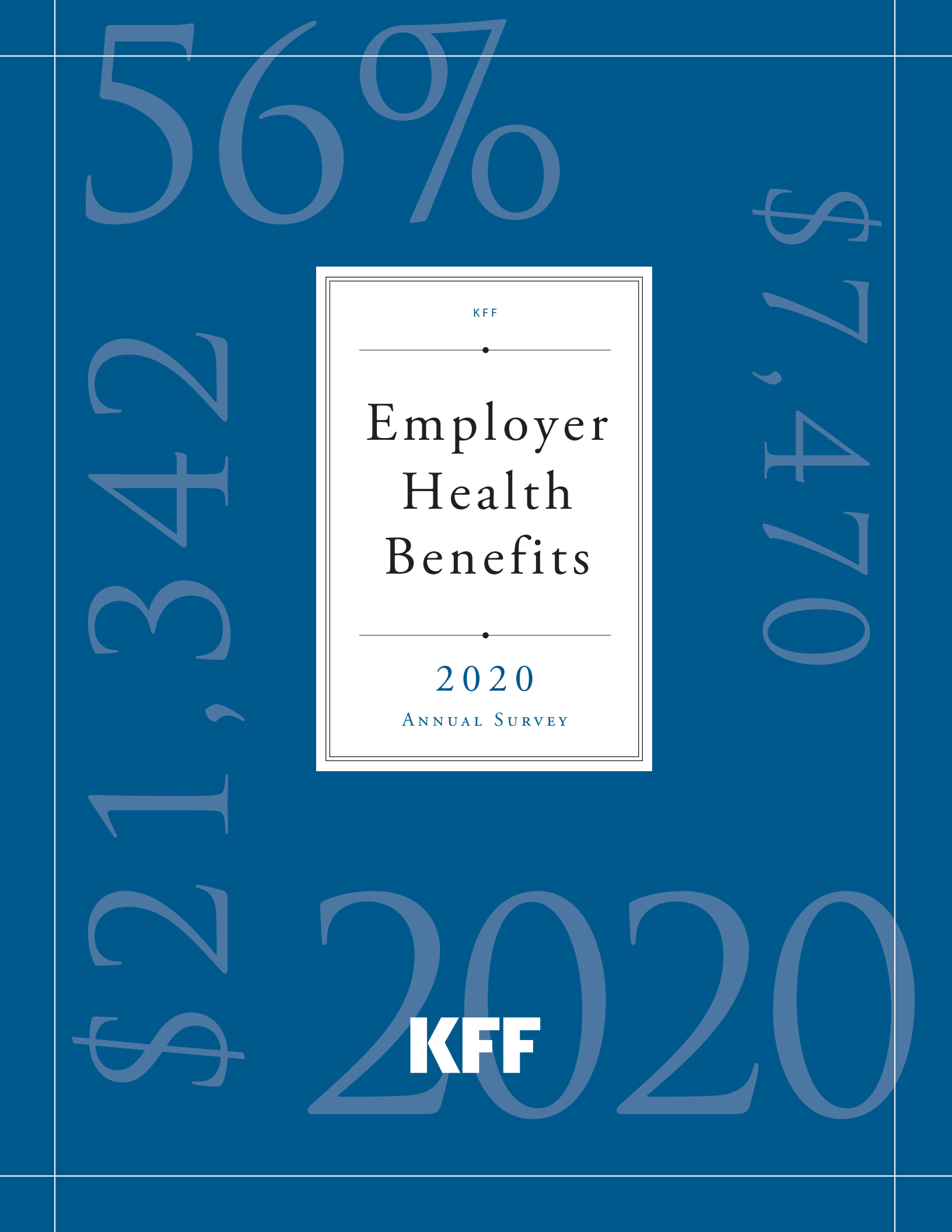
KFF

Employer Health Benefits

2020

Annual Survey



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The authors would like to thank Tricia Neuman (KFF), Karen Pollitz (KFF), and Cynthia Cox (KFF), for their contributions to the instrument. Furthermore we would like to thank Ashley Kirzinger (KFF) for her advice on methodological issues; Steve Paradowski (NORC) for assisting in interviewer training and CATI testing; Larry Levitt (KFF), Nisha Kurani (KFF), and Drew Altman (KFF), for their review. And lastly, Carene Clark (KFF) and Evonne Young (KFF).

Filling the need for trusted information on national health issues, KFF (Kaiser Family Foundation) is a nonprofit organization based in San Francisco, California.

NORC at the University of Chicago is an objective, non-partisan research institution that delivers reliable data and rigorous analysis to guide critical programmatic, business, and policy decisions. Since 1941, NORC has conducted groundbreaking studies, created and applied innovative methods and tools, and advanced principles of scientific integrity and collaboration. Today, government, corporate, and nonprofit clients around the world partner with NORC to transform increasingly complex information into useful knowledge.

Printed in the United States of America.

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ANNUAL SURVEY

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Abstract

This annual survey of employers provides a detailed look at trends in employer-sponsored health coverage, including premiums, employee contributions, cost-sharing provisions, offer rates, wellness programs, and employer practices. The 2020 survey included 1,765 interviews with non-federal public and private firms.

Annual premiums for employer-sponsored family health coverage reached $21,342 this year, up 4% from last year, with workers on average paying $5,588 toward the cost of their coverage. The average deductible among covered workers in a plan with a general annual deductible is $1,644 for single coverage. Fifty-five percent of small firms and 99% of large firms offer health benefits to at least some of their workers, with an overall offer rate of 56%.

Survey results are released in several formats, including a full report with downloadable tables on a variety of topics, a summary of findings, and an article published in the journal *Health Affairs*.

Summary of Findings

Employer-sponsored insurance covers approximately 157 million people.[1] To provide current information about employer-sponsored health benefits, the Kaiser Family Foundation (KFF) conducts an annual survey of private and non-federal public employers with three or more workers. This is the twenty-second Employer Health Benefits Survey (EHBS) and reflects employer-sponsored health benefits in 2020.

The social and economic upheavals resulting from the coronavirus pandemic have certainly impacted employers, workers and employee benefits. The EHBS was fielded between January and late July, which means that a portion of the interviews were conducted before the full impact of the pandemic became apparent, and other interviews were conducted as the implications unfolded; including during the period of significant job loss that occurred during and after March. Many of the metrics we look at, such as premiums, contributions, cost sharing and plan offerings, are determined before plan year begins, so it is likely that responses for those items were largely unaffected by the pandemic. Responses for other items, such as incentives for health screenings or inclusion of coverage for telehealth visits, may have changed during the course of the pandemic: employers for example, may have suspended certain incentives to accommodate employee reluctance to visit provider offices. As such we cannot determine how the pandemic has affected employer responses. Because of the timing of the survey, we were unable to include any direct questions about how employers reacted to the pandemic.

HEALTH INSURANCE PREMIUMS AND WORKER CONTRIBUTIONS

In 2020, the average annual premiums for employer-sponsored health insurance are $7,470 for single coverage and $21,342 for family coverage [Figure A]. The average single premium increased 4% and the average family premium increased 4% over the past year. Workers' wages increased 3.4% and inflation increased 2.1%.[2]

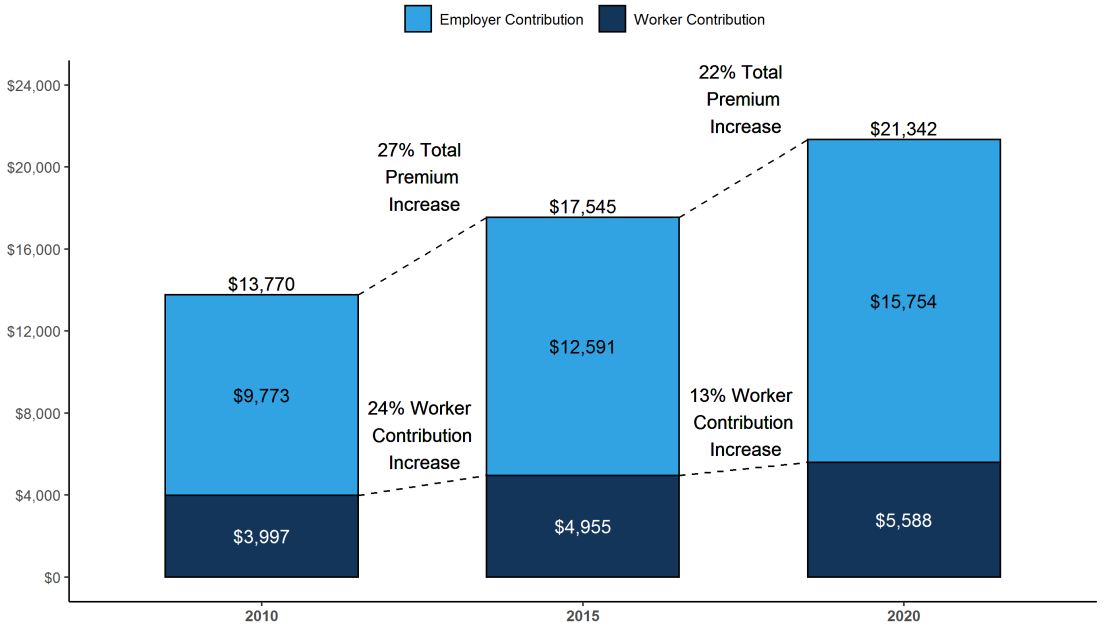
The average premium for family coverage has increased 22% over the last five years and 55% over the last ten years [Figure A].

For covered workers in small firms, the average premium is similar to the average premium in large firms for single coverage ($7,483 vs. $7,466) but is lower than the average premium in large firms for family coverage ($20,438 vs. $21,691). The average premiums for covered workers in HDHP/SOs is lower for single coverage ($6,890) but similar for family coverage ($20,359) to the overall average premiums [Figure B]. Covered workers enrolled in PPOs have higher average premiums for single ($7,880) and family coverage ($22,248) than the overall average premiums. The average premium for family coverage for covered workers in firms with a relatively large share of lower-wage workers (where at least 35% of the workers earn $26,000 annually or less) is lower than the average premium for covered workers in firms with a smaller share of lower-wage workers ($19,332 vs. $21,486).

[1] Kaiser Family Foundation. Health Insurance Coverage of the Total Population [Internet]. KFF (Kaiser Family Foundation). 2019 [cited 2020 Aug 10]. Available from: https://www.kff.org/other/state-indicator/total-population/ Coverage is based on calculations from the 2018 American Community Survey. During the winter and spring of 2020, there was a steep increase in the unemployment rate, potentially decreasing the number of people covered by employer coverage.

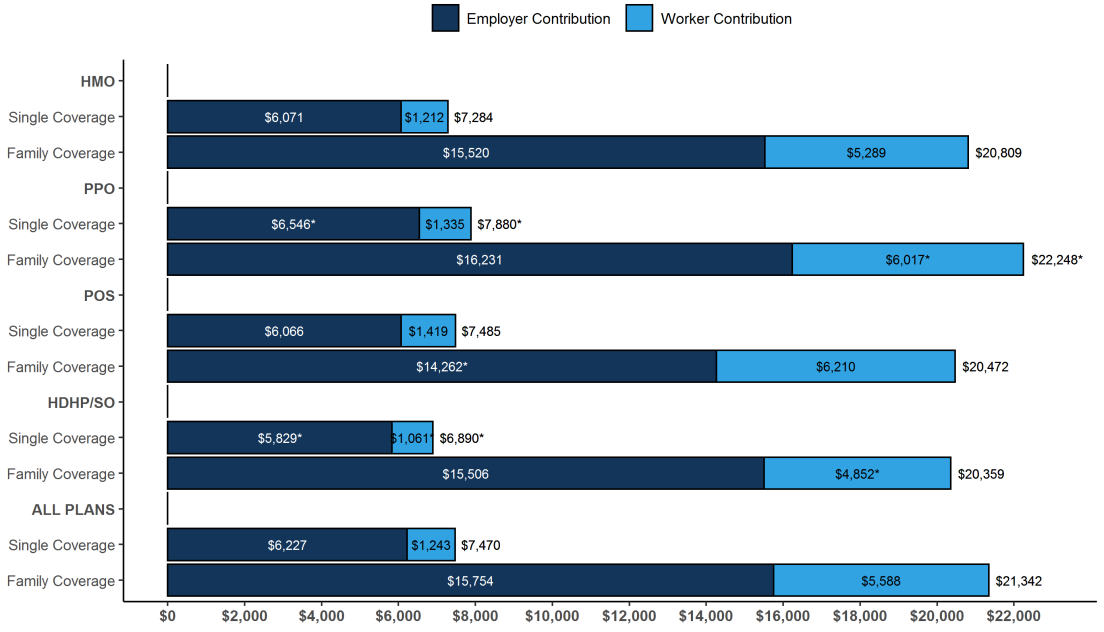
[2] Bureau of Labor Statistics. Consumer Price Index historical tables for, U.S. City Average of Annual Inflation [Internet]. Washington (DC): BLS; [cited 2020 Aug 10]. Available from: https://www.bls.gov/regions/mid-atlantic/data/consumerpriceindexhistorical1967base_us_table.htm AND Bureau of Labor Statistics. Current Employment Statistics—CES (National) [Internet]. Washington (DC): BLS; [cited 2020 Aug 10]. Available from: https://www.bls.gov/ces/publications/highlights/highlights-archive.htm

Figure A
Average Annual Worker and Employer Premium Contributions for Family Coverage, 2010, 2015, and 2020



SOURCE: KFF Employer Health Benefits Survey, 2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2010 and 2015

Figure B
Average Annual Worker and Employer Premium Contributions for Single and Family Coverage, by Plan Type, 2020



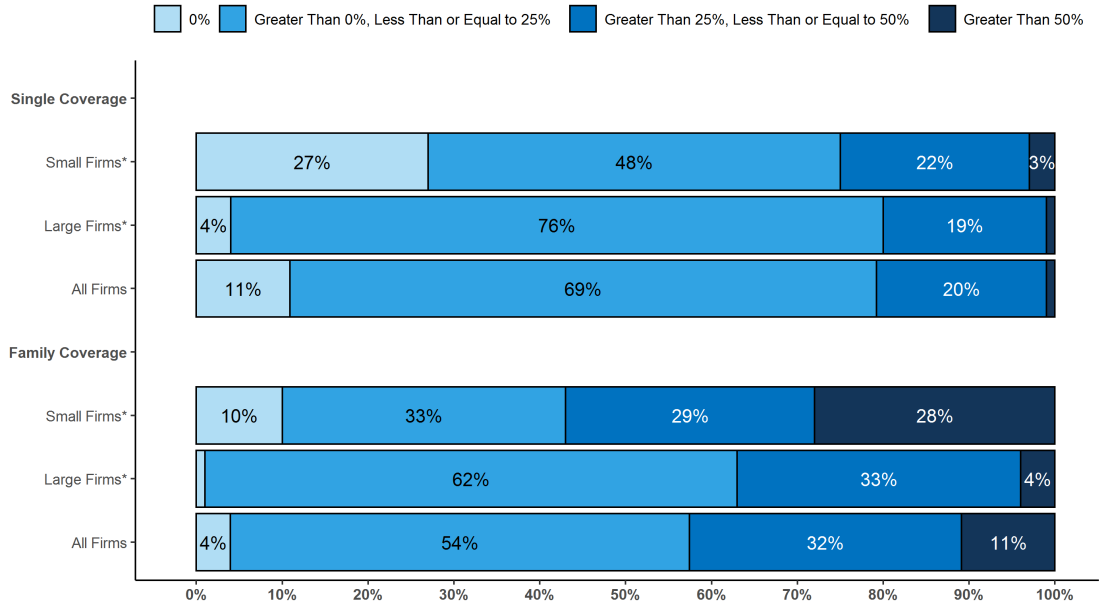
* Estimate is statistically different from All Plans estimate within coverage type ($p < .05$).
SOURCE: KFF Employer Health Benefits Survey, 2020

Most covered workers make a contribution toward the cost of the premium for their coverage. On average, covered workers contribute 17% of the premium for single coverage and 27% of the premium for family coverage. Compared to covered workers in large firms, covered workers in small firms on average contribute a higher percentage of the premium for family coverage (35% vs. 24%). Covered workers in firms with a relatively large share of lower-wage workers have higher average contribution rates for family coverage (38% vs. 26%) than those in firms with a smaller share of lower-wage workers.[3] Covered workers at private for-profit firms on average contribute a higher percentage of the premium for both single and family coverage than covered workers at other firms for both single and family coverage.

Twenty-seven percent of covered workers in small firms are in a plan where the employer pays the entire premium for single coverage, compared to only 4% of covered workers in large firms. In contrast, 28% of covered workers in small firms are in a plan where they must contribute more than one-half of the premium for family coverage, compared to 4% of covered workers in large firms [Figure C].

The average annual dollar amounts contributed by covered workers for 2020 are $1,243 for single coverage and $5,588 for family coverage, similar to the amounts last year. The average dollar contribution for family coverage has increased 13% since 2015 and 40% since 2010 [Figure A]. Average contribution amounts for covered workers in HDHP/SOs are lower than the average overall worker contribution amounts for both single and family coverage [Figure B]. Six percent of covered workers, including 17% of covered workers in small firms, are in a plan with a worker contribution of $12,000 or more for family coverage.

Figure C
Distribution of Percentage of Premium Paid by Covered Workers for Single and Family Coverage, by Firm Size, 2020



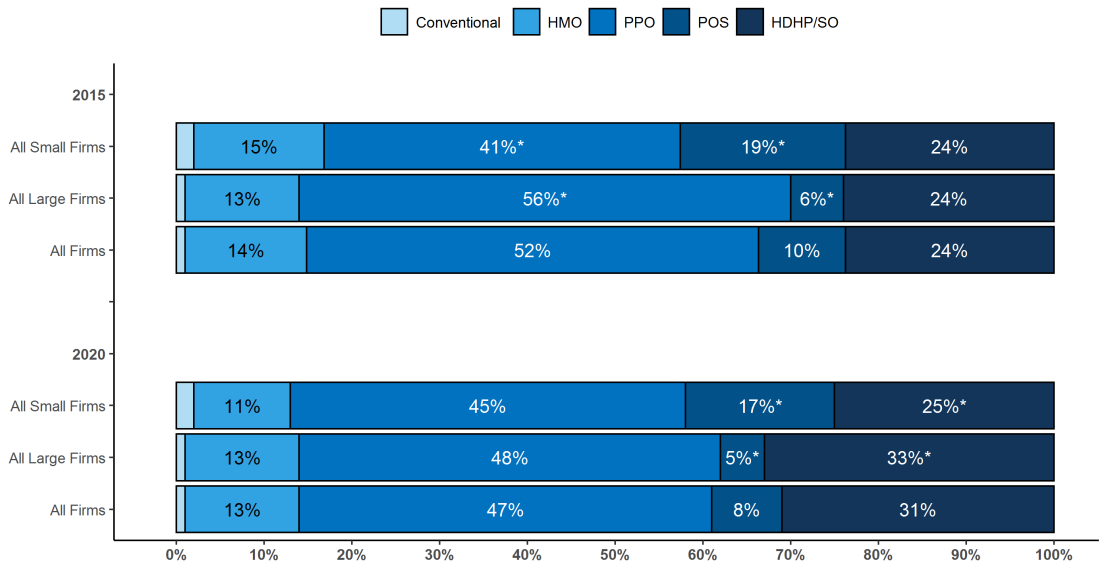
* Distributions are statistically different between Small Firms and Large Firms within coverage type ($p < 0.05$).
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2020

[3]This threshold is based on the twenty-fifth percentile of workers' earnings ($26,000 in 2020). Bureau of Labor Statistics. May 2018 National Occupational Employment and Wage Estimates: United States. Washington (DC): BLS. Available from: http://www.bls.gov/oes/current/oes_nat.htm

PLAN ENROLLMENT

PPOs are the most common plan type, enrolling 47% of covered workers in 2020. Thirty-one percent of covered workers are enrolled in a high-deductible plan with a savings option (HDHP/SO), 13% in an HMO, 8% in a POS plan, and 1% in a conventional (also known as an indemnity) plan [Figure D]. The percentage of covered workers enrolled in HMOs is significantly lower than the percentage last year (13% vs. 19%). This percentage has risen and fallen over the last four years so it is unclear if this trend will continue.

Figure D
Distribution of Health Plan Enrollment for Covered Workers, by Plan Type and Firm Size, 2015 and 2020



* Enrollment in plan type is statistically different between All Small Firms and All Large Firms within year ($p < .05$).
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers. HMO is health maintenance organization. PPO is preferred provider organization. POS is point-of-service plan. HDHP/SO is high-deductible health plan with a savings option, such as a health reimbursement arrangement (HRA) or health savings account (HSA).
SOURCE: KFF Employer Health Benefits Survey, 2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2015

Self-Funding. Sixty-seven percent of covered workers, including 23% of covered workers in small firms and 84% in large firms, are enrolled in plans that are self-funded. The percentage of firms offering health benefits that are self funded in 2020 is higher than the percentage (61%) last year.

Thirteen percent of small firms report that they have a level-funded plan, similar to the percentage last year. These arrangements combine a relatively small self-funded component with stoploss insurance with low attachment points that may transfer a substantial share of the risk to insurers. These arrangements are complex and some small employers may not be entirely certain about the funding status of their plans. Among covered workers in small firms, 31% are in a plan that is either self-funded or told us that their plan was level-funded, higher than the percentage (24%) last year.

EMPLOYEE COST SHARING

Most covered workers must pay a share of the cost when they use health care services. Eighty-three percent of covered workers have a general annual deductible for single coverage that must be met before most services are paid for by the plan.

Among covered workers with a general annual deductible, the average deductible amount for single coverage is $1,644, similar to the average deductible last year. The average deductible for covered workers is higher in small firms than large firms ($2,295 vs. $1,418). The average single coverage annual deductible among covered workers with a deductible has increased 25% over the last five years and 79% over the last ten years.

Deductibles have increased in recent years due to higher deductibles within plan types and higher enrollment in HDHP/SOs. While growing deductibles in PPOs and other plan types generally increase enrollee out-of-pocket liability, the shift to enrollment in HDHP/SOs does not necessarily do so if HDHP/SO enrollees receive an offsetting account contribution from their employers. Ten percent of covered workers in an HDHP with a Health Reimbursement Arrangement (HRA), and 3% of covered workers in a Health Savings Account (HSA)-qualified HDHP receive an account contribution for single coverage at least equal to their deductible, while another 41% of covered workers in an HDHP with an HRA and 19% of covered workers in an HSA-qualified HDHP receive account contributions that, if applied to their deductible, would reduce their actual liability to less than $1,000.

We can look at the increase in the average deductible as well as the growing share of covered workers who have a deductible together by calculating an average deductible among *all* covered workers (assigning a zero to those without a deductible). The 2020 value of $1,364 is 27% higher than the average general annual deductible for single coverage of $1,077 in 2015 and 111% higher than the average general annual deductible of $646 in 2010.

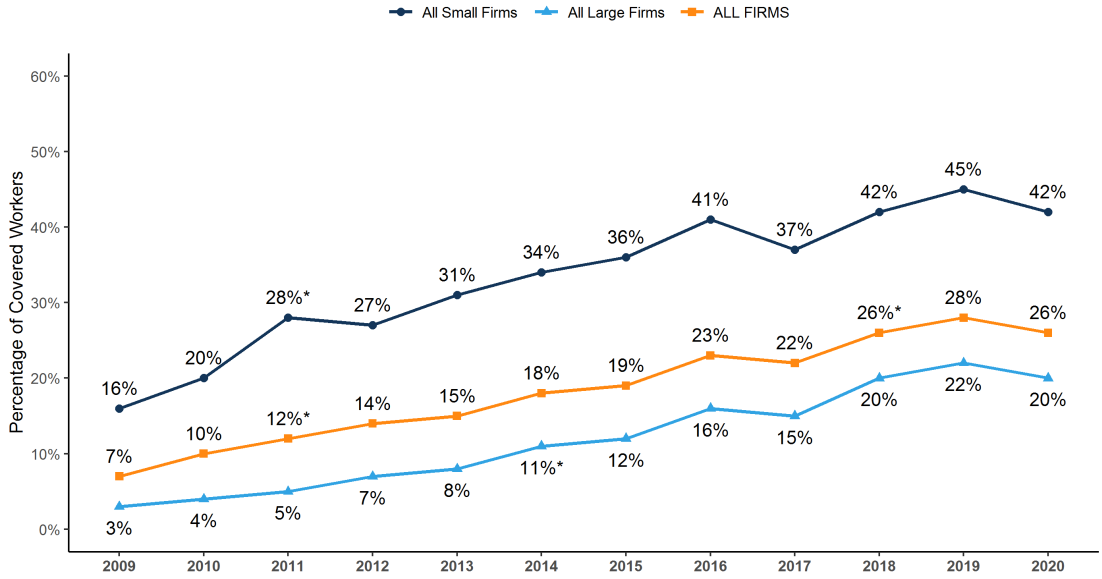
Another way to look at deductibles is the percentage of all covered workers who are in a plan with a deductible that exceeds certain thresholds. Over the past five years, the percentage of covered workers with a general annual deductible of $2,000 or more for single coverage has grown from 19% to 26% [Figure E].

Whether or not a deductible applies, a large share of covered workers also pay a portion of the cost when they visit an in-network physician. Most covered workers face a copayment (a fixed dollar amount) when they visit a doctor, although some workers face coinsurance requirements (a percentage of the covered amount). The average copayments are $26 for primary care and $42 for specialty care. The average coinsurance rates are 18% for primary care and 19% for specialty care. These amounts are similar to those in 2019.

Most workers also face additional cost sharing for a hospital admission or outpatient surgery. Sixty-five percent of covered workers have coinsurance and 13% have a copayment for hospital admissions. The average coinsurance rate for a hospital admission is 20% and the average copayment is $311 per hospital admission. The cost-sharing provisions for outpatient surgery follow a similar pattern to those for hospital admissions.

Virtually all covered workers are in plans with a limit on in-network cost sharing (called an out-of-pocket maximum) for single coverage, though the limits vary significantly. Among covered workers in plans with an out-of-pocket maximum for single coverage, 11% are in a plan with an out-of-pocket maximum of less than $2,000, while 18% are in a plan with an out-of-pocket maximum of $6,000 or more.

Figure E
Percentage of Covered Workers Enrolled in a Plan with a General Annual Deductible of $2,000 or More for Single Coverage, by Firm Size, 2009-2020



* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers. These estimates include workers enrolled in HDHP/SOs and other plan types. Average general annual deductibles are for in-network providers.
SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2009-2017

AVAILABILITY OF EMPLOYER-SPONSORED COVERAGE

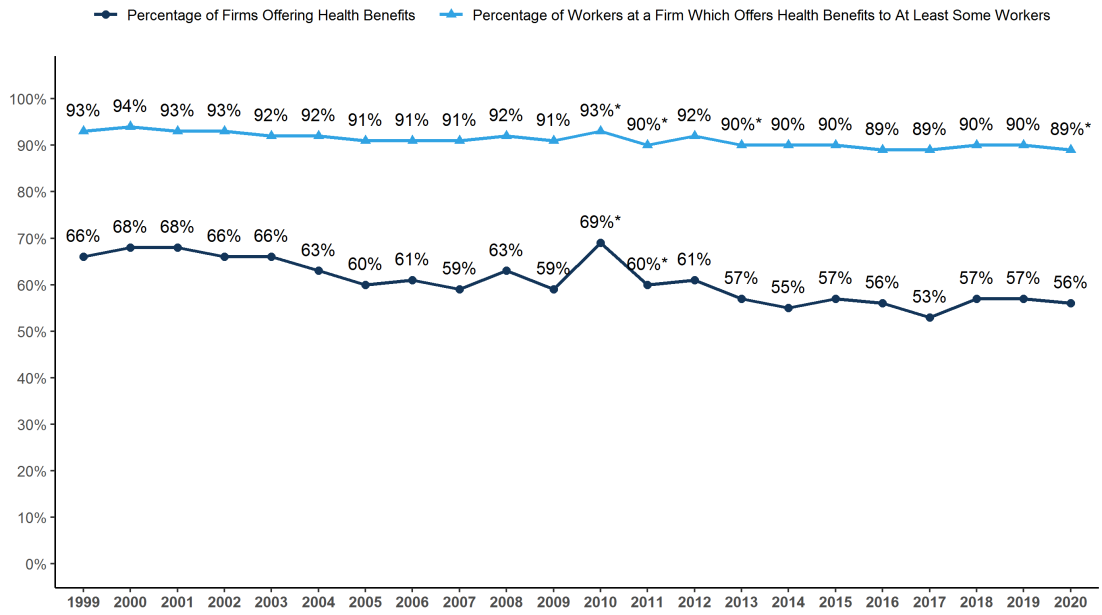
Fifty-six percent of firms offer health benefits to at least some of their workers, similar to the percentage last year [Figure F]. The likelihood of offering health benefits differs significantly by firm size; only 48% of firms with 3 to 9 workers offer coverage, while virtually all firms with 1,000 or more workers offer coverage.

While the vast majority of firms are small, most workers work for large firms that offer coverage. In 2020, 89% of workers are employed by a firm that offers health benefits to at least some of its workers [Figure F].

Although the vast majority of workers are employed by firms that offer health benefits, many workers are not covered at their job. Some are not eligible to enroll (e.g., waiting periods or part-time or temporary work status) and others who are eligible choose not to enroll (e.g., they feel the coverage is too expensive or they are covered through another source). In firms that offer coverage, 82% of workers are eligible for the health benefits offered, and of those eligible, 78% take up the firm's offer, resulting in 64% of workers in offering firms enrolling in coverage through their employer. All of these percentages are similar to 2019.

Looking at workers in both firms that offer and firms that do not offer health benefits, 57% of workers are covered by health plans offered by their employer, similar to the percentage last year.

Figure F
Percentage of Firms and Workers at Firms that Offer Health Benefits, 1999-2020



* Estimate is statistically different from estimate for the previous year shown (p < .05).
NOTE: As noted in the Survey Design and Methods section, estimates are based on the sample of both firms that completed the entire survey and those that answered just one question about whether they offer health benefits.
SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

HEALTH AND WELLNESS PROGRAMS

Most large firms and many small firms have programs that help workers identify health issues and manage chronic conditions, including health risk assessments, biometric screenings, and health promotion programs.

Health Risk Assessments. Among firms offering health benefits, 42% of small firms and 60% of large firms provide workers the opportunity to complete a health risk assessment [Figure G]. A health risk assessment includes questions about a person's medical history, health status, and lifestyle. Fifty-two percent of large firms with a health risk assessment program offer an incentive to encourage workers to complete the assessment. Incentives may include: gift cards, merchandise or similar rewards; lower premium contributions or cost sharing; and financial rewards, such as cash, contributions to health-related savings accounts, or avoiding a payroll fee.

Biometric Screenings. Among firms offering health benefits, 33% of small firms and 50% of large firms provide workers the opportunity to complete a biometric screening. A biometric screening is an in-person health examination that measures a person's risk factors, such as body mass index (BMI), cholesterol, blood pressure, stress, and nutrition. Sixty-five percent of large firms with biometric screening programs offer workers an incentive to complete the screening.

Additionally, among large firms with biometric screening programs, 18% reward or penalize workers based on achieving specified biometric outcomes (such as meeting a target BMI). The size of these incentives varies considerably: among large firms offering a reward or penalty for meeting biometric outcomes, the maximum reward is valued at $150 or less in 12% of firms and more than $1,000 in 32% of firms.

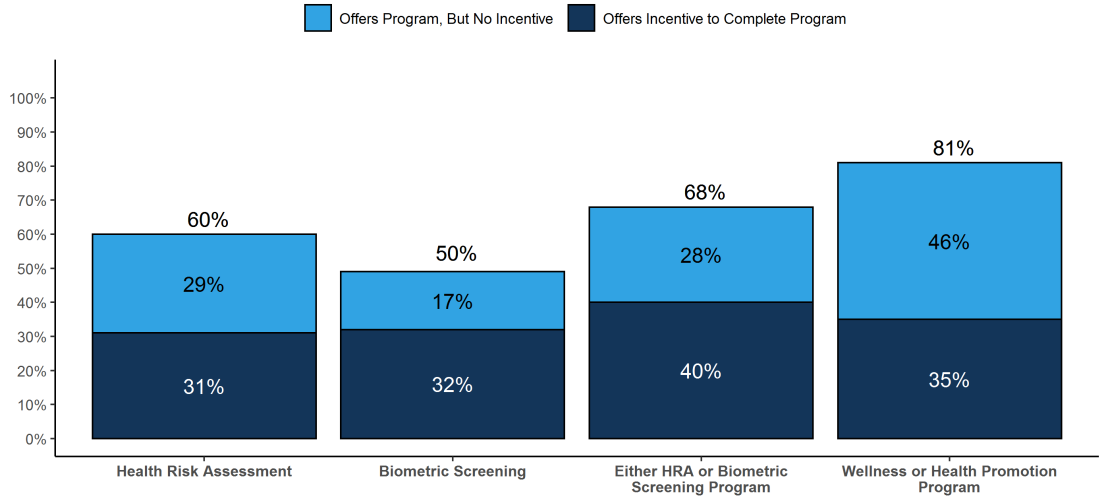
Effectiveness of Incentives. This year we asked large firms with an incentive to participate in a health promotion or health screening program, how effective they believed these incentives were at increasing employee participation. 30% believed incentives were 'very effective' and 47% believed they were 'moderately effective'.

Health and Wellness Promotion Programs. Most firms offering health benefits offer programs to help workers identify and address health risks and unhealthy behaviors. Fifty-three percent of small firms and 81% of large firms offer a program in at least one of these areas: smoking cessation, weight management, and behavioral or lifestyle coaching. Among large firms offering at least one of these programs, 44% offer workers an incentive to participate in or complete the program [Figure G].

As health screenings and wellness programs have become more complex, incentives have become more sophisticated and may involve participating in or meeting goals in different programs. We asked firms that had incentives for any of these programs to estimate the maximum incentive for a worker across all of their screening and promotion programs combined. Among large firms with any type of incentive, 20% have a maximum incentive of $150 or less, while 20% have a maximum incentive of more than $1,000.

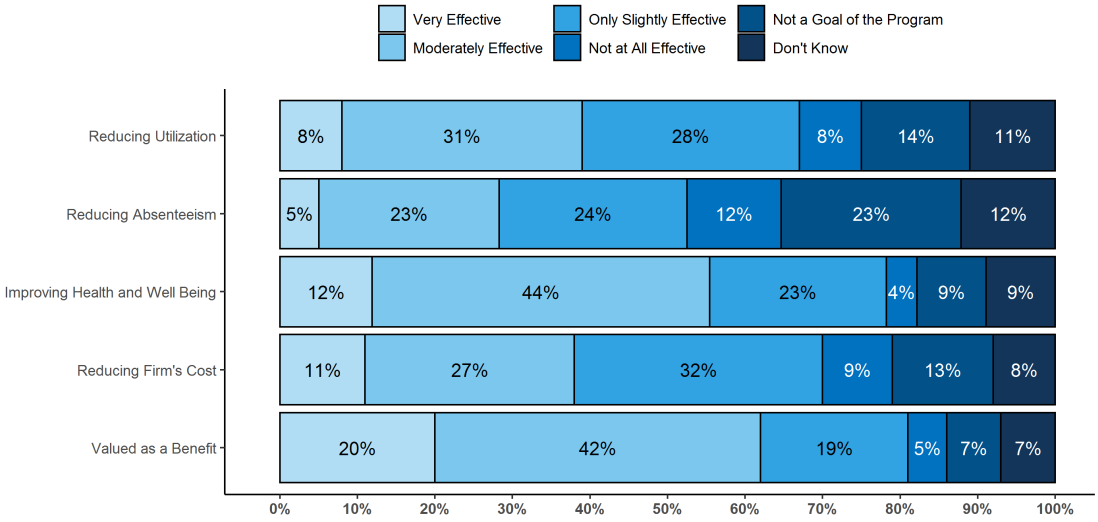
Effectiveness of Programs. Firms may have a variety of objectives for offering health screening and health promotion programs, including improving the health and wellbeing of enrollees, reducing absences from work, and reducing costs. Firms generally responded that their programs were effective to some degree in meeting certain specified objectives, although there were many who responded that they did not know [Figure H].

Figure G
Among Large Firms Offering Health Benefits, Percentage With Health Screening or Wellness or Health Promotion Programs, 2020



NOTE: A health risk assessment or appraisal includes questions on medical history, health status, and lifestyle and is designed to identify the health risks of the person being assessed. Biometric screening is a health examination that measures a person's risk factors for certain medical issues. Biometric outcomes could include meeting a target body mass index (BMI) or cholesterol level, but not goals related to smoking. Wellness programs include programs to help employees lose weight, lifestyle or behavioral coaching or tobacco cessation programs. Among large firms offering health benefits, 87% have a health screening or wellness and/or health promotion program and 47% have an incentive to participate in at least one program. Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2020

Figure H
Among Large Firms Offering Health Benefits and a Wellness or Health Screening Programs, Firms Opinion of How Effective Programs are at Meeting Various Goals, 2020



NOTE: A health risk assessment or appraisal includes questions on medical history, health status, and lifestyle and is designed to identify the health risks of the person being assessed. Biometric screening is a health examination that measures a person's risk factors for certain medical issues. Biometric outcomes could include meeting a target body mass index (BMI) or cholesterol level, but not goals related to smoking. Wellness programs include programs to help employees lose weight, lifestyle or behavioral coaching or tobacco cessation programs. Among large firms offering health benefits, 87% have a health screening or wellness and/or health promotion program. Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2020

SITES OF CARE

Telemedicine. Telemedicine is the delivery of health care services through telecommunications to a patient from a provider who is at a remote location, including video chat and remote monitoring. In 2020, 85% of firms with 50 or more workers offering health benefits cover the provision of health care services through telemedicine in their largest health plan, higher than the percentage last year. Offering firms with 5,000 or more workers are more likely to cover services provided through telemedicine than smaller firms.

Over the past year, there was a significant increase in the percentage of firms, particularly smaller firms (50-199 workers), reporting that they cover some services through telemedicine. While telemedicine has grown in recent years, it is possible that some of the growth this year reflects changes in response to the coronavirus pandemic as well as to an increased awareness. It will be important to watch if this heightened focus on access to care through telemedicine continues or abates as concerns about the coronavirus recede.

Retail Health Clinics. Seventy-six percent of large firms offering health benefits cover health care services received in retail clinics, such as those located in pharmacies, supermarkets and retail stores, in their largest health plan. These clinics are often staffed by nurse practitioners or physician assistants and treat minor illnesses and provide preventive services.

PROVIDER NETWORKS

Firms and health plans can structure their networks of providers and their cost sharing to encourage enrollees to use providers who charge lower costs and/or who provide better care. This involves assuring that there are a

sufficient number of providers to assure reasonable access while also limiting the network to those that deliver good quality and cost-effective care.

Satisfaction with Network Choices. Among employers offering health benefits, 45% of firms report being 'very satisfied' and 38% report being 'satisfied' by the choice of provider networks available to them [Figure I]. They are somewhat less satisfied with the cost of the provider networks available to them. Only 22% of these firms report being 'very satisfied' while 39% report being 'satisfied' with the cost of provider networks available. Small firms are more likely than large firms to be 'very dissatisfied' with the cost of the provider networks available.

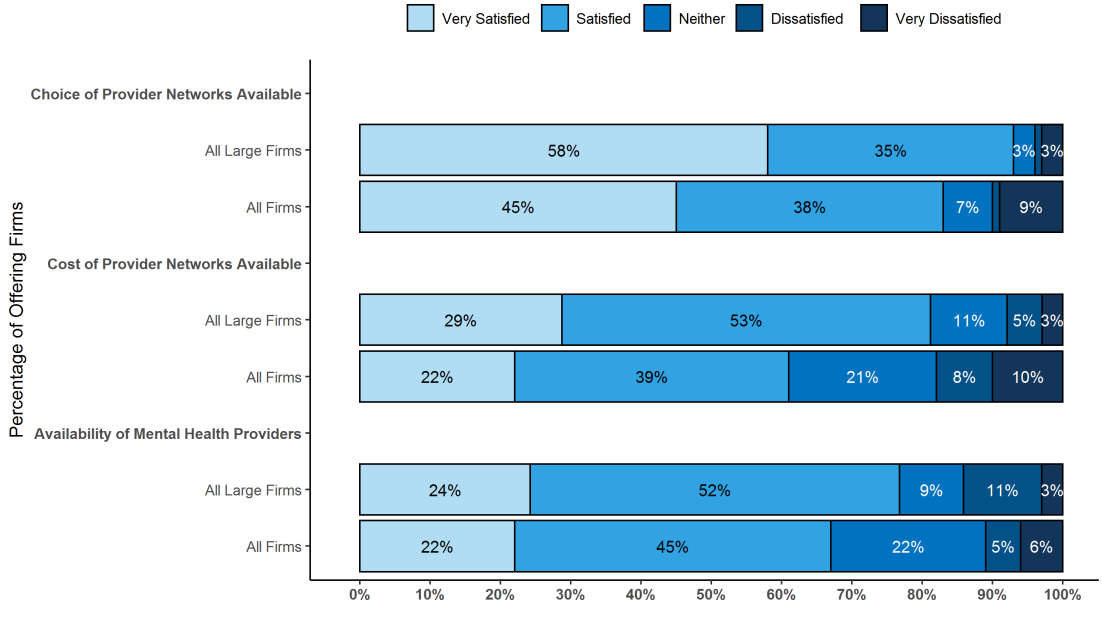
Breadth of Provider Networks. Employers offering health benefits were asked to characterize the breadth of the provider network in their plan with the largest enrollment. Fifty-one percent of firms say that the network in the plan with the largest enrollment is 'very broad', 42% say it is 'somewhat broad', and 6% say it is 'somewhat narrow'.

Seven percent of firms offering health benefits report that they offer at least one plan that they considered to be a narrow network plan, similar to the percentage last year. Firms with 5,000 or more workers were more likely to offer a narrow network plan than smaller firms.

Breadth of Provider Networks for Mental Health. Employers offering health benefits were also asked to characterize the breadth of the network for mental health and substance abuse providers in their plan with the largest enrollment. Thirty-five percent of firms say that the network for mental health and substance abuse in the plan with the largest enrollment is 'very broad', 46% say it is 'somewhat broad', 15% say it is 'somewhat narrow', and 4% say it is 'very narrow'.

Only about one-in-five (22%) employers offering health benefits report being very satisfied with the availability of mental health providers in their provider networks. Among employers offering health benefits, 15% of employers with 1,000 to 4,999 employees and 23% of employers with 5,000 or more employees asked their insurer or third party administrator to increase access to in-network mental health and substance abuse providers.

Figure I
Among Firms Offering Health Benefits, Satisfaction with Provider Networks Available from Insurer or Third Party Administrator, by Firm Size, 2020



NOTE: Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2020

COST SHARING FOR PEOPLE WITH CHRONIC CONDITIONS

Among employers with 200 or more employees offering health benefits, 21% say that their health plan with the largest enrollment waives cost-sharing for some medications or supplies to encourage employees with chronic illnesses to follow their treatment. This likelihood increases with firm size.

Recent changes in federal rules expanded the number and types of items and services that may be considered preventive by HSA-qualified health plans, allowing plan sponsors to pay for part or all of these services before enrollees meet the plan deductibles. Among employers with 200 or more employees offering an HSA-qualified health plan, 29% say that they changed the services or products that individuals with chronic conditions could receive without first meeting their deductibles. Firms with 5,000 or more employees (48%) are more likely to say they changed the services or products available before the deductible is met.

DISCUSSION

Looking at the metrics we usually consider, such as premiums, contributions, cost sharing, offer and coverage rates, we would conclude that the marketplace for employer-based health coverage had another stable year in 2020. Premium increases were modest and consistent with recent years, contributions and cost sharing largely did not change, nor did the shares of workers offered coverage or covered at their jobs. There is a meaningful increase in the share of workers in self-funded plans, which will be important to understand if the higher level persists. We will include additional questions in the 2021 survey to explore why employers are taking this option.

Of course the economic and social changes caused by the coronavirus pandemic have dramatically changed the employment landscape across the nation. Unprecedented job loss combined with shelter-at-home requirements and continuing delays in reopening of workplaces and schools are challenging employers and workers in many ways, including health benefits. There are questions, for example, about the continued availability of coverage for furloughed workers, the share of laid-off workers who are electing COBRA continuation coverage, and changes being made to employee assistance programs and health benefit plans to support workers with the emotional, social and financial stresses. As noted above, however, because the survey was fielded as the pandemic unfolded, we are not yet in a position to address how employers responded to the pandemic. Most of the metrics discussed above are fixed at the beginning of the plan year and may not reflect current circumstances. Some other responses may have been affected by the unfolding of the pandemic.

While we observed a relatively modest change in premiums in 2020, this does not capture the pandemic's turbulent impacts on health care costs this year. During the spring, employers and plans saw lower health care utilization and correspondingly lower spending. With enrollees skipping some care, insurers reported lower than predicted cost through the first half of the year. As stay-at-home orders have lifted, health care utilization has again started picking up. Spending in 2021 remains uncertain as employers and insurers continue to adapt to an evolving situation. We do not know how the reduced use of care earlier this year will affect future costs and premiums: in some cases the need for care will have passed but in others the care will just have been deferred. Missed preventive and diagnostic care may also lead to worsening health and higher costs in the future. Beyond any potential pent-up demand, employer-based plans may face higher costs due to new COVID-19 tests, treatments and vaccines. Conversely, we have witnessed a dramatic economic slowdown which may lead to reduced utilization, offsetting some cost on plans.

For a year that started with historically low levels of unemployment, 2020 saw a stark increase in the unemployment rate. A less competitive job market and the economic slowdown may reduce pressure on employers to offer competitive benefit packages in the coming year. We largely reported similar average cost-sharing amounts to 2019 but some employers may be considering reducing plan generosity depending on how the economic crisis unfolds.

The challenge for the 2021 survey will be to understand how employers are responding to the pandemic and accompanying economic fallout while still maintaining the core questions and purpose of the survey. We do not know how long the pandemic will last nor what the longer term economic consequences will be, but we can ask

employers about how this uncertainty affected their benefit plan decisions, what types of benefits they added and/or changed, whether they saw changes in how employees used their benefits, and whether they expect any changes to be more permanent. We also expect to ask how the disruption and uncertainty caused by the pandemic affected employer decisions about changing their plans or shopping for new vendors. The pandemic has already affected many employer benefits, and will continue to shape their decision-making as they anticipate new workplace accommodations, changes in premiums and the direct cost of the pandemic.

METHODOLOGY

The Kaiser Family Foundation 2020 Employer Health Benefits Survey reports findings from a telephone survey of 1,765 randomly selected non-federal public and private employers with three or more workers. Researchers at NORC at the University of Chicago and the Kaiser Family Foundation designed and analyzed the survey. Davis Research , LLC conducted the fieldwork between January and July 2020. In 2020, the overall response rate is 22%, which includes firms that offer and do not offer health benefits. Among firms that offer health benefits, the survey's response rate is 22%. Unless otherwise noted, differences referred to in the text and figures use the 0.05 confidence level as the threshold for significance. Small firms have 3-199 workers. Values below 3% are not shown on graphical figures to improve the readability of those graphs. Some distributions may not sum due to rounding. For the first time since 1999, we contracted with a new data collection firm to conduct the survey. For more information on potential 'house effects' resulting from this change, as well as information on changes to our weighting methodology and measurements of workers' wage and inflation see the Survey Design and Methods section.

For more information on the survey methodology, please visit the Survey Design and Methods section at http://ehbs.kff.org/.

Filling the need for trusted information on national health issues, the Kaiser Family Foundation is a nonprofit organization based in San Francisco, California.

56%

$21,342

$7,047

2020

Employer Health Benefits

2020 Annual Survey

Survey Design and Methods

Survey Design and Methods

The Kaiser Family Foundation (KFF) has conducted this annual survey of employer-sponsored health benefits since 1999. KFF works with NORC at the University of Chicago (NORC) and Davis Research LLC (Davis) to field and analyze the survey. From January to July 2020, Davis completed computer-assisted telephone interviews with business owners as well as human resource and benefits managers at 1,765 firms.

SURVEY TOPICS

The survey includes questions on the cost of health insurance, health benefit offer rates, coverage, eligibility, plan type enrollment, premium contributions, employee cost sharing, prescription drug benefits, retiree health benefits, and wellness benefits.

Firms that offer health benefits are asked about the plan attributes of their largest health maintenance organization (HMO), preferred provider organization (PPO), point-of-service (POS) plan, and high-deductible health plan with a savings option (HDHP/SO).[4] We treat exclusive provider organizations (EPOs) and HMOs as one plan type and conventional (or indemnity) plans as PPOs. The survey defines an HMO as a plan that does not cover nonemergency out-of-network services. POS plans use a primary care gatekeeper to screen for specialist and hospital visits. HDHP/SOs were defined as plans with a deductible of at least $1,000 for single coverage and $2,000 for family coverage and that either offer a health reimbursement arrangement (HRA) or are eligible for a health savings account (HSA).

Throughout this report, we use the term "in-network" to refer to services received from a preferred provider. Definitions of the health plan types are available in Section 4, and a detailed explanation of the HDHP/SO plan type is in Section 8.

To reduce survey burden, some questions on worker cost sharing for stoploss coverage, hospitalization, outpatient surgery and prescription drugs were only asked about the firm's largest plan type.

Firms with 50 or more workers were asked: "Does your firm offer health benefits for current employees through a private or corporate exchange?" Employers were still asked for plan information about their HMO, PPO, POS and HDHP/SO plan regardless of whether they purchased health benefits through a private exchange or not.

Firms are asked about the attributes of their current plans during the interview. While the survey's fielding period begins in January, many respondents may have a plan whose 2020 plan year lags behind the calendar year [Figure M.1]. In some cases, plans may report the attributes of their 2019 plans and some plan attributes (such as HSA deductible limits) may not meet the calendar year regulatory requirements.

[4] HDHP/SO includes high-deductible health plans with a deductible of at least $1,000 for single coverage and $2,000 for family coverage and that offer either a Health Reimbursement Arrangement (HRA) or a Health Savings Account (HSA). Although HRAs can be offered along with a health plan that is not an HDHP, the survey collected information only on HRAs that are offered along with HDHPs. For specific definitions of HDHPs, HRAs, and HSAs, see the introduction to Section 8.

Figure M.1

Among Firms Offering Health Benefits, Month in Which Plan Year Begins, 2020

	Percentage of Covered Workers	Percentage of Firms
January	74%	46%
February	<1	2
March	1	6
April	2	3
May	1	3
June	2	5
July	7	4
August	1	3
September	2	3
October	3	7
November	2	5
December	4%	13%

SOURCE: KFF Employer Health Benefits Survey, 2020

The Affordable Care Act (ACA) exempts certain health plans that were in effect when the law was passed, referred to as grandfathered plans, from some standards in the law, including the requirement to cover preventive services without cost sharing, have an external appeals process, or comply with the new benefit and rating provisions in the small group market. In 2020, 16% of firms offering health benefits offer at least one grandfathered health plan, and 14% of covered workers are enrolled in a grandfathered plan.

SAMPLE DESIGN

The sample for the annual Kaiser Employer Health Benefits Survey includes private firms and nonfederal government employers with three or more employees. The universe is defined by the U.S. Census' 2016 Statistics of U.S. Businesses (SUSB) for private firms and the 2017 Census of Governments (COG) for non-federal public employers. At the time of the sample design (December 2019), these data represented the most current information on the number of public and private firms nationwide with three or more workers. As in the past, the post-stratification is based on the most up-to-date Census data available (the 2017 SUSB). We determine the sample size based on the number of firms needed to ensure a target number of completes in six size categories.

We attempted to repeat interviews with prior years' survey respondents (with at least ten employees) who participated in either the 2018 or the 2019 survey, or both. Firms with 3-9 employees are not included in the panel to minimize the potential of panel effects. As a result, 1,235 of the 1,765 firms that completed the full survey also participated in either the 2018 or 2019 surveys, or both. In total, 243 firms participated in 2018, 169 firms participated in 2019, and 823 firms participated in both 2018 and 2019. Non-panel firms are randomly selected within size and industry groups.

Since 2010, the sample has been drawn from a Dynata list (based on a census assembled by Dun and Bradstreet) of the nation's private employers and the COG for public employers. To increase precision, we stratified the sample by ten industry categories and six size categories. The federal government and business with fewer than three employees are not included. Education is a separate category for the purposes of sampling, and included in Service category for weighting. For information on changes to the sampling methods over time, please consult

the Survey Design and Methods Sections of prior Employer Health Benefits Surveys as well as extended methods at http://ehbs.kff.org/

Each year, we conduct a series of checks on our instrument to confirm the accuracy of data collection, including test interviews prior to the official launch. Beginning in 2019, we included firms with at least ten employees that had completed a pre-test during the prior year in the current year's sample. Starting in 2020, we included firms completing a pre-test during either of the two prior surveys. Firms eligible to complete pre-testing had been sampled from the same two universe datasets as the main non-panel sample, differing only by when they made contact with the interview team. We expect to continue including these firms completing an interview during the pre-testing phase of our survey, and believe they will improve our response rate without adding any bias to our data collection effort.

RESPONSE RATE

Response rates are calculated using a CASRO method, which accounts for firms that are determined to be ineligible in its calculation. The overall response rate is 22% [Figure M.2].[5] The response rate for panel firms is higher than the response rate for non-panel firms. Similar to other employer and household surveys, the Employer Health Benefits Survey has seen a general decrease in response rates over time. Since 2017, we have attempted to increase the number of completes by increasing the number of non-panel firms in the sample. While this generally increases the precision of estimates by ensuring a sufficient number of respondents in various sub-groups, it has the effect of reducing the overall response rate.

The vast majority of questions are asked only of firms that offer health benefits. A total of 1,418 of the 1,765 responding firms indicated they offered health benefits. This year we have a smaller number of completes than in previous years (247 fewer respondents). The decrease may be attributed to a combination of factors including changing data collection firms, disruptions from the COVID-19 pandemic and starting the fielding period later into January.

We asked one question of all firms in the study with which we made phone contact but where the firm declined to participate: "Does your company offer a health insurance program as a benefit to any of your employees?". A total of 3,582 firms responded to this question (including 1,765 who responded to the full survey and 1,817 who responded to this one question). These responses are included in our estimates of the percentage of firms offering health benefits.[6] The response rate for this question is 46% [Figure M.2].

Figure M.2

Response Rates for Various Subsets of the Sample, 2020

	Response Rate for Full Survey	Response Rate for Firms Answering A6
Small Firms (3-9 Workers)	19%	44%
Small Firms (3-199 Workers)	26%	51%
Large Firms (200 or More Workers)	20%	41%
Panel Firms (Completed Survey in at Least One of the Past Two Years)	51%	74%
Non Panel Firms	11%	36%
ALL FIRMS	**22%**	**46%**

SOURCE: KFF Employer Health Benefits Survey, 2020

[5] Response rate estimates are calculated by dividing the number of completes over the number of refusals and the fraction of the firms with unknown eligibility to participate estimated to be eligible. Firms determined to be ineligible to complete the survey are not included in the response rate calculation.

[6] Estimates presented in [Figure 2.1], [Figure 2.2], [Figure 2.3], [Figure 2.4], [Figure 2.5], and [Figure 2.6] are based on the sample of both firms that completed the entire survey and those that answered just one question about whether they offer health benefits.

While response rates have decreased, elements of the survey design limit the potential impact of a response bias. First, most major statistics are weighted by the percentage of covered workers at a firm. The percentage of the population whose employers completed the full survey has not decreased with response rates. The most important statistic that is weighted by the number of employers is the offer rate; firms that do not complete the full survey are asked whether their firm offers health benefits to any employees. As noted this question relies on a wider set of respondents than just those completing the full survey.

FIRM SIZES AND KEY DEFINITIONS

Throughout the report, we report data by size of firm, region, and industry. Unless otherwise specified, firm size definitions are as follows: small firms: 3-199 workers; and large firms: 200 or more workers. [Figure M.3] shows selected characteristics of the survey sample. A firm's primary industry classification is determined from Dynata's designation on the sampling frame and is based on the U.S. Census Bureau's North American Industry Classification System (NAICS), [Figure M.4]. A firm's ownership category and other firm characteristics such as the firm's wage level and the age of the work force are based on respondents' answers. While there is considerable overlap in firms in the "State/Local Government" industry category and those in the "public" ownership category, they are not identical. For example, public school districts are included in the service industry even though they are publicly owned. Family coverage is defined as health coverage for a family of four.

Figure M.3

Selected Characteristics of Firms in the Survey Sample, 2020

	Sample Size	Sample Distribution After Weighting	Percentage of Total for Weighted Sample
FIRM SIZE			
3-9 Workers	161	1,929,879	59.4%
10-24 Workers	243	780,150	24
25-49 Workers	184	284,519	8.8
50-199 Workers	256	195,677	6
200-999 Workers	392	45,945	1.4
1,000-4,999 Workers	321	8,420	0.3
5,000 or More Workers	208	2,295	0.1
REGION			
Northeast	269	563,062	17.3%
Midwest	540	686,171	21.1
South	588	1,251,410	38.5
West	368	746,242	23
INDUSTRY			
Agriculture/Mining/Construction	117	358,475	11%
Manufacturing	176	176,086	5.4
Transportation/Communications/Utilities	94	124,319	3.8
Wholesale	83	162,476	5
Retail	139	375,268	11.6
Finance	101	205,634	6.3
Service	672	1,385,310	42.7
State/Local Government	124	48,567	1.5
Health Care	259	410,750	12.7
ALL FIRMS	**1,765**	**3,246,885**	**100%**

SOURCE: KFF Employer Health Benefits Survey, 2020

Figure M.4
Industries by NAICS code

Industry	SIC Code Range	NAICS Sector	NAICS Description
Agriculture/Mining/Construction	0100-1799	11	Agriculture Support, Forestry, Fishing, and Hunting
		21	Mining
		23	Construction
Manufacturing	2000-3999	31	Manufacturing
Transportation/Communications /Utilities	4000-4299 & 4400-4999	22	Utilities
		48	Transportation and Warehousing
		51	Information
Wholesale	5000-5199	42	Wholesale Trade
Retail	5200-5999	44	Retail Trade
Finance	6000-6799	52	Finance and Insurance
		53	Real Estate and Rental & Leasing
Service	7000-7999 & 8100-8199 & 8300-8999	54	Professional, Scientific, and Technical Services
		55	Management of Companies and Enterprises
		56	Administrative & Support and Waste Management & Remediation Services
		71	Arts, Entertainment, and Recreation
		72	Accommodation and Food Services
		81	Other Services (except Public Administration)
State/Local Government	9000-9999	NA	
Education	8200-8299	61	Educational Services
Health Care	8000-8099	62	Health Care and Social Assistance

[Figure M.5] presents the breakdown of states into regions and is based on the U.S Census Bureau's categorizations. State-level data are not reported both because the sample size is insufficient in many states and we only collect information on a firm's primary location rather than where all workers may actually be employed. Some mid- and large-size employers have employees in more than one state, so the location of the headquarters may not match the location of the plan for which we collected premium information.

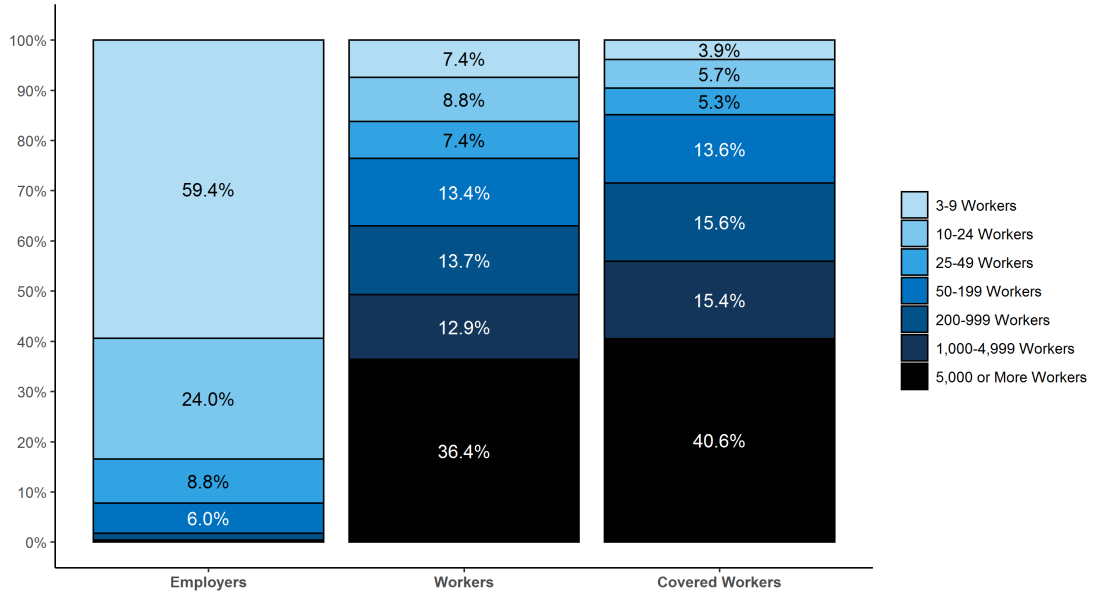
Figure M.5
States by Region, 2020

Northeast	Midwest	South	West
Connecticut	Illinois	Alabama	Alaska
Maine	Indiana	Arkansas	Arizona
Massachusetts	Iowa	Delaware	California
New Hampshire	Kansas	District of Columbia	Colorado
New Jersey	Michigan	Florida	Hawaii
New York	Minnesota	Georgia	Idaho
Pennsylvania	Missouri	Kentucky	Montana
Rhode Island	Nebraska	Louisiana	Nevada
Vermont	North Dakota	Maryland	New Mexico
	Ohio	Mississippi	Oregon
	South Dakota	North Carolina	Utah
	Wisconsin	Oklahoma	Washington
		South Carolina	Wyoming
		Tennessee	
		Texas	
		Virginia	
		West Virginia	

Source: KFF Employer Health Benefits Survey, 2020. From U.S. Department of Commerce, Economics and Statistics Administration, U.S. Census Bureau, available at http://www2.census.gov/geo/pdfs/maps-data/maps/reference/us_regdiv.pdf

[Figure M.6] displays the distribution of the nation's firms, workers, and covered workers (employees receiving coverage from their employer). Among the three million firms nationally, approximately 59.4% employ 3 to 9 workers; such firms employ 7.4% of workers, and 3.9% of workers covered by health insurance. In contrast, less than one percent of firms employ 5,000 or more workers; these firms employ 36.4% of workers and 40.6% of covered workers. Therefore, the smallest firms dominate any statistics weighted by the number of employers. For this reason, most statistics about firms are broken out by size categories. In contrast, firms with 1,000 or more workers are the most influential employer group in calculating statistics regarding covered workers, since they employ the largest percentage of the nation's workforce. Statistics among small firms and those weighted by the number of firms tend to have more variability.

Figure M.6
Distribution of Employers, Workers, and Workers Covered by Health Benefits, by Firm Size, 2020



NOTE: Data are based on a data request to the U.S. Census Bureau for their most recent (2014) Statistics of U.S. Businesses data on private sector firms. State and local government data are from the Census Bureau's 2012 Census of Governments.
SOURCE: KFF Employer Health Benefits Survey, 2020

Although most firms in the United States are small, most workers covered by health benefits are employed at large firms: 72% of the covered worker weight is controlled by firms with 200 or more employees. Conversely, firms with 3–199 employees represent 98% percent of the employer weight.

The survey asks firms what percentage of their employees earn more or less than a specified amount in order to identify the portion of a firm's workforce that has relatively lower or higher wages. This year, the income threshold is $26,000 or less per year for lower-wage workers and $64,000 or more for higher-wage workers. These thresholds are based on the 25th and 75th percentile of workers' earnings as reported by the Bureau of Labor Statistics using data from the Occupational Employment Statistics (OES) (2018).[7] The cutoffs were inflation-adjusted and rounded to the nearest thousand.

Annual inflation estimates are calculated as an average of the first three months of the year. The 12 month percentage change for this period was 2.1%.[8] Data presented is nominal unless indicated specifically otherwise.

ROUNDING AND IMPUTATION

Some figures in the report do not sum to totals due to rounding. Although overall totals and totals for size and industry are statistically valid, some breakdowns may not be available due to limited sample sizes or high relative standard errors. Where the unweighted sample size is fewer than 30 observations, figures include the notation "NSD" (Not Sufficient Data). Estimates with high relative standard errors are reviewed and in some cases not published. Many breakouts by subsets may have a large standard error, meaning that even large differences between estimates are not statistically different. Values below 3% are not shown on graphical figures to improve

[7] General information on the OES can be found at http://www.bls.gov/oes/oes_emp.htm#scope.
[8] Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation, 1998-2019; (cited 2019 Sept 6). https://beta.bls.gov/dataViewer/view/timeseries/CUUR0000SA0.

the readability of those graphs. The underlying data for all estimates presented in graphs are available in the Excel documents accompanying each section on http://ehbs.kff.org/.

To control for item nonresponse bias, we impute values that are missing for most variables in the survey. On average, 9% of observations are imputed. All variables are imputed following a hotdeck approach. The hotdeck approach replaces missing information with observed values from a firm similar in size and industry to the firm for which data are missing. In 2020, there were twenty-seven variables where the imputation rate exceeded 20%; most of these cases were for individual plan level statistics. When aggregate variables were constructed for all of the plans, the imputation rate is usually much lower. There are a few variables that we have decided not to impute; these are typically variables where "don't know" is considered a valid response option. Some variables are imputed based on their relationship to each other. For example, if a firm provided a worker contribution for family coverage but no premium information, a ratio between the family premium and family contribution was imputed and then the family premium was calculated. We estimate separate single and family coverage premiums for firms that provide premium amounts as the average cost for all covered workers.

To ensure data accuracy we have several processes to review outliers and illogical responses. Every year several hundred firms are called back to confirm or correct responses. In some cases, answers are edited based on responses to open-ended questions or based on established logic rules.

WEIGHTING

Because we select firms randomly, it is possible through the use of weights to extrapolate the results to national (as well as firm size, regional, and industry) averages. These weights allow us to present findings based on the number of workers covered by health plans, the number of total workers, and the number of firms. In general, findings in dollar amounts (such as premiums, worker contributions, and cost sharing) are weighted by covered workers. Other estimates, such as the offer rate, are weighted by firms.

Calculation of the weights follows a common approach. The employer weight was determined by calculating the firm's probability of selection. This weight was trimmed of overly influential weights and calibrated to U.S. Census Bureau's 2017 Statistics of U.S. Businesses for firms in the private sector, and the 2017 Census of Governments totals. The worker weight was calculated by multiplying the employer weight by the number of workers at the firm and then following the same weight adjustment process described above. The covered-worker weight and the plan-specific weights were calculated by multiplying the percentage of workers enrolled in each of the plan types by the firm's worker weight. These weights allow analyses of all workers covered by health benefits and of workers in a particular type of health plan.

The trimming procedure follows the following steps: First, we grouped firms into size and offer categories of observations. Within each strata, we calculated the trimming cut point as the median plus six times the interquartile range (M + [6 * IQR]). Weight values larger than this cut point are trimmed. In all instances, very few weight values were trimmed.

The survey collects information on primary and specialty care physician office visits for each plan type. Different plan types at the same firm may have different cost-sharing structures (e.g., copayments or coinsurance). Because the composite variables (using data from across all plan types) are reflective of only those plans with that provision, separate weights for the relevant variables were created in order to account for the fact that not all covered workers have such provisions.

To account for design effects, the statistical computing package R version 4.0.2 (2020-06-22) and the library "survey" version 4.0 were used to calculate standard errors.

STATISTICAL SIGNIFICANCE AND LIMITATIONS

All statistical tests are performed at the .05 confidence level. For figures with multiple years, statistical tests are conducted for each year against the previous year shown, unless otherwise noted. No statistical tests are

conducted for years prior to 1999.

Statistical tests for a given subgroup (firms with 25-49 workers, for instance) are tested against all other firm sizes not included in that subgroup (all firm sizes NOT including firms with 25-49 workers, in this example). Tests are done similarly for region and industry; for example, Northeast is compared to all firms NOT in the Northeast (an aggregate of firms in the Midwest, South, and West). However, statistical tests for estimates compared across plan types (for example, average premiums in PPOs) are tested against the "All Plans" estimate. In some cases, we also test plan-specific estimates against similar estimates for other plan types (for example, single and family premiums for HDHP/SOs against single and family premiums for HMO, PPO, and POS plans); these are noted specifically in the text. The two types of statistical tests performed are the t-test and the Wald test. The small number of observations for some variables resulted in large variability around the point estimates. These observations sometimes carry large weights, primarily for small firms. The reader should be cautioned that these influential weights may result in large movements in point estimates from year to year; however, these movements are often not statistically significant. Standard Errors for most key statistics are available in a technical supplement available at http://ehbs.kff.org/.

Due to the complexity of many employer health benefits programs, this survey is not able to capture all the components of any particular plan. For example, many employers have complex and varied prescription drug benefits, premium contributions, and incentives for wellness programs. We attempted to complete interviews with the person who is most knowledgeable about the firm's health benefits. In some cases, the firm may not know details of some elements of their plan.

While we collect information on the number of workers enrolled in health benefits, the survey is not able to capture the characteristics of the workers offered or enrolled in any particular plan. As discussed above, statistics weighted by the percentage of employers often display a high level of variability.

2020 SURVEY

2020 was a challenging year both in administering the survey, as well as for many of our respondents who were scrambling to respond to the pandemic and the ensuing economic downturn. Our questionnaire was developed before the extent of the pandemic became apparent and the fielding period included response from both before and after. We asked respondents about their plans at the time of the interview, with approximately half of the responses (composing 50% of the covered worker weight) collected between January and March. The remaining interviews were completed before the middle of July. The survey is designed to track changes in benefit and cost between years and is not well suited to answer many of the important questions that emerged this year for a couple of reasons. Firstly, employers make decisions about their plans before the plan year begins. Premiums for self-funded employers are usually reported as the cost for a former worker to enroll in COBRA (deflated by an administrative fee) and do not reflect real-time spending. Many other plan features, including provider networks and cost-sharing, are set before a plan's open enrollment period. We expect to learn more about how changes in benefits and utilization affected cost in the 2021 survey. Secondly, the month in which a respondent completes the survey is not random, the data collection firm completes interviews with larger panel firms first. We do not believe that these firms are similar to the non-panel firms that complete the survey later in the year. We believe these firms differ in ways which are not corrected for by weighting, which means we cannot look at how responses changed over the period to detect patterns of change. Thirdly, our sample is not sufficient to make many comparisons across fielding period. We plan to ask employers about changes to their plans and the impact of COVID-19 on their decision making in the 2021 survey.

In the summer of 2019, National Research LLC, which had conducted the Employer Health Benefit Survey since its inception, ceased operation. We engaged in a search to identify a new firm to conduct the 2020 survey and selected Davis Research LLC, based on their extensive experience in research on firms and establishments. While we believe that the sampling methodology, questionnaire and survey procedures were consistent between years, readers are strongly encouraged to consider "total survey error" when drawing conclusions about differences between statistics. Survey-adjusted standard errors (and statistical testing) measure uncertainty in estimates based on the sampling strategy, but do not measure biases that may be introduced through the data

collection process such as interviewer or house effects. House effects refer to the impact of a data collection firm's management and workflow processes on final statistics. We do not know how, or if at all, changing the data collection firm from National Research to Davis impacted estimates. Empirical studies of house effects vary greatly, with some reporting almost no impact [9] and others observing significant differences in point estimates [10]. One place where house effects may manifest itself is in the frequency of unit-nonresponse [11], or the extent to which different firms code edge cases as "don't know". [Figure M.7] illustrates the difference in missing values for key statistics between 2016 and 2020. On an unweighted basis, there appears to be a marginal increase in unit non-response for some variables; we do not know the extent to which this increase is attributed to changing firms, or other significant disruptions throughout the 2020 fielding period.

Figure M.7

Imputation Rates of Premiums, Worker Contributions, and Deductibles, by Plan Type, 2016-2020

	2016	2017	2018	2019	2020
HMO					
Single Premium	3%	4.3%	1.6%*	3.9%	5.1%
Single Contribution	2.7	2.1	2.3	2.5	3.7
Single Deductible	2	3.3	1.6	1.5	2.7
Family Premium	4	6	3.9	5.2	5.7
Family Contribution	4.7	4.8	5.5	5	6.4
Family Deductible	3	5.3	3	2.5	4.7
PPO					
Single Premium	4.2%	4%	3.7%	4.4%	7%*
Single Contribution	3	2.3	2.5	2.5	3.6
Single Deductible	1.2	1.5	1	0.8	2.7*
Family Premium	5.4	5.6	4.6	5.3	9.1*
Family Contribution	4.4	4.4	4.3	4.4	6.4*
Family Deductible	3.1	4.5	3.3	2.8	5.4*
POS					
Single Premium	12%	8.4%	3.9%	10%*	15.5%
Single Contribution	4.6	4	1.9	7.4*	10
Single Deductible	3.2	3.1	2.9	2.6	8.2*
Family Premium	16.1	12.2	8.3	11.6	21.3*
Family Contribution	12.3	9.5	7.3	11.6	21.3*
Family Deductible	5.7	9	2.9*	5.8	15.7*
HDHP/SO					
Single Premium	4.3%	4.6%	3.9%	4%	4.9%
Single Contribution	3.3	1.8*	2.3	2.4	3.3
Single Deductible	0.6	0.5	0.6	0.8	1.6
Family Premium	5.9	5.6	4.1	4.6	6
Family Contribution	4.5	3.6	3	3.6	4.8
Family Deductible	2.3	2.5	1.6	1.8	3.4

* Estimate is statistically different from estimate for the previous year shown ($p < .05$).

SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2016-2017

In order to minimize house effect impacts, we conducted extensive interview training with managers and interviewers at Davis, including sessions lead by interviewers with prior experience on the project. In addition, KFF pretested and observed interviews to verify that Davis' quality assurance process was consistent with our understanding of how the survey had been conducted historically.

Starting in 2020, we limited the number of margins used to calibrate weights and adjust for non-response. Until 2019, our weighting procedure incorporated offer status, firm size, geographic region, and metropolitan

[9] Russell, J. N., & Bose, J. (2004). House Effects in a Household Transportation Telephone Survey. American Association for Public Opinion Research Annual Meeting, Phoenix, Arizona.

[10] Schumann, D., & Shamon, H. (2019). The Importance of House Effects for Repeated Public Opinion Surveys. International Journal of Public Opinion Research. https://doi.org/10.1093/ijpor/edz039

[11] Smith, T. W. (1982). House Effects and the Reproducibility of Survey Measurements: A Comparison of the 1980 GSS and the 1980 American National Election Study. The Public Opinion Quarterly, 46(1), 54–68.

status to adjust for unit nonresponse. Our 2020 weighting algorithm no longer relies on metropolitan vs. non-metropolitan as part of the non-response calculation. Separately, earlier surveys post-stratified each firm's set of weights to industry, firm size, census division, and panel versus non-panel margins. Starting in 2020, we reduced this weight calibration to only industry and firm size controls. Finally, we collapsed industries in our 5,000+ employee firm size category, owing to the fact that many large businesses operate across multiple industries. All three of these changes were prompted by an increase in the number of calibration cells with low sample, which can result in individual firms with highly influential weights if not revised. Without this revision, some 2020 statistics would had been driven by a small number of firms with overly influential weights. Reducing the number of variables in these improves the stability of some published estimates. This issue arose in part due to the smaller number of completed interviews in 2020 relative to 2019.

Historically we measured the annual changes in workers' wages and in inflation by comparing the values for April of the previous year and April of the current year. This year the labor market underwent significant disruptions in March and April as employers laid off and furloughed large numbers of workers in response to the COVID-19 pandemic. A relatively high share of lower-wage workers were furloughed and laid off during these months, resulting in a high change in wages as measured from April to April [12]. In response to this unprecedented change in the labor market, we have elected to change how we calculate workers wages and inflation. Beginning with our 2020 publication, we are now calculating the change in workers wages and inflation based on an average of the first quarter of each year. Using this method, workers wages increased 3.4% compared to 7.7% between April and April. And similarly inflation increased 2.1% compared to 0.3%. Prior to 2020, both methods produced very similar estimates.

OTHER RESOURCES

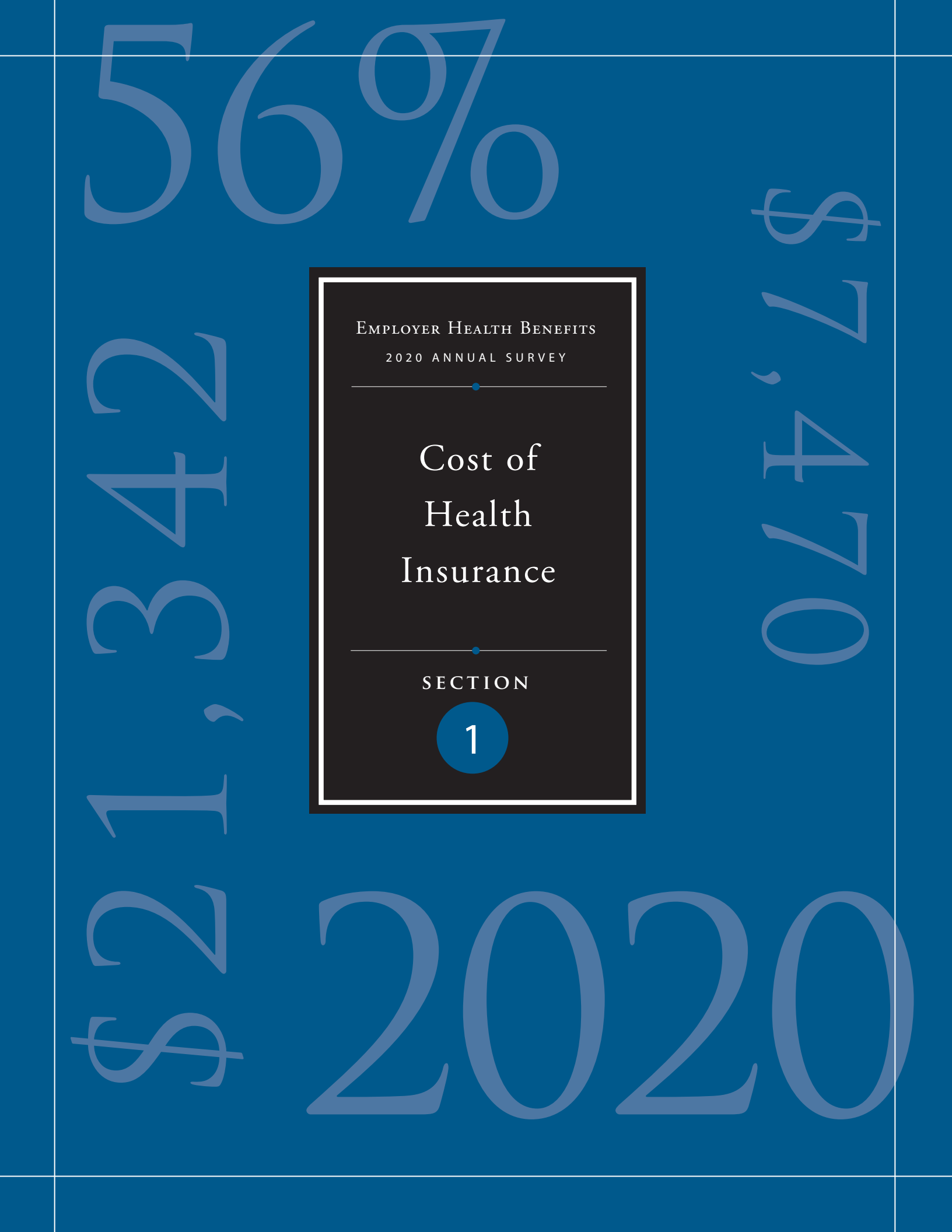
Additional information on the 2020 Employer Health Benefit Survey is available at http://ehbs.kff.org/, including an article in the Journal Health Affairs, an interactive graphic and historic reports. Standard errors for some statistics are available in the online technical supplement. Researchers may also request a public use dataset here: https://www.kff.org/contact-us/

The survey design and methods section found on our website (http://ehbs.kff.org/) contains an extended methods document that was not included in the portable document format (PDF) or the printed versions of this book. Readers interested in the extended methodology should consult the online edition of this publication.

The authors would like to thank Tricia Neuman (KFF), Karen Pollitz (KFF), and Cynthia Cox (KFF), for their contributions to the instrument. Furthermore we would like to thank Ashley Kirzinger (KFF) for her advice on methodological issues; Lawrence Strange and Steve Paradowski (NORC) for assisting in interviewer training and CATI testing; Larry Levitt (KFF), and Drew Altman (KFF), for their review. And lastly, Jackie Cifuentes, Jason Kerns and the staff at Davis Research LLC for their diligence in data collection

Published: October 8, 2020. Last Updated: October 02, 2020.

[12] Crust E, Daly M, Hobijn B. The Illusion of Wage Growth [Internet]. Federal Reserve Bank of San Francisco; 2020 Aug [cited 2020 Sep 14]. Available from: https://www.frbsf.org/economic-research/publications/economic-letter/2020/august/illusion-of-wage-growth/



Employer Health Benefits

2020 Annual Survey

Cost of Health Insurance

SECTION

1

Section 1

Cost of Health Insurance

In 2020, the average annual premiums are $7,470 for single coverage and $21,342 for family coverage. The average premium for single coverage increased by 4% since 2019 and the average premium for family coverage increased by 4%. The average family premium has increased 55% since 2010 and 22% since 2015.

