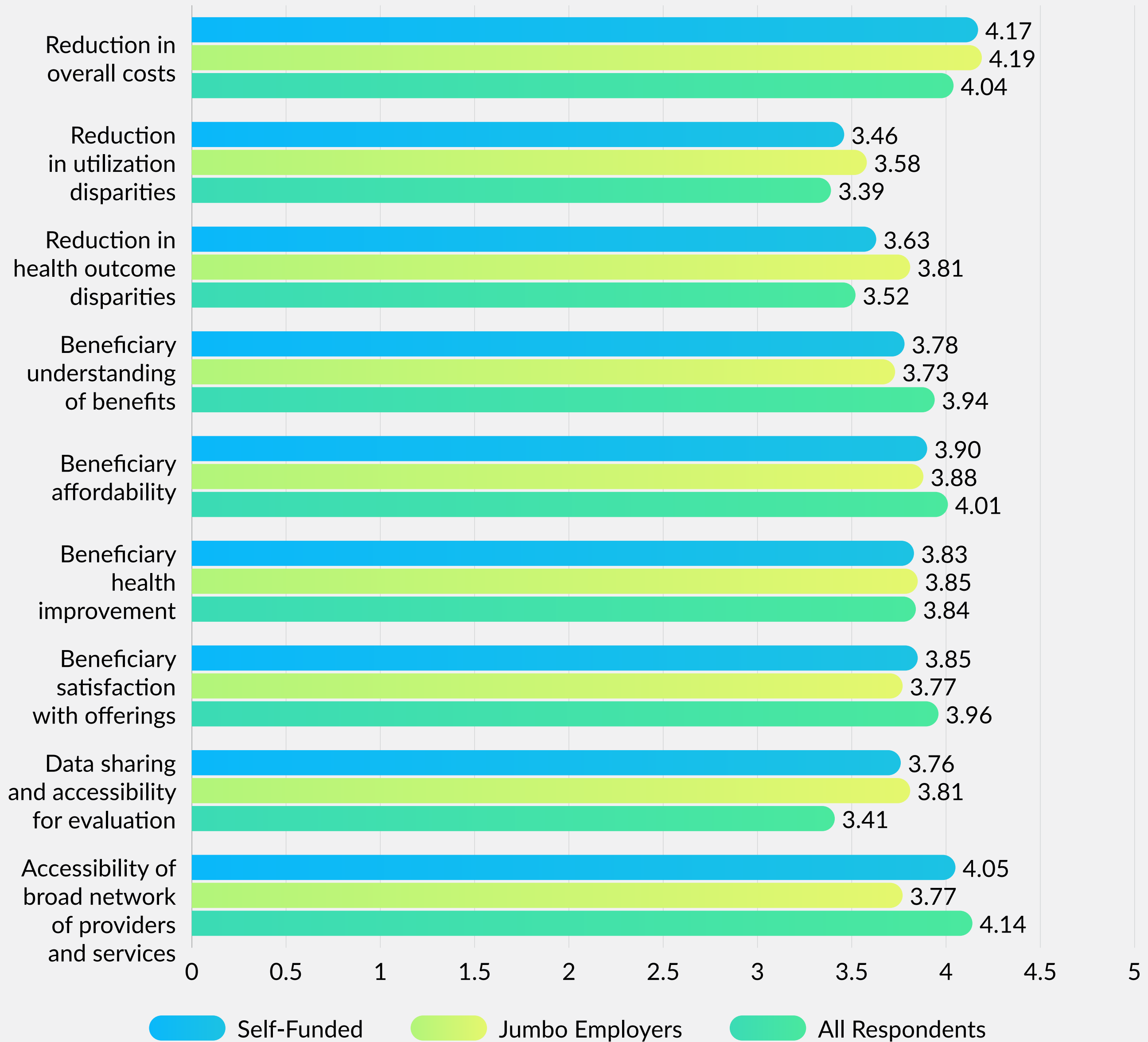
1. **Expands preventive care**
2. **Increases access to primary care**
3. **Focuses on whole-person health**
4. **Integrates behavioral health care**
5. **Pays for quality, not volume of services**
6. **Better care navigation**
7. **Reduces health outcome disparities**
8. **Increases access to digital care**

Source: *Milken Institute (2024)*

Respondents were asked to consider the importance of a series of factors on a five-point scale (1=Not at All Important to 5=Extremely Important) in response to "When making health benefit decisions for your organization, how important are the following considerations?" All factors were rated above a 3, or "important," on the five-point scale (see Figure 3).

