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Annual Survey

KFF

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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.

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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 2021 survey included 1,686 interviews with non-federal public and private firms.

Annual premiums for employer-sponsored family health coverage reached $22,221 this year, up 4% from last year, with workers on average paying $5,969 toward the cost of their coverage. The average deductible among covered workers in a plan with a general annual deductible is $1,669 for single coverage. Fifty-eight 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 59%.

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 almost 155 million nonelderly people.[1] To provide current information about employer-sponsored health benefits, KFF conducts an annual survey of private and non-federal public employers with three or more workers. This is the twenty-third Employer Health Benefits Survey (EHBS) and reflects employer-sponsored health benefits in 2021.

For the second consecutive year, the COVID-19 pandemic has dominated public policy, including health care and employment policy. The survey was fielded from mid-January through July, which means we began collecting data before COVID vaccines were widely available and stopped interviews after a reasonably large share of the population (in at least some places) had been vaccinated. We revised the survey for 2021 to ask about changes employers and health plans made to address potential issues and uncertainties arising from the pandemic.

HEALTH INSURANCE PREMIUMS AND WORKER CONTRIBUTIONS

In 2021, the average annual premiums for employer-sponsored health insurance are $7,739 for single coverage and $22,221 for family coverage [Figure A]. The average single and family premiums increased 4% over the past year. During this period, workers' wages increased 5% and inflation increased 1.9%.[2]

The average premium for family coverage has increased 22% over the last five years and 47% over the last ten years [Figure A].

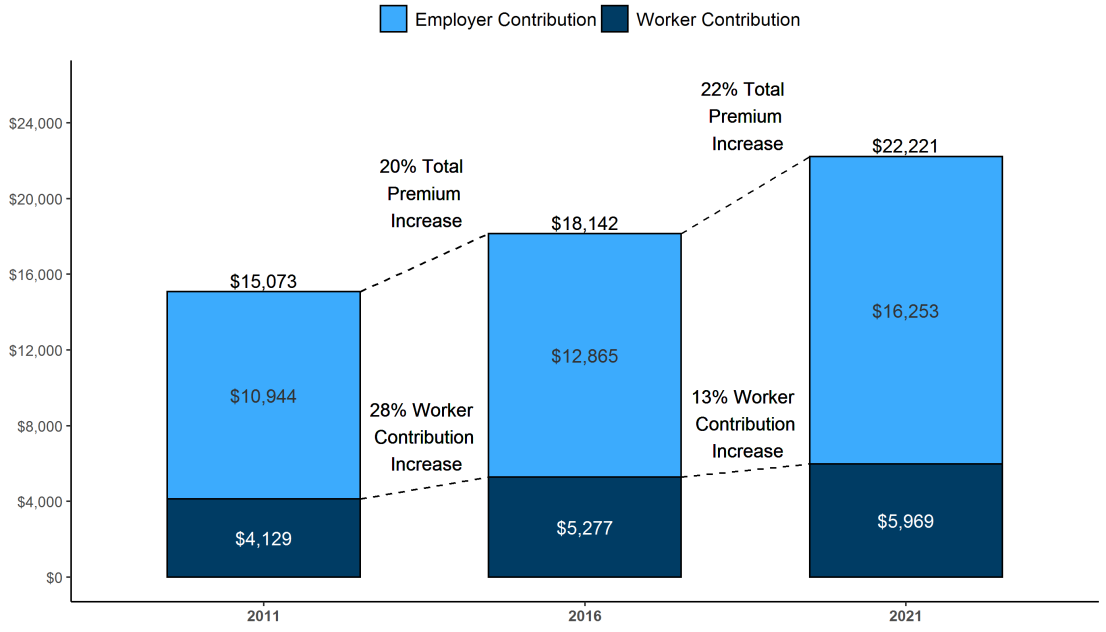
Covered workers in small and large firms have similar premiums for single coverage ($7,813 vs. $7,709) and family coverage ($21,804 vs. $22,389). The average premiums for covered workers in firms with a relatively large share of lower-wage workers (where at least 35% of the workers earn $28,000 annually or less) are lower than the average premiums for covered workers in firms with a smaller share of lower-wage workers for single coverage ($7,156 vs. $7,796) and family coverage ($20,315 vs. $22,407)[3]. The average premiums for covered workers in high-deductible health plans with a savings option (HDHP/SO) are lower that the overall average premiums for single coverage ($7,016) and family coverage ($20,802) [Figure B]. In contrast, the average premiums for covered workers enrolled in PPOs are higher that the overall average premiums for single ($8,092) and family coverage ($23,312).

[1] KFF. Health Insurance Coverage of the Nonelderly (Internet). San Francisco (CA): KFF; 2019 [cited 2021 Aug 19]. Available from: https://www.kff.org/other/state-indicator/nonelderly-0-64/ Estimate from the American Community Survey.