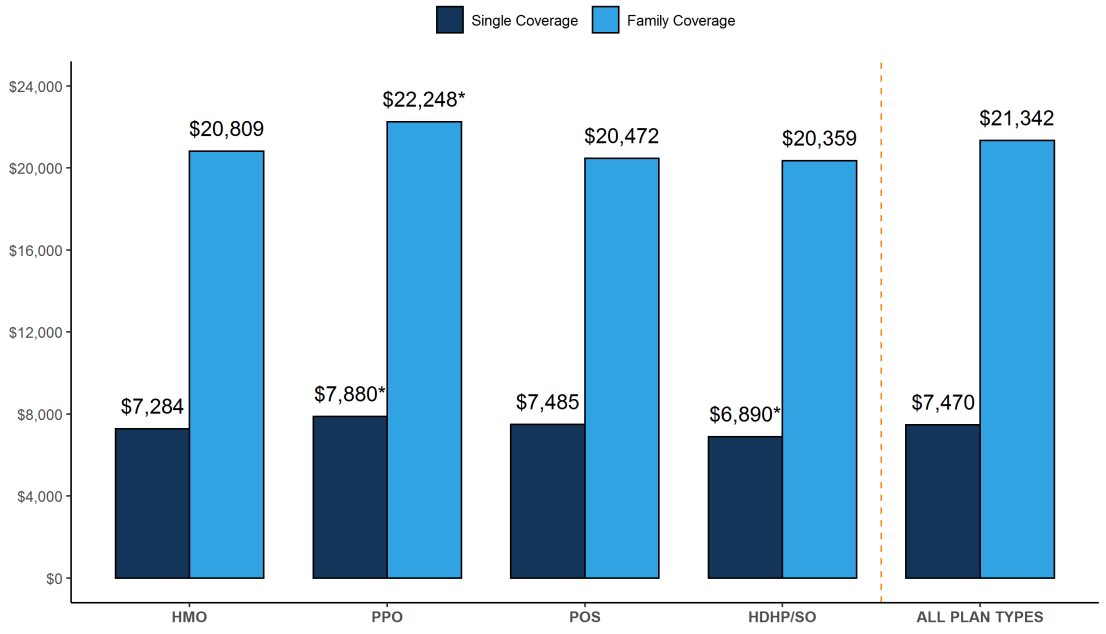
This graphing tool allows users to look at changes in premiums and worker contributions for covered workers at different types of firms over time: https://www.kff.org/interactive/premiums-and-worker-contributions/

PREMIUMS FOR SINGLE AND FAMILY COVERAGE

- The average premium for single coverage in 2020 is $7,470 per year. The average premium for family coverage is $21,342 per year [Figure 1.1].
- The average annual premium for single coverage for covered workers in small firms ($7,483) is similar to the average premium for covered workers in large firms ($7,466). The average annual premium for family coverage for covered workers in small firms ($20,438) is lower than the average premium for covered workers in large firms ($21,691). [Figure 1.2].
- The average annual premiums for covered workers in HDHP/SOs is lower for single coverage ($6,890) but similar for family coverage ($20,359) to the overall average premiums. The average premiums for covered workers enrolled in PPOs are higher for single ($7,880) and family coverage ($22,248) than the overall average premiums [Figure 1.1].
- The average premiums for covered workers with single coverage are relatively high in the Northeast and relatively low in the South. The average premiums for covered workers with family coverage are relatively high in the Northeast and relatively low in the South and West [Figure 1.3].
- The average premium for single coverage varies across industries. Compared to the average single premiums for covered workers in other industries, the average premiums for covered workers in the Manufacturing, Retail, and Agriculture/Mining/Construction categories are relatively low and the average premium for Health Care workers is relatively high [Figure 1.4].
- The average premium for family coverage for covered workers in firms with a relatively large share of lower-wage workers (where at least 35% of the workers earn $26,000 annually or less) is lower than the average premium for covered workers in firms with a smaller share of lower-wage workers ($19,332 vs. $21,486) [Figure 1.6].
- The average premium for single coverage for covered workers in firms with a relatively large share of older workers (where at least 35% of the workers are age 50 or older) is higher than the average premium for covered workers in firms with a smaller share of older workers ($7,665 vs. $7,288) [Figure 1.6].
- The average premium for family coverage for covered workers in firms with a relatively large share of younger workers (where at least 35% of the workers are age 26 or younger) is lower than the average premium for covered workers in firms with a smaller share of younger workers ($19,893 vs. $21,441) [Figure 1.6].

- Covered workers at private for-profit firms have lower average annual premiums than covered workers at public firms or private not-for-profit firms for single coverage [Figure 1.6].

Figure 1.1
Average Annual Premiums for Covered Workers, Single and Family Coverage, by Plan Type, 2020



* Estimate is statistically different from All Plans estimate ($p < .05$).
SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 1.2
Average Monthly and Annual Premiums for Covered Workers, by Plan Type and Firm Size, 2020

	Monthly		Annual	
	Single Coverage	Family Coverage	Single Coverage	Family Coverage
HMO				
All Small Firms	$585	$1,573*	$7,022	$18,878*
All Large Firms	614	1,787*	7,369	21,439*
ALL FIRM SIZES	**$607**	**$1,734**	**$7,284**	**$20,809**
PPO				
All Small Firms	$685*	$1,837	$8,216*	$22,044
All Large Firms	646*	1,860	7,752*	22,324
ALL FIRM SIZES	**$657**	**$1,854**	**$7,880**	**$22,248**
POS				
All Small Firms	$567*	$1,572*	$6,800*	$18,860*
All Large Firms	699*	1,885*	8,392*	22,620*
ALL FIRM SIZES	**$624**	**$1,706**	**$7,485**	**$20,472**
HDHP/SO				
All Small Firms	$559	$1,593	$6,712	$19,122
All Large Firms	578	1,725	6,940	20,706
ALL FIRM SIZES	**$574**	**$1,697**	**$6,890**	**$20,359**
ALL PLANS				
All Small Firms	$624	$1,703*	$7,483	$20,438*
All Large Firms	622	1,808*	7,466	21,691*
ALL FIRM SIZES	**$623**	**$1,779**	**$7,470**	**$21,342**

NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers.

* Estimates are statistically different within plan and coverage types between All Small Firms and All Large Firms ($p < .05$).

SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 1.3

Average Monthly and Annual Premiums for Covered Workers, by Plan Type and Region, 2020

	Monthly		Annual	
	Single Coverage	Family Coverage	Single Coverage	Family Coverage
HMO				
Northeast	$643	$1,867	$7,712	$22,399
Midwest	590	1,662	7,075	19,948
South	604	1,744	7,250	20,934
West	593	1,671	7,115	20,049
ALL REGIONS	**$607**	**$1,734**	**$7,284**	**$20,809**
PPO				
Northeast	$681	$1,996*	$8,176	$23,953*
Midwest	684*	1,935*	8,213*	23,223*
South	624*	1,738*	7,487*	20,853*
West	657	1,830	7,888	21,966
ALL REGIONS	**$657**	**$1,854**	**$7,880**	**$22,248**
POS				
Northeast	$696*	$1,955*	$8,350*	$23,462*
Midwest	622	1,689	7,469	20,265
South	635	1,686	7,616	20,227
West	513*	1,424*	6,152*	17,084*
ALL REGIONS	**$624**	**$1,706**	**$7,485**	**$20,472**
HDHP/SO				
Northeast	$604	$1,851	$7,248	$22,207
Midwest	562	1,686	6,748	20,227
South	571	1,672	6,855	20,066
West	574	1,590	6,890	19,078
ALL REGIONS	**$574**	**$1,697**	**$6,890**	**$20,359**
ALL PLANS				
Northeast	$655*	$1,929*	$7,862*	$23,151*
Midwest	626	1,804	7,515	21,652
South	608*	1,716*	7,296*	20,593*
West	610	1,699*	7,317	20,390*
ALL REGIONS	**$623**	**$1,779**	**$7,470**	**$21,342**

* Estimates are statistically different within plan and coverage types from estimate for all firms not in the indicated region ($p < .05$).

SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 1.4

Average Monthly and Annual Premiums for Covered Workers, by Plan Type and Industry, 2020

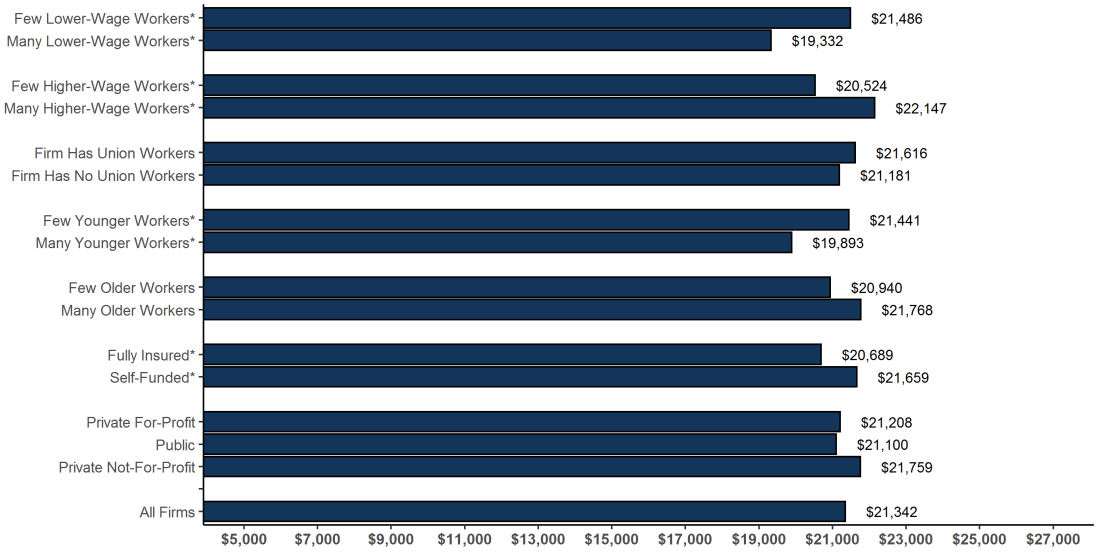
	Monthly		Annual	
	Single Coverage	Family Coverage	Single Coverage	Family Coverage
HMO				
Agriculture/Mining/Construction	NSD	NSD	NSD	NSD
Manufacturing	$545	$1,675	$6,539	$20,104
Transportation/Communications/Utilities	NSD	NSD	NSD	NSD
Wholesale	NSD	NSD	NSD	NSD
Retail	NSD	NSD	NSD	NSD
Finance	NSD	NSD	NSD	NSD
Service	611	1,699	7,329	20,386
State/Local Government	NSD	NSD	NSD	NSD
Health Care	NSD	NSD	NSD	NSD
ALL INDUSTRIES	**$607**	**$1,734**	**$7,284**	**$20,809**
PPO				
Agriculture/Mining/Construction	$594*	$1,729	$7,124*	$20,750
Manufacturing	648	1,888	7,774	22,658
Transportation/Communications/Utilities	639	1,834	7,668	22,004
Wholesale	666	1,839	7,997	22,070
Retail	591*	1,773	7,087*	21,274
Finance	671	1,958	8,050	23,496
Service	673	1,845	8,080	22,135
State/Local Government	668	1,800	8,015	21,602
Health Care	674	1,917	8,092	23,006
ALL INDUSTRIES	**$657**	**$1,854**	**$7,880**	**$22,248**
HDHP/SO				
Agriculture/Mining/Construction	$512*	$1,432*	$6,143*	$17,180*
Manufacturing	527*	1,546*	6,324*	18,550*
Transportation/Communications/Utilities	576	1,815	6,910	21,785
Wholesale	523*	1,568	6,276*	18,818
Retail	533*	1,772	6,394*	21,261
Finance	617	1,930	7,408	23,156
Service	585	1,687	7,022	20,240
State/Local Government	601	1,561	7,214	18,729
Health Care	617*	1,723	7,403*	20,680
ALL INDUSTRIES	**$574**	**$1,697**	**$6,890**	**$20,359**
ALL PLANS				
Agriculture/Mining/Construction	$542*	$1,574*	$6,504*	$18,892*
Manufacturing	579*	1,699	6,948*	20,383
Transportation/Communications/Utilities	632	1,872*	7,583	22,466*
Wholesale	607	1,713	7,280	20,560
Retail	572*	1,772	6,863*	21,266
Finance	644	1,939	7,733	23,266
Service	630	1,758	7,564	21,099
State/Local Government	649	1,749	7,794	20,987
Health Care	657*	1,838	7,883*	22,060
ALL INDUSTRIES	**$623**	**$1,779**	**$7,470**	**$21,342**

NOTE: POS premiums are included in the All Plans average. In most cases, there is an insufficient number of firms to report the average POS premium by industry.
NSD: Not Sufficient Data

* Estimate is statistically different within plan type from estimate for all firms not in the indicated industry ($p < .05$).

SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 1.5
Average Annual Premiums for Covered Workers with Family Coverage, by Firm Characteristics, 2020



* Estimates are statistically different from each other within category ($p < .05$).
NOTE: Firms with many lower-wage workers are those where at least 35% earn the 25th percentile or less of national earnings ($26,000 in 2020). Firms with many higher-wage workers are those where at least 35% earn the 75th percentile or more than of national earnings ($64,000 in 2020). Firms with many older workers are those where at least 35% of workers are age 50 or older. Firms with many younger workers are those where at least 35% of workers are age 26 or younger.
SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 1.6

Average Annual Premiums for Covered Workers, by Firm Characteristics and Firm Size, 2020

	Single Coverage			Family Coverage		
	All Small Firms	All Large Firms	All Firms	All Small Firms	All Large Firms	All Firms
LOWER WAGE LEVEL						
Few Lower-Wage Workers	$7,494	$7,493	$7,493	$20,588	$21,811*	$21,486*
Many Lower-Wage Workers	$7,388	$6,946	$7,148	$19,213	$19,431*	$19,332*
HIGHER WAGE LEVEL						
Few Higher-Wage Workers	$7,344	$7,154*	$7,218*	$19,932	$20,821*	$20,524*
Many Higher-Wage Workers	$7,686	$7,727*	$7,717*	$21,183	$22,424*	$22,147*
UNIONS						
Firm Has Union Workers	$7,458	$7,451	$7,452	$20,807	$21,673	$21,616
Firm Has No Union Workers	$7,485	$7,479	$7,481	$20,403	$21,708	$21,181
YOUNGER WORKERS						
Few Younger Workers	$7,516	$7,499*	$7,504	$20,638*	$21,754	$21,441*
Many Younger Workers	$6,942	$6,996*	$6,982	$17,236*	$20,804	$19,893*
OLDER WORKERS						
Few Older Workers	$7,142*	$7,347	$7,288*	$19,358*	$21,571	$20,940
Many Older Workers	$7,870*	$7,589	$7,665*	$21,639*	$21,816	$21,768
FUNDING ARRANGEMENT						
Fully Insured	$7,454	$7,541	$7,484	$20,363	$21,305	$20,689*
Self-Funded	$7,579	$7,452	$7,464	$20,686	$21,763	$21,659*
FIRM OWNERSHIP						
Private For-Profit	$7,145*	$7,238*	$7,209*	$19,908	$21,794	$21,208
Public	$8,154	$7,726	$7,792*	$21,274	$21,069	$21,100
Private Not-For-Profit	$8,038*	$7,746*	$7,830*	$21,377	$21,911	$21,759
ALL FIRMS	**$7,483**	**$7,466**	**$7,470**	**$20,438**	**$21,691**	**$21,342**

NOTE: Firms with many lower-wage workers are those where at least 35% earn the 25th percentile or less of national earnings ($26,000 in 2020). Firms with many higher-wage workers are those where at least 35% earn the 75th percentile or more than of national earnings ($64,000 in 2020). Firms with many older workers are those where at least 35% of workers are age 50 or older. Firms with many younger workers are those where at least 35% of workers are age 26 or younger. Small Firms have 3-199 workers and Large Firms have 200 or more workers.

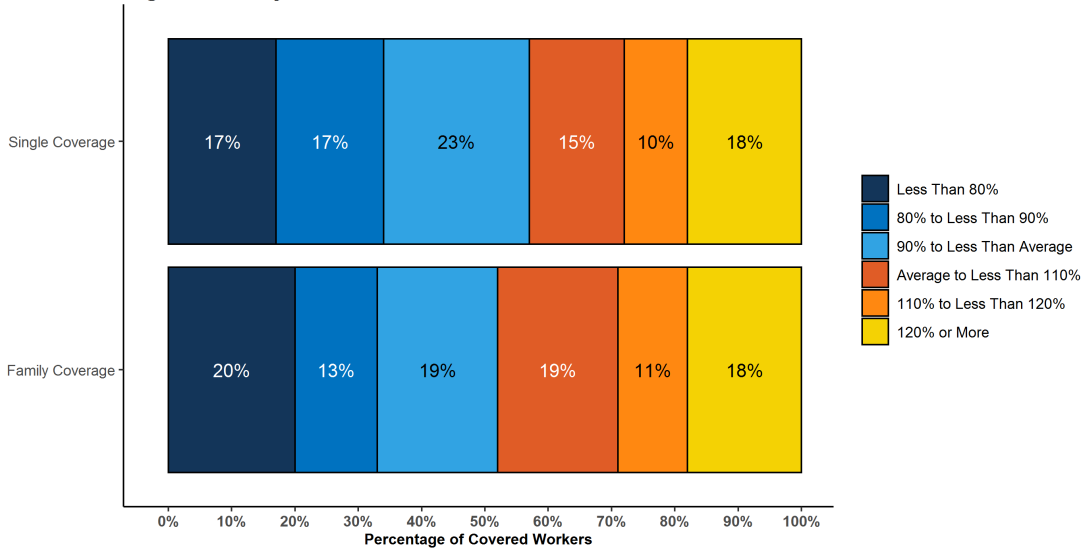
* Estimates are statistically different from estimate for all other firms not in the indicated category within each firm size ($p < .05$).

SOURCE: KFF Employer Health Benefits Survey, 2020

PREMIUM DISTRIBUTION

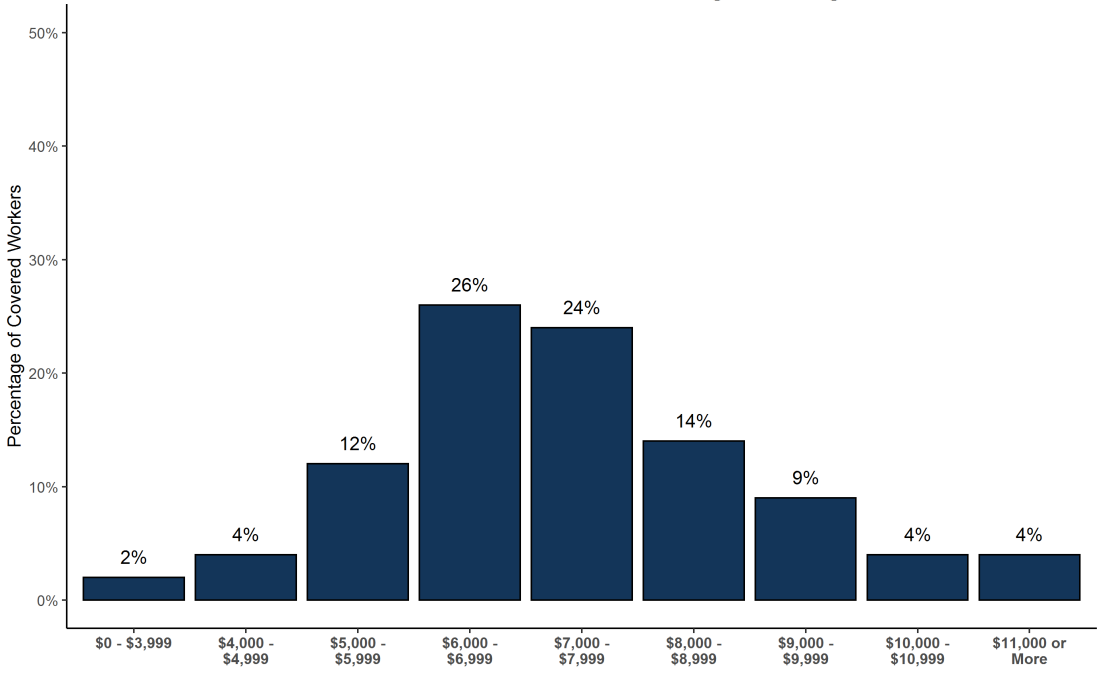
- There remains considerable variation in premiums for both single and family coverage.
  - Eighteen percent of covered workers are employed in a firm with a single premium at least 20% higher than the average single premium, while 17% of covered workers are in firms with a single premium less than 80% of the average single premium [Figure 1.7].
  - For family coverage, 18% of covered workers are employed in a firm with a family premium at least 20% higher than the average family premium, while 20% of covered workers are in firms with a family premium less than 80% of the average family premium [Figure 1.7].
- Nine percent of covered workers are in a firm with an average annual premium of at least $10,000 for single coverage [Figure 1.8]. Ten percent of covered workers are in a firm with an average annual premium of at least $28,000 for family coverage [Figure 1.9].

Figure 1.7
Distribution of Annual Premiums for Single and Family Coverage Relative to the Average Annual Single or Family Premium, 2020



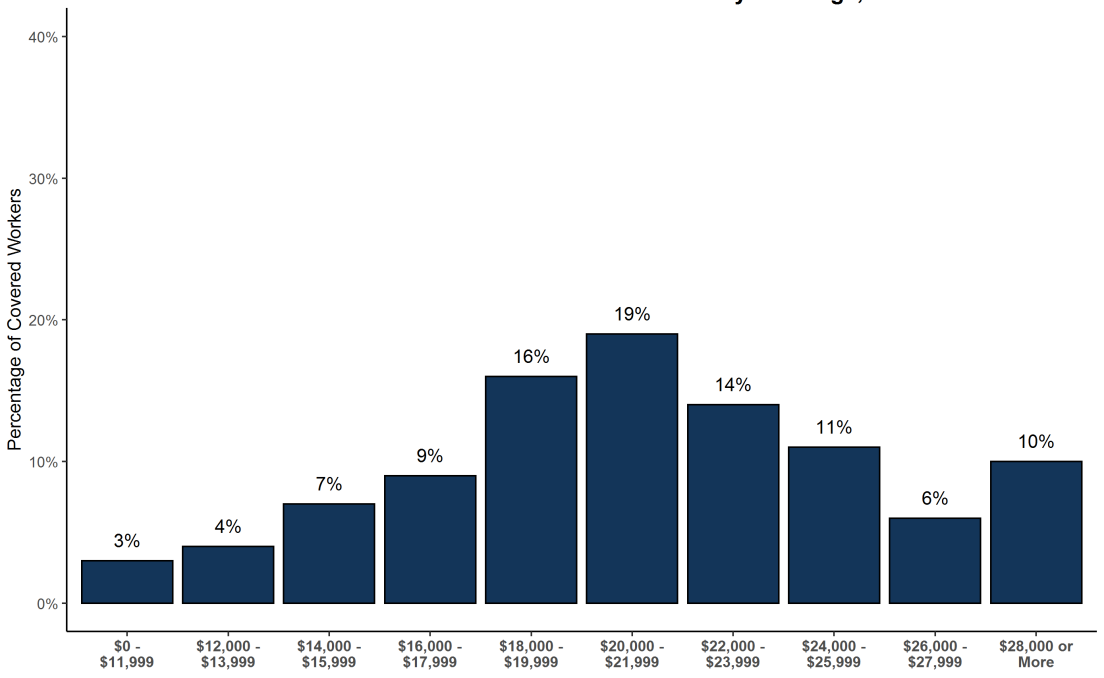
NOTE: The average annual premium is $7,470 for single coverage and $21,342 for family coverage. The premium distribution is relative to the average single or family premium. For example, $5,976 is 80% of the average single premium, $6,723 is 90% of the average single premium, $8,217 is 110% of the average single premium, and $8,964 is 120% of the average single premium. The same break points relative to the average are used for the distribution for family coverage.
SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 1.8
Distribution of Annual Premiums for Covered Workers with Single Coverage, 2020



SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 1.9
Distribution of Annual Premiums for Covered Workers with Family Coverage, 2020

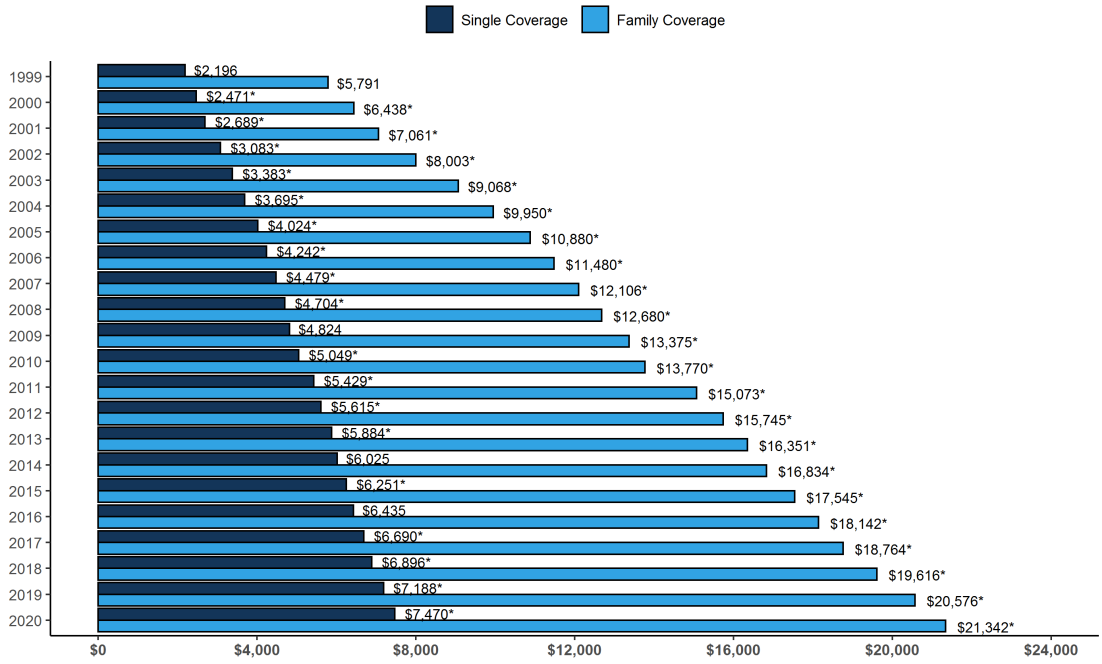


SOURCE: KFF Employer Health Benefits Survey, 2020

PREMIUM CHANGES OVER TIME

- The average premium for single coverage is 4% higher than the single premium last year, and the average premium for family coverage is 4% higher than the average family premium last year [Figure 1.10].
  - The average premium for single coverage has grown 20% since 2015, similar to the growth in the average premium for family coverage (22%) over the same period [Figure 1.10].
  - The average family premiums for both small and large firms have increased at similar rates since 2015 (23% for small firms and 21% for large firms). For small firms, the average family premium rose from $16,625 in 2015 to $20,438 in 2020. For large firms, the average family premium rose from $17,938 in 2015 to $21,691 in 2020 [Figures 1.11 and 1.12].
  - The $21,342 average family premium in 2020 is 22% higher than the average family premium in 2015 and 55% higher than the average family premium in 2010. The 22% family premium growth in the past five years is slower than the 27% growth between 2010 and 2015 [Figure 1.14].
  - The average family premiums for both small and large firms have increased at similar rates since 2010 (54% for small firms and 55% for large firms). For small firms, the average family premium rose from $13,250 in 2010 to $20,438 in 2020. For large firms, the average family premium rose from $14,038 in 2010 to $21,691 in 2020 [Figures 1.11 and 1.12].
- For covered workers in large firms, over the past five years, the average family premium in firms that are fully insured has grown at a similar rate to the average family premium for covered workers in fully or partially self-funded firms (19% for fully insured plans and 21% for self-funded firms) [Figure 1.13].
- Over the last five years, the average premium for family coverage has risen 22% percent, more than inflation (10%).

Figure 1.10
Average Annual Premiums for Single and Family Coverage, 1999-2020



* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

Figure 1.11

Average Annual Premiums for Covered Workers With Family Coverage, by Firm Size, 1999-2020

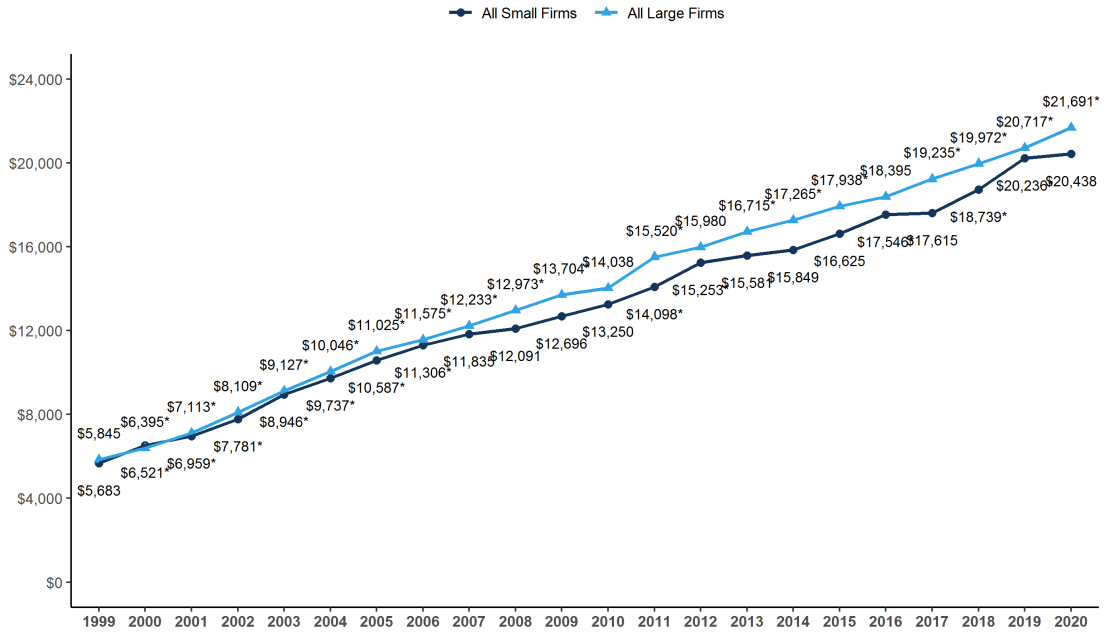
	All Small Firms	All Large Firms
1999	$5,683	$5,845
2000	$6,521	$6,395
2001	$6,959	$7,113
2002*	$7,781	$8,109
2003	$8,946	$9,127
2004	$9,737	$10,046
2005*	$10,587	$11,025
2006	$11,306	$11,575
2007	$11,835	$12,233
2008*	$12,091	$12,973
2009*	$12,696	$13,704
2010*	$13,250	$14,038
2011*	$14,098	$15,520
2012*	$15,253	$15,980
2013*	$15,581	$16,715
2014*	$15,849	$17,265
2015*	$16,625	$17,938
2016*	$17,546	$18,395
2017*	$17,615	$19,235
2018*	$18,739	$19,972
2019	$20,236	$20,717
2020*	$20,438	$21,691

NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers.

* Estimate is statistically different between All Small Firms and All Large Firms within year ($p < .05$).

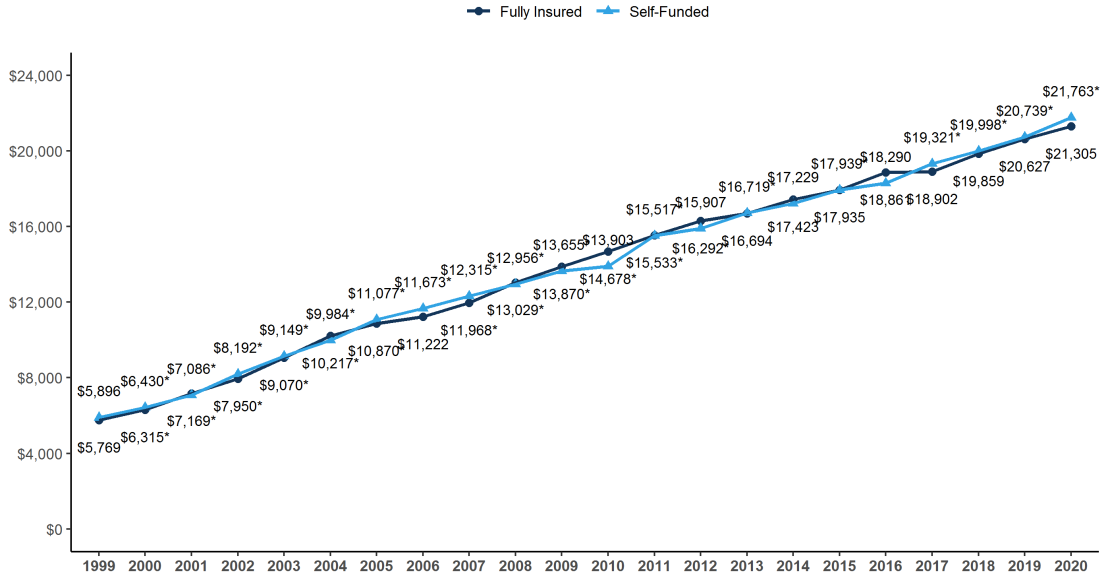
SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

Figure 1.12
Average Annual Premiums for Covered Workers with Family Coverage, by Firm Size, 1999-2020



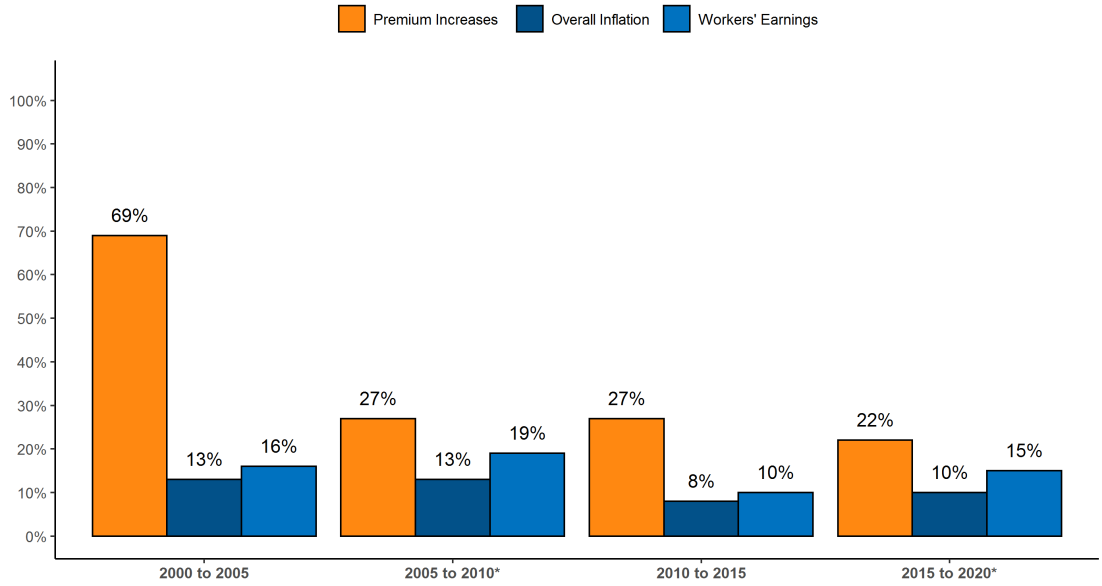
* Estimate is statistically different from estimate for the previous year shown (p < .05).
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

Figure 1.13
Among Workers in Large Firms, Average Annual Premiums for Family Coverage, by Funding Arrangement, 1999-2020

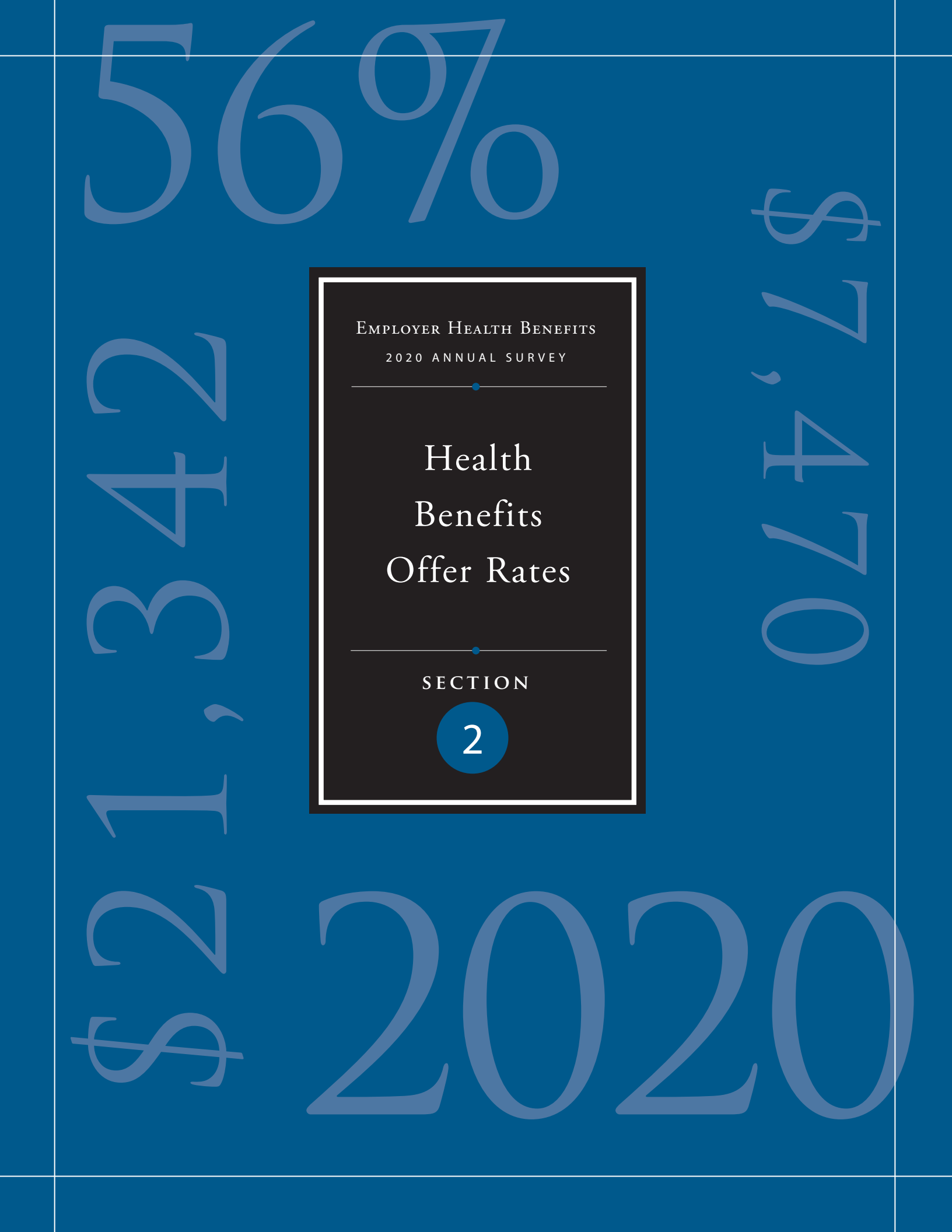


* Estimate is statistically different from estimate for the previous year shown (p < .05).
NOTE: Large Firms have 200 or more workers. For definitions of Self-Funded and Fully Insured Plans, see Section 10. Self-Funded includes plans that purchase stoploss coverage.
SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

Figure 1.14
Cumulative Premium Increases, Inflation, and Earnings for Covered Workers with Family Coverage, 2000-2020



* Percentage change in family premium is statistically different from previous five year period shown ($p < .05$).
SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2000-2017. Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation, 2000-2020; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 2000-2020.



Employer Health Benefits

2020 Annual Survey

Health Benefits Offer Rates

SECTION

2

Section 2

Health Benefits Offer Rates

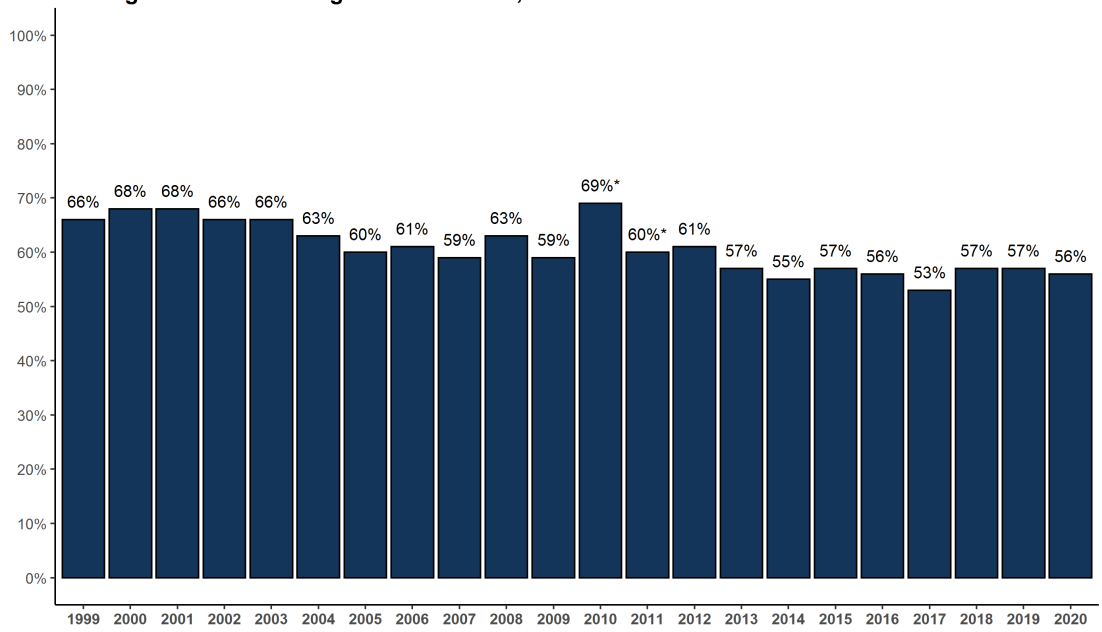
While nearly all large firms (200 or more workers) offer health benefits to at least some workers, small firms (3-199 workers) are significantly less likely to do so. The percentage of all firms offering health benefits in 2020 (56%) is similar to the percentages of firms offering health benefits last year (57%) and five years ago (57%).

Firms not offering health benefits continue to cite cost as the most important reason they do not do so. Almost all firms that offer coverage offer benefits to dependents such as children and the spouses of eligible employees.

FIRM OFFER RATES

- In 2020, 56% of firms offer health benefits, similar to the percentage last year [Figure 2.1].
  - The overall percentage of firms offering health benefits in 2020 is similar to the percentages offering health benefits in 2015 (57%). The percentage of offering firms in 2010 was an aberration so we are not making a 10-year comparison [Figure 2.1].
  - Ninety-nine percent of large firms offer health benefits to at least some of their workers. In contrast, only 55% of small firms offer health benefits [Figure 2.2] and [Figure 2.3]. The percentages of both small and large firms offering health benefits to at least some of their workers in 2020 are similar to those last year [Figure 2.2].
    - The smallest-sized firms are least likely to offer health insurance: 48% of firms with 3-9 workers offer coverage, compared to 59% of firms with 10-24 workers, 70% of firms with 25-49 workers, and 92% of firms with 50-199 workers [Figure 2.3]. Since most firms in the country are small, variation in the overall offer rate is driven largely by changes in the percentages of the smallest firms (3-9 workers) offering health benefits. For more information on the distribution of firms in the country, see the Survey Design and Methods Section and [Figure M.6].
    - Only 53% of firms with 3-49 workers offer health benefits to at least some of their workers, compared to 94% of firms with 50 or more workers [Figure 2.4].
- Because most workers are employed by larger firms, most workers work at a firm that offers health benefits to at least some of its employees. Eighty-nine percent of all workers are employed by a firm that offers health benefits to at least some of its workers [Figure 2.6].

Figure 2.1
Percentage of Firms Offering Health Benefits, 1999-2020



* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
NOTE: As noted in the Survey Design and Methods section, estimates are based on the sample of both firms that completed the entire survey and those that answered just one question about whether they offer health benefits.
SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

Figure 2.2

Percentage of Firms Offering Health Benefits, by Firm Size, 1999-2020

	3-9 Workers	10-24 Workers	25-49 Workers	50-199 Workers	All Small Firms	All Large Firms	**All Firms**
1999	55%	74%	88%	97%	65%	99%	**66%**
2000	57%	80%	91%	97%	68%	99%	**68%**
2001	58%	77%	90%	96%	67%	99%	**68%**
2002	58%	70%*	87%	95%	65%	98%	**66%**
2003	55%	76%	84%	95%	65%	97%	**66%**
2004	52%	74%	87%	92%	62%	98%	**63%**
2005	47%	72%	87%	93%	59%	97%	**60%**
2006	49%	73%	87%	92%	60%	98%	**61%**
2007	45%	76%	83%	94%	59%	99%	**59%**
2008	50%	78%	90%*	94%	62%	99%	**63%**
2009	47%	72%	87%	95%	59%	98%	**59%**
2010	59%*	76%	92%	95%	68%*	99%	**69%***
2011	48%*	71%	85%*	93%	59%*	99%	**60%***
2012	50%	73%	87%	94%	61%	98%	**61%**
2013	45%	68%	85%	91%	57%	99%	**57%**
2014	44%	64%	83%	91%	54%	98%	**55%**
2015	47%	63%	82%	92%	56%	98%	**57%**
2016	46%	61%	80%	91%	55%	98%	**56%**
2017	40%	66%	78%	92%	53%	99%	**53%**
2018	47%	64%	71%*	91%	56%	98%	**57%**
2019	47%	63%	77%	93%	56%	99%	**57%**
2020	48%	59%	70%*	92%	55%	99%	**56%**

NOTE: As noted in the Survey Design and Methods section, estimates are based on the sample of both firms that completed the entire survey and those that answered just one question about whether they offer health benefits. Small Firms have 3-199 workers and Large Firms have 200 or more workers.

* Estimate is statistically different from estimate for the previous year shown ($p < .05$).

SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

Figure 2.3

Percentage of Firms Offering Health Benefits, by Firm Size, Region, and Industry, 2020

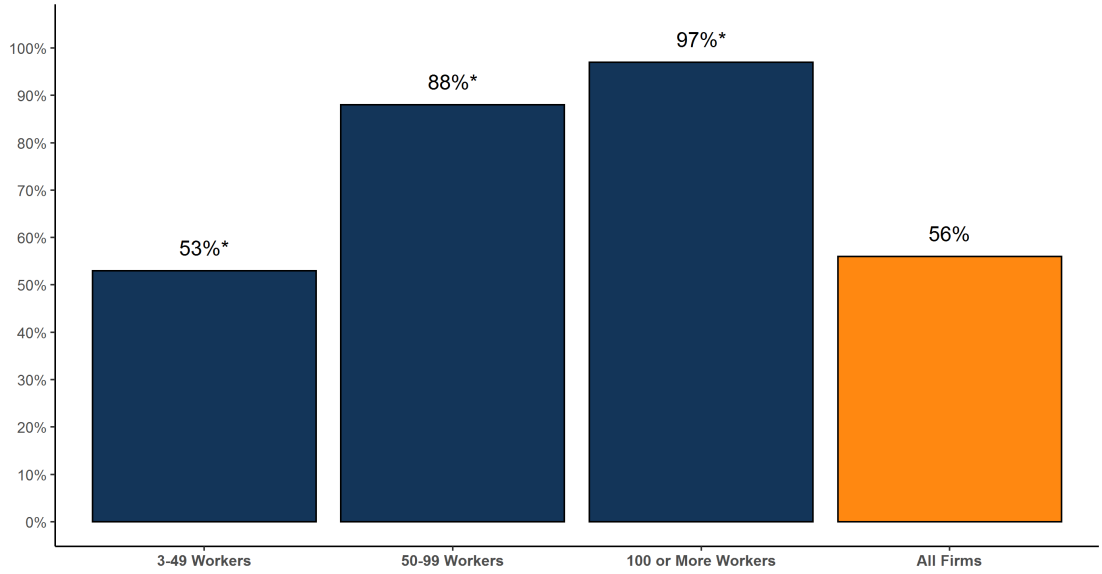
	Percentage of Firms Offering Health Benefits
FIRM SIZE	
3-9 Workers	48%*
10-24 Workers	59
25-49 Workers	70*
50-199 Workers	92*
200-999 Workers	99*
1,000-4,999 Workers	99*
5,000 or More Workers	99*
All Small Firms (3-199 Workers)	**55%***
All Large Firms (200 or More Workers)	**99%***
REGION	
Northeast	60%
Midwest	59
South	50*
West	59
INDUSTRY	
Agriculture/Mining/Construction	55%
Manufacturing	62
Transportation/Communications/Utilities	64
Wholesale	68
Retail	38*
Finance	62
Service	54
State/Local Government	92*
Health Care	62
ALL FIRMS	**56%**

NOTE: As noted in the Survey Design and Methods section, estimates are based on the sample of both firms that completed the entire survey and those that answered just one question about whether they offer health benefits.

* Estimate is statistically different from estimate for all firms not in the indicated size, region, or industry category ($p < .05$).

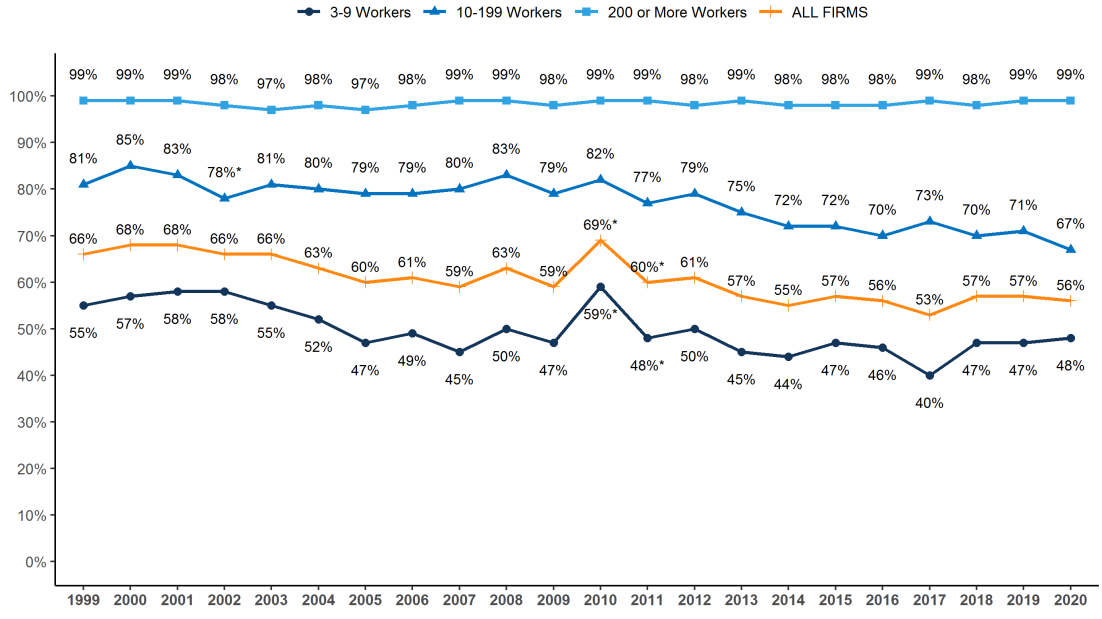
SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 2.4
Percentage of Firms Offering Health Benefits to At Least Some of Their Workers, by Firm Size, 2020



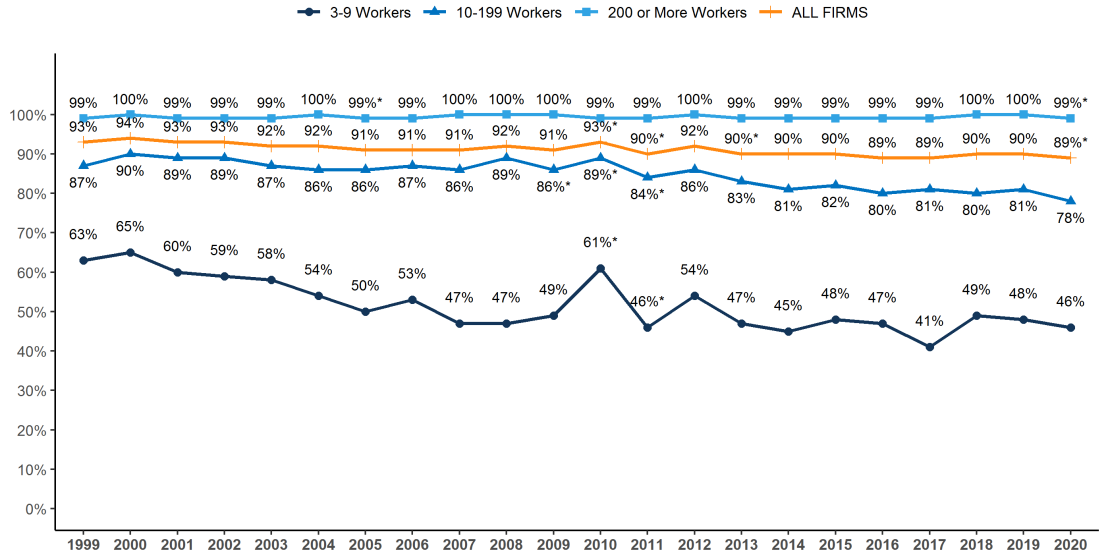
* Estimate is statistically different from estimate for all other firms not in the indicated size category (p < .05).
NOTE: As noted in the Survey Design and Methods section, estimates are based on the sample of both firms that completed the entire survey and those that answered just one question about whether they offer health benefits. Firm size categories are determined by the number of workers at a firm, which may include full-time and part-time workers.
SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 2.5
Percentage of Firms Offering Health Benefits, by Firm Size, 1999-2020



* Estimate is statistically different from estimate for the previous year shown (p < .05).
NOTE: As noted in the Survey Design and Methods section, estimates are based on the sample of both firms that completed the entire survey and those that answered just one question about whether they offer health benefits.
SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

Figure 2.6
Percentage of Workers at Firms That Offer Health Benefits to at Least Some Workers, by Firm Size, 1999-2020



* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
NOTE: As noted in the Survey Design and Methods section, estimates are based on the sample of both firms that completed the entire survey and those that answered just one question about whether they offer health benefits. Not all workers at a firm offering benefits are eligible or enrolled in their firm's health benefits.
SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

PART-TIME WORKERS

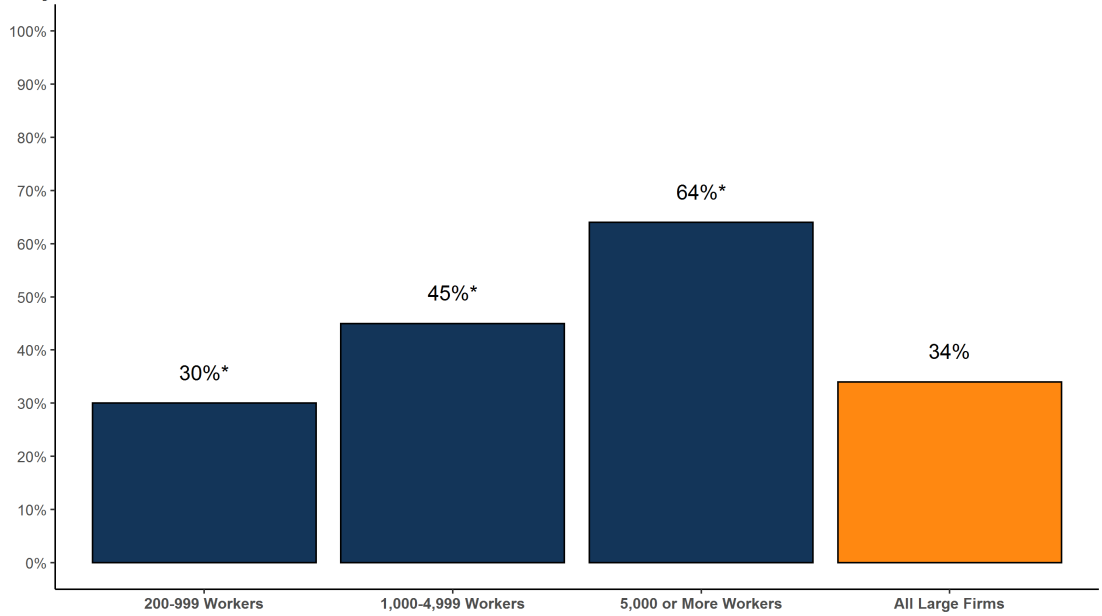
- Among firms offering health benefits, relatively few offer benefits to their part-time workers.
  - The Affordable Care Act (ACA) defines full-time workers as those who on average work at least 30 hours per week, and part-time workers as those who on average work fewer than 30 hours per week. The employer shared responsibility provision of the ACA requires that firms with at least 50 full-time equivalent employees offer most full-time employees coverage that meets minimum standards or be assessed a penalty.[1]

Beginning in 2015, we modified the survey to explicitly ask employers whether they offered benefits to employees working fewer than 30 hours. Our previous question did not include a definition of "part-time". For this reason, historical data on part-time offer rates are shown, but we did not test whether the differences between 2014 and 2015 were significant. Many employers may work with multiple definitions of part-time; one for their compliance with legal requirements and another for internal policies and programs.

- Thirty-four percent of large firms offer health benefits in 2020 offer health benefits to part-time workers, similar to the percentage in 2019. The share of large firms offering health benefits to part-time workers increases with firm size [Figure 2.7].

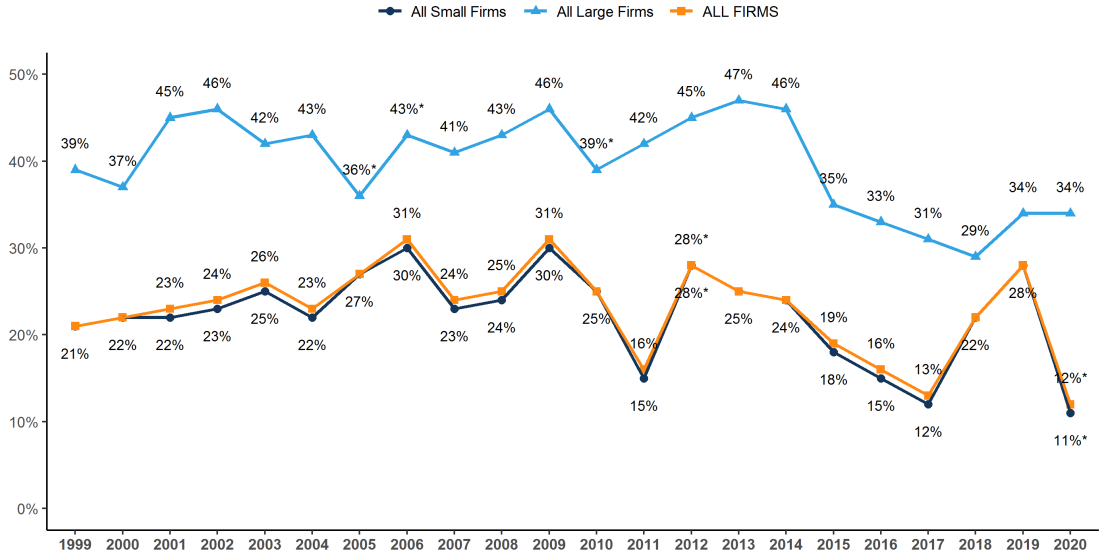
[1] Internal Revenue Code. 26 U.S. Code § 4980H - Shared responsibility for employers regarding health coverage. 2011. https://www.gpo.gov/fdsys/pkg/USCODE-2011-title26/pdf/USCODE-2011-title26-subtitleD-chap43-sec4980H.pdf

Figure 2.7
Among Large Firms Offering Health Benefits, Percentage That Offer to Part-Time Workers, by Firm Size, 2020



* Estimate is statistically different from estimate for all other firms not in the indicated size category (p < .05).
NOTE: Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 2.8
Among Firms Offering Health Benefits, Percentage That Offer to Part-Time Workers, by Firm Size, 1999-2020

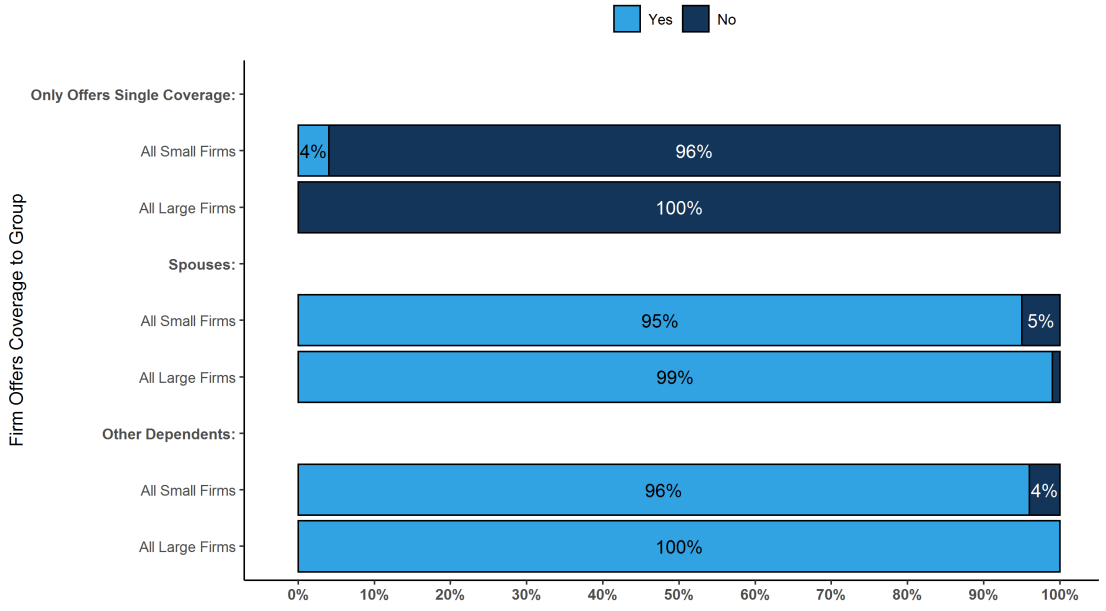


* Estimate is statistically different from estimate for the previous year shown (p < .05).
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers. Prior to 2015, each respondent defined part-time according to their firm's policies; starting in 2015, respondents were asked whether employees working fewer than 30 hours per week were eligible for benefits. There was no statistical testing between 2014 and 2015.
SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

SPOUSES AND DEPENDENTS

- The vast majority of firms offering health benefits offer to spouses and dependents, such as children.
  - In 2020, 95% of firms offering health benefits offer coverage to spouses, similar to the percentage last year [Figure 2.9].
  - Ninety-six percent of firms offering health benefits cover dependents other than spouses, such as children, similar to the percentages last year [Figure 2.9].
  - Four percent of small firms offering health benefits offer only single coverage to their workers, similar to the percentage last year [Figure 2.9].

Figure 2.9
Among Firms Offering Benefits, Percentage That Offer to Spouses and Dependents, by Firm Size, 2020



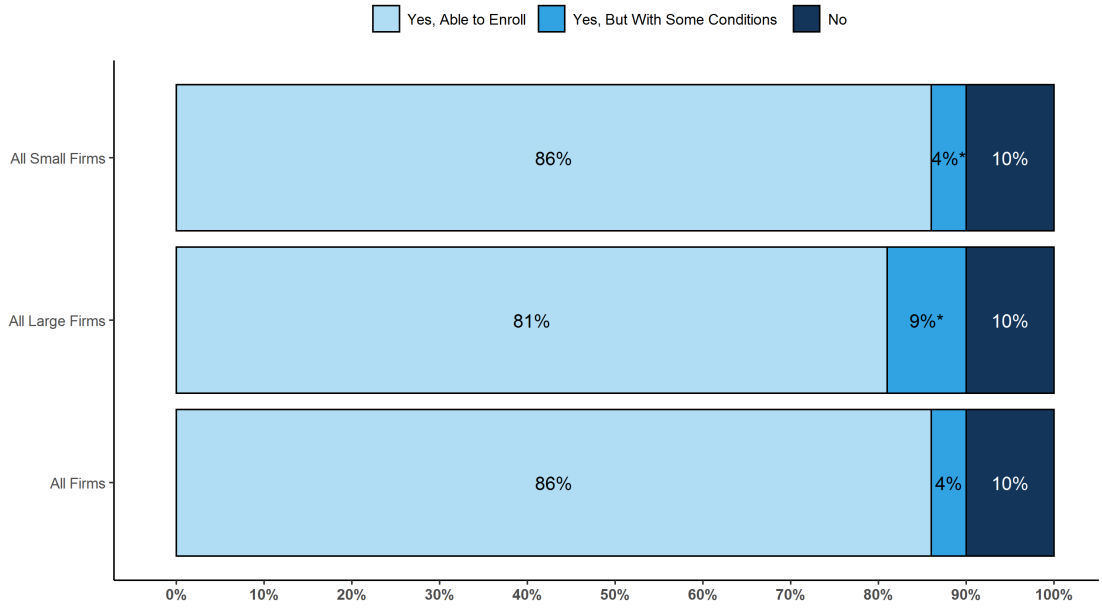
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2020

SPOUSAL SURCHARGES

Some employers place conditions on the ability of dependent spouses to enroll in a health plan if the spouse is offered health insurance from another source, such as his or her own place of work.

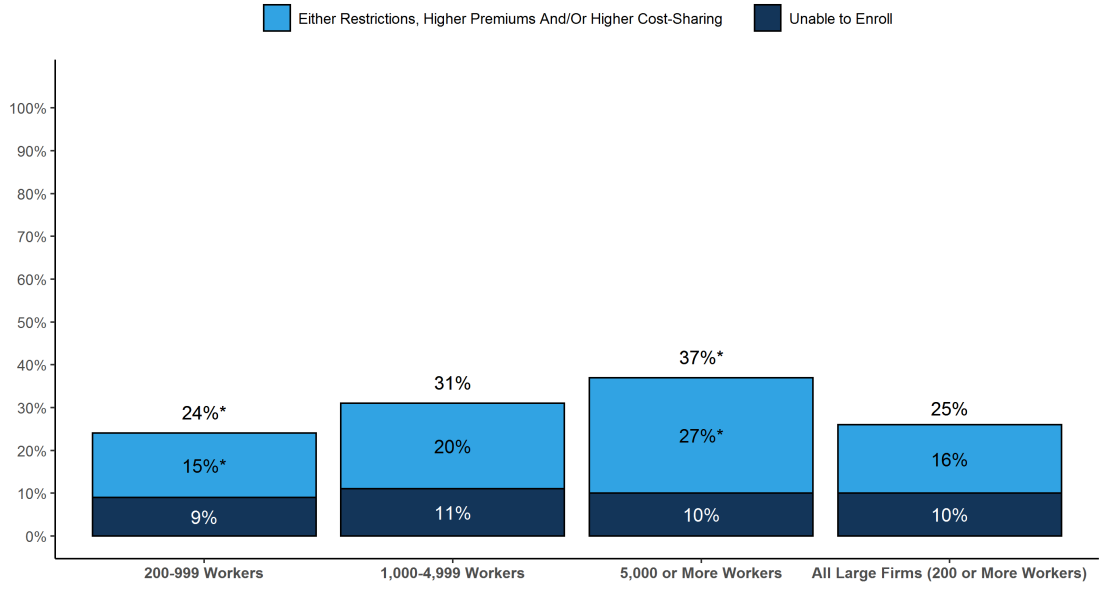
- Among firms offering health benefits to spouses, 86% say that an employee's spouse is able to enroll in the employee's health plan even if the spouse is offered coverage from another source, 4% say the spouse can enroll subject to some conditions (for example, the type of coverage offered), and 10% say that the spouse is not eligible to enroll [Figure 2.10].
- Among large firms that say that spouses are eligible to enroll in an employee's health plan even if the spouse has access to coverage from another source, 13% require the spouse to pay more to enroll than other spouses, such as a higher premium contribution or cost sharing [Figure 2.12].

Figure 2.10
Percent of Firms Offering Spousal Coverage Which Restrict Spouses' Eligibility if They Have an Offer from Another Source, by Firm Size, 2020



* Estimate is statistically different between All Small Firms and All Large Firms estimate ($p < .05$).
NOTE: Other restrictions may include requirements on the work status of the spouse, or the type of coverage they have access to.
SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 2.11
Among Large Firms that Offer Spousal Coverage, Spouses' Eligibility if They Have an Offer from Another Source, by Firm Size, 2020



* Estimate is statistically different from estimate for all other firms not in the indicated size category ($p < .05$).
NOTE: Large Firms have 200 or more workers. Other restrictions may include requirements on the work status of the spouse, or the type of coverage they have access to.
SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 2.12

Among Firms Offering Health Benefits to Spouses, Firm's Approach to Spousal Coverage If Employee's Spouse Is Offered Coverage From Another Source, by Firm Size, 2014-2020

	2014	2016	2019	2020
Spouse Not Eligible to Enroll				
All Small Firms (3-199 Workers)	9%	13%	12%	10%
All Large Firms (200 or More Workers)	8%	5%	11%*	10%
ALL FIRMS	9%	13%	12%	10%
Spouse Required to Contribute More to Coverage				
All Small Firms (3-199 Workers)	5%	12%	3%*	2%
All Large Firms (200 or More Workers)	9%	14%*	10%	13%
ALL FIRMS	5%	12%	3%*	3%

NOTE: A higher contribution includes either a higher premium contribution or higher cost-sharing such as deductibles and copays. Percent required to contribute more is asked of firms who allow spouses to enroll

* Estimate is statistically different from estimate for the previous year shown ($p < .05$).

SOURCE: KFF Employer Health Benefits Survey, 2019-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2014-2016

FIRMS NOT OFFERING HEALTH BENEFITS

- The survey asks firms that do not offer health benefits several questions, including whether they have offered insurance or shopped for insurance in the recent past, their most important reasons for not offering coverage, and their opinion on whether their employees would prefer an increase in wages or health insurance if additional funds were available to increase their compensation. Because such a small percentage of large firms report not offering health benefits, we present responses for small non-offering firms only.
  - The cost of health insurance remains the primary reason cited by firms for not offering health benefits. Among small firms not offering health benefits, 37% cite high cost as "the most important reason" for not doing so. Other factors include "the firm is too small" (20%), employees are covered by another health plan (including a spouse's plan) (17%) and "most employees are part-time or temporary workers" (11%). Few small firms indicate that they do not offer because they believe employees will get a better deal on the health insurance exchanges (4%) [Figure 2.13].
- Some small non-offering firms have either offered health insurance in the past five years or shopped for health insurance in the past year.
  - Seven percent of small non-offering firms have offered health benefits in the past five years, lower than the percentage reported last year or in recent years [Figure 2.14]. We will monitor this percentage to determine if this is a single-year change or a new and different level.
  - Seventeen percent of small non-offering firms have shopped for coverage in the past year, similar to the percentage last year (14%) [Figure 2.14].
- Among small non-offering firms that report they stopped offering coverage within the past five years, 30% stopped offering coverage within the past year.
- Eight percent of small firms not offering health benefits report that they provide funds for employees to purchase insurance on their own in the individual market or through a health insurance exchange, similar to the percentage in 2019 [Figure 2.15].
- Sixty-nine percent of small firms not offering health benefits believed that their employees would prefer a two dollar per hour increase in wages rather than health insurance. [Figure 2.16].

Figure 2.13

Among Small Firms Not Offering Health Benefits, Most Important Reason for Not Offering, 2020

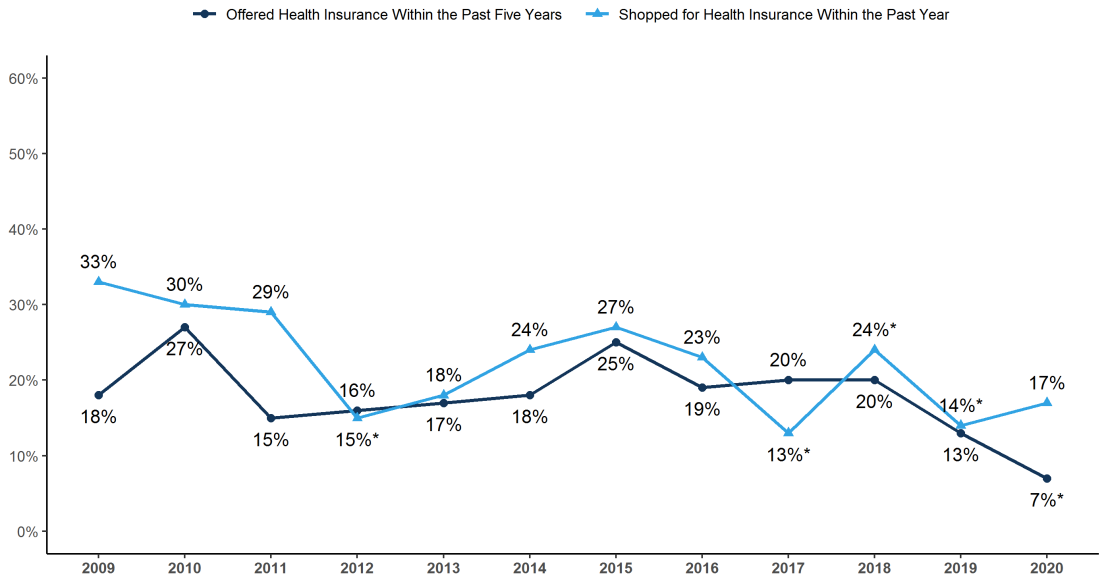
	3-9 Workers	10-199 Workers	**All Small Firms**
Cost of Health Insurance Too High	28%	56%	**37%**
Firm Is Too Small	23	14	**20**
Employees Are Covered Under Another Plan, Including Spouse's	19	11	**17**
Employees Will Get a Better Deal On Health Insurance Exchanges	5	2	**4**
Employee Turnover Is Too Great	2	2	**2**
No Interest/Employees Do Not Want It	5	3	**4**
Most Employees Are Part-Time or Temporary Workers	13	6	**11**
Other	4	4	**4**
Don't Know	1%	2%	**1%**

NOTE: Small Firms have 3-199 workers.

SOURCE: KFF Employer Health Benefits Survey, 2020

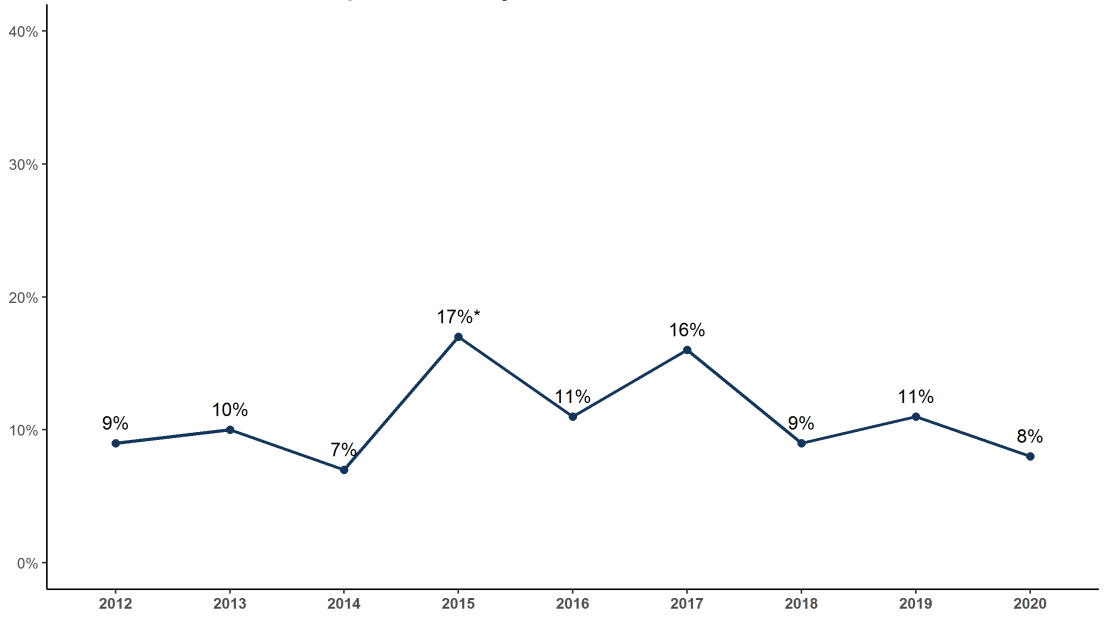
Figure 2.14

Among Small Firms Not Offering Health Benefits, Percentage of Firms That Report the Following Actions, 2009-2020



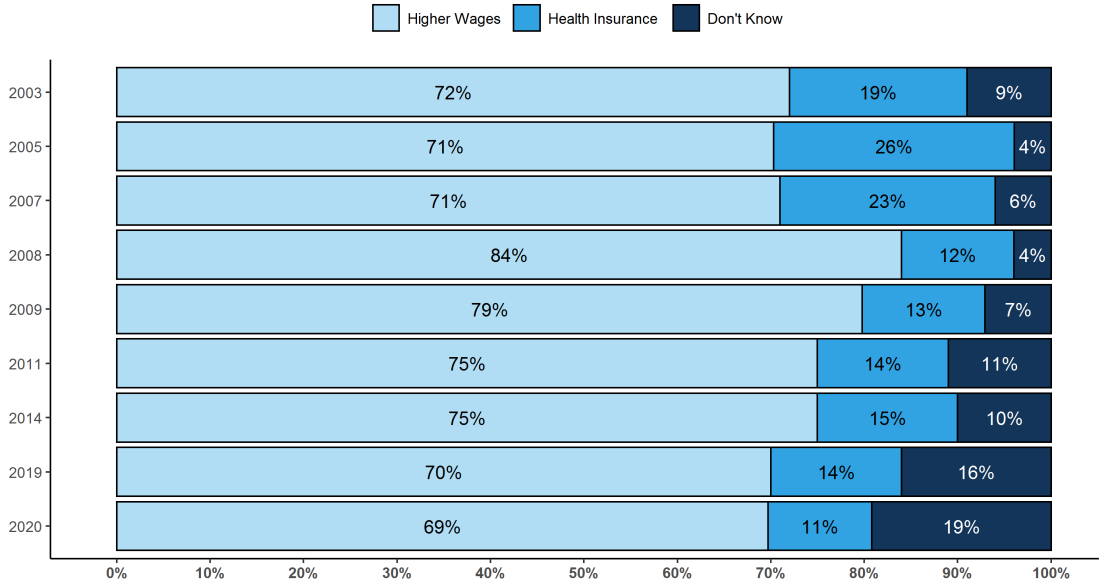
* Estimate is statistically different from estimate for the previous year shown (p < .05).
NOTE: Small Firms have 3-199 workers. 30% of small non-offering firms who indicated they had offered health insurance in the past five years said they stopped offering health benefits in the past 12 months.
SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2009-2017

Figure 2.15
Among Small Firms Not Offering Health Benefits, Percentage of Firms That Provide Workers Funds to Purchase Non-Group Insurance, by Firm Size, 2012-2020



* Estimate is statistically different from estimate for the previous year shown (p < .05).
NOTE: Small Firms have 3-199 workers.
SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2012-2017

Figure 2.16
Among Small Firms Not Offering Health Benefits, Firms' View of Employees' Preference for Higher Wages or Health Insurance Benefits, 2003-2020



Tests found no statistical difference from distribution for the previous year shown (p < .05).
NOTE: Small Firms have 3-199 workers. The question asks firms whether they believe employees would rather receive an additional $2 per hour in the form of higher wages or health insurance.
SOURCE: KFF Employer Health Benefits Survey, 2019-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2003-2014

Employer Health Benefits
2020 Annual Survey

Employee Coverage, Eligibility, and Participation

SECTION

3

Section 3

Employee Coverage, Eligibility, and Participation

Employers are the principal source of health insurance in the United States, providing health benefits for about 157 million people.[1] Most workers are offered health coverage at work, and most of the workers who are offered coverage take it. Workers may not be covered by their own employer for several reasons: their employer may not offer coverage, they may not be eligible for the benefits offered by their firm, they may elect to receive coverage through their spouse's employer, or they may refuse coverage from their firm. In 2020, 64% of workers in firms offering health benefits are covered by their own firm, similar to the percentages last year, five years ago and ten years ago.

Before eligible workers may enroll in benefits at their firm, 68% of covered workers face a waiting period.

ELIGIBILITY

- Even in firms that offer health benefits, some workers may not be eligible to participate.[2] Many firms, for example, do not offer coverage to part-time or temporary workers. Among workers in firms offering health benefits in 2020, 82% are eligible to enroll in the benefits offered by their firm, similar to the percentages last year, five years ago, and 10 years ago, for both small and large firms [Figure 3.1].
  - The percentage of workers eligible to enroll in health benefits at their firm is relatively higher in firms with 3-24 workers (86%) [Figure 3.3].
  - Eligibility varies considerably by firm wage level. Workers in firms with a relatively large share of lower-wage workers (where at least 35% of workers earn $26,000 a year or less) have a lower average eligibility rate than workers in firms with a smaller share of lower-wage workers (72% vs. 82%) [Figure 3.6].
  - Workers in firms with a relatively large share of higher-wage workers (where at least 35% earn $64,000 or more annually) have a higher average eligibility rate than workers in firms with a smaller share of higher-wage workers (88% vs. 77%) [Figure 3.6].
  - Eligibility also varies by the age of the workforce. Those in firms with a relatively small share of younger workers (where fewer than 35% of the workers are age 26 or younger) have a higher average eligibility rate than those in firms with a larger share of younger workers (84% vs. 62%) [Figure 3.6].
  - Eligibility rates vary considerably for workers in different industries. The average eligibility rate remains particularly low for workers in retail firms (54%) [Figure 3.3].

[1] Kaiser Family Foundation. Health Insurance Coverage of the Total Population [Internet]. KFF (Kaiser Family Foundation). 2019 [cited 2020 Aug 10]. Available from: https://www.kff.org/other/state-indicator/total-population/ Coverage is based on calculations from the 2018 American Community Survey. During the winter and spring of 2020, there was a steep increase in the unemployment rate, potentially decreasing the number of people covered by employer coverage.

[2] See Section 2 for part-time and temporary worker offer rates.

Figure 3.1

Eligibility, Take-Up, and Coverage Rates for Workers in Firms Offering Health Benefits, by Firm Size, 1999-2020

	Percentage Eligible			Percentage of Eligible That Take Up			Percentage Covered		
	Small Firms	Large Firms	All Firms	Small Firms	Large Firms	All Firms	Small Firms	Large Firms	All Firms
1999	81%	78%	79%	83%	86%	85%	67%	66%	66%
2000	82%	80%	81%	83%	84%	84%	68%	67%	68%
2001	85%	82%	83%	83%	85%	84%	71%	69%	70%
2002	82%*	80%	81%*	82%	86%	85%	67%*	69%	68%
2003	84%	80%	81%	81%	85%	84%	68%	68%	68%
2004	80%	81%	80%	80%	84%	83%	64%	68%	67%
2005	81%	79%	80%	81%	85%	83%	65%	67%	66%
2006	83%	76%	78%	81%	84%	83%	67%	63%	65%
2007	80%	78%	79%	80%	84%	82%	64%	65%	65%
2008	81%	79%	80%	80%	84%	82%	65%	66%	65%
2009	81%	79%	79%	79%	82%	81%	64%	65%	65%
2010	82%	77%	79%	77%	82%	80%	63%	63%	63%
2011	83%	78%	79%	78%	83%	81%	65%	65%	65%
2012	78%*	76%	77%	78%	82%	81%	61%	62%	62%
2013	80%	76%	77%	77%	81%	80%	62%	62%	62%
2014	79%	76%	77%	77%	81%	80%	61%	62%	62%
2015	81%	79%	79%	76%	81%	79%	61%	63%	63%
2016	82%	78%	79%	77%	79%	79%	63%	62%	62%
2017	82%	78%	79%	75%	79%	78%	62%	62%	62%
2018	82%	77%	79%	73%	78%	76%	60%	60%	60%
2019	82%	79%	80%	74%	78%	76%	60%	61%	61%
2020	84%	81%	82%	74%	80%	78%	61%	65%	64%

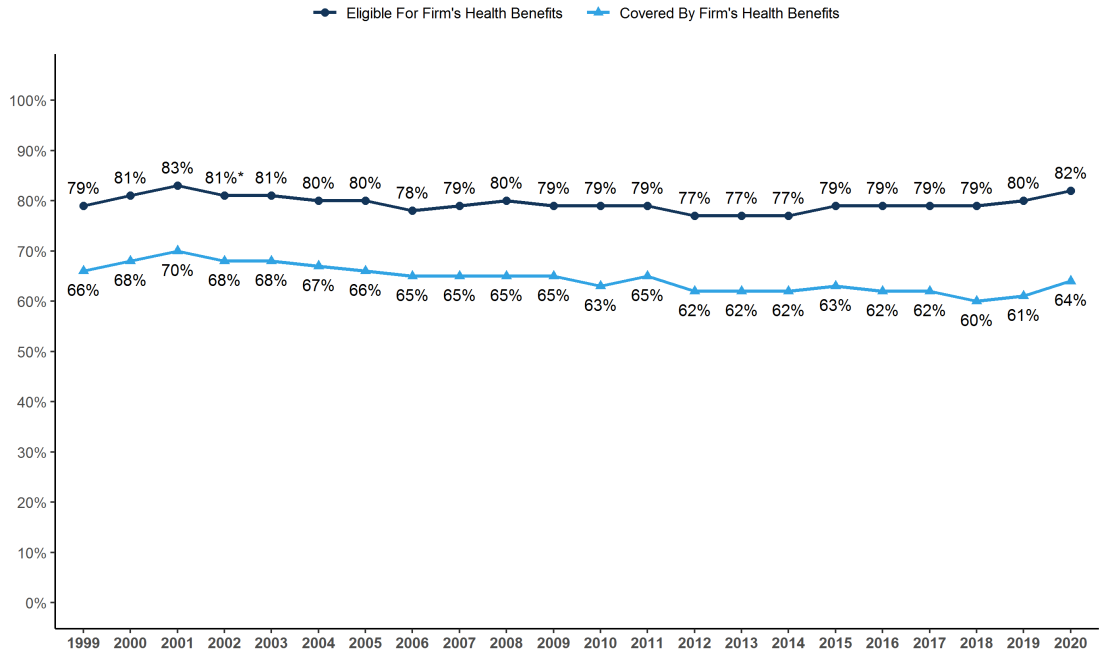
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers.

