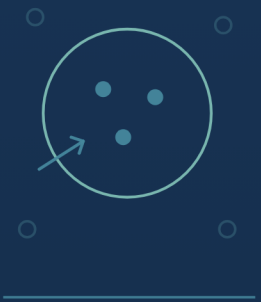
BENEFITS STRATEGY FOR PART-TIME AND CONTINGENT WORKERS

COVERAGE FOR THE OTHER WORKFORCE

A growing share of the people doing the work are part-time, temporary, or contingent, and conventional benefits are built to screen them out. This paper shows why the gap is widening, what it costs the employer, and how a Section 125 structure reaches the workers a major-medical offer cannot.



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WHITE PAPER · WORKFORCE STRATEGY

EXECUTIVE SUMMARY

The American workforce no longer fits the shape that employer benefits were built around. A growing share of the people who do the work are part-time, temporary, seasonal, or contingent. They carry the shift, and when the benefits conversation happens they are standing outside it.

The numbers tell a consistent story. Contingent workers are a measurable and rising share of employment, concentrated among younger, part-time, and lower-paid workers. The gap is sharpest where it matters most: roughly one in four part-time workers has access to employer medical-care benefits, against roughly nine in ten full-time workers. The people most likely to be excluded are the people least able to absorb the cost of going without.[1]

This paper makes a single argument to the employer. The segment conventional benefits leave out is the segment growing fastest, and the employer who solves coverage for it first gains an advantage in retention and reputation that compounds while competitors wait. The instrument that makes the solution practical is a supplemental benefit funded through a Section 125 cafeteria plan, which sets its own eligibility terms and reaches the variable-hour employees a conventional major-medical offer screens out.[2]

A word on what this paper is not. It does not claim that supplemental coverage substitutes for comprehensive major medical, and it does not argue that an employer should drop one in favor of the other. The structure reaches a population that major medical does not, alongside whatever comprehensive coverage an employer already provides to the workers who qualify for it.

HOW TO READ THIS

An important note before the analysis.

WHAT IT IS

An analysis of the part-time and contingent coverage gap and a settled statutory mechanism that closes it.

WHAT IT IS NOT

Not legal or tax advice, and not a recommendation for any specific employer. Consult your own counsel.

1 **BLS, Employee Benefits in the United States, March 2025**
89% of full-time vs 25% of part-time workers with access to medical-care benefits.

2 **IRC §§125, 106, 105(b), 213(d)**
The cafeteria-plan funding election and the benefit exclusion chain.

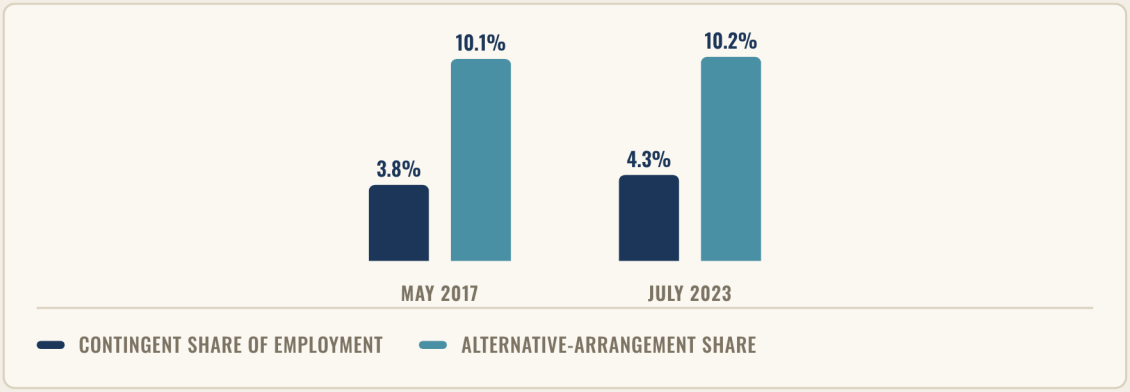
The Optiv Group has a commercial interest in the structures described and publishes this paper; the analysis may not be independent. The carrier is an A-rated, state-licensed insurance carrier and is not named. The benefit is a limited-benefit supplement, not ACA-qualified major-medical coverage.