[2] Bureau of Labor Statistics. Consumer Price Index historical tables for, U.S. City Average of Annual Inflation (Internet). Washington (DC): BLS; [cited 2021 Oct 4]. 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 2021 Oct 4]. Available from: https://www.bls.gov/ces/publications/highlights/highlights-archive.htm

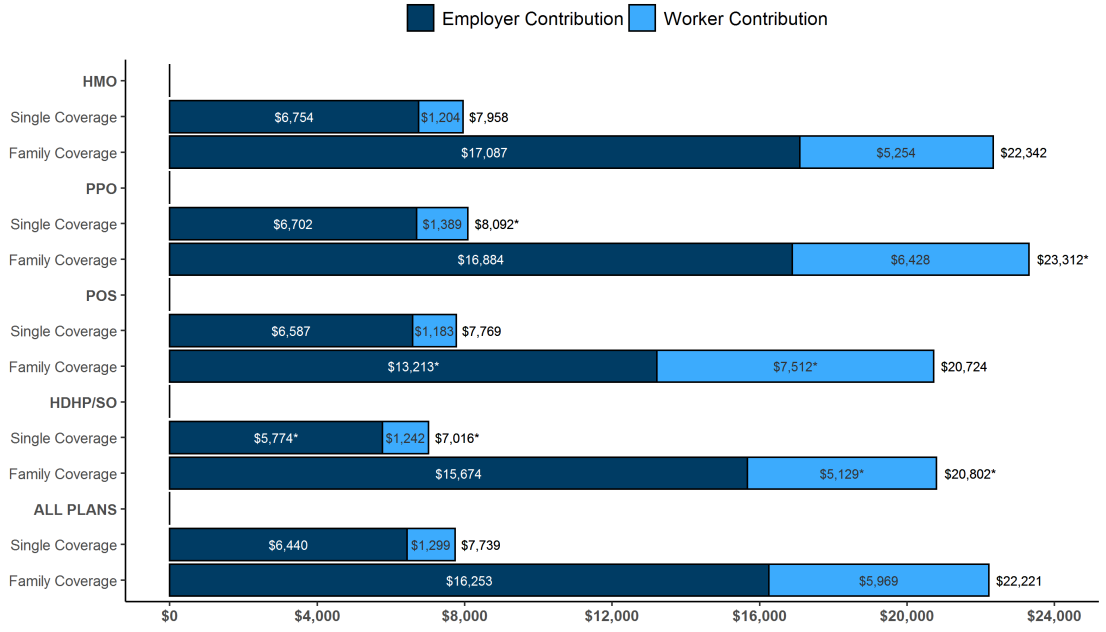
[3] This threshold is based on the twenty-fifth percentile of workers' earnings ($28,000 in 2021). Bureau of Labor Statistics. May 2019 National Occupational Employment and Wage Estimates: United States. Washington (DC): BLS. Available from: http://www.bls.gov/oes/current/oes_nat.htm

Figure A
Average Annual Worker and Employer Premium Contributions for Family Coverage, 2011, 2016, and 2021



SOURCE: KFF Employer Health Benefits Survey, 2021; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2011 and 2016

Figure B
Average Annual Worker and Employer Premium Contributions for Single and Family Coverage, by Plan Type, 2021



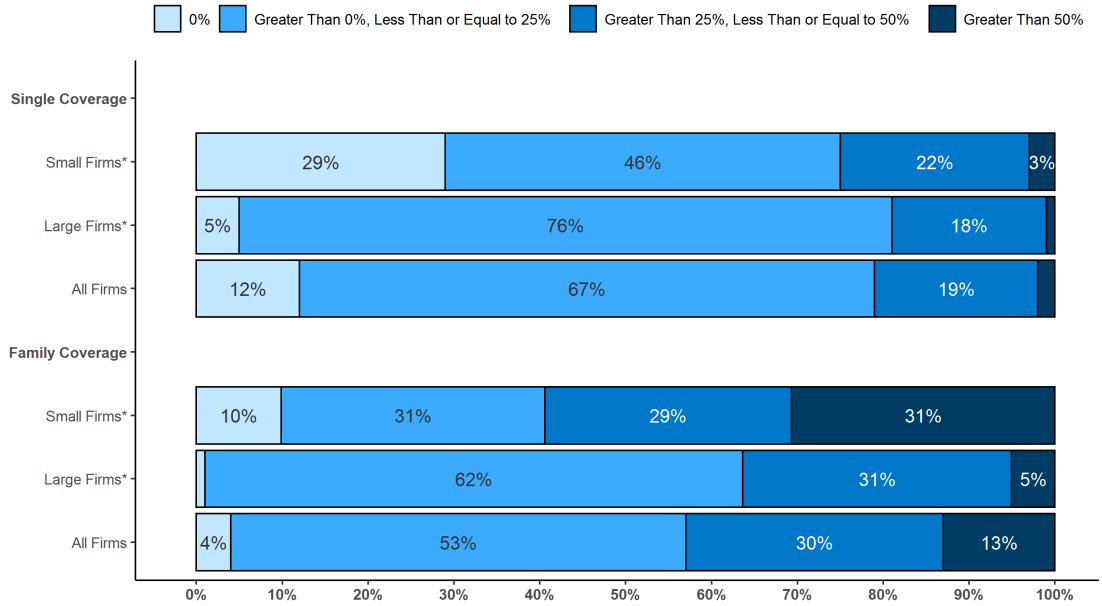
* Estimate is statistically different from All Plans estimate within coverage type ($p < .05$).
SOURCE: KFF Employer Health Benefits Survey, 2021