* Estimate is statistically different from estimate for the previous year shown (p < .05).

SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

Figure 3.2

Eligibility and Coverage Rates for Workers in Firms Offering Health Benefits, 1999-2020



* Estimate is statistically different from estimate for the previous year shown (p < .05).

SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

Figure 3.3

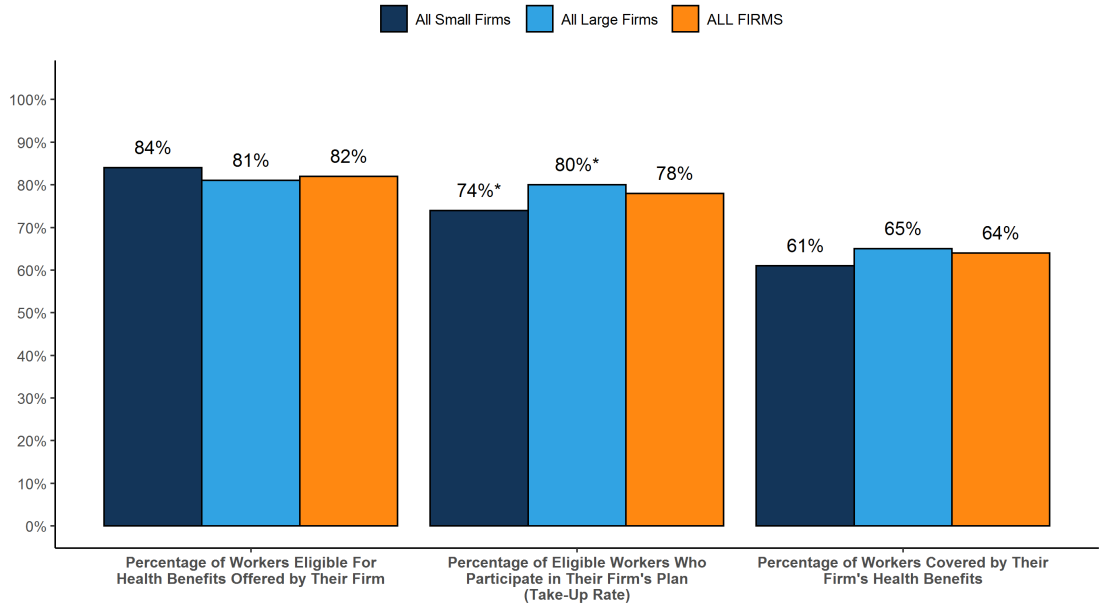
Eligibility, Take-Up, and Coverage Rates in Firms Offering Health Benefits, by Firm Size, Region, and Industry, 2020

	Percentage of Workers Eligible for Health Benefits Offered by Their Firm	Percentage of Eligible Workers Who Participate in Their Firm's Plan (Take-Up Rate)	Percentage of Workers Covered by Their Firm's Health Benefits
FIRM SIZE			
3-24 Workers	86%*	73%*	63%
25-49 Workers	82	72*	59
50-199 Workers	82	75*	61
200-999 Workers	83	78	65
1,000-4,999 Workers	84	81*	68*
5,000 or More Workers	79	81	63
All Small Firms (3-199 Workers)	**84%**	**74%***	**61%**
All Large Firms (200 or More Workers)	**81%**	**80%***	**65%**
REGION			
Northeast	84%	78%	65%
Midwest	82	78	64
South	82	78	64
West	79	80	63
INDUSTRY			
Agriculture/Mining/Construction	79%	72%*	57%*
Manufacturing	92*	81	75*
Transportation/Communications/Utilities	92*	86*	79*
Wholesale	89*	81	72*
Retail	54*	73	40*
Finance	95*	81	77*
Service	81	76*	61
State/Local Government	90*	90*	80*
Health Care	82	75	61
ALL FIRMS	**82%**	**78%**	**64%**

* Estimate for eligibility, take-up, or coverage rate is statistically different from all other firms not in the indicated size, region, or industry category ($p < .05$).

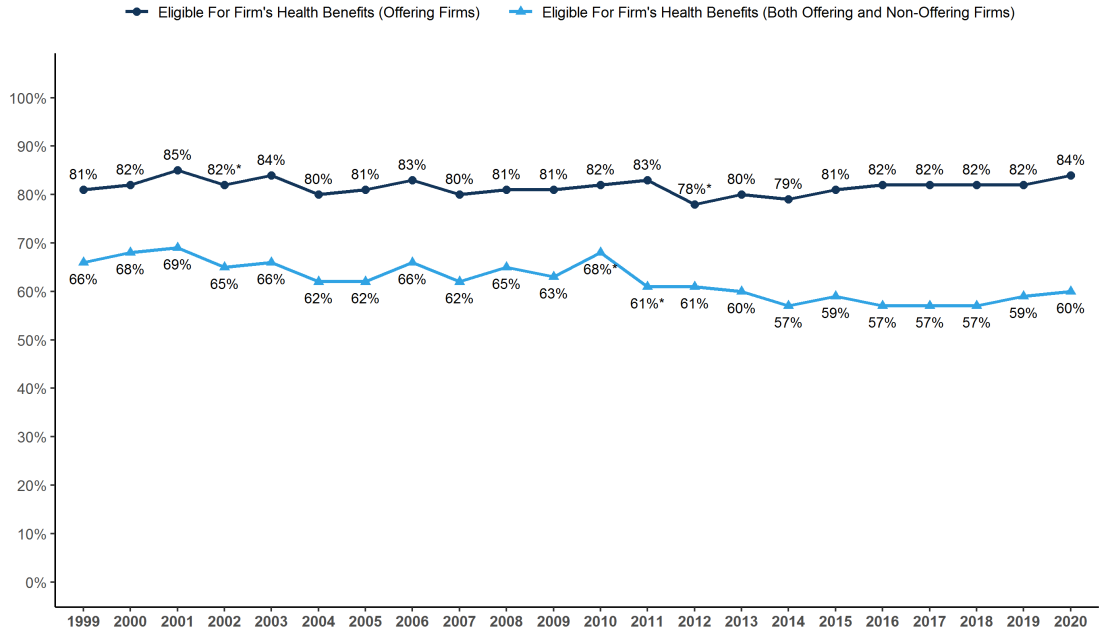
SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 3.4
Eligibility, Take-Up, and Coverage Rates in Firms Offering Health Benefits, by Firm Size, 2020



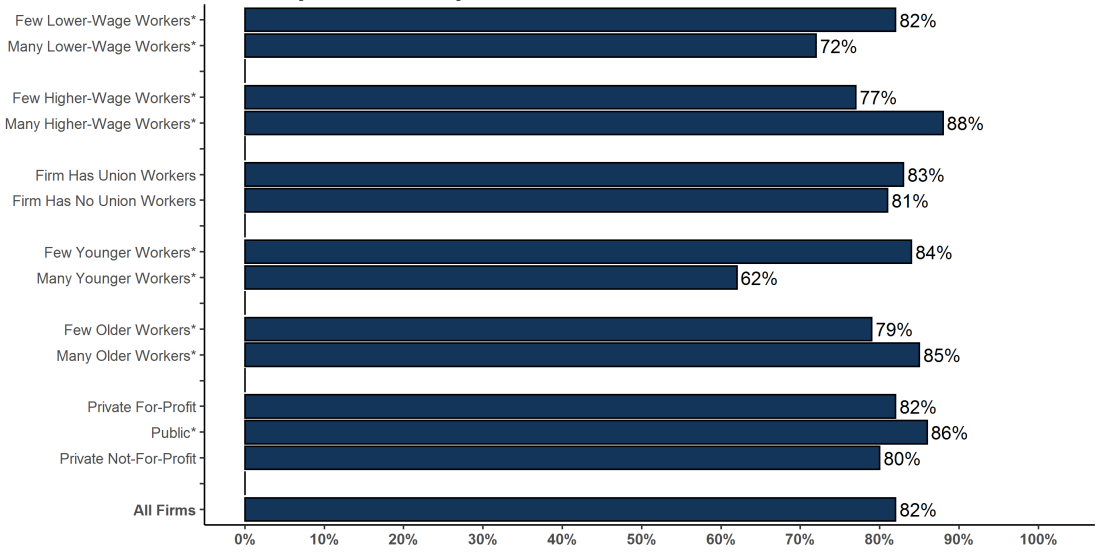
* Estimate for eligibility, take-up, or coverage rate is statistically different between large and small firms ($p < .05$).
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 3.5
Among Workers at Small Firms, Eligibility for Workers At Their Own Firms, 1999-2020



* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
NOTE: By definition, no workers at non-offering firms are eligible for health benefits.
SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

Figure 3.6
Among Workers in Firms Offering Health Benefits, Percentage of Workers Eligible for Health Benefits Offered by Their Firm, by Firm Characteristics, 2020



* Estimates are statistically different from each other within category ($p < .05$).
NOTE: Firms with many lower-wage workers are those where at least 35% earn the 25th percentile or less of national earnings ($26,000 in 2020). Firms with many higher-wage workers are those where at least 35% earn the 75th percentile or more than of national earnings ($64,000 in 2020). Firms with many older workers are those where at least 35% of workers are age 50 or older. Firms with many younger workers are those where at least 35% of workers are age 26 or younger.
SOURCE: KFF Employer Health Benefits Survey, 2020

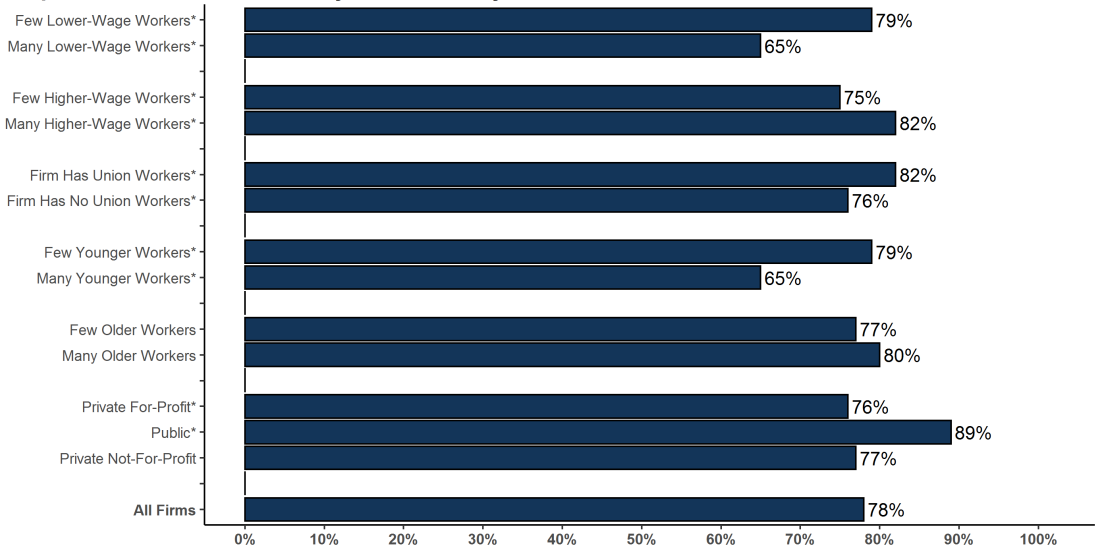
TAKE-UP RATE

- Seventy-eight percent of eligible workers take up coverage when it is offered to them, similar to the percentage last year. The share of eligible workers taking up coverage in large firms is higher than the share in small firms [Figure 3.1].[3]
  - The likelihood of a worker accepting a firm's offer of coverage varies by firm wage level. Eligible workers in firms with a relatively large share of lower-wage workers have a lower average take up rate than eligible workers in firms with a smaller share of lower-wage workers (65% vs. 79%) [Figure 3.7].
  - Eligible workers in firms with a relatively large share of higher-wage workers have a higher average take up rate than those in firms with a smaller share of higher-wage workers (82% vs. 75%) [Figure 3.7].
  - The likelihood of a worker accepting a firm's offer of coverage also varies with the age distribution of the workforce. Eligible workers in firms with a relatively large share of younger workers have a lower average take up rate than those in firms with a smaller share of younger workers (65% vs. 79%) [Figure 3.7].
- Eligible workers in private, for-profit firms have a lower average take up rate (76%) and eligible workers in public firms have a higher average take up rate (89%) than workers in other firm types [Figure 3.7].
- Eligible workers in firms with some union workers have a higher average takeup rate than those in firms with no union workers (82% vs. 76%) [Figure 3.7].

[3] In 2009, we began weighting the percentage of workers that take up coverage by the number of workers eligible for coverage. The historical take-up estimates have also been updated. See the Survey Design and Methods section for more information.

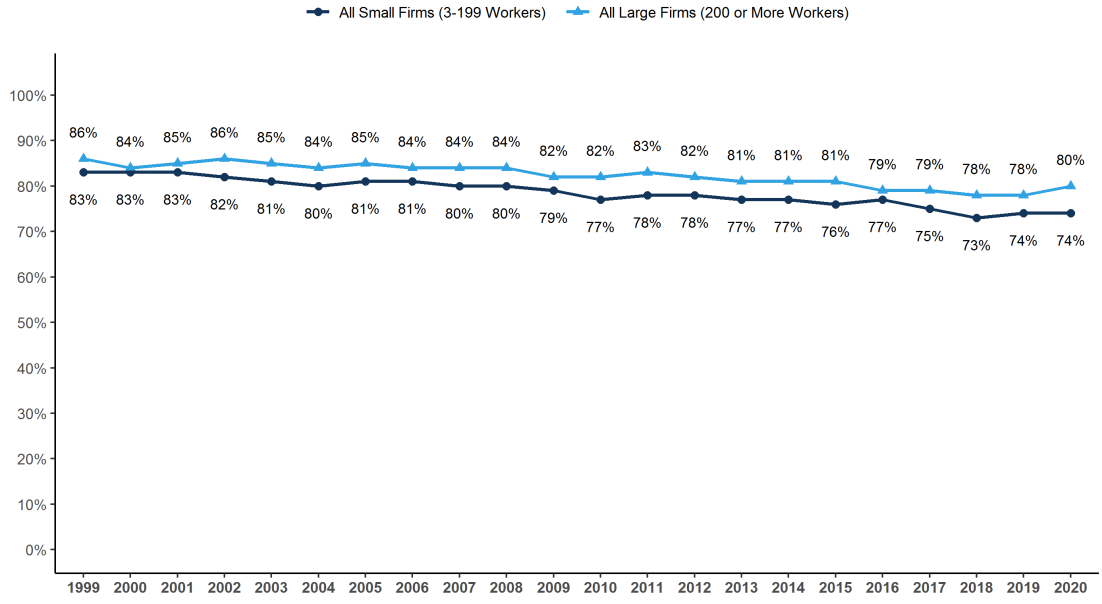
- The average percentages of eligible workers taking up benefits in offering firms also varies across industries [Figure 3.3].
- The share of eligible workers taking up benefits in offering firms (78%) is similar to the shares in 2015 (79%) and in 2010 (80%) [Figure 3.1].

Figure 3.7
Among Workers in Firms Offering Health Benefits, Percentage of Eligible Workers Who Take Up Health Benefits Offered by Their Firm, by Firm Characteristics, 2020



* Estimates are statistically different from each other within category ($p < .05$).
NOTE: Firms with many lower-wage workers are those where at least 35% earn the 25th percentile or less of national earnings ($26,000 in 2020). Firms with many higher-wage workers are those where at least 35% earn the 75th percentile or more than of national earnings ($64,000 in 2020). Firms with many older workers are those where at least 35% of workers are age 50 or older. Firms with many younger workers are those where at least 35% of workers are age 26 or younger.
SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 3.8
Among Workers in Firms Offering Health Benefits, Percentage of Eligible Workers Who Take Up Health Benefits Offered by Their Firm, by Firm Size, 1999-2020



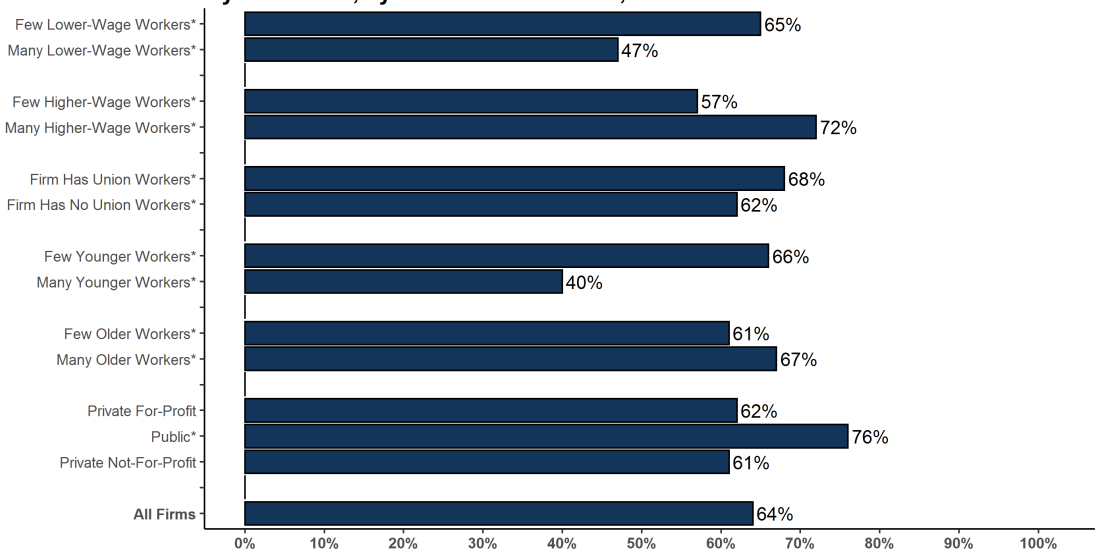
Tests found no statistical difference from estimate for the previous year shown ($p < .05$).
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

COVERAGE

- In 2020, the percentage of workers at firms offering health benefits covered by their firm's health plan is 64%, similar to the percentage last year [Figure 3.1] and [Figure 3.2].
  - The coverage rate at firms offering health benefits is similar for small firms and large firms in 2020. These rates are similar to the rates last year for both small firms and large firms [Figure 3.1] and [Figure 3.3].
- There is significant variation by industry in the coverage rate among workers in firms offering health benefits. The average coverage rate is particularly low in the retail industry (40%) [Figure 3.3].
- There also is variation by firm wage levels. Among workers in firms offering health benefits, those in firms with a relatively large share of lower-wage workers are less likely to be covered by their own firm than workers in firms with a smaller share of lower-wage workers (47% vs. 65%). A similar pattern exists in firms with a relatively large share of higher-wage workers, with workers in these firms being more likely to be covered by their employer's health benefits than those in firms with a smaller share of higher-wage workers (72% vs. 57%) [Figure 3.9].
- The age distribution of workers is also related to variation in coverage rates. Among workers in firms offering health benefits, those in firms with a relatively small share of younger workers are more likely to be covered by their own firm than those in firms with a larger share of younger workers (66% vs. 40%). Similarly, workers in offering firms with a relatively large share of older workers are more likely to be covered by their own firm than those in firms with a smaller share of older workers (67% vs. 61%) [Figure 3.9].

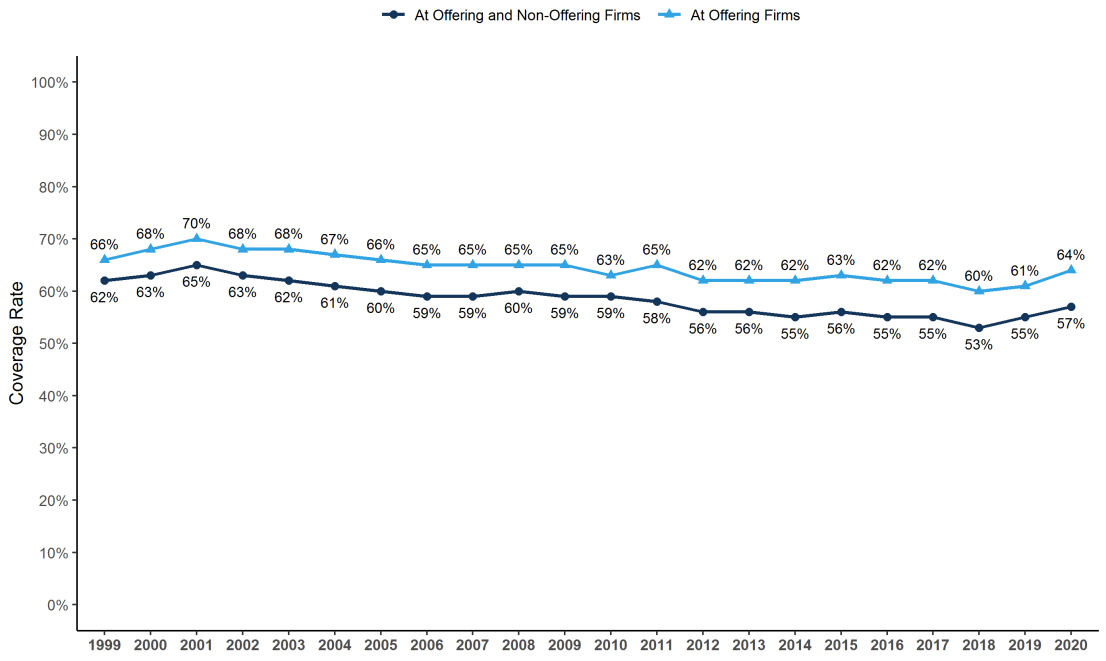
- Among workers in firms offering health benefits, those working in public firms are more likely than workers in other firm types to be covered by their own firm [Figure 3.9].
- Among workers in all firms, including those that offer and those that do not offer health benefits, 57% are covered by health benefits offered by their employer, similar to the percentages last year and five years ago [Figure 3.10]. The offer rate estimate for 2010 was an aberration so we are not making a coverage rate comparison to ten years ago.

Figure 3.9
Among Workers in Firms Offering Health Benefits, Percentage of Workers Covered by Health Benefits Offered by Their Firm, by Firm Characteristics, 2020



* Estimates are statistically different from each other within category ($p < .05$).
NOTE: Firms with many lower-wage workers are those where at least 35% earn the 25th percentile or less of national earnings ($26,000 in 2020). Firms with many higher-wage workers are those where at least 35% earn the 75th percentile or more than of national earnings ($64,000 in 2020). Firms with many older workers are those where at least 35% of workers are age 50 or older. Firms with many younger workers are those where at least 35% of workers are age 26 or younger.
SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 3.10
Percentage of Workers Covered by Their Firm's Health Benefits, 1999-2020



Tests found no statistical difference from estimate for the previous year shown ($p < .05$).
SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

Figure 3.11
Percentage of All Workers Covered by Their Firm's Health Benefits, Both in Firms Offering and Not Offering Health Benefits, by Firm Size, 1999-2020

	3-24 Workers	25-49 Workers	50-199 Workers	200-999 Workers	1,000-4,999 Workers	5,000 or More Workers	All Small Firms	All Large Firms	**All Firms**
1999	50%	56%	61%	69%	68%	64%	55%	66%	**62%**
2000	50%	63%	62%	69%	68%	66%	57%	67%	**63%**
2001	49%	62%	67%	71%	69%	69%	58%	69%	**65%**
2002	45%	57%	64%	69%	70%	68%	54%	69%	**63%**
2003	44%	59%	61%	68%	69%	68%	53%	68%	**62%**
2004	43%	56%	56%	69%	68%	67%	50%	68%	**61%**
2005	41%	55%	59%	65%	69%	66%	50%	66%	**60%**
2006	45%	55%	62%	66%	68%	60%	53%	63%	**59%**
2007	42%	51%	59%	65%	69%	63%	50%	65%	**59%**
2008	43%	57%	60%	67%	69%	64%	52%	66%	**60%**
2009	39%	54%	59%	63%	67%	65%	49%	65%	**59%**
2010	44%	59%	60%	61%	66%	63%	52%	63%	**59%**
2011	38%	49%	59%	63%	66%	64%	48%*	64%	**58%**
2012	36%	54%	58%	61%	66%	61%	47%	62%	**56%**
2013	36%	53%	57%	63%	67%	58%	46%	61%	**56%**
2014	33%	52%	55%	60%	66%	61%	44%	62%	**55%**
2015	35%	49%	54%	61%	66%	63%	45%	63%	**56%**
2016	32%	47%	57%	62%	63%	60%	44%	61%	**55%**
2017	32%	45%	55%	60%	64%	61%	43%	62%	**55%**
2018	30%	44%	54%	62%	62%	59%	41%	60%	**53%**
2019	32%	48%	56%	65%	66%	58%	44%	61%	**55%**
2020	34%	41%	58%	65%	68%	63%	44%	65%	**57%**

NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers.
* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

WAITING PERIODS

- Waiting periods are a specified length of time after beginning employment before a worker is eligible to enroll in health benefits. With some exceptions, the Affordable Care Act (ACA) requires that waiting periods cannot exceed 90 days. For example, employers are permitted to have orientation periods before the waiting period begins which, in effect, means a worker is not eligible for coverage three months after being hired. If a worker is eligible to enroll on the 1st of the month after three months of employment, this survey rounds up and considers the firm's waiting period four months. For these reasons, some employers still have waiting periods exceeding the 90-day maximum.
- Sixty-eight percent of covered workers face a waiting period before coverage is available, similar to two years ago [Figure 3.12]. Covered workers in small firms are more likely than those in large firms to have a waiting period (78% vs. 64%) [Figure 3.12].
- The average waiting period among covered workers who face a waiting period is 1.9 months [Figure 3.12]. A small percentage (5%) of covered workers with a waiting period have a waiting period of more than 3 months.
  - Respondents with waiting periods greater than 4 months generally indicated that employees had training, orientation, or measurement periods in which they were employees but were not eligible for health benefits. Some employers have measurement periods to determine whether variable hour employees will meet the requirements for the firm's health benefits.

Figure 3.12

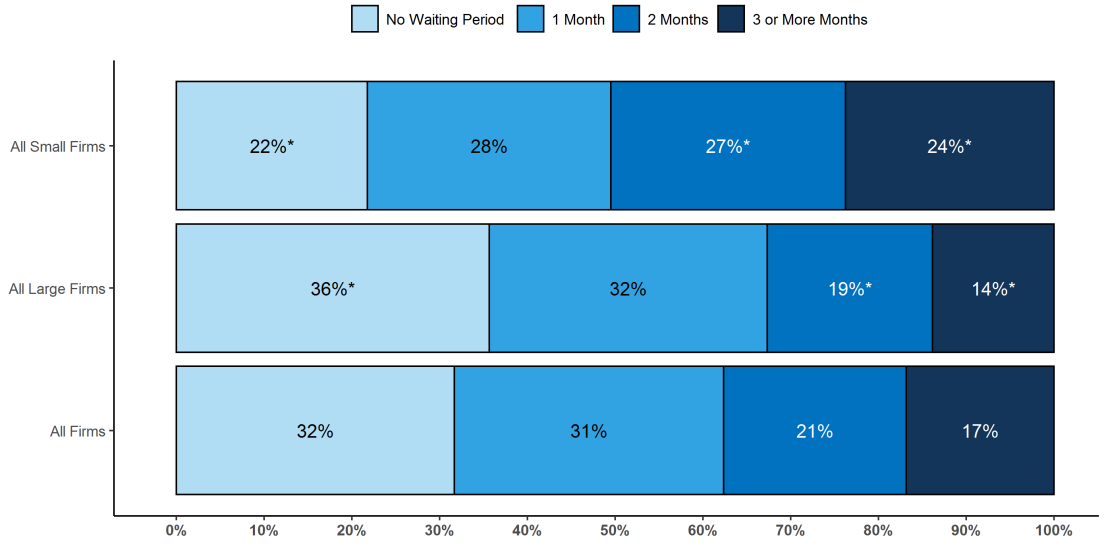
Percentage of Covered Workers in Firms With a Waiting Period for Coverage and Average Waiting Period in Months, by Firm Size, Region, and Industry, 2020

	Percentage of Covered Workers in Firms With a Waiting Period	Among Covered Workers With a Waiting Period, Average Waiting Period (Months)
FIRM SIZE		
All Small Firms (3-199 Workers)	78%*	2.1*
All Large Firms (200 or More Workers)	64%*	1.8*
REGION		
Northeast	63%	2.3*
Midwest	70	1.8
South	68	1.8
West	71	1.9
INDUSTRY		
Agriculture/Mining/Construction	86%*	2.6*
Manufacturing	78	1.9
Transportation/Communications/Utilities	53	1.5*
Wholesale	73	2.2
Retail	78	2.7*
Finance	76	2.1
Service	61*	1.8
State/Local Government	60	1.3*
Health Care	74	1.7*
ALL FIRMS	**68%**	**1.9**

* Estimate is statistically different from estimate for all firms not in the indicated size, region, or industry category ($p < .05$).

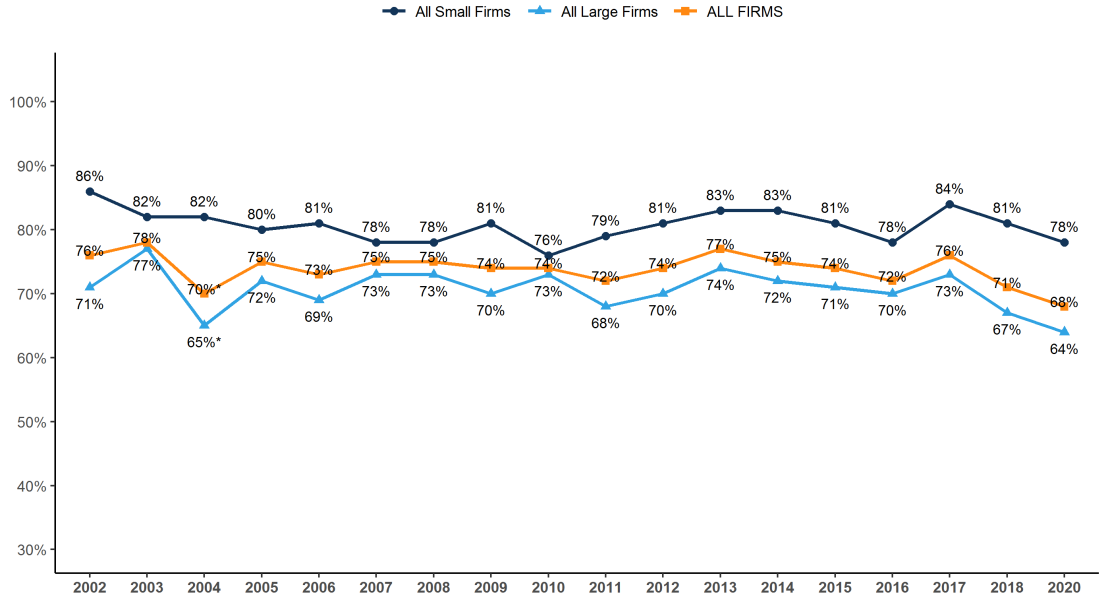
SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 3.13
Distribution of Covered Workers with the Following Waiting Periods for Coverage, by Firm Size, 2020



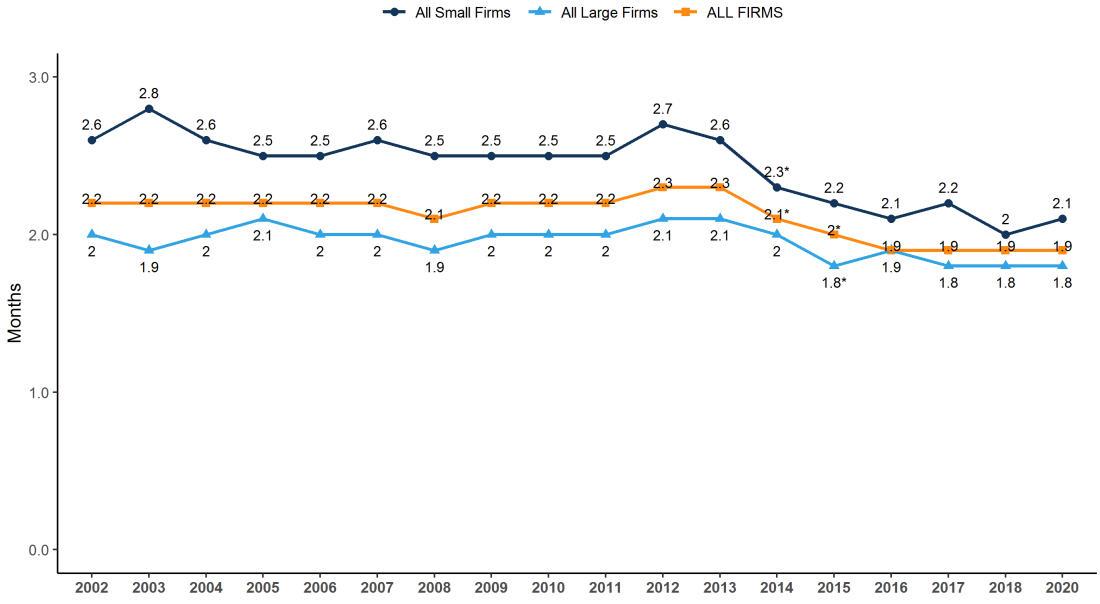
* Estimates are statistically different from each other within category (p < .05).
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers. If a worker is eligible to enroll on the 1st of the month after three months of employment, this survey rounds up and considers the firm's waiting period four months. Some firms indicated that employees had training or measurement periods during which they were not eligible for health benefits. For these reasons, some firms still have waiting periods exceeding the 90-day maximum.
SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 3.14
Percentage of Covered Workers in Firms with a Waiting Period for Coverage, by Firm Size, 2002-2020



* Estimate is statistically different from estimate for the previous year shown (p < .05).
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2002-2017

Figure 3.15
Among Covered Workers With A Waiting Period for Health Benefits, Average Waiting Period in Months, by Firm Size, 2002-2020



* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2002-2017

Employer Health Benefits

2020 Annual Survey

Types of Plans Offered

SECTION

4

Section 4

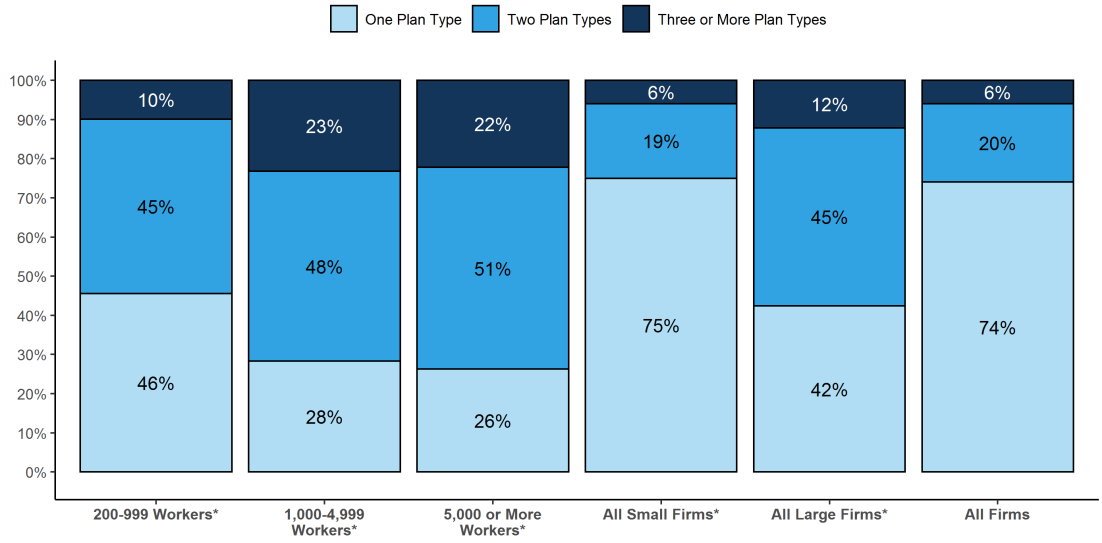
Types of Plans Offered

Most firms that offer health benefits offer only one type of health plan (74%). Large firms (200 or more workers) are more likely than small firms (3-199 workers) to offer more than one type of health plan. Firms are most likely to offer their workers a PPO plan and are least likely to offer a conventional plan (sometimes known as indemnity insurance).

NUMBER OF PLAN TYPES OFFERED

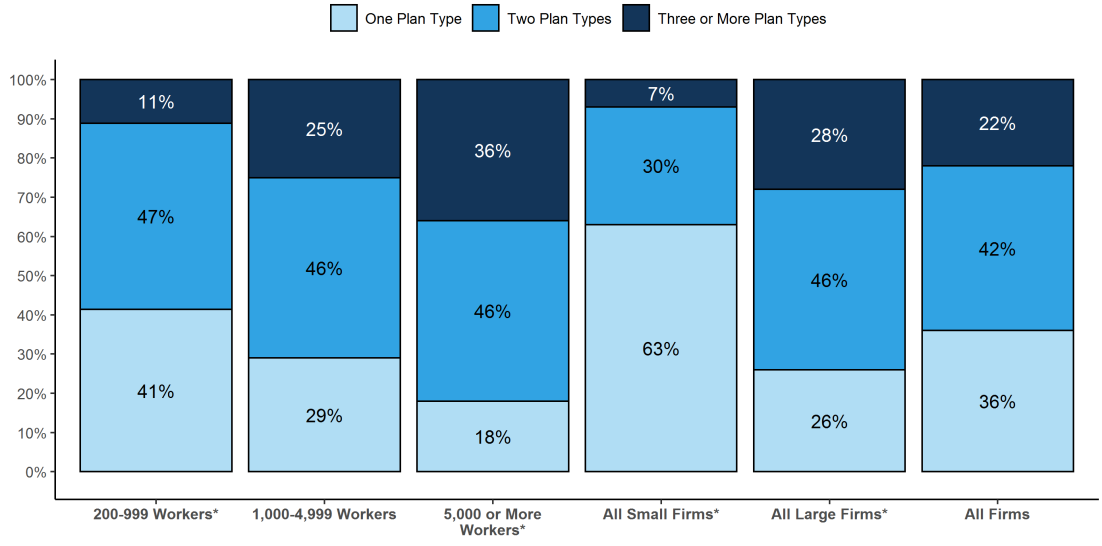
- In 2020, 74% of firms offering health benefits offer only one type of health plan. Large firms are more likely than small firms to offer more than one plan type (58% vs. 25%) [Figure 4.1].
- Sixty-four percent of covered workers are employed in a firm that offers more than one type of health plan. Seventy-four percent of covered workers in large firms are employed by a firm that offers more than one plan type, compared to 37% in small firms [Figure 4.2].
- Seventy-eight percent of covered workers in firms offering health benefits work in firms that offer one or more PPOs; 62% work in firms that offer one or more HDHP/SOs; 30% work in firms that offer one or more HMOs; 15% work in firms that offer one or more POS plans; and 3% work in firms that offer one or more conventional plans [Figure 4.4].
- Among covered workers in firms offering only one type of health plan, 56% are in firms that only offer one or more PPOs and 24% are in firms that only offer one or more HDHP/SOs [Figure 4.5].

Figure 4.1
Among Firms Offering Health Benefits, Percentage of Firms That Offer One, Two, or Three or More Plan Types, by Firm Size, 2020



* Distribution is statistically different from distribution for all other firms not in the indicated size category ($p < .05$).
NOTE: The survey collects information on a firm's plan with the largest enrollment in each of the plan types. While we know the number of plan types a firm has, we do not know the total number of plans a firm offers, as firms may offer more than one of each plan type. Additionally, firms may offer different types of plans to different workers. The survey asks how many Conventional, HMO, PPO, POS, and HDHP/SO plans are offered. Small Firms have 3-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 4.2
Among Firms Offering Health Benefits, Percentage of Covered Workers in Firms Offering One, Two, or Three or More Plan Types, by Firm Size, 2020



* Distribution is statistically different from distribution for all other firms not in the indicated size category ($p < .05$).
NOTE: The survey collects information on a firm's plan with the largest enrollment in each of the plan types. While we know the number of plan types a firm has, we do not know the total number of plans a firm offers, as firms may offer more than one of each plan type. Additionally, firms may offer different types of plans to different workers. The survey asks how many Conventional, HMO, PPO, POS, and HDHP/SO plans are offered. Small Firms have 3-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 4.3

Among Firms Offering Health Benefits, Percentage of Firms That Offer the Following Plan Types, by Firm Size, 2020

	Conventional	HMO	PPO	POS	HDHP/SO
FIRM SIZE					
3-24 Workers	4%	10%	54%	34%	21%*
25-199 Workers	1	16	59	25	39*
200-999 Workers	2	21*	69*	16*	53*
1,000-4,999 Workers	4	31*	86*	10*	67*
5,000 or More Workers	3	32*	84*	10*	71*
All Small Firms (3-199 Workers)	**3%**	**11%***	**55%***	**32%***	**25%***
All Large Firms (200 or More Workers)	**2%**	**23%***	**72%***	**15%***	**56%***
ALL FIRMS	**3%**	**11%**	**56%**	**31%**	**26%**

NOTE: The survey collects information on a firm's plan with the largest enrollment in each of the plan types. While we know the number of plan types a firm has, we do not know the total number of plans a firm offers, as firms may offer more than one of each plan type. Additionally, firms may offer different types of plans to different workers. The survey asks how many Conventional, HMO, PPO, POS, and HDHP/SO plans are offered.

* Estimate is statistically different from estimate for all other firms not in the indicated size category ($p < .05$).

SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 4.4

Among Firms Offering Health Benefits, Percentage of Covered Workers in Firms That Offer the Following Plan Types, by Firm Size, 2020

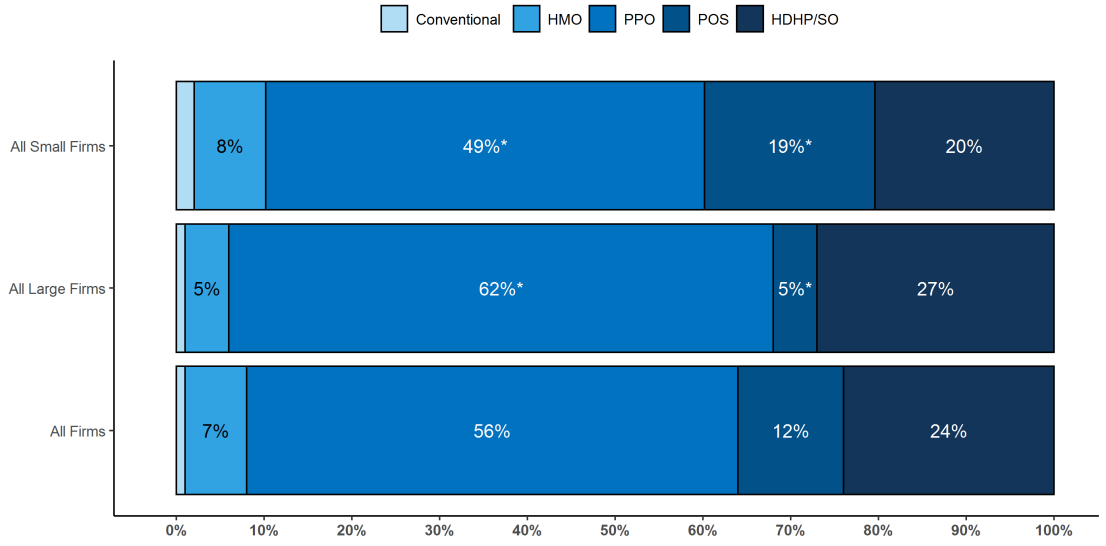
	Conventional	HMO	PPO	POS	HDHP/SO
FIRM SIZE					
200-999 Workers	2%	22%*	75%	13%	57%
1,000-4,999 Workers	4	30	87*	9*	70*
5,000 or More Workers	3	44*	86*	11	77*
All Small Firms (3-199 Workers)	**2%**	**16%***	**63%***	**23%***	**38%***
All Large Firms (200 or More Workers)	**3%**	**36%***	**84%***	**11%***	**71%***
ALL FIRMS	**3%**	**30%**	**78%**	**15%**	**62%**

NOTE: The survey collects information on a firm's plan with the largest enrollment in each of the plan types. While we know the number of plan types a firm has, we do not know the total number of plans a firm offers, as firms may offer more than one of each plan type. Additionally, firms may offer different types of plans to different workers. The survey asks how many Conventional, HMO, PPO, POS, and HDHP/SO plans are offered.

* Estimate is statistically different from estimate for all other firms not in the indicated size category ($p < .05$).

SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 4.5
Among Firms Offering Only One Type of Health Plan, Percentage of Covered Workers in Firms That Offer the Following Plan Type, by Firm Size, 2020

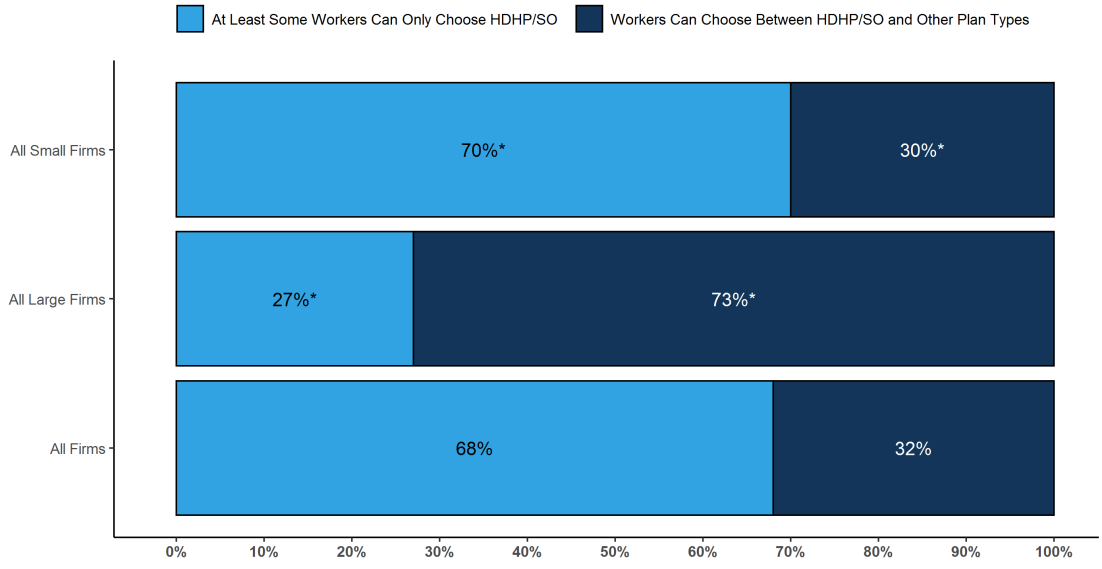


* Estimate is statistically different from estimate for all other firms not in the indicated size category ($p < .05$).
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers. The survey collects information on a firm's plan with the largest enrollment in each of the plan types. While we know the number of plan types a firm has, we do not know the total number of plans a firm offers, as firms may offer more than one of each plan type. Additionally, firms may offer different types of plans to different workers. The survey asks how many Conventional, HMO, PPO, POS, and HDHP/SO plans are offered.
SOURCE: KFF Employer Health Benefits Survey, 2020

CHOICE OF HDHP/SO PLANS

- Some firms only offer workers an HDHP/SO, or do not make other plan choices available to some workers. At 68% of firms that offer an HDHP/SO, at least some workers can only choose an HDHP/SO, while 32% of firms that offer an HDHP/SO allow workers to choose between an HDHP/SO and other plan types [Figure 4.6].

Figure 4.6
Among Firms Offering an HDHP/SO, Percentage of Firms That Offer Workers Various Plan Type Choices, by Firm Size, 2020



* Estimate is statistically different from estimate for all other firms not in the indicated size category ($p < .05$).
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers. Firms with an HDHP/SO and at least one other plan type were asked if any workers are offered only an HDHP/SO. Among offering firms, 13% of firms only offer workers an HDHP/SO. These firms are considered to not offer a choice of plan types. Workers may still have a choice of plan, even if the firm only offers one type.
SOURCE: KFF Employer Health Benefits Survey, 2020

The survey collects information on a firm's plan with the largest enrollment in each of the plan types. While we know the number of plan types a firm has, we do not know the total number of plans a firm offers workers. In addition, firms may offer different types of plans to different workers. For example, some workers might be offered one type of plan at one location, while workers at another location are offered a different type of plan.

HMO is a health maintenance organization. The survey defines an HMO as a plan that does not cover non-emergency out-of-network services.

PPO is a preferred provider organization. The survey defines PPOs as plans that have lower cost sharing for in-network provider services, and do not require a primary care gatekeeper to screen for specialist and hospital visits.

POS is a point-of-service plan. The survey defines POS plans as those that have lower cost sharing for in-network provider services, but do require a primary care gatekeeper to screen for specialist and hospital visits.

HDHP/SO is a high-deductible health plan with a savings option such as an HRA or HSA. HDHP/SOs are treated as a distinct plan type even if the plan would otherwise be considered a PPO, HMO, POS plan, or indemnity plan. These plans have a deductible of at least $1,000 for single coverage and $2,000 for family coverage and are offered with an HRA, or are HSA-qualified. See Section 8 for more information on HDHP/SOs.

Conventional/Indemnity The survey defines conventional or indemnity plans as those that have no preferred provider networks and the same cost sharing regardless of physician or hospital.

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Market Shares of Health Plans

SECTION

5

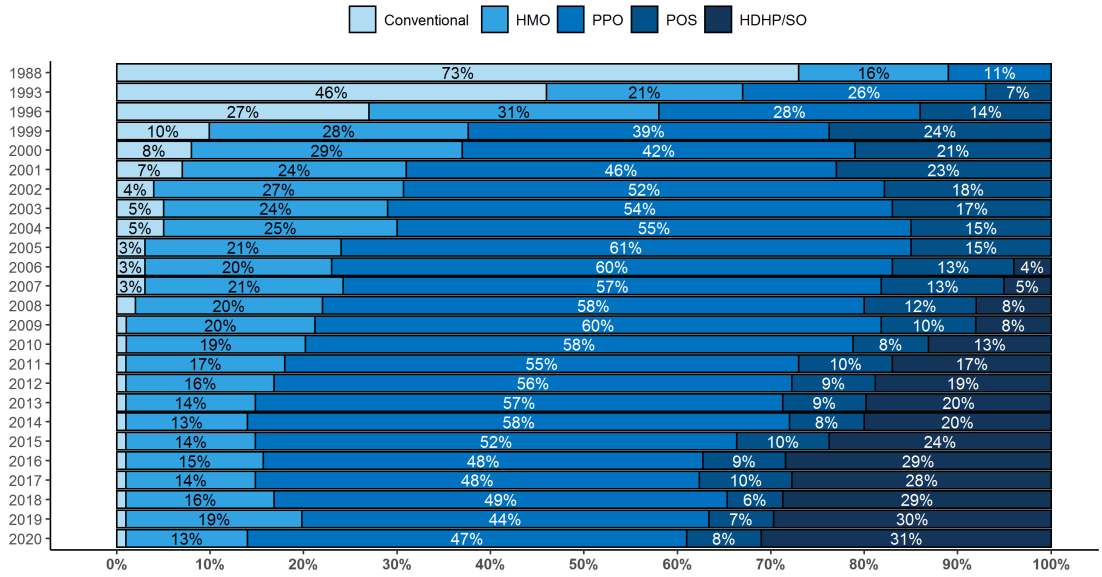
Section 5

Market Shares of Health Plans

PPOs are the most common plan type, covering 47% of covered workers, followed by HDHP/SOs, HMOs, POS plans, and conventional plans. The drop in the share of covered workers in PPOs in 2019 was not statistically significant.

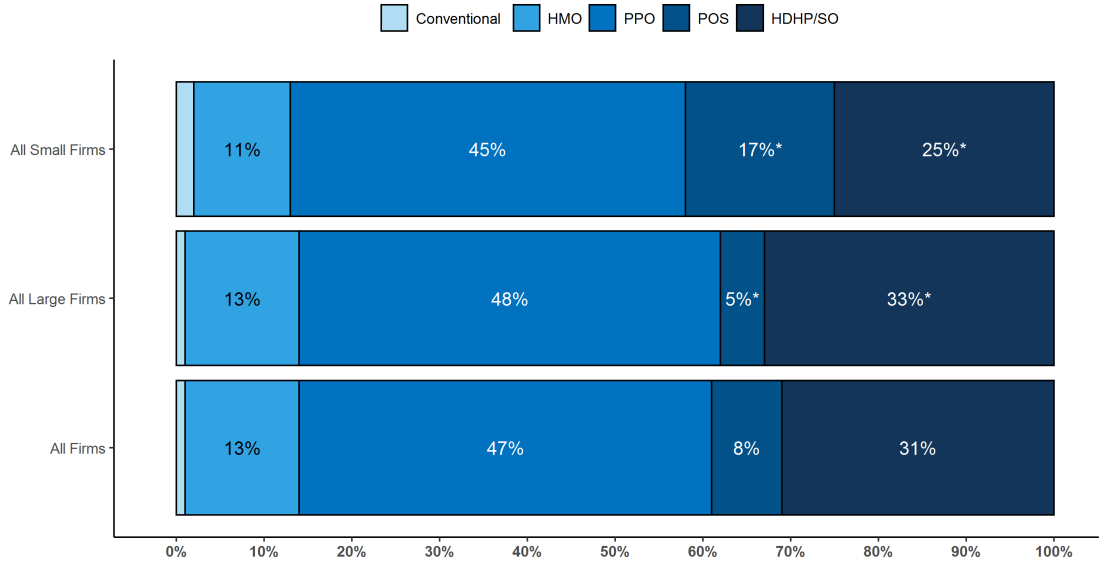
- Forty-seven percent of covered workers are enrolled in PPOs, followed by HDHP/SOs (31%), HMOs (13%), POS plans (8%), and conventional plans (1%) [Figure 5.1].
- The percentage of covered workers enrolled in HDHP/SOs is similar to last year, but has increased over the past decade. The percentage of covered workers enrolled in PPOs decreased by 11% over the past decade.
- The percentage of covered workers enrolled in HMOs (13%) is significantly lower than the percentage last year (19%) but not different from 2015 (14%). This percentage has moved over the last few years and we are unsure as to why. As noted above, we employed a new survey firm in 2020 and the change could represent a difference in interpretation of plan characteristics by new interviewers. There also may be measurement error in any of they years. We will continue to watch this topic.
- A larger share of covered workers are enrolled in HDHP/SOs than in HMOs in small and large firms.
- Covered workers in large firms are more likely to be enrolled in HDHP/SOs than covered workers in small firms (33% vs. 25%)[Figure 5.2]. Covered workers in small firms are much more likely than covered workers in large firms to be enrolled in POS plans (17% vs. 5%) [Figure 5.2].
- Plan enrollment patterns also differ across regions.
  - HMO enrollment is significantly higher in the West (22%), and significantly lower in the Midwest (7%) [Figure 5.3].
  - Covered workers in the Midwest (39%) are more likely to be enrolled in HDHP/SOs than workers in other regions, while covered workers in the West (24%) are less likely to be enrolled in HDHP/SOs [Figure 5.3].

Figure 5.1
Distribution of Health Plan Enrollment for Covered Workers, by Plan Type, 1988-2020



NOTE: Information was not obtained for POS plans in 1988 or for HDHP/SO plans until 2006. A portion of the change in 2005 is likely attributable to incorporating more recent Census Bureau estimates of the number of state and local government workers and removing federal workers from the weights. See the Survey Design and Methods section from the 2005 Kaiser/HRET Survey of Employer-Sponsored Health Benefits.
SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017; KPMG Survey of Employer-Sponsored Health Benefits, 1993 and 1996; The Health Insurance Association of America (HIAA), 1988.

Figure 5.2
Distribution of Health Plan Enrollment for Covered Workers, by Plan Type and Firm Size, 2020



* Enrollment in plan type is statistically different between All Small Firms and All Large Firms ($p < .05$).
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers. HMO is health maintenance organization. PPO is preferred provider organization. POS is point-of-service plan. HDHP/SO is high-deductible health plan with a savings option, such as a health reimbursement arrangement (HRA) or health savings account (HSA).
SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 5.3

Distribution of Health Plan Enrollment for Covered Workers, by Firm Size, Region, and Industry, 2020

	Conventional	HMO	PPO	POS	HDHP/SO
FIRM SIZE					
3-24 Workers	4%	9%	41%	25%*	21%*
25-49 Workers	0*	9	38	22*	31
50-199 Workers	1	13	50	9	27
200-999 Workers	1	12	51	8	28
1,000-4,999 Workers	<1	11	55*	5*	29
5,000 or More Workers	<1	15	45	4*	36*
All Small Firms (3-199 Workers)	**2%***	**11%**	**45%**	**17%***	**25%***
All Large Firms (200 or More Workers)	**<1%***	**13%**	**48%**	**5%***	**33%***
REGION					
Northeast	<1%	16%	42%	13%	29%
Midwest	<1	7*	47	6	39*
South	1	10	53	8	29
West	1	22*	43	9	24*
INDUSTRY					
Agriculture/Mining/Construction	2%	7%	57%	14%	21%*
Manufacturing	<1*	7*	48	5	40
Transportation/Communications/Utilities	<1*	15	45	3*	37
Wholesale	1	6*	49	6	38
Retail	1	11	51	6	32
Finance	1	10	43	3*	43
Service	1	16	42*	10	31
State/Local Government	0*	12	53	11	23
Health Care	1	14	55	12	17*
ALL FIRMS	**1%**	**13%**	**47%**	**8%**	**31%**

NOTE: HMO is health maintenance organization. PPO is preferred provider organization. POS is point-of-service plan. HDHP/SO is high-deductible health plan with a savings option, such as a health reimbursement arrangement (HRA) or health savings account (HSA).

* Estimate is statistically different from estimate for all firms not in the indicated size, region, or industry category ($p < .05$).

SOURCE: KFF Employer Health Benefits Survey, 2020

56%

$21,342

$7,047

2020

Employer Health Benefits

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Worker and Employer Contributions for Premiums

SECTION

6

Section 6

Worker and Employer Contributions for Premiums

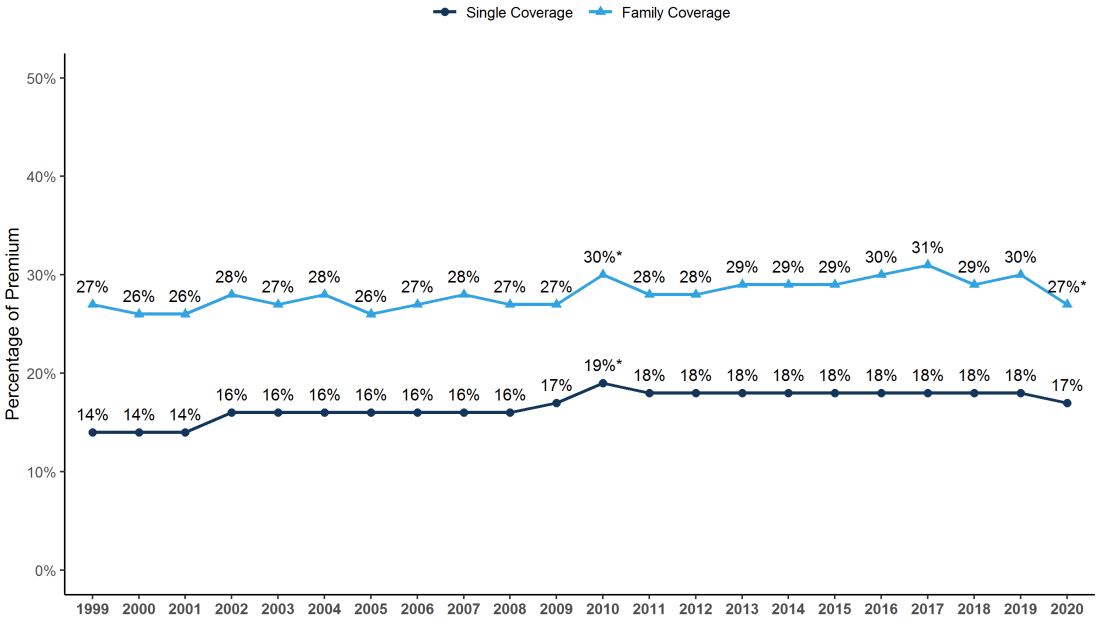
In 2020, covered workers on average contribute 17% of the premium for single coverage and 27% of the premium for family coverage.[1] The average monthly worker contributions are $104 for single coverage ($1,243 annually) and $466 for family coverage ($5,588 annually). The average contribution amount for family coverage is higher for covered workers in small firms (3-199 workers) than for covered workers in large firms (200 or more workers) ($6,820 vs. $5,112).

- In 2020, covered workers on average contribute 17% of the premium for single coverage and 27% of the premium for family coverage. The average percentage contributed for single coverage has remained stable in recent years. The average percentage contributed for family coverage is lower in 2020 than the percentage (30%) last year [Figure 6.1].[2]
  - Covered workers in small firms on average contribute a much higher percentage of the premium for family coverage (35% vs. 24%) than covered workers in large firms [Figure 6.2].
- Workers with single coverage have an average contribution of $104 per month ($1,243 annually), and workers with family coverage have an average contribution of $466 per month ($5,588 annually) toward their health insurance premiums [Figure 6.3], [Figure 6.4], and [Figure 6.5].
  - The average worker contributions in HDHP/SOs are lower than the overall average worker contribution for single coverage ($1,061 vs. $1,243) and family coverage ($4,852 vs. $5,588). The average worker contributions in PPOs are higher than the overall average worker contribution for family coverage ($6,017 vs. $5,588) [Figure 6.6].
- Worker contributions also differ by firm size.
  - Covered workers in small firms on average contribute significantly more annually for family coverage than covered workers in large firms ($6,820 vs. $5,112). The average contributions amounts for covered workers in small and large firms are similar for single coverage [Figure 6.7].

[1] Estimates for premiums, worker contributions to premiums, and employer contributions to premiums presented in Section 6 do not include contributions made by the employer to Health Savings Accounts (HSAs) or Health Reimbursement Arrangements (HRAs). See Section 8 for estimates of employer contributions to HSAs and HRAs.

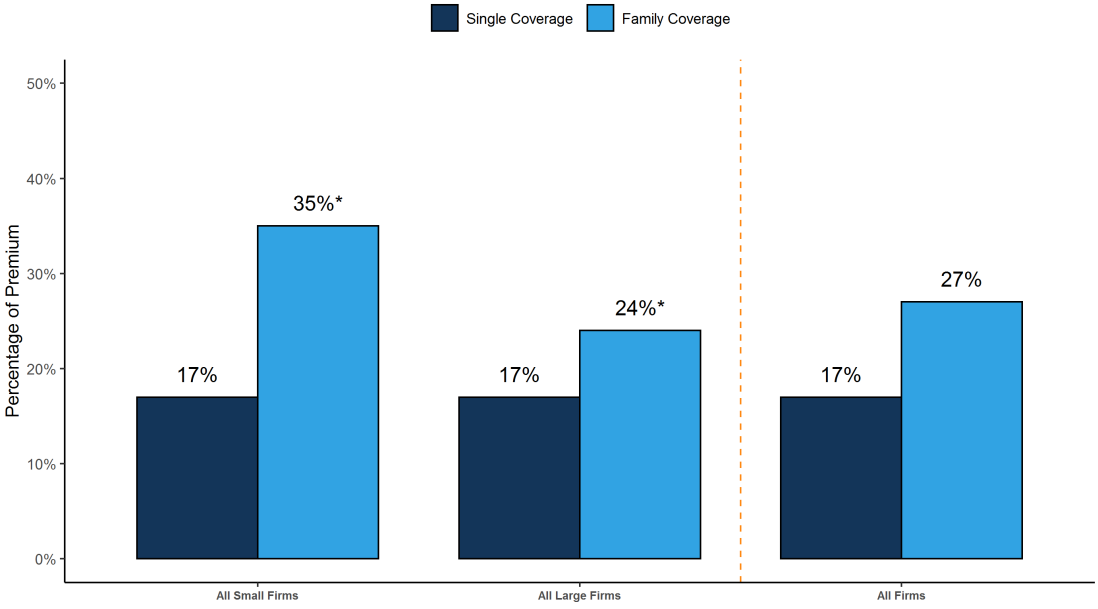
[2] The average percentage contribution is calculated as a weighted average of all a firm's plan types and may not necessarily equal the average worker contribution divided by the average premium.

Figure 6.1
Average Percentage of Premium Paid by Covered Workers for Single and Family Coverage, 1999-2020



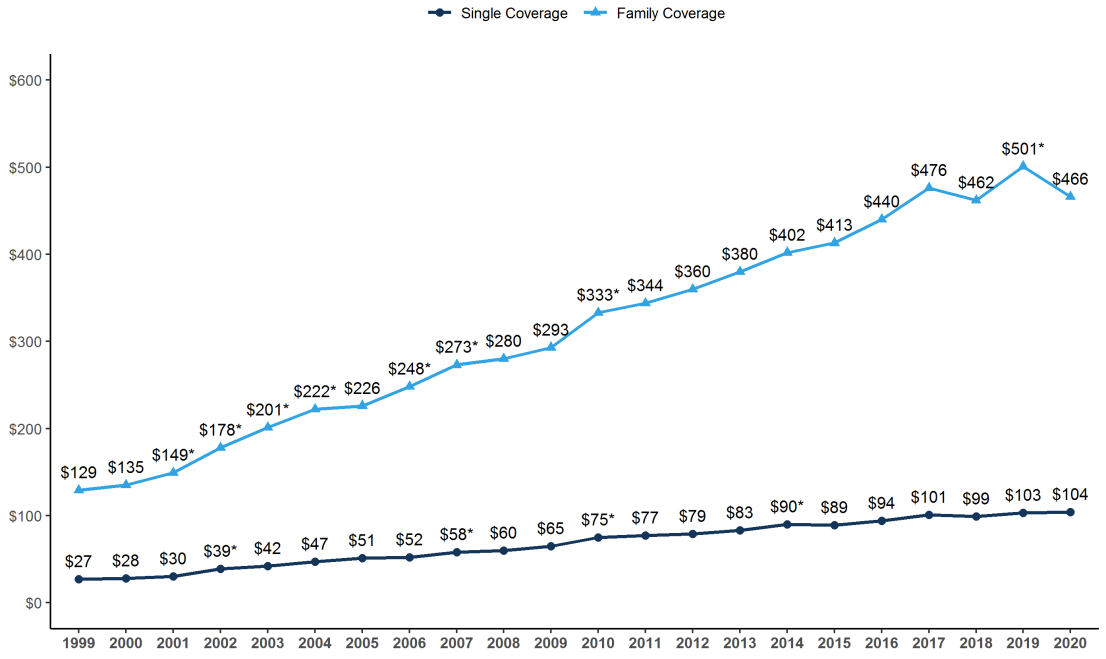
* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

Figure 6.2
Average Percentage of Premium Paid by Covered Workers for Single and Family Coverage, by Firm Size, 2020



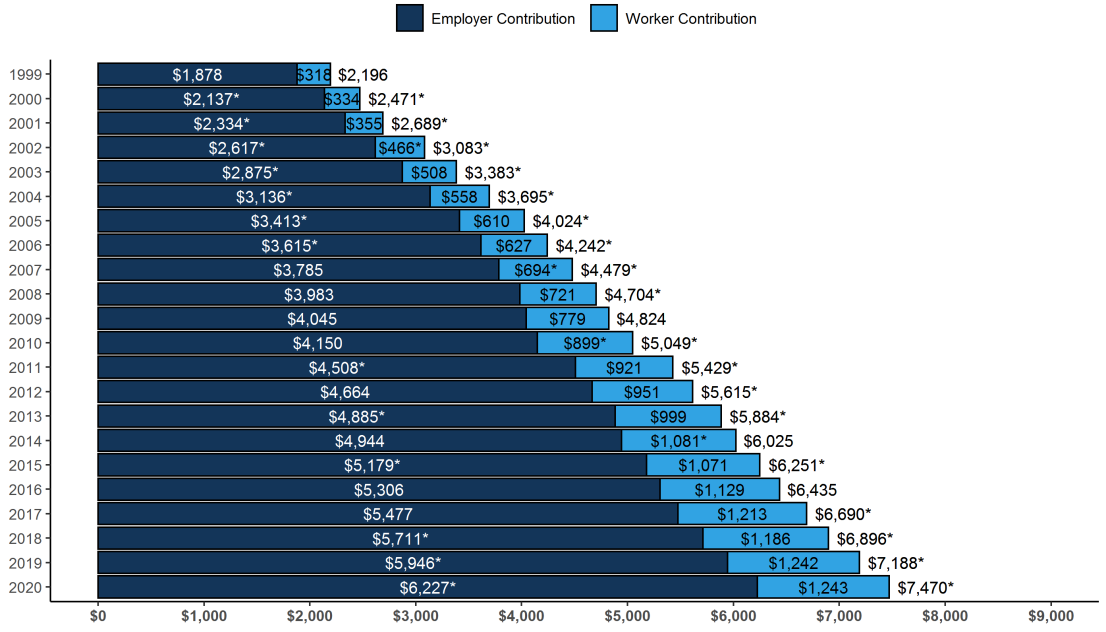
* Estimate is statistically different between All Small Firms and All Large Firms within coverage type ($p < .05$).
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 6.3
Average Monthly Worker Premium Contributions for Single and Family Coverage, 1999-2020



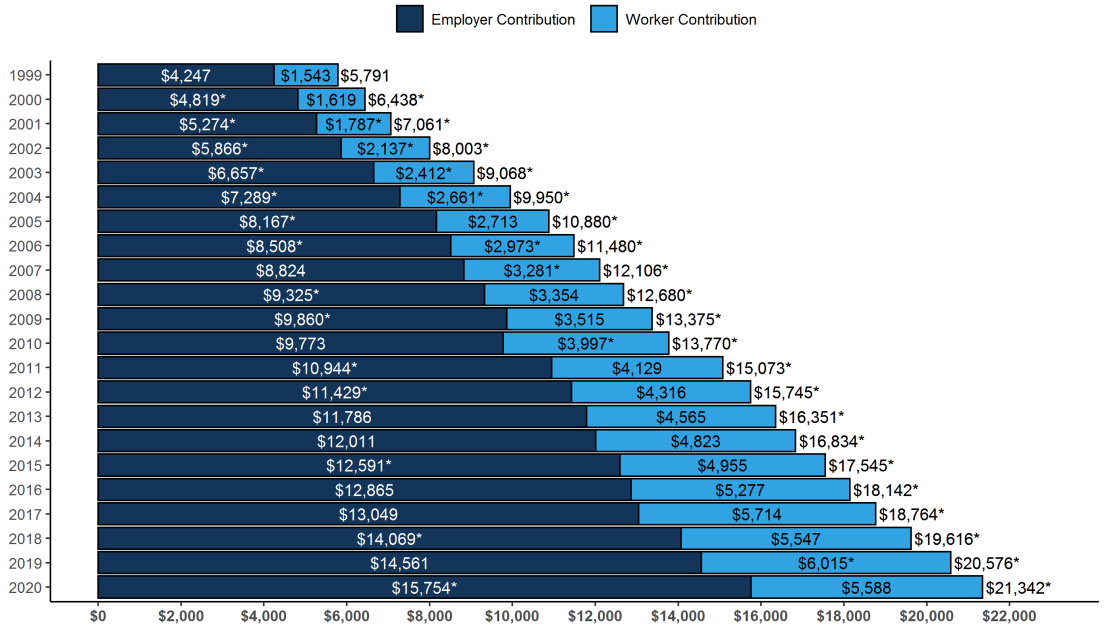
* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

Figure 6.4
Average Annual Worker and Employer Contributions to Premiums and Total Premiums for Single Coverage, 1999-2020



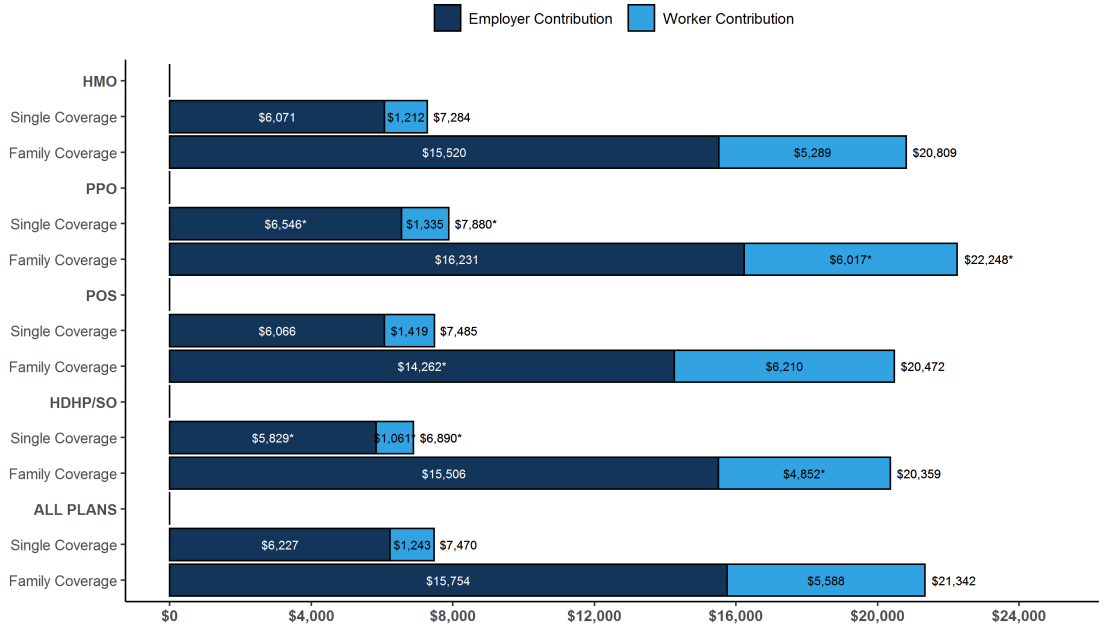
* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

Figure 6.5
Average Annual Worker and Employer Contributions to Premiums and Total Premiums for Family Coverage, 1999-2020



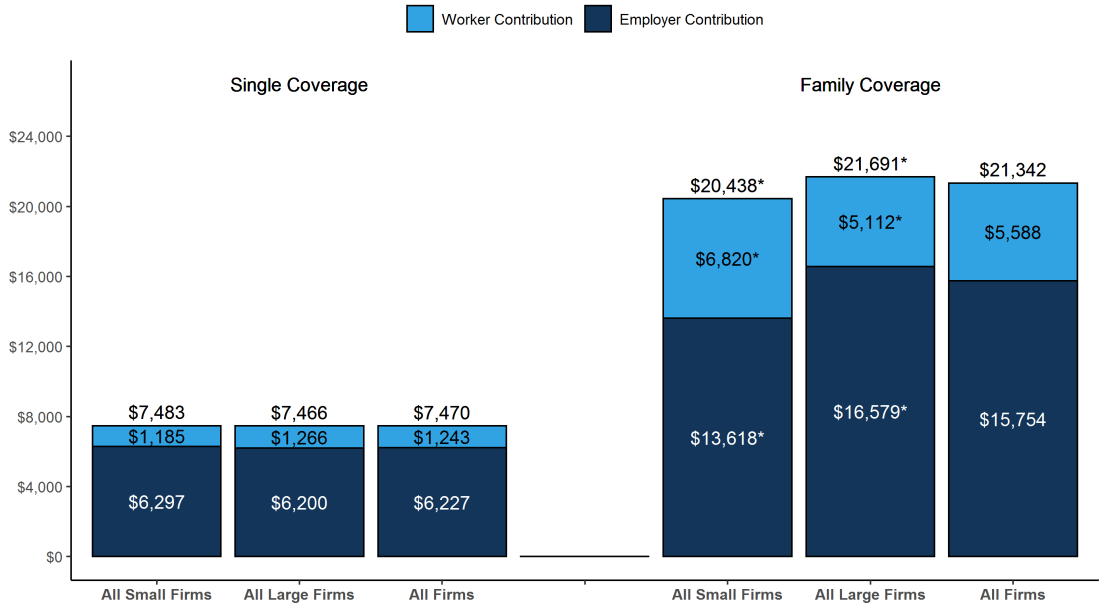
* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

Figure 6.6
Average Annual Worker and Employer Premium Contributions and Total Premiums for Single and Family Coverage, by Plan Type, 2020



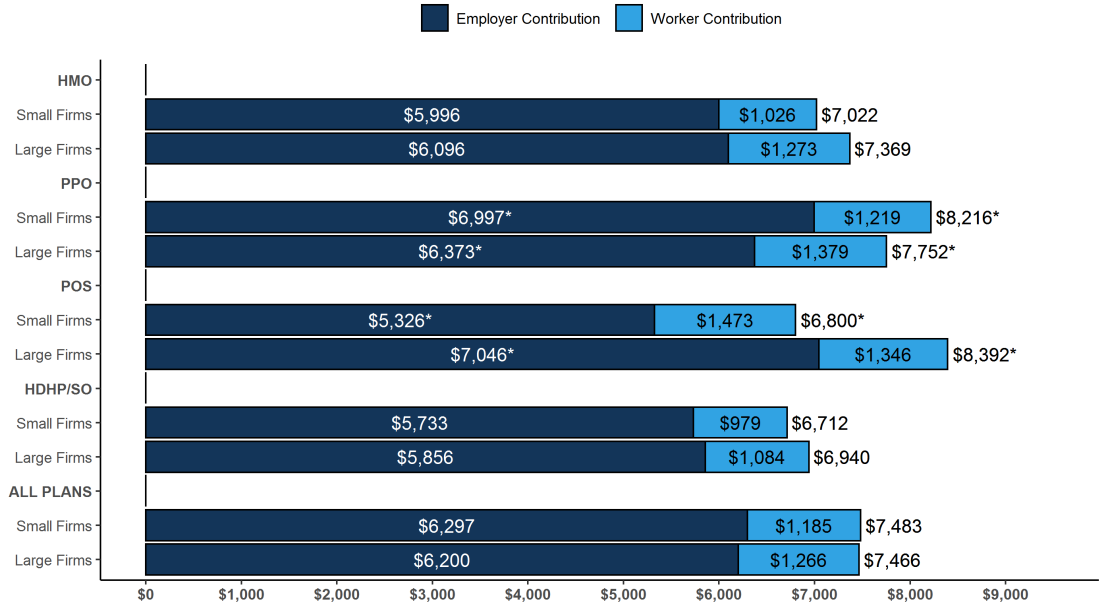
* Estimate is statistically different from All Plans estimate within coverage type ($p < .05$).
SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 6.7
Average Annual Worker and Employer Premium Contributions and Total Premiums for Single and Family Coverage, by Firm Size, 2020



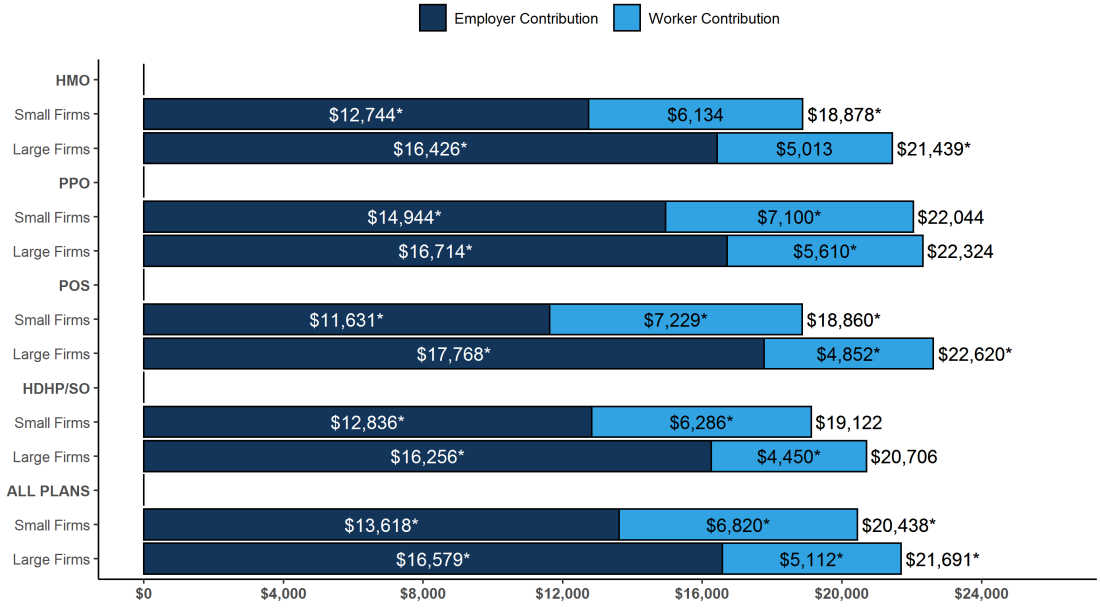
* Estimate is statistically different between All Small Firms and All Large Firms estimate ($p < .05$).
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 6.8
Average Annual Worker and Employer Premium Contributions and Total Premiums for Single Coverage, by Plan Type and Firm Size, 2020



* Estimates are statistically different within plan type between All Small Firms and All Large Firms ($p < .05$).
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 6.9
Average Annual Employer and Worker Premium Contributions and Total Premiums for Family Coverage, by Plan Type and Firm Size, 2020



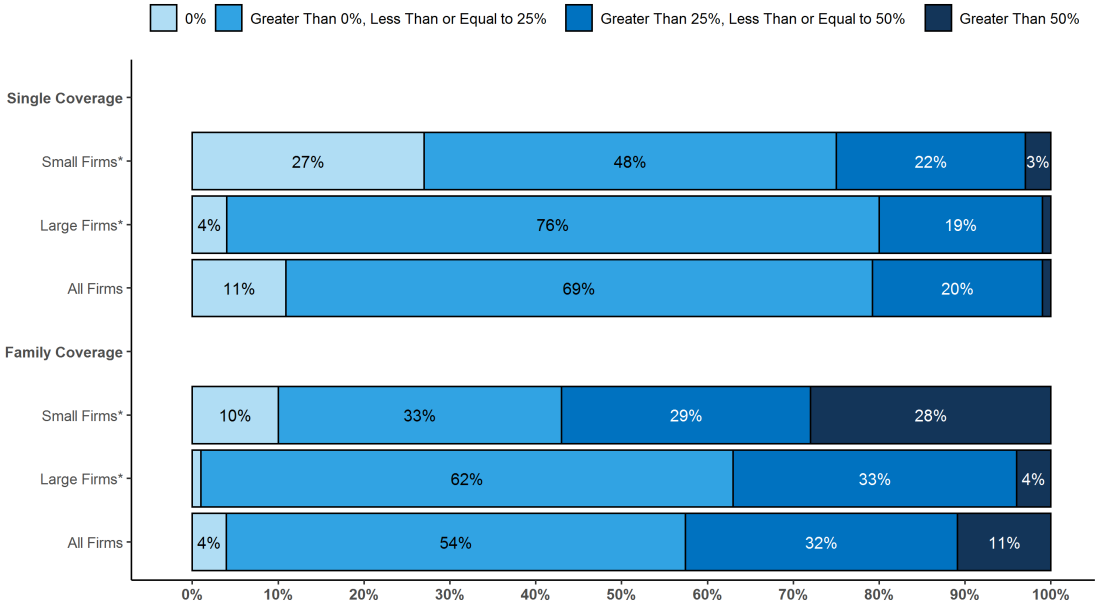
* Estimates are statistically different within plan type between All Small Firms and All Large Firms ($p < .05$).
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2020

DISTRIBUTIONS OF WORKER CONTRIBUTIONS TO THE PREMIUM

- About nine-tenths of covered workers are in a plan where the employer contributes at least half of the premium for both single and family coverage.
  - Eleven percent of covered workers are in a plan where the employer pays the entire premium for single coverage, while only 4% of covered workers are in a plan where the employer pays the entire premium for family coverage [Figure 6.10].
- Covered workers in small firms are much more likely than covered workers in large firms to be in a plan where the employer pays the entire premium.
  - Twenty-seven percent of covered workers in small firms have an employer that pays the full premium for single coverage, compared to 4% of covered workers in large firms [Figure 6.10].
  - For family coverage, 10% of covered workers in small firms have an employer that pays the full premium, compared to 1% of covered workers in large firms [Figure 6.10].
- Eleven percent of covered workers are in a plan with a worker contribution of more than half of the premium for family coverage [Figure 6.10].
  - Twenty-eight percent of covered workers in small firms work in a firm where the worker contribution for family coverage is more than 50% of the premium, a much higher percentage than the 4% of covered workers in large firms [Figure 6.10].
  - Small shares of covered workers in small firms (3%) and large firms (1%) must pay more than 50% of the premium for single coverage [Figure 6.10].