When making health benefit decisions, respondents indicated **reductions in overall costs (4.04), accessibility of a broad network of providers and service options (4.14),** and **beneficiary affordability (4.01)** were "very important." Self-funded and jumbo employers rated reductions in overall costs higher than the average, with a 4.17 and 4.19 rating, respectively. Self-funded and jumbo employers rated reduction in utilization and outcomes disparities among different demographic groups as being of higher importance than the overall average. However, beneficiary affordability and satisfaction were both rated lower for these subgroups compared to the overall average.

Figure 3: Considerations for Health Benefit Decisions on a Five-Point Scale
(1-Not at All Important to 5-Extremely Important)



Source: *Milken Institute (2024)*

Measuring and Addressing Health Outcome Disparities

Evidence is building that addressing drivers of health can help employers improve workplace productivity, reduce absenteeism costs, and lower health disparity–related costs that currently account for roughly $320 billion of the US annual health spending.[10]

To understand how this evidence impacts employer behavior, this survey sought to understand how often and in what ways employers assess health disparities among their employee base.

Seventy-nine percent of employers responded to the open-ended question. **Forty-four percent of respondents indicated in some way that they were not currently or directly measuring health outcome disparities. Thirty-eight percent of respondents measured health outcome disparities annually or more frequently.** When narrowing in on responses, self-funded and jumbo respondents most frequently reported **annual measurements of health outcome disparities**.

Responses to the question on ways to address health outcome disparities highlighted several strategies. Responses emphasized outreach and engagement strategies, including targeted or special programs, tailored communications, proactive outreach, and education with their employee base. This focus on engagement opportunities highlighted the need for employers to understand the barriers that prevent service utilization and the methods that help raise awareness of offerings.

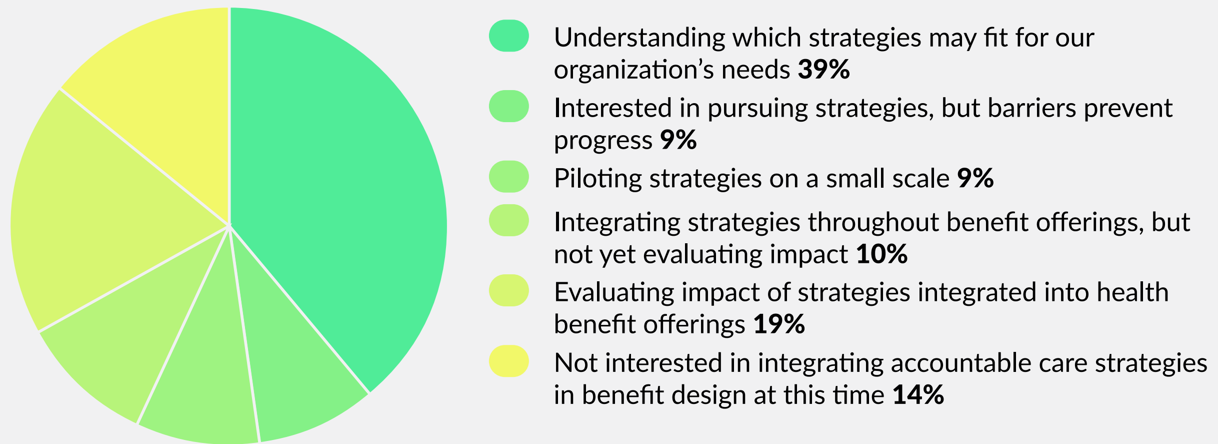
Operational-focused responses included partnering with internal diversity, equity, and inclusion teams, human resources (HR), and talent departments. Other responses detailed care, coverage, and cost-saving opportunities, such as delivering culturally competent care, free telemedicine, on-site mammograms, and chronic condition programs. Emphasizing the importance of affordability barriers, responses mentioned providing prescription and health-care expense savings while making plan, coverage, and cost changes as necessary. Respondents not yet addressing health outcome disparities cited poor data quality, recent funding changes (i.e., newly self-funded), and planning challenges as their barriers.