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 28% of the premium for family coverage. Covered workers in small firms on average contribute a higher percentage of the premium for family coverage than covered workers in large firms (24% vs. 37%). Covered workers in firms with a relatively large share of lower-wage workers have higher average contribution rates for family coverage than those in firms with a smaller share of lower-wage workers (35% vs. 27%). 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, while covered workers in public firms on average contribute a lower percentage of the premium for both single and family coverage. Covered workers in firms with a relatively large share of younger workers (where at least 35% of workers are age 26 or younger) have higher average contribution rates for single coverage (23% vs. 17%) and for family coverage (35% vs. 28%) than those in firms with a smaller share of younger workers.

Twenty-nine percent of covered workers in small firms are in a plan where the employer pays the entire premium for single coverage, compared to only 5% of covered workers in large firms. In contrast, 31% 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 5% of covered workers in large firms [Figure C].

The average annual dollar amounts contributed by covered workers for 2021 are $1,299 for single coverage and $5,969 for family coverage, similar to the amounts last year. The average dollar contribution for family coverage has increased 13% since 2016 and 45% since 2011 [Figure A]. Eight percent of covered workers, including 20% 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, 2021



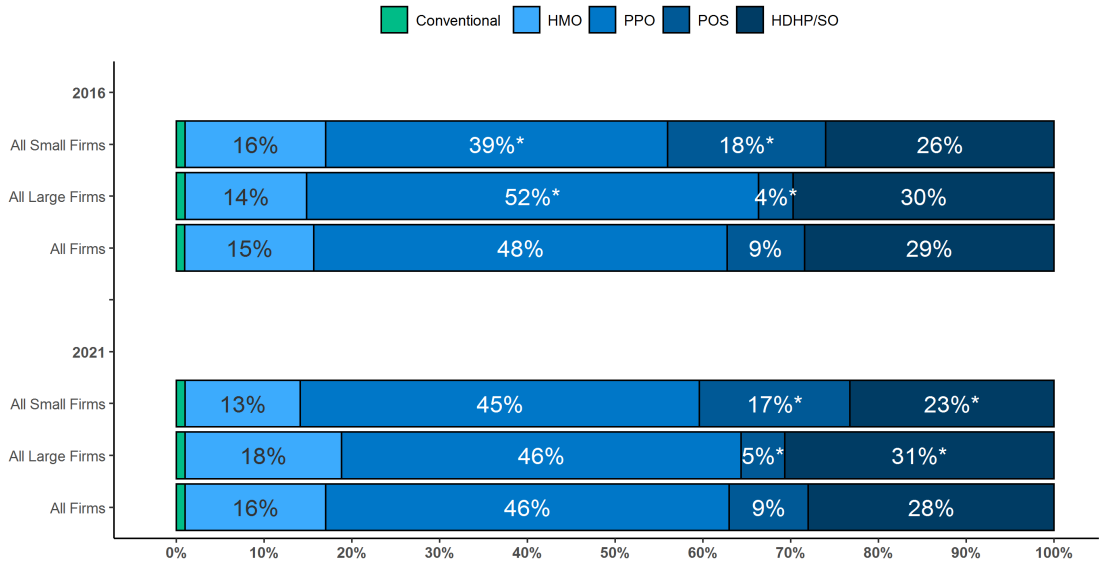
* Distributions are statistically different between Small Firms and Large Firms within coverage type ($p < 0.05$).
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2021

PLAN ENROLLMENT

PPOs are the most common plan type, enrolling 46% of covered workers in 2021. Twenty-eight percent of covered workers are enrolled in a high-deductible plan with a savings option (HDHP/SO), 16% in an HMO, 9% in

a POS plan, and 1% in a conventional (also known as an indemnity) plan [Figure D]. These percentages are each similar to the percentages for the corresponding plan type last year.

Figure D
Distribution of Health Plan Enrollment for Covered Workers, by Plan Type and Firm Size, 2016 and 2021



* 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, 2021; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2016

SELF FUNDING

Many firms, particularly larger firms, self fund, or pay for some or all health services for their workers directly from their own funds rather than by purchasing health insurance. Sixty-four percent of covered workers, including 21% of covered workers in small firms and 82% in large firms, are enrolled in plans that are self-funded. The percentage of firms offering health benefits that are self funded in 2021 is similar to the percentage last year.