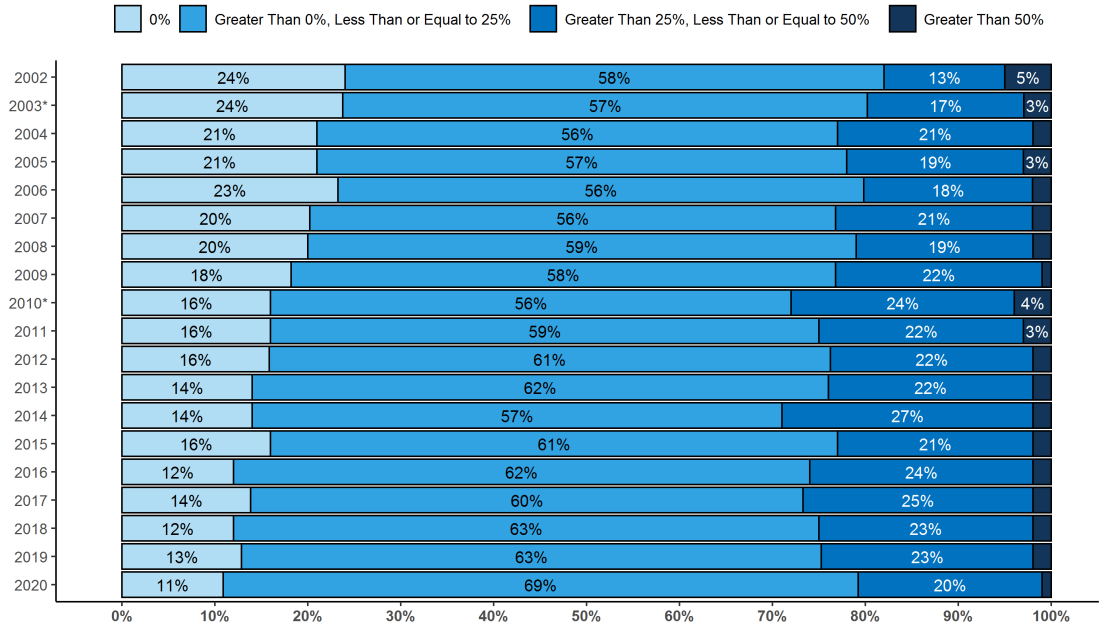
- There is substantial variation among workers in both small and large firms in the dollar amounts they must contribute.
  - Among covered workers in small firms, 39% have a contribution for single coverage of less than $500, while 21% have a contribution of $2,000 or more. For family coverage, 15% have a contribution of less than $1,500, while 22% have a contribution of $10,500 or more [Figure 6.13] and [Figure 6.14].
  - Among covered workers in large firms, 13% have a contribution for single coverage of less than $500, while 12% have a contribution of $2,000 or more. For family coverage, 6% have a contribution of less than $1,500, while only 4% have a contribution of $10,500 or more [Figure 6.13] and [Figure 6.14].

Figure 6.10
Distribution of Percentage of Premium Paid by Covered Workers for Single and Family Coverage, by Firm Size, 2020



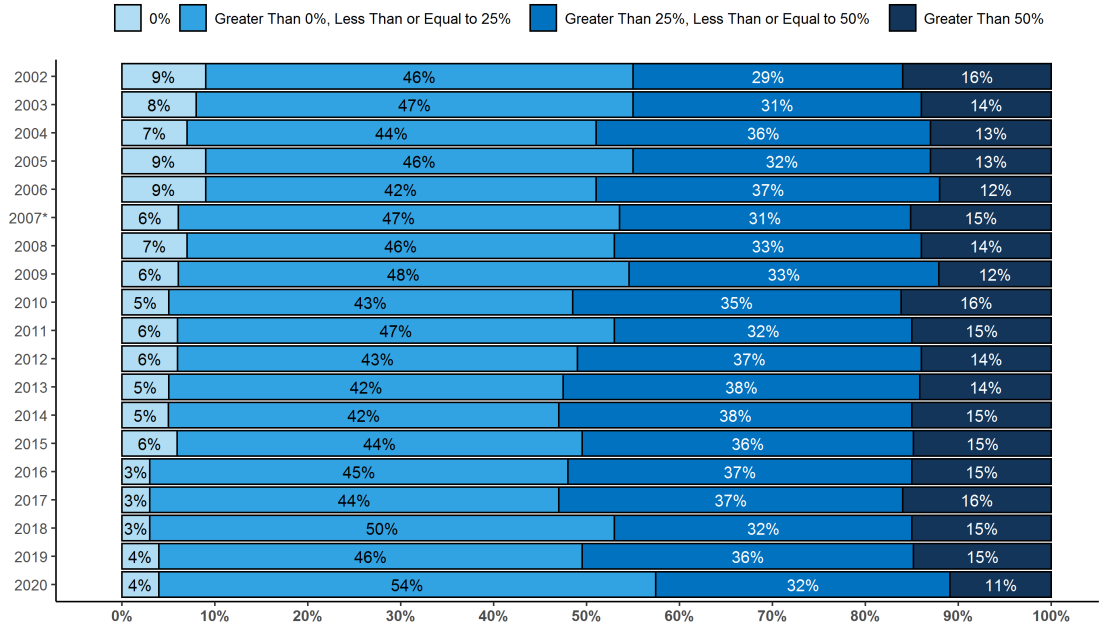
* Distributions are statistically different between All Small Firms and All Large Firms within coverage type ($p < 0.05$).
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 6.11
Distribution of Percentage of Premium Paid by Covered Workers for Single Coverage, 2002-2020



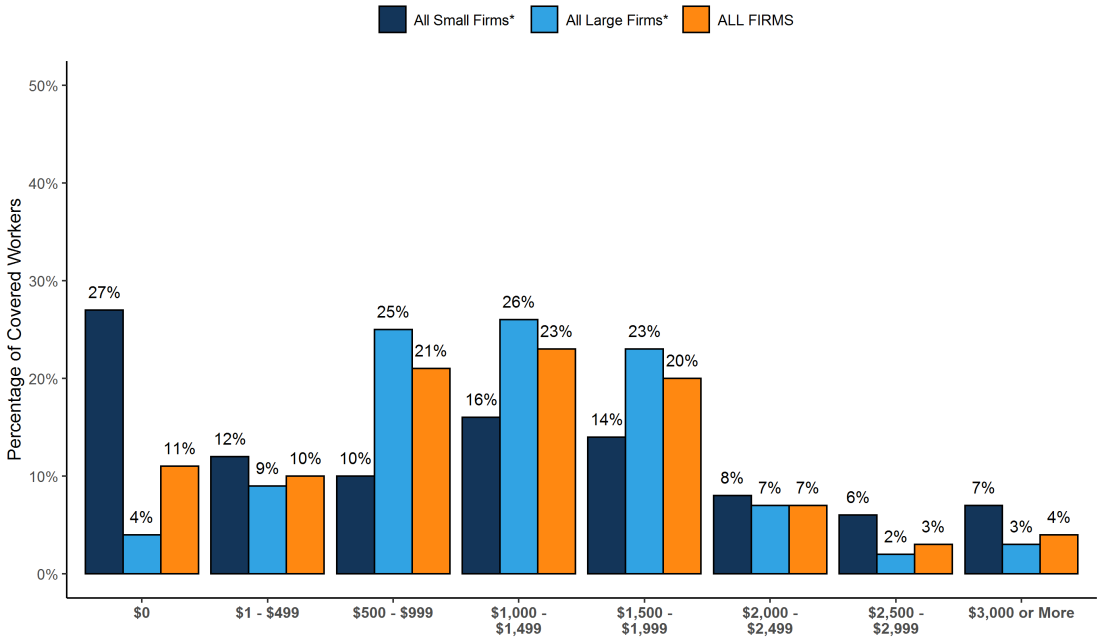
* Distribution is statistically different from distribution for the previous year shown ($p < .05$).
SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2002-2017

Figure 6.12
Distribution of Percentage of Premium Paid by Covered Workers for Family Coverage, 2002-2020



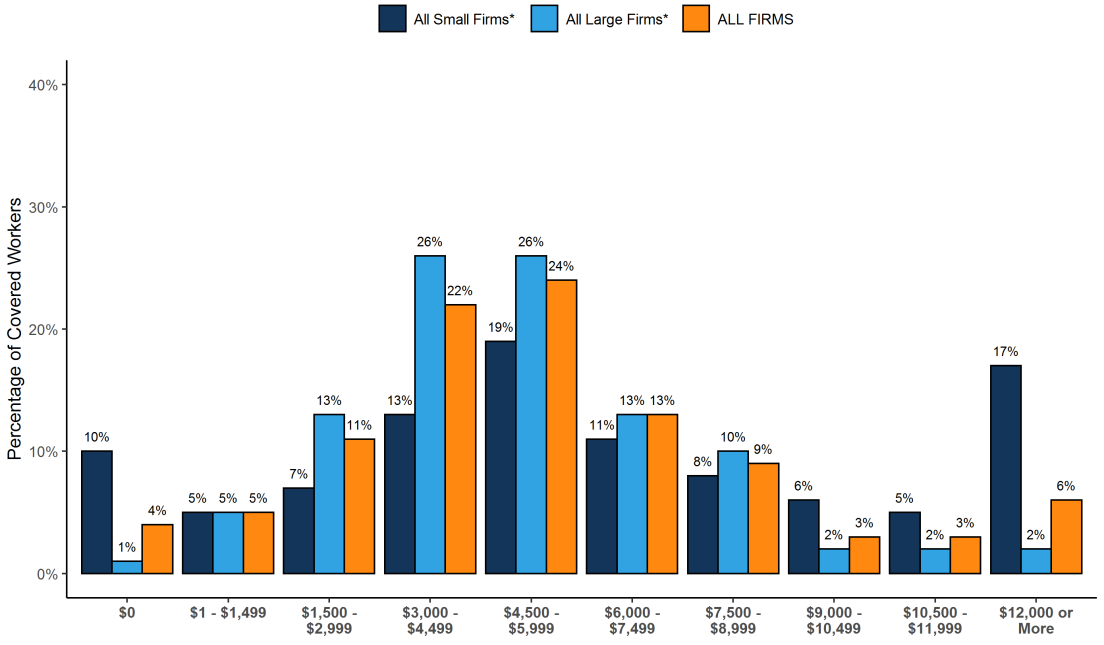
* Distribution is statistically different from distribution for the previous year shown ($p < .05$).
SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2002-2017

Figure 6.13
Distribution of Worker Contributions for Single Coverage, by Firm Size, 2020



* Distribution is statistically different from distribution for all other firms not in the indicated size category (p < .05).
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 6.14
Distribution of Worker Contributions for Family Coverage, by Firm Size, 2020

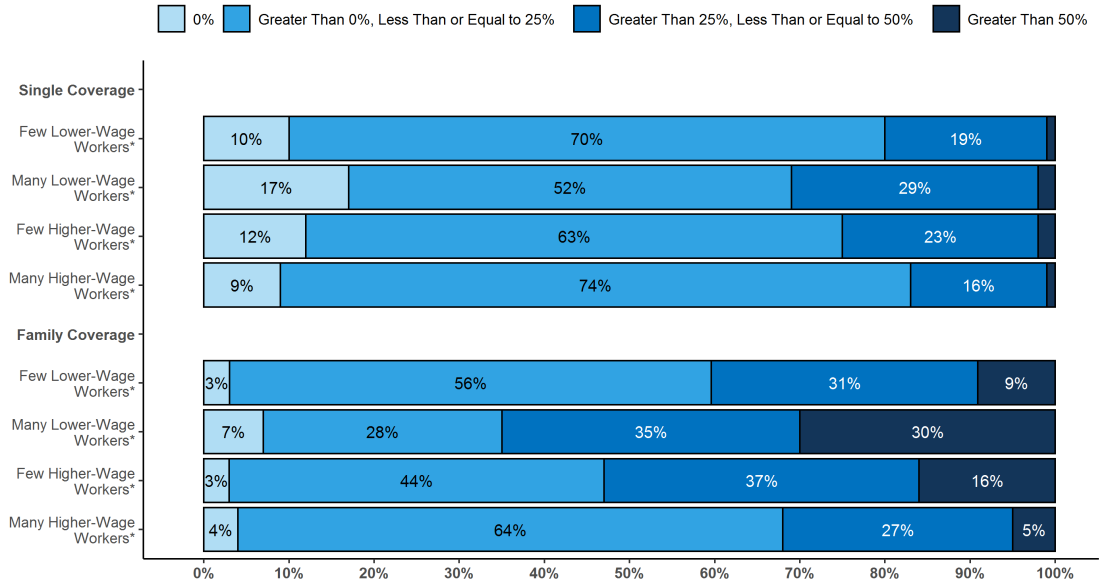


* Distribution is statistically different from distribution for all other firms not in the indicated size category (p < .05).
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2020

DIFFERENCES BY FIRM CHARACTERISTICS

- The percentage of the premium paid by covered workers also varies by firm characteristics.
  - Covered workers in private, for-profit firms have relatively high premium contributions for single ($1,381) and family ($5,988) coverage. Covered workers in public firms have relatively low premium contributions for single ($865) and family ($4,724) coverage [Figure 6.17] .
  - Covered workers in firms with a relatively large share of lower-wage workers (where at least 35% of workers earn $26,000 a year or less) have a higher average contribution rate for family coverage (38% vs. 26%) than those in firms with a smaller share of lower-wage workers [Figure 6.17].
  - Covered workers in firms with a relatively large share of higher-wage workers (where at least 35% earn $64,000 or more annually) have lower average contribution rates for single coverage (16% vs. 18%) and for family coverage (23% vs. 31%) than those in firms with a smaller share of higher-wage workers [Figure 6.17].
  - Covered workers in firms that have at least some union workers have lower average contribution rates for single coverage (15% vs. 18%) for family coverage (20% vs. 31%) than those in firms without any union workers [Figure 6.17].
  - Covered workers in firms that are partially or completely self-funded on average have a lower average contribution rate for family coverage than workers in firms that are fully-insured (24% vs. 33%) [Figure 6.17].[3]

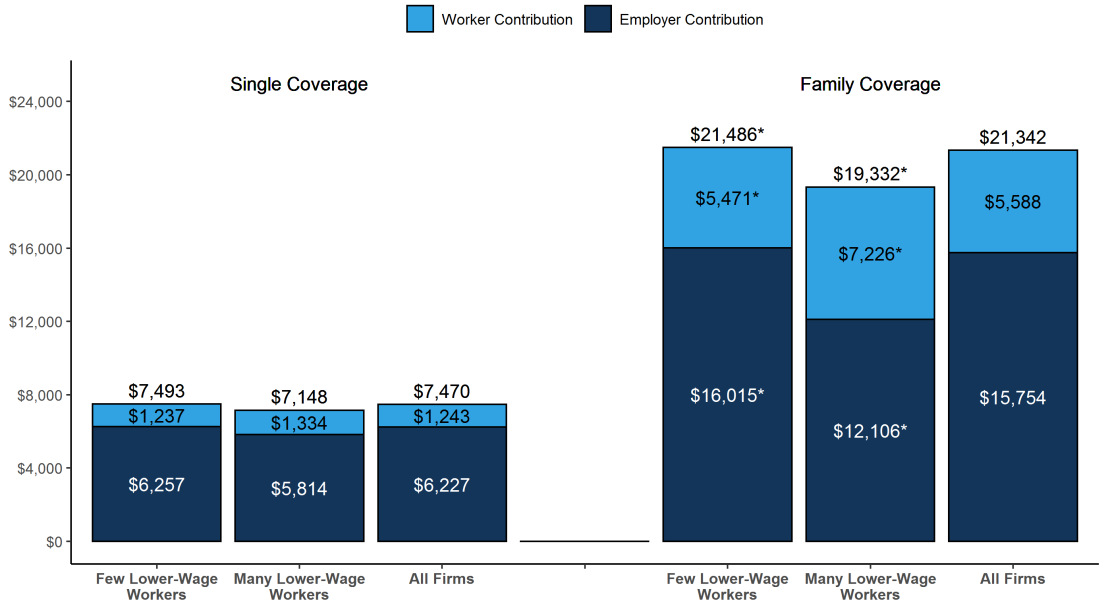
Figure 6.15
Distribution of the Percentage of Total Premium Paid by Covered Workers for Single and Family Coverage, by Firm Wage Level, 2020



*Distributions for higher-wage and lower-wage firms are statistically different within single and family coverage ($p < .05$).
NOTE: Firms with many lower-wage workers are those where at least 35% earn the 25th percentile or less of national earnings ($26,000 in 2020). Firms with many higher-wage workers are those where at least 35% earn the 75th percentile or more than of national earnings ($64,000 in 2020).
SOURCE: KFF Employer Health Benefits Survey, 2020

[3] For definitions of self-funded and fully-insured plans, see the introduction to Section 10.

Figure 6.16
Average Annual Worker and Employer Contributions to Premiums and Total Premiums for Single and Family Coverage, By Firm Wage Level, 2020



* Estimate is statistically different between firm wage level categories ($p < .05$).
NOTE: Firms with many lower-wage workers are those where at least 35% earn the 25th percentile or less of national earnings ($26,000 in 2020).
SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 6.17

Average Annual Premium Contributions Paid by Covered Workers for Single and Family Coverage, by Firm Characteristics, 2020

	Single Coverage		Family Coverage	
	Worker Contribution	Percent Contribution	Worker Contribution	Percent Contribution
LOWER WAGE LEVEL				
Few Lower-Wage Workers	$1,237	17%	$5,471*	26%*
Many Lower-Wage Workers	$1,334	20%	$7,226*	38%*
HIGHER WAGE LEVEL				
Few Higher-Wage Workers	$1,278	18%*	$6,149*	31%*
Many Higher-Wage Workers	$1,209	16%*	$5,036*	23%*
UNIONS				
Firm Has Union Workers	$1,130*	15%*	$4,477*	20%*
Firm Has No Union Workers	$1,309*	18%*	$6,240*	31%*
YOUNGER WORKERS				
Few Younger Workers	$1,239	17%	$5,580	27%
Many Younger Workers	$1,298	20%	$5,713	30%
OLDER WORKERS				
Few Older Workers	$1,217	17%	$5,679	28%
Many Older Workers	$1,271	17%	$5,491	26%
FUNDING ARRANGEMENT				
Fully Insured	$1,162	16%	$6,585*	33%*
Self-Funded	$1,283	18%	$5,105*	24%*
FIRM OWNERSHIP				
Private For-Profit	$1,381*	20%*	$5,988*	29%*
Public	$865*	11%*	$4,724*	24%*
Private Not-For-Profit	$1,173	15%*	$5,260	25%*
ALL FIRMS	**$1,243**	**17%**	**$5,588**	**27%**

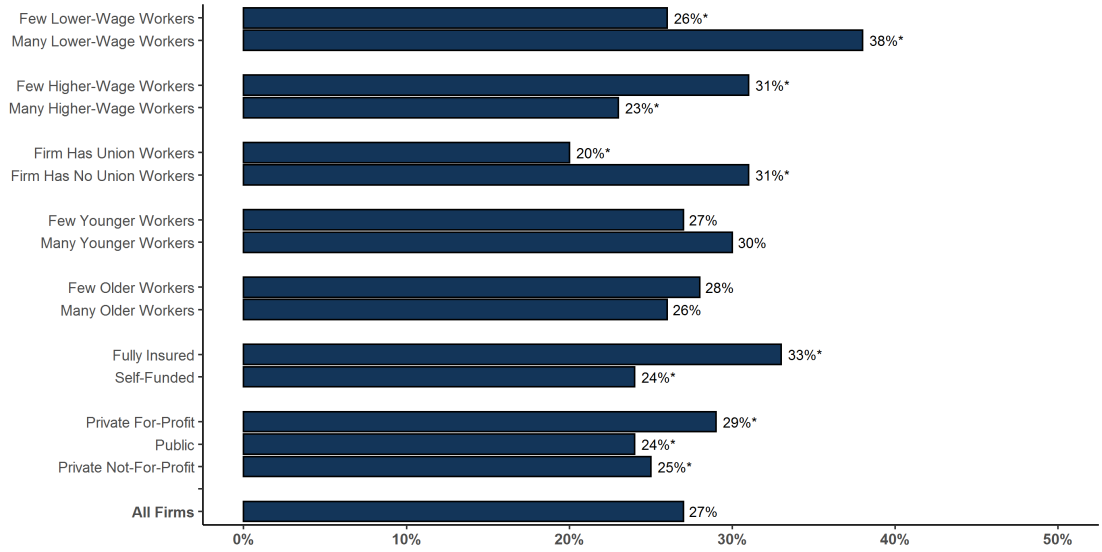
NOTE: Firms with many lower-wage workers are those where at least 35% earn the 25th percentile or less of national earnings ($26,000 in 2020). Firms with many higher-wage workers are those where at least 35% earn the 75th percentile or more than of national earnings ($64,000 in 2020). Firms with many older workers are those where at least 35% of workers are age 50 or older. Firms with many younger workers are those where at least 35% of workers are age 26 or younger.

* Estimates are statistically different from each other within firm characteristic ($p < .05$).

SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 6.18

Average Percentage of Family Premium Paid by Covered Workers, by Firm Characteristics, 2020



* Estimates are statistically different from each other within category ($p < .05$).

NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers. Firms with many lower-wage workers are those where at least 35% earn the 25th percentile or less of national earnings ($26,000 in 2020). Firms with many higher-wage workers are those where at least 35% earn the 75th percentile or more than of national earnings ($64,000 in 2020). Firms with many older workers are those where at least 35% of workers are age 50 or older. Firms with many younger workers are those where at least 35% of workers are age 26 or younger.

SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 6.19

Average Percentage of Premium Paid by Covered Workers, by Firm Characteristics and Size, 2020

	Single Coverage			Family Coverage		
	All Small Firms	All Large Firms	All Firms	All Small Firms	All Large Firms	All Firms
LOWER WAGE LEVEL						
Few Lower-Wage Workers	16%	17%	17%	34%*	23%*	26%*
Many Lower-Wage Workers	19%	21%	20%	45%*	32%*	38%*
HIGHER WAGE LEVEL						
Few Higher-Wage Workers	18%*	18%	18%*	41%*	26%*	31%*
Many Higher-Wage Workers	14%*	16%	16%*	26%*	22%*	23%*
UNIONS						
Firm Has Union Workers	8%*	16%*	15%*	17%*	21%*	20%*
Firm Has No Union Workers	17%*	19%*	18%*	37%*	27%*	31%*
YOUNGER WORKERS						
Few Younger Workers	16%	17%	17%	35%	24%	27%
Many Younger Workers	24%	18%	20%	43%	25%	30%
OLDER WORKERS						
Few Older Workers	17%	18%	17%	37%	24%	28%
Many Older Workers	16%	17%	17%	33%	23%	26%
FUNDING ARRANGEMENT						
Fully Insured	16%	16%	16%	36%	27%*	33%*
Self-Funded	18%	18%	18%	32%	23%*	24%*
FIRM OWNERSHIP						
Private For-Profit	19%*	20%*	20%*	36%	26%*	29%*
Public	7%*	12%*	11%*	34%	22%	24%*
Private Not-For-Profit	15%	15%*	15%*	32%	21%*	25%*
ALL FIRMS	**17%**	**17%**	**17%**	**35%**	**24%**	**27%**

NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers. Firms with many lower-wage workers are those where at least 35% earn the 25th percentile or less of national earnings ($26,000 in 2020). Firms with many higher-wage workers are those where at least 35% earn the 75th percentile or more than of national earnings ($64,000 in 2020). Firms with many older workers are those where at least 35% of workers are age 50 or older. Firms with many younger workers are those where at least 35% of workers are age 26 or younger.

* Estimates are statistically different from estimate for all other firms not in the indicated category within each firm size ($p < .05$).

SOURCE: KFF Employer Health Benefits Survey, 2020

DIFFERENCES BY REGION AND INDUSTRY

- The average worker contribution rate for single coverage is lower in the West (14%) than in other regions [Figure 6.20].
- The average worker contribution rate for family coverage is lower in the Northeast (23%) and higher in the South (31%) than in other regions [Figure 6.20].
- There is considerable variation in average worker contribution rates across industries for both single and family coverage [Figure 6.21].

Figure 6.20

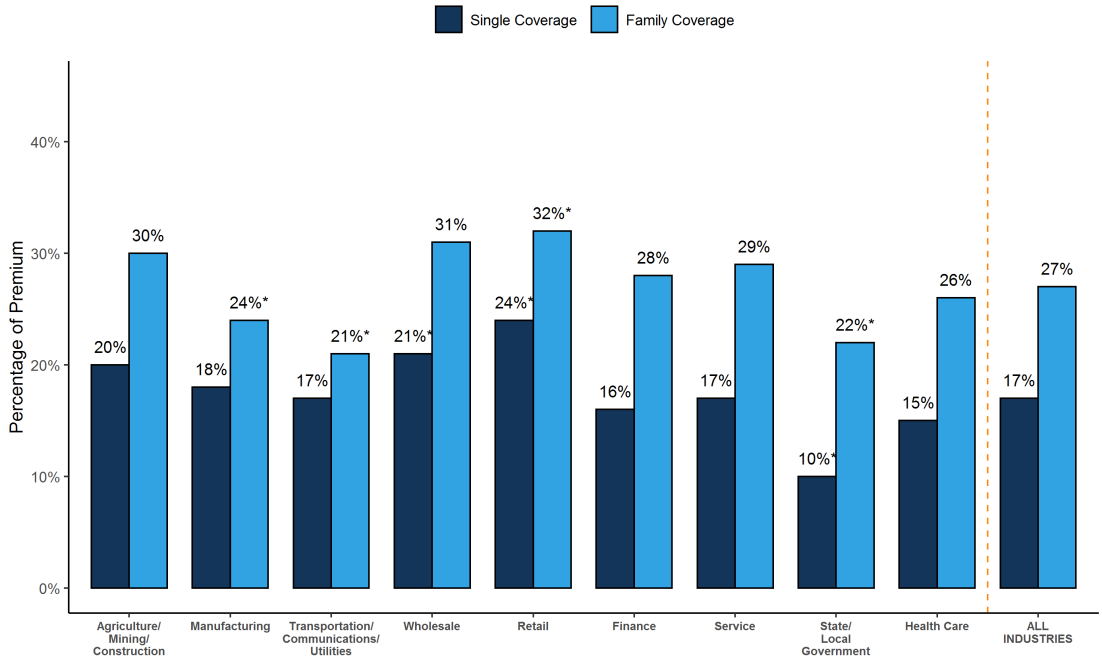
Average Premium Paid by Covered Workers for Single and Family Coverage, by Plan Type and Region, 2020

	Single Coverage		Family Coverage	
	Percent Contribution	Worker Contribution	Percent Contribution	Worker Contribution
HMO				
Northeast	19%	$1,483	20%*	$4,551
Midwest	19	1,302	25	4,751
South	19	1,380	30	6,394
West	14*	854*	28	5,186
ALL REGIONS	**17%**	**$1,212**	**26%**	**$5,289**
PPO				
Northeast	19%	$1,506	23%*	$5,488
Midwest	18	1,440	28	6,341
South	17	1,263	32*	6,366
West	15*	1,155*	24*	5,269*
ALL REGIONS	**18%**	**$1,335**	**28%**	**$6,017**
POS				
Northeast	21%	$1,815	24%*	$5,652
Midwest	22	1,460	28	5,383
South	19	1,367	39*	7,389
West	14	916*	34	6,106
ALL REGIONS	**19%**	**$1,419**	**32%**	**$6,210**
HDHP/SO				
Northeast	15%	$1,077	23%	$5,006
Midwest	16	1,044	23	4,632
South	18	1,214	28*	5,364
West	11*	777*	22	4,165
ALL REGIONS	**16%**	**$1,061**	**24%**	**$4,852**
ALL PLANS				
Northeast	18%	$1,420*	23%*	$5,226
Midwest	18	1,277	26	5,511
South	18	1,269	31*	6,167*
West	14*	976*	25	5,066
ALL REGIONS	**17%**	**$1,243**	**27%**	**$5,588**

* Estimate is statistically different within plan and coverage type from estimate for all other firms not in the indicated region ($p < .05$).

SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 6.21
Average Percentage of Premium Paid by Covered Workers, by Industry, 2020

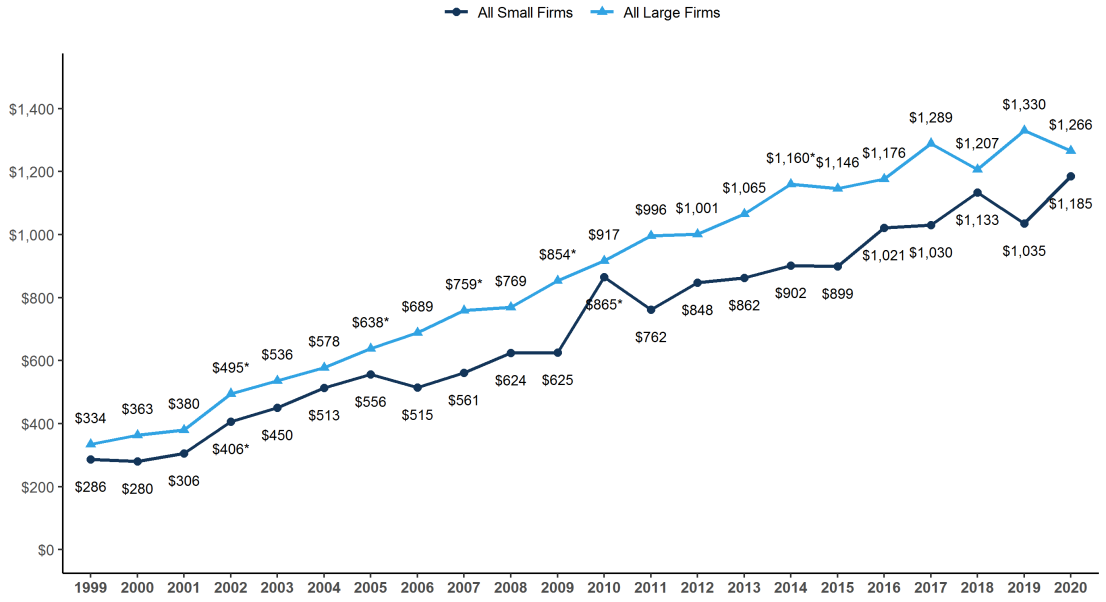


* Estimate is statistically different within coverage type from estimate for all other firms not in the indicated industry category ($p < .05$).
SOURCE: KFF Employer Health Benefits Survey, 2020

CHANGES OVER TIME

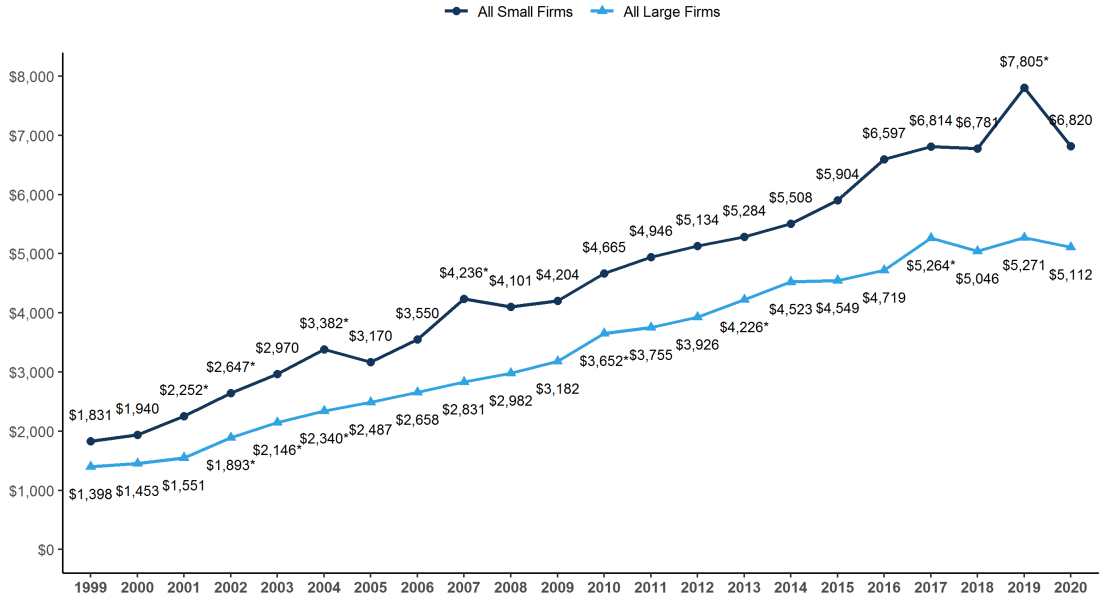
- The average worker contribution for single coverage ($1,243 in 2020) is similar to the amount last year. The average worker contribution for family coverage ($5,588 in 2020) appears lower than the average contribution for family coverage last year ($6,015), but the difference is not statistically significant [Figure 6.4] and [Figure 6.5].
- The average worker contributions for single and family coverage have increased over the last five years (16% and 13%, respectively) and over the last 10 years (38% and 40%, respectively).

Figure 6.22
Average Annual Worker Contributions for Covered Workers with Single Coverage, by Firm Size, 1999-2020



* Estimate is statistically different from estimate for the previous year shown (p < .05).
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

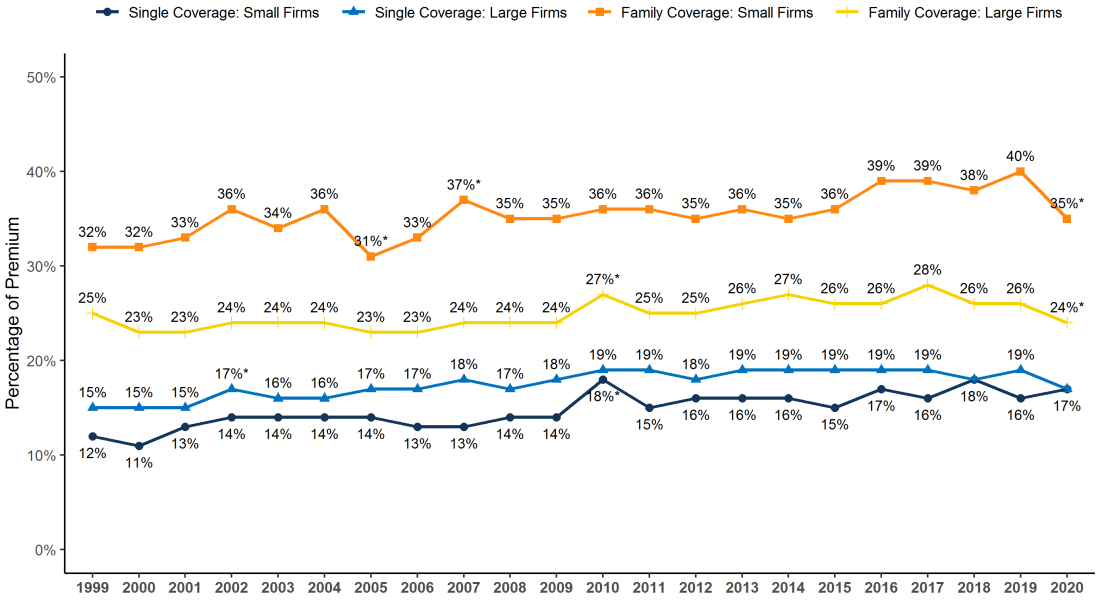
Figure 6.23
Average Annual Worker Contributions for Covered Workers with Family Coverage, by Firm Size, 1999-2020



* Estimate is statistically different from estimate for the previous year shown (p < .05).
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

Figure 6.24

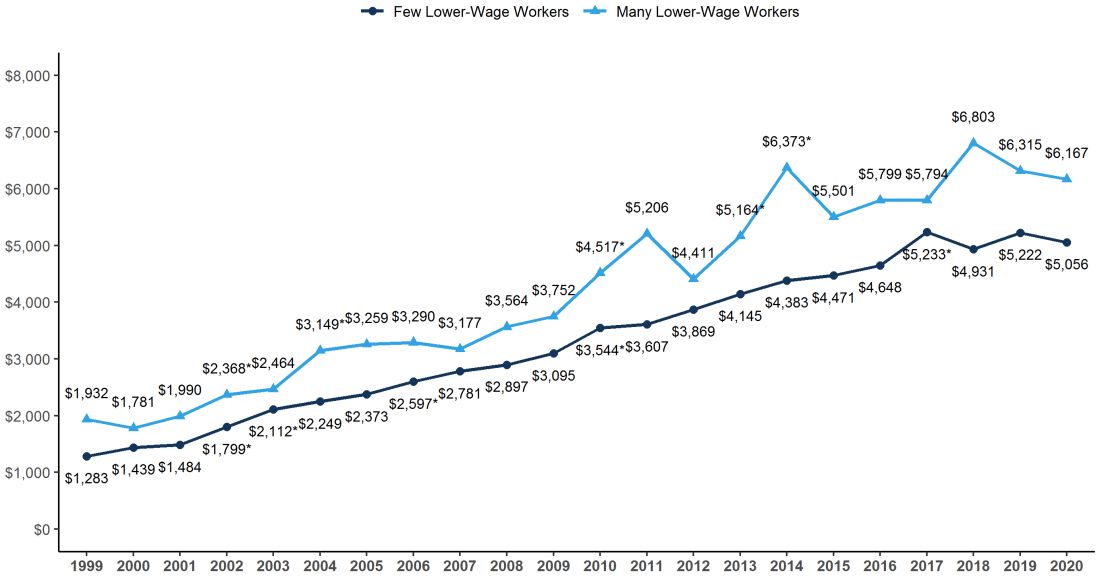
Average Percentage of Premium Paid by Covered Workers for Single and Family Coverage, by Firm Size, 1999-2020



* Estimate is statistically different from estimate for the previous year shown (p < .05).
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

Figure 6.25

Among Large Firms, Average Annual Worker Contributions for Covered Workers with Family Coverage, by Firm Wage Level, 1999-2020



* Estimate is statistically different from estimate for the previous year shown (p < .05).
NOTE: Large Firms have 200 or more workers. Firms with many lower-wage workers are those where at least 35% earn the 25th percentile or less of national earnings ($26,000 in 2020).
SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

Employer Health Benefits

2020 Annual Survey

Employee Cost Sharing

SECTION

7

Section 7

Employee Cost Sharing

In addition to any required premium contributions, most covered workers must pay a share of the cost for the medical services they use. The most common forms of cost sharing are: deductibles (an amount that must be paid before most services are covered by the plan), copayments (fixed dollar amounts), and coinsurance (a percentage of the charge for services). Sometimes cost sharing forms are mixed, such as assessing coinsurance for a service up to a maximum amount, or assessing coinsurance or copayment for a service, whichever is higher. The type and level of cost sharing often vary by the type of plan in which the worker is enrolled. Cost sharing may also vary by the type of service, such as office visits, hospitalizations, or prescription drugs.

The cost-sharing amounts reported here are for covered workers using in-network services. Plan enrollees receiving services from providers that do not participate in plan networks often face higher cost sharing and may be responsible for charges that exceed the plan's allowable amounts. The framework of this survey does not allow us to capture all of the complex cost-sharing requirements in modern plans, particularly for ancillary services (such as durable medical equipment or physical therapy) or cost-sharing arrangements that vary across different settings (such as tiered networks). Therefore, we do not collect information on all plan provisions and limits that affect enrollee out-of-pocket liability.

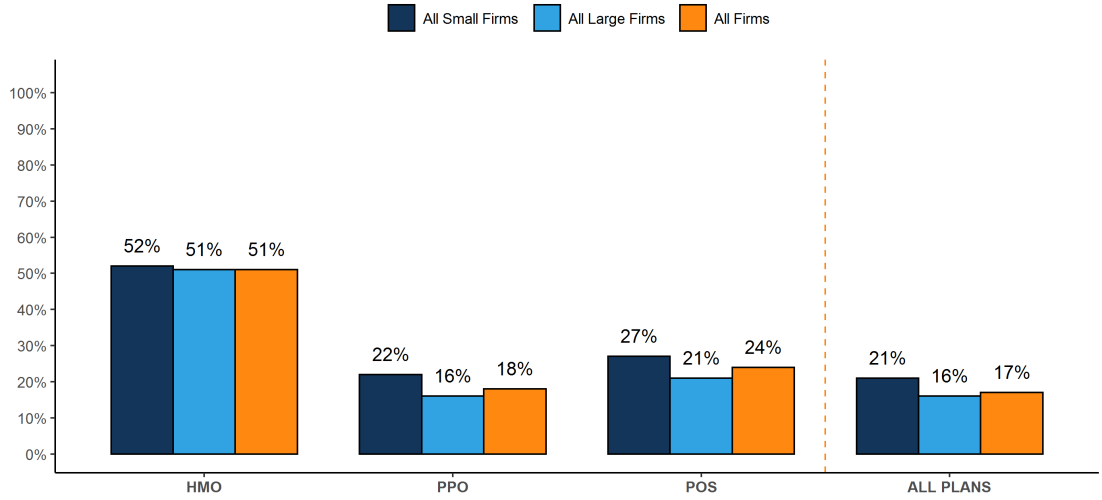
GENERAL ANNUAL DEDUCTIBLES FOR WORKERS IN PLANS WITH DEDUCTIBLES

- We consider a general annual deductible to be an amount that must be paid by enrollees before most services are covered by their health plan. Non-grandfathered health plans are required to cover some services, such as preventive care, without cost sharing. Some plans require enrollees to meet a service-specific deductible, such as for prescription drugs or hospital admissions, in lieu of or in addition to a general annual deductible. As discussed below, some plans with a general annual deductible for most services exclude specified classes of care from the deductible, such as prescriptions or physician office visits.
  - In 2020, 83% of covered workers are enrolled in a plan with a general annual deductible for single coverage, similar to the percentage last year (82%) and much higher than the percentage ten years ago (70%) [Figure 7.2].
  - The percentages of covered workers enrolled in a plan with a general annual deductible for single coverage are similar for small firms (3-199 workers) (79%) and large firms (200 or more workers) (84%) [Figure 7.2].
  - The likelihood of being in a plan with a general annual deductible varies by plan type. Fifty-one percent of covered workers in HMOs do not have a general annual deductible for single coverage, compared to 24% of workers in POS plans and 18% of workers in PPOs [Figure 7.1].
- For covered workers in a plan with a general annual deductible, the average annual deductible for single coverage is $1,644, similar to the average deductible ($1,655) last year [Figure 7.3] and [Figure 7.8].
  - For covered workers in plans with a general annual deductible, the average deductibles for single coverage are $1,201 in HMOs, $1,204 in PPOs, $1,714 in POS plans, and $2,303 in HDHP/SOs [Figure 7.6].

- The average deductibles for single coverage are higher for most plan types for covered workers in small firms than for covered workers in large firms. For covered workers in PPOs, the most common plan type, the average deductible for single coverage in small firms is considerably higher than the average deductible in large firms ($1,888 vs. $960) [Figure 7.6]. Overall, for covered workers in plans with a general annual deductible, the average deductible for single coverage in small firms ($2,295) is higher than the average deductible in large firms ($1,418) [Figure 7.3].
- The average general annual deductible for single coverage for covered workers in plans with a general annual deductible has increased 25% over the past five years, from $1,318 in 2015 to $1,644 in 2020 [Figure 7.8].

Figure 7.1

Percentage of Covered Workers with No General Annual Deductible for Single Coverage, by Plan Type and Firm Size, 2020



Tests found no statistical difference between All Small Firms and All Large Firms estimate within plan type ($p < .05$).
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers. Average general annual deductibles are for in-network providers. HDHP/SOs are not shown because all covered workers in these plans face a minimum deductible. HDHP/SOs are included in the All Plans estimate. In HDHP/HRA plans, as defined by the survey, the minimum deductible is $1,000 for single coverage and $2,000 for family coverage. For HSA-qualified HDHPs, the legal minimum deductible for 2020 is $1,350 for single coverage and $2,700 for family coverage. Average general annual health plan deductibles for PPOs, POS plans, and HDHP/SOs are for in-network services. A similar percentage of covered workers do not face a general annual deductible for single and family coverage within each plan type.
SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 7.2

Percentage of Covered Workers in a Plan That Includes a General Annual Deductible for Single Coverage, by Plan Type and Firm Size, 2006-2020

	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
HMO															
All Small Firms	17%	14%	25%	27%	34%	38%	33%	44%	59%	46%	44%	41%	56%	58%	48%
All Large Firms	10%	20%*	18%	12%	25%*	27%	29%	40%	28%	40%	47%	37%	53%	43%	49%
ALL FIRMS	**12%**	**18%**	**20%**	**16%**	**28%***	**29%**	**30%**	**41%**	**37%**	**42%**	**46%**	**38%**	**54%***	**48%**	**49%**
PPO															
All Small Firms	69%	72%	73%	74%	80%	76%	76%	78%	83%	85%	85%	78%	86%	87%	78%
All Large Firms	69%	71%	66%	74%	76%	83%	77%	82%	85%	84%	84%	88%	89%	84%	84%
ALL FIRMS	**69%**	**71%**	**68%**	**74%**	**77%**	**81%**	**77%**	**81%**	**85%**	**85%**	**84%**	**86%**	**88%**	**85%**	**82%**
POS															
All Small Firms	35%	53%*	59%	63%	64%	68%	58%	78%*	69%	80%	81%	71%	86%	75%	73%
All Large Firms	28%	41%	41%	58%	70%	71%	63%	49%	72%*	61%	66%	58%	63%	76%	79%
ALL FIRMS	**32%**	**48%***	**50%**	**62%**	**66%**	**69%**	**60%**	**66%**	**70%**	**72%**	**76%**	**65%**	**76%**	**76%**	**76%**
ALL PLANS															
All Small Firms	56%	60%	65%	67%	73%	75%	72%	77%	82%	82%	82%	77%	85%*	83%	79%
All Large Firms	54%	59%	56%	61%	68%*	74%	73%	78%	80%	81%	83%	83%	85%	81%	84%
ALL FIRMS	**55%**	**59%***	**59%**	**63%**	**70%***	**74%**	**72%**	**78%***	**80%**	**81%**	**83%**	**81%**	**85%***	**82%**	**83%**

NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers. Average general annual deductibles are for in-network providers. By definition, all HDHP/SOs have a deductible.

* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006-2017

Figure 7.3

Percentage of Covered Workers in a Plan That Includes a General Annual Deductible and Average Deductible for Single Coverage, by Firm Size and Region, 2020

	Percentage of Covered Workers in a Plan With a General Annual Deductible	Among Covered Workers With a General Annual Deductible for Single Coverage, Average Deductible
FIRM SIZE		
3-49 Workers	77%	$2,413*
50-199 Workers	81	2,179*
200-999 Workers	81	1,668
1,000-4,999 Workers	81	1,404*
5,000 or More Workers	87*	1,331*
All Small Firms (3-199 Workers)	**79%**	**$2,295***
All Large Firms (200 or More Workers)	**84%**	**$1,418***
REGION		
Northeast	84%	$1,605
Midwest	92*	1,669
South	79	1,733
West	75*	1,497
ALL FIRMS	**83%**	**$1,644**

* Estimate is statistically different from estimate for all other firms not in the indicated size or region category ($p < .05$).

SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 7.4

Percentage of Covered Workers in a Plan That Includes a General Annual Deductible and Average Deductibles for Single Coverage, by Firm Characteristics, 2020

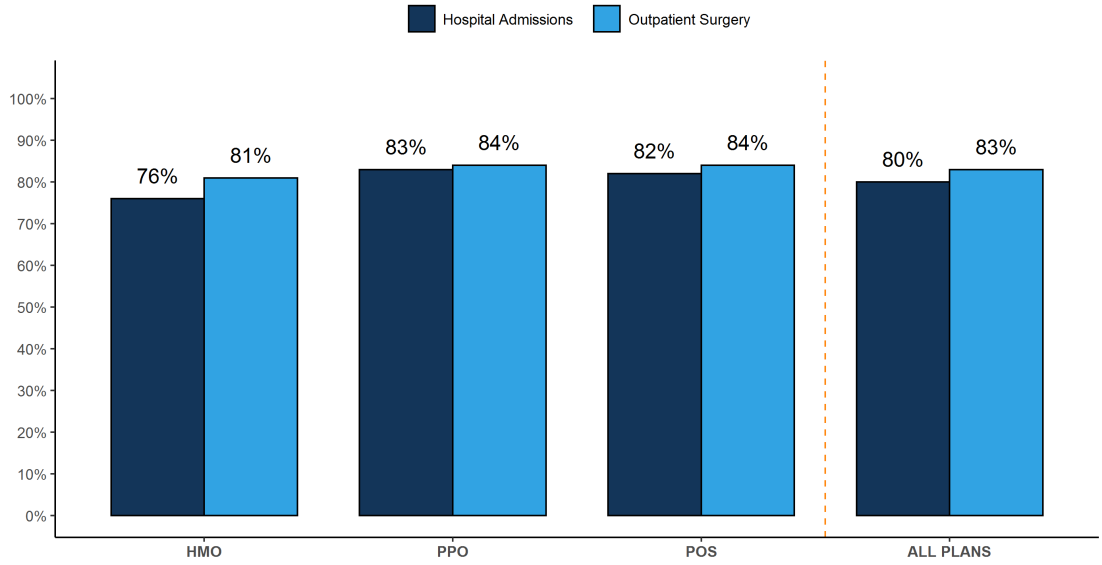
	Percentage of Covered Workers in a Plan With a General Annual Deductible	Among Covered Workers With a General Annual Deductible for Single Coverage, Average Deductible
LOWER WAGE LEVEL		
Few Lower-Wage Workers	84%*	$1,620*
Many Lower-Wage Workers	71%*	$2,060*
HIGHER WAGE LEVEL		
Few Higher-Wage Workers	82%	$1,768*
Many Higher-Wage Workers	83%	$1,527*
UNIONS		
Firm Has Union Workers	84%	$1,220*
Firm Has No Union Workers	82%	$1,902*
YOUNGER WORKERS		
Few Younger Workers	83%	$1,643
Many Younger Workers	76%	$1,664
OLDER WORKERS		
Few Older Workers	84%	$1,740*
Many Older Workers	81%	$1,541*
FIRM OWNERSHIP		
Private For-Profit	87%*	$1,755*
Public	75%*	$1,177*
Private Not-For-Profit	79%	$1,668
ALL FIRMS	**83%**	**$1,644**

NOTE: Firms with many lower-wage workers are those where at least 35% earn the 25th percentile or less of national earnings ($26,000 in 2020). Firms with many higher-wage workers are those where at least 35% earn the 75th percentile or more than of national earnings ($64,000 in 2020). Firms with many older workers are those where at least 35% of workers are age 50 or older. Firms with many younger workers are those where at least 35% of workers are age 26 or younger.

* Estimates are statistically different from each other within firm characteristic ($p < .05$).

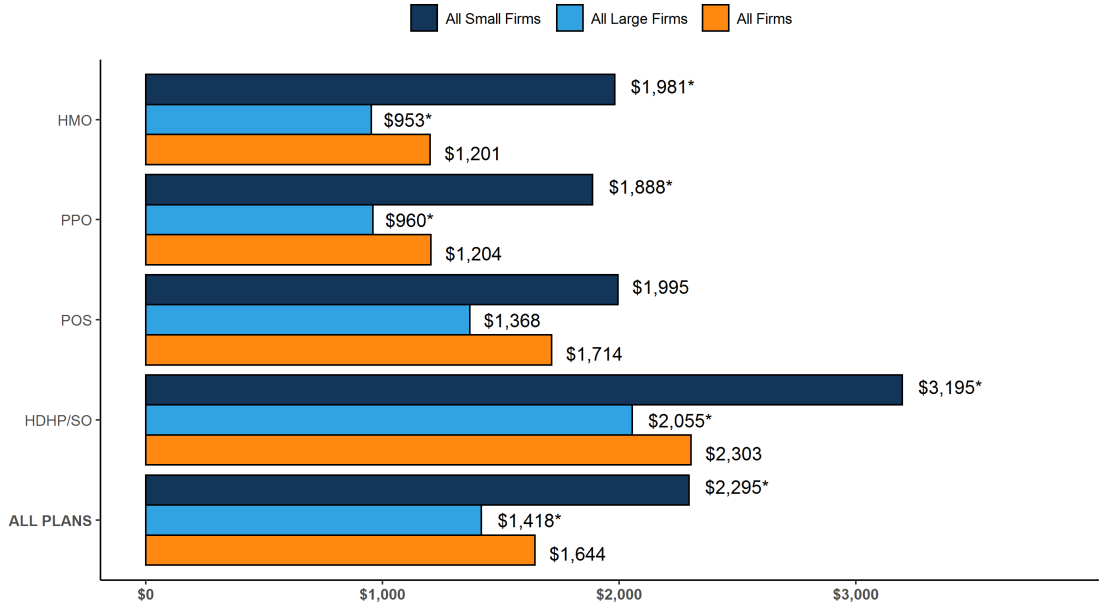
SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 7.5
Among Covered Workers with No General Annual Deductible, Percentage with Other Forms of Cost Sharing for Various Services, by Plan Type, 2020



NOTE: Other cost sharing could include a separate annual deductible, copayment, coinsurance or charge per day (for Hospital Admissions). HDHP/SOs are excluded because, by definition, all workers face a deductible. All Plans percentages do not statistically differ between single coverage and family coverage (not shown).
SOURCE: KFF Employer Health Benefits Survey, 2020

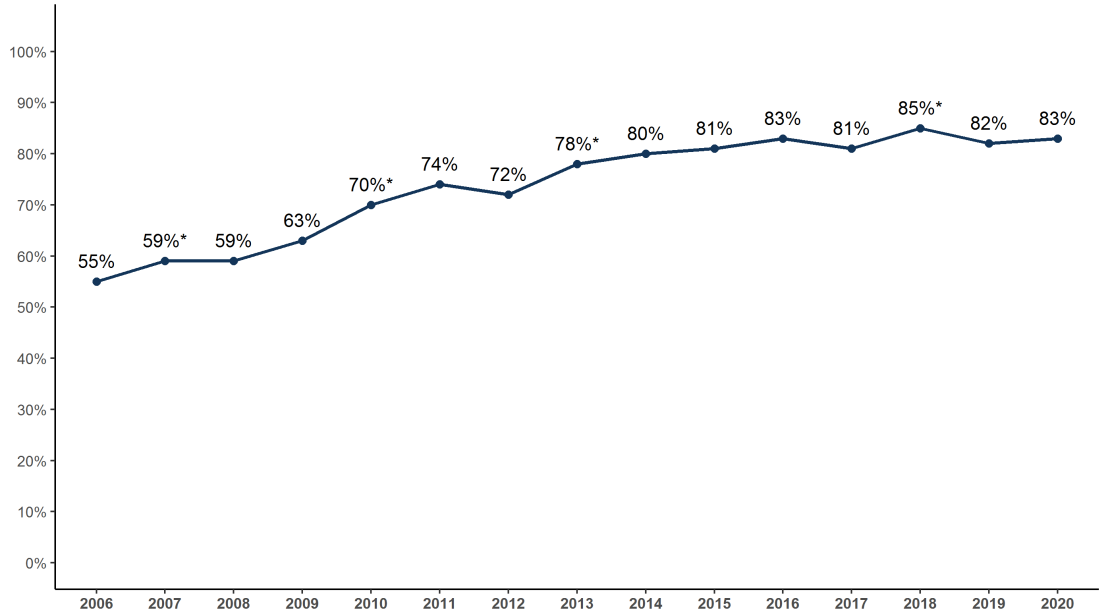
Figure 7.6
Among Covered Workers with a General Annual Deductible for Single Coverage, Average Deductible, by Plan Type and Firm Size, 2020



* Estimate is statistically different between All Small Firms and All Large Firms estimate within plan type ($p < .05$).
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers. Average general annual deductibles are for in-network providers.
SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 7.7

Percentage of Covered Workers with a General Annual Deductible for Single Coverage, 2006-2020



* Estimate is statistically different from estimate for the previous year shown (p < .05).
NOTE: Average general annual deductibles are for in-network providers.
SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006-2017

Figure 7.8

Among Covered Workers With a General Annual Deductible, Average Single and Family Coverage Deductible, by Plan Type, 2006-2020

	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Single Coverage															
HMO	$352	$401	$503	$699*	$601	$911	$691	$729	$1,032*	$1,025	$917	$1,175	$870	$1,200	$1,201
PPO	$473	$461	$560*	$634*	$675	$675	$733	$799	$843	$958	$1,028	$1,046	$1,204*	$1,206	$1,204
POS	$553	$621	$752	$1,061	$1,048	$928	$1,014	$1,314	$1,215	$1,230	$1,737*	$1,301	$1,598	$1,857	$1,714
HDHP/SO	$1,715	$1,729	$1,812	$1,838	$1,903	$1,908	$2,086	$2,003	$2,215*	$2,099	$2,199	$2,304	$2,349	$2,486	$2,303
ALL PLANS	$584	$616	$735*	$826*	$917*	$991	$1,097*	$1,135	$1,217	$1,318	$1,478*	$1,505	$1,573	$1,655	$1,644
Family Coverage Deductible With Aggregate Structure															
HMO	$751	$759	$1,053	$1,524*	$1,321	$1,487	$1,329	$1,743	$2,328	$2,758	$2,245	$2,732	$2,317	$2,905	$3,035
PPO	$1,034	$1,040	$1,344*	$1,488	$1,518	$1,521	$1,770	$1,854	$1,947	$2,012	$2,147	$2,503*	$3,000*	$2,883	$2,716
POS	$1,227	$1,359	$1,860	$2,191	$2,253	$1,769	$2,163	$2,821	$2,470	$2,467	$3,769*	$2,697	$3,497	$4,347	$3,902
HDHP/SO	$3,511	$3,596	$3,559	$3,626	$3,780	$3,666	$3,924	$4,079	$4,522*	$4,332	$4,343	$4,527	$4,676	$4,779	$4,552
Family Coverage Deductible With Separate Per-Person Structure															
HMO	NSD	NSD	NSD	$686	$500	$885	$754	$609	$870	$852	$632	$1,045	$691	$881	NSD
PPO	$710	$492*	$514	$633	$596	$646	$632	$782*	$821	$944	$1,052	$914	$1,005	$1,091	$1,115
POS	$992	$592	$778	$1,050	$1,164	$912	$1,092	$1,080	$1,153	$1,153	$1,180	$1,128	$1,864*	$1,932	NSD
HDHP/SO	NSD	NSD	$2,334*	$2,091	$2,053	$2,149	$2,821*	$2,033*	$2,126	$1,965	$2,411	$2,645	$2,560	$3,078	$2,523

NOTE: Average general annual deductibles are for in-network providers. The survey distinguishes between plans that have an aggregate deductible amount in which all family members' out-of-pocket expenses count toward the deductible, and plans that have a separate amount for each family member, typically with a limit on the number of family members required to reach that amount.
NSD: Not Sufficient Data
* Estimate is statistically different from estimate for the previous year shown (p < .05).
SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006-2017

GENERAL ANNUAL DEDUCTIBLES AMONG ALL COVERED WORKERS

- As discussed above, the share of covered workers in plans with a general annual deductible has increased significantly over time, from 70% in 2010 to 83% in 2020 [Figure 7.9]. The average deductible amounts for covered workers in plans with a deductible have also increased, over the period, from $917 in 2010 to $1,644 in 2020 [Figure 7.10]. Neither trend by itself, however, captures the full impact of changes in deductibles on covered workers. We can look at the average impact of both trends together on covered workers by assigning a zero deductible value to covered workers in plans with no deductible and looking

at how the resulting averages change over time. These average deductible amounts are lower in any given year but the changes over time reflect both the higher deductibles in plans with a deductible and the fact that more workers face them.

  - Using this approach, the average general annual deductible for single coverage for all covered workers in 2020 is $1,364, similar to the amount last year ($1,396) [Figure 7.10].
  - The 2020 value is 27% higher than the average general annual deductible of $1,077 in 2015 and 111% higher than the average general annual deductible of $646 in 2010 [Figure 7.10].

- Another way to look at deductibles is the percentage of all covered workers who are in a plan with a deductible that exceeds certain thresholds. Fifty-seven percent of covered workers are in plans with a general annual deductible of $1,000 or more for single coverage, similar to the percentage last year [Figure 7.13].

  - Over the past five years, the percentage of covered workers with a general annual deductible of $1,000 or more for single coverage has grown 23%, from 46% to 57% [Figure 7.13].
  - Workers in small firms are considerably more likely to have a general annual deductible of $1,000 or more for single coverage than workers in large firms (64% vs. 54%) [Figure 7.12].
  - In 2020, 26% of covered workers are enrolled in a plan with a deductible of $2,000 or more, similar to the percentage last year (28%) [Figure 7.15]. This percentage is much higher for covered workers in small firms than large firms (42% vs. 20%) [Figure 7.12].

Figure 7.9

Prevalence and Value of General Annual Deductibles for Single Coverage, by Firm Size, 2006-2020

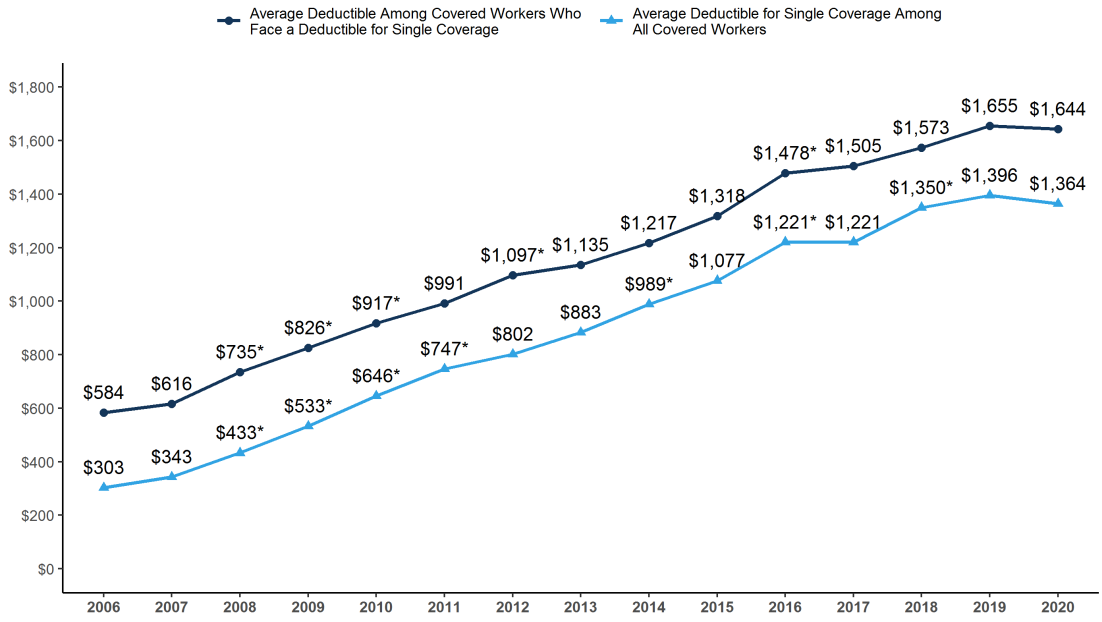
	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Average General Annual Deductible Among Covered Workers Who Face a Deductible for Single Coverage															
All Small Firms	$775	$852	$1,124*	$1,254	$1,391	$1,537	$1,596	$1,715	$1,797	$1,836	$2,069	$2,120	$2,132	$2,271	$2,295
All Large Firms	496	519	553	640*	686	757	875*	884	971	1,105*	1,238	1,276	1,355	1,412	1,418
ALL FIRMS	$584	$616	$735*	$826*	$917*	$991	$1,097*	$1,135	$1,217	$1,318	$1,478*	$1,505	$1,573	$1,655	$1,644
Percentage of Covered Workers With a General Annual Deductible for Single Coverage															
All Small Firms	56%	60%	65%	67%	73%	75%	72%	77%	82%	82%	82%	77%	85%*	83%	79%
All Large Firms	54	59	56	61	68*	74	73	78	80	81	83	83	85	81	84
ALL FIRMS	55%	59%*	59%	63%	70%*	74%	72%	78%*	80%	81%	83%	81%	85%*	82%	83%
Average General Annual Deductible for Single Coverage Among ALL COVERED WORKERS															
All Small Firms	$431	$494	$727*	$851	$1,001	$1,177	$1,163	$1,330	$1,493	$1,507	$1,669	$1,631	$1,818	$1,896	$1,819
All Large Firms	234	269	284	376*	456*	546*	629*	670	765*	890*	1,026	1,049	1,159	1,184	1,187
ALL FIRMS	$303	$343	$433*	$533*	$646*	$747*	$802	$883	$989*	$1,077	$1,221*	$1,221	$1,350*	$1,396	$1,364

NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers. Average general annual deductibles are for in-network providers. Average general annual deductibles are among all covered workers. Workers in plans without a general annual deductible for in-network services are assigned a value of zero.

* Estimate is statistically different from estimate for the previous year shown ($p < .05$).

SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006-2017

Figure 7.10
Average General Annual Deductibles for Single Coverage, 2006-2020

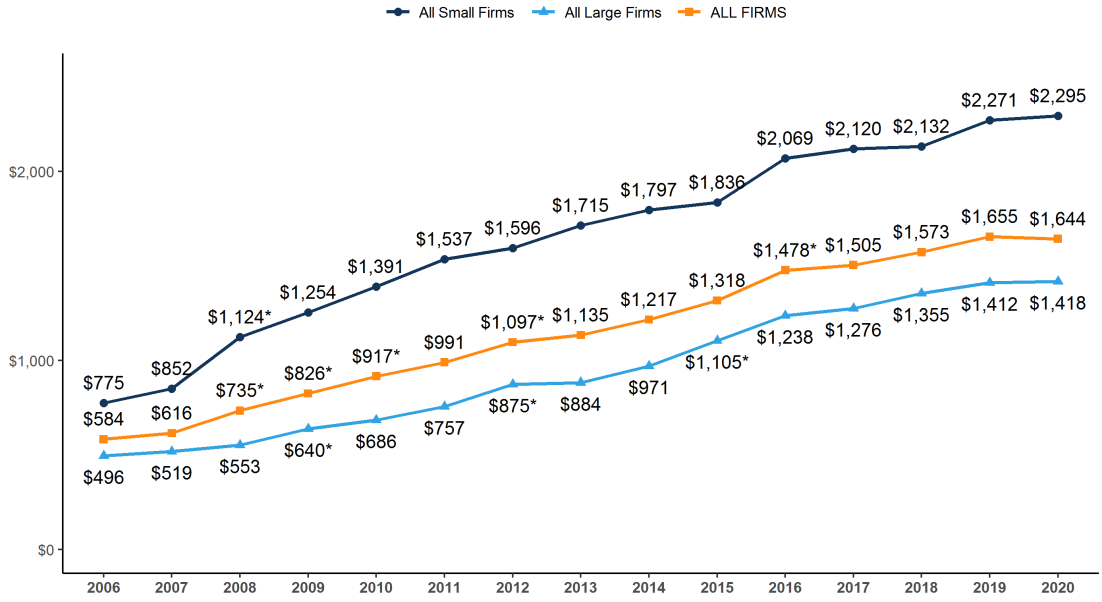


* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
NOTE: Average general annual deductibles are among all covered workers. Workers in plans without a general annual deductible for in-network services are assigned a value of zero.
SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006-2017

GENERAL ANNUAL DEDUCTIBLES AND ACCOUNT CONTRIBUTIONS

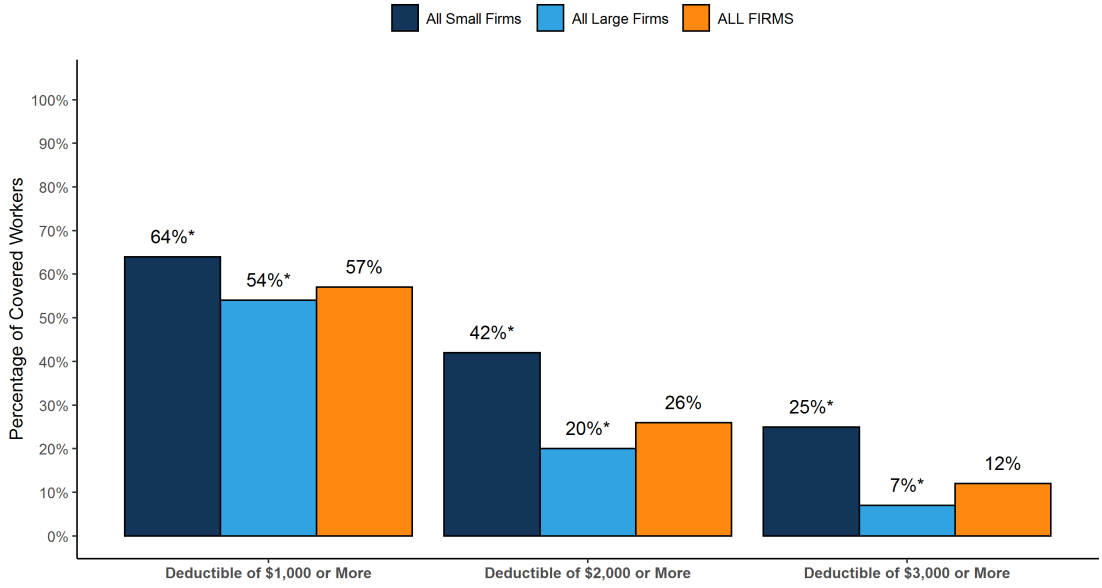
- One of the reasons for the growth in general annual deductibles has been the growth in enrollment in HDHP/SOs, which have higher deductibles than other plans. While growing deductibles in other plan types generally increases enrollee out-of-pocket liability, the shift in enrollment to HDHP/SOs does not necessarily do so because many HDHP/SO enrollees receive an account contribution from their employers, which in essence reduces the high cost sharing in these plans.
  - Ten percent of covered workers in an HDHP with an HRA and 3% of covered workers in an HSA-qualified HDHP receive an account contribution from their employer for single coverage at least equal to their deductible, while another 41% of covered workers in an HDHP with an HRA and 19% of covered workers in an HSA-qualified HDHP receive account contributions that, if applied to their deductible, would reduce the deductible to $1,000 or less [Figure 7.17].
  - If we reduce the general annual deductibles by employer account contributions, the percentage of covered workers with a deductible of $1,000 or more would be reduced from 57% to 47% [Figure 7.13] and [Figure 7.14].