SECTION 1 · THE WORKFORCE

THE OTHER WORKFORCE, COUNTED

Start with the size of the thing. In its July 2023 Contingent Worker Supplement, the Bureau of Labor Statistics counted 6.9 million workers whose sole or main job was contingent, 4.3 percent of total employment, up from 3.8 percent in 2017. Counted more broadly, workers in alternative arrangements reached about 16.3 million, roughly one in ten of the employed.[3]

FIGURE 1 · THE CONTINGENT SHARE IS RISING



U.S. Bureau of Labor Statistics, Contingent and Alternative Employment Arrangements, July 2023. Percent of total employment.

12.9%
Contingent rate for workers ages 16 to 24, over four times the 3.1% rate for older workers.

40%
Of contingent workers usually work part-time, against 16% of noncontingent workers.

74%
Contingent median weekly earnings as a share of the noncontingent figure.

The composition matters more than the headline. The worker most likely to be contingent is younger, more likely part-time, and paid less for the week, which is to say the worker least equipped to self-fund the coverage an employer does not provide. The same statistics that make this worker least likely to be offered employer coverage make them least able to buy it on the open market in its absence.[4]

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3 **BLS, Contingent and Alternative Employment Arrangements, July 2023**
6.9M contingent (4.3% of employment, up from 3.8%); ~16.3M in alternative arrangements.

4 **Id., tbl. 11**
12.9% contingent rate ages 16 to 24; 40% part-time; median weekly earnings of $838 vs $1,137 (published BLS medians).

THE FLOOR, NOT THE CEILING

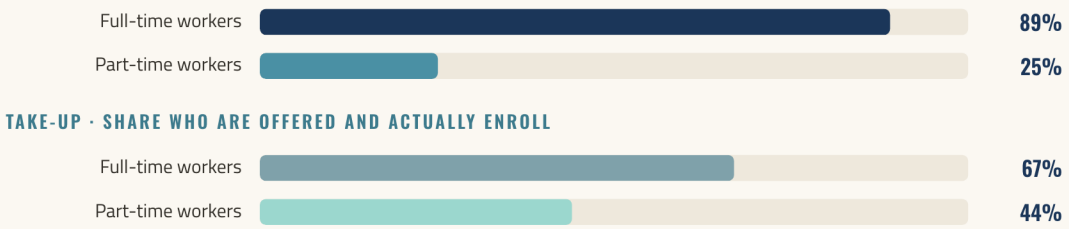
The 6.9 million is the floor of the underserved population. The practical population an employer schedules is wider still.

SECTION 1 · THE COVERAGE GAP

WHERE THE GAP IS WIDEST

The benefit gap follows the same line. The Bureau's data for March 2025 found that 89 percent of full-time civilian workers had access to employer medical-care benefits, while only 25 percent of part-time workers did. For the part-time worker, employer medical coverage is the exception, not the rule.[5]

FIGURE 2 · THE COVERAGE GAP, FULL-TIME VS PART-TIME



U.S. Bureau of Labor Statistics, Employee Benefits in the United States, March 2025. Access and take-up rates for medical-care benefits.

Access is the more generous of the two measures, and it still leaves three in four part-time workers outside. The narrower measure, take-up, widens the gap further: 44 percent of part-time workers who are offered a plan actually enroll, against 67 percent of full-time workers. Multiply a 25 percent access rate by a 44 percent take-up rate and the share of part-time workers genuinely enrolled in employer medical coverage falls into the low double digits.[6]

The exclusion is structural, not incidental. Conventional eligibility is keyed to full-time hours, and these workers are by definition outside that threshold. The screen was reasonable when a clear majority of the workforce was full-time and permanent; as the part-time and contingent share rises, the same screen excludes a larger slice of the people doing the work. The eligibility rule did not change. The workforce moved underneath it.[7]

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5 **BLS, Employee Benefits in the United States, March 2025, tbl. 2**
89% full-time vs 25% part-time access; 87% vs 25% in private industry.

6 **Id.**
Take-up rate of 67% for full-time and 44% for part-time medical-care benefits.

7 **GAO/HEHS-00-76 (2000); GAO-06-656 (2006)**
Contingent workers' incomes and benefits lag the rest of the workforce; a longstanding, structural gap.

ACCESS OVERSTATES COVERAGE

The headline access figure overstates how many part-time workers are genuinely covered.