Forty-two percent of small firms report that they have a level-funded plan, a much higher percentage than the previous two years. These arrangements combine a relatively small self-funded component with stoploss insurance which limits the employer's liability to low attachment points that 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. The substantial increase for 2021 suggests that that there may be a significant shift in the small group market toward health-status-based rating, so it will be important to monitor this trend over the next several years.

EMPLOYEE COST SHARING

Most covered workers must pay a share of the cost when they use health care services. Eighty-five 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 $1,669, similar to last year. The average deductible for covered workers is higher in small firms than large firms ($2,379 vs. $1,397). The average single coverage annual deductible among covered workers with a deductible has increased 13% over the last five years and 68% over the last ten years.

Deductibles have increased in recent years due to both 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. Twenty-seven percent of covered workers in an HDHP with a Health Reimbursement Arrangement (HRA), and 2% 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 20% of covered workers in an HDHP with an HRA and 17% 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 2021 value of $1,434 is 17% higher than the average general annual deductible for single coverage of $1,221 in 2016 and 92% higher than the average general annual deductible of $747 in 2011.

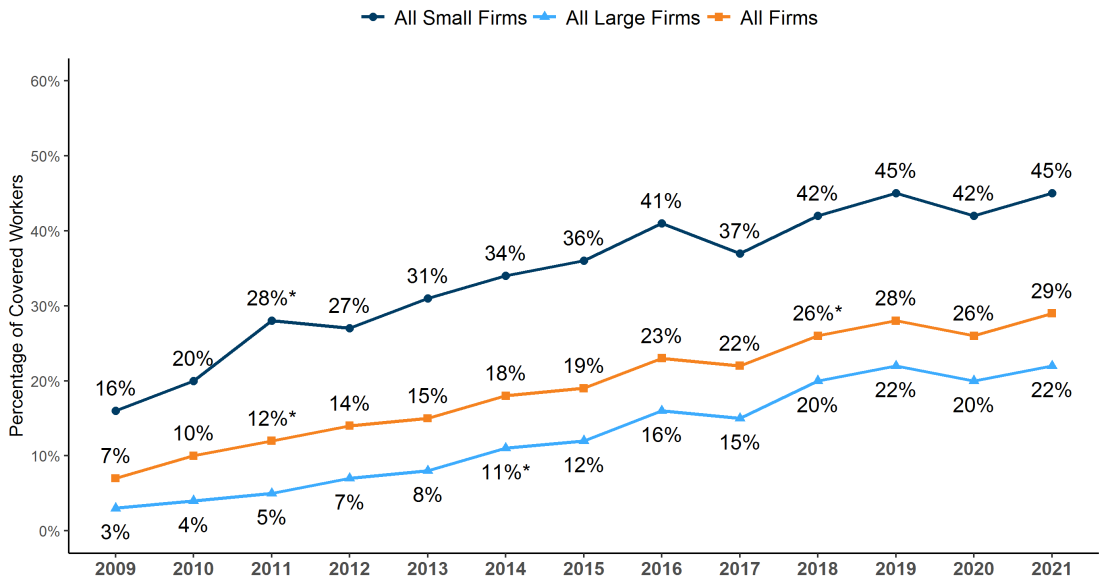
Another way to look at deductibles is the percentage of all covered workers who are in a plan with a deductible that exceeds certain thresholds. Over the past five years, the percentage of covered workers with a general annual deductible of $2,000 or more for single coverage has grown from 23% to 29% [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 $25 for primary care and $42 for specialty care. The average coinsurance rates are 19% for primary care and 20% for specialty care. These amounts are similar to those in 2020.

Most workers also face additional cost sharing for a hospital admission or outpatient surgery. Sixty-eight percent of covered workers have coinsurance and 12% have a copayment for hospital admissions. The average coinsurance rate for a hospital admission is 20% and the average copayment is $321 per hospital admission. The cost sharing requirements 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, 13% are in a plan with an out-of-pocket maximum of less than $2,000, while 27% 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, 2009-2021



* 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, 2018-2021; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2009-2017

AVAILABILITY OF EMPLOYER-SPONSORED COVERAGE

Fifty-nine percent of firms offer health benefits to at least some of their workers, similar to the percentage last year. The likelihood of offering health benefits increase with firm size; only 49% of firms with 3 to 9 workers offer coverage, while virtually all firms with 1,000 or more workers offer coverage to at least some workers.

While the vast majority of firms are small, most workers work for large firms that offer coverage. In 2021, 91% of workers are employed by a firm that offers health benefits to at least some of its workers.

Although the vast majority of workers are employed by firms that offer health benefits, many workers are not covered by their own job. Some are not eligible to enroll (e.g., waiting periods or part-time or temporary work status) while 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, 81% of workers are eligible for the health benefits offered, and of those eligible, 77% take up the firm's offer, resulting in 62% of workers in offering firms enrolling in coverage through their employer. All of these percentages are similar to those in 2020.

Looking at workers in both firms that offer health benefits and firms that do not, 56% of workers are covered by health plans offered by their employer, similar to the percentage last year.