Figure 7.11
Among Covered Workers Who Face a Deductible for Single Coverage, Average General Annual Deductible for Single Coverage, by Firm Size, 2006-2020



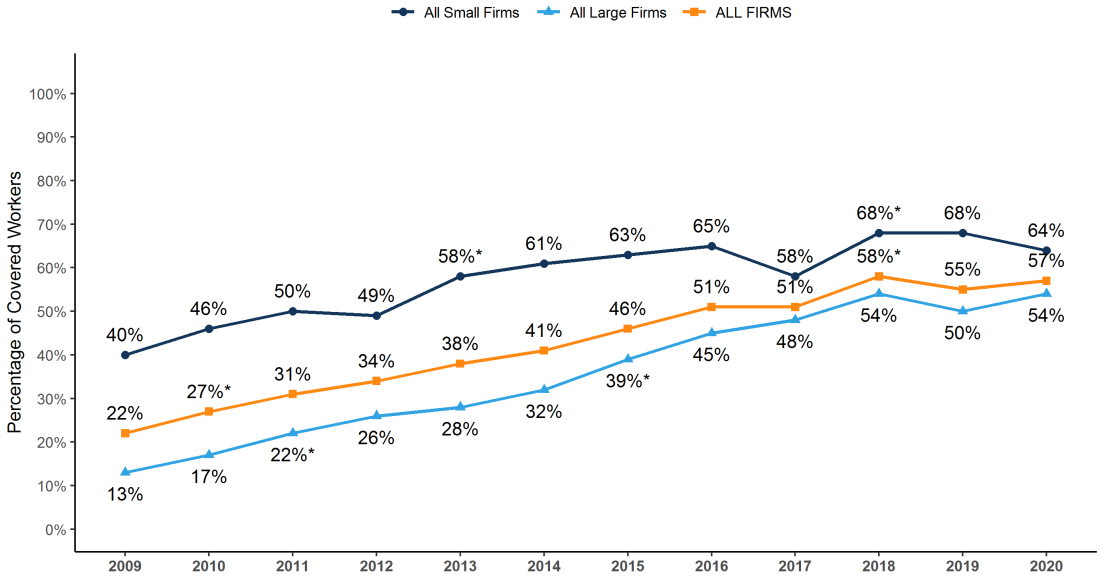
* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers. Average general annual deductibles are for in-network providers.
SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006-2017

Figure 7.12
Percentage of Covered Workers Enrolled in a Plan with a High General Annual Deductible for Single Coverage, by Firm Size, 2020



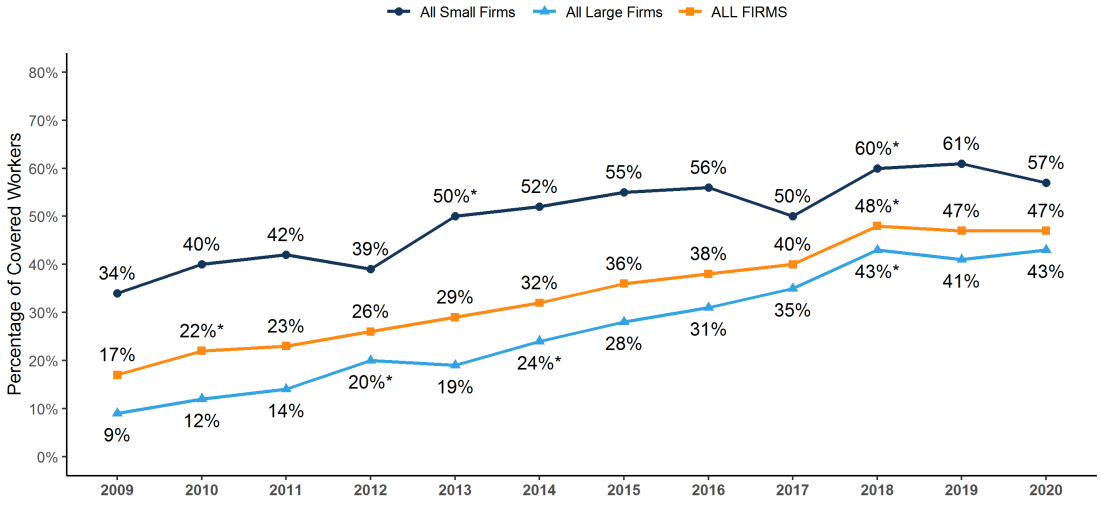
* Estimate is statistically different between All Small Firms and All Large Firms estimate ($p < .05$).
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers. These estimates include workers enrolled in HDHP/SOs and other plan types. Average general annual health plan deductibles for PPOs, POS plans, and HDHP/SOs are for in-network services.
SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 7.13
Percentage of Covered Workers Enrolled in a Plan with a General Annual Deductible of $1,000 or More for Single Coverage, by Firm Size, 2009-2020



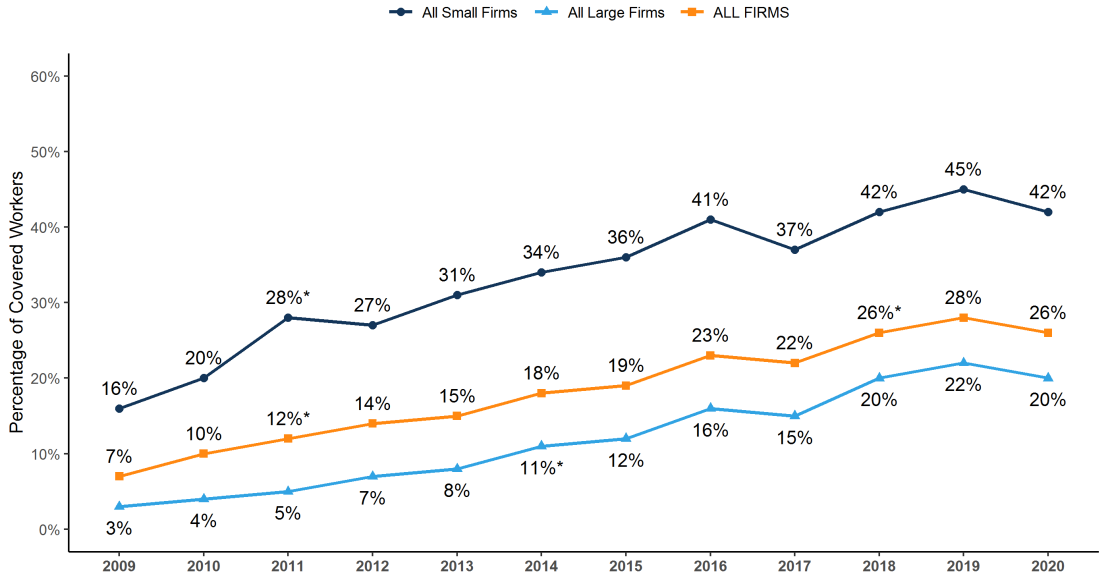
* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers. These estimates include workers enrolled in HDHP/SOs and other plan types. Average general annual deductibles are for in-network providers.
SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2009-2017

Figure 7.14
Percentage of Covered Workers Enrolled in a Plan with a General Annual Deductible of $1,000 or More for Single Coverage, Reduced by Any HRA/HSA Contributions, by Firm Size, 2009-2020



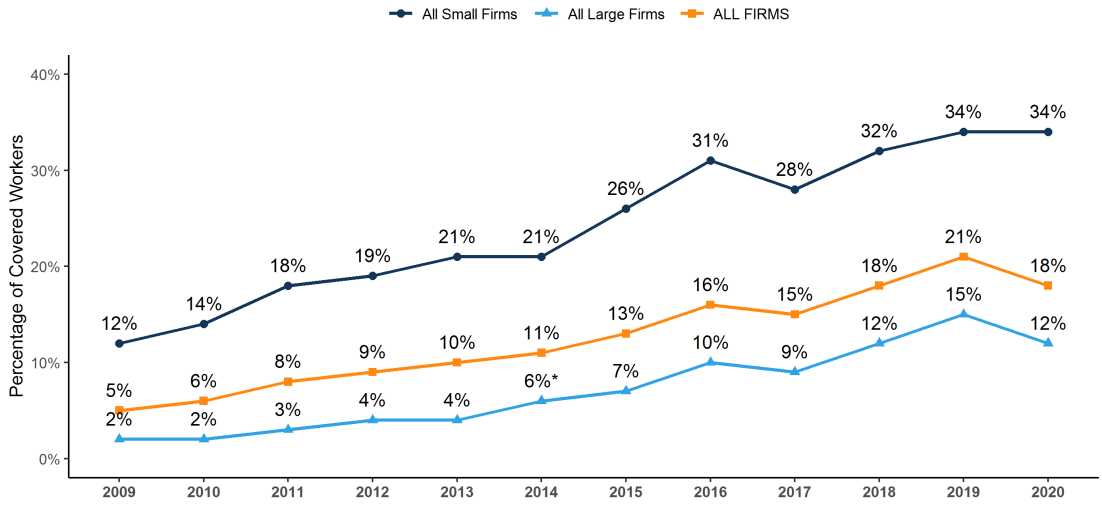
* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers. These estimates include workers enrolled in HDHP/SO and other plan types. The net liability for covered workers enrolled in a plan with an HSA or HRA is calculated by subtracting the account contribution from the single coverage deductible. HRAs are notional accounts, and employers are not required to actually transfer funds until an employee incurs expenses. General annual deductibles are for in-network providers.
SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2009-2017

Figure 7.15
Percentage of Covered Workers Enrolled in a Plan with a General Annual Deductible of $2,000 or More for Single Coverage, by Firm Size, 2009-2020



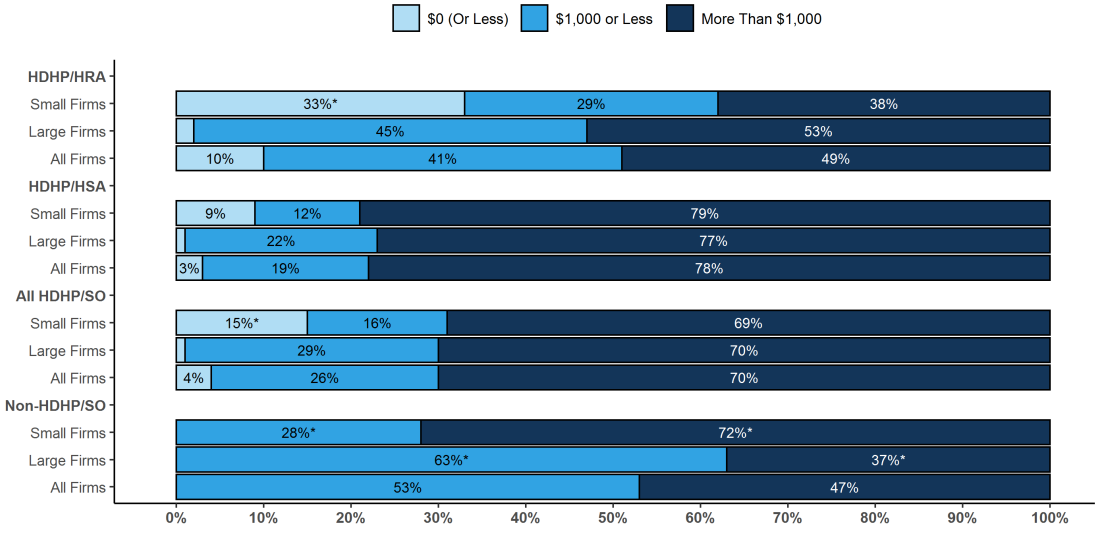
* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers. These estimates include workers enrolled in HDHP/SOs and other plan types. Average general annual deductibles are for in-network providers.
SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2009-2017

Figure 7.16
Percentage of Covered Workers Enrolled in a Plan with a General Annual Deductible of $2,000 or More for Single Coverage, Reduced by Any HRA/HSA Contributions, by Firm Size, 2009-2020



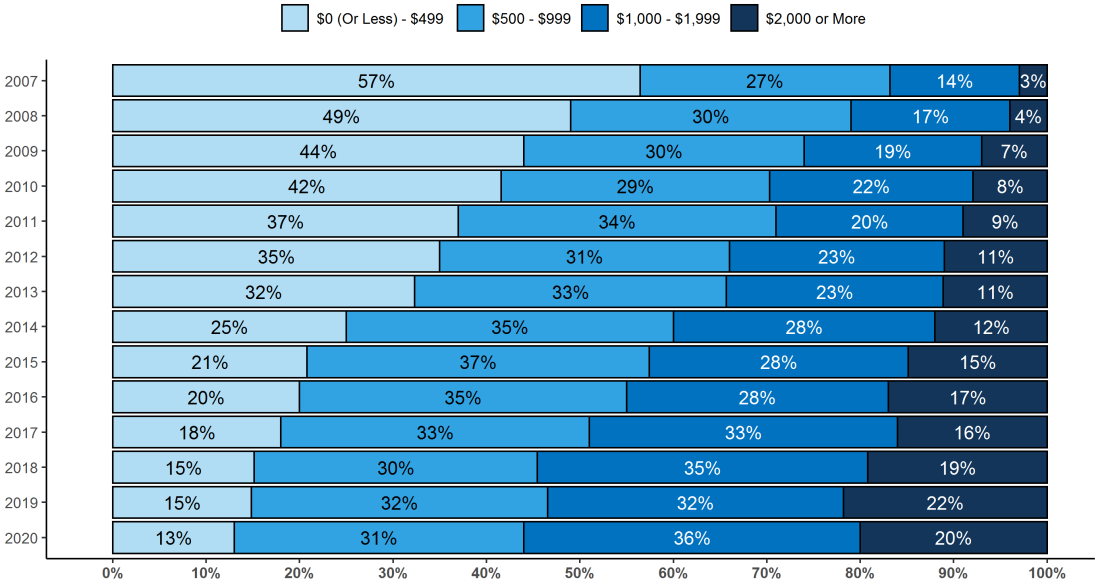
* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers. These estimates include workers enrolled in HDHP/SOs and other plan types. The net liability for covered workers enrolled in a plan with an HSA or HRA is calculated by subtracting the account contribution from the single coverage deductible. HRAs are notional accounts, and employers are not required to actually transfer funds until an employee incurs expenses. General annual deductibles are for in-network providers.
SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2009-2017

Figure 7.17
Among Covered Workers with a General Annual Deductible, Average General Annual Deductibles for Single Coverage, Reduced by Any HRA/HSA Contributions, by Plan Type and Firm Size, 2020



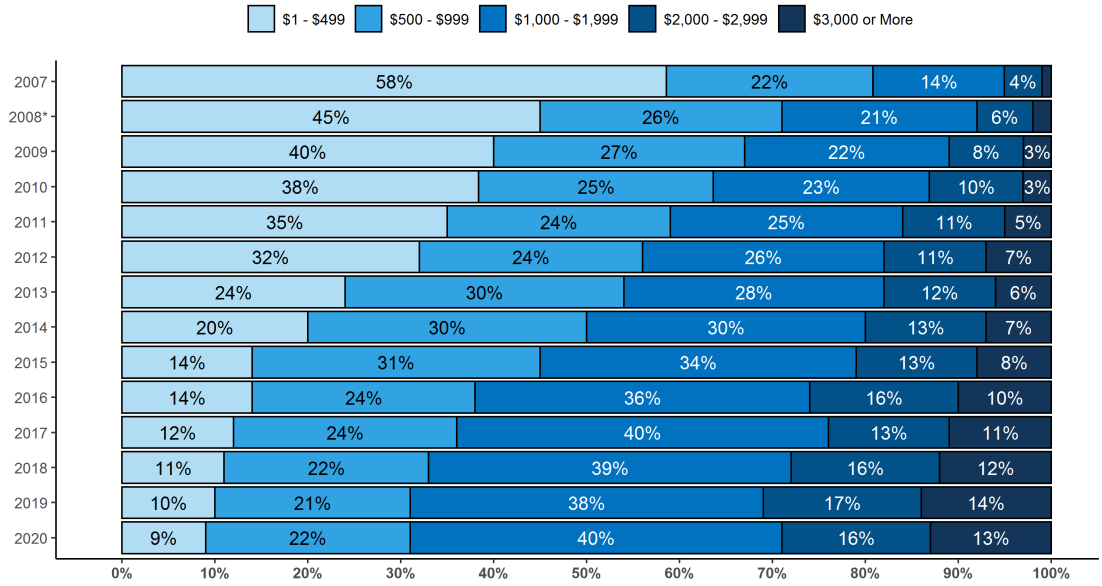
* Estimate is statistically different between All Small Firms and All Large Firms estimate ($p < .05$).
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers. The net liability for covered workers enrolled in a plan with an HSA or HRA is calculated by subtracting the account contribution from the single coverage deductible. HRAs are notional accounts, and employers are not required to actually transfer funds until an employee incurs expenses. General annual deductibles are for in-network providers.
SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 7.18
Among Covered Workers with a General Annual Deductible, Distribution of General Annual Deductibles for Single Coverage, Reduced by Any HRA/HSA Contributions, 2007-2020



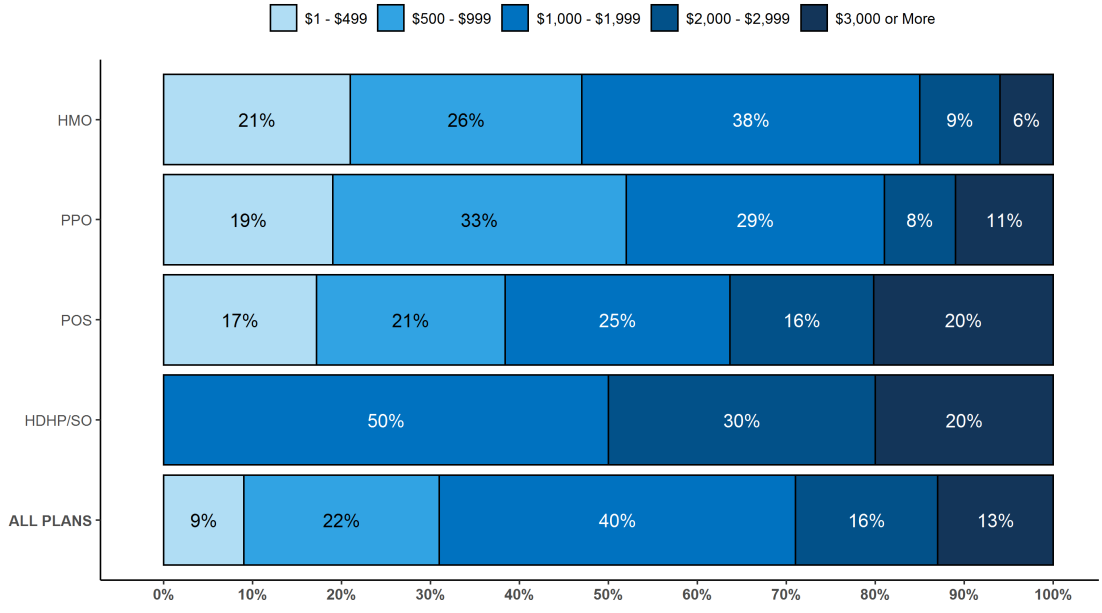
Tests found no statistical difference from distribution for the previous year shown ($p < .05$).
NOTE: Account contributions include an employer's contribution to an HSA or HRA. These estimates include workers enrolled in HDHP/SOs and other plan types. Average general annual deductibles are for in-network providers.
SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2007-2017

Figure 7.19
Among Covered Workers with a General Annual Deductible, Distribution of General Annual Deductible for Single Coverage, 2007-2020



* Distribution is statistically different from distribution for the previous year shown ($p < .05$).
NOTE: Average general annual deductibles are for in-network providers. In 2020, 83% of covered workers are enrolled in a plan with a general annual deductible.
SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2007-2017

Figure 7.20
Among Covered Workers with a General Annual Deductible, Distribution of General Annual Deductibles for Single Coverage, by Plan Type, 2020



NOTE: Average general annual deductibles are for in-network providers.
SOURCE: KFF Employer Health Benefits Survey, 2020

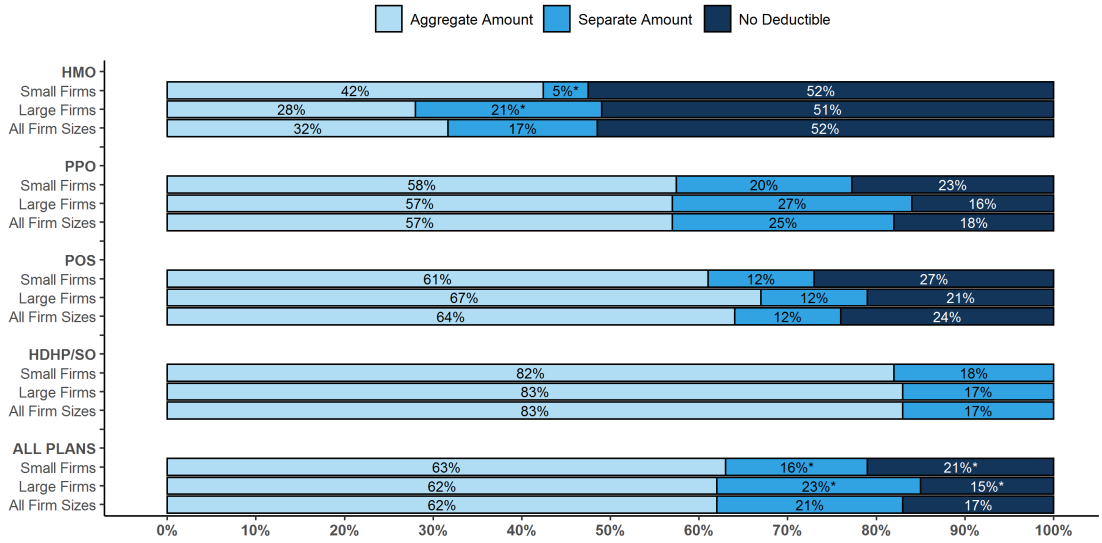
GENERAL ANNUAL DEDUCTIBLES FOR WORKERS ENROLLED IN FAMILY COVERGE

General annual deductibles for family coverage are structured in two primary ways: (1) with an aggregate family deductible, the out-of-pocket expenses of all family members count against a specified family deductible amount, and the deductible is considered met when the combined family expenses exceed the deductible amount; (2) with a separate per-person family deductible, each family member is subject to a specified deductible amount before the plan covers expenses for that member, although many plans consider the deductible for all family members met once a specified number (typically two or three) of family members meet their specified deductible amount.[1]

- About one-half (52%) of covered workers in HMOs are in plans without a general annual deductible for family coverage; the percentages in plans without family dedictibles are lower for workers in PPOs (18%) and POS plans (24%). As defined, all covered workers in HDHP/SOs have a general annual deductible for family coverage [Figure 7.21].
- Among covered workers enrolled in family coverage, the percentages of covered workers in a plan with an aggregate general annual deductible are 32% for workers in HMOs; 57% for workers in PPOs; 64% for workers in POS plans; and 83% for workers in HDHP/SOs [Figure 7.21].
  - The average deductible amounts for covered workers in plans with an aggregate annual deductible for family coverage are $3,035 for HMOs; $2,716 for PPOs; $3,902 for POS plans; and $4,552 for HDHP/SOs [Figure 7.22]. Deductible amounts for aggregate family deductibles are similar to last year for each plan type.
- For covered workers in plans with an aggregate deductible for family coverage, the average annual family deductibles in small firms are higher than the average annual family deductibles in large firms for covered workers in HMOs, PPOs and HDHP/SOs [Figure 7.22].
- Among covered workers enrolled in family coverage, the percentages of covered workers in plans with a separate per-person annual deductible for family coverage are 17% for workers in HMOs; 25% for workers in PPOs; 12% for workers in POS plans; and 17% for workers in HDHP/SOs [Figure 7.21].
  - The average deductible amounts for covered workers in plans with separate per-person annual deductibles for family coverage are $1,115 for PPOs and $2,523 for HDHP/SOs [Figure 7.22].
  - Forty percent covered workers in plans with a separate per-person annual deductible for family coverage have a limit for the number of family members required to meet the separate deductible amounts [Figure 7.25]. Among those covered workers in plans with a limit on the number of family members, the most frequent number of family members required to meet the separate per-person deductible is two [Figure 7.26].

[1] Some workers with separate per-person deductibles or out-of-pocket maximums for family coverage do not have a specific number of family members that are required to meet the deductible amount and instead have another type of limit, such as a per-person amount with a total dollar amount limit. These responses are included in the averages and distributions for separate family deductibles and out-of-pocket maximums.

Figure 7.21
Distribution of Type of General Annual Deductible for Covered Workers with Family Coverage, by Plan Type and Firm Size, 2020



* Estimate is statistically different between All Small Firms and All Large Firms estimate ($p < .05$).
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers. HDHP/SOs are defined as having a minimum deductible of $1,000 for single coverage and $2,000 for family coverage and either an HRA or HSA. Among workers with a general annual family deductible, 65% in HMOs, 69% in PPOs, and 84% in POS plans,The survey distinguishes between plans that have an aggregate family deductible and plans that have a separate per-person deductible, typically with a limit on the number of family members required to reach that amount. N/A: Not Applicable.
SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 7.22

Among Covered Workers With a General Annual Deductible, Average Deductibles for Family Coverage, by Deductible Type, Plan Type, and Firm Size, 2020

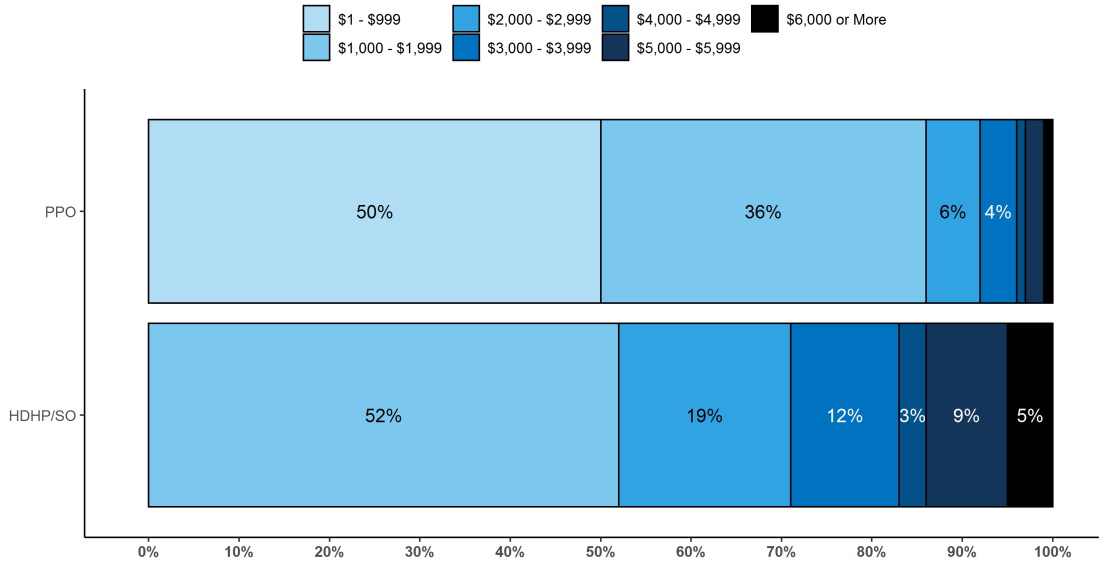
	Aggregate Amount	Separate Per-Person Amount
HMO		
All Small Firms	$4,181*	NSD
All Large Firms	$2,467*	NSD
ALL FIRM SIZES	**$3,035**	**NSD**
PPO		
All Small Firms	$4,231*	$1,585*
All Large Firms	$2,137*	$986*
ALL FIRM SIZES	**$2,716**	**$1,115**
POS		
All Small Firms	$4,467	NSD
All Large Firms	$3,210	NSD
ALL FIRM SIZES	**$3,902**	**NSD**
HDHP/SO		
All Small Firms	$6,189*	$3,763*
All Large Firms	$4,099*	$2,152*
ALL FIRM SIZES	**$4,552**	**$2,523**

NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers. Average general annual deductibles are for in-network providers. The survey distinguishes between plans that have an aggregate family deductible and plans that have a separate per-person deductible, typically with a limit on the number of family members required to reach that amount.
NSD: Not Sufficient Data

* Estimate is statistically different between All Small Firms and All Large Firms estimate ($p < .05$).

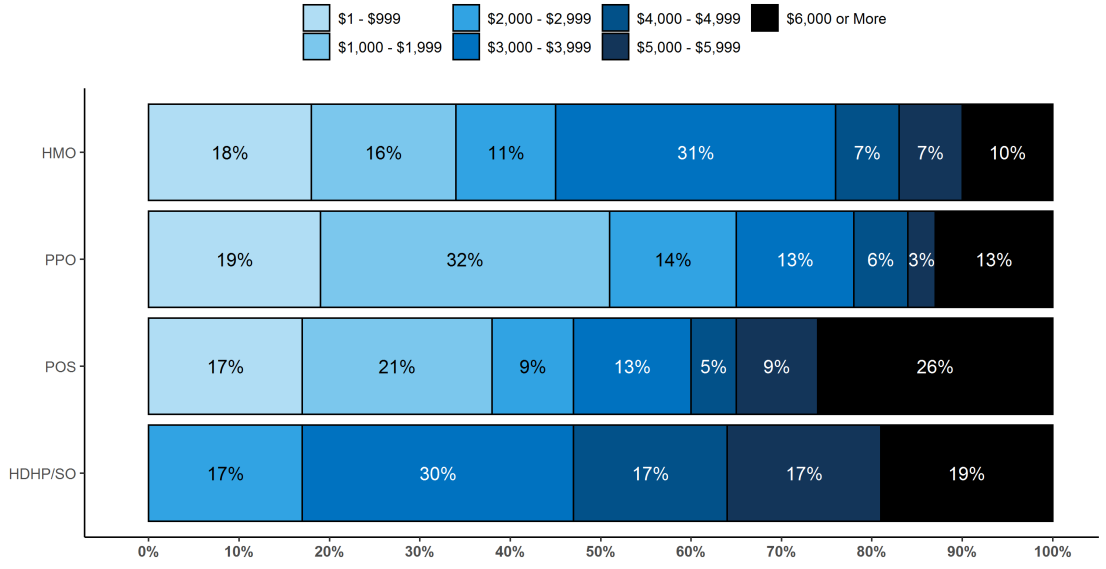
SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 7.23
Among Covered Workers with a Separate Per-Person General Annual Deductible for Family Coverage, Distribution of Deductibles, by Plan Type, 2020



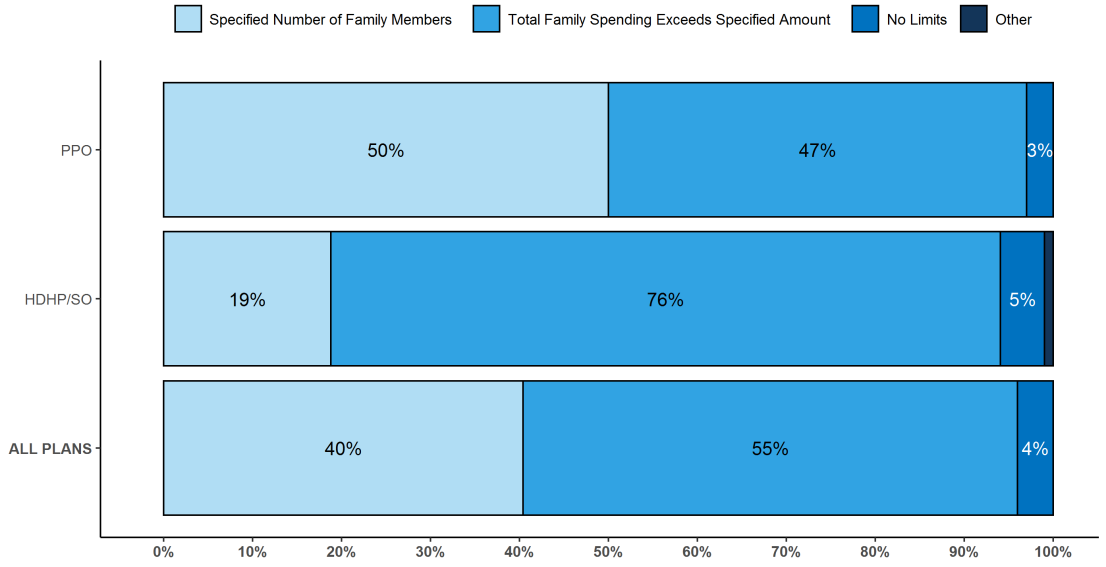
NOTE: Average general annual deductibles are for in-network providers. The survey distinguishes between plans that have an aggregate family deductible and plans that have a separate per-person deductible, typically with a limit on the number of family members required to reach that amount.
SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 7.24
Among Covered Workers with an Aggregate General Annual Deductible for Family Coverage, Distribution of Deductibles, by Plan Type, 2020



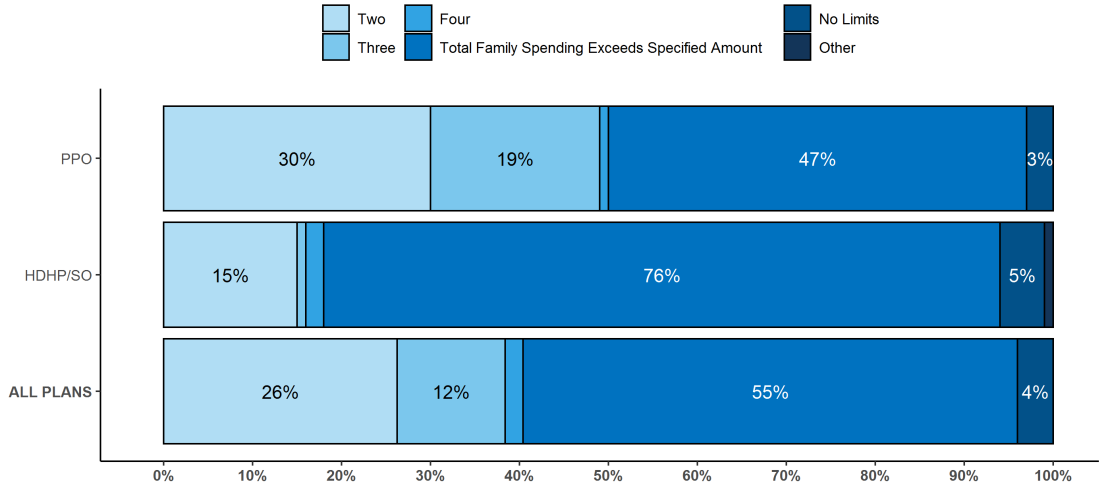
NOTE: By definition, 100% of covered workers in an HDHP/SO with an aggregate deductible have a family deductible of $2,000 or more. Average general annual deductibles are for in-network providers. The survey distinguishes between plans that have an aggregate family deductible and plans that have a separate per-person deductible, typically with a limit on the number of family members required to reach that amount.
SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 7.25
Among Covered Workers With a Separate Per-Person General Annual Deductible for Family Coverage, Structure of Deductible Limits, by Plan Type, 2020



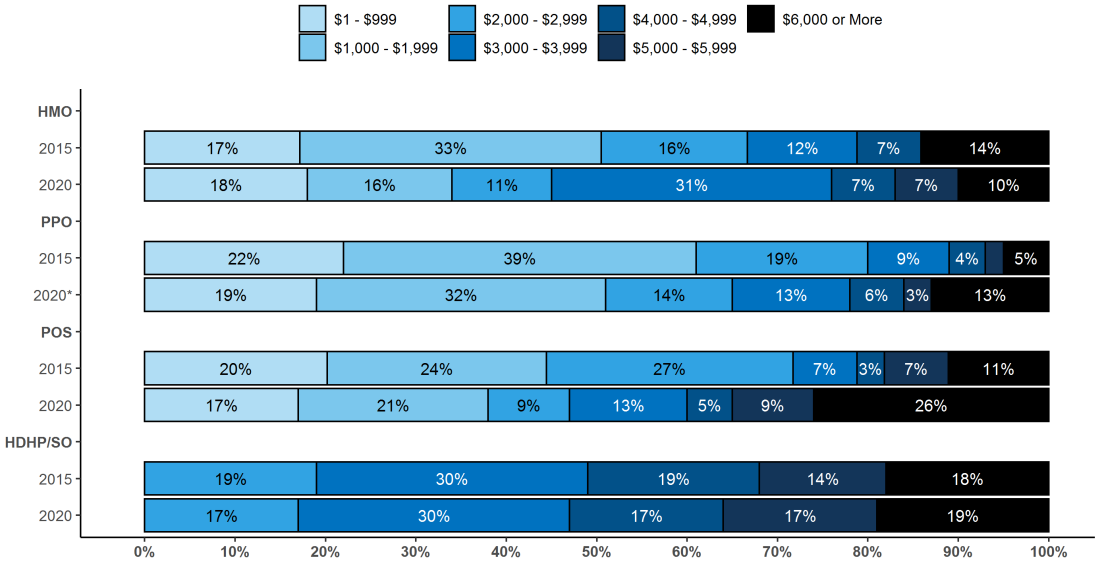
NOTE: Average general annual deductibles are for in-network providers. The survey distinguishes between plans that have an aggregate family deductible and plans that have a separate per-person deductible, typically with a limit on the number of family members required to reach that amount. Plan types with insufficient sample are not shown independently, but included in the all plan estimate.
SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 7.26
Among Covered Workers With a Separate Per-Person General Annual Deductible for Family Coverage and a Per-Person Limit, Distribution of Maximum Number of Family Members Required to Meet the Deductible, by Plan Type, 2020



NOTE: Average general annual deductibles are for in-network providers. The survey distinguishes between plans that have an aggregate family deductible and plans that have a separate per-person deductible, typically with a limit on the number of family members required to reach that amount. Firms that reported having a separate family deductible were asked if they had a combined limit or if the limit was considered met when a specified number of family members reached their separate per-person limit. 'Other' category may include per-person limits with a total family dollar limit. Plan types with insufficient sample are not shown independently, but included in the all plan estimate.
SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 7.27
Among Covered Workers With an Aggregate General Annual Deductible for Family Coverage, Distribution of Aggregate Deductibles, by Plan Type, 2015 and 2020

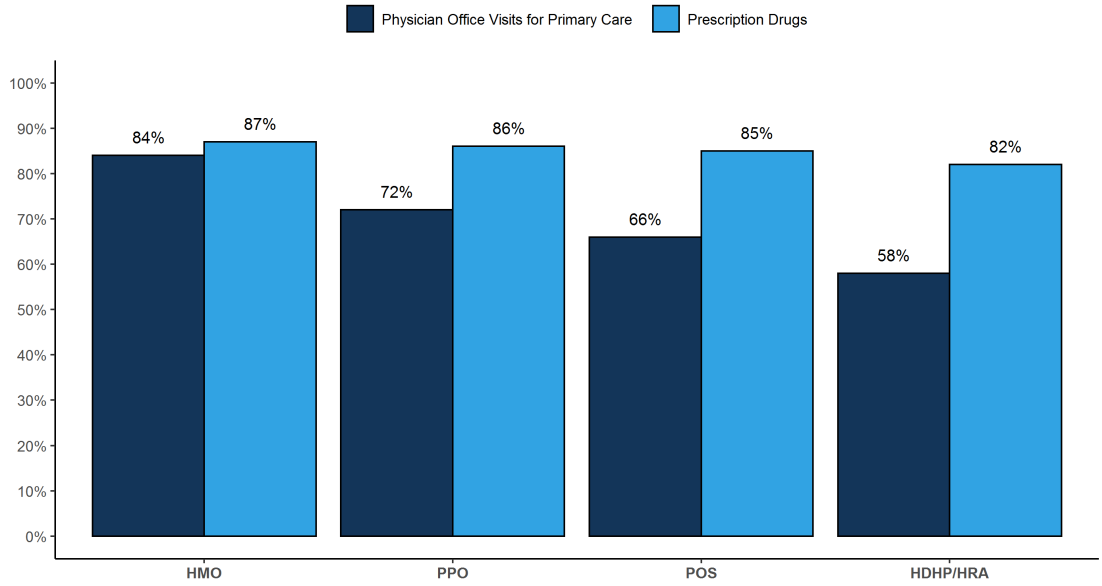


* Distribution is statistically different from distribution for the previous year shown ($p < .05$).
NOTE: By definition, 100% of covered workers in an HDHP/SO with an aggregate deductible have a family deductible of $2,000 or more. Average general annual deductibles are for in-network providers. The survey distinguishes between plans that have an aggregate family deductible and plans that have a separate per-person deductible, typically with a limit on the number of family members required to reach that amount.
SOURCE: KFF Employer Health Benefits Survey, 2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2015

CHARACTERISTICS OF GENERAL ANNUAL DEDUCTIBLES

- The majority of covered workers with a general annual deductible are in plans where the deductible does not have to be met before certain services, such as physician office visits or prescription drugs, are covered.
  - Majorities of covered workers (84% in HMOs, 72% in PPOs, 66% in POS plans, and 58% in HDHP/HRAs) who are enrolled in plans with general annual deductibles are in plans where the deductible does not have to be met before physician office visits for primary care are covered [Figure 7.28].
  - Similarly, among workers with a general annual deductible, large shares of covered workers in HMOs (87%), PPOs (86%), POS plans (85%), and HDHP/HRAs (82%) are enrolled in plans where the general annual deductible does not have to be met before prescription drugs are covered [Figure 7.28].

Figure 7.28
Among Covered Workers with a General Annual Deductible, Percentage with Coverage for the Following Services Without Having to First Meet the Deductible, by Plan Type, 2020



NOTE: These questions are asked of firms with a deductible for single or family coverage. HSA-Qualified HDHPs are required by law to apply the plan deductible to nearly all services and therefore are not included here.
SOURCE: KFF Employer Health Benefits Survey, 2020

HOSPITAL ADMISSIONS AND OUTPATIENT SURGERY

- Whether or not a worker has a general annual deductible, most workers face additional types of cost sharing (such as a copayment, coinsurance, or a per diem charge) when admitted to a hospital or having outpatient surgery. The distribution of workers with cost sharing for hospital admissions or outpatient surgery does not equal 100%, as workers may face a complex combination of types of cost sharing. For this reason, the average copayment and coinsurance rates include workers who may have a combination of these types of cost sharing.
- Beginning in 2017, to reduce the burden on respondents, we revised the survey to ask about cost sharing for hospital admissions and outpatient surgery only for their largest health plan type; previously, we asked for this information for each of the plan types that they offered.
- In addition to any general annual deductible that may apply, 65% of covered workers have coinsurance and 13% have a copayment that apply to inpatient hospital admissions. Lower percentages of workers have per day (per diem) payments (7%), a separate hospital deductible (1%), or both a copayment and coinsurance (8%), while 16% have no additional cost sharing for hospital admissions after any general annual deductible has been met [Figure 7.29].
  - For covered workers in HMOs, copayments are more common (33%) and coinsurance (43%) is less common than the average for all covered workers [Figure 7.29].
  - HDHP/SOs, on average, have a different cost-sharing structure than other plan types for hospital admissions. Only 3% of covered workers in HDHP/SOs have a copayment for hospital admissions, lower than the average for all covered workers [Figure 7.29].

- The average coinsurance rate for a hospital admission is 20%, the average copayment is $311 per hospital admission, and the average per diem charge is $313 [Figure 7.32]. Sixty-six percent of workers enrolled in a plan with a per diem for hospital admissions have a limit on the number of days a worker must pay the amount [Figure 7.33].

- The cost-sharing provisions for outpatient surgery are similar to those for hospital admissions, as most workers have coinsurance or copayments. In 2020, 15% of covered workers have a copayment and 68% have coinsurance for outpatient surgery. In addition, 6% have both a copayment and coinsurance, while 16% have no additional cost sharing after any general annual deductible has been met [Figure 7.30] and [Figure 7.31].

  - For covered workers with cost sharing for outpatient surgery, the average coinsurance rate is 20% and the average copayment is $188 [Figure 7.32].

Figure 7.29

Distribution of Covered Workers With Other Cost Sharing for Hospital Admissions, in Addition to Any General Annual Deductible, by Plan Type, 2020

Plan Type	Separate Annual Deductible for Hospital Admissions	Copayment	Coinsurance	Both Copayment and Coinsurance	Charge Per Day	None
HMO	<1%*	33%*	43%*	8%	9%	19%
PPO	2	11	73*	8	6	11*
POS	4	27*	39*	6	15*	25
HDHP/SO	<1*	3*	69	6	6	21
ALL PLANS	**1%**	**13%**	**65%**	**8%**	**7%**	**16%**

NOTE: We collect information on the cost-sharing provisions in addition to any general annual plan deductible. The distribution of workers with different types of cost sharing does not equal 100% because workers may face a combination of types of cost sharing. Less than one percent of covered workers have an 'Other' type of cost sharing. Information on separate deductibles for hospital admissions was collected only for HDHP/HRAs because federal regulations for HSA-qualified HDHPs make it unlikely these plans would have a separate deductible for specific services. 'Both Copayment and Coinsurance' category includes workers who are required to pay the higher amount of either the copayment or coinsurance under the plan. Zero percent of covered workers are enrolled in a plan that does not cover hospital admissions.

* Estimate is statistically different from All Plans estimate (p < .05).

SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 7.30

Distribution of Covered Workers With Other Cost Sharing for Outpatient Surgery, in Addition to Any General Annual Deductible, by Plan Type, 2020

Plan Type	Separate Annual Deductible for Outpatient Surgery	Copayment	Coinsurance	Both Copayment and Coinsurance	None
HMO	1%	40%*	40%*	11%	16%
PPO	1	11	77*	8	11*
POS	3	37*	46*	7	15
HDHP/SO	<1*	4*	72	2*	23
ALL PLANS	**1%**	**15%**	**68%**	**6%**	**16%**

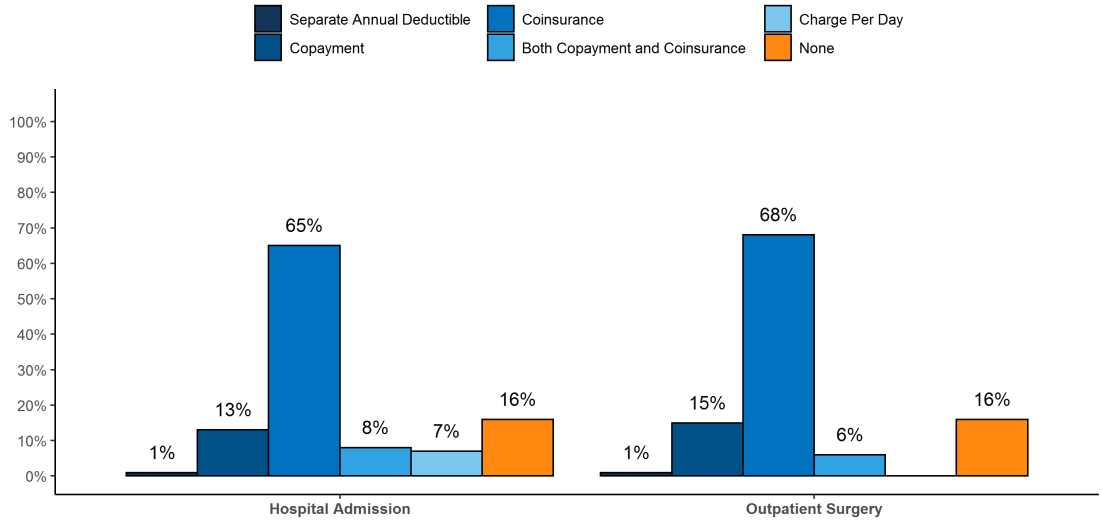
NOTE: We collect information on the cost-sharing provisions in addition to any general annual plan deductible. The distribution of workers with different types of cost sharing does not equal 100% because workers may face a combination of types of cost sharing. Less than one percent of covered workers have an 'Other' type of cost sharing. Information on separate deductibles for hospital admissions was collected only for HDHP/HRAs because federal regulations for HSA-qualified HDHPs make it unlikely these plans would have a separate deductible for specific services. 'Both Copayment and Coinsurance' category includes workers who are required to pay the higher amount of either the copayment or coinsurance under the plan. Zero percent of covered workers are enrolled in a plan that does not cover outpatient surgery.

* Estimate is statistically different from All Plans estimate (p < .05).

SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 7.31

Percentage of Covered Workers with the Following Types of Cost Sharing for Hospital Admissions and Outpatient Surgery, in Addition to Any General Annual Deductible, 2020



NOTE: We collect information on the cost-sharing provisions in addition to any general annual plan deductible. The distribution of workers with different types of cost sharing does not equal 100% because workers may face a combination of types of cost sharing. Less than one percent of covered workers have an 'Other' type of cost sharing. Information on separate deductibles for hospital admissions was collected only for HDHP/HRAs because federal regulations for HSA-qualified HDHPs make it unlikely these plans would have a separate deductible for specific services. 'Both Copayment and Coinsurance' category includes workers who are required to pay the higher amount of either the copayment or coinsurance under the plan.
SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 7.32

Among Covered Workers With Separate Cost Sharing for Hospital Admissions or Outpatient Surgery, Average Cost Sharing, by Type, 2020

	Charge Per Day	Coinsurance	Copayment
Outpatient Surgery	N/A	20%	$188
Hospital Admission	$313	20%	$311

NOTE: Estimates represent cost sharing in addition to any general annual deductible. The average amounts include workers who may have a combination of types of cost sharing. Cost sharing amounts are for in-network providers.

SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 7.33

Among Covered Workers With a Charge Per Day for Hospital Admissions, Average Cost Sharing Features, 2020

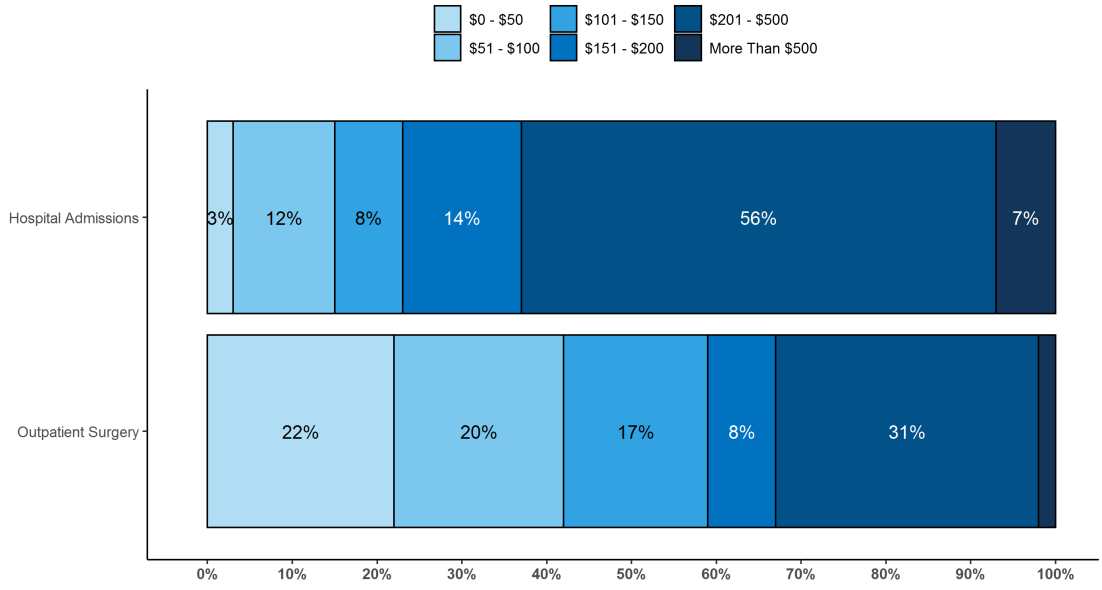
	Among Covered Workers With a Charge Per Day for Hospital Admissions
Average Charge Per Day	$313
Percentage of Covered Workers With a Limit On the Number of Days a Worker Must Pay Per-Day Amount	66%
Average Number of Days the Per-Day Amount Must Be Paid	5

NOTE: Estimates represent cost sharing in addition to any general annual deductible. Average amounts include workers who may have a combination of types of cost sharing. Amounts are for in-network services.

SOURCE: KFF Employer Health Benefits Survey, 2020

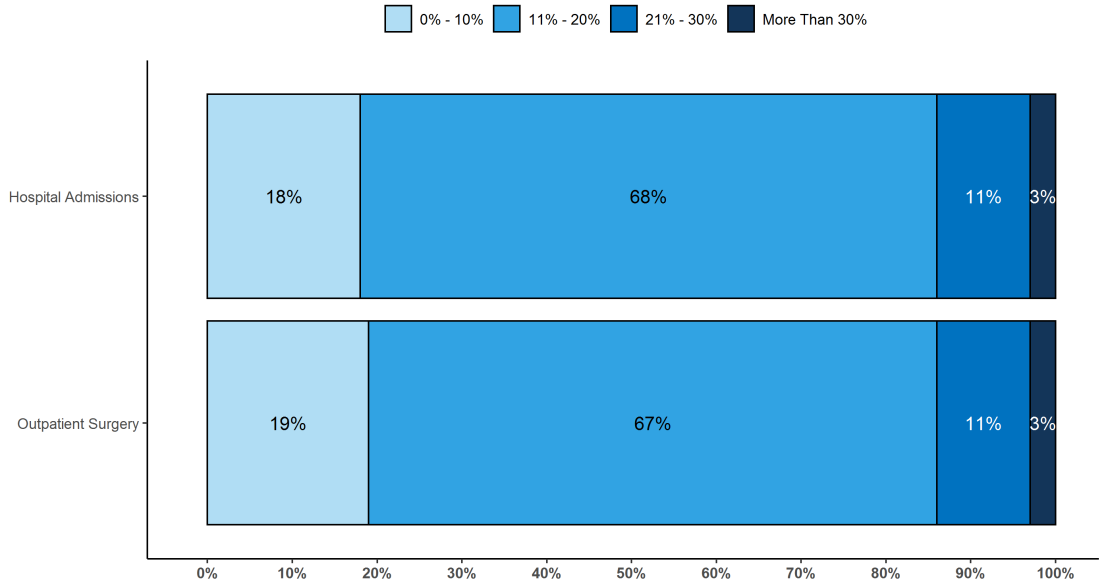
Figure 7.34

Among Covered Workers with a Copayment for Hospital Admissions or Outpatient Surgery, Distribution of Copayments, 2020



NOTE: Estimates represent cost sharing in addition to any general annual deductible. Distribution includes workers who may have a combination of types of cost sharing. Cost sharing amounts are for in-network providers.
SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 7.35
Among Covered Workers with Coinsurance for Hospital Admissions or Outpatient Surgery, Distribution of Coinsurance Rates, 2020



NOTE: Estimates represent cost sharing in addition to any general annual deductible. Distribution includes workers who may have a combination of types of cost sharing. Cost sharing amounts are for in-network providers.
SOURCE: KFF Employer Health Benefits Survey, 2020

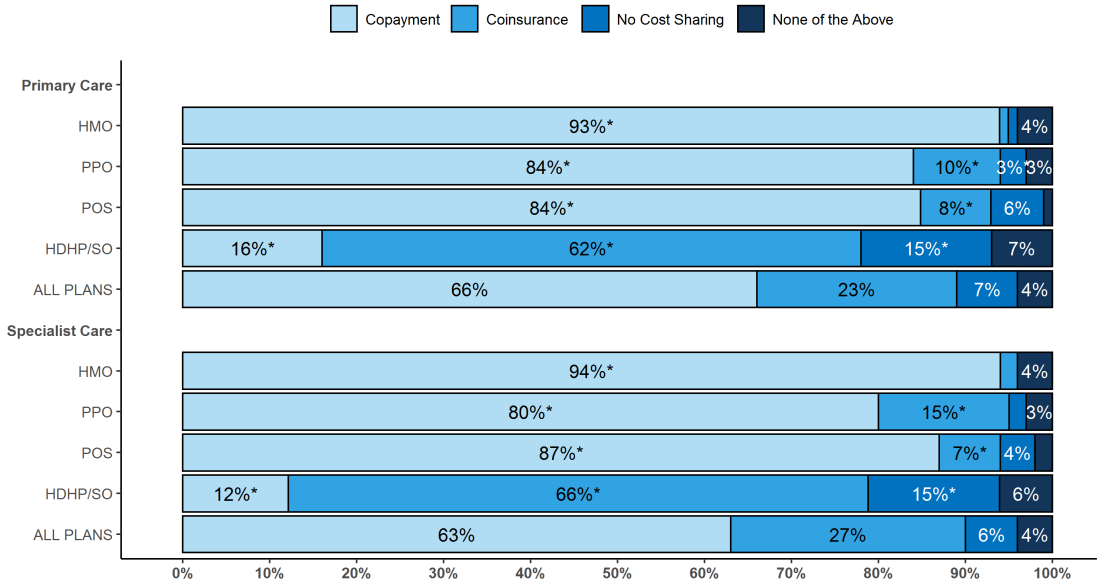
COST SHARING FOR PHYSICIAN OFFICE VISITS

- The majority of covered workers are enrolled in health plans that require cost sharing for an in-network physician office visit, in addition to any general annual deductible.[2]
  - The most common form of physician office visit cost sharing for in-network services is a copayment. Sixty-six percent of covered workers have a copayment for a primary care physician office visit and 23% have coinsurance. For office visits with a specialty physician, 63% of covered workers have a copayment and 27% have coinsurance [Figure 7.36].
  - Covered workers in HMOs, PPOs, and POS plans are much more likely to have copayments for both primary care and specialty care physician office visits than workers in HDHP/SOs. For primary care physician office visits, 16% of covered workers in HDHP/SOs have a copayment, 62% have coinsurance, and 15% have no cost sharing after the general annual plan deductible is met [Figure 7.36].
  - Among covered workers with a copayment for in-network physician office visits, the average copayment is $26 for primary care and $42 for specialty physician office visits [Figure 7.37], similar to the amounts last year.
  - Among covered workers with coinsurance for in-network physician office visits, the average coinsurance rates are 18% for a visit with a primary care physician and 19% for a visit with a specialist [Figure 7.37], similar to the rates last year.

[2]For those enrolled in an HDHP/HSA, the out-of-pocket maximum may be no more than $6,900 for an individual plan and $13,800 for a family plan in 2020. See https://www.irs.gov/irb/2019-22_IRB#REV-PROC-2019-25

Figure 7.36

Percentage of Covered Workers with the Following Types of Cost Sharing for Physician Office Visits, by Plan Type, 2020



* Estimate is statistically different from All Plans estimate (p < .05).
NOTE: Figure represents cost sharing in addition to any general annual deductible. The survey includes questions on cost sharing for in-network services only.
SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 7.37

Among Covered Workers With Copayments And/Or Coinsurance for Physician Office Visits, Average Copayments and Coinsurance, by Plan Type, 2020

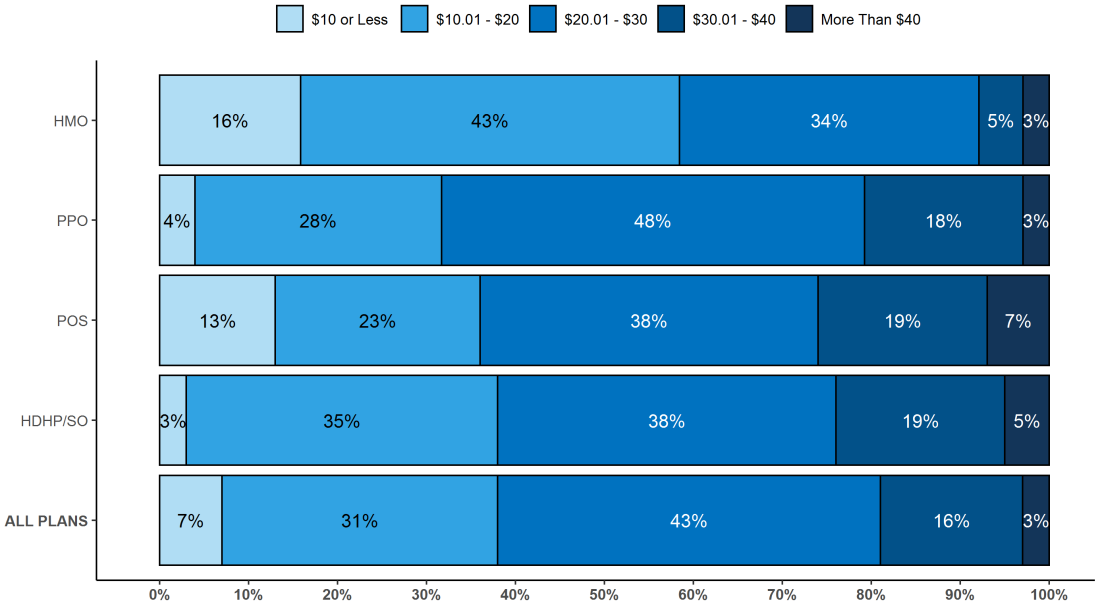
	HMO	PPO	POS	HDHP/SO	All Plans
Primary Care Office Visit					
Average Copayment ($)	$22*	$26	$26	$28	**$26**
Average Coinsurance (%)	NSD	21%	NSD	18%	**18%**
Specialty Care Office Visit					
Average Copayment ($)	$37*	$42	$43	$53*	**$42**
Average Coinsurance (%)	NSD	21%*	NSD	18%	**19%**

NOTE: Cost-sharing averages are for in-network visits.
NSD: Not Sufficient Data

* Estimate is statistically different from All Plans estimate (p < .05).

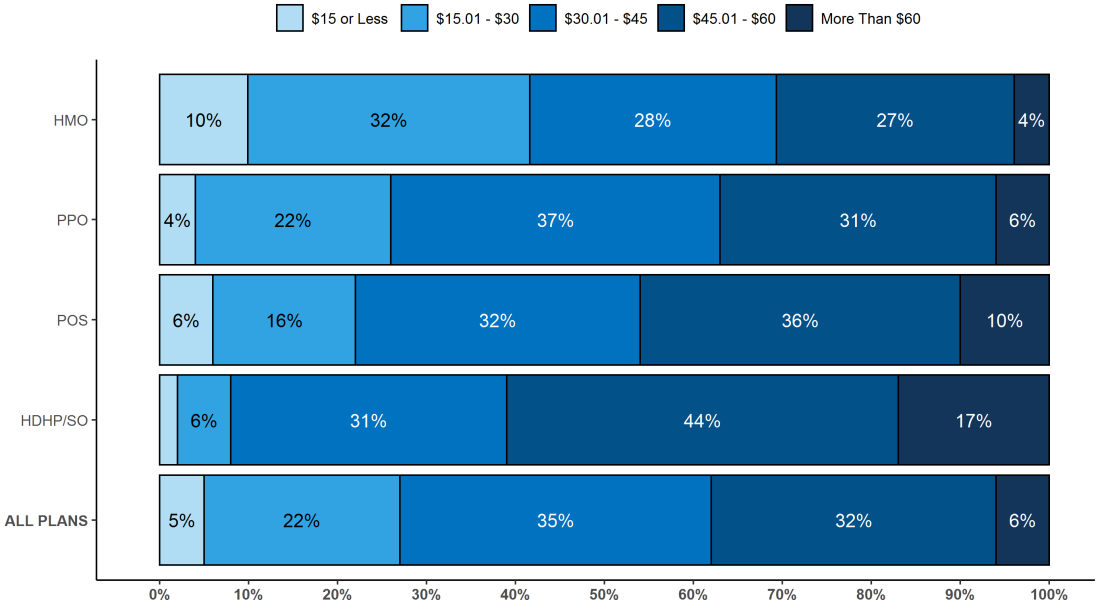
SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 7.38
Among Covered Workers with a Copayment for a Primary Care Physician Office Visit, Distribution of Copayments, by Plan Type, 2020



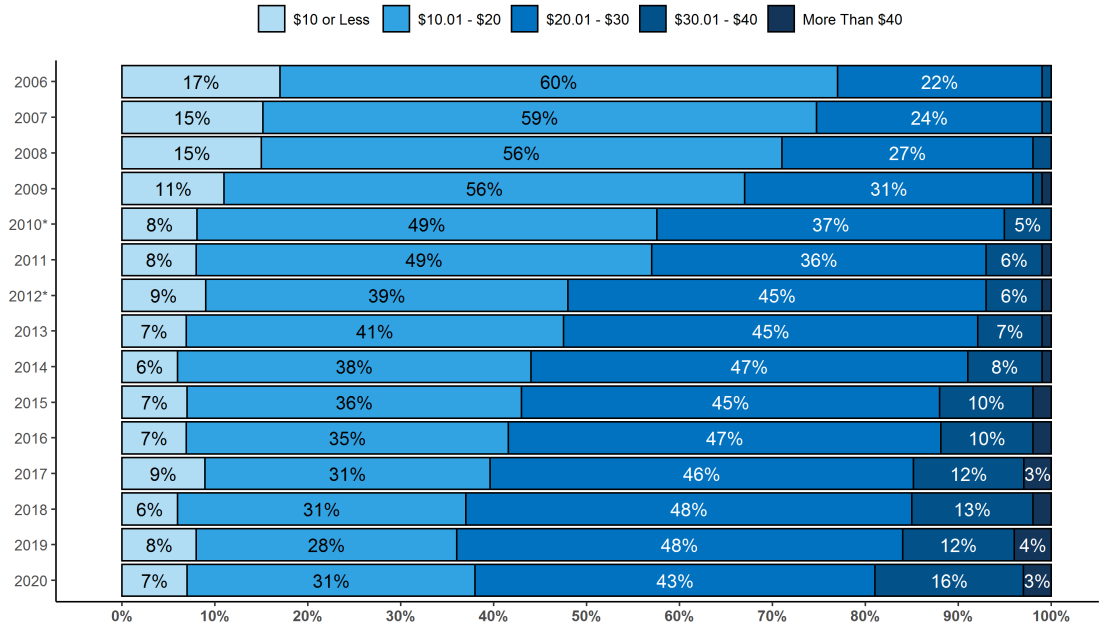
NOTE: Copayments are for in-network providers.
SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 7.39
Among Covered Workers with a Copayment for a Specialist Physician Office Visit, Distribution of Copayments, by Plan Type, 2020



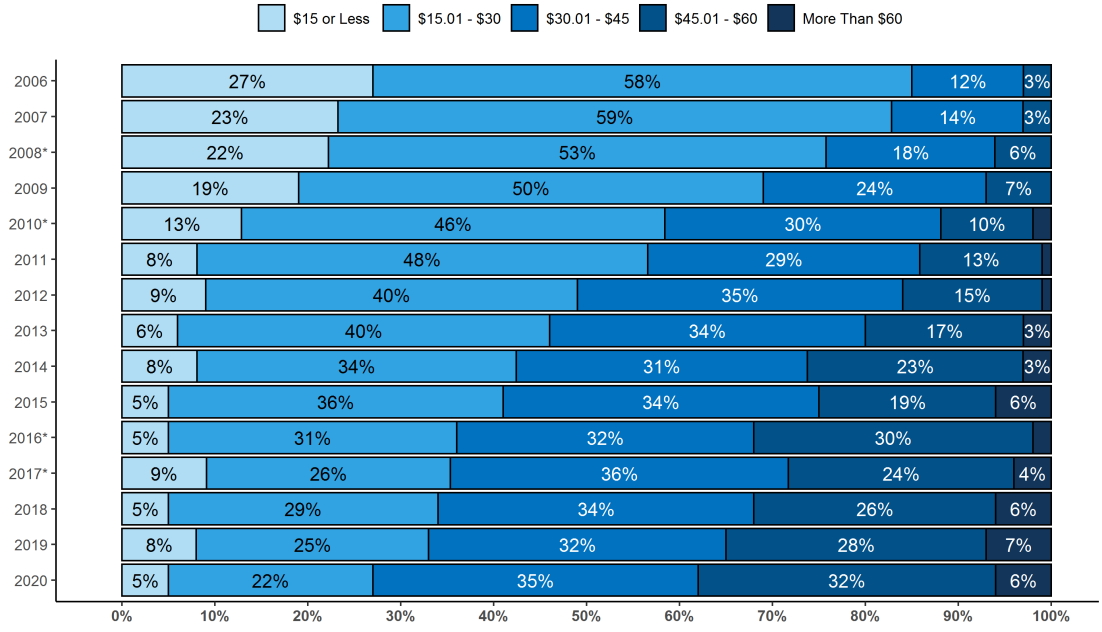
NOTE: Copayments are for in-network providers.
SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 7.40
Among Covered Workers with a Copayment for a Primary Care Physician Office Visit, Distribution of Copayments, 2006-2020



* Distribution is statistically different from distribution for the previous year shown ($p < .05$).
SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006-2017

Figure 7.41
Among Covered Workers with a Copayment for a Specialist Physician Office Visit, Distribution of Copayments, 2006-2020



* Distribution is statistically different from distribution for the previous year shown ($p < .05$).
SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006-2017

Figure 7.42

Among Covered Workers With a Copayment And/Or Coinsurance for Physician Office Visits, Average Copayment and Coinsurance, 2006-2020

	Primary Care: Copayment	Primary Care: Coinsurance	Specialist Care: Copayment	Specialist Care: Coinsurance
2006	$18		$23	
2007	$19	17%	$24	
2008	$19	17%	$26*	
2009	$20*	18%	$28*	
2010	$22*	18%	$31*	18%
2011	$22	18%	$32	18%
2012	$23	18%	$33	19%
2013	$23	18%	$35	19%
2014	$24	18%	$36	19%
2015	$24	18%	$37	19%
2016	$24	18%	$38	19%
2017	$25	19%	$38	19%
2018	$25	18%	$40	18%
2019	$25	18%	$40	19%
2020	$26	18%	$42	19%

NOTE: Cost-sharing averages are for in-network visits.

* Estimate is statistically different from estimate for the previous year shown ($p < .05$).

SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006-2017

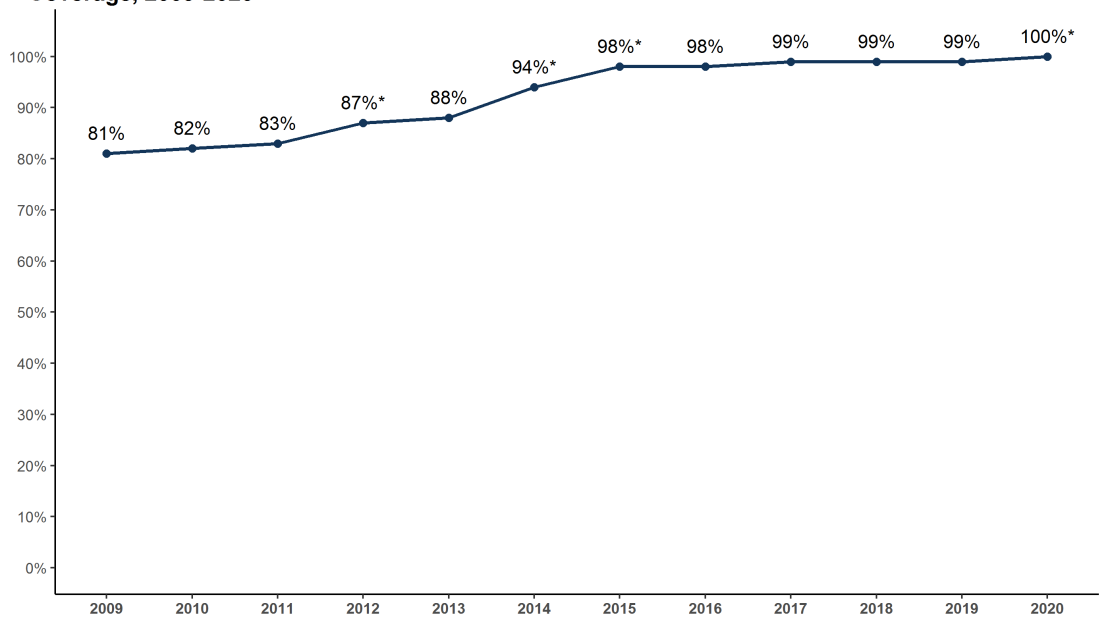
OUT-OF-POCKET MAXIMUMS

- Most covered workers are in a plan that partially or totally limits the cost sharing that an enrollee must pay in a year. This limit is generally referred to as an out-of-pocket maximum. The Affordable Care Act (ACA) requires that non-grandfathered health plans have an out-of-pocket maximum of no more than $8,150 for single coverage and $16,300 for family coverage in 2020. Out-of-pocket limits in HSA qualified HDHP/SOs are required to be somewhat lower.[3] Many plans have complex out-of-pocket structures, which makes it difficult to accurately collect information on this element of plan design.

[3]Starting in 2010, the survey asked about the prevalence and cost of physician office visits separately for primary care and specialty care. Prior to the 2010 survey, if the respondent indicated the plan had a copayment for office visits, we assumed the plan had a copayment for both primary and specialty care visits. The survey did not allow for a respondent to report that a plan had a copayment for primary care visits and coinsurance for visits with a specialist physician. The changes made in 2010 allow for variations in the type of cost sharing for primary care and specialty care visits. The survey includes cost sharing for in-network services only.

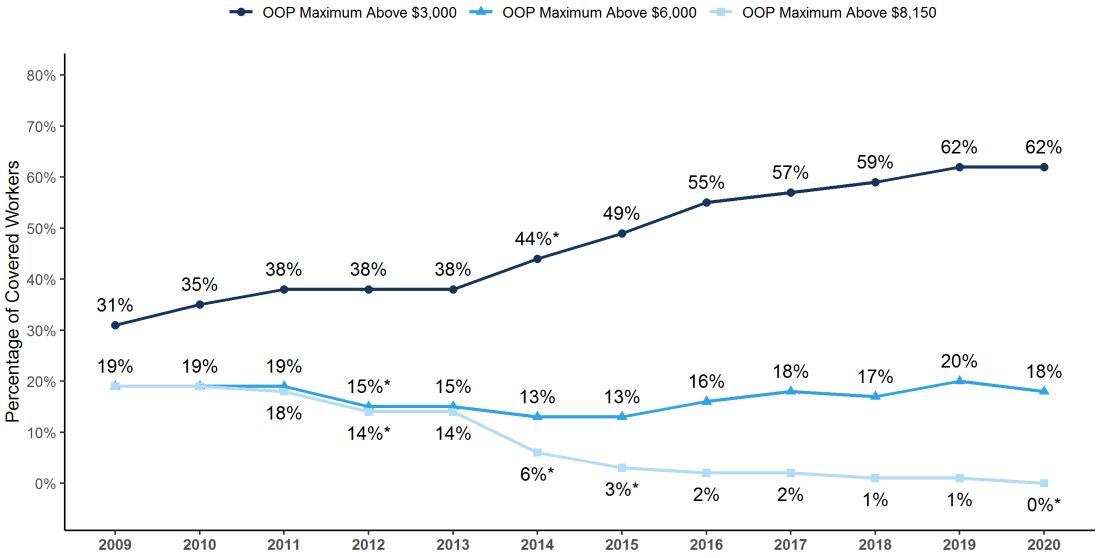
- In 2020, 100% of covered workers are in a plan with an out-of-pocket maximum for single coverage. This is a significant increase from 98% in 2015 [Figure 7.43].
- For covered workers in plans with an out-of-pocket maximum for single coverage, there is wide variation in spending limits.
  - Eleven percent of covered workers in plans with an out-of-pocket maximum for single coverage have an out-of-pocket maximum of less than $2,000, while 18% have an out-of-pocket maximum of $6,000 or more [Figure 7.45].

Figure 7.43
Percentage of Covered Workers in a Plan with an Out-of-Pocket Maximum for Single Coverage, 2009-2020



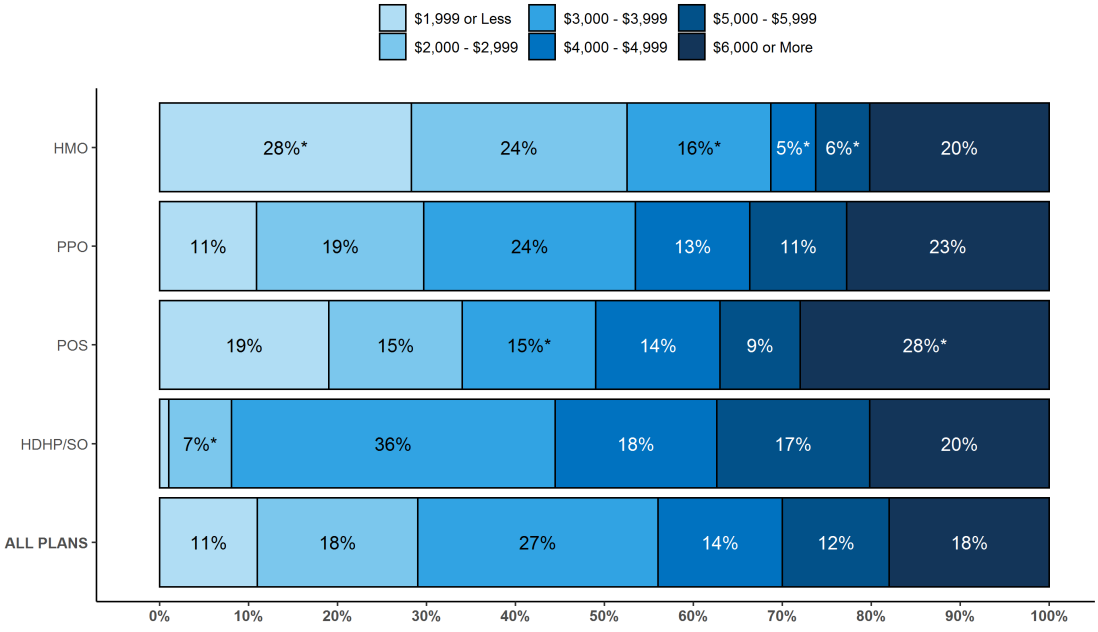
* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
NOTE: Out-of-pocket maximums reported are for in-network services.
SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2009-2017

Figure 7.44
Percentage of Covered Workers in a Plan with an Out-of-Pocket Maximum Above Certain Thresholds for Single Coverage, 2009-2020



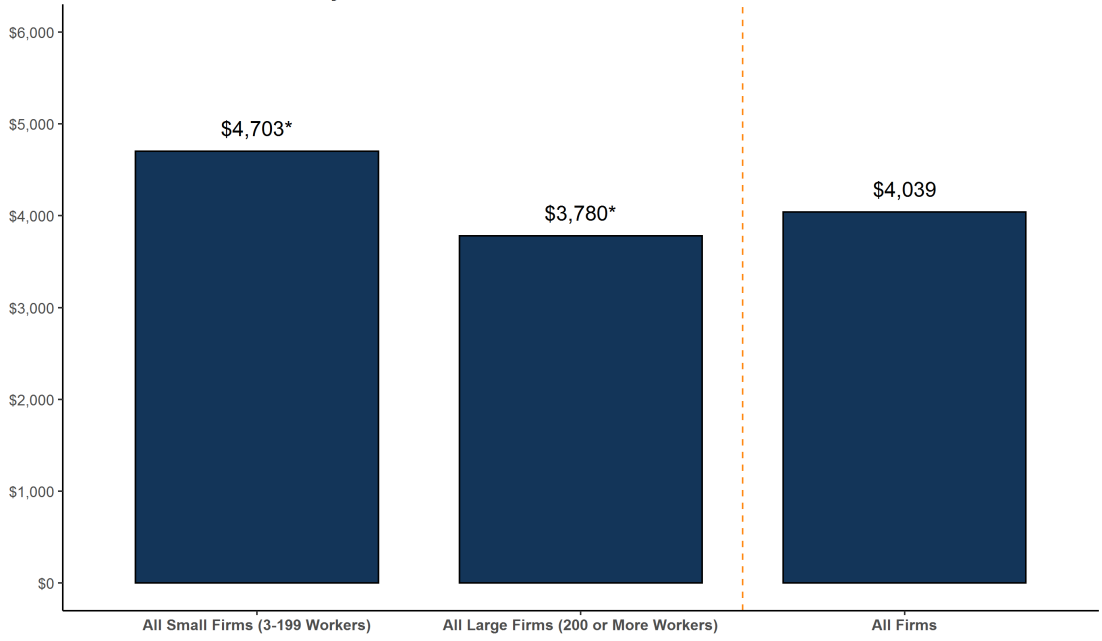
* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
NOTE: OOP is 'out-of-pocket'. OOP maximums are for in-network services. Values include covered workers without an OOP max. Covered workers without an OOP maximum are considered to be exposed to at least the specified threshold. Some of these workers may be enrolled in plans whose cost-sharing structure has other limits that make it impossible to reach the specified threshold.
SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2009-2017

Figure 7.45
Among Covered Workers with an Out-of-Pocket Maximum for Single Coverage, Distribution of Out-of-Pocket Maximums, by Plan Type, 2020



* Estimate is statistically different from All Plans estimate within plan type ($p < .05$).
SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 7.46
Among Covered Workers with an Out-of-Pocket Maximum for Single Coverage, Average Out-of-Pocket Maximums, by Firm Size, 2020



* Estimate is statistically different between All Small Firms and All Large Firms estimate ($p < .05$).
SOURCE: KFF Employer Health Benefits Survey, 2020

Employer Health Benefits
2020 Annual Survey

High-Deductible Health Plans with Savings Option

SECTION

8

Section 8

High-Deductible Health Plans with Savings Option

To help cover out-of-pocket expenses not covered by a health plan, some firms offer high-deductible plans that are paired with an account that allows enrollees to use tax-preferred funds to pay plan cost sharing and other out-of-pocket medical expenses. The two most common types are health reimbursement arrangements (HRAs) and health savings accounts (HSAs). HRAs and HSAs are financial accounts that workers or their family members can use to pay for health care services. These savings arrangements are often (or, in the case of HSAs, always) paired with health plans with high deductibles. The survey treats high-deductible plans paired with a savings option as a distinct plan type - High-Deductible Health Plan with Savings Option (HDHP/SO) - even if the plan would otherwise be considered a PPO, HMO, POS plan, or conventional health plan. Specifically for the survey, HDHP/SOs are defined as (1) health plans with a deductible of at least $1,000 for single coverage and $2,000 for family coverage[1] offered with an HRA (referred to as HDHP/HRAs); or (2) high-deductible health plans that meet the federal legal requirements to permit an enrollee to establish and contribute to an HSA (referred to as HSA-qualified HDHPs).[2]

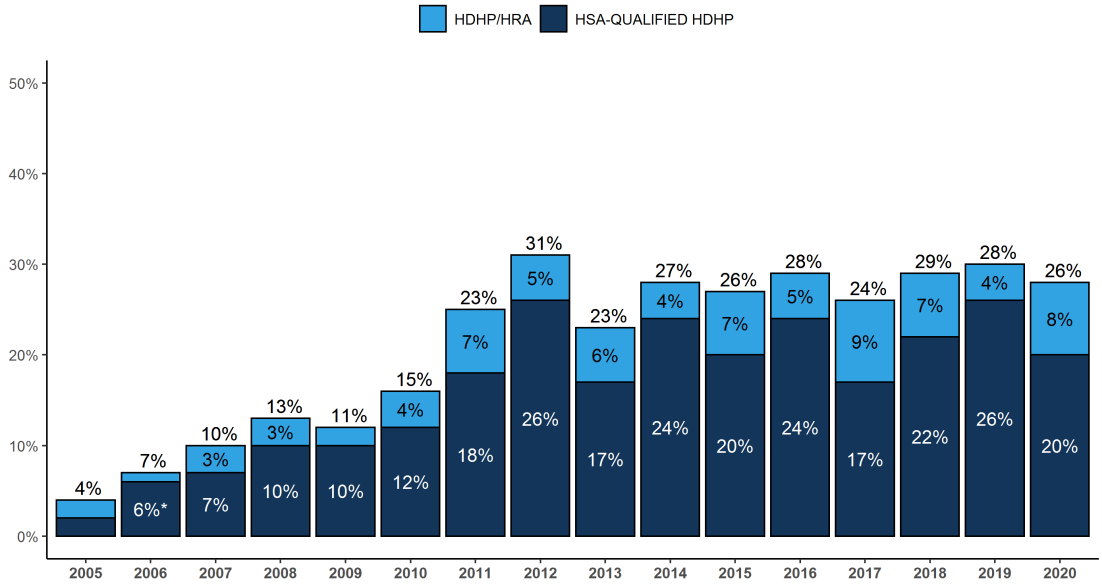
PERCENTAGE OF FIRMS OFFERING HDHP/HRAS AND HSA-QUALIFIED HDHPS

- Twenty-six percent of firms offering health benefits offer an HDHP/HRA, an HSA-qualified HDHP, or both. Among firms offering health benefits, 8% offer an HDHP/HRA and 20% offer an HSA-qualified HDHP [Figure 8.1]. The percentage of firms offering an HDHP/SO is similar to last year.
  - Large firms (200 or more workers) are more much likely than small firms (3-199 workers) to offer an HDHP/SO (56% vs. 25%) [Figure 8.3].

[1] There is no legal requirement for the minimum deductible in a plan offered with an HRA. The survey defines a high-deductible HRA plan as a plan with a deductible of at least $1,000 for single coverage and $2,000 for family coverage. Federal law requires a deductible of at least $1,400 for single coverage and $2,800 for family coverage for HSA-qualified HDHPs in 2020 (or $1,350 and $2,700, respectively, for plans in their 2019 plan year). Not all firms' plan years correspond with the calendar year, so some firms may report a plan with limits from the prior year. See definitions at the end of this Section for more information on HDHP/HRAs and HSA-qualified HDHPs.

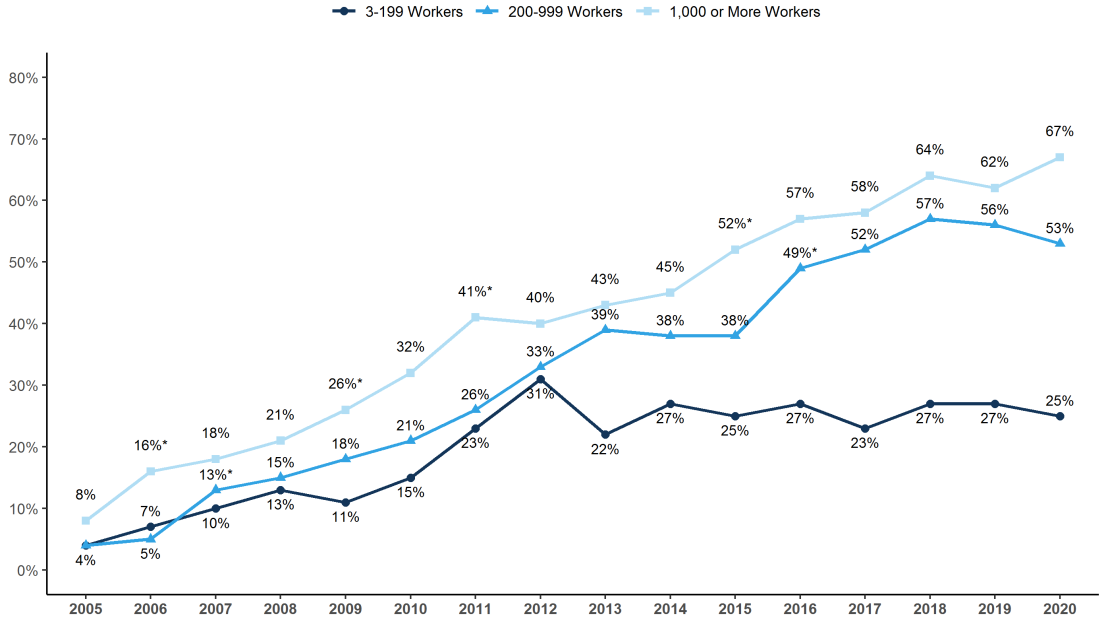
[2] The definitions of HDHP/SOs do not include other consumer-driven plan options, such as arrangements that combine an HRA with a lower-deductible health plan or arrangements in which an insurer (rather than the employer as in the case of HRAs or the enrollee as in the case of HSAs) establishes an account for each enrollee. Other arrangements may be included in future surveys as the market evolves.