Stages of Accountable Care Implementation

Looking at how these attitudes translate to implementation, the organizations surveyed were at different stages of incorporating accountable care strategies that pay for quality over service volume (see Figure 4). When asked about their stage of implementation, **38 percent of respondents (n=69) were integrating accountable care strategies** that pay for quality over service volume at some capacity, from piloting strategies to evaluating the impact of strategies integrated throughout benefit offerings. Of the 13 respondents who were evaluating the impact of strategies integrated into benefit offerings, 10 were self-funded organizations. Of the 10 organizations not interested in integrating accountable care strategies, only 4 were self-funded, and one was a jumbo employer.

Additionally, over one-third of respondents were working to understand the best-fit strategies for their organization. As organizations build an accountable care strategy, these findings may present an opportunity for both technical assistance and peer-to-peer learning.

Figure 4: Stages of Accountable Care Strategy Implementation

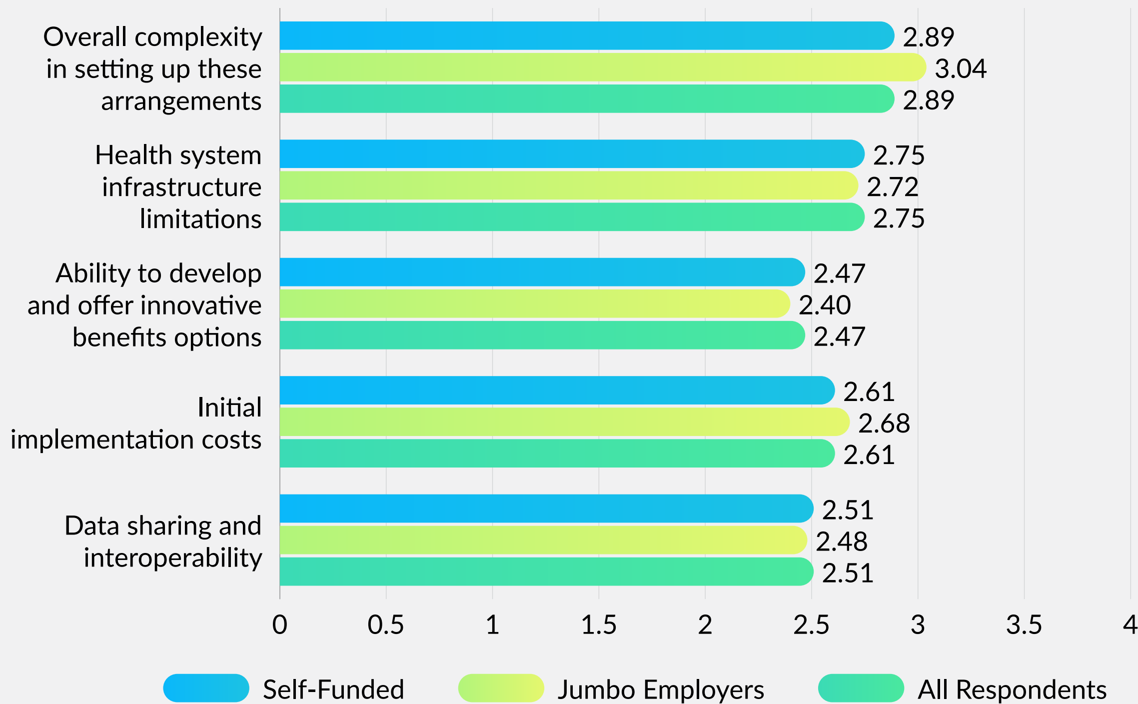


Source: *Milken Institute (2024)*

Challenges in Adopting or Scaling Accountable Care

The survey asked a series of questions about the barriers that prevent organizations from adopting or further scaling accountable care strategies. Using a four-point scale (1=Not at All to 4=Extremely), respondents indicated that all the listed barriers were slightly to moderately preventing adoption or scaling of accountable care arrangements (see Figure 5). **Health system infrastructure limitations and the overall complexity in setting up accountable care arrangements had an average response of moderately preventing adoption or scaling**.