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. Dislocations caused by the COVID-19 pandemic, including job disruptions, remote work, and social distancing,

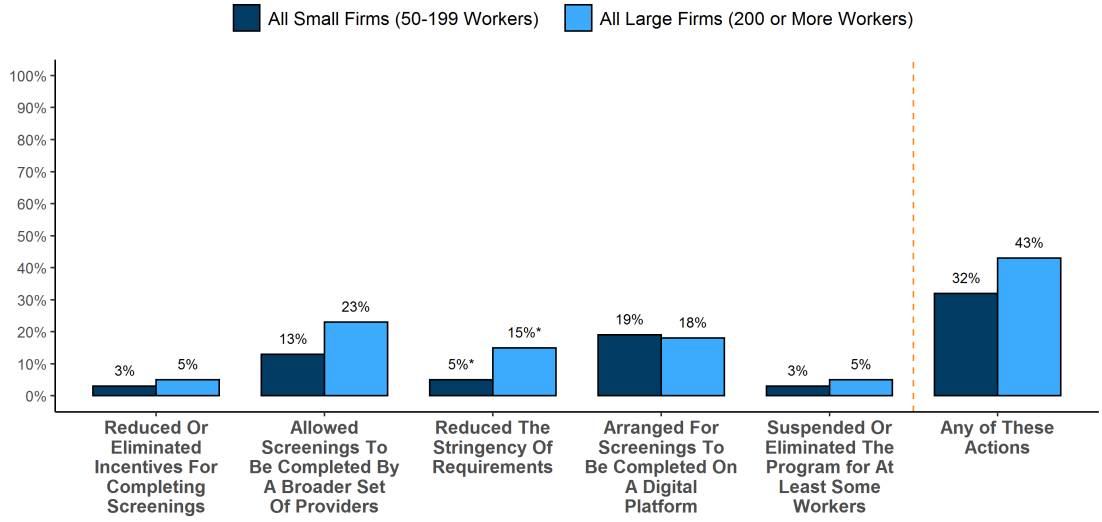
challenged workers' abilities to participate in some of the activities associated with these programs. Some employers addressed these challenges by adjusting incentives, adding new services, vendors, or digital content, or by expanding service locations. For 2021, we modified our questions to focus on the changes made by employers to address challenges arising from the COVID-19 pandemic.

Biometric Screenings. Among firms offering health benefits, 26% of small firms and 38% of large firms provide workers the opportunity to complete a biometric screening. The percentage of large firms providing workers the opportunity to complete a biometric screening is lower than the percentage last year (50%). Among large firms offering health benefits, 16% not offering a biometric screening opportunity in 2021 reported offering a biometric screening opportunity in 2020.

Firms with at least 50 employees offering a biometric screening opportunity both this year and last year were asked about changes that they have made to their programs since the start of the COVID-19 pandemic. Overall, among firms offering a biometric screening opportunity both this year and last year, 32% of smaller firms (50-199 employees) and 43% of larger firms report making some change in their biometric screening programs since the start of the COVID-19 pandemic [Figure F]. The changes include:

- Three percent of smaller firms and 5% of larger firms reduced or eliminated incentives for completing the screening.
- Thirteen percent of smaller firms and 23% of larger firms permitted screenings to be completed by a broader set of providers.
- Five percent of smaller firms and 15% of larger firms reduced the stringency of screening requirements.
- Nineteen percent of smaller firms and 18% of larger firms arranged for biometric screenings to be performed on a digital platform.
- Three percent of smaller firms and 5% of larger firms suspended or eliminated the program for at least some workers.

Figure F
Among Firms Which Offered Biometric Screening This Year and Last Year, Changes Firm Made to Biometric Screening Programs Due to the COVID-19 Pandemic, 2021



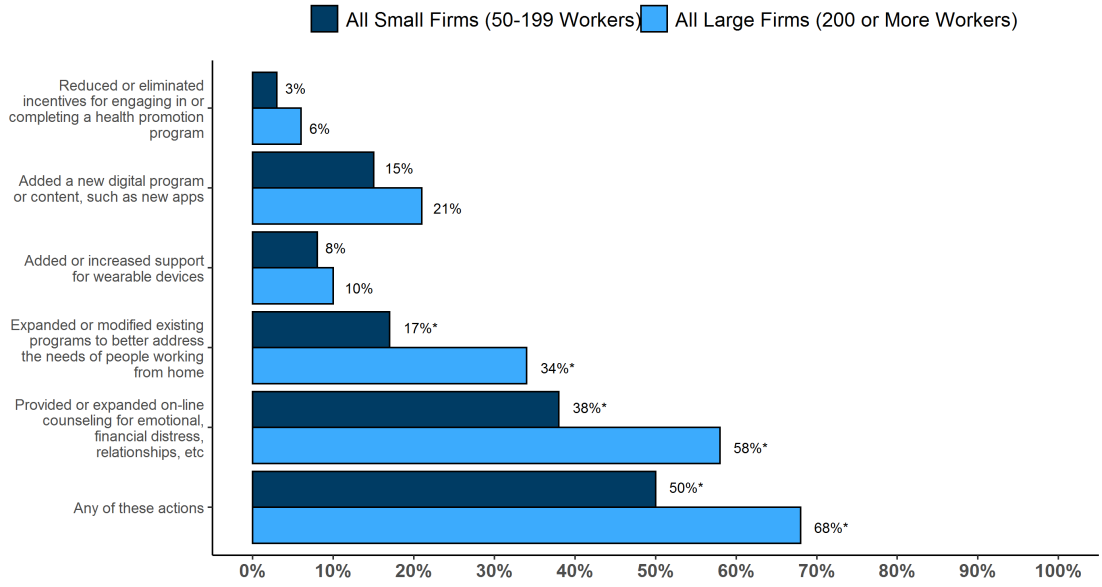
* Estimate is statistically different between All Small Firms and All Large Firms estimate ($p < .05$).
NOTE: 33% of firms with 50 or more workers offering health benefits reported that they offered employees the opportunity to complete a biometric screening program last year. Biometric screening is 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. We asked respondents about changes they made due to the COVID-19 pandemic from January 2020 that were still in effect at the time of the interview. Small Firms have 50 to 199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2021