SECTION 2 · THE STAKES

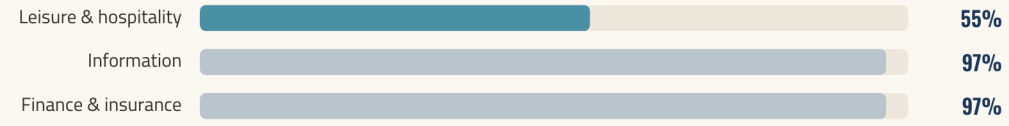
WHAT THE GAP COSTS THE EMPLOYER

An employer can read the coverage gap as a social fact and leave it there. The competitive reading is more useful. Benefits move the hiring decision and the stay-or-go decision, and they move both in measurable ways.

A Randstad US benefits study found that 66 percent of workers regard a strong benefits package as the largest single factor when they weigh a job offer, and 61 percent said they would accept a lower salary in exchange for better benefits. Asked which benefit mattered most, 75 percent named health insurance ahead of every other category.[8] The benefit workers rank first is precisely the one the part-time and contingent workforce is least likely to be offered, so the employer competing for these workers is competing on the dimension where the conventional offer is weakest.

The pressure is not spread evenly. It concentrates in the verticals that run on part-time, variable-hour, and contingent staff: home care, staffing, hospitality, and retail, where turnover is chronic and the benefit offer is thinnest.[9]

FIGURE 3 · PAID SICK LEAVE ACCESS, BY INDUSTRY



U.S. Bureau of Labor Statistics, Employee Benefits in the United States, March 2025. Private-industry workers with access to paid sick leave. Illustrates thin benefit coverage in a named vertical; it is not a health-coverage statistic.

An industry that cannot reliably offer a sick day is not competing on the benefit workers say decides the job. For the employer in one of these verticals, every voluntary departure restarts the cost of recruiting, screening, onboarding, and training a replacement, and the cycle repeats whenever a better-resourced competitor opens a location nearby.[10]

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Sources for this page.

8 **Randstad US employee benefits study (2023)**
66% rank benefits the largest factor; 61% would accept lower salary; 75% name health insurance first.

9 **Id.; BLS industry benefit data**
42% considering leaving over inadequate benefits; 55% have left a job for better benefits.

10 **BLS, Employee Benefits, March 2025; Job Openings and Labor Turnover Survey**
Paid sick leave from 55% in leisure and hospitality to 97% in information and finance; quits concentrated in high-churn sectors.

SECTION 3 · THE CONVENTIONAL ANSWER

WHY THE USUAL TOOLS DO NOT REACH THEM

An employer in one of these verticals has almost certainly tried at least one conventional answer and watched it fall short. The failure is not a matter of effort or good intentions. It is a matter of structure, and naming the structure is what makes the alternative legible.

01 · OFFER IT TO EVERYONE

Even where a part-time worker is offered major medical, fewer than half enroll, because the employee share of the premium is too large a bite out of a smaller paycheck. The plan exists on paper; the workers stay uncovered, and the employer pays the administrative cost of an offer that does not produce coverage.

02 · RAISE THE CONTRIBUTION

Lifting take-up by loading the premium onto the employer's budget works only where the budget can carry it. In thin-margin verticals, a contribution large enough to make major medical affordable for the whole class is one most employers cannot sustain. The result strains the budget without reaching everyone.

03 · RECLASSIFY TO FULL-TIME

Converting variable-hour staff to guaranteed full-time hours clears the eligibility threshold by eliminating the part-time category, which trades a benefits problem for a larger labor-cost and scheduling one. The schedule is variable because demand is variable.