Figure 5: Barriers to Implementing Accountable Care on a Four-Point Scale
(1=Not at All to 4=Extremely)



Source: *Milken Institute (2024)*

Responses to an open-ended "What other challenges is your organization facing in adopting or further scaling accountable care strategies?" revealed several main barriers: **capacity, bandwidth challenges, geographic limitations, cost, ease of benefit integration, employer size, and unclear understanding of accountable care**. Challenges with capacity and bandwidth highlighted the time needed to evaluate strategies internally and to effect change management in the face of competing priorities. Respondents noted several geographic limitations, including consistency in offerings across the country, scalability across geographies with smaller head count, difficulty explaining location-specific accountable care organizations to beneficiaries, and the need for stronger options in key markets. The cost-related challenges cited included the need for partnerships that demonstrate quality improvements and cost savings, budgetary constraints, and organizational focus on cost mitigation as the primary concern. Challenges related to benefit integration referenced confusion for beneficiaries when offered multiple plans, the effect of changes that uniquely impact union employees' plan design, integration with a third-party administrator, and internal changes in structure.

Small business respondents reported a lack of negotiation power and resources, small participant group size, and privacy considerations as challenges. Lastly, respondents indicated challenges related to a lack of understanding of accountable care strategies, viewing strategies as invasive, receiving conflicting expert advice, and the perception of limited alternative health care offerings to replace the status quo.

Opportunities for Future Innovation

This survey closed with the opportunity for respondents to describe their organization's thoughts about innovation in health benefit offerings for the future. **Respondents identified affordability, quality, equity, and holistic health as considerations for the future of ESI and health benefit innovations**.

Respondents noted the **importance of quality and equity when considering future health benefit offerings and innovation**. These responses included providing and improving access to "affordable, high-quality health care to all employees, no matter where they live," offering less restrictive plans that provide employees with more options, and aiming to improve the health outcomes of their workforce to impact inequities. Other respondents addressed the need for easy-to-use, easily integrated strategies and a better understanding of how to measure and transparently share quality.

Responses cited cost as a barrier to scaling accountable care approaches, emphasizing the need to balance budgetary constraints and to set care at the "right price" while driving better outcomes. Some potential solutions are offering lower-cost plans for the hourly workforce and leveraging data to identify cost drivers. Respondents expressed interest in offering benefits from a holistic, comprehensive point of view to improve employee experience and ensure workforce competitiveness. Some of the comprehensive approaches mentioned were plans to enhance family planning (including infertility coverage), mental health resources, women's care, health advocate services, family support and caregiving benefits, and assistance to employees impacted by chronic illnesses.

CONCLUSION

With ESI representing the most common type of health insurance in the US, impacting 180 million Americans, our nation's employers are uniquely positioned to spur ESI reform through innovation to drive high-quality, whole-person health care that is affordable and equitable. The insights in this brief highlight several learning opportunities for future focus within the ESI landscape and accountable care:

- Employers seek peer learning, information sharing, and technical assistance to help accelerate employer integration of accountable care strategies.
- Employers recognize the need for a broad network of providers and service options to reflect a commitment to beneficiary accessibility.
- Employers identified gaps in the development and utilization of measurement and evaluation tools to easily identify and assess health outcome disparities within their employee base.
- Employers expressed interest in understanding what is necessary to increase employee awareness and utilization of health benefit offerings.
- Employers are prioritizing whole-person approaches that center preventive and mental health care when considering future health benefit offerings and innovation to drive health outcome and employee experience improvements.

These insights from employers highlight the need to explore opportunities in partnership with other stakeholders to effectively drive accountable care and improve health outcomes. Through a whole ecosystem approach, stakeholders can build a holistic health system infrastructure that fosters the establishment or scaling up of accountable care arrangements. US federal and state policymakers and influencers have a unique opportunity to address gaps by employing levers in public programs and ESI policies. The voices of employers, employees, policymakers, health-care providers, and health insurance payers must all be considered and explored to accelerate change. The Milken Institute Public Health team is committed to driving value in ESI and stands ready to leverage our cross-sector network to advance initiatives that lead to better health for employees, their families, the surrounding communities, and beyond.