Health and Wellness Promotion Programs. Most firms offering health benefits offer programs to help workers identify and address health risks and unhealthy behaviors. Fifty-eight percent of small firms and 83% of large firms offer a program in at least one of these areas: smoking cessation, weight management, and behavioral or lifestyle coaching.

Firms with 50 or more employees with a wellness or health promotion program were asked if they made changes to their programs since the beginning of the COVID-19 pandemic. Overall, 50% of smaller firms (50-199 employees) and 68% of larger firms reported some type of change [Figure G].

- Three percent of smaller firms and 6% of larger firms reduced or eliminated incentives associated with their program.
- Fifteen percent of smaller firms and 21% of larger firms added a new digital program or digital content to their program.
- Eight percent of smaller firms and 10% of larger firms increased support for wearable devices.
- Seventeen percent of smaller firms and 34% of larger firms expanded or modified the content of their existing programs to better address the health needs of people working from home.
- Thirty-eight percent of smaller firms and 58% of larger firms provided or expanded on-line counseling services for emotional or financial distress, relationship issues, or other stressful situations.

Figure G
Among Firms Offering a Specified Wellness Program, Percentage of Firms Which Changed Wellness Programs Due to the COVID-19 Pandemic, by Firm Size, 2021



* Estimate is statistically different between All Small Firms and All Large Firms estimate ($p < .05$).
NOTE: Small Firms have 50 to 199 workers and Large Firms have 200 or more workers. We asked respondents about changes they made due to the COVID-19 pandemic from January 2020 that were still in effect at the time of the interview.
SOURCE: KFF Employer Health Benefits Survey, 2021

TELEMEDICINE

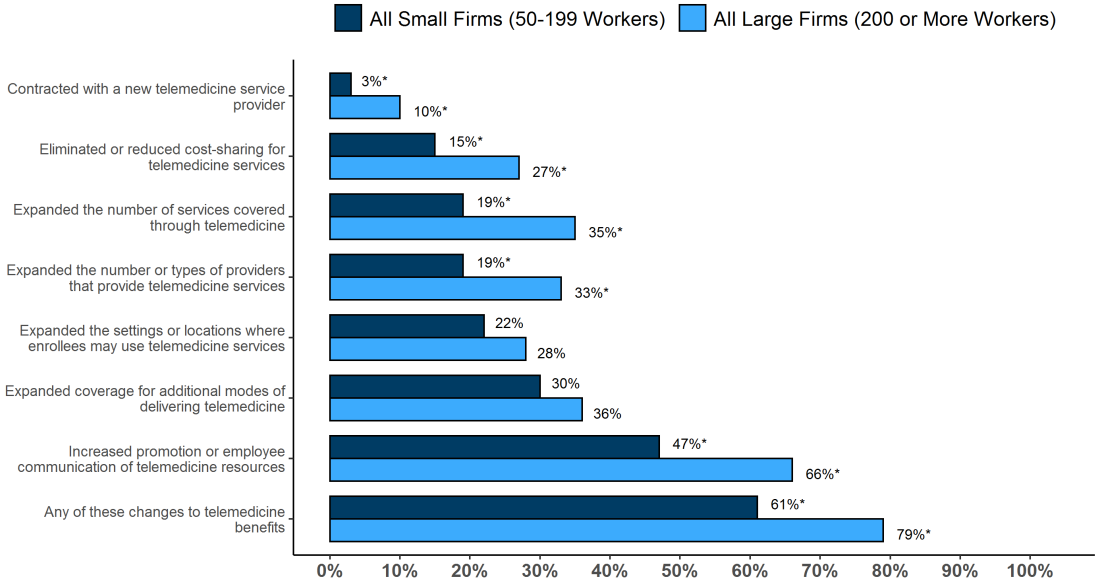
Telemedicine is the delivery of health care services through telecommunications to a patient from a provider who is at a remote location, including video chat and remote monitoring. While telemedicine was becoming

an increasingly popular benefit prior to the COVID-19 pandemic, its use has increased dramatically since the pandemic began, drawing significant attention from policymakers. In 2021, 95% 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, higher than the percentages last year (85%) and three years ago (67%).