WHAT EACH OF THESE SHARES

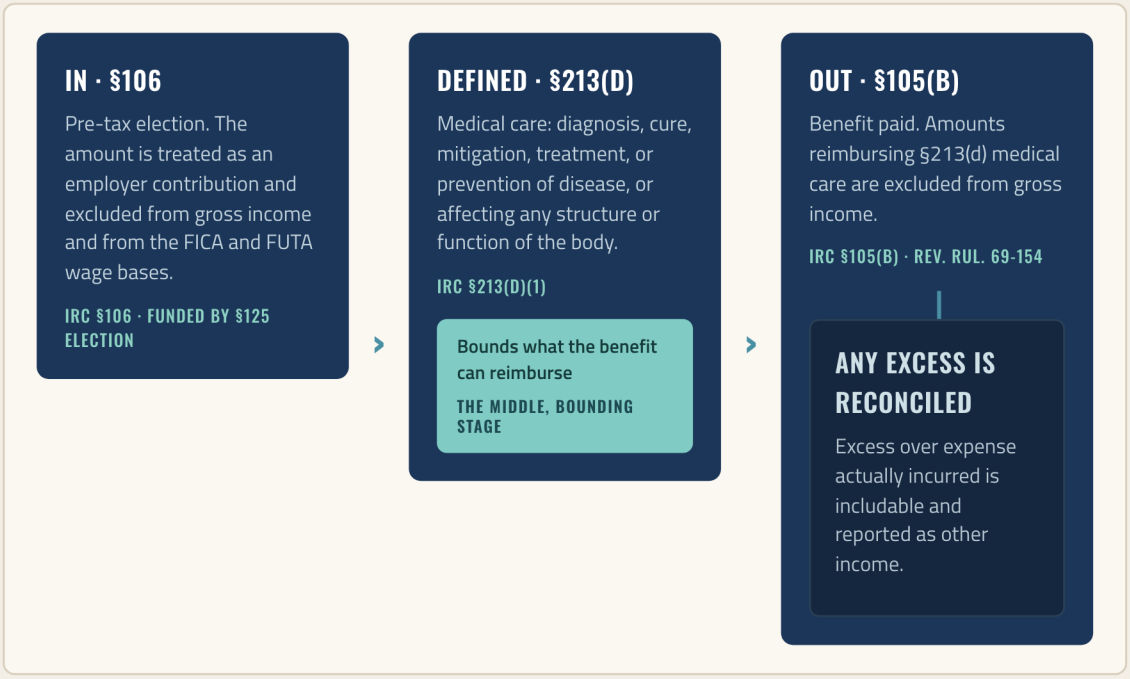
Each tries to force the part-time workforce through a structure built for full-time employees, by persuading them to buy into it, subsidizing their way into it, or redefining them until they fit. None changes the structure itself. The eligibility screen built for a full-time workforce stays in place, and the part-time worker is bought through it, pushed through it, or left outside it. The alternative this paper describes does the opposite: rather than forcing the workforce through a structure built for someone else, it uses a structure that sets its own eligibility terms and is built to reach the workforce as it actually is.

SECTION 4 · THE MECHANISM

HOW A SECTION 125 STRUCTURE REACHES THEM

The reason conventional coverage misses these workers is structural, and so is the solution. A Section 125 cafeteria plan lets participants choose among cash and one or more qualified benefits, and two features of that structure are what let it reach the workers a major-medical offer leaves out.[11]

FIGURE 4 · THE SECTION 125 EXCLUSION CHAIN



IRC §§106, 105(b), 213(d); Treas. Reg. §1.125-1; Rev. Rul. 69-154. Structural, not numeric. No dollar values.

The first feature is the funding pathway. The amount an employee elects pre-tax is treated as an employer contribution, excluded from gross income under Section 106 and from the Social Security, Medicare, and federal unemployment wage bases. Because the elected amount never enters the wage base, it is not subject to the combined 7.65 percent employer payroll tax, which is what makes the structure affordable to offer and to elect.[12]

The second feature is eligibility, and it does the work this paper is about. A Section 125 plan defines its own class of eligible participants, subject to the Code's nondiscrimination rules. It does not inherit the full-time-hours thresholds that screen part-time and variable-hour workers out of conventional coverage. The screen that excludes them from major medical is a feature of the major-medical plan, not a requirement of the Code, and a separate Section 125 structure is free to set a broader one. The benefit then pays on a substantiated Section 213(d) medical event; a design that pays without that tether sits outside the exclusion.[13]

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11 **IRC §125(a), (d); Treas. Reg. §1.125-1**
The only arrangement offering a choice between cash and a nontaxable benefit without making the benefit taxable.

12 **IRC §106; §§3121(a)(5)(G), 3306(b)(5)(G); §§3101, 3111**
Pre-tax election excluded from income and the wage base; 7.65% combined employer FICA and Medicare share.

13 **IRC §105(b); §213(d); Treas. Reg. §1.105-2; Rev. Rul. 69-154**
Eligibility set by the plan within the nondiscrimination rules; benefit tied to a substantiated medical event.