Figure 8.1
Among Firms Offering Health Benefits, Percentage That Offer an HDHP/HRA and/or an HSA-Qualified HDHP, 2005-2020



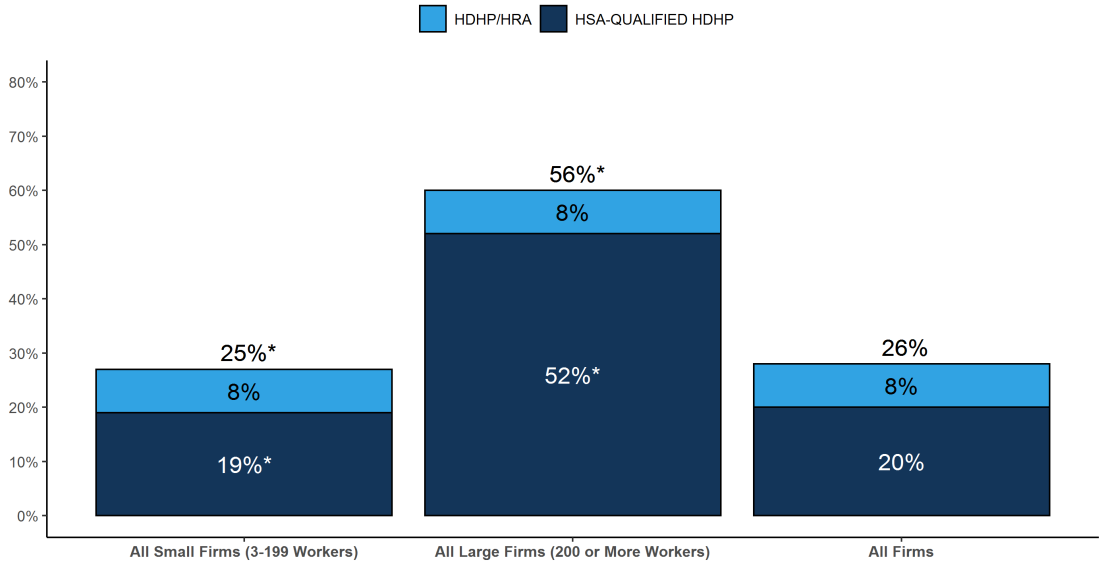
* Estimate is statistically different from estimate for the previous year shown (p < .05).
NOTE: Among all firms that offer health benefits, 2.3% offer both an HDHP/HRA and an HSA-qualified HDHP. Adding the percentage of firms offering HDHP/HRA and HSA-Qualified HDHPs may not sum to the percentage of firms offering HDHP/SOs because some firms offer both.
SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2005-2017

Figure 8.2
Among Firms Offering Health Benefits, Percentage That Offer an HDHP/SO, by Firm Size, 2005-2020



* Estimate is statistically different from estimate for the previous year shown (p < .05).
SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2005-2017

Figure 8.3
Among Firms Offering Health Benefits, Percentage That Offer an HDHP/HRA and/or an HSA-Qualified HDHP, by Firm Size, 2020

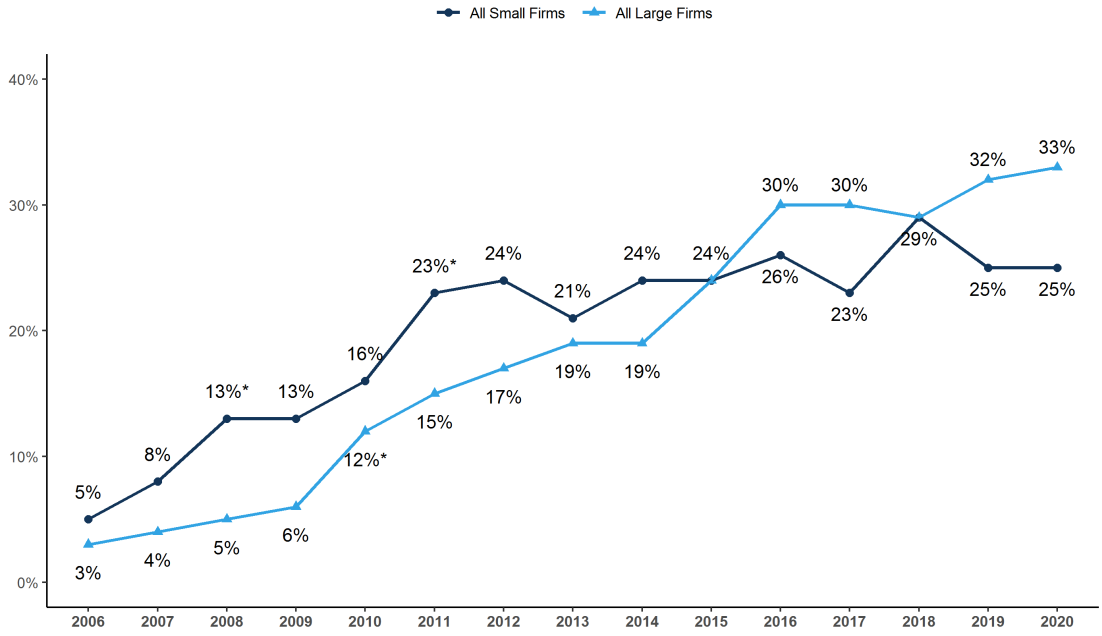


* Estimate is statistically different between All Small Firms and All Large Firms estimate ($p < .05$).
NOTE: Among all firms that offer health benefits, 2.3% offer both an HDHP/HRA and an HSA-qualified HDHP. Adding the percentage of firms offering HDHP/HRA and HSA-Qualified HDHPs may not sum to the percentage of firms offering HDHP/SOs because some firms offer both. Values may not sum to totals due to rounding.
SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2005-2017

ENROLLMENT IN HDHP/HRAS AND HSA-QUALIFIED HDHPS

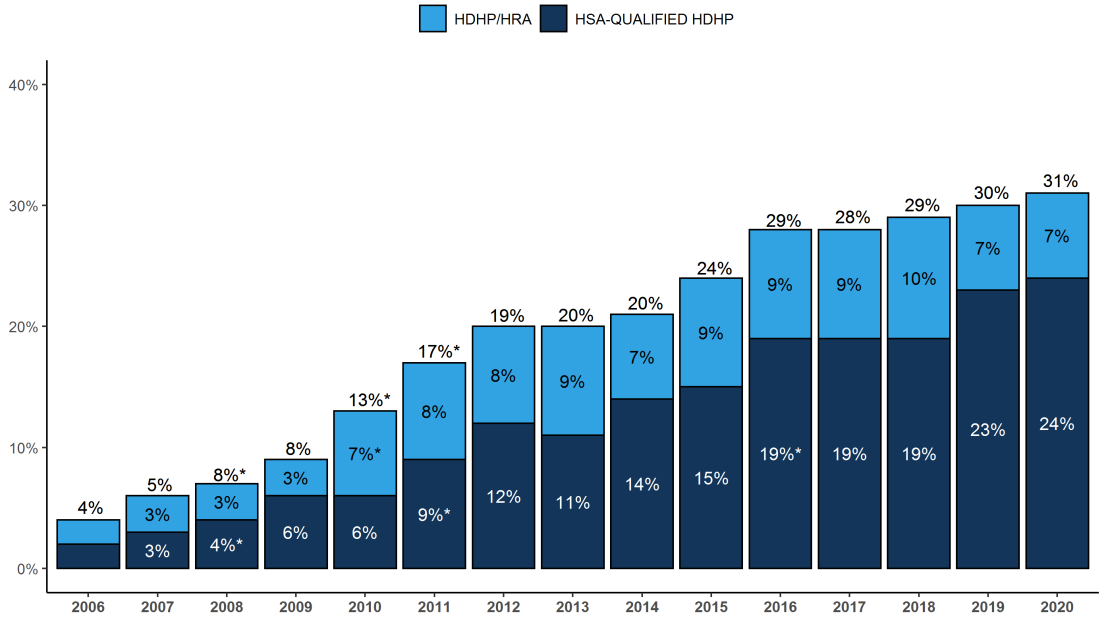
- Thirty-one percent of covered workers are enrolled in an HDHP/SO in 2020, similar to the percentage last year (30%) [Figure 8.5].
- Enrollment in HDHP/SOs has increased over the past five years, from 24% of covered workers in 2015 to 31% in 2020 [Figure 8.5].
  - Seven percent of covered workers are enrolled in HDHP/HRAs and 24% of covered workers are enrolled in HSA-qualified HDHPs in 2020. These percentages are similar to the percentages last year [Figure 8.5].
    - The percentage of covered workers enrolled in HDHP/SOs is higher in large firms (33%) than in small firms (25%) [Figure 8.6].

Figure 8.4
Percentage of Covered Workers Enrolled in an HDHP/SO, by Firm Size, 2006-2020



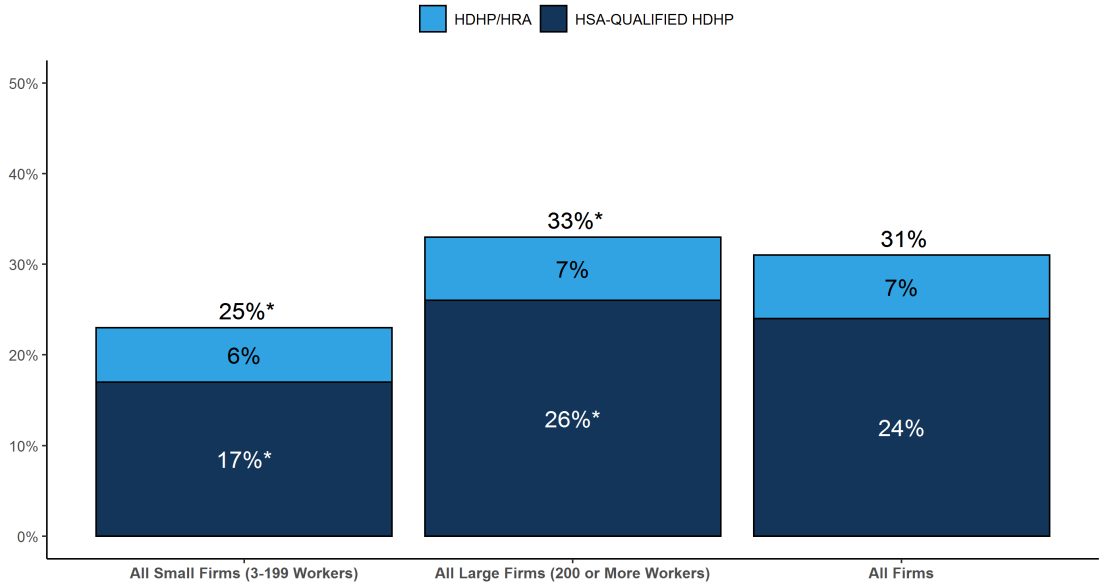
* Estimate is statistically different from estimate for the previous year shown (p < .05).
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006-2017

Figure 8.5
Percentage of Covered Workers Enrolled in an HDHP/HRA or HSA-Qualified HDHP, 2006-2020



* Estimate is statistically different from estimate for the previous year shown (p < .05).
NOTE: Covered workers enrolled in an HDHP/SO are enrolled in either an HDHP/HRA or a HSA-Qualified HDHP. Values may not sum to totals due to rounding.
SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006-2017

Figure 8.6
Percentage of Covered Workers Enrolled in an HDHP/HRA or HSA-Qualified HDHP, by Firm Size, 2020



* Estimate is statistically different between All Small Firms and All Large Firms estimate ($p < .05$).
NOTE: Covered workers enrolled in an HDHP/SO are enrolled in either an HDHP/HRA or a HSA-Qualified HDHP. Values may not sum to totals due to rounding.
SOURCE: KFF Employer Health Benefits Survey, 2020

PREMIUMS AND WORKER CONTRIBUTIONS

- In 2020, the average annual premiums for covered workers in HDHP/HRAs are $7,464 for single coverage and $22,643 for family coverage [Figure 8.7].
- The average annual premiums for workers in HSA-qualified HDHPs are $6,737 for single coverage and $19,819 for family coverage. These amounts are significantly less than the average single and family premium for covered workers in plans that are not HDHP/SOs [Figure 8.8].
- The average premium for single coverage for covered workers enrolled in HSA-qualified HDHPs is lower than the average premium for single coverage for covered workers enrolled in HDHP/HRAs.
- The average annual worker contributions to premiums for workers enrolled in HDHP/HRAs are $1,221 for single coverage and $5,480 for family coverage [Figure 8.7]. The average contribution for family coverage for covered workers in HDHP/HRAs are similar to the average premium contribution made by covered workers in plans that are not HDHP/SOs [Figure 8.8].
- The average annual worker contributions to premiums for workers in HSA-qualified HDHPs are $1,019 for single coverage and $4,742 for family coverage. The average contributions for single and family coverage for covered workers in HSA-qualified HDHPs are significantly less than the average premium contribution made by covered workers in plans that are not HDHP/SOs [Figure 8.8].

Figure 8.7

HDHP/HRA and HSA-Qualified HDHP Features for Covered Workers, 2020

	HDHP/HRA		HSA-QUALIFIED HDHP	
Annual Plan Averages For:	Single Coverage	Family Coverage	Single Coverage	Family Coverage
Premium	$7,464	$22,643	$6,737	$19,819
Worker Contribution to Premium	$1,221	$5,480	$1,019	$4,742
General Annual Deductible	$2,195	$4,508	$2,349	$4,601
Out-Of-Pocket Maximum	$4,485	Not Available	$4,273	Not Available
Firm Contribution to the HRA or HSA	$1,276	$2,315	$550	$1,018

NOTE: Firms were not asked about out-of-pocket maximums for family coverage in 2020. Deductibles for family coverage are for covered workers with an aggregate amount. 12% of covered workers enrolled in an HDHP/HRA and 19% of covered workers in an HSA-qualified HDHP are in a plan with a separate per-person amount. When those firms that do not contribute to the HSA (51% for single coverage and 53% for family coverage) are excluded, the average firm HSA contribution for covered workers is $741 for single coverage and $1,389 for family coverage. Five percent percent of covered workers are enrolled in a plan where the firm matches employee HSA contributions. For HDHP/HRAs, we refer to the amount the employer commits to make available to an HRA as a contribution. HRAs are notional accounts, and employers are not required to transfer funds until an employee incurs expenses. Thus, employers may not expend the entire amount they commit to make available. Covered workers enrolled in a plan where the firm matches any employee HSA contribution are not included in the average contribution (Five percent for single coverage and five percent for family coverage).

SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 8.8

Average Annual Premiums and Contributions to Savings Accounts for Covered Workers in HDHP/HRAs or HSA-Qualified HDHPs, Compared to Non-HDHP/SOs, 2020

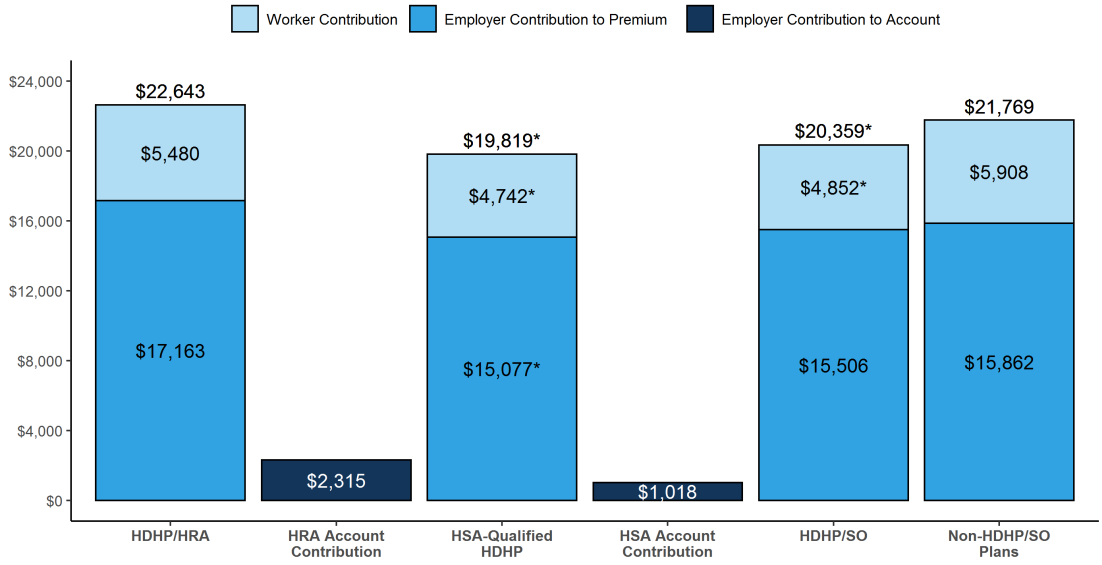
	Single Coverage			Family Coverage		
	HDHP/HRA	HSA-Qualified HDHP	Non-HDHP/SO Plans	HDHP/HRA	HSA-Qualified HDHP	Non-HDHP/SO Plans
Annual Premium	$7,464	$6,737*	$7,724	$22,643	$19,819*	$21,769
Worker Contribution to Premium	$1,221	$1,019*	$1,323	$5,480	$4,742*	$5,908
Firm Contribution to Premium	$6,243	$5,719*	$6,401	$17,163	$15,077*	$15,862
Annual Firm Contribution to HRA or HSA	$1,276	$550	Not Applicable	$2,315	$1,018	Not Applicable
Total Annual Firm Contribution (Firm Share of Premium Plus Firm Contribution to HRA or HSA)	$7,519*	$6,270	$6,401	$19,477*	$16,083	$15,862
Total Annual Cost (Total Premium Plus Firm Contribution to HRA or HSA)	**$8,739***	**$7,305***	**$7,724**	**$24,958**	**$20,688***	**$21,769**

NOTE: Values shown in the table may not equal the sum of their component parts. The averages presented in the table are aggregated at the firm level and then averaged, which is methodologically more appropriate than adding the averages. See the note in Figure 8.7 for additional information on HSA and HRA contributions.

* Estimate is statistically different from estimate from Non-HDHP/SO plans ($p < .05$).

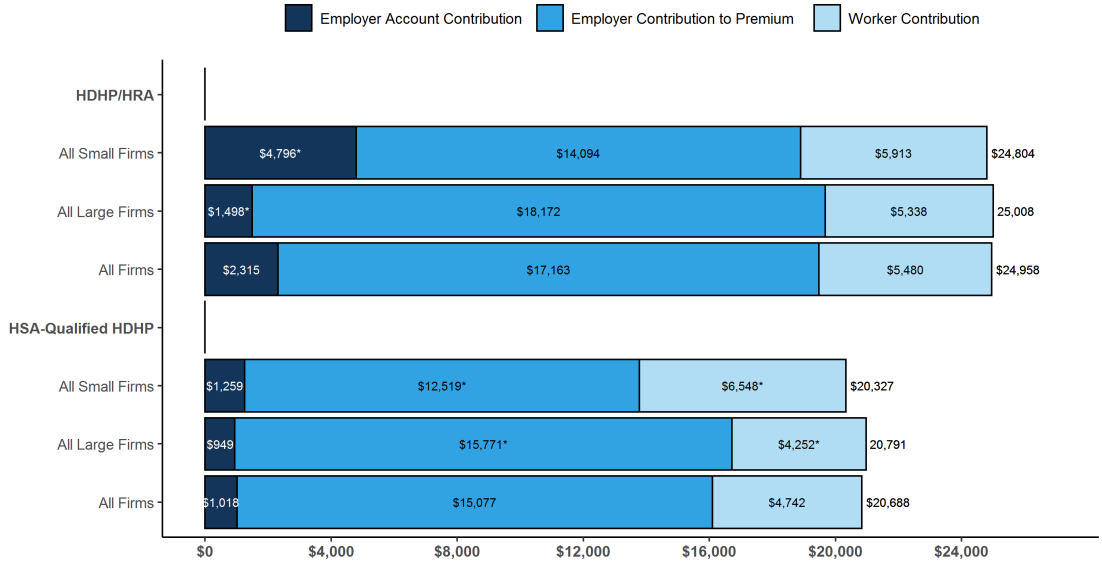
SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 8.9
Average Annual Premiums and Contributions for Covered Workers in HDHP/SOs and Non-HDHP/SOs, for Family Coverage, 2020



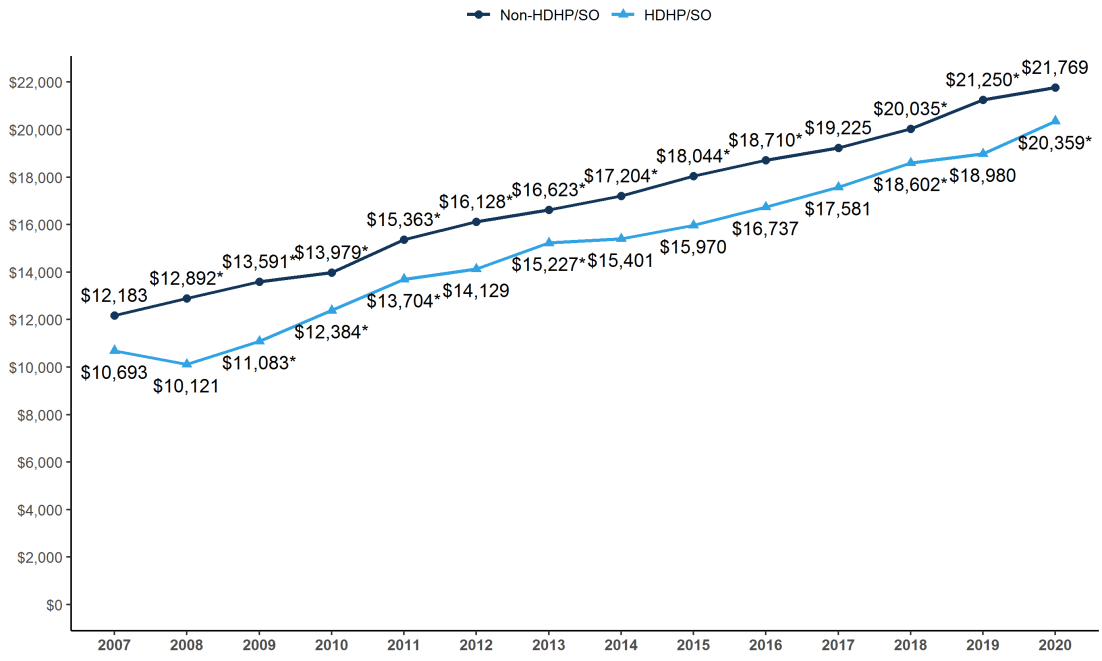
* Estimate is statistically different from estimate from Non-HDHP/SO plans (p < .05).
NOTE: Values shown in the table may not equal the sum of their component parts. The averages presented in the table are aggregated at the firm level and then averaged, which is methodologically more appropriate than adding the averages. See the note in Figure 8.7 for additional information on HSA and HRA contributions.
SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 8.10
Total Annual Costs (Premiums and Account Contributions) for Covered Workers in HDHP/SOs, for Family Coverage, by Firm Size, 2020



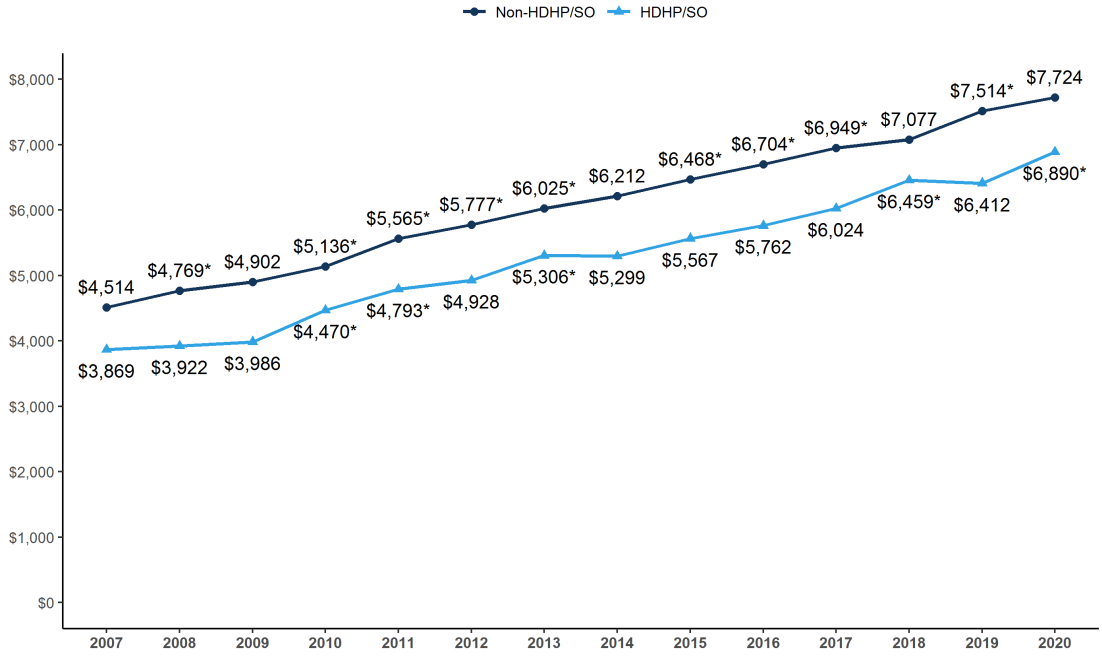
* Estimate is statistically different between All Small Firms and All Large Firms estimate (p < .05).
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers. Values shown in the table may not equal the sum of their component parts. The averages presented in the table are aggregated at the firm level and then averaged, which is methodologically more appropriate than adding the averages. See the note in Figure 8.7 for additional information on HSA and HRA contributions.
SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 8.11
Average Annual Premiums for Covered Workers with Family Coverage, by Plan Type, 2007-2020



* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2007-2017

Figure 8.12
Average Annual Premiums for Covered Workers with Single Coverage, by Plan Type, 2007-2020



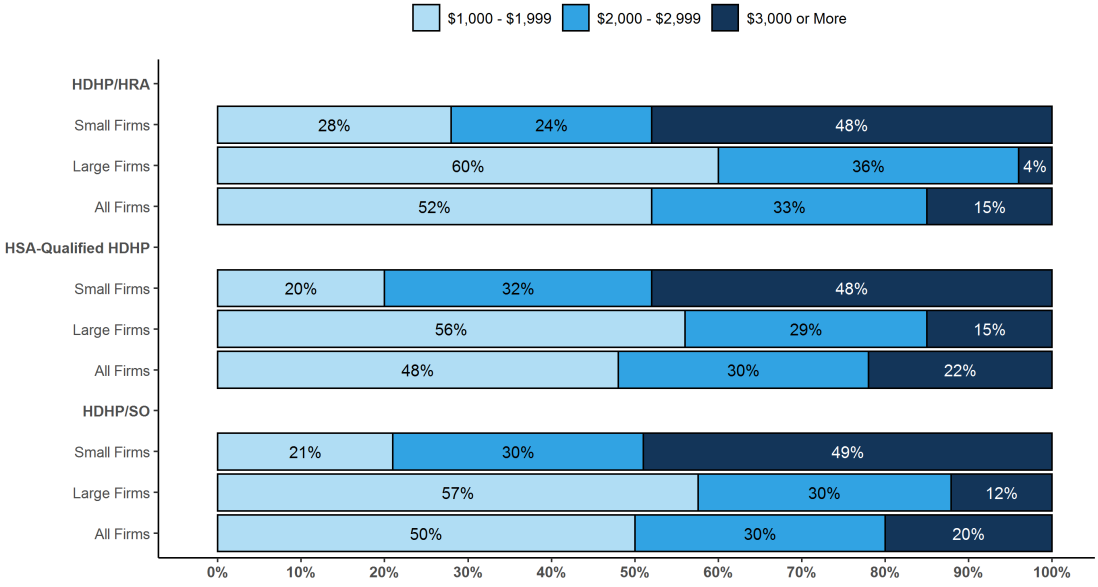
* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2007-2017

OUT-OF-POCKET MAXIMUMS AND PLAN DEDUCTIBLES

- HSA-qualified HDHPs are legally required to have an annual out-of-pocket maximum of no more than $6,900 for single coverage and $13,800 for family coverage in 2020. Non-grandfathered HDHP/HRA plans are required to have out-of-pocket maximums of no more than $8,150 for single coverage and $16,300 for family coverage in 2020.[^803] Virtually all HDHP/HRA plans have an out-of-pocket maximum for single coverage in 2020.
  - The average annual out-of-pocket maximum for single coverage is $4,485 for HDHP/HRAs and $4,273 for HSA-qualified HDHPs [Figure 8.7].
- As expected, workers enrolled in HDHP/SOs have higher deductibles than workers enrolled in HMOs, PPOs, or POS plans.
  - The average general annual deductible for single coverage is $2,195 for HDHP/HRAs and $2,349 for HSA-qualified HDHPs [Figure 8.14]. These averages are similar to the amounts reported in recent years. There is wide variation around these averages: 50% of covered workers enrolled in an HDHP/SO are in a plan with a deductible of $1,000 to $1,999 for single coverage while 20% are in a plan with a deductible of $3,000 or more [Figure 8.13].
- The survey asks firms whether the family deductible amount is (1) an aggregate amount (i.e., the out-of-pocket expenses of all family members are counted until the deductible is satisfied), or (2) a per-person amount that applies to each family member (typically with a limit on the number of family members that would be required to meet the deductible amount) (see Section 7 for more information).
  - The average aggregate deductibles for workers with family coverage are $4,508 for HDHP/HRAs and $4,601 for HSA-qualified HDHPs [Figure 8.7]. As with single coverage, there is wide variation around these averages for family coverage: 17% of covered workers enrolled in HDHP/SOs with an aggregate family deductible have a deductible of $2,000 to $2,999 while 19% have a deductible of $6,000 dollars or more [Figure 8.16].

Figure 8.13

Distribution of Covered Workers in HDHP/SOs with the Following General Annual Deductibles for Single Coverage, by Firm Size, 2020



NOTE: For HSA-qualified HDHPs, the legal minimum deductible for 2020 is $1,350 for single coverage and $2,700 for family coverage. Small Firms have 3-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 8.14

General Annual Deductible for Workers in HDHP/SOs After Any Employer Account Contributions for Single Coverage, by Firm Size, 2020

	HDHP/HRA	HSA-Qualified HDHP	HDHP/SO
General Annual Deductible			
All Small Firms	$3,026*	$3,202*	$3,195*
All Large Firms	1,921*	2,120*	2,055*
All Firms	**$2,195**	**$2,349**	**$2,303**
General Annual Deductible After Any HRA or HSA Contributions			
All Small Firms	$912	$2,528*	$2,136*
All Large Firms	1,123	1,641*	1,495*
All Firms	**$1,071**	**$1,837**	**$1,638**

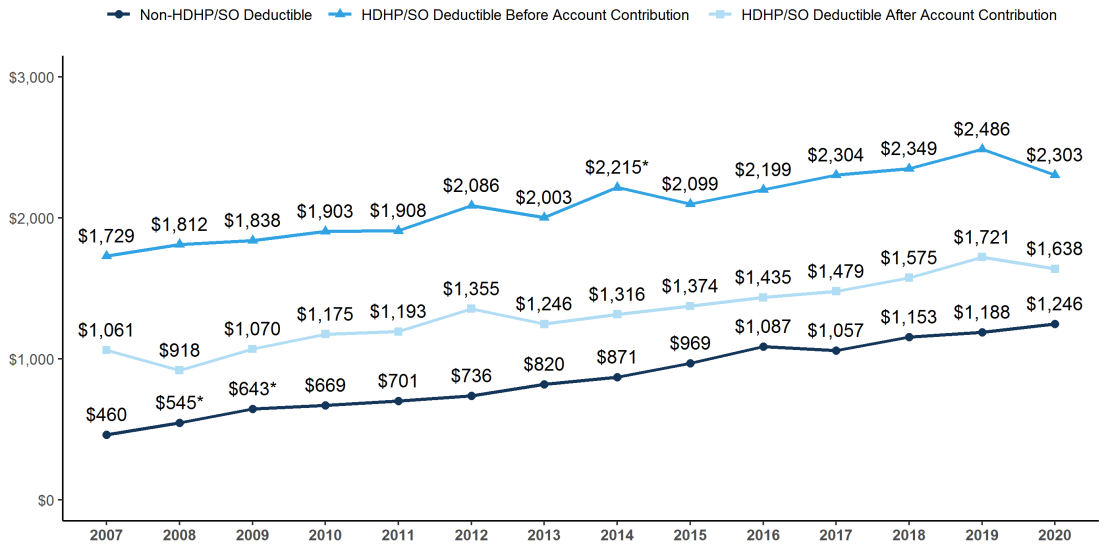
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers. The net liability for covered workers enrolled in a plan with an HSA or HRA is calculated by subtracting the account contribution from the single coverage deductible. HRAs are notional accounts, and employers are not required to actually transfer funds until an employee incurs expenses. General annual deductibles are for in-network providers.

* Estimate is statistically different from estimate for all other firms not in the indicated size category ($p < .05$).

SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 8.15

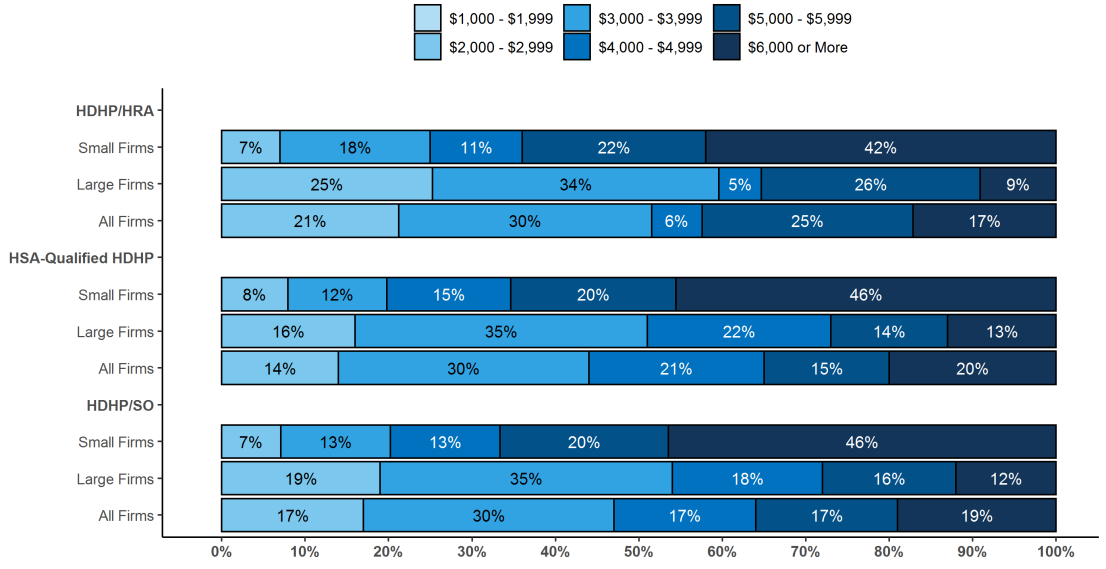
Among Covered Workers with a General Annual Deductible, Average Deductibles for Workers in Non-HDHP/SOs Compared to HDHP/SOs Before and After Any Employer Account Contributions, for Single Coverage, 2007-2020



* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
NOTE: The net liability for covered workers enrolled in a plan with an HSA or HRA is calculated by subtracting the account contribution from the single coverage deductible. General annual deductibles are for in-network providers.
SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2007-2017

Figure 8.16

Distribution of Covered Workers in HDHP/SOs with the Following Aggregate Family Deductibles, 2020



NOTE: Deductibles for family coverage are for covered workers with an aggregate amount. 12% of covered workers enrolled in an HDHP/HRA and 19% of covered workers in an HSA-qualified HDHP are in a plan with a separate per-person amount. For HSA-qualified HDHPs, the legal minimum deductible for 2020 is $1,350 for single coverage and $2,700 for family coverage. Small Firms have 3-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2020

EMPLOYER ACCOUNT CONTRIBUTIONS

- Employers contribute to HDHP/SOs in two ways: through their contributions toward the premium for the health plan and through their contributions (if any, in the case of HSAs) to the savings account option (i.e., the HRAs or HSAs themselves).
  - Looking at only the annual employer contributions to premiums, covered workers in HDHP/HRAs on average receive employer contributions of $6,243 for single coverage and $17,163 for family coverage [Figure 8.8]. These amounts are similar to the contribution amounts last year.
    - The average annual employer contributions to premiums for workers in HSA-qualified HDHPs are $5,719 for single coverage and $15,077 for family coverage. Both amounts are significantly higher than the contribution amounts last year. The average employer contributions for covered workers in HSA-qualified HDHPs for single coverage and family coverage are lower than the average contribution for covered workers in plans that are not HDHP/SOs [Figure 8.8].
- Looking at employer contributions to the savings options, covered workers enrolled in HDHP/HRAs on average receive an annual employer contribution to their HRA of $1,276 for single coverage and $2,315 for family coverage [Figure 8.8].
  - HRAs are generally structured in such a way that employers may not actually spend the whole amount that they make available to their employees' HRAs.[3] Amounts committed to an employee's HRA that are not used by the employee generally roll over and can be used in future years, but any balance may revert back to the employer if the employee leaves his or her job. Thus, the employer contribution amounts to HRAs that we capture in the survey may exceed the amount that employers will actually spend.
- Covered workers enrolled in HSA-qualified HDHPs on average receive an annual employer contribution to their HSA of $550 for single coverage and $1,018 for family coverage [Figure 8.8].
  - In many cases, employers that sponsor HSA-qualified HDHP/SOs do not make contributions to HSAs established by their employees. Fifty-one percent of employers offering single coverage and 53% offering family coverage through HSA-qualified HDHPs do not make contributions toward the HSAs that their workers establish. Among covered workers enrolled in an HSA-qualified HDHP, 25% enrolled in single coverage and 25% enrolled in family coverage do not receive an account contribution from their employer [Figure 8.17] and [Figure 8.18].
  - The average HSA contributions reported above include the portion of covered workers whose employer contribution to the HSA is zero. When those firms that do not contribute to the HSA are excluded from the calculation of the average amounts, the average employer contribution for covered workers is $741 for single coverage and $1,389 for family coverage.
    - The percentages of covered workers enrolled in a plan where the employer makes no HSA contribution (25% for single coverage and 25% for family coverage) are similar to the percentages in recent years [Figure 8.17] and [Figure 8.18].
- There is considerable variation in the amount that employers contribute to savings accounts.
  - Forty-seven percent of covered workers in an HDHP/HRA receive an annual HRA contribution of less than $800 for single coverage, while 18% receive an annual HRA contribution of $1,600 or more [Figure 8.17].

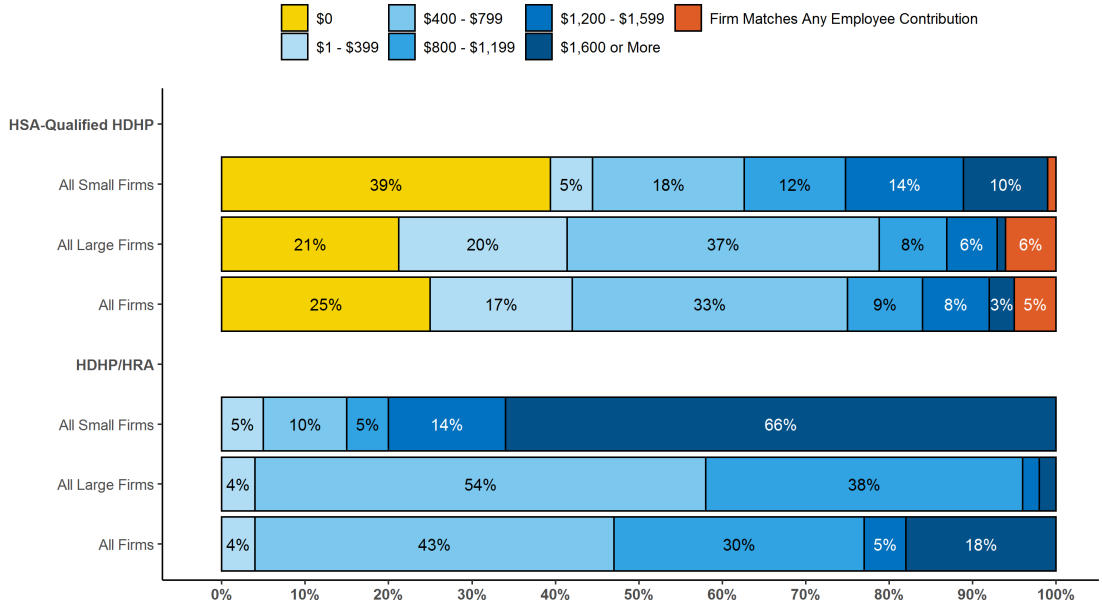
[3] The survey asks "Up to what dollar amount does your firm promise to contribute each year to an employee's HRA or health reimbursement arrangement for single coverage?" We refer to the amount that the employer commits to make available to an HRA as a contribution for ease of discussion. As discussed, HRAs are notional accounts, and employers are not required to actually transfer funds until an employee incurs expenses. Thus, employers may not expend the entire amount that they commit to make available to their employees through an HRA. Some employers may make their HRA contribution contingent on other factors, such as completing wellness programs.

- Forty-one percent of covered workers in an HSA-qualified HDHP receive an annual HSA contribution of less than $400 for single coverage, including 25% that receive no HSA contribution from their employer [Figure 8.17]. In contrast, 11% of covered workers in an HSA-qualified HDHP receive an annual HSA contribution of $1,200 or more. Five percent of covered workers have an employer that matches any HSA contribution for single coverage.

- Employer contributions to savings account options (i.e., the HRAs and HSAs themselves) for their workers can be added to their health plan premium contributions to calculate total employer contributions toward HDHP/SOs. We note that HRAs are a promise by an employer to pay up to a specified amount and that many employees will not receive the full amount of their HRA in a year, so adding the employer premium contribution amount and the HRA contribution represents an upper bound for employer liability that overstates the amount that is actually expended. Since employer contributions to employee HSAs immediately transfer the full amount to the employee, adding employer premium and HSA contributions is an instructive way to look at their total liability under these plans.

  - For HDHP/HRAs, the average annual total employer contribution for covered workers is $7,519 for single coverage and $19,477 for family coverage. The average total employer contributions for covered workers for single coverage and family coverage in HDHP/HRAs are higher than the average firm contributions toward single and family coverage in plans that are not HDHP/SOs [Figure 8.8].
  - For HSA-qualified HDHPs, the average total annual firm contribution for covered workers is $6,270 for single coverage and $16,083 for workers with family coverage. The average total firm contribution amounts for single coverage and family coverage in HSA-qualified HDHPs are similar to the average firm contributions toward health plans that are not HDHP/SOs [Figure 8.8].

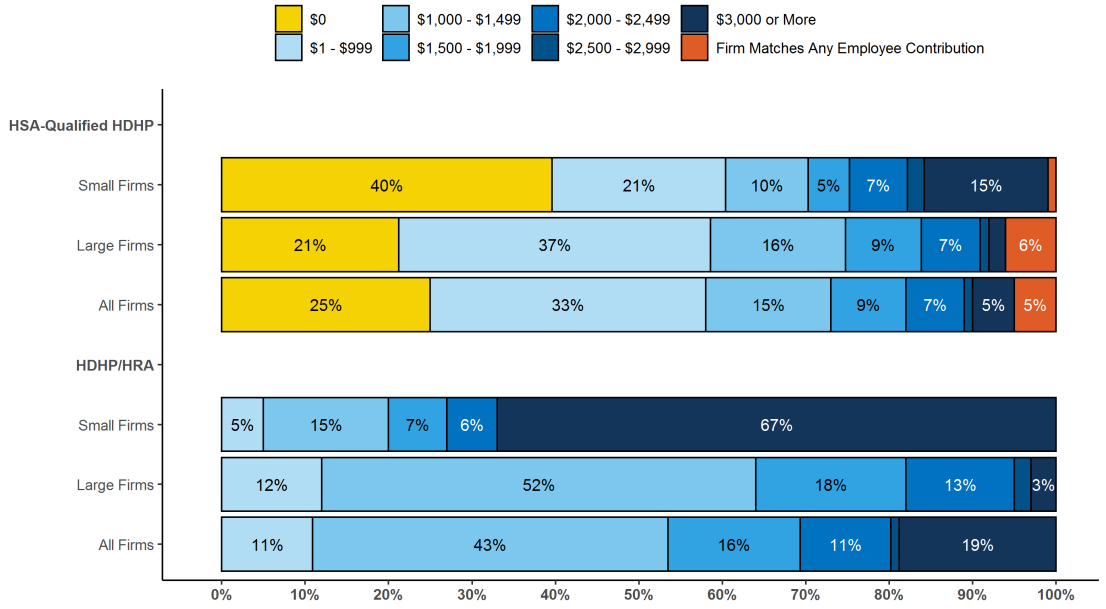
Figure 8.17
Distribution of Covered Workers with the Following Annual Employer Contributions to Their HRA or HSA, for Single Coverage, 2020



NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 8.18

Distribution of Covered Workers with the Following Annual Employer Contributions to Their HRA or HSA, for Family Coverage, 2020



NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 8.19

Average Annual Employer Contributions to HSA Accounts for Covered Workers Enrolled in an HSA-Qualified HDHP, 2009-2020

	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Among All Workers Enrolled in an HSA-Qualified HDHP: Average Employer HSA Contribution												
Single Coverage												
All Small Firms	$868	$549	$813	$845	$842	$1,142	$776	$958	$870	$784	$730	$739
All Large Firms	450	567	446	402	547	544	481	563	535	531	530	496
All Firms	**$688**	**$558**	**$611**	**$609**	**$658**	**$769**	**$568***	**$686**	**$608**	**$603**	**$572**	**$550**
Family Coverage												
All Small Firms	$1,364	$928	$1,327	$1,423	$1,429	$1,963	$1,158*	$1,487	$1,396	$1,302	$1,182	$1,259
All Large Firms	815	1,087	864	760	992	976	923	1,084	999	981	1,031	949
All Firms	**$1,126**	**$1,006**	**$1,069**	**$1,070**	**$1,154**	**$1,346**	**$991***	**$1,208**	**$1,086**	**$1,073**	**$1,062**	**$1,018**
Among Workers Enrolled in an HSA-Qualified HDHP With an Employer HSA Contribution: Average Employer HSA Contribution												
Single Coverage												
All Small Firms	$1,319	$999	$1,189	$1,246	$1,384	$1,510	$1,224	$1,486	$1,337	$1,277	$1,427	$1,226
All Large Firms	619	748	641	618	737	707	657	707	670	645	658	636
All Firms	**$1,000**	**$858**	**$886**	**$919**	**$951**	**$1,006**	**$809**	**$916**	**$795**	**$790**	**$768**	**$741**
Family Coverage												
All Small Firms	$2,077	$1,696	$1,971	$2,091	$2,383	$2,531	$1,836*	$2,330	$2,132	$2,119	$2,404	$2,122
All Large Firms	1,121	1,433	1,241	1,169	1,337	1,267	1,261	1,363	1,253	1,193	1,280	1,227
All Firms	**$1,640**	**$1,546**	**$1,559**	**$1,611**	**$1,675**	**$1,744**	**$1,412***	**$1,617**	**$1,417**	**$1,406**	**$1,433**	**$1,389**

NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers. In 2020, 25% of workers in an HSA-qualified single coverage plan and 25% of workers in an HSA-qualified family coverage plan were enrolled in a plan without an employer contribution to the HSA account. Covered workers enrolled in a plan where the firm matches any employee HSA contribution are not included in the average contribution (Five percent for single coverage and five percent for family coverage).

* Estimate is statistically different from estimate for the previous year shown ($p < .05$).

SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2009-2017

Figure 8.20

Among Covered Workers in HDHP/HRAs and HSA-Qualified HDHPs, Average Annual Employer HSA and HRA Contributions, 2020

	Average Employer Account Contribution
HSA: Single Coverage	
All Small Firms	$739
All Large Firms	496
ALL FIRMS	**$550**
HSA: Family Coverage	
All Small Firms	$1,259
All Large Firms	949
ALL FIRMS	**$1,018**
HRA: Single Coverage	
All Small Firms	$2,649*
All Large Firms	824*
ALL FIRMS	**$1,276**
HRA: Family Coverage	
All Small Firms	$4,796*
All Large Firms	1,498*
ALL FIRMS	**$2,315**

NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers. See the note in Figure 8.7 for additional information on HSA and HRA contributions.

* Estimate is statistically different between All Small Firms and All Large Firms estimate ($p < .05$).

SOURCE: KFF Employer Health Benefits Survey, 2020

COST SHARING FOR OFFICE VISITS

- The cost-sharing pattern for primary care office visits differs for workers enrolled in HDHP/SOs. Thirty-five percent of covered workers in HDHP/HRAs have a copayment for primary care physician office visits compared to 9% enrolled in HSA-qualified HDHPs [Figure 8.21]. Workers in other plan types are much more likely to face copayments than coinsurance for physician office visits (see Section 7 for more information).

Figure 8.21

Distribution of Covered Workers in HDHP/HRAs and HSA-Qualified HDHPs With the Following Types of Cost Sharing in Addition to the General Annual Deductible, 2020

	HDHP/HRA	HSA-Qualified HDHP	HDHP/SO	Non-HDHP/SO
Separate Cost Sharing for Primary Care Physician Office Visits				
Copayment	35%	9%*	16%	81%*
Coinsurance	56%	65%	62%	12%*
None	5%	18%*	15%	4%*
Other	3%	7%	7%	3%*
Separate Cost Sharing for Specialty Care Physician Office Visits				
Copayment	24%	9%*	12%	78%*
Coinsurance	67%	65%	66%	16%*
None	6%	18%*	15%	3%*
Other	3%	7%	6%	3%*

NOTE: The survey asks firms about the characteristics of either their largest HRA or HSA-Qualified HDHP. The HDHP/SO category is the aggregate of both the HRA and HSA plans. For more information, see the Methods Section.

* Estimates are statistically different between HDHP/HRAs and HSA-Qualified HDHPs or HDHP/SO plans and Non-HDHP/SO plans ($p < .05$).

SOURCE: KFF Employer Health Benefits Survey, 2020

Health Reimbursement Arrangements (HRAs) are medical care reimbursement plans established by employers that can be used by employees to pay for health care. HRAs are funded solely by employers. Employers may commit to make a specified amount of money available in the HRA for premiums and medical expenses incurred by employees or their dependents. HRAs are accounting devices, and employers are not required to expend funds until an employee incurs expenses that would be covered by the HRA. Unspent funds in the HRA usually can be carried over to the next year (sometimes with a limit). Employees cannot take their HRA balances with them if they leave their job, although an employer can choose to make the remaining balance available to former employees to pay for health care. HRAs often are offered along with a high-deductible health plan (HDHP). In such cases, the employee pays for health care first from his or her HRA and then out-of-pocket until the health plan deductible is met. Sometimes certain preventive services or other services such as prescription drugs are paid for by the plan before the employee meets the deductible.

Health Savings Accounts (HSAs) are savings accounts created by individuals to pay for health care. An individual may establish an HSA if he or she is covered by a "qualified health plan" - a plan with a high deductible (at least $1,400 for single coverage and $2,800 for family coverage in 2020 or $1,350 and $2,700, respectively, in 2019) that also meets other requirements. Employers can encourage their employees to create HSAs by offering an HDHP that meets the federal requirements. Employers in some cases also may assist their employees by identifying HSA options, facilitating applications, or negotiating favorable fees from HSA vendors. Both employers and employees can contribute to an HSA, up to the statutory cap of $3,550 for single coverage and $7,100 for family coverage in 2020. Employee contributions to the HSA are made on a pre-income tax basis, and some employers arrange for their employees to fund their HSAs through payroll deductions. Employers are not required to contribute to HSAs established by their employees but if they elect to do so, their contributions are not taxable to the employee. Interest and other earnings on amounts in an HSA are not taxable. Withdrawals from the HSA by the account owner to pay for qualified health care expenses are not taxed. The savings account is owned by the individual who creates the account, so employees retain their HSA balances if they leave their

job. See https://www.federalregister.gov/d/2019-08017/p-850 For those enrolled in an HDHP/HSA, see https://www.irs.gov/pub/irs-pdf/p969.pdf

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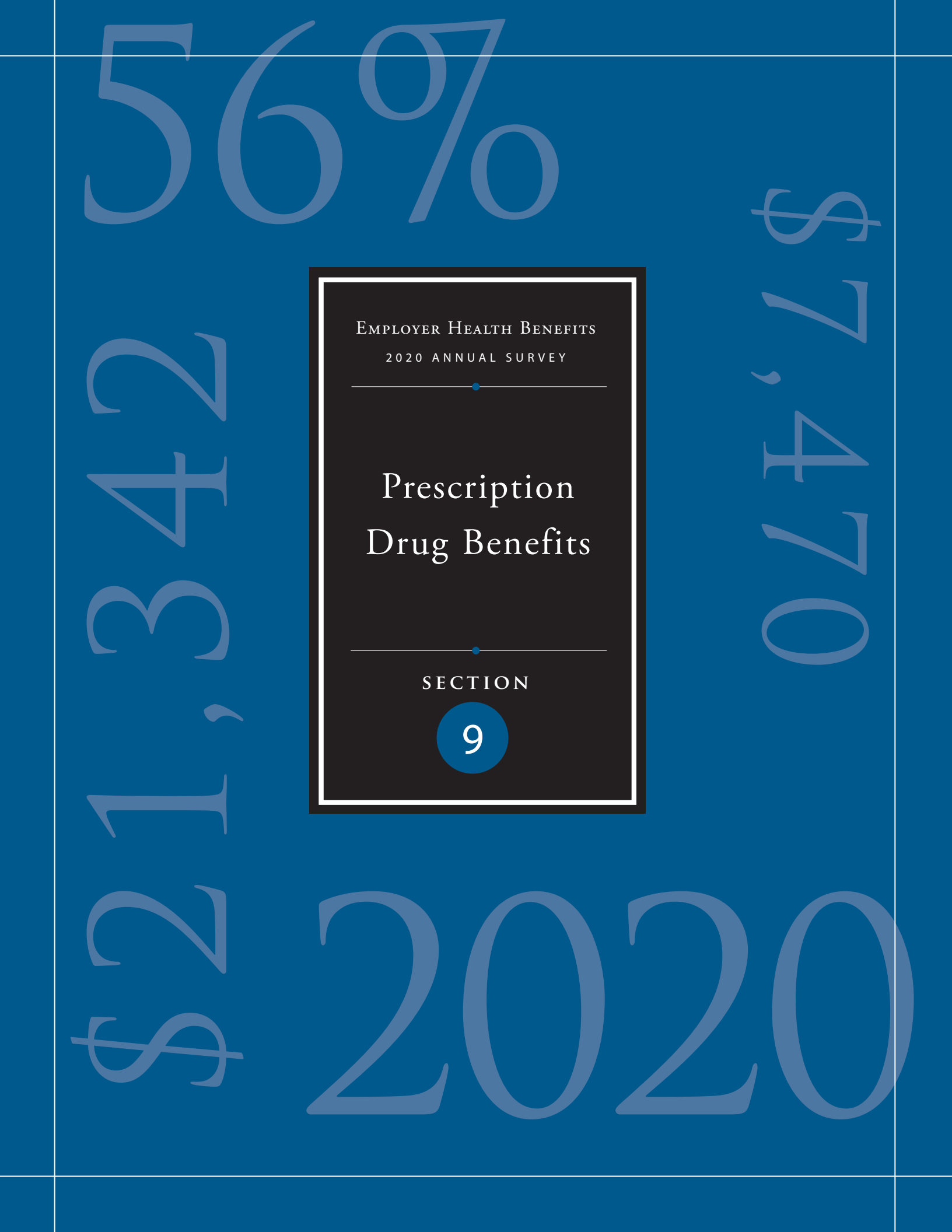
Prescription Drug Benefits

SECTION 9



Section 9

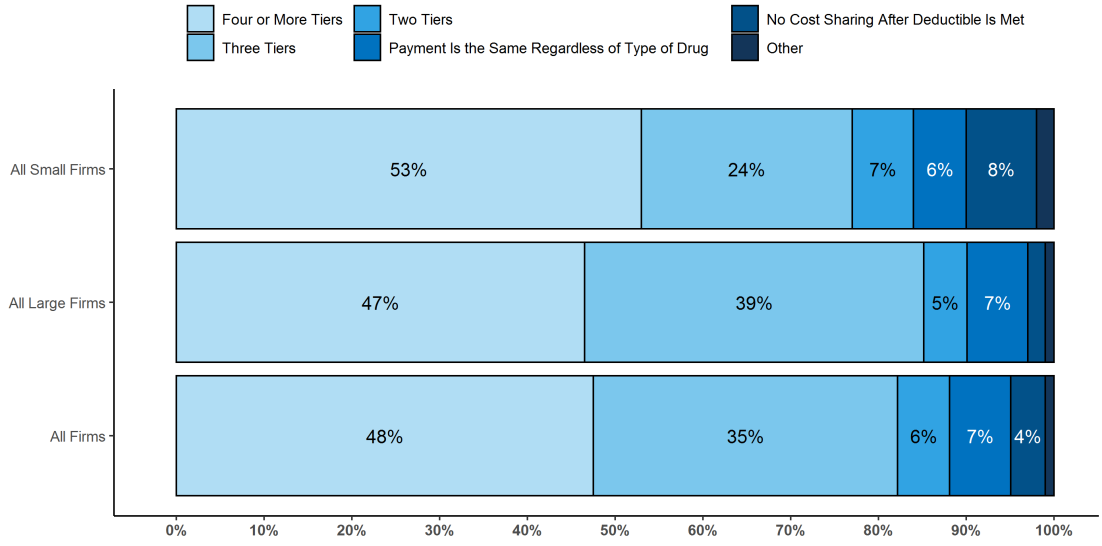
Prescription Drug Benefits

Nearly all (99%) covered workers are at a firm that provides prescription drug coverage in its largest health plan. Many employer plans have increasingly complex benefit designs for prescriptions drugs, as employers and insurers expand the use of formularies with multiple cost-sharing tiers as well as other management approaches. To reduce the burden on respondents, we ask offering firms about the attributes of prescription drug coverage only for their largest health plan. This survey asks employers about the cost-sharing in up to four tiers, and for a tier exclusively for specialty drugs. Some plans may have more than one tier for specialty drugs or other variations. There also may be considerable variation in how plans structure their formularies.

DISTRIBUTION OF COST SHARING

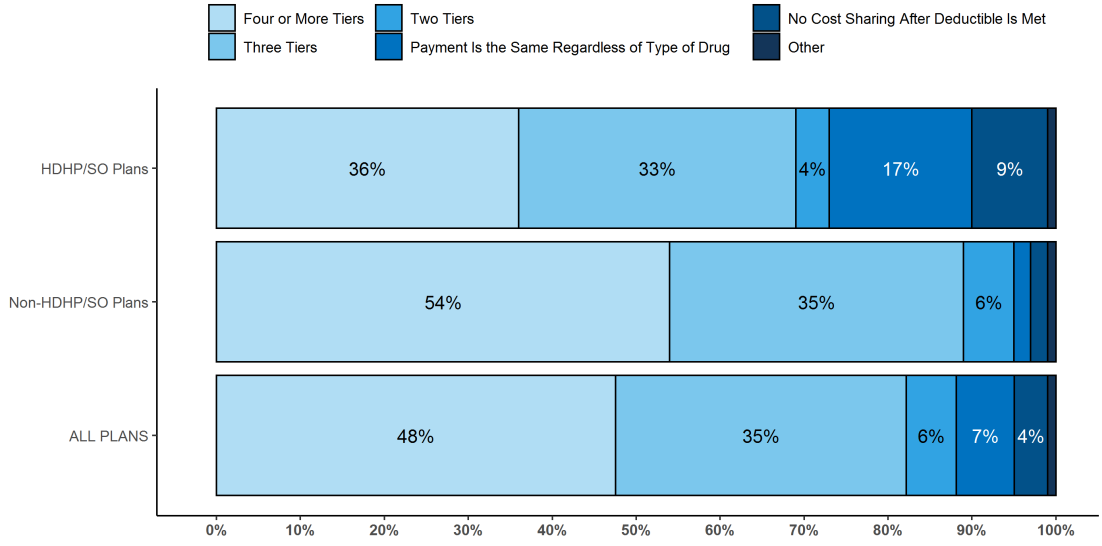
- The large majority of covered workers (89%) are in a plan with tiered cost sharing for prescription drugs [Figure 9.1]. Cost-sharing tiers generally refer to a health plan placing a drug on a formulary or preferred drug list that classifies drugs into categories that are subject to different cost sharing or management. It is common for there to be different tiers for generic, preferred and non-preferred drugs. In recent years, plans have created additional tiers that may, for example, be used for specialty drugs or expensive biologics. Some plans may have multiple tiers for different categories; for example, a plan may have preferred and non-preferred specialty tiers. The survey obtains information about the cost-sharing structure for up to five tiers.
- Eighty-three percent of covered workers are in a plan with three, four, or more tiers of cost sharing for prescription drugs [Figure 9.1]. These totals include tiers that cover only specialty drugs, even though the cost-sharing information for those tiers is reported separately.
  - Although the overall distribution of HDHP/SOs does not statistically differ from non-HDHP/SO plans, certain segments of that distribution have a different cost-sharing pattern for prescription drugs than other plan types. Compared to covered workers in other plan types, those in HDHP/SOs are more likely to be in a plan with the same cost sharing regardless of drug type (17% vs. 2%) or in a plan that has no cost sharing for prescriptions once the plan deductible is met (9% vs. 2%) [Figure 9.2].

Figure 9.1
Distribution of Covered Workers Facing Different Cost-Sharing Formulas for Prescription Drug Benefits, by Firm Size, 2020



Tests found no statistical difference between Small Firm and Large Firm distributions ($p < .05$).
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers. Number of tiers include any tiers specifically for specialty drugs. Excluding tiers specifically for specialty drugs, 57% of covered workers with prescription drug coverage are enrolled in a plan with four or more tiers, 11% have three tiers, 6% have two tiers, 5% have the same cost sharing regardless of the drug, and 1% have no cost sharing after the deductible is met. For more information on the definition of specialty drugs and how this survey defines drug formulary tiers, see Section 9.
SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 9.2
Distribution of Covered Workers Facing Different Cost-Sharing Formulas for Prescription Drug Benefits, by Plan Type, 2020

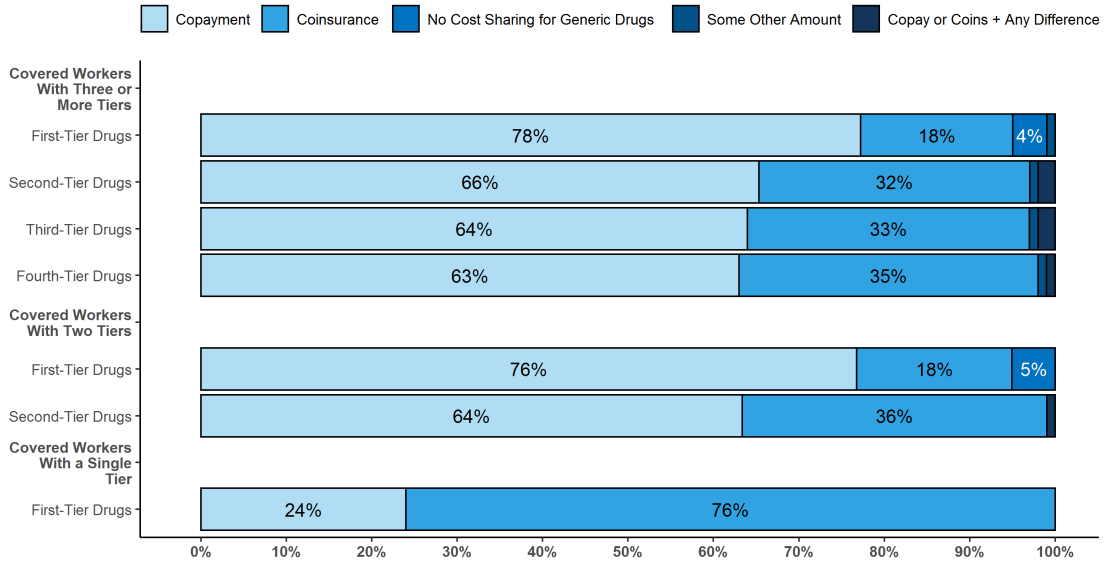


Tests found no statistical difference between HDHP/SO Plan and Non-HDHP/SO distributions ($p < .05$).
NOTE: Number of tiers include any tiers specifically for specialty drugs. Excluding tiers specifically for specialty drugs, 57% of covered workers with prescription drug coverage are enrolled in a plan with four or more tiers, 11% have three tiers, 6% have two tiers, 5% have the same cost sharing regardless of the drug, and 1% have no cost sharing after the deductible is met. For more information on the definition of specialty drugs and how this survey defines drug formulary tiers, see Section 9.
SOURCE: KFF Employer Health Benefits Survey, 2020

TIERS NOT EXCLUSIVELY FOR SPECIALTY DRUGS

- Even when formulary tiers covering only specialty drugs are not counted, a large share (77%) of covered workers are in a plan with three or more tiers of cost sharing for prescription drugs. The cost-sharing statistics presented in this section do not include information about tiers that cover only specialty drugs. In cases in which a plan covers specialty drugs on a tier with other drugs, they will still be included in these averages. Cost-sharing statistics for tiers covering only specialty drugs are presented further down in this section.
- For covered workers in a plan with three or more tiers of cost sharing for prescription drugs, copayments are the most common form of cost sharing in the first four tiers and coinsurance is the next most common [Figure 9.3].
  - Among covered workers in plans with three or more tiers of cost sharing for prescription drugs, the average copayments are $11 for first-tier drugs, $35 second-tier drugs, $62 for third-tier drugs, and $116 for fourth-tier drugs [Figure 9.6].
  - Among covered workers in plans with three or more tiers of cost sharing for prescription drugs, the average coinsurance rates are 18% for first-tier drugs, 25% second-tier drugs, 37% third-tier drugs, and 28% for fourth-tier drugs [Figure 9.6].
- Eleven percent of covered workers are in a plan with two tiers for prescription drug cost sharing (excluding tiers covering only specialty drugs).
  - For these workers, copayments are more common than coinsurance for first-tier and second-tier drugs [Figure 9.3]. The average copayment for the first tier is $12 and the average copayment for the second tier is $37 [Figure 9.6].
- Six percent of covered workers are in a plan with the same cost sharing for prescriptions regardless of the type of drug (excluding tiers covering only specialty drugs).
  - Among these workers, 24% have copayments and 76% have coinsurance [Figure 9.3]. The average coinsurance rate is 20% [Figure 9.6].

Figure 9.3
Among Covered Workers with Prescription Drug Coverage, Distribution with the Following Types of Cost Sharing for Prescription Drugs, 2020



NOTE: Number of tiers refers to the number of tiers excluding those specifically for specialty drugs. 'Copayment or Coinsurance Plus Any Difference' category includes workers who pay a copayment or coinsurance plus the difference between the cost of the prescription and the cost of a comparable generic drug. Coins is an abbreviation of Coinsurance.
SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 9.4

Among Covered Workers With Three or More Tiers of Prescription Drug Cost Sharing, Distribution With the Following Types of Cost Sharing, by Firm Size, 2020

	Copayment	Coinsurance	No Cost Sharing for Generic Drugs	Some Other Amount
First-Tier Drugs, Often Called Generics				
All Small Firms	92%*	3%*	5%	<1%
All Large Firms	73*	23*	3	1
ALL FIRMS	**78%**	**18%**	**4%**	**1%**
Second-Tier Drugs, Often Called Preferred Drugs			**Copayment or Coinsurance Plus Any Difference**	
All Small Firms	92%*	5%*	2%	<1%
All Large Firms	57*	41*	2	<1
ALL FIRMS	**66%**	**32%**	**2%**	**<1%**
Third-Tier Drugs, Often Called Non-Preferred Drugs				
All Small Firms	88%*	9%*	2%	1%
All Large Firms	55*	42*	2	2
ALL FIRMS	**64%**	**33%**	**2%**	**1%**
Fourth-Tier Drugs				
All Small Firms	66%	31%	1%	2%
All Large Firms	60	37	1	1
ALL FIRMS	**63%**	**35%**	**1%**	**1%**

NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers. Number of tiers refers to the number of tiers excluding those specifically for specialty drugs. 'Copayment or Coinsurance Plus Any Difference' category includes workers who pay a copayment or coinsurance plus the difference between the cost of the prescription and the cost of a comparable generic drug.

* Estimates are statistically different between Small Firm and Large Firm estimates within category ($p < .05$).

SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 9.5

Among Covered Workers With Three or More Tiers of Prescription Drug Cost Sharing, Distribution With the Following Types of Cost Sharing, by Plan Type, 2020

	Copayment	Coinsurance	No Cost Sharing for Generic Drugs	Some Other Amount
First-Tier Drugs, Often Called Generics				
HDHP/SO Plans	59%*	36%*	5%	0%
Non-HDHP/SO Plans	85*	11*	3	1
ALL PLANS	**78%**	**18%**	**4%**	**1%**
Second-Tier Drugs, Often Called Preferred Drugs			**Copayment or Coinsurance Plus Any Difference**	
HDHP/SO Plans	41%*	57%*	2%	<1%
Non-HDHP/SO Plans	75*	23*	2	1
ALL PLANS	**66%**	**32%**	**2%**	**<1%**
Third-Tier Drugs, Often Called Non-Preferred Drugs				
HDHP/SO Plans	38%*	60%*	2%	<1%
Non-HDHP/SO Plans	72*	24*	2	2
ALL PLANS	**64%**	**33%**	**2%**	**1%**
Fourth-Tier Drugs				
HDHP/SO Plans	66%	30%	3%	1%
Non-HDHP/SO Plans	62	36	1	1
ALL PLANS	**63%**	**35%**	**1%**	**1%**

NOTE: Number of tiers refers to the number of tiers excluding those specifically for specialty drugs. 'Copayment or Coinsurance Plus Any Difference' category includes workers who pay a copayment or coinsurance plus the difference between the cost of the prescription and the cost of a comparable generic drug.

* Estimates are statistically different between plan type estimates within category ($p < .05$).

SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 9.6

Among Covered Workers With Prescription Drug Coverage, Average Copayments and Coinsurance, 2020

	Average Copayment	Average Coinsurance
Plans With Three or More Tiers		
First Tier	$11	18%
Second Tier	$35	25%
Third Tier	$62	37%
Fourth Tier	$116	28%
Plans With Two Tiers		
First Tier	$12	NSD
Second Tier	$37	29%
Plans With the Same Cost Sharing For All Covered Drugs		
First Tier	NSD	20%

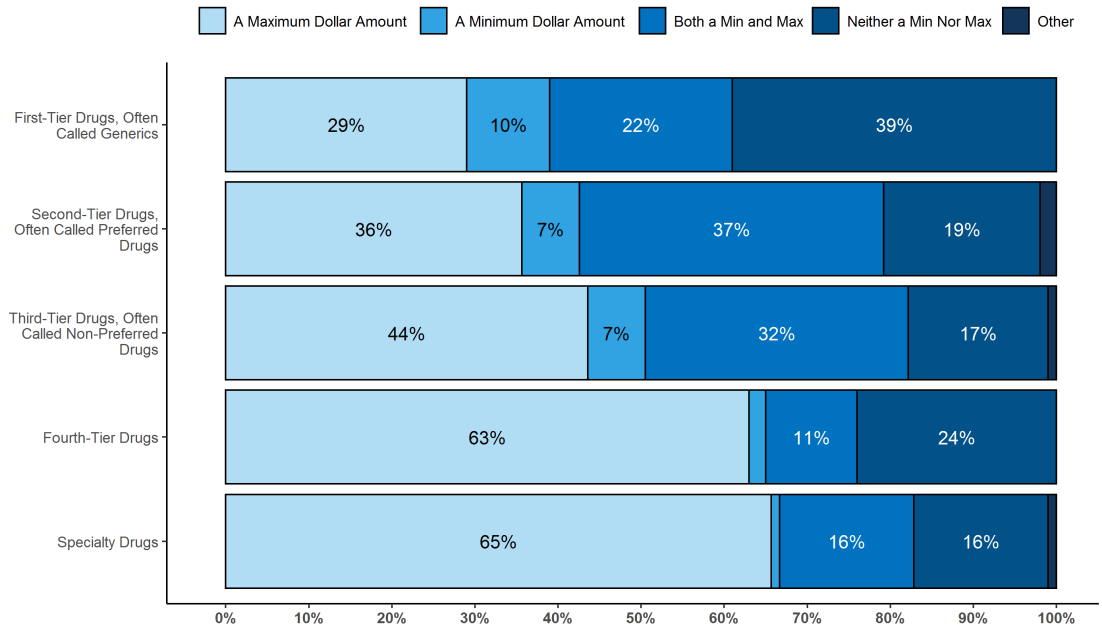
NOTE: Number of tiers refers to the number of tiers excluding those specifically for specialty drugs.
NSD: Not Sufficient Data

SOURCE: KFF Employer Health Benefits Survey, 2020

COINSURANCE MAXIMUMS

- Coinsurance rates for prescription drugs often include maximum and/or minimum dollar amounts. Depending on the plan design, coinsurance maximums may significantly limit the amount an enrollee must spend out-of-pocket for higher-cost drugs. Even in plans without explicit coinsurance maximum amounts, the overall plan out-of-pocket maximum limits enrollee cost sharing on covered services, including prescription drugs.
- These coinsurance minimum and maximum amounts vary across the tiers.
  - For example, among covered workers in a plan with coinsurance for the first cost-sharing tier, 29% have only a maximum dollar amount attached to the coinsurance rate, 10% have only a minimum dollar amount, 22% have both a minimum and maximum dollar amount, and 39% have neither. For those in a plan with coinsurance for the fourth cost-sharing tier, 63% have only a maximum dollar amount attached to the coinsurance rate, 2% have only a minimum dollar amount, 11% have both a minimum and maximum dollar amount, and 24% have neither [Figure 9.7].

Figure 9.7
Distribution of Coinsurance Structures for Covered Workers Facing a Coinsurance for Prescription Drugs, 2020



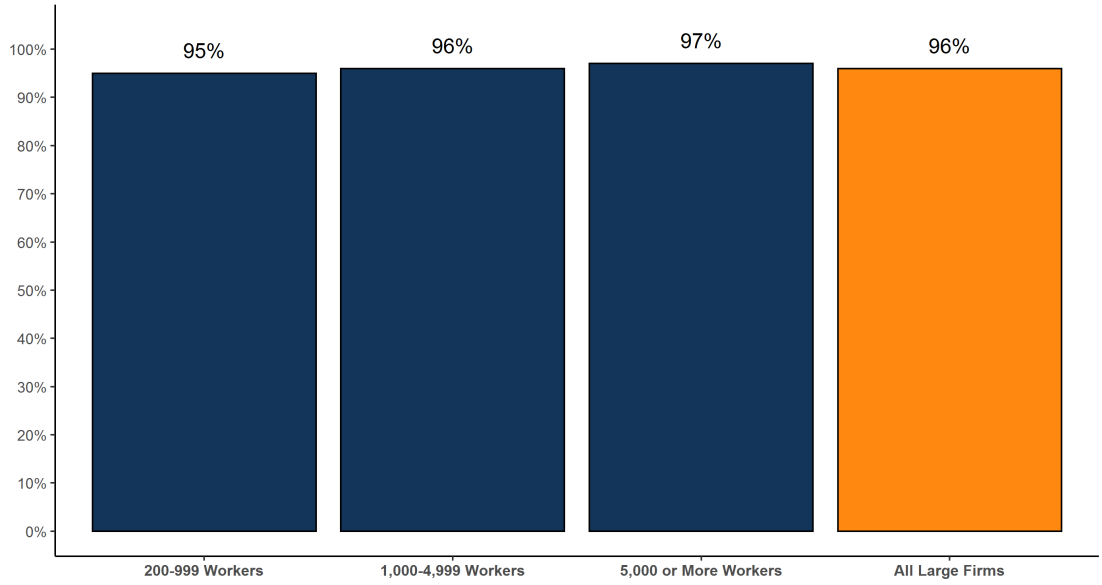
SOURCE: KFF Employer Health Benefits Survey, 2020

SEPARATE TIERS FOR SPECIALTY DRUGS

- Specialty drugs, such as biologics that may be used to treat chronic conditions, or some cancer drugs, can be quite expensive and often require special handling and administration. We revised our questions beginning with the 2016 survey to obtain more information about formulary tiers that are exclusively for specialty drugs. We are reporting results only among large firms because a small firm respondents had large shares of "don't know" responses to some of these questions.

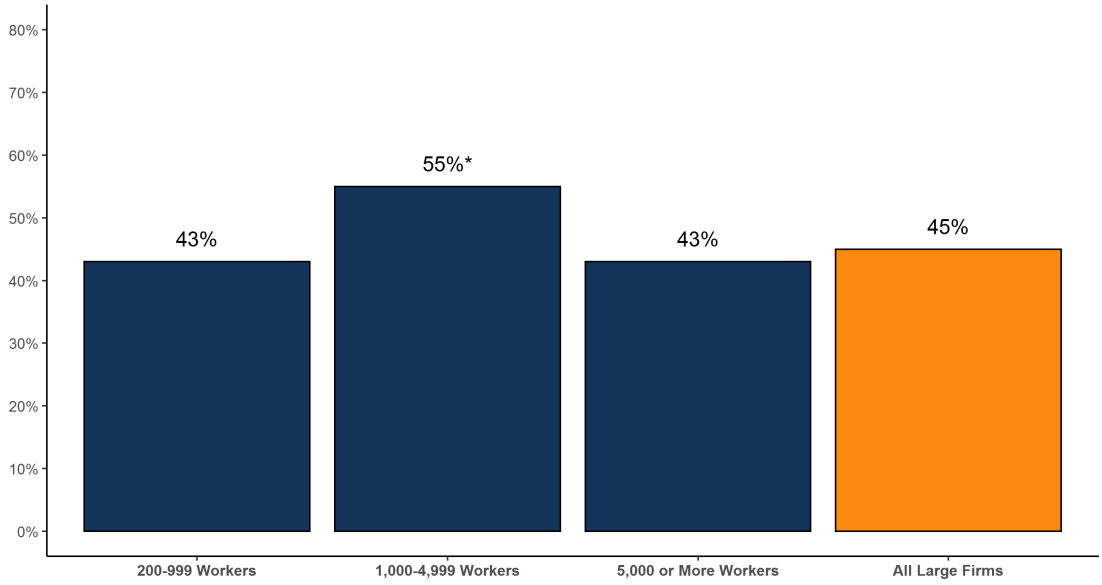
- Ninety-six percent of covered workers at large firms have coverage for specialty drugs [Figure 9.8]. Among these workers, 45% are in a plan with at least one cost-sharing tier just for specialty drugs [Figure 9.9].
- Among covered workers at large firms in a plan with at least one separate tier for specialty drugs, 45% have a copayment for specialty drugs and 53% have coinsurance [Figure 9.10]. The average copayment is $109 and the average coinsurance rate is 26% [Figure 9.11]. Eighty-seven percent of those with coinsurance have a maximum dollar limit on the amount of coinsurance they must pay.

Figure 9.8
Among Large Firms with Prescription Drug Coverage, Percentage of Covered Workers Whose Plan with the Largest Enrollment Includes Coverage for Specialty Drugs, by Firm Size, 2020



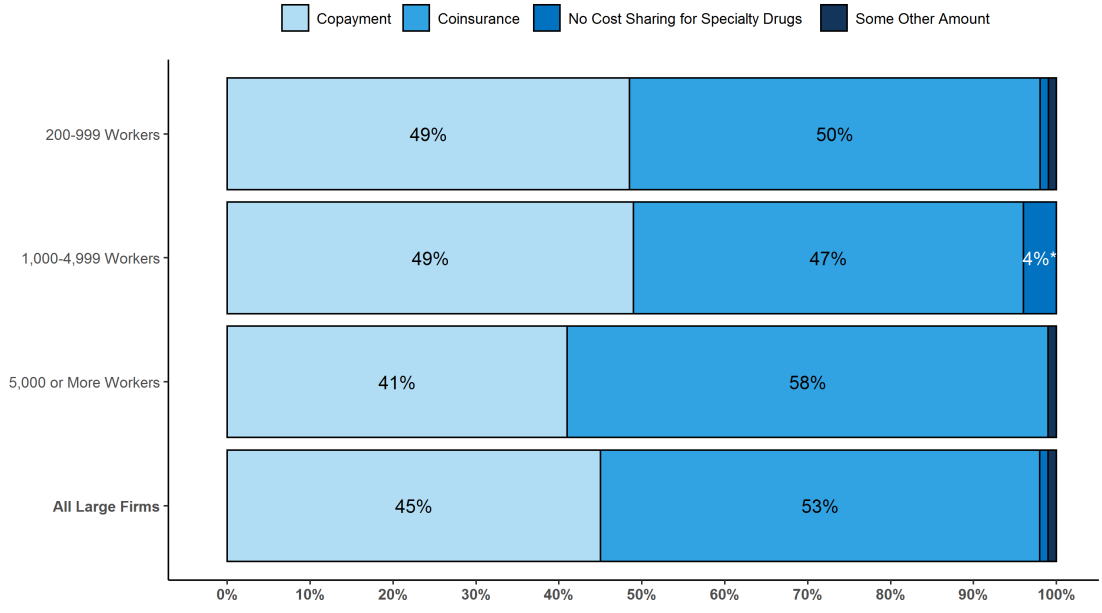
Tests found no statistical difference from estimate for all other firms not in the indicated size category ($p < .05$).
NOTE: Large Firms have 200 or more workers. One-hundred percent of firms offering health benefits offer prescription drug coverage.
SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 9.9
Among Large Firms Whose Prescription Drug Coverage Includes Specialty Drugs, Percentage of Covered Workers Enrolled in a Plan That Has a Separate Tier for Specialty Drugs, by Firm Size, 2020



* Estimate is statistically different from estimate for all other firms not in the indicated size category (p < .05).
NOTE: Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 9.10
Among Covered Workers at Large Firms Enrolled in a Plan with a Separate Tier for Specialty Drugs, Distribution of the Following Types of Cost Sharing, by Firm Size, 2020



* Estimates are statistically different from estimate for all other firms not in the indicated category within each firm size (p < .05).
NOTE: Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 9.11

Among Covered Workers at Large Firms Enrolled in a Plan With a Separate Tier for Specialty Drugs, Average Copayments and Coinsurance, by Firm Size, 2020

	Average Copayment ($)	Average Coinsurance (%)
FIRM SIZE		
200-999 Workers	$106	27%
1,000-4,999 Workers	97*	25
5,000 or More Workers	118	27
All Large Firms (200 or More Workers)	**$109**	**26%**

* Estimate is statistically different from estimate for all other firms not in the indicated size category ($p < .05$).

SOURCE: KFF Employer Health Benefits Survey, 2020

Generic drugs Drugs that are no longer covered by patent protection and thus may be produced and/or distributed by multiple drug companies.

Preferred drugs Drugs included on a formulary or preferred drug list; for example, a brand-name drug without a generic substitute.

Non-preferred drugs Drugs not included on a formulary or preferred drug list; for example, a brand-name drug with a generic substitute.

Fourth-tier drugs New types of cost-sharing arrangements that typically build additional layers of higher copayments or coinsurance for specifically identified types of drugs, such as lifestyle drugs or biologics.

Specialty drugs Specialty drugs such as biological drugs are high cost drugs that may be used to treat chronic conditions such as blood disorder, arthritis or cancer. Often times they require special handling and may be administered through injection or infusion.

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Plan Funding

SECTION 10

Section 10

Plan Funding

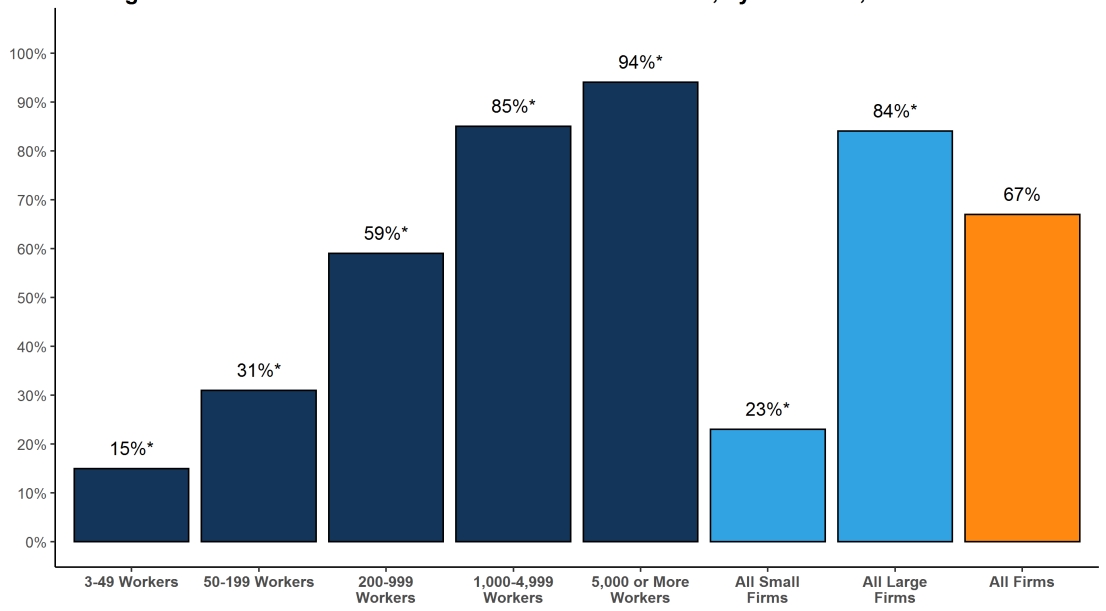
Many firms, particularly larger firms, choose to pay for some or all of the health services of their workers directly from their own funds rather than by purchasing health insurance for them. This is called self-funding. Both public and private employers use self-funding to provide health benefits. Federal law (the Employee Retirement Income Security Act of 1974, or ERISA) exempts self-funded plans established by private employers (but not public employers) from most state insurance laws, including reserve requirements, mandated benefits, premium taxes, and many consumer protection regulations. Sixty-seven percent of covered workers are in a self-funded health plan in 2020. Self-funding is common among larger firms because they can spread the risk of costly claims over a large number of workers and dependents. Some employers which sponsor self-funded plans purchase stoploss coverage to limit their liabilities.

In recent years, a complex funding option, often called level-funding, has become more widely available to small employers. Level-funded arrangements are nominally self-funded options that package together a self-funded plan with extensive stoploss coverage that significantly reduces the risk retained by the employer. Sixteen percent of covered workers in small firms (3-199 workers) are in a level-funded plan.