Employers with 50 or more employees offering telemedicine services were asked about changes they made to their programs after the beginning of the COVID-19 pandemic. Among these firms:

- Nineteen percent of smaller firms and 35% of larger firms expanded the number of services covered through telemedicine [Figure H].
- Nineteen percent of smaller firms and 33% of larger firms expanded the number or type of providers that could provide telemedicine services.
- Fifteen percent of smaller firms and 27% of larger firms reduced or eliminated cost sharing for telemedicine services.
- Twenty-four percent of employers expanded the settings or locations where enrollees may use telemedicine services.
- Thirty-one percent of employers expanded coverage for additional modes of delivering telemedicine, such as by telephone.
- Three percent of smaller firms and 10% of larger firms contracted with a new telemedicine service provider, such as a specialized telemedicine vendor.
- Forty-seven percent of smaller firms and 66% of larger firms increased promotion or employee communication of telemedicine resources.

Figure H
Among Firms Offering Telemedicine Benefits, Changes the Firm Made to Telemedicine Benefits During the COVID-19 Pandemic, by Firm Size, 2021



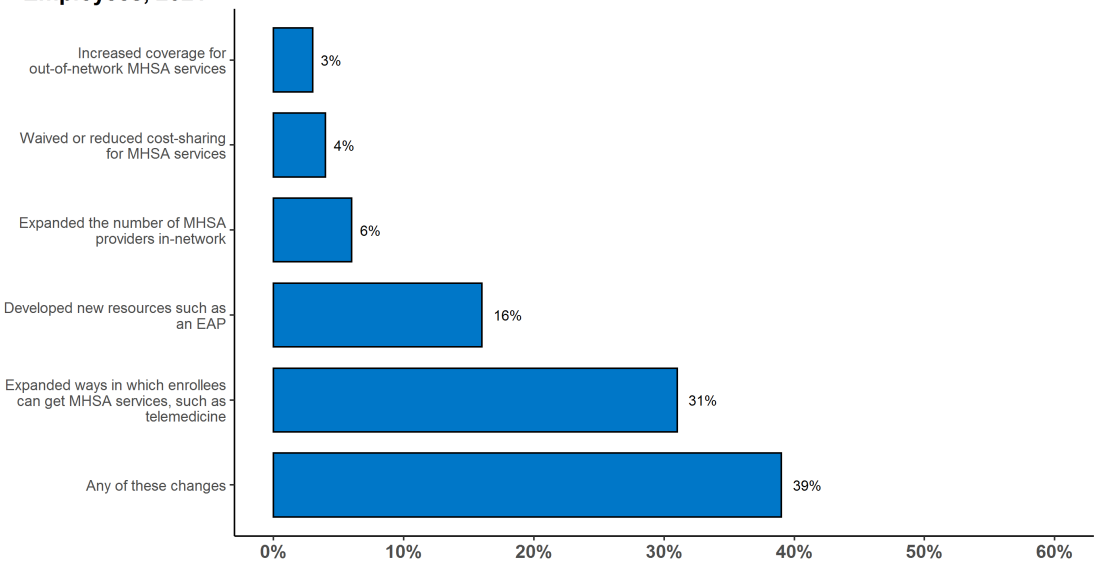
* Estimate is statistically different between All Small Firms and All Large Firms estimate ($p < .05$).
NOTE: Small Firms have 50 to 199 workers and Large Firms have 200 or more workers. We asked respondents about changes they made due to the COVID-19 pandemic from January 2020 that were still in effect at the time of the interview.
SOURCE: KFF Employer Health Benefits Survey, 2021

CHANGES TO MENTAL AND BEHAVIORAL HEALTH BENEFITS DUE TO COVID-19

The social and economic disruptions caused by the COVID-19 pandemic have placed an unprecedented level of stress on people all over the world. Many employers took steps to assist employees and family members facing these stresses. Employers with at least 50 employees offering health benefits were asked about changes they made to their health plans after the start of the COVID-19 pandemic to support the mental health of their employees.

- Sixteen percent of employers developed new resources, such as an employee assistance program [Figure I].
- Three percent of employers increased coverage for out-of-network mental health or substance abuse services. Firms with 1,000 or more employees were more likely than smaller firms (50 to 999 employees) to increase coverage for out-of-network services (9% v. 3%).
- Six percent of employers, including 16% of employers with 5,000 or more employees, expanded the number of mental health or substance abuse providers in their plans' networks.
- Four percent of employers waived or reduced cost-sharing for mental health or substance abuse services. The percentage of firms waiving or reducing cost sharing for these services increased with firm size.
- Thirty-one percent of employers expanded the ways through which enrollees could get mental health or substance abuse services, such as through telemedicine.