THE DESIGN SETS ITS OWN DOOR

The people left out of conventional coverage can be brought inside a Section 125 design because the design sets its own eligibility terms.

SECTION 5 · THE OFFER

WHAT AN EMPLOYER CAN PUT IN FRONT OF THEM

The structure is only useful if the worker can feel it. The supplemental design built on the Section 125 foundation is meant to be felt at the point of care, not only on the pay stub, and its terms are set to fit the workforce this paper is about.

GUARANTEED ISSUE

No underwriting, no medical exam, no exclusion, so every eligible employee qualifies regardless of health history. Coverage begins without a waiting period, which matters where median tenure is measured in months rather than years.

VIRTUAL & IMMEDIATE CARE

The indemnity benefit is paired with around-the-clock telehealth and a prescription benefit covering 400-plus medications, so a worker who needs a clinician or a refill can reach one the same day rather than choosing between a clinic visit and a shift.

CASH AT THE POINT OF CARE

A fixed indemnity benefit pays a scheduled cash amount when a covered medical event occurs, which the worker can apply to the costs a high-deductible major-medical plan, where one exists at all, leaves exposed.

THE DIVISION OF RESPONSIBILITY

None of this requires the employer to bear medical risk or administer claims. The carrier underwrites and pays, a licensed third-party administrator adjudicates, and the recordkeeping that comes with claims, including any medical information, sits with the carrier program rather than the employer. The employer's role is to offer the structure and to set, within the Code's nondiscrimination limits, the class of employees who may elect it. **Optiv Advantage** is the supplemental design built on this structure, carried by an A-rated, state-licensed insurance carrier that bears the risk and adjudicates claims through a licensed administrator.

ALONGSIDE, NOT INSTEAD OF

The supplemental structure works alongside whatever coverage a worker does or does not already carry. It is a limited-benefit supplement, **not ACA-qualified major-medical coverage**, and it does not require the worker to drop or change existing coverage.

CONCLUSION

THE TIMING IS THE ARGUMENT

The shape of the workforce has moved, and the benefit structures most employers run have not moved with it. The part-time, temporary, and contingent segment is large, it is growing, and the people inside it rank health coverage as the benefit that decides where they work. Conventional major medical misses them by design, through eligibility thresholds built for a full-time workforce that is now a smaller share of the whole.

What is settled here is the mechanism. A Section 125 cafeteria plan funds a supplemental benefit with dollars excluded from the wage base, sets its own class of eligible participants, and pays a benefit on a substantiated medical event through the long-established exclusion chain of Sections 106, 105(b), and 213(d). That structure reaches the workers a major-medical offer cannot, and it does so without putting the employer in the business of bearing risk or holding medical records. The statutory ground under it is not novel or contested; it is the ordinary law of cafeteria plans and accident-and-health benefits, applied to a workforce the conventional offer leaves out.

The practical takeaway is a matter of timing. The employer who extends coverage to the other workforce first competes for those workers on the benefit they care about most, while the employer who waits competes on wages alone against a rival who has already closed the gap. The segment is not shrinking, and the advantage of moving early does not wait for permission.

Solve coverage for the other workforce first, and the next several hiring cycles turn on the opening you created.

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SUPPORTING AUTHORITY

SOURCES AND DISCLOSURES

STATUTE AND REGULATION

Internal Revenue Code §§105(b), 106, 125, 213(d), 3101, 3111, and the Section 125 exclusions at §§3121(a)(5)(G) and 3306(b)(5)(G); Treasury Regulation §§1.125-1, 1.451-2(a), 1.105-2.

IRS GUIDANCE AND RULINGS

Revenue Ruling 69-154, 1969-1 C.B. 46 (excess-benefit rule for fixed indemnity health benefits); IRS Notice 2005-42, 2005-1 C.B. 1204 (cafeteria-plan framework).

GOVERNMENT REPORTS AND DATA

U.S. Bureau of Labor Statistics, Contingent and Alternative Employment Arrangements, July 2023; Employee Benefits in the United States, March 2025; Job Openings and Labor Turnover Survey (quits by industry). U.S. Government Accountability Office, GAO/HEHS-00-76 (2000) and GAO-06-656 (2006).

INDUSTRY RESEARCH

Randstad US, employee benefits study (2023). Third-party survey figures, reported as published; verify independently.

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