SELF-FUNDED PLANS

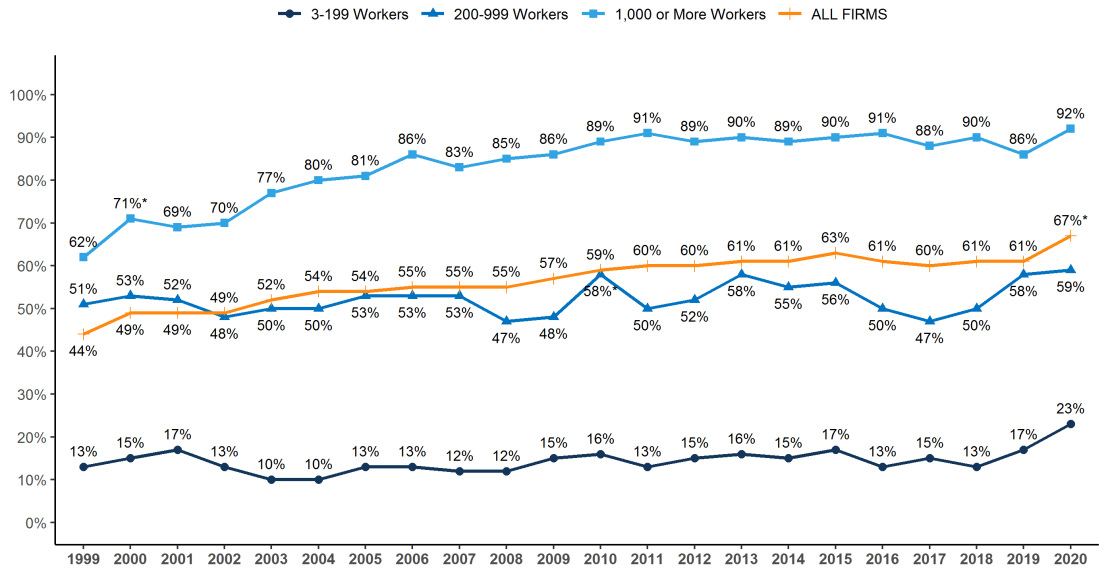
- Sixty-seven percent of covered workers are in a plan that is self-funded, significantly higher than the percentage 61% last year [Figure 10.1] and [Figure 10.2].
  - The percentage of covered workers enrolled in self-funded plans is similar to the percentage in five years ago (63%) but higher than the percentage (59%) ten years ago [Figure 10.2].
    - As expected, covered workers in large firms are significantly more likely to be in a self-funded plan than covered workers in small firms (84% vs. 23%). The percentage of covered workers in self-funded plans generally increases as the number of workers in a firm increases. [Figure 10.1] and [Figure 10.3].

Figure 10.1
Percentage of Covered Workers Enrolled in a Self-Funded Plan, by Firm Size, 2020



* Estimate is statistically different from estimate for all other firms not in the indicated size category ($p < .05$).
NOTE: Includes covered workers enrolled in self-funded plans in which the firm's liability is limited through stoploss coverage. See the glossary at the end of Section 10 for definitions of self-funded, fully-insured, and level-funded premium plans. Small Firms have 3-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 10.2
Percentage of Covered Workers Enrolled in a Self-Funded Plan, by Firm Size, 1999-2020



* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
NOTE: Includes covered workers enrolled in self-funded plans in which the firm's liability is limited through stoploss coverage. Overall, 67% of covered workers are in a self-funded plan in 2020. Due to a change in the survey questionnaire, funding status was not asked of firms with conventional plans in 2006; therefore, conventional plan funding status is not included in the averages in this figure for 2006. See the glossary at the end of Section 10 for definitions of self-funded, fully-insured, and level-funded premium plans.
SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

Figure 10.3

Percentage of Covered Workers Enrolled in a Self-Funded Plan, by Firm Size, Region, and Industry, 2020

	Covered Workers in a Self-Funded Plan
FIRM SIZE	
200-999 Workers	59%*
1,000-4,999 Workers	85*
5,000 or More Workers	94*
All Small Firms (3-199 Workers)	**23%***
All Large Firms (200 or More Workers)	**84%***
REGION	
Northeast	68%
Midwest	73*
South	69
West	55*
INDUSTRY	
Agriculture/Mining/Construction	59%
Manufacturing	70
Transportation/Communications/Utilities	88*
Wholesale	67
Retail	80*
Finance	67
Service	54*
State/Local Government	81*
Health Care	73
ALL FIRMS	**67%**

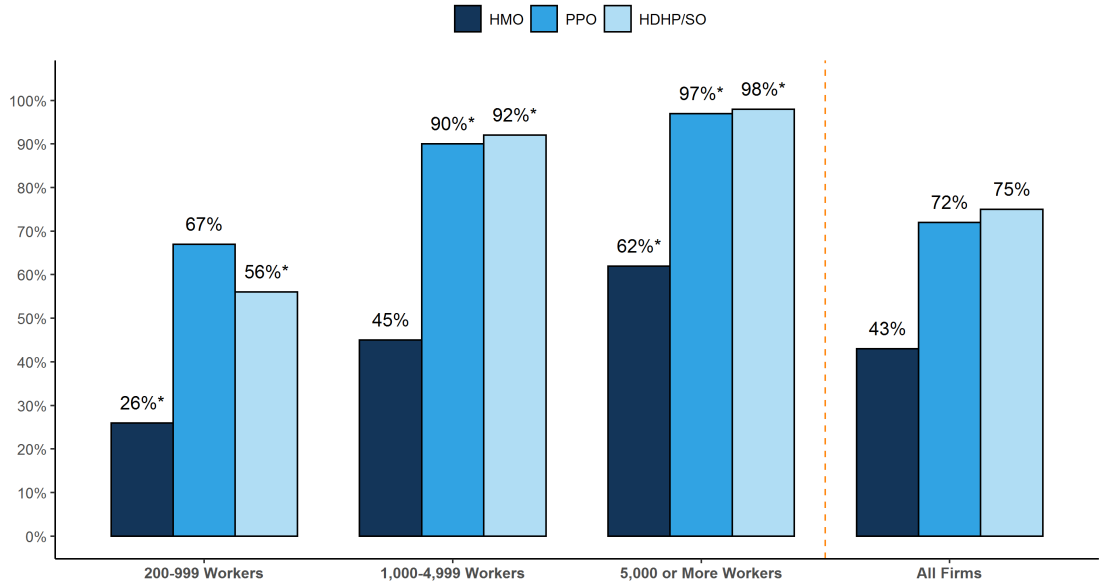
NOTE: Includes covered workers enrolled in self-funded plans in which the firm's liability is limited through stoploss coverage. See the glossary at the end of Section 10 for definitions of self-funded, fully-insured, and level-funded premium plans.

* Estimate is statistically different from estimate for all firms not in the indicated size, region, or industry category ($p < .05$).

SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 10.4

Percentage of Covered Workers Enrolled in a Self-Funded Plan, by Plan Type and Firm Size, 2020



* Estimate is statistically different from estimate for all other firms not in the indicated size category within plan type ($p < .05$).
NOTE: Includes covered workers enrolled in self-funded plans in which the firm's liability is limited through stoploss coverage. See the glossary at the end of Section 10 for definitions of self-funded, fully-insured, and level-funded premium plans.
SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 10.5

Percentage of Covered Workers Enrolled in Self-Funded HMO, PPO, and HDHP/SO Plans, by Firm Size, 1999-2020

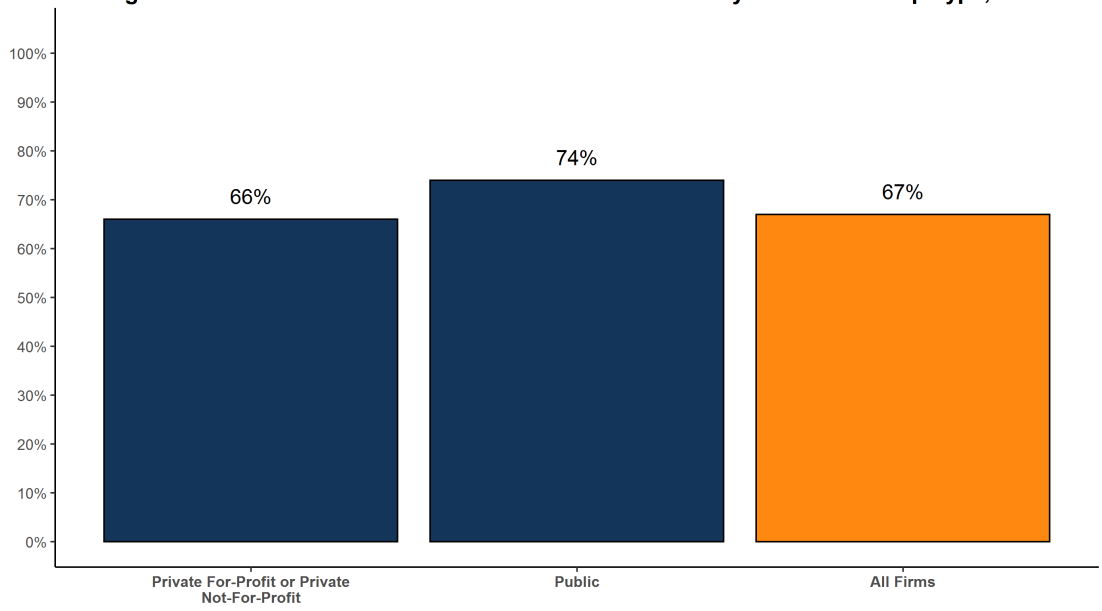
	HMO					PPO					HDHP/SO				
	3-199 Workers	200-999 Workers	1,000-4,999 Workers	5,000 or More Workers	All HMO Plans	3-199 Workers	200-999 Workers	1,000-4,999 Workers	5,000 or More Workers	All PPO Plans	3-199 Workers	200-999 Workers	1,000-4,999 Workers	5,000 or More Workers	All HDHP/SO Plans
1999	5%	14%	22%	19%	16%	19%	69%	84%	87%	60%					
2000	4%	13%	27%	35%*	23%*	23%	72%	89%	88%	63%					
2001	14%	23%	32%	40%	31%*	23%	66%	87%	87%	61%					
2002	10%	16%	31%	38%	27%	15%	63%	83%	93%	61%					
2003	5%	21%	37%	44%	29%	13%	60%	85%	93%	61%					
2004	4%	18%	49%	40%	29%	13%	63%	88%	93%	64%					
2005	10%	17%	50%	44%	32%	18%	67%	88%	95%	65%					
2006	3%	29%	54%	47%	33%	19%	61%	85%	97%	63%	7%	57%	81%	100%	50%
2007	1%	19%	44%	58%	34%	17%	65%	87%	90%*	65%	4%	27%	86%	97%	41%
2008	10%	22%	48%	66%	40%	15%	55%	85%	94%	64%	7%	48%	72%	91%	35%
2009	6%	26%	50%	61%	40%	21%	55%	87%	93%	67%	18%	36%	81%	96%	48%*
2010	9%	23%	59%	65%	41%	18%	69%*	85%	96%	67%	24%	53%	88%	99%	61%*
2011	5%	16%	54%	67%	41%	19%	65%	84%	98%	70%	11%	45%	89%	98%	54%
2012	13%	14%	45%	60%	37%	20%	63%	84%	97%	70%	14%	39%	85%	98%	54%
2013	10%	12%	50%	52%	31%	18%	69%	87%	98%	70%	17%	57%	83%	97%	62%
2014	1%*	22%	59%	47%	32%	21%	67%	86%	96%	71%	15%	49%	85%	97%	60%
2015	11%	15%	41%	66%	38%	21%	63%	89%	94%	70%	18%	59%	89%	99%	68%*
2016	5%	23%	44%	70%	37%	17%	61%	91%	95%	69%	20%	38%*	87%	98%	67%
2017	5%	20%	39%	35%*	24%	19%	60%	88%	95%	67%	19%	46%	90%	99%	71%
2018	7%	29%	58%	56%	39%*	17%	56%	92%	95%	67%	14%	48%	89%	98%	65%
2019	10%	24%	53%	69%	43%	21%	66%	93%	93%	69%	20%	66%*	90%	84%*	66%
2020	14%	26%	45%	62%	43%	29%	67%	90%	97%	72%	26%	56%	92%	98%*	75%*

NOTE: Includes covered workers enrolled in self-funded plans in which the firm's liability is limited through stoploss coverage. Estimates for POS plans are not shown due to high relative standard errors. See the glossary at the end of Section 10 for definitions of self-funded, fully-insured, and level-funded premium plans. Information on funding status for HDHP/SOs was not collected prior to 2006.

* Estimate is statistically different from estimate for the previous year shown ($p < .05$).

SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

Figure 10.6
Percentage of Covered Workers Enrolled in a Self-Funded Plan by Firm Ownership Type, 2020



Tests found no statistical difference between firm ownership type ($p < .05$).
NOTE: Includes covered workers enrolled in self-funded plans in which the firm's liability is limited through stoploss coverage. Private firms include both private for-profit and private not-for-profit. Sixty-nine percent of covered workers in private for-profits and 61% of workers enrolled at private not-for-profits are self-funded
SOURCE: KFF Employer Health Benefits Survey, 2020

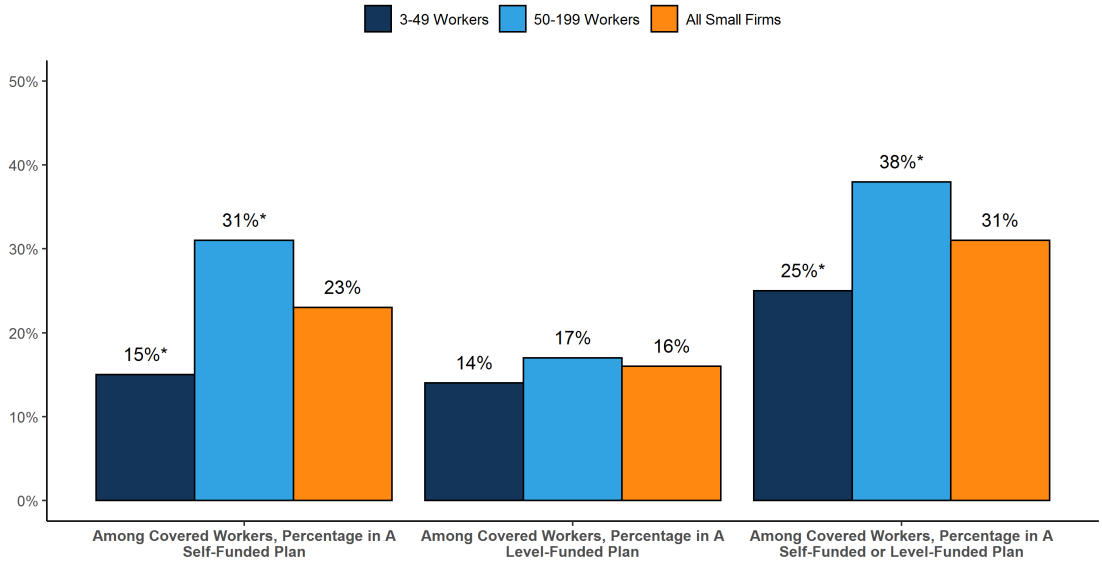
LEVEL-FUNDED PLANS

In the past few years, insurers have begun offering health plans that provide a nominally self-funded option for small or mid-sized employers that incorporates stoploss insurance with relatively low attachment points. Often, the insurer calculates an expected monthly expense for the employer, which includes a share of the estimated annual cost for benefits, premium for the stoploss protection, and an administrative fee. The employer pays this "level premium" amount, with the potential for some reconciliation between the employer and the insurer at the end of the year, if claims differ significantly from the estimated amount. These policies are sold as self-funded plans, so they generally are not subject to state requirements for insured plans and, for those sold to employers with fewer than 50 employees, are not subject to the rating and benefit standards in the ACA for small firms.

Due to the complexity of the funding (and regulatory status) of these plans, and because employers often pay a monthly amount that resembles a premium, respondents may be confused as to whether or not their health plan is self-funded or insured. We asked employers with fewer than 200 workers whether they have a level-funded plan.

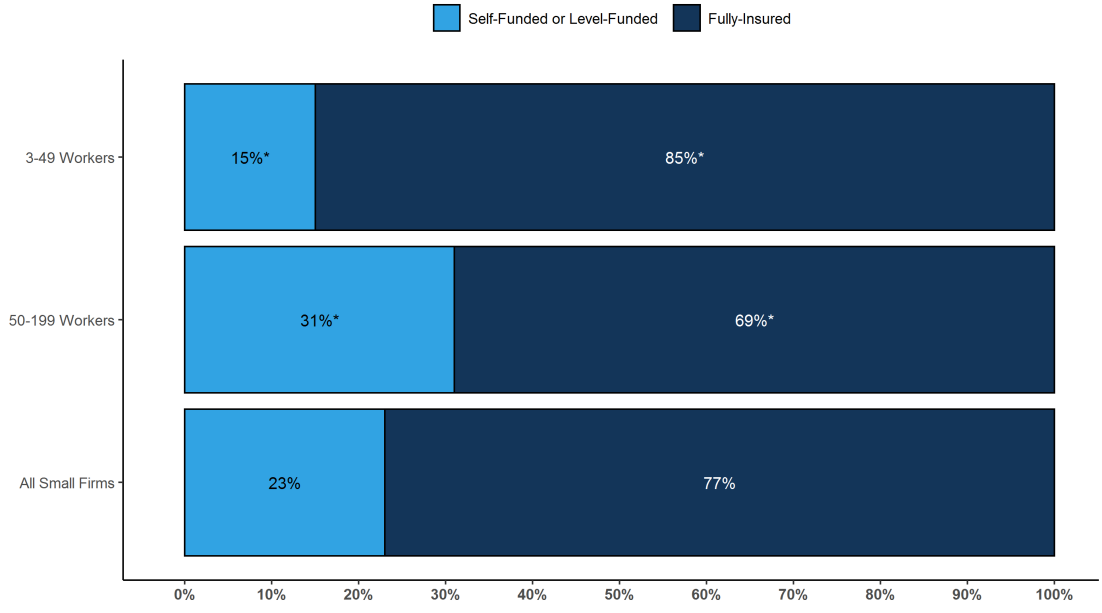
- Thirteen percent of small firms offer a level-funded plan in 2020, similar to the percentage (7%) last year.
- Thirty-one percent of covered workers in small firms are in a plan that is either self-funded or level-funded in 2020, higher than the percentage (24%) last year [Figure 10.7].

Figure 10.7
Among Covered Workers at Small Firms, Percentage Enrolled in a Level-Funded or Self-Funded Plan, by Firm Size, 2020



* Estimates are statistically different from estimate for all other firms not in the indicated category within each firm size ($p < .05$).
NOTE: See the glossary at the end of Section 10 for definitions of self-funded, fully-insured, and level-funded premium plans. Small Firms have 3-199 workers. This figure shows the percentage of covered workers; In 2020,13% of small firms reported that they had a level-funded plan. This includes respondents who indicated both that their plan was level-funded and fully insured.
SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 10.8
Among Covered Workers at Small Firms, Percentage Enrolled in a Level-Funded or Self-Insured Plan, by Firm Size, 2020



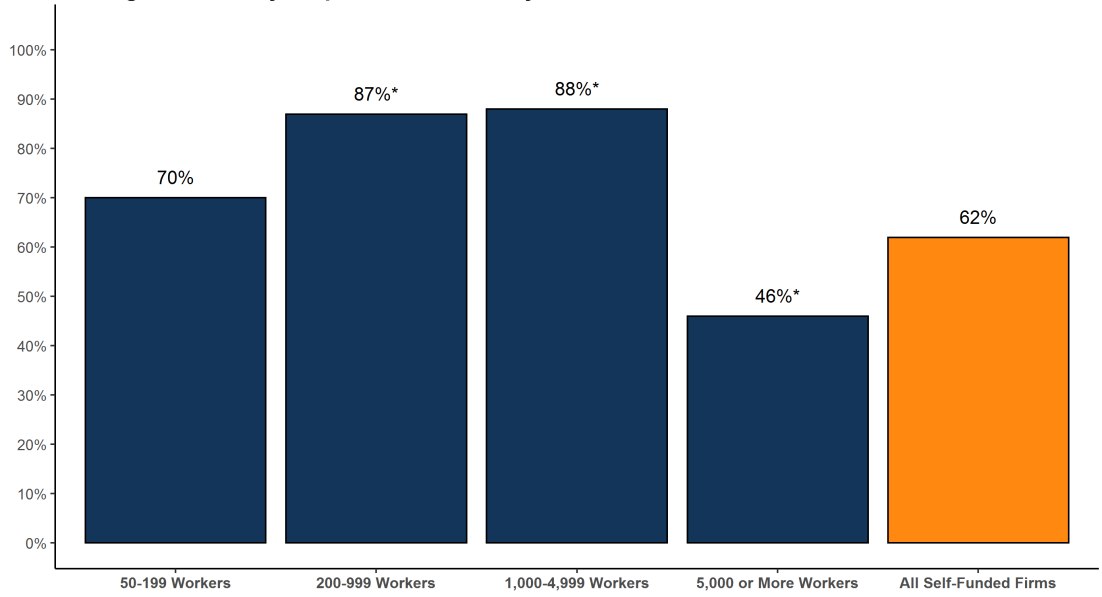
* Estimate is statistically different from estimate for all other firms not in the indicated size category ($p < .05$).
NOTE: See the glossary at the end of Section 10 for definitions of self-funded, fully-insured, and level-funded premium plans.
SOURCE: KFF Employer Health Benefits Survey, 2020

STOPLOSS COVERAGE AND ATTACHMENT POINTS

Stoploss coverage may limit the amount of claims that must be paid by a plan sponsor for each worker or may limit the total amount the plan sponsor must pay for all claims over the plan year. At firms with 50 or more workers, sixty-two percent of covered workers in self-funded health plans are in plans that have stoploss insurance, similar to percentage the last time we asked the question in 2018 [Figure 10.9].

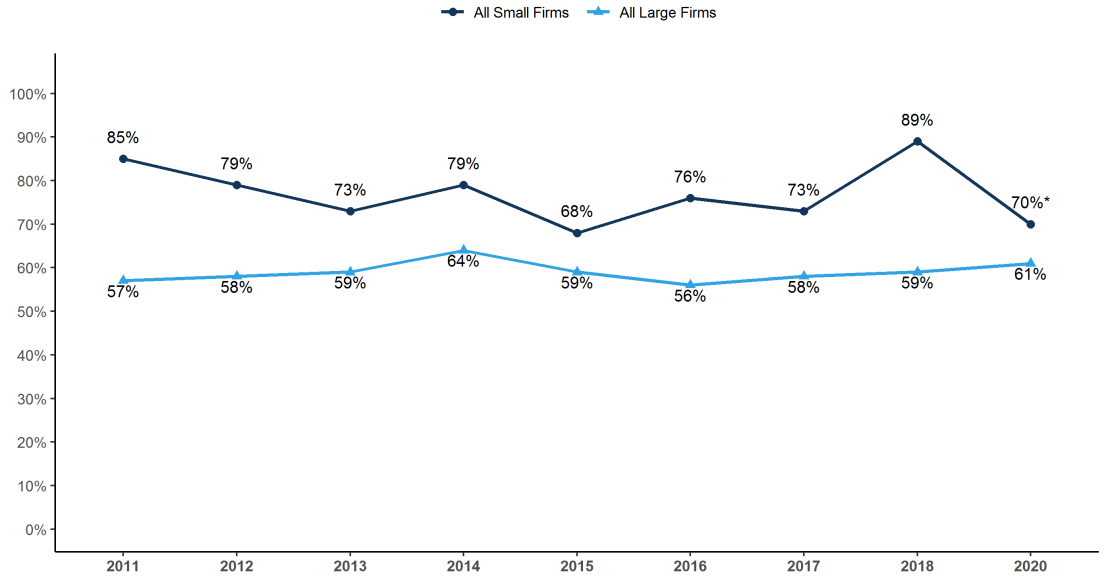
- The percentage of covered workers in self-funded plans with stoploss insurance (62%) is similar to the value when the survey first asked about stoploss insurance in 2011 (58%). [Figure 10.10].
- Among covered workers in self-funded plans with 50 or more workers that have stoploss, 87% are in plans where the stoploss insurance limits the amount the plan must spend on each worker or enrollee, 57% are in plans where the stoploss insurance limits the overall amount the plan must pay, 70% are in plans where the stoploss insurance limits the amounts that the plans must pay for high claims or episodes, and 10% are in plans where the stoploss insurance includes a different type of limit. Respondents were asked to choose all of the options that applied to their stoploss coverage [Figures 10.11]. Some plans have several limits applying to their plan. Starting in 2020, we restructured these questions and, while we believe the answers are similar to 2011 through 2018, changes in question wording may impact responses.
- Firms with 50 or more workers who have a per-enrollee stoploss coverage component were asked for the dollar amount where the stoploss coverage would start to pay for most or all of the claim (called an attachment point). The average attachment points for these firms are $100,000 for small firms (50-199) and $380,000 for large firms [Figure 10.13].

Figure 10.9
Among Covered Workers Enrolled in a Self-Funded Plan (At Firms with 50 of More Workers), Percentage Covered by Stoploss Insurance, by Firm Size, 2020



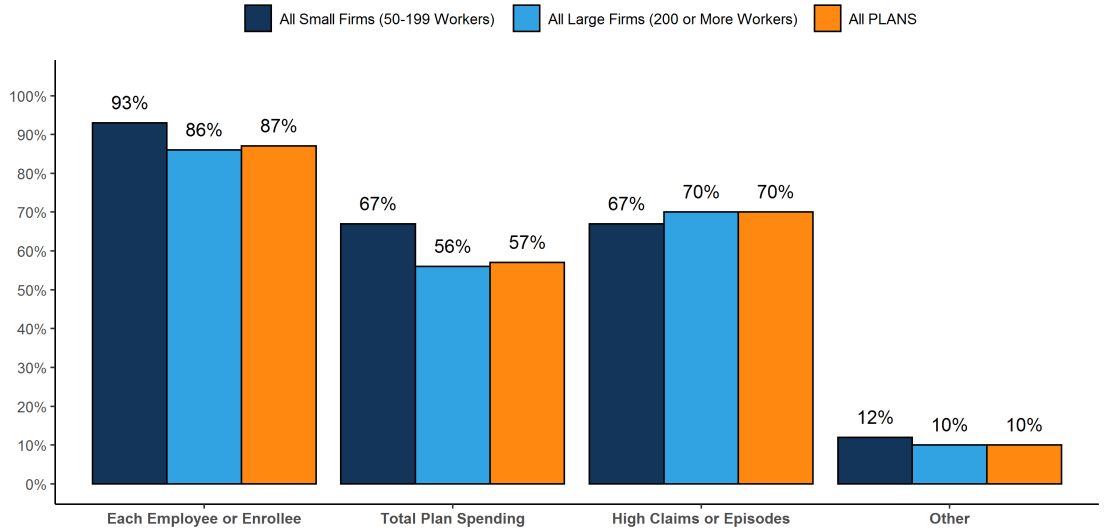
* Estimate is statistically different from estimate for all other firms not in the indicated size category ($p < .05$).
NOTE: Includes covered workers enrolled in self-funded plans in which the firm's liability is limited through stoploss coverage. See the glossary at the end of Section 10 for definitions of self-funded, fully-insured, and level-funded premium plans.
SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 10.10
Among Covered Workers Enrolled in a Self-Funded Plan, Percentage Covered by Stoploss Insurance (At Firms with 50 or More Workers), by Firm Size, 2011-2020



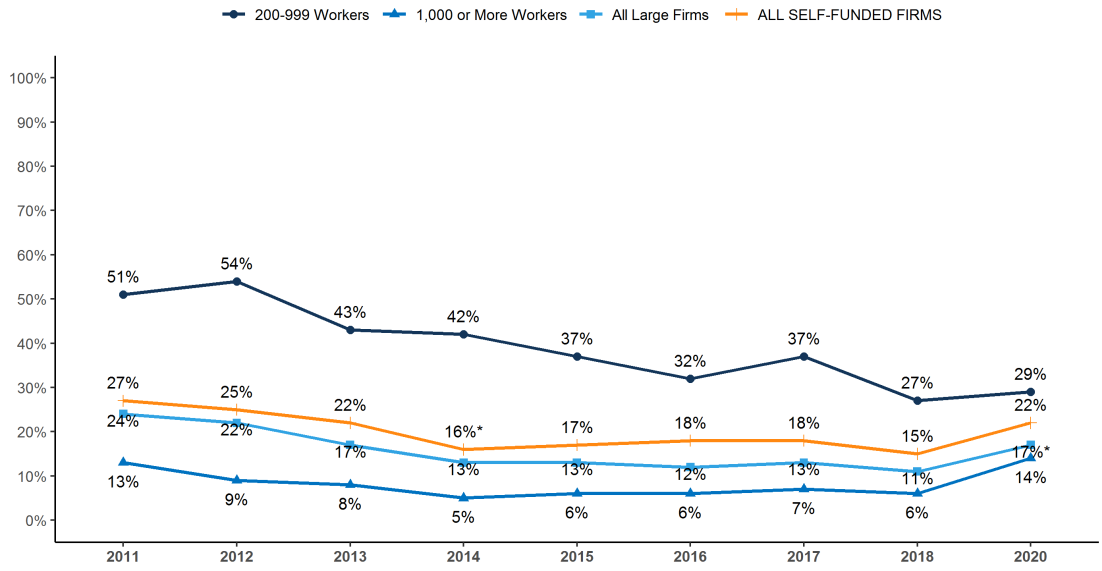
* Estimate is statistically different from estimate for the previous year shown (p < .05).
NOTE: Includes covered workers enrolled in self-funded plans in which the firm's liability is limited through stoploss coverage. Small Firms have 3-199 workers and Large Firms have 200 or more workers. We did not ask about stoploss coverage in 2019.
SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2011-2017

Figure 10.11
Among Covered Workers at Firms (50 or More Workers) Who Purchase Stoploss Coverage, Percent of Covered Workers Enrolled in Plans With Various Limits on the Plan's Liability, by Firm Size, 2020



Tests found no statistical difference from estimate for all other firms not in the indicated size or region category (p < .05).
NOTE: A per-enrollee spending limit includes stoploss insurance plans that limit a firm's per-enrollee spending. Attachment points refer to the dollar amount at which stoploss coverage begins to pay for most or all of a claimSee the glossary at the end of Section 10 for definitions of self-funded, fully-insured, and level-funded premium plans.
SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 10.12
Among Self-Funded Firms (50 or More Workers) With Stoploss Coverage, Percentage of Covered Workers Enrolled in a Plan With an Attachment Point of $100,000 or Less, by Firm Size, 2011-2020



* Estimate is statistically different from estimate for the previous year shown (p < .05).
NOTE: Among workers covered by a stoploss policy that includes a per-person limit. Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2011-2017

Figure 10.13
Prevalence and Average Attachment Points of Stoploss Insurance, by Firm Size and Region, 2020

	Percentage of Covered Workers in a Self-Funded Plan	Percentage Enrolled in a Self-Funded Plan With Stoploss Insurance	Percentage Enrolled in a Self-Funded Plan With Stoploss Insurance With a Per-Enrollee Spending Limit	Average Attachment Point
FIRM SIZE				
200-999 Workers	59*	87*	87	230,000*
1,000-4,999 Workers	85*	88*	86	310,000
5,000 or More Workers	94*	46*	86	510,000*
All Small Firms (3-199 Workers)	**31%***	**70%**	**93%**	**$100,000***
All Large Firms (200 or More Workers)	**84%***	**61%**	**86%**	**$380,000***
All Self-Funded Firms	**76%**	**62%**	**87%**	**$350,000**

NOTE: A per-enrollee spending limit includes stoploss insurance plans that limit a firm's per-enrollee spending as well as plans that have other limits. Attachment points refer to the dollar amount at which stoploss coverage begins to pay for most or all of a claim, and are rounded to the nearest $1,000. See the glossary at the end of Section 10 for definitions of self-funded, fully-insured, and level-funded premium plans. There was insufficient data to report estimates for firms with 3 to 49 workers.

* Estimate is statistically different from estimate for all other firms not in the indicated size or region category (p < .05).

SOURCE: KFF Employer Health Benefits Survey, 2020

Self-Funded Plan An insurance arrangement in which the employer assumes direct financial responsibility for the costs of enrollees' medical claims. Employers sponsoring self-funded plans typically contract with a third-party administrator or insurer to provide administrative services for the self-funded plan. In some cases, the employer may buy stoploss coverage from an insurer to protect the employer against very large claims.

Fully-Insured Plan An insurance arrangement in which the employer contracts with a health plan that assumes financial responsibility for the costs of enrollees' medical claims.

Level-Funded Plan An insurance arrangement in which the employer makes a set payment each month to an insurer or third party administrator which funds a reserve account for claims, administrative costs, and premiums for stop-loss coverage. When claims are lower than expected, surplus claims payments may be refunded at the end of the contract.

Stoploss Coverage Stoploss coverage limits the amount that a plan sponsor has to pay in claims. Stoploss coverage may limit the amount of claims that must be paid for each employee or may limit the total amount the plan sponsor must pay for all claims over the plan year.

Attachment Point Attachment points refer to the amount at which the insurer begins to pay its obligations for stoploss coverage, either because plan, individual or claim spending exceed a designated value.

Employer Health Benefits
2020 Annual Survey

Retiree Health Benefits

SECTION 11

Section 11

Retiree Health Benefits

Retiree health benefits are an important consideration for older workers making decisions about their retirement. Retiree benefits can be a crucial source of coverage for people retiring before Medicare eligibility. For retirees with Medicare coverage, retiree health benefits can provide an important supplement to Medicare, helping them pay for cost sharing and benefits not otherwise covered by Medicare.

In 2019, we modified the question that we use to ask firms whether or not they provide retiree health benefits; specifically, in contrast to prior years, the 2019 and 2020 surveys explicitly stated that firms that had terminated retiree health benefits but still has some retirees getting coverage, or that had current employees who will get retiree health coverage in the future, should answer 'yes' to the question. For this reason, estimates of retiree health benefits from 2019 onwards are not comparable to prior surveys.

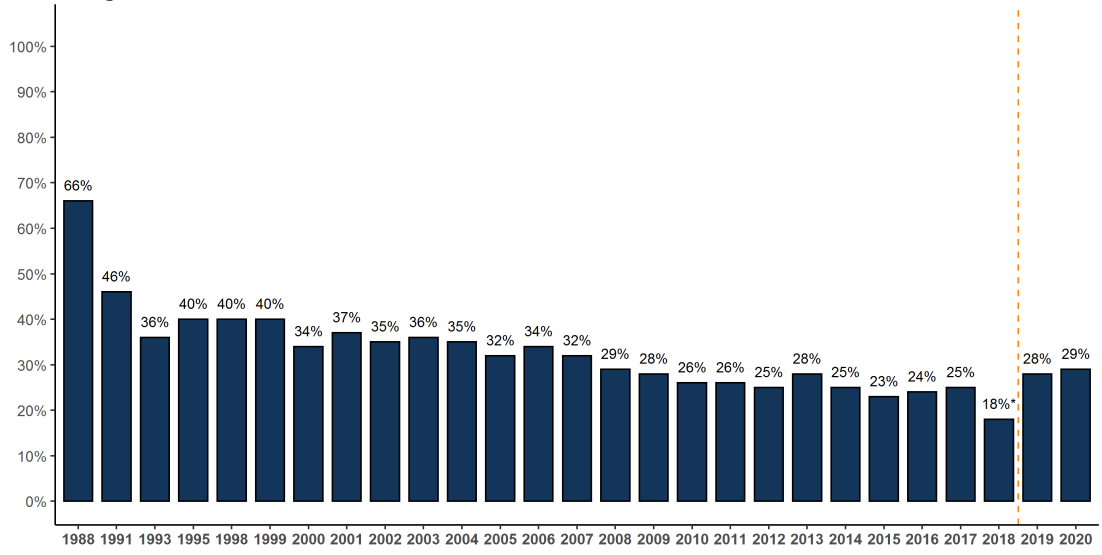
This year's survey finds that 29% of large firms offering health benefits offer retiree health benefits, similar to the percentage (28%) in 2019.

This survey asks retiree health benefits questions only of large firms (200 or more workers).

EMPLOYER RETIREE BENEFITS

- In 2020, 29% of large firms that offer health benefits offer retiree health benefits for at least some current workers or retirees, similar to the percentage last year [Figure 11.1]. See the Methods section for a discussion of changes to survey question on retiree health benefits for 2019 survey. Due to this change, we did not test to see if current percentage is different than those in 2018 or before.
- Retiree health benefits offer rates vary considerably by firm characteristics.
  - Among large firms offering health benefits, the likelihood that a firm will offer retiree health benefits increases with firm size [Figure 11.2].
  - The share of large firms offering retiree health benefits varies considerably by industry [Figure 11.2].
  - Among large firms offering health benefits, public employers are more likely (66%) to offer retiree health benefits than other firm types [Figure 11.3].
  - Large firms offering health benefits with at least some union workers are more likely to offer retiree health benefits than large firms without any union workers (47% vs. 23%) [Figure 11.3].
  - Large firms offering health benefits with a relatively large share of older workers (where at least 35% of the workers are age 50 or older) are more likely to offer retiree health benefits than large firms with a smaller share of older workers (39% vs. 20%) [Figure 11.3].
  - Large firms offering health benefits with a relatively large share of higher-wage workers (where at least 35% of workers earn $64,000 a year or more) are more likely to offer retiree health benefits than large firms with a smaller share of higher-wage workers (38% vs. 23%) [Figure 11.3].

Figure 11.1
Among Large Firms Offering Health Benefits to Active Workers, Percentage of Firms Offering Retiree Health Benefits, 1988-2020



* Estimate is statistically different from estimate for the previous year shown ($p < .05$). No statistical tests are conducted for years prior to 1999.
NOTE: Large Firms have 200 or more workers. In 2019, this question was reworded. Because of this there was no statistical testing between 2018 and 2019. See the Methods section for details.
SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017; KPMG Survey of Employer-Sponsored Health Benefits, 1991, 1993, 1995, 1998; The Health Insurance Association of America (HIAA), 1988.

Figure 11.2

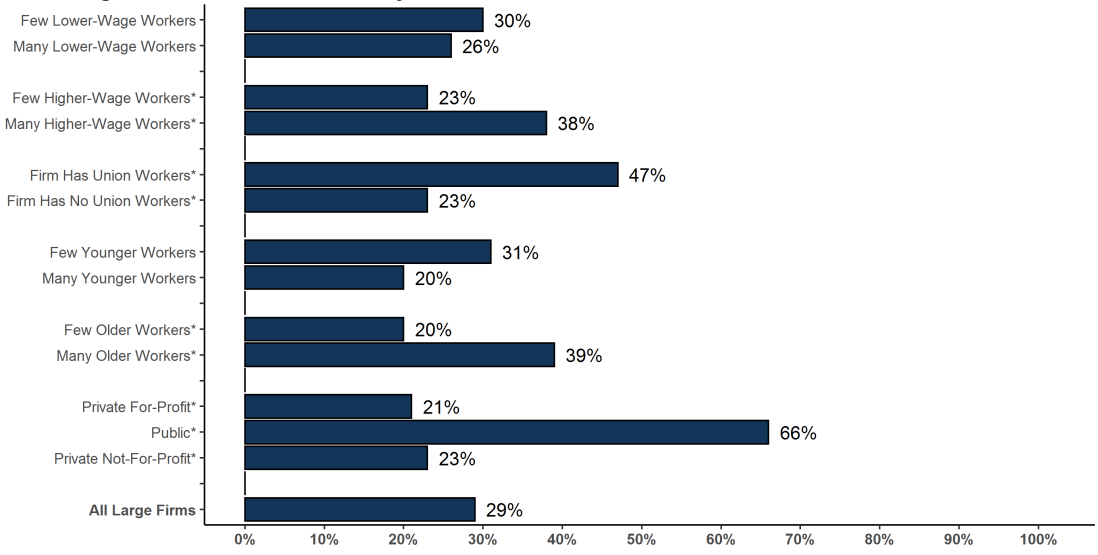
Among Large Firms Offering Health Benefits to Active Workers, Percentage of Firms Offering Retiree Health Benefits, by Firm Size, Region, and Industry, 2020

	Large Firms Offering Retiree Health Benefits
FIRM SIZE	
200-999 Workers	27%*
1,000-4,999 Workers	37*
5,000 or More Workers	52*
REGION	
Northeast	28%
Midwest	29
South	33
West	25
INDUSTRY	
Agriculture/Mining/Construction	15%*
Manufacturing	16*
Transportation/Communications/Utilities	58*
Wholesale	13*
Retail	12*
Finance	42
Service	26
State/Local Government	74*
Health Care	16*
All Large Firms (200 or More Workers)	**29%**

* Estimate is statistically different from estimate for all other Large Firms not in the indicated size, region, or industry category ($p < .05$).

SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 11.3
Among Large Firms Offering Health Benefits to Active Workers, Percentage of Firms Offering Retiree Health Benefits, by Firm Characteristics, 2020

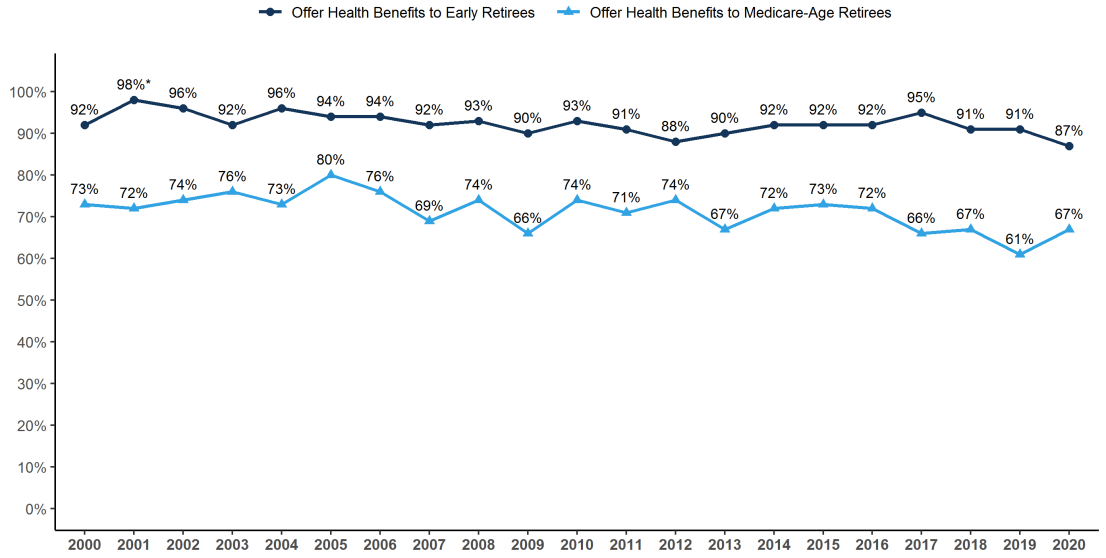


* Estimates are statistically different from each other within category ($p < .05$).
NOTE: Large Firms have 200 or more workers. Firms with many lower-wage workers are those where at least 35% earn the 25th percentile or less of national earnings ($26,000 in 2020). Firms with many higher-wage workers are those where at least 35% earn the 75th percentile or more than of national earnings ($64,000 in 2020). Firms with many older workers are those where at least 35% of workers are age 50 or older. Firms with many younger workers are those where at least 35% of workers are age 26 or younger.
SOURCE: KFF Employer Health Benefits Survey, 2020

EARLY RETIREES, MEDICARE-AGE RETIREES AND SPOUSES

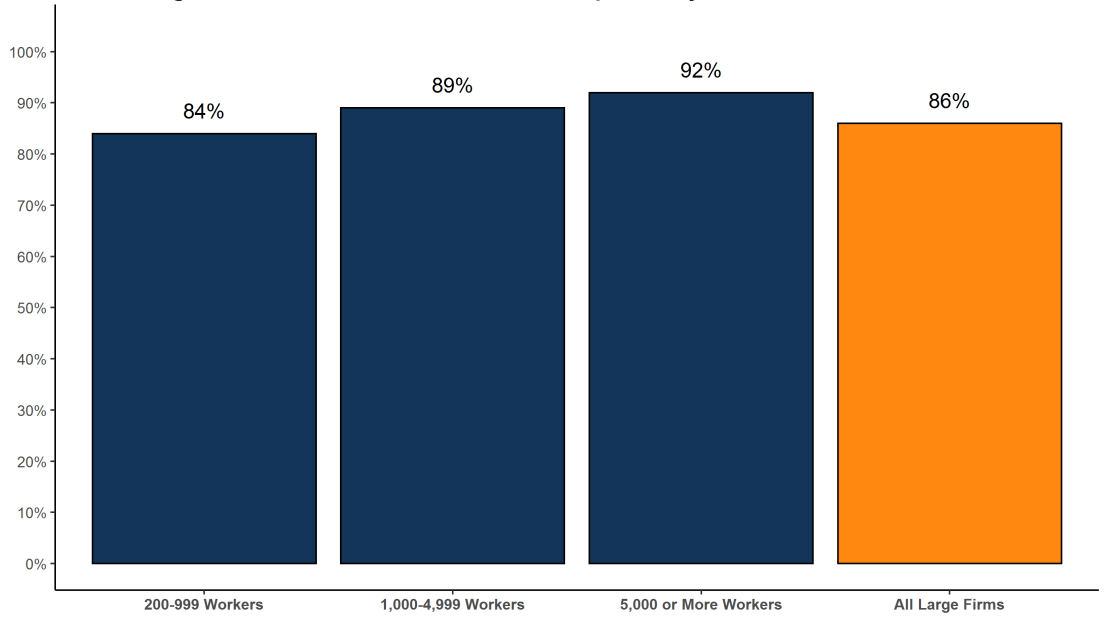
- Among large firms offering retiree health benefits, 87% offer benefits to early retirees under the age of 65 and 67% offer them to Medicare-age retirees [Figure 11.4].
- Among all large firms offering health benefits to current workers, 20% offer retiree health benefits to Medicare-age retirees.
- Among large firms offering retiree health benefits, 56% offer benefits to both early and Medicare-age retirees.
- Among large firms offering retiree benefits, a large share (86%) report offering health benefits to the spouses of retirees [Figure 11.5].

Figure 11.4
Among Large Firms Offering Health Benefits to Active Workers and Retirees, Percentage of Firms Offering Health Benefits to Early and Medicare-Age Retirees, 2000-2020



* Estimate is statistically different from estimate for the previous year shown (p < .05).
NOTE: Among Large Firms offering health benefits to active workers and offering retiree coverage, 56% offer health benefits to both early and Medicare-age retirees. Large Firms have 200 or more workers. Early retirees are those who retire before the age of 65. In 2019 this question was reworded. Because of this there was no statistical testing between 2018 and 2019. See the Methods section for details.
SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2000-2017

Figure 11.5
Among Large Firms Offering Health Benefits to Active Workers and Retirees, Percentage of Firms Offering Retiree Health Benefits to Retirees' Spouse, by Firm Size, 2020

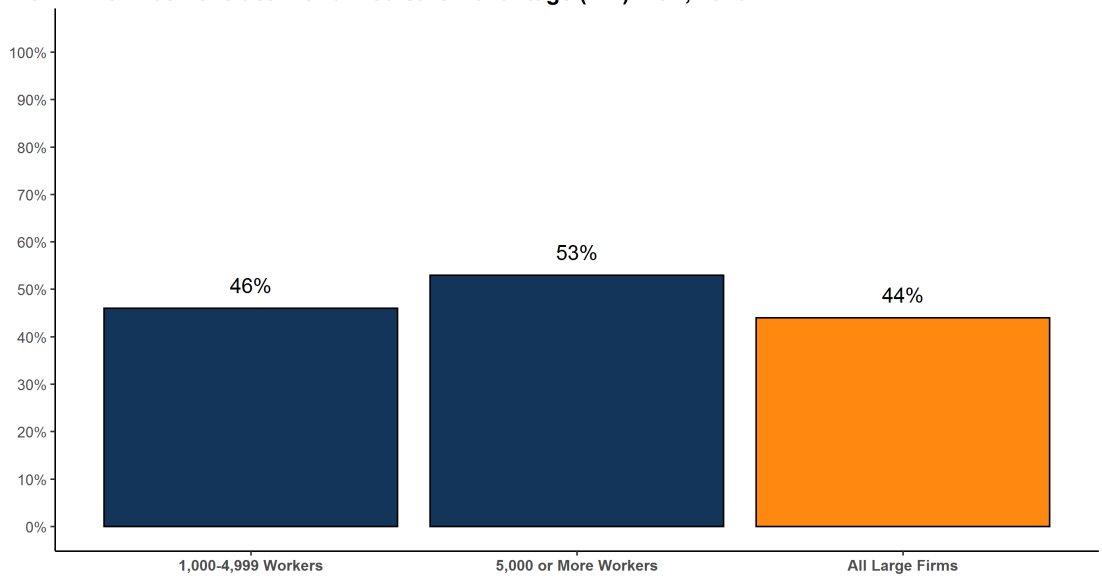


Tests found no statistical difference from estimate for all other firms not in the indicated size category (p < .05).
NOTE: Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2020

MEDICARE ADVANTAGE

- Forty-four percent of large employers offering retiree health benefits to Medicare-age retirees offer coverage to at least some Medicare-age retirees through a contract with a Medicare Advantage plan, similar to the percentage last year (44%) [Figure 11.6].

Figure 11.6
Among Large Firms That Offer Retiree Health Benefits to Medicare-Age Retirees, Percentage of Firms That Contract with a Medicare Advantage (MA) Plan, 2020



Tests found no statistical difference from estimate for all other firms not in the indicated size category ($p < .05$).
NOTE: MA refers to Medicare Advantage, an arrangement where private health plans receive capitated payments to provide all Medicare-covered services to enrollees. Sixty-seven percent of large firms offering retiree health benefits offer retiree health benefits to Medicare-age retirees. Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2020

Employer Health Benefits
2020 Annual Survey

Health Screening and Health Promotion and Wellness Programs

SECTION 12

Section 12

Health Screening and Health Promotion and Wellness Programs

Most firms offer some form of wellness program to help workers and family members identify health issues and manage chronic conditions. Many employers believe that improving the health of their workers and their family members can improve morale and productivity, as well as reduce health care costs.

In addition to offering wellness programs, a majority of large firms now offer health screening programs, including health risk assessments, which are questionnaires asking workers about lifestyle, stress, or physical health, and biometric screening, which we define as in-person health examinations conducted by a medical professional. Firms and insurers may use the health information collected during screenings to target wellness offerings or other health services to workers with certain conditions or behaviors. Some firms have incentive programs that reward or penalize workers for different activities, including participating in wellness programs or completing health screenings.

Among large firms offering health benefits in 2020, 60% offer workers the opportunity to complete a health risk assessment, 50% offer workers the opportunity to complete a biometric screening, and 81% offer workers one or more wellness programs, such as programs to help them stop smoking or lose weight, or programs that offer lifestyle and behavioral coaching. Substantial shares of these large firms provide incentives for workers to participate in or complete the programs.

Only firms offering health benefits were asked about their wellness and health promotion programs.

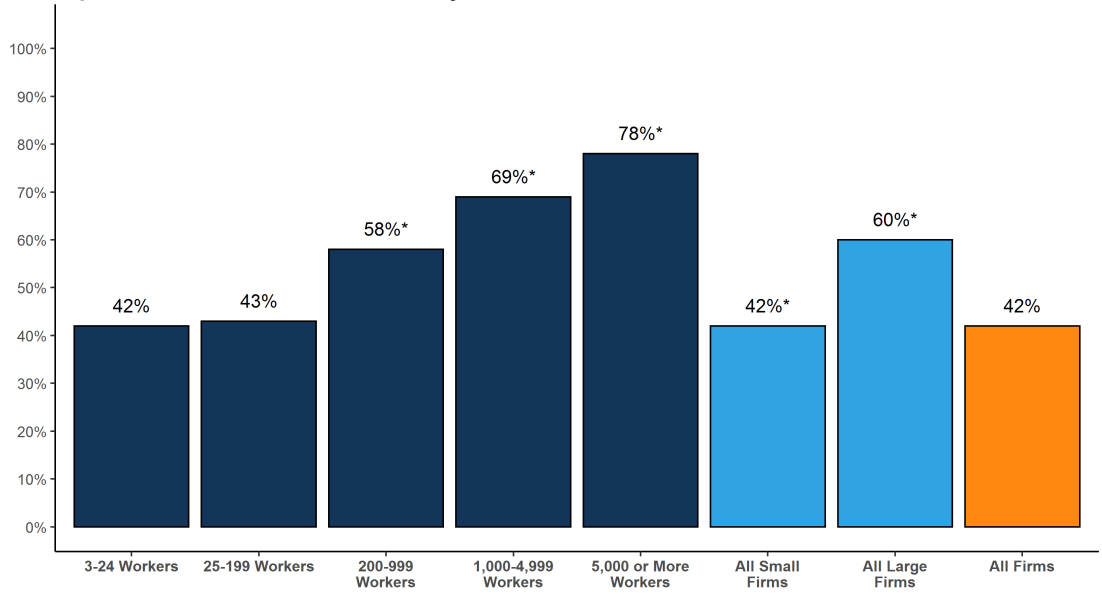
Employers have been and continue to deal with the coronavirus pandemic, including by modifying wellness and screening programs and employee assistance programs. For example, some employees may not be available for health screening or may not be able to participate in wellness-related programs. Some employers may have chosen to modify or suspend financial incentives due to potential difficulties with employees achieving compliance. Due to the timing of the survey, we were not able to include questions about how employers may have adapted their health plans and employee assistance programs to address some of the impacts of the epidemic.

HEALTH RISK ASSESSMENTS

Many firms provide workers the opportunity to complete a health risk assessment to identify potential health issues. Health risk assessments generally include questions about medical history, health status, and lifestyle. At small firms, health risk assessments are often administered by an insurer.

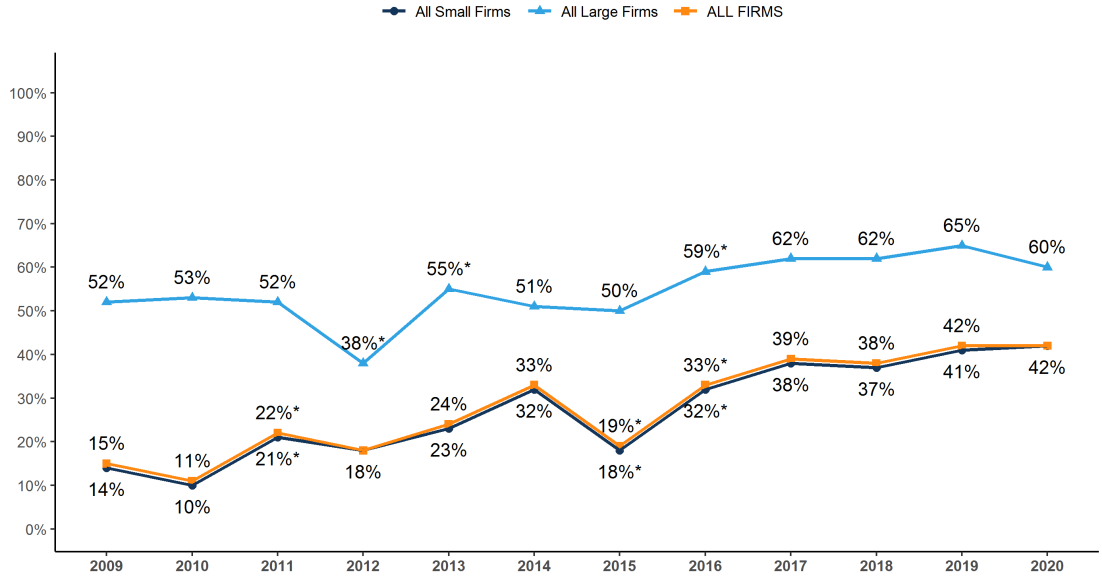
- Among firms offering health benefits, 42% of small firms and 60% of large firms provide workers the opportunity to complete a health risk assessment [Figure 12.1]. These percentages are similar to the corresponding percentages for 2019 (41% for small firms and 65% for large firms) [Figure 12.2].
- Some firms offer incentives to encourage workers to complete a health risk assessment.
  - Among large firms that offer a health risk assessment, 52% offer workers an incentive to complete the assessment [Figure 12.3].

Figure 12.1
Among Firms Offering Health Benefits, Percentage of Firms That Provide an Opportunity to Complete a Health Risk Assessment, by Firm Size, 2020



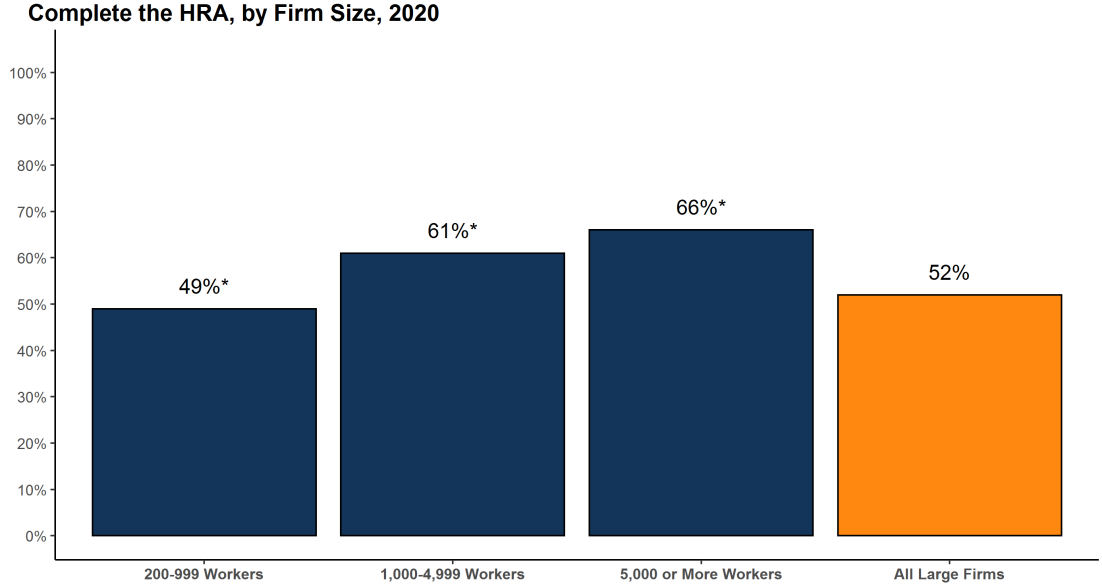
* Estimate is statistically different from estimate for all other firms not in the indicated size category (p < .05).
NOTE: A health risk assessment or appraisal includes questions on medical history, health status, and lifestyle and is designed to identify the health risks of the person being assessed. Small Firms have 3-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 12.2
Among Firms Offering Health Benefits, Percentage of Firms That Provide an Opportunity to Complete a Health Risk Assessment, by Firm Size, 2009-2020



* Estimate is statistically different from estimate for the previous year shown (p < .05).
NOTE: A health risk assessment or appraisal includes questions on medical history, health status, and lifestyle and is designed to identify the health risks of the person being assessed. Small Firms have 3-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2009-2017

Figure 12.3
Among Large Firms Offering Health Benefits and Providing an Opportunity to Complete a Health Risk Assessment (HRA), Percentage of Firms That Offer Workers Incentives to Complete the HRA, by Firm Size, 2020



* Estimate is statistically different from estimate for all other firms not in the indicated size category ($p < .05$).
NOTE: A health risk assessment or appraisal includes questions on medical history, health status, and lifestyle and is designed to identify the health risks of the person being assessed. Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2020

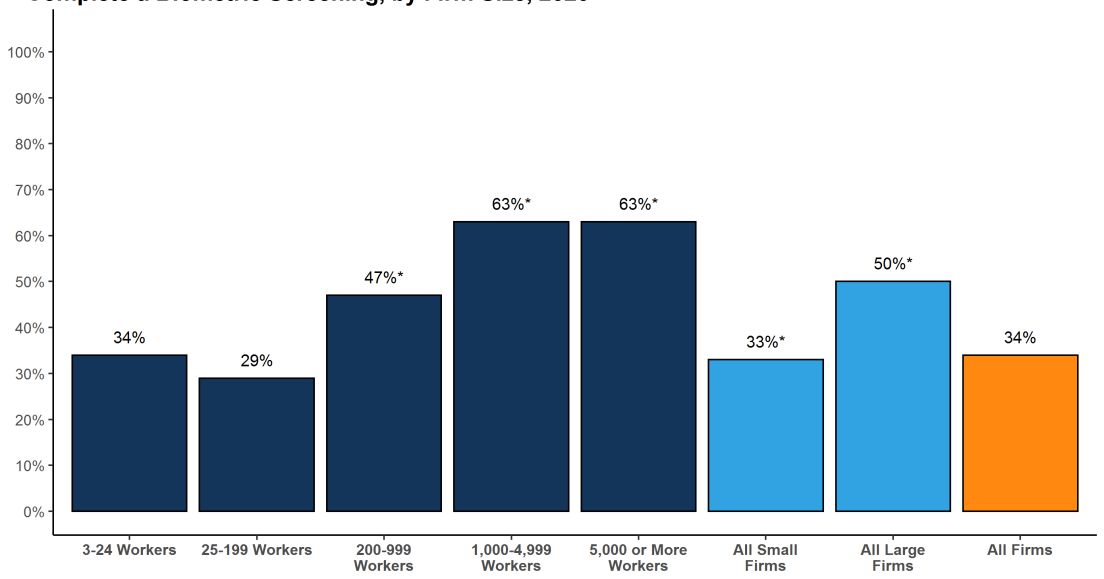
BIOMETRIC SCREENING

Biometric screening is a health examination that measures a person's risk factors (such as cholesterol, blood pressure, and body mass index (BMI)) for certain medical issues. A biometric outcome involves assessing whether the person meets specified health targets related to certain risk factors, such as meeting a target BMI or cholesterol level. As defined by this survey, goals related to smoking are not included in the biometric screening questions.

- Among firms offering health benefits, 33% of small firms and 50% of large firms provide workers the opportunity to complete a biometric screening [Figure 12.4]. These percentages are similar to 2019 (26% and 52%) [Figure 12.5].
- Some firms offer incentives to encourage workers to complete the biometric screening.
  - Among firms with biometric screening programs, 17% of small firms and 65% of large firms offer workers an incentive to complete the screening [Figure 12.6].
- In addition to incentives for completing a biometric screening, some firms offer workers incentives to meet biometric outcomes. Among large firms with biometric screening programs, 18% reward or penalize workers based on achieving specified biometric outcomes (such as meeting a target BMI) [Figure 12.6].
  - The size of the incentives firms offer for meeting biometric outcomes varies considerably. Among large firms offering a reward or penalty for meeting biometric outcomes, the maximum reward is valued at $150 or less for 12% of firms and more than $1,000 for 32% of firms [Figure 12.7]. Seven percent of these firms combine the reward with incentives for other activities. This may

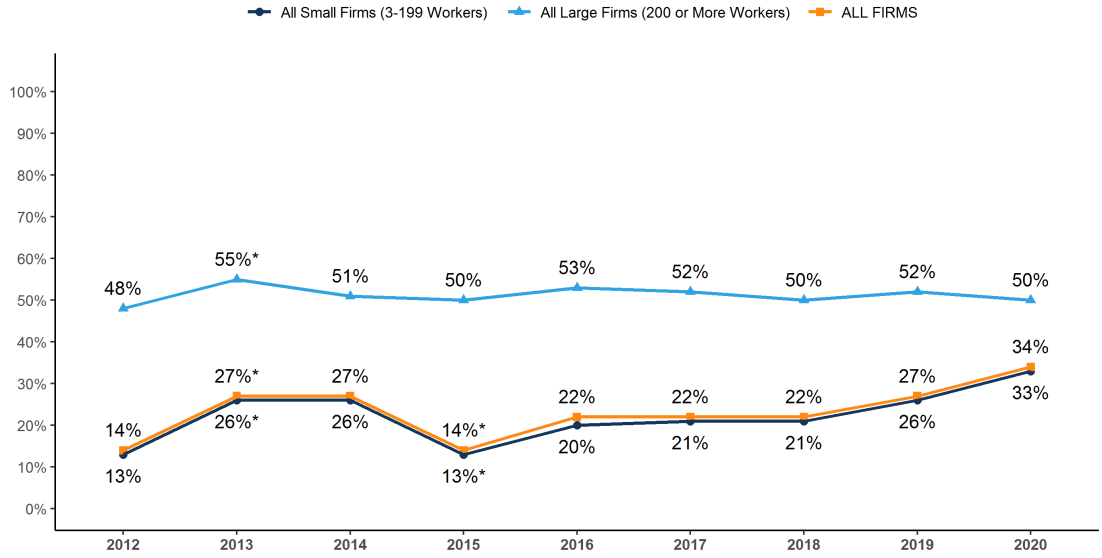
include employers who ask employees to complete several health screening, disease management, wellness/health promotion activities in order to qualify for incentives.

Figure 12.4
Among Firms Offering Health Benefits, Percentage of Firms That Provide an Opportunity to Complete a Biometric Screening, by Firm Size, 2020



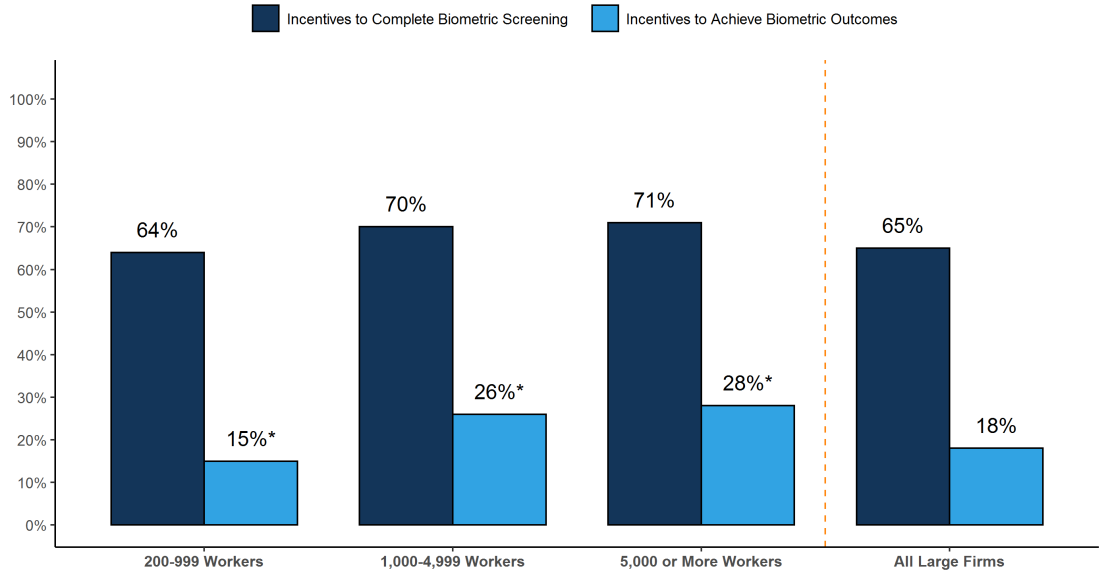
* Estimate is statistically different from estimate for all other firms not in the indicated size category ($p < .05$).
NOTE: Biometric screening is a health examination that measures a person's risk factors for certain medical issues. Biometric outcomes could include meeting a target body mass index (BMI) or cholesterol level, but not goals related to smoking. Small Firms have 3-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 12.5
Among Firms Offering Health Benefits, Percentage of Firms That Provide an Opportunity to Complete Biometric Screening, by Firm Size, 2012-2020



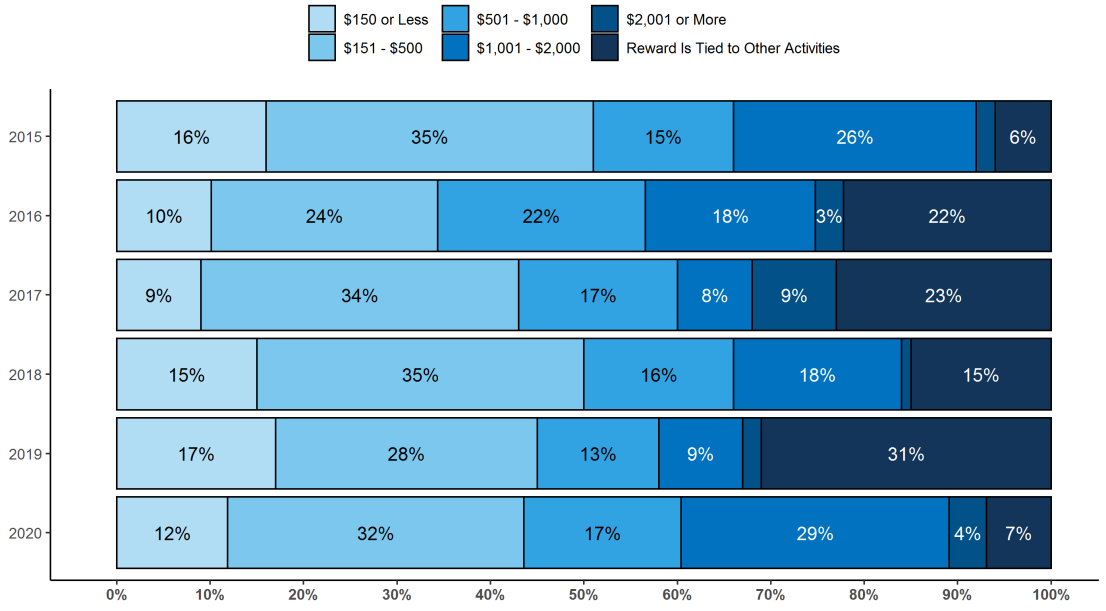
* Estimate is statistically different from estimate for the previous year shown (p < .05).
NOTE: Biometric screening is a health examination that measures a person's risk factors for certain medical issues. Biometric outcomes could include meeting a target body mass index (BMI) or cholesterol level, but not goals related to smoking. Small Firms have 3-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2012-2017

Figure 12.6
Among Large Firms Offering Health Benefits and Providing an Opportunity to Complete a Biometric Screening, Percentage of Firms with Incentives to Complete the Screening or Achieve Biometric Outcomes, by Firm Size, 2020



* Estimate is statistically different from estimate for all other firms not in the indicated size category (p < .05).
NOTE: Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 12.7
Among Large Firms Offering Workers an Incentive to Meet Biometric Outcomes, Maximum Value a Worker Can Receive for Achieving Outcomes, 2015-2020



Tests found no statistical difference from distribution for the previous year shown ($p < .05$).
NOTE: Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2015-2017

HEALTH SCREENING PROGRAMS

Among firms offering health benefits, 50% of small firms and 68% of large firms offer workers a health risk assessment, biometric screening or both screening programs.

- Forty percent of large firms offering health benefits have an incentive for workers to complete a biometric screening or health risk assessment [Figure 12.9].
- In large firms providing workers the opportunity to complete a health risk assessment, 44% of covered workers complete an assessment [Figure 12.11].
  - There is considerable variation across firms in the percentage of workers who complete the assessment. Twenty-one percent of large firms providing workers the opportunity to complete a health risk assessment report that more than 75% of their workers complete the assessment, while 37% report no more than 25% of workers complete the assessment.
- In large firms providing workers the opportunity to complete a biometric screening, 45% of covered workers complete a screening [Figure 12.11].
  - There is considerable variation across firms in the percentage of workers who complete a biometric screening. Twenty-one percent of large firms providing workers the opportunity to complete a biometric screening report that more than 75% of their workers complete the screening, while 33% report no more than 25% of workers complete the screening.

Figure 12.8

Among Large Firms Offering Health Benefits, Percentage of Firms That Provide an Opportunity to Complete a Biometric Screening or a Health Risk Assessment, by Region and Industry, 2020

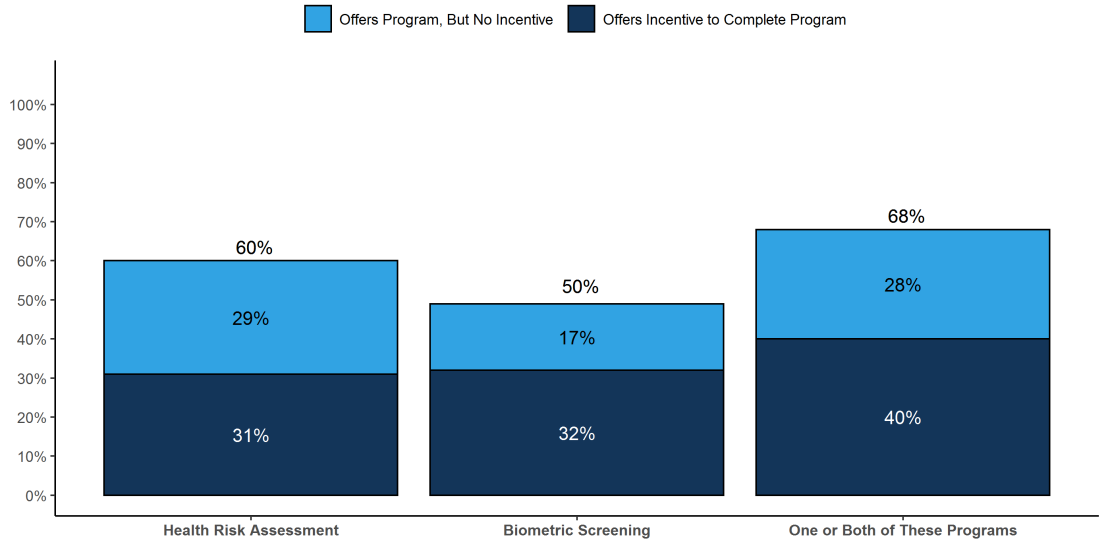
	Health Risk Assessment	Biometric Screening
REGION		
Northeast	55%	48%
Midwest	63	55
South	63	51
West	55	43
INDUSTRY		
Agriculture/Mining/Construction	56%	37%
Manufacturing	57	55
Transportation/Communications/Utilities	67	63
Wholesale	76	52
Retail	37*	29*
Finance	64	60
Service	60	47
State/Local Government	76*	71*
Health Care	51	40*
All Large Firms (200 or More Workers)	**60%**	**50%**

NOTE: A health risk assessment or appraisal includes questions on medical history, health status, and lifestyle and is designed to identify the health risks of the person being assessed. Biometric screening is a health examination that measures a person's risk factors for certain medical issues. Biometric outcomes could include meeting a target body mass index (BMI) or cholesterol level, but not goals related to smoking.

* Estimate is statistically different from estimate for all firms not in the indicated region or industry category ($p < .05$).

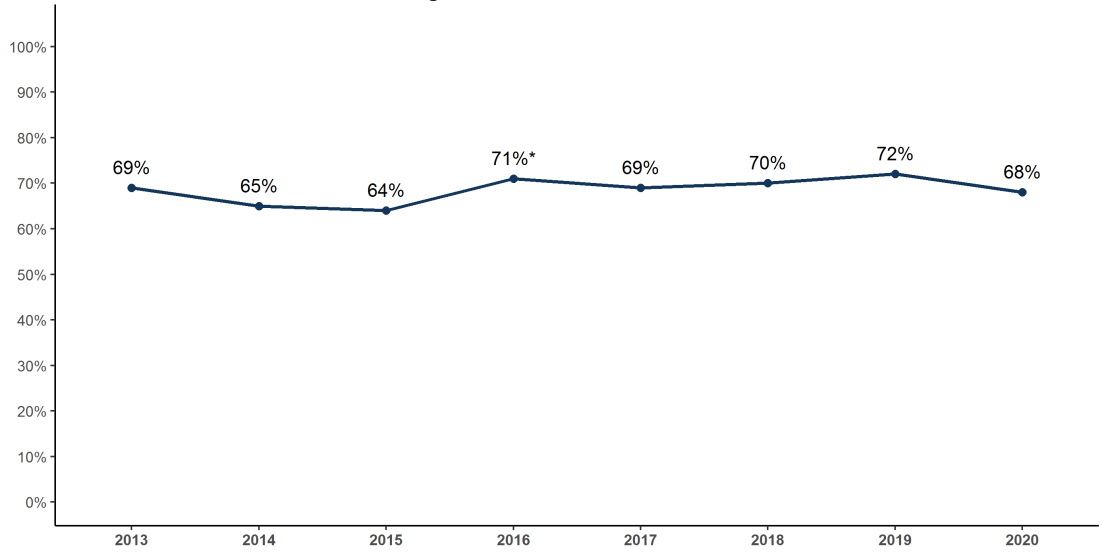
SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 12.9
Among Large Firms Offering Health Benefits, Percentage With Health Screening Programs, 2020



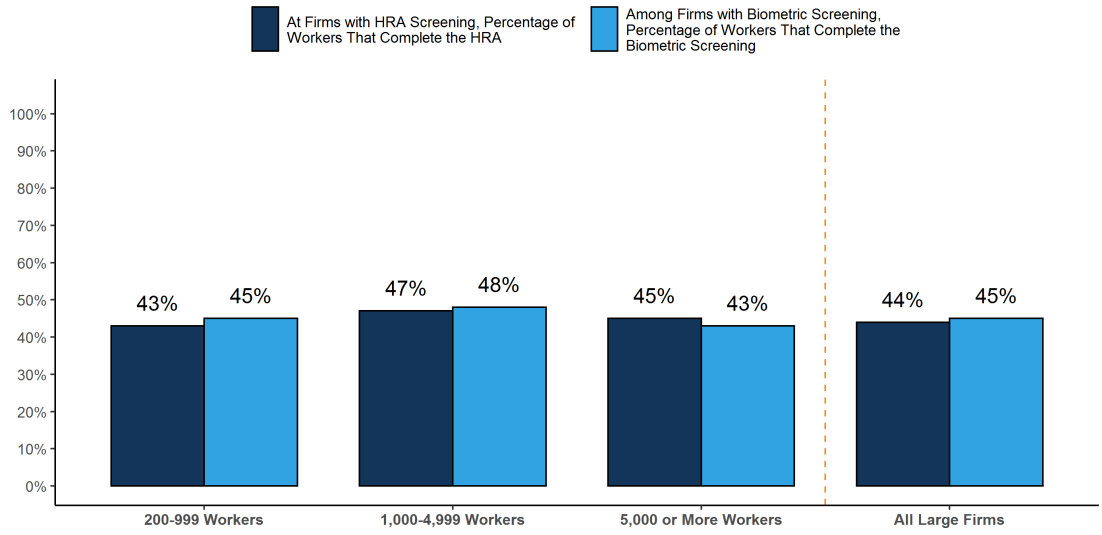
NOTE: A health risk assessment or appraisal includes questions on medical history, health status, and lifestyle and is designed to identify the health risks of the person being assessed. Biometric screening is a health examination that measures a person's risk factors for certain medical issues. Biometric outcomes could include meeting a target body mass index (BMI) or cholesterol level, but not goals related to smoking. Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 12.10
Among Large Firms Offering Health Benefits, Percentage With Either a Health Risk Assessment or a Biometric Screening, 2013-2020



* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
NOTE: A health risk assessment or appraisal includes questions on medical history, health status, and lifestyle and is designed to identify the health risks of the person being assessed. Biometric screening is a health examination that measures a person's risk factors for certain medical issues. Biometric outcomes could include meeting a target body mass index (BMI) or cholesterol level, but not goals related to smoking. Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 12.11
Among Large Firms Providing Workers an Opportunity to Complete a Biometric Screening or Health Risk Assessment, Percentage of Workers That Complete the Screening, by Firm Size, 2020



Tests found no statistical difference from estimate for all other firms not in the indicated size category ($p < .05$).
NOTE: There is considerable variation around these averages. For Health Risk Assessments: At 8% of firms, less than 10% of workers complete the screening, while at 5% of firms more than 90% complete it. For Biometric Scrrening. At 8% of firms, less than 10% of workers complete the screening, while at 5% of firms more than 90% complete it. Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2020

WELLNESS AND HEALTH PROMOTION PROGRAMS

Large shares of employers continue to offer educational and other programs to help workers engage in healthy lifestyles and reduce health risks. Wellness and health promotion programs may include exercise programs, health education classes, health coaching, and stress-management counseling. These programs may be offered directly by the firm, an insurer, or a third-party contractor.

- Among firms offering health benefits, 41% of small firms and 69% of large firms offer programs to help workers stop smoking or using tobacco, 36% of small firms and 58% of large firms offer programs to help workers lose weight, and 38% of small firms and 67% of large firms offer some other lifestyle or behavioral coaching program. Overall, 53% of small firms and 81% of large firms offering health benefits offer at least one of these three programs [Figure 12.12] and [Figure 12.13].
- Forty-four percent of large firms offering one of these wellness or health promotion programs offer an incentive to encourage workers to participate in or complete the programs [Figure 12.15]

Figure 12.12

Among Firms Offering Health Benefits, Percentage of Firms Offering Specific Wellness Programs to Their Workers, by Firm Size and Region, 2020

	Programs to Help Workers Stop Smoking	Programs to Help Workers Lose Weight	Other Lifestyle or Behavioral Coaching	At Least One of These Programs
FIRM SIZE				
3-49 Workers	38%*	34%*	36%*	51%*
50-199 Workers	60*	47*	51*	72*
200-999 Workers	66*	56*	65*	79*
1,000-4,999 Workers	81*	67*	74*	89*
5,000 or More Workers	87*	78*	84*	95*
All Small Firms (3-199 Workers)	**41%***	**36%***	**38%***	**53%***
All Large Firms (200 or More Workers)	**69%***	**58%***	**67%***	**81%***
REGION				
Northeast	50%	41%	46%	62%
Midwest	40	29	34	49
South	41	41	42	62
West	37	33	31	40*
ALL FIRMS	**41%**	**36%**	**38%**	**54%**

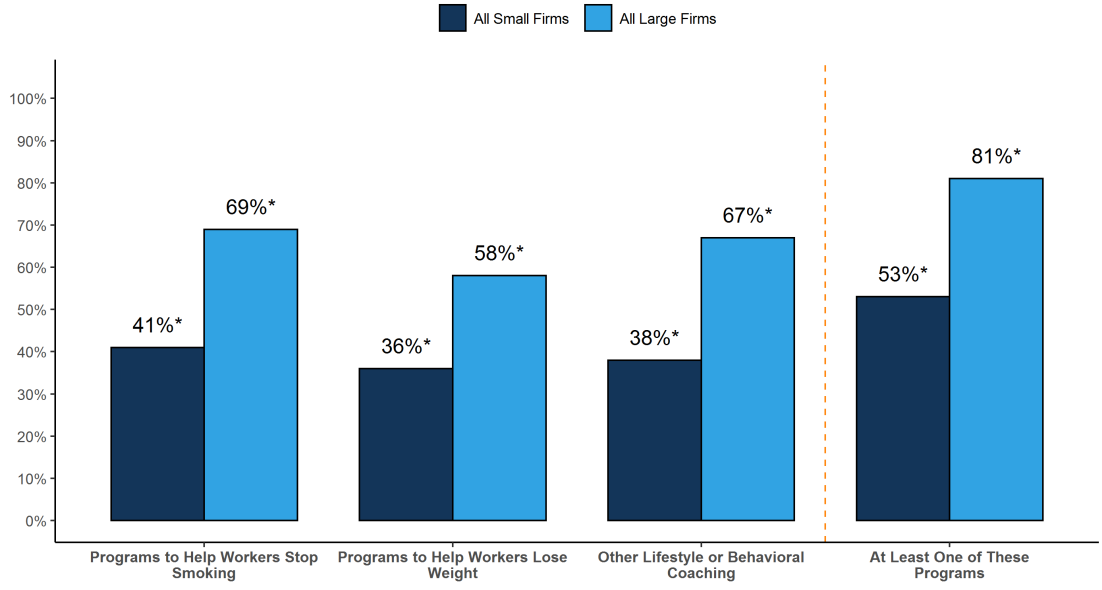
NOTE: 'Other Lifestyle or Behavioral Coaching' can include health education classes, stress management, or substance abuse counseling.