APPENDIX

Milken Institute Public Health Survey: Reimagining the Future of Employer-Sponsored Health Care to Drive Value

1) How many full-time US-based employees does your organization have?

a) Small (1–99)
b) Medium (100–499)
c) Large (500–4,999)
d) Extra Large (5,000–9,999)
e) Jumbo (10,000+)

2) What sector is your organization a part of?

a) Private
b) Government
c) Nonprofit
d) Other

3) If private sector, which of the following is your organization a part of?

a) Communication Services
b) Consumer Products and Services
c) Energy
d) Financials
e) Health Care
f) Industrials
g) Information Technology
h) Materials
i) Real Estate
j) Utilities
k) Other
l) N/A

4) How much of your workforce is represented by a union?

a) All
b) The Majority (>50%)
c) Some (<50%)
d) None

5) How would you describe the function of your role within your organization?

a) Benefits (plan administration, design, employee engagement)
b) Clinical (chief medical officer, other clinical roles)
c) Financial (CFO, COO, vendor contracting)
d) Investments (strategic investments)
e) Government Affairs (lobbying, policy, advocacy)
f) Chief Executive
g) Other (please describe)

6) Which of the following describes how your organization's employer-sponsored health insurance is selected and funded? (Please select all that apply)

a) Fully insured (contracts with a health plan that assumes financial responsibility for the costs of enrollees' medical claims)
b) Level-funded (makes a set payment each month to an insurer or third-party administrator that funds a reserve account for claims, administrative costs, and premiums for stop-loss coverage)
c) Self-funded (assumes direct financial responsibility for the costs of enrollees' medical claims)
d) Group captive (part of a collection of organizations that assume direct financial responsibility for the costs of enrollees' medical claims)
e) Broker-facilitated
f) Other (please describe)

7) Which of the following health benefits does your organization offer? (Select all that apply)

a) Health insurance coverage from one or multiple carriers
b) Stand-alone accountable care arrangement
c) Accountable care arrangement embedded as an option within a health plan
d) Lower cost, narrow network option health plan
e) High-deductible plan option(s)
f) Health Savings Account
g) Health Reimbursement Arrangements
h) Flexible Spending Account

8) What carrier(s) does your organization use for health benefits? *(open response)*

9) How does your organization offer the following benefits? Please check all that apply. *Multi-select matrix options: Not offered; Under the health plan; Through an Employee Assistance Program; Directly contracted through third-party vendor*

a) Nurse or advice lines
b) Health coaching
c) Virtual primary care
d) Mental health resources
e) Expanded substance use disorder treatments
f) Maternal health offerings
g) Family planning services
h) Smoking cessation
i) Fitness benefit
j) Healthy food benefit
k) Caregiver resources

10) Which of the following benefits is your organization planning to enhance in the next 2-3 years?

a) Nurse or advice lines
b) Health coaching
c) Virtual primary care
d) Mental health resources
e) Expanded substance use disorder treatments
f) Maternal health offerings
g) Family planning services
h) Smoking cessation
i) Fitness benefit
j) Healthy food benefit
k) Caregiver resources

11) When making health benefit decisions for your organization, how important are the following considerations? *Scale: "Not at all important," "Somewhat Important," "Important," "Very Important," and "Extremely Important"*

a) Accessibility of broad network of providers and service options
b) Data sharing and accessibility for evaluation
c) Beneficiary satisfaction with health plan offerings
d) Beneficiary health improvement
e) Beneficiary affordability
f) Beneficiary understanding of available benefits
g) Reduction in health outcome disparities among employees from different demographic groups
h) Reduction in utilization disparities among employees from different demographic groups
i) Reduction in overall costs

12) How often are you measuring health outcome disparities among your employee base? In what ways are you addressing health outcome disparities in your employee base? *(open response)*

13) In the context of your organization's health benefit decisions, rank the following tenets of accountable care in order of importance, 1 being the most important, 8 being the least important.

a) Expands preventive care
b) Focuses on whole-person health
c) Increases access to primary care
d) Integrates behavioral health care
e) Increases access to digital care
f) Better care navigation
g) Pays for quality, not volume of services
h) Reduces health outcome disparities