* Estimate is statistically different from estimate for all other firms not in the indicated size or region category ($p < .05$).

SOURCE: KFF Employer Health Benefits Survey, 2020

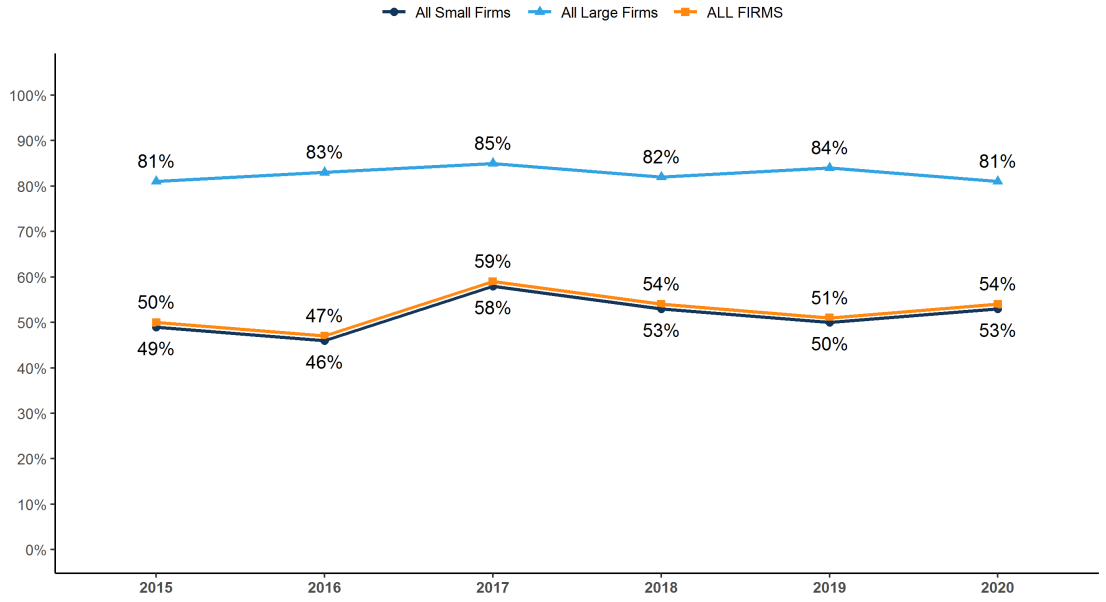
Figure 12.13

Among Firms Offering Health Benefits, Percentage of Firms Offering Specific Wellness Programs to Their Workers, by Firm Size, 2020



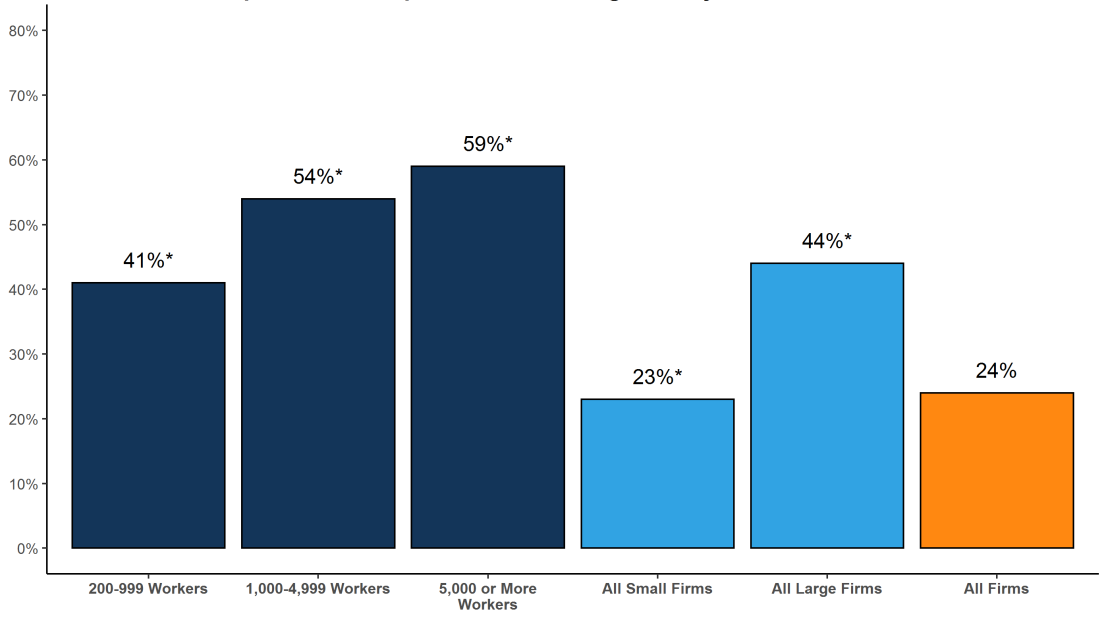
* Estimate is statistically different between All Small Firms and All Large Firms estimate ($p < .05$).
NOTE: 'Other Lifestyle or Behavioral Coaching' can include health education classes, stress management, or substance abuse counseling. Small Firms have 3-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 12.14
Among Firms Offering Health Benefits, Percentage of Firms Offering Wellness Programs, by Firm Size, 2015-2020



Tests found no statistical difference from estimate for the previous year shown ($p < .05$).
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2015-2017

Figure 12.15
Among Firms Offering Specific Wellness Programs, Percentage of Firms That Offer Incentives to Participate In or Complete Wellness Programs, by Firm Size, 2020



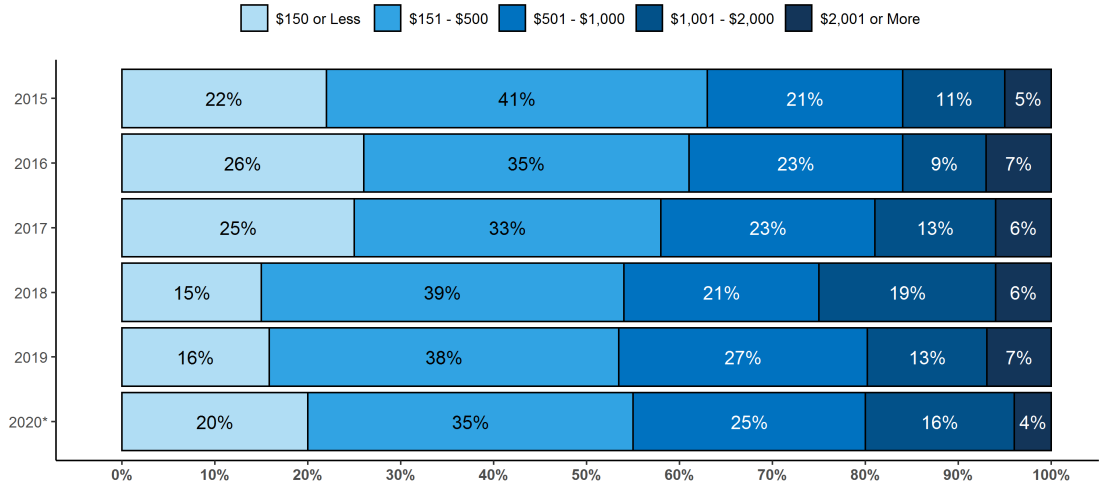
* Estimate is statistically different from estimate for all other firms not in the indicated size category ($p < .05$).
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2020

INCENTIVES FOR WELLNESS AND HEALTH SCREENING PROGRAMS

Firms with incentives for health risk assessments, biometric screenings, or wellness or health promotion programs were asked to report the maximum reward or penalty a worker could earn for all of the firm's health promotion activities combined. Some firms do not offer incentives for individual activities, but offer rewards to workers who complete a variety of activities.[1] Among large firms offering incentives for any of these programs, the maximum value for all wellness-related incentives is $150 or less in 20% of firms and more than $1,000 in 20% of firms [Figure 12.16].

- This year we asked large firms with an incentive to participate in a health promotion or health screening program, how effective they believed these incentives were at increasing employee participation. 30% believed incentives were 'very effective' and 47% said 'moderately effective'. [Figure 12.18].

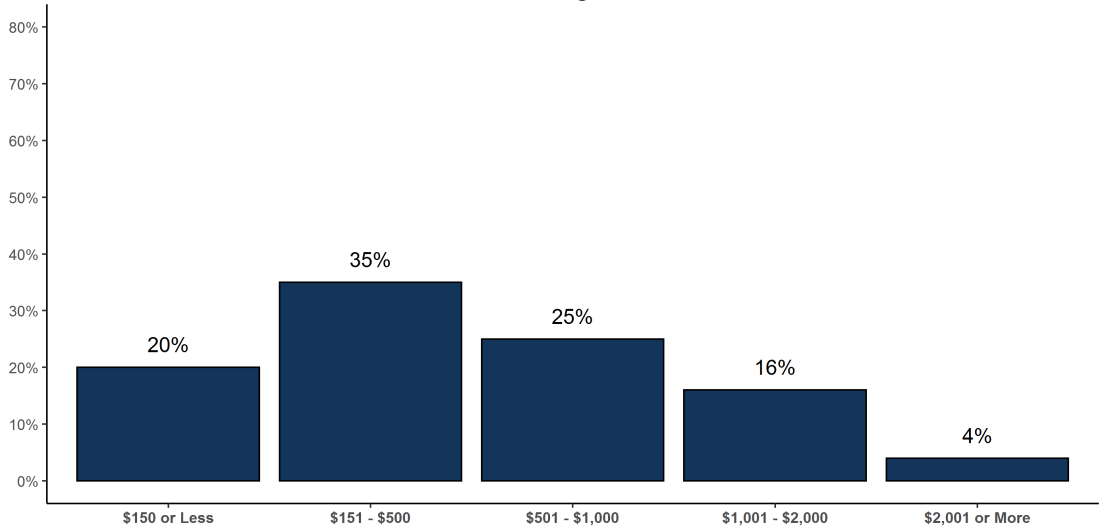
Figure 12.16
Among Large Firms That Offer Workers an Incentive to Participate In or Complete Any Health Promotion Programs, Maximum Annual Value of the Incentive for All Programs Combined, 2015-2020



* Distribution is statistically different from distribution for the previous year shown ($p < .05$).
NOTE: Includes incentives for health risk assessments, biometric screenings, and wellness programs. Firms with at least one of the listed health promotion programs were asked to report the maximum incentive a worker and his/her dependents could receive for all the firm's health promotion programs combined. Forty-seven percent of large offering firms offer an incentive to complete any of their health promotion programs. In 2020, less than one percent of firms indicated they had a reward of zero dollars. In most cases, this indicates a non-monetary incentive such as a preferred parking spot. Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2015-2017

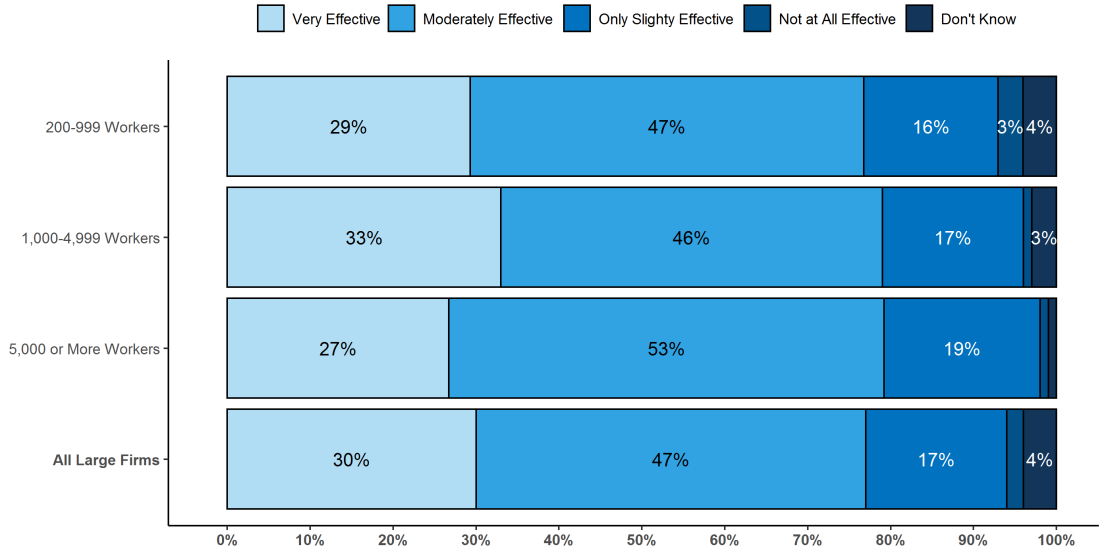
[1] In 2020, less than one percent of firms indicated that they had an incentive for completing health risk assessments, biometric screenings, or wellness or health promotion programs, but had a maximum incentive of zero dollars. These firms may have non-monetary incentives such as preferred parking spots or employee recognition programs.

Figure 12.17
Among Large Firms Offering Workers an Incentive for Any Health Promotion Programs, Maximum Annual Value of the Incentive for All Programs Combined, 2020



NOTE: Includes incentives for health risk assessments, biometric screenings, and wellness programs. Firms with at least one of the listed health promotion programs were asked to report the maximum incentive a worker and his/her dependents could receive for all the firm's health promotion programs combined. Forty-seven percent of large offering firms offer an incentive to complete any of their health promotion programs. In 2020, less than one percent of firms indicated they had a reward of zero dollars. In most cases, this indicates a non-monetary incentive such as a preferred parking spot. Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 12.18
Among Large Firms Offering Health Benefits and an Incentive to Participate In or Complete Wellness or Health Screening Programs, Firms' Opinion on How Effective Incentives are for Employee Participation, by Firm Size, 2020



Tests found no statistical difference for response choice from estimate for all other large firms.
NOTE: Includes incentives for health risk assessments, biometric screenings, and wellness programs. Forty-seven percent of large offering firms offer an incentive to complete any of their health promotion or health screening programs.Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2020

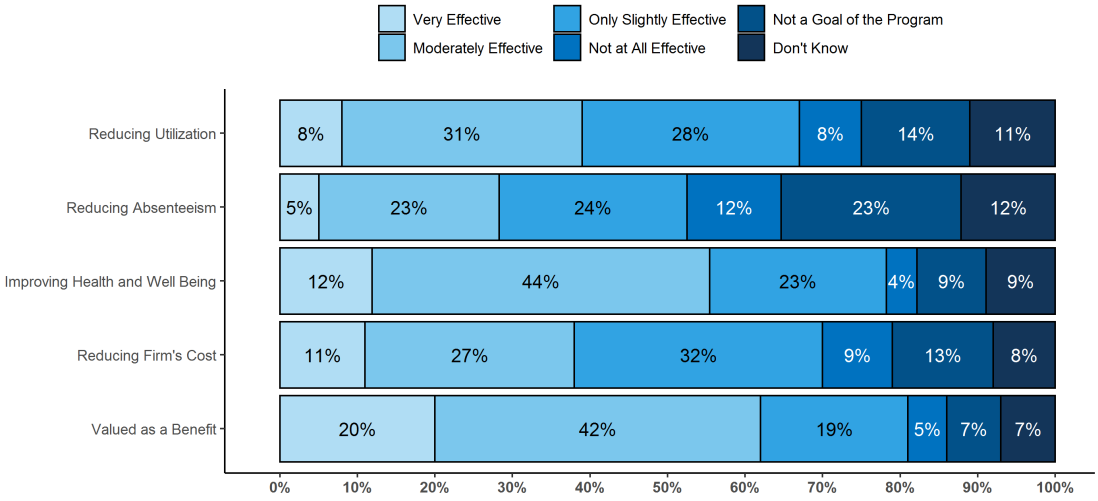
EFFECTIVENESS OF WELLNESS AND HEALTH SCREENING PROGRAMS

This year we asked firms offering one or more health promotion or health screening programs whether they believed the programs were effective in meeting certain objectives often offered as reasons to have these programs. Firms offering these programs may have different objectives for different programs, so we offered respondents the opportunity to say that a specific objective was not a goal of their programs.

- Reducing utilization. Sixteen percent of small firms and 8% of large firms said that their programs were very effective in reducing utilization, 33% of small firms and 59% of large firms said that their programs were moderately or only slightly effective, while 8% of small firms and 8% of large firms said that their programs were not at all effective. Among large firms offering a health screening or wellness program, 14% said that reducing utilization was not a program goal and 11% said that they did not know.
- Reducing absenteeism. Twelve percent of small firms and 5% of large firms said that their programs were very effective in reducing employee absenteeism, 31% of small firms and 48% of large firms said that their programs were moderately or only slightly effective, while 13% of small firms and 12% of large firms said that their programs were not at all effective. Among large firms offering a health screening or wellness program, 23% said that reducing absenteeism was not a program goal and 12% said that they did not know.
- Improving enrollee health and well being. Fourteen percent of small firms and 12% of large firms said that their programs were very effective in improving enrollee health and well being, 44% of small firms and 66% of large firms said that their programs were moderately or only slightly effective, while 9% of small firms and 4% of large firms said that their programs were not at all effective. Among large firms offering a health screening or wellness program, 9% said that improving enrollee health and well being was not a program goal and 9% said that they did not know.
- Reducing the firm's health costs. Sixteen percent of small firms and 11% of large firms said that their programs were very effective in reducing the firm's health costs, 30% of small firms and 59% of large firms said that their programs were moderately or only slightly effective, while 16% of small firms and 9% of large firms said that their programs were not at all effective. Among large firms offering a health screening or wellness program, 13% said that reducing the firm's health costs was not a program goal and 8% said that they did not know.
- Being valued by employees as a benefit. Thirty-four percent of small firms and 20% of large firms said that their programs were very effective in being valued by employees as a benefit, 26% of small firms and 61% of large firms said that their programs were moderately or only slightly effective, while 6% of small firms and 5% of large firms said that their programs were not at all effective. Among large firms offering a health screening or wellness program, 7% said that being valued by employees as a benefit was not a program goal and 7% said that they did not know.

Figure 12.19

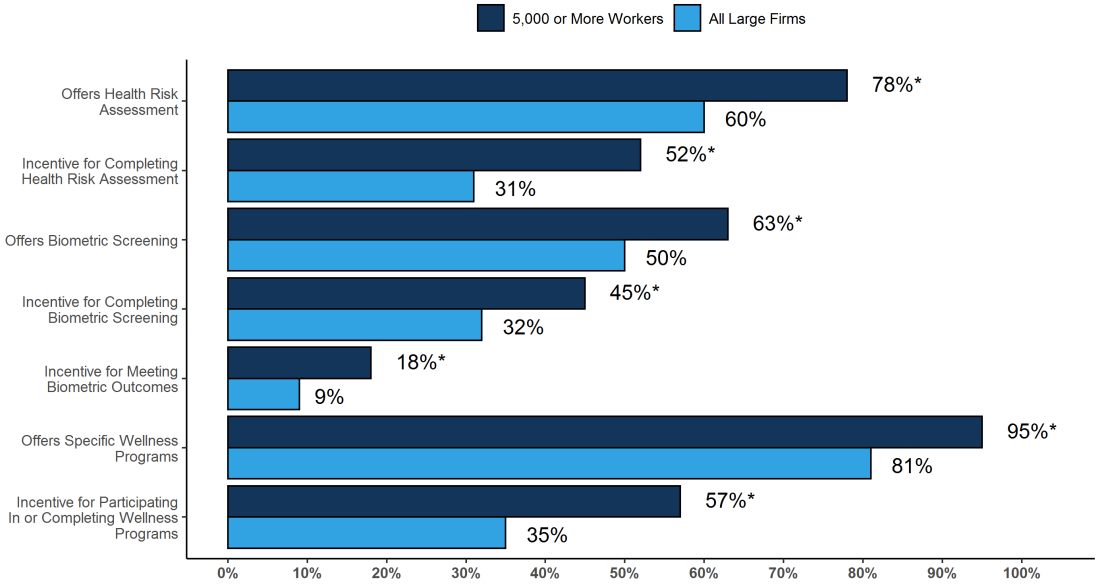
Among Large Firms Offering Health Benefits and a Wellness or Health Screening Programs, Firms Opinion of How Effective Programs are at Meeting Various Goals, 2020



NOTE: A health risk assessment or appraisal includes questions on medical history, health status, and lifestyle and is designed to identify the health risks of the person being assessed. Biometric screening is a health examination that measures a person's risk factors for certain medical issues. Biometric outcomes could include meeting a target body mass index (BMI) or cholesterol level, but not goals related to smoking. Wellness programs include programs to help employees lose weight, lifestyle or behavioral coaching or tobacco cessation programs. Among large firms offering health benefits, 87% have a health screening or wellness and/or health promotion program and 47% have an incentive to participate in at least one program. Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 12.20

Among Large Firms Offering Health Benefits, Percentage of Firms Offering Various Wellness and Health Promotion Activities and Incentives, by Firm Size, 2020



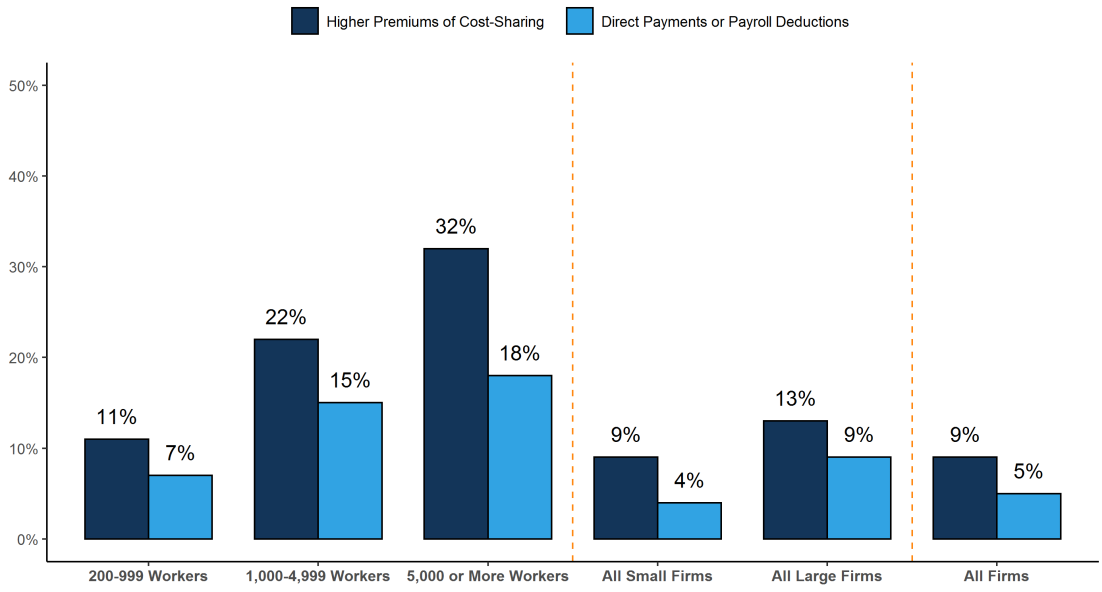
* Estimates are statistically different between firm size estimates within category ($p < .05$).
NOTE: 'Specific Wellness Programs' include 'Programs to Help Workers Stop Smoking', 'Programs to Help Workers Lose Weight', or 'Other Lifestyle or Behavioral Coaching'. Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2020

SURCHARGES AND INCENTIVES RELATED TO TOBACCO USE

Some firms require employees that use tobacco products to pay higher premium contributions or cost sharing.

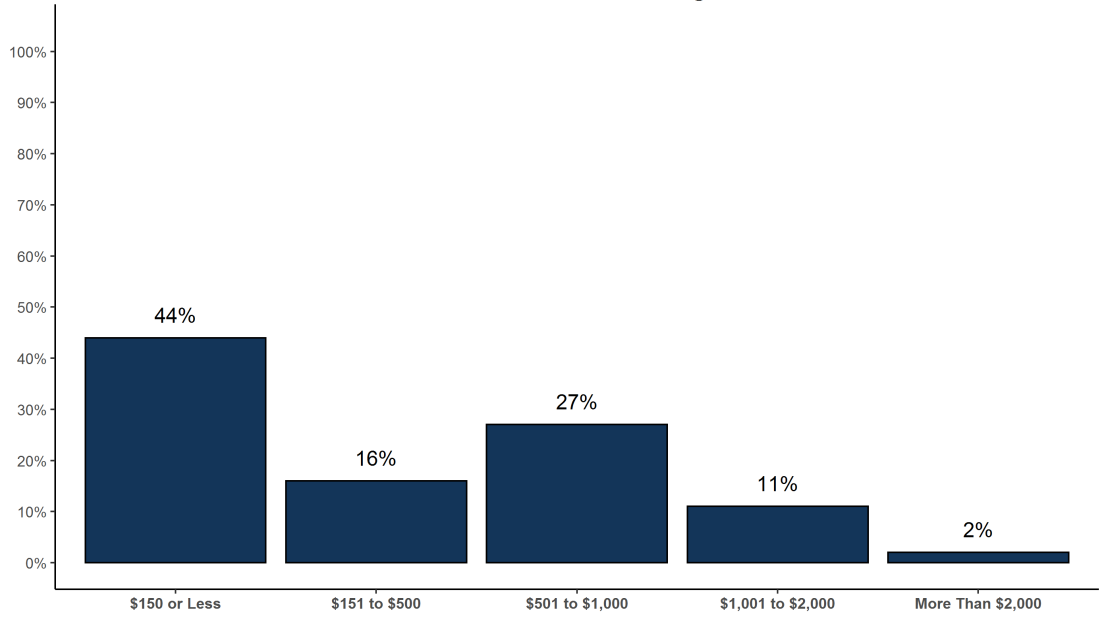
- Nine percent of firms offering health benefits have higher premium contributions or cost-sharing for employees who use tobacco products or vape. Five percent of firms offering health benefits provide employees with some form of direct payment (such as a higher account contribution) based on whether or not an employee uses tobacco products or vapes. Some firms noted that not smoking is a condition of employment.
  - Among firms with one of these incentives (higher premium contributions or cost sharing, or direct payments or account contributions), 52% say that the maximum incentive or penalty for an employee based on the employees smoking status was $150 or less, 32% say the maximum amount was between $151 and $500, and 15% say the maximum amount was between $501 and $1,000 [Figure 12.22].
  - Among firms with 1,000 or more employees with tobacco cessation programs, 53% say that their program targets people who use electronic cigarettes (known as vaping), 19% say the program does not target vaping, and 28% did not know [Figure 12.23].

Figure 12.21
Among Firms Offering Health Benefits, Percentage of Firms which Charge Penalties to Employees Who Use Tobacco or Vape, by Firm Size, 2020



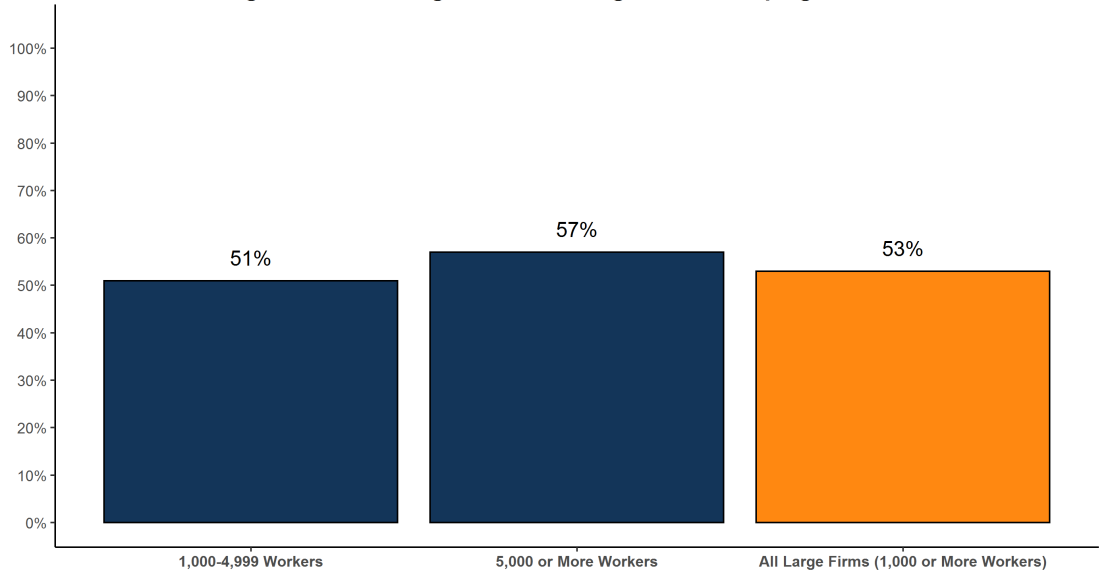
Tests found no statistical difference from estimate for all other firms not in the indicated size category ($p < .05$).
NOTE: Excludes three percent of firms offering benefits that indicated that not smoking was a condition of employment. Contributions to a health savings account are included as direct payments. Small Firms have 3-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 12.22
Among Large Firms Offering Workers an Incentive or Penalty for Smoking or Vaping, Maximum Annual Value of the Incentive Based on an Enrollee's Smoking Status, 2020



NOTE: Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 12.23
Among Firms with 1,000 or More Workers That Offer Smoking Cessation Programs, Percent of Firms that Offer Programs Which Target Electronic Cigarettes or Vaping, 2020



Tests found no statistical difference from estimate for all other firms not in the indicated size category ($p < .05$).
NOTE: Among firms offering health benefits, 82% of firms with 1,000 or more employees offer a smoking cessation program, including 87% of firms with 5,000 or more workers. Among those firms with 1,000 or more employees offering a smoking cessation program, 28% did not know if that program targeted electronic cigarettes.
SOURCE: KFF Employer Health Benefits Survey, 2020

Employer Health Benefits
2020 Annual Survey

Employer Practices, Alternative Sites of Care and Provider Networks

SECTION 13

Section 13

Employer Practices, Alternative Sites of Care and Provider Networks

Employers frequently review and modify their health plans to incorporate new options or adapt to new circumstances. We monitor new options, such as telemedicine, and ask about changes in the health or policy environments. This year employers have been dealing with the coronavirus pandemic, which affects health, access to care, workplace health programs and even open enrollments. Because the survey started fielding in January, before the full impacts of the pandemic became apparent, we did not include questions about employers responses to it this year.

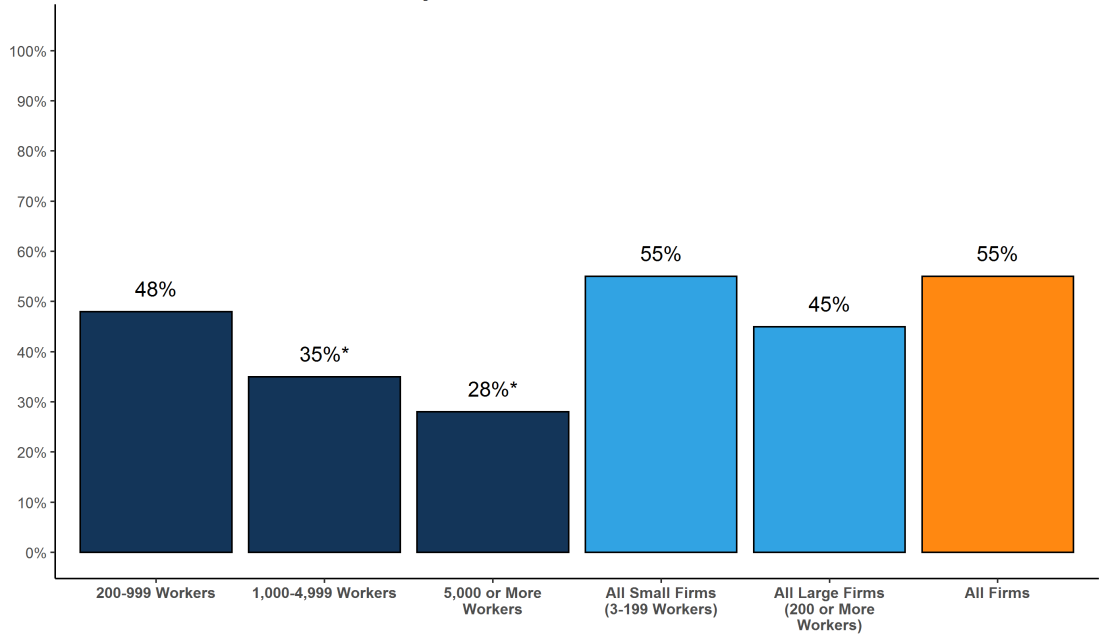
We note that there is a significant increase in the percentage of firms, particularly smaller firms (50-199 workers), reporting that they cover some services through telemedicine. While telemedicine has grown in recent years, it is possible that some of the growth reflects plan changes in response to the coronavirus pandemic as well as to the increased awareness in telemedicine that has occurred over the spring and summer. About one-half of the responses to this year's survey occurred after March, which is when people began to shelter at home and seek alternative ways to get medical care. It will be important to monitor how plans and employers adapt over the longer term when concerns over the coronavirus have ended.

SHOPPING FOR HEALTH COVERAGE

Fifty-five percent of firms offering health benefits reported shopping for a new health plan or a new insurance carrier in the past year, similar to the percentage last year. Firms with 5,000 or more workers were less likely to shop for coverage (28%) than firms in other size categories [Figure 13.1].

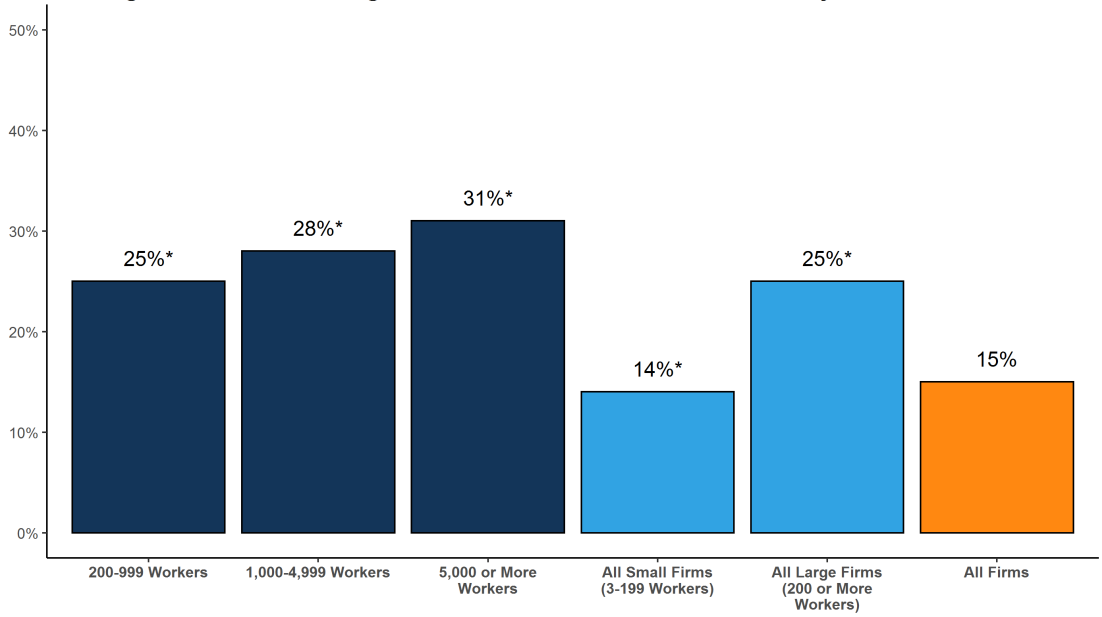
- Among firms that offer health benefits and who shopped for a new plan or carrier in the past year, 15% changed insurance carriers [Figure 13.2].

Figure 13.1
Percentage of Firms Offering Health Benefits That Shopped For a New Plan or Health Insurance Carrier in the Past Year, by Firm Size, 2020



* Estimate is statistically different from estimate for all other firms not in the indicated size category (p < .05).
SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 13.2
Among Firms Offering Health Benefits That Shopped for a New Plan or Insurance Carrier, Percentage of Firms That Changed Insurance Carriers in the Past Year, by Firm Size, 2020



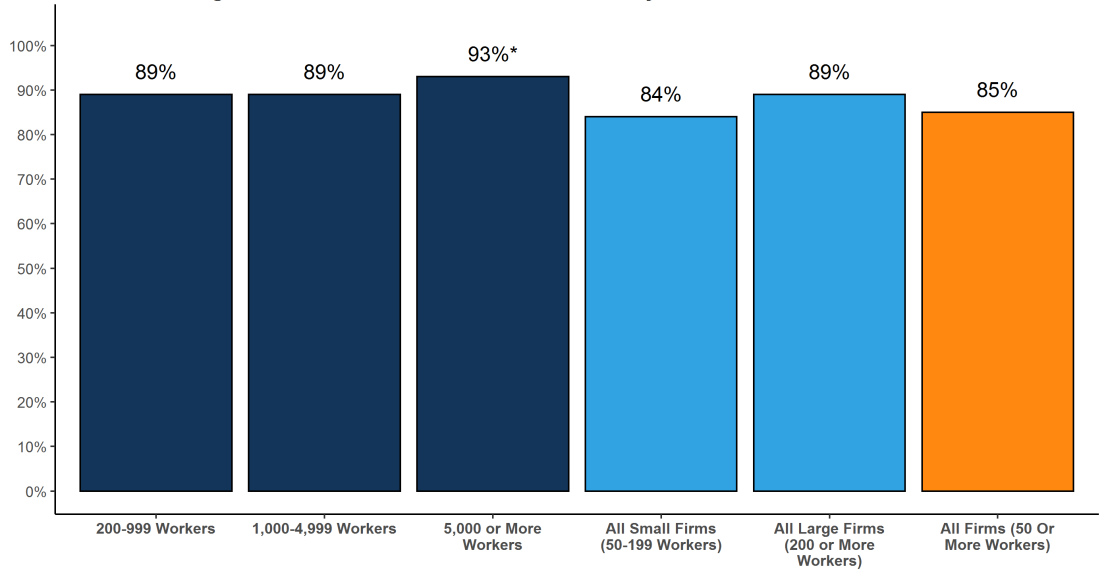
* Estimate is statistically different from estimate for all other firms not in the indicated size category (p < .05).
NOTE: In 2020, 55% of firms offering health benefits shopped for a new plan.
SOURCE: KFF Employer Health Benefits Survey, 2020

ALTERNATIVE CARE SETTINGS: TELEMEDICINE AND RETAIL CLINICS

Many firms provide coverage for health services delivered outside typical provider settings. Telemedicine is the delivery of health care services through telecommunications to a patient from a provider who is at a remote location, including video chat and remote monitoring. This generally would not include the mere exchange of information via email, exclusively web-based resources, or online information a plan may make available unless a health professional provides information specific to the enrollee's condition. We note that during the coronavirus pandemic, some plans have eased their definitions to allow more types of digital communication to be reimbursed.

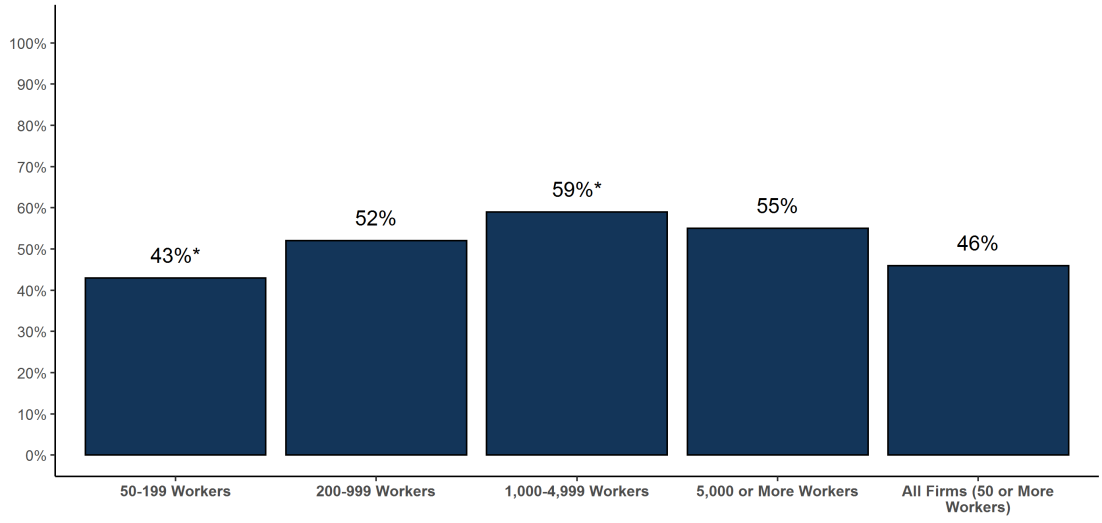
- Eighty-five percent of firms with 50 or more workers that offer health benefits cover the provision of some health care services through telemedicine in their largest health plan, a significant increase from the percentage (69%) in 2019. [Figure 13.3].
  - Over the last year, the percentage of small firms (50-199 workers) reporting that they cover services through telemedicine increased from 65% last year to 84% this year and the percentage of large firms increased from 82% to 89% [Figure 13.5].
  - Among firms with 50 or more workers with plans that cover health services through telemedicine, 46% provide a financial incentive for workers to use telemedicine instead of visiting a traditional physician's office in-person, similar to the percentage in 2019 [Figure 13.4].
- Seventy-nine percent of firms with 10 or more employees that offer health benefits cover health care services received in retail clinics, such as those located in pharmacies, supermarkets and retail stores, in their largest health plan [Figure 13.6]. These clinics are often staffed by nurse practitioners or physician assistants and treat minor illnesses and provide preventive services.
  - Among firms with 10 or more employees covering health services received in retail clinics in their largest plan, 17% provide a financial incentive for workers to use a retail health clinic instead of visiting a traditional physician's office [Figure 13.6].

Figure 13.3
Among Firms with 50 or More Workers Offering Health Benefits, Percentage of Firms Whose Plan with the Largest Enrollment Covers Telemedicine, by Firm Size, 2020



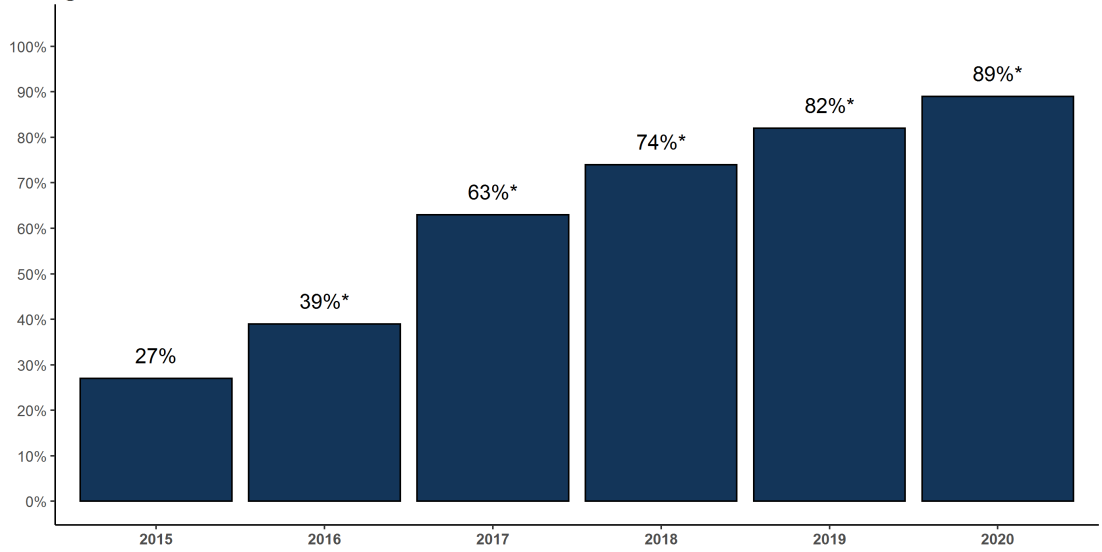
* Estimate is statistically different from estimate for all other firms not in the indicated size category ($p < .05$).
NOTE: Telemedicine is the delivery of health care services through telecommunications to a patient from a provider who is at a remote location, including video chat and remote monitoring. This would not include the mere exchange of information via email, exclusively web-based resources, or online information a plan may make available unless a health professional provides information specific to the enrollee's condition.
SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 13.4
Among Firms with 50 or More Workers Whose Plan with the Largest Enrollment Covers Telemedicine, Percentage of Firms with Lower Cost-Sharing for Telemedicine, by Firm Size, 2020



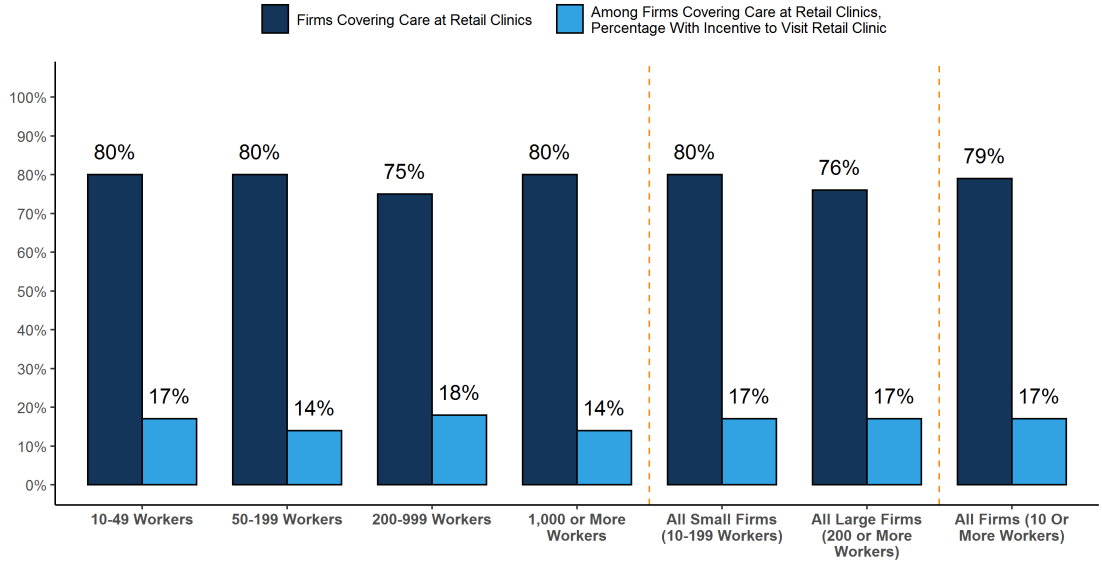
* Estimate is statistically different from estimate for all other firms not in the indicated size category ($p < .05$).
NOTE: Telemedicine is the delivery of health care services through telecommunications to a patient from a provider who is at a remote location, including video chat and remote monitoring. This would not include the mere exchange of information via email, exclusively web-based resources, or online information a plan may make available unless a health professional provides information specific to the enrollee's condition. Lower cost-sharing may included reduced copays or coinsurances
SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 13.5
Among Large Firms Offering Health Benefits, Percentage of Firms Whose Plan with the Largest Enrollment Covers Telemedicine, 2015-2020



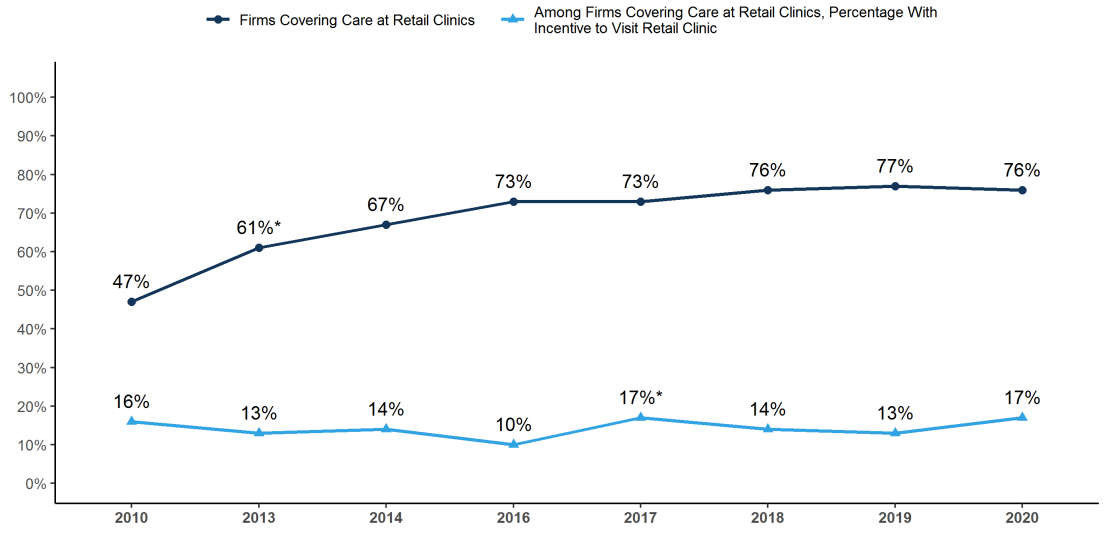
* Estimate is statistically different from estimate for the previous year shown (p < .05).
NOTE: Telemedicine is the delivery of health care services through telecommunications to a patient from a provider who is at a remote location, including video chat and remote monitoring. This would not include the mere exchange of information via email, exclusively web-based resources, or online information a plan may make available unless a health professional provides information specific to the enrollee's condition. Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2015-2017

Figure 13.6
Among Firms with 10 or More Workers Offering Health Benefits, Percentage of Firms Whose Plan with the Largest Enrollment Covers Care at Retail Clinics, by Firm Size, 2020



Tests found no statistical difference from estimate for all other firms not in the indicated size category (p < .05).
NOTE: A retail clinic is a health care clinic located in a retail store, supermarket, or pharmacy that treats minor illnesses and provides preventive health care services such as flu shots. Financial incentives include lower cost sharing for care received at retail clinics instead of traditional physician offices.
SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 13.7
Among Large Firms Offering Health Benefits, Percentage of Firms Whose Plan with the Largest Enrollment Covers Care at Retail Clinics and That Have a Financial Incentive for Workers to Visit Retail Clinics Instead of a Physician's Office, 2010-2020



* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
NOTE: A retail clinic is a health care clinic located in a retail store, supermarket, or pharmacy that treats minor illnesses and provides preventive health care services such as flu shots. Financial incentives include lower cost sharing for care received at retail clinics instead of traditional physician offices. Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2010-2017

FIRM APPROACHES TO PLAN NETWORKS

Firms and health plans can structure their networks of providers and their cost sharing to encourage enrollees to use providers who are lower cost or who provide better care. Periodically we ask employers about network strategies, such as using tiered or narrow networks.

- Employers overall report being quite satisfied with the choice of provider networks made available to them by their insurer or plan administrator.
  - Among employers offering health benefits, 45% of firms report being 'very satisfied' and 38% report being 'satisfied' by the choice of provider networks available to them. Large firms are more likely to be 'very satisfied' with the available network choices than smaller firms. [Figure 13.8].
  - Employers are somewhat less satisfied with the cost of the provider networks available to them from their insurer or administrator. Among employers offering health benefits, only 22% of firms report being 'very satisfied' while 39% report being 'satisfied' with the cost of provider networks available to them. Small firms are more likely to be 'very dissatisfied' with the cost of the provider networks available to them [Figure 13.8].
- One way that employers and health plans can affect the cost and quality of services in their provider networks is to eliminate hospitals or health systems that are not performing well.
  - Only a small share (4%) of firms offering health benefits say that either they or their insurer eliminated a hospital or health system from a provider network during the past year in order to reduce the plan's cost [Figure 13.9].

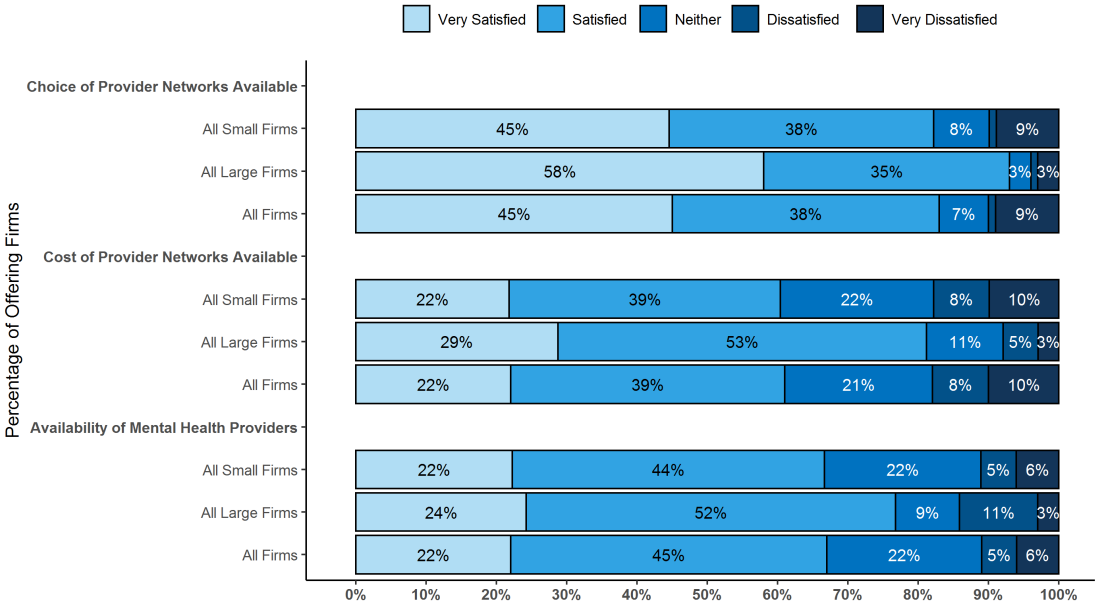
- Another approach that employers can use is to offer a health plan with a relatively small, or narrow network of providers. Narrow network plans limit the number of providers that can participate in order to reduce costs and generally are more restrictive than standard HMO networks.
  - Seven percent of firms offering health benefits report that they offer at least one plan that they considered to be a narrow network plan, similar to the percentage reported last year [Figure 13.9].
  - Firms with 5,000 or more workers offering health benefits are more likely than firms of other sizes to offer at least one plan with a narrow network (26%) [Figure 13.9].
- Employers offering health benefits were asked to characterize the breadth of the provider network in their plan with the largest enrollment. Fifty-one percent of firms say that the network in the plan with the largest enrollment is 'very broad', 42% say it is 'somewhat broad', and 6% say it is 'somewhat narrow' [Figure 13.11].

Employees with mental or behavioral health claims disproportionately receive services from providers outside of plan networks.[1] The coronavirus pandemic has placed a spotlight on the importance of mental and behavioral health care and access to these services, and many plans have been able to enhance access to these services through telemedicine. We asked employers if they were satisfied with the availability of mental health providers in their provider networks. We note that the survey was conducted between January and July this year, so it is possible that employer views changed over the period as the scope of the pandemic became more apparent and as alternative means of providing services became available.

- Only about one-in-five (22%) employers is very satisfied with the availability of mental health providers in their provider networks. The share does not vary with firm size [Figure 13.8].
- Employers offering health benefits also were asked to characterize the breadth of the network for mental health and substance abuse in their plan with the largest enrollment. Thirty-five percent of firms say that the network for mental health and substance abuse in the plan with the largest enrollment is 'very broad', 46% say it is 'somewhat broad', 15% say it is 'somewhat narrow', and 4% say it is 'very narrow'. The responses do not vary for by firm size. [Figure 13.11]
- Among employers with 50 or more employees offering health benefits, 9% asked their insurer or third party administrator to increase access to in-network mental health and substance abuse providers over the last two years. Firms with 1,000 or more employees were more likely to request more in-network access for these services [Figure 13.12].

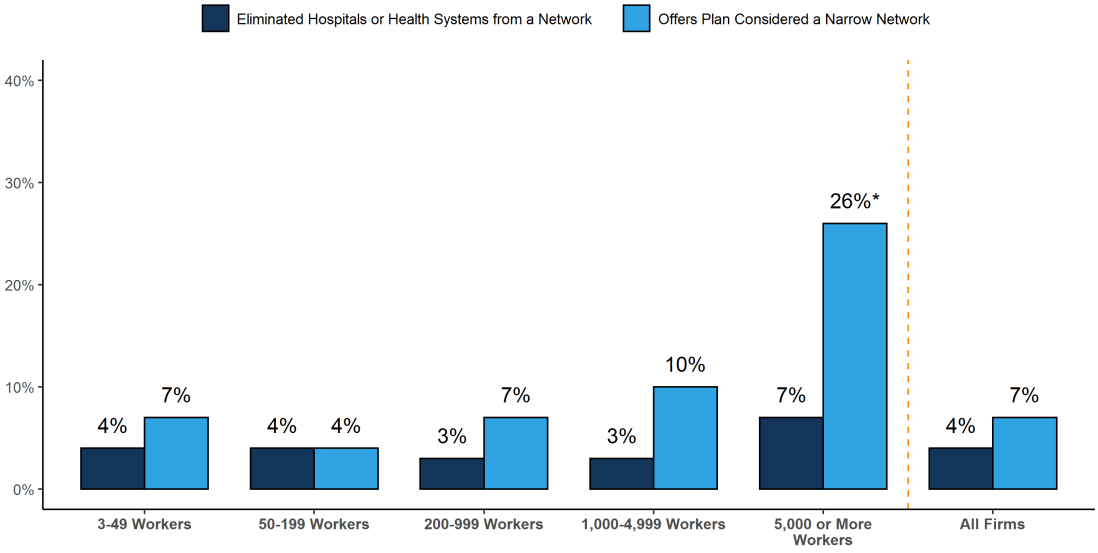
[1] Pollitz K, Rae M, Claxton G, Cox C, Levitt L. An examination of surprise medical bills and proposals to protect consumers from them [Internet]. Peterson-KFF Health System Tracker. 2020 [cited 2020 Aug 10]. Available from: https://www.healthsystemtracker.org/brief/an-examination-of-surprise-medical-bills-and-proposals-to-protect-consumers-from-them-3/ Rae M, Cox C, Claxton G. Coverage and utilization of telemedicine services by enrollees in large employer plans [Internet]. Peterson-KFF Health System Tracker. 2020 [cited 2020 Aug 31]. Available from: https://www.healthsystemtracker.org/brief/coverage-and-utilization-of-telemedicine-services-by-enrollees-in-large-employer-plans/

Figure 13.8
Among Firms Offering Health Benefits, Satisfaction with Provider Networks Available from Insurer or Third Party Administrator, by Firm Size, 2020



NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 13.9
Among Firms Offering Health Benefits, Percentage of Firms That Eliminated Hospitals From Any of Their Networks in the Past Year to Reduce Cost or Offer a Narrow Network Plan, by Firm Size, 2020



* Estimate is statistically different from estimate for all other firms not in the indicated size category ($p < .05$).
NOTE: Narrow network plans limit the number of providers that can participate in order to reduce costs and generally are more restrictive than standard HMO networks.
SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 13.10

Among Firms With 50 or More Workers Offering Health Benefits, Percentage of Firms That Eliminated Hospitals From Any of Their Networks in Past Year to Reduce Cost or Offer a Narrow Network Plan, by Firm Size, 2014-2020

	2014	2015	2016	2017	2018	2019	2020
Eliminated Hospitals or Health Systems From Network							
All Small Firms (50-199 Workers)	8%	6%	6%	8%	9%	7%	4%
All Large Firms (200 or More Workers)	8	5	6	9	5*	6	8
ALL FIRMS (50 or More Workers)	**8%**	**6%**	**6%**	**8%**	**8%**	**6%**	**5%**
Offers Plan Considered Narrow Network							
All Small Firms (50-199 Workers)	6%	4%	4%	4%	6%	4%	4%
All Large Firms (200 or More Workers)	6	6	5	3	3	3	3
ALL FIRMS (50 or More Workers)	**6%**	**5%**	**4%**	**4%**	**6%**	**4%**	**4%**

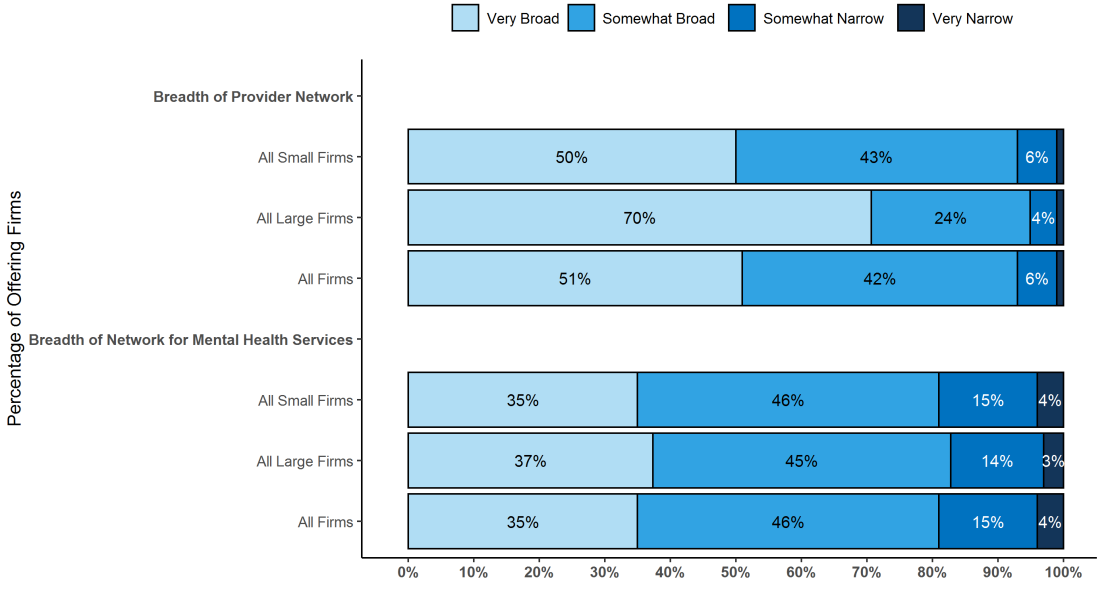
NOTE: This question was asked of offering firms with 50 or more workers in 2014, but has since been asked of all offering firms regardless of firm size. In 2020, 4% of all offering firms eliminated a hospital or health system from their network and 7% of all offering firms offer a plan that could be considered a narrow network plan.Narrow network plans limit the number of providers that can participate in order to reduce costs and generally are more restrictive than standard HMO networks.

* Estimate is statistically different from estimate for the previous year shown ($p < .05$).

SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2014-2017

Figure 13.11

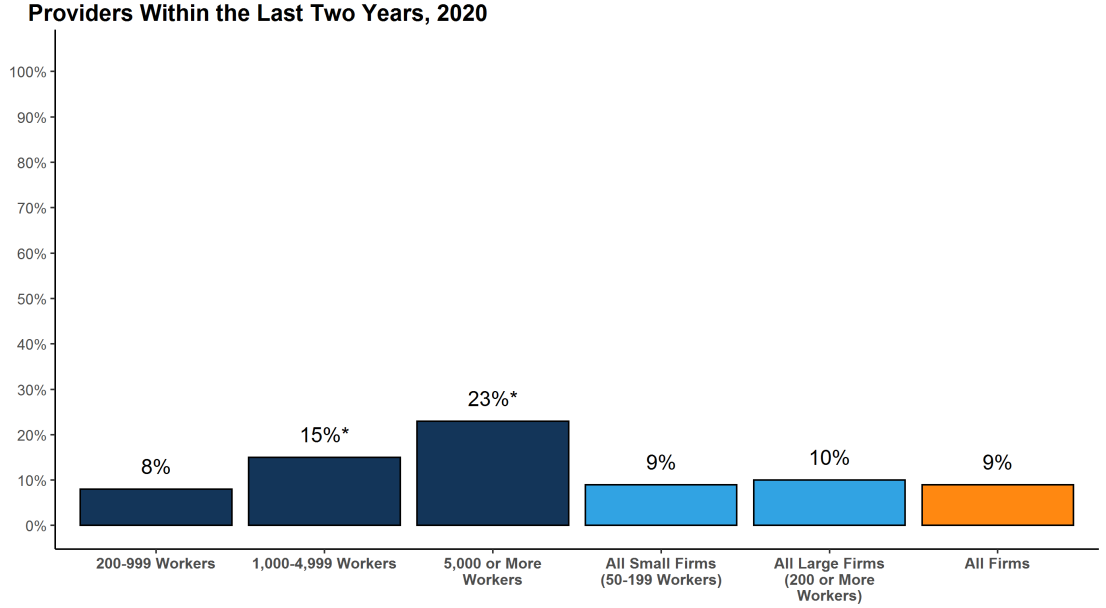
Among Firms Offering Health Benefits, How Broad the Firm Considers Their Largest Plan's Provider Network, by Firm Size, 2020



NOTE: A broad network includes most doctors and hospitals in the area, a narrow network is one which is limited to a small number of providers. Small Firms have 3-199 workers and Large Firms have 200 or more workers.

SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 13.12
Percentage of Firms (50 or More Workers) Offering Health Benefits That Have Asked Insurers or TPAs to Increase Access to In-Network Mental Health or Substance Abuse Providers Within the Last Two Years, 2020



* Estimate is statistically different from estimate for all other firms not in the indicated size category (p < .05).
NOTE: TPA refers to third party administrator.
SOURCE: KFF Employer Health Benefits Survey, 2020

CHRONIC CONDITIONS

In recent years employers and health plans have taken steps to encourage people with chronic illnesses to obtain the services they may need to maintain their health. Efforts may include communications, case and disease management, or reducing financial barriers, such as cost sharing.

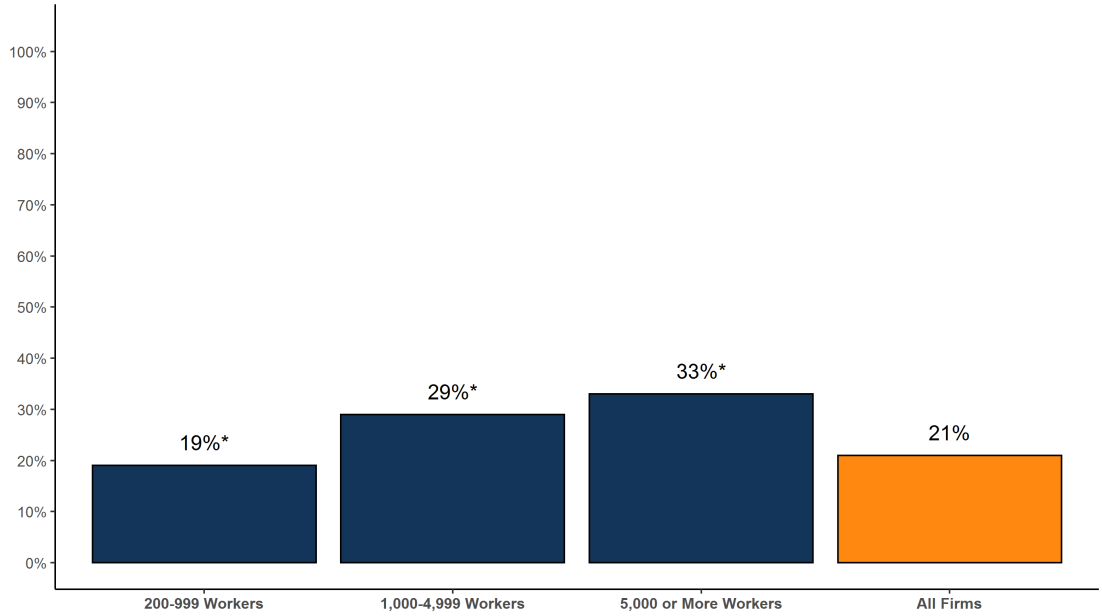
- Among employers with 200 or more employees offering health benefits, 21% say that their health plan with the largest enrollment waives cost sharing for some medications or supplies to encourage employees with chronic illnesses to follow their treatment. This likelihood increases with firm size [Figure 13.13].

In 2019, the federal government issued new rules that expanded the number and types of items and services that may be considered preventive by HSA-qualified health plans, which means that plan sponsors may pay for part or all of these services before enrollees meet the plan deductibles in these plans [2].

- Among employers with 200 or more employees offering an HSA-qualified health plan, 29% say that they changed the services or products that individuals with chronic conditions could receive without first meeting their deductibles. Firms with 5,000 or more employees (48%) are more likely and firms with 200 to 999 employees are less likely (26%) to say they changed the services or products available before the deductible is met [Figure 13.14].

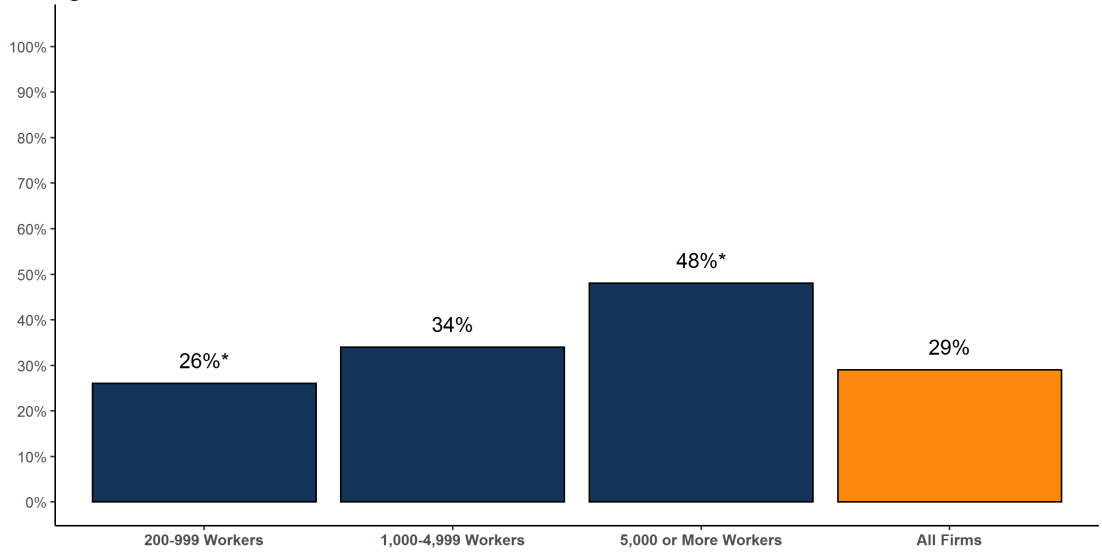
[2] Internal Revenue Service. Additional Preventive Care Benefits Permitted to be Provided by a High Deductible Health Plan Under § 223 [Internet]. NOTICE 2019-45; 2019. Available from: https://www.irs.gov/pub/irs-drop/n-19-45.pdf

Figure 13.13
Percentage of Large Firms Offering Health Benefits That Waive Cost-Sharing for Medication to Treat Chronic Conditions, 2020



* Estimate is statistically different from estimate for all other firms not in the indicated size category ($p < .05$).
NOTE: Large Firms have 200 or more workers. This may include plans which eliminated cost-sharing for insulin to treat diabetes.
SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 13.14
Percentage of Large Firms Offering an HSA-Qualified Plan Which Increased the Number of Drugs and Services to Chronic Conditions which were Considered Preventative, 2020



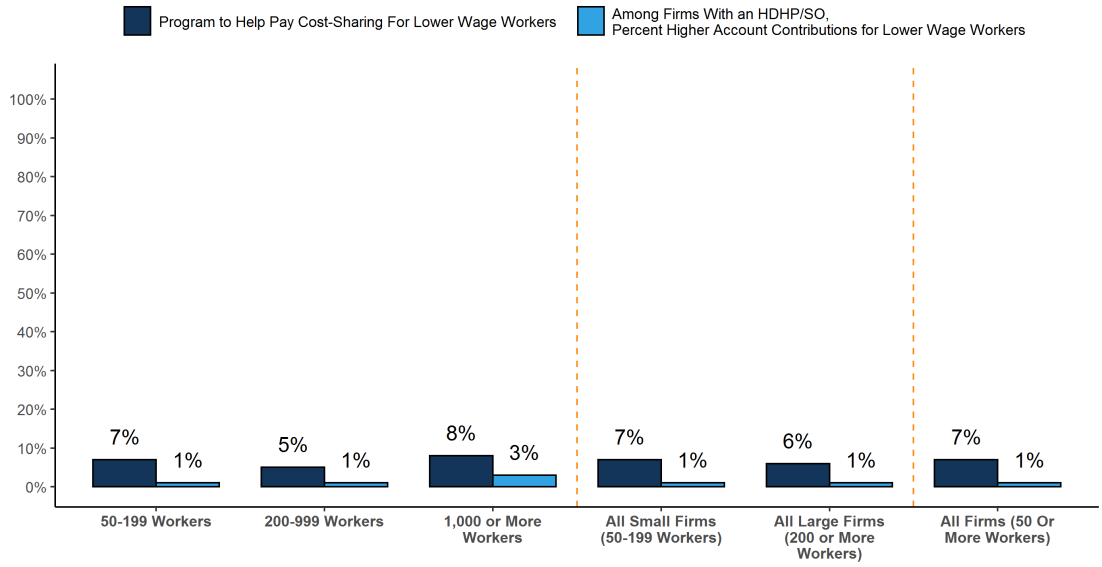
* Estimate is statistically different from estimate for all other firms not in the indicated size category ($p < .05$).
NOTE: Large Firms have 200 or more workers. Employers were asked if they changed their coverage based on a rule which allowed that certain services and prescription drugs, for certain chronic conditions be classified as preventive care for people with those conditions. Under the rule, enrollees in a HSA qualified plan should face no cost-sharing for these services and products, even though these services would not generally be considered preventive care.)
SOURCE: KFF Employer Health Benefits Survey, 2020

LOWER WAGE WORKERS

Some firms help lower-wage workers by reducing or subsidizing their cost sharing liability.

- Among employers with 50 or more employees offering health benefits, 7% have a program that reduces cost sharing for lower-wage workers. Among firms with 50 or more employees offering health benefits that make contributions to workers' HSA or HRAs, 1% provide larger account contributions for their lower-wage workers [Figure 13.15].

Figure 13.15
Among Firms with 50 or More Workers Offering Health Benefits, Percentage of Firms Which Have Programs to Lower Cost-Sharing for Lower Wage Workers, 2020



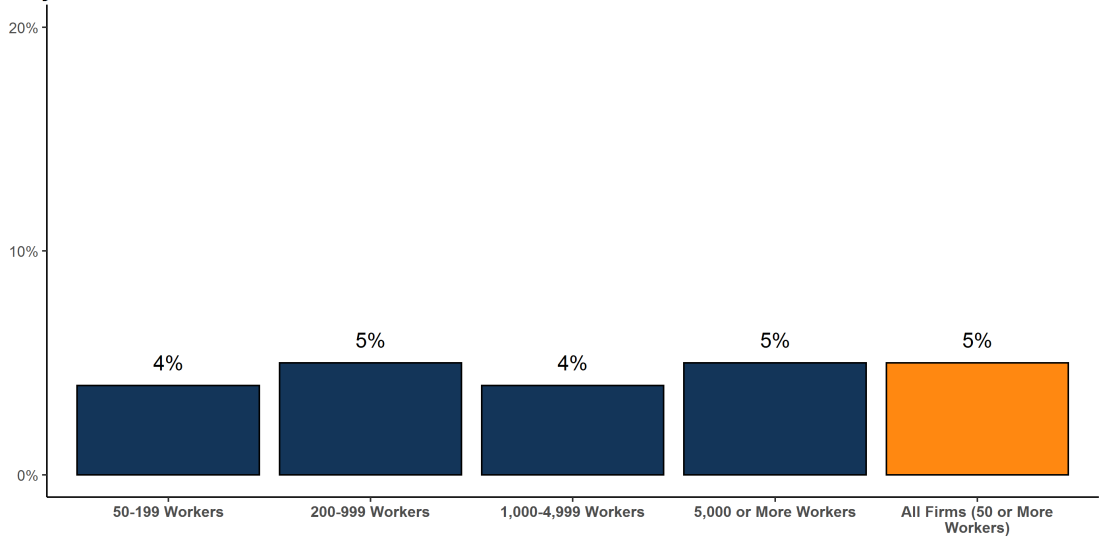
Tests found no statistical difference from estimate for all other firms not in the indicated size category ($p < .05$).
NOTE: This could include help paying deductibles or copayments for eligible workers. HDHP/SOs are treated as a distinct plan type even if the plan would otherwise be considered a PPO, HMO, POS plan, or indemnity plan. These plans have a deductible of at least $1,000 for single coverage and $2,000 for family coverage and are offered with an HRA, or are HSA-qualified.For More Information, see Section 8.
SOURCE: KFF Employer Health Benefits Survey, 2020

PRIVATE EXCHANGES AND DEFINED CONTRIBUTIONS

A private exchange is a virtual market that allows employers to provide their workers with a choice of several different health benefit options, often including voluntary or ancillary benefits options. Private exchanges generally are created by consulting firms, insurers, or brokers, and are different than the public exchanges run by the states or the federal government. There is considerable variation in the types of exchanges currently offered: some exchanges allow workers to choose between multiple plans offered by the same carrier while in other cases multiple carriers participate. Private exchanges have been operating for several years, but enrollment remains modest.

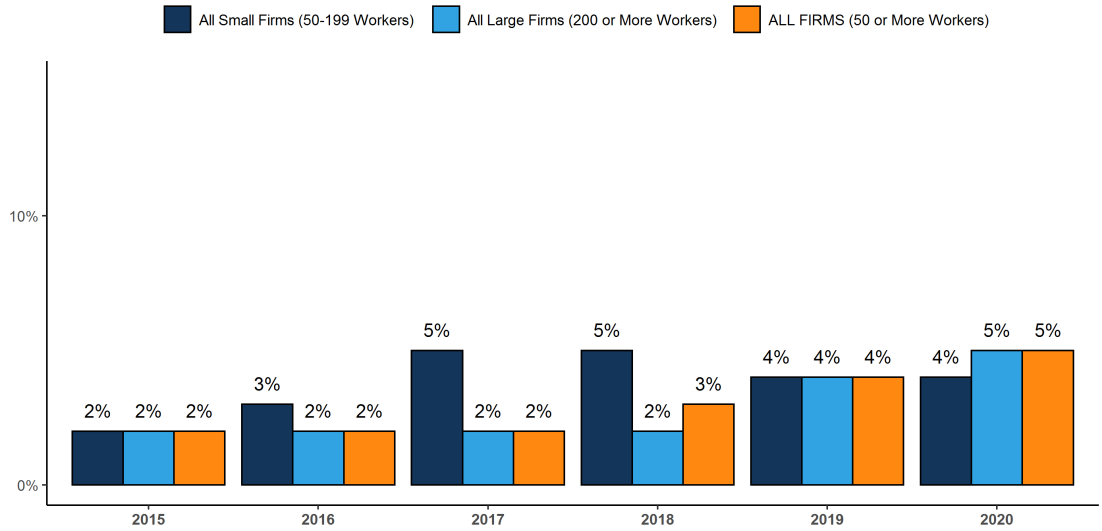
- Five percent of firms offering health benefits with 50 or more workers offer coverage through a private exchange. These firms provide coverage to 5% of covered workers in firms with 50 or more workers. These percentages are similar to those in 2019.

Figure 13.16
Among Firms with 50 or More Workers Offering Health Benefits, Percentage of Covered Workers Enrolled at a Firm That Offers Benefits Through a Private or Corporate Exchange, by Firm Size, 2020



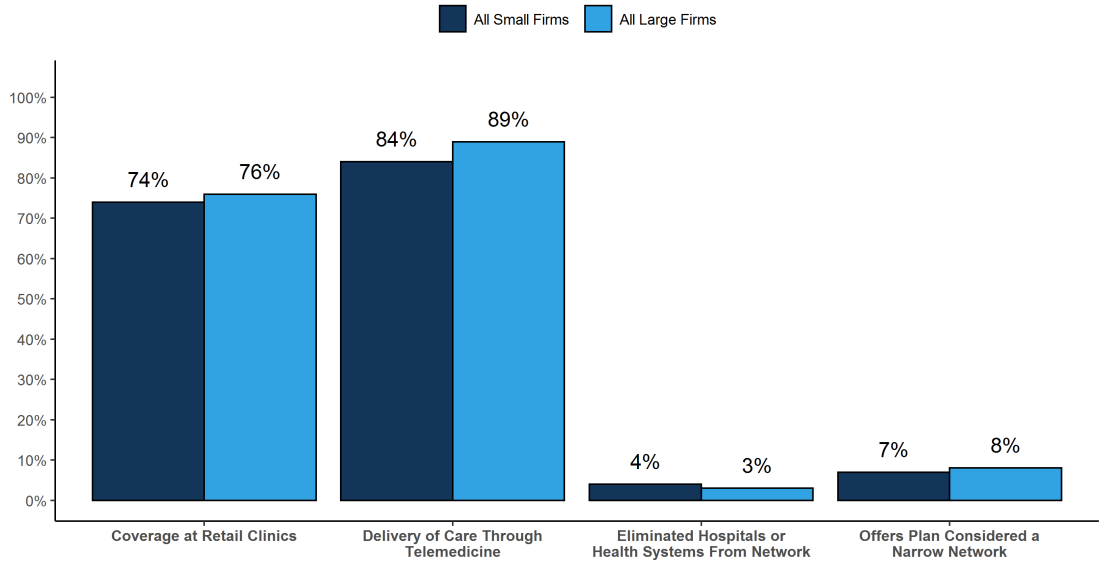
NOTE: A private exchange is one created by a consulting company; not by a federal or state government. Private exchanges allow employees to choose from several health benefit options offered on the exchange. In 2020, 5.0% of offering firms with 50 or more workers offered coverage through a private exchange.
SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 13.17
Among Firms with 50 or More Workers Offering Health Benefits, Percentage of Covered Workers Enrolled at a Firm That Offers Benefits Through a Private or Corporate Exchange, by Firm Size, 2015-2020



Tests found no statistical difference from estimate for the previous year shown ($p < .05$).
NOTE: A private exchange is one created by a consulting company; not by a federal or state government. Private exchanges allow employees to choose from several health benefit options offered on the exchange. In 2020, 5.0% of offering firms with 50 or more workers offered coverage through a private exchange.
SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2015-2017

Figure 13.18
Among Firms Offering Health Benefits, Percentage of Firms Whose Plan Has Various Features, by Firm Size, 2020



Tests found no statistical difference between All Small Firms and All Large Firms estimate ($p < .05$).
NOTE: See Section 13 text for definitions of these features. For Retail Clinics and Telemedicine, firms were asked if their plan with the largest enrollment had these features. Large Firms have 200 or more workers. Small Firms have 3-199 workers, with the exception of Telemedicine, which were only asked of firms with at least 50 workers.
SOURCE: KFF Employer Health Benefits Survey, 2020

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KFF (Kaiser Family Foundation) is a nonprofit organization
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October 2020