14) **From your perspective, which of the following statements best describes your organization's current stage of implementing accountable care strategies that pay for quality over service volume?**

    a) Understanding which strategies may fit for our organization's needs
    b) Interested in pursuing strategies, but barriers prevent progress
    c) Piloting strategies on a small scale
    d) Integrating strategies throughout benefit offerings but not yet evaluating impact
    e) Evaluating impact of strategies integrated into health benefit offerings
    f) Not interested in integrating accountable care strategies in benefit design at this time

15) **To what extent are the following barriers preventing your organization from adopting or further scaling accountable care strategies?** *Scale: Not at all; Slightly; Moderately; Extremely*

    a) Data sharing and interoperability
    b) Initial implementation costs
    c) Ability to develop and offer innovative benefits options
    d) Health system infrastructure limitations
    e) Overall complexity in setting up these arrangements

16) **What other challenges is your organization facing in adopting or further scaling accountable care strategies?** *(open response)*

17) **What other information do you wish to share about how your organization is thinking about innovating within your health benefit offerings in the future?** *(open response)*

18) **Please add your contact information if your organization is interested in sharing further insights and connecting with other employers innovating in the employer-sponsored health care space.** *(open response)*

ENDNOTES

1. Katherine Keisler-Starkey and Lisa N. Bunch, "Health Insurance Coverage in the United States: 2021," US Census Bureau, September 13, 2022, https://www.census.gov/library/publications/2022/demo/p60-278.html; *National Health Expenditures 2022 Highlights* (Centers for Medicare & Medicaid Services, n.d.), https://www.cms.gov/files/document/highlights.pdf.
2. *2023 Employer Health Benefits Survey* (KFF, October 18, 2023), https://www.kff.org/report-section/ehbs-2023-section-1-cost-of-health-insurance/.
3. "Employers Project 7% Rise in Health Care Costs for 2024," International Foundation of Employee Benefit Plans, August 15, 2023, https://blog.ifebp.org/employers-project-7-rise-in-health-care-costs-for-2024/; "Insurers Say Health Care Costs Will Jump in 2024," Society for Human Resource Management, January 2, 2024, https://www.shrm.org/topics-tools/news/benefits-compensation/health-care-costs-2024-growth-wtw-buck#:~:text=Meanwhile%2C%20a%20survey%20of%20nearly,6.8%20percent%20and%207.3%20percent.
4. Munira Gunja, Evan Gumas, and Reginald Williams II, *US Health Care from a Global Perspective, 2022: Accelerating Spending, Worsening Outcomes* (Commonwealth Fund, January 31, 2023), https://www.commonwealthfund.org/publications/issue-briefs/2023/jan/us-health-care-global-perspective-2022.
5. "What Is Self Funding?," Health Care Administrators Association, accessed February 13, 2023, https://www.hcaa.org/page/selffunding; "Self-Insured vs. Fully Insured," SHRM, accessed February 13, 2023, https://www.shrm.org/topics-tools/news/hr-magazine/self-insured-vs-fully-insured.
6. "Self-Insured vs. Fully Insured," SHRM.
7. 2023 Employer Health Benefits Survey (KFF).
8. "Group Captives 101: What Is a Group Captive?," Captive Resources, accessed February 21, 2024, https://www.captiveresources.com/insight/group-captives-101-what-is-a-group-captive/.
9. "Whole Person Health: What You Need to Know," National Center for Complementary and Integrative Health, accessed February 13, 2024, https://www.nccih.nih.gov/health/whole-person-health-what-you-need-to-know.
10. "Increase Productivity," Centers for Disease Control and Prevention, accessed February 12, 2024, https://www.cdc.gov/workplacehealthpromotion/model/control-costs/benefits/productivity.html; Andy Davis et al., "US Health Care Can't Afford Health Inequities," Deloitte, June 22, 2022, https://www2.deloitte.com/us/en/insights/industry/health-care/economic-cost-of-health-disparities.html.

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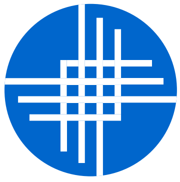
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