Figure I
Among Firms with 50 or More Employees Offering Health Benefits, Changes the Firm Made Since the Beginning of the COVID-19 Pandemic to Meet the Mental Health Needs of Employees, 2021



NOTE: MHSA refers to Mental Health and/or Substance Abuse. EAP refers to Employee Assistance Programs. We asked respondents about changes they made due to the COVID-19 pandemic from January 2020 that were still in effect at the time of the interview.
SOURCE: KFF Employer Health Benefits Survey, 2021

PRESCRIPTION DRUG MANAGEMENT

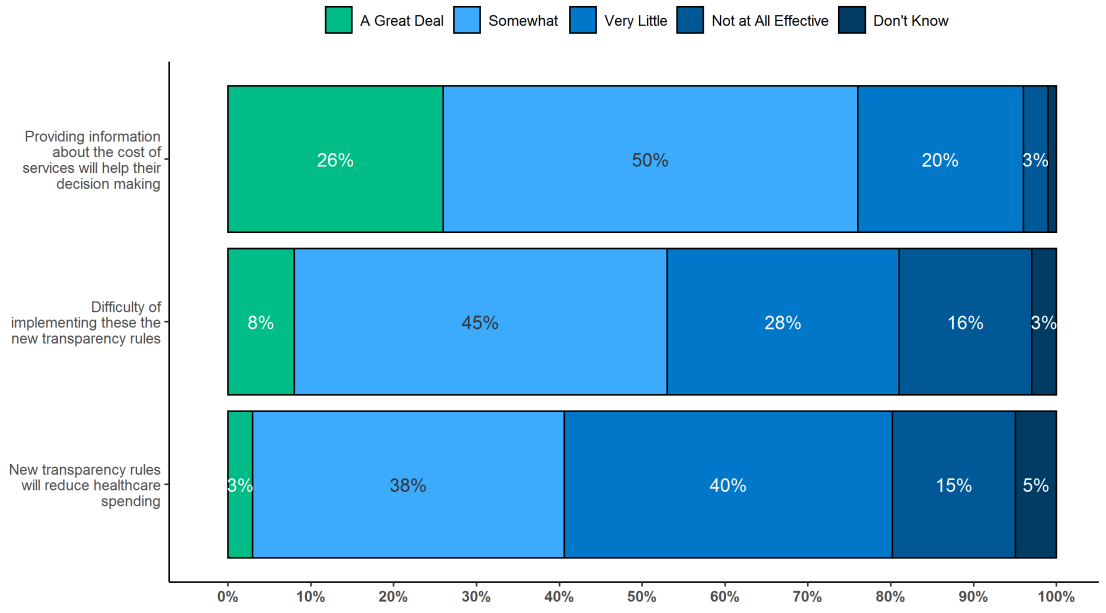
Among employers with 500 or more employees offering prescription drug benefits in 2021, 18% have programs that exclude subsidies from prescription drug manufacturers, such as coupons, from counting towards an

enrollee's deductible or out-of-pocket limit. Among these same employers, 13% made a change to their prescription program in the last two years to delay the inclusion of new high-cost drug therapies until the therapy is proven effective.

HEALTH CARE PRICE TRANSPARENCY

New federal rules will require health plans (including self-funded plans) make information available to enrollees about the estimated cost of services and cost sharing on a "real-time" basis. Twenty-six percent of large employers offering health benefits believe that providing employees with additional information about the cost of services will help their health care decision-making "a great deal" and an additional 50% say that it will help their decision-making "somewhat". Employers were less certain about the impact of health care costs, with only 3% of large employers saying that the new transparency rules will reduce health spending "a great deal", while 15% say that they will be reduce health spending "not at all." Thirty-eight percent of these firms say that the new rules will reduce spending "somewhat" and 40% say that they will reduce spending "very little" [Figure J].

Figure J
Among Large Firms Offering Health Benefits, Firms Opinions on Health Transparency Requirements, 2021



NOTE: Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2021

DISCUSSION

The COVID-19 pandemic remains the most important story of 2021, and how employers are adapting their benefits to meet the changing needs of employees is the most important health benefit story. Overall market characteristics changed little: premiums continued on a modest growth trend, the share of people offered coverage at their work and the share of those covered by their jobs remained unchanged, as did the average deductible and other cost-sharing levels. While there was a modest amount of coverage loss, likely due to

employment disruptions caused by the pandemic, the market was quite stable for the large share of enrollees who retained their coverage.[4]

Employers did make a number of changes to their benefit programs and how services are delivered in response to COVID-19 challenges. One that has received a good amount of attention is telemedicine. Not only did the percentages of small and large employers with a telemedicine benefit increase again in 2021, but many employers also made the benefit easier to use by expanding the number and types of providers available, expanding the settings or locations where the benefit could be used, supporting additional modes of communicating with providers, or waiving cost sharing for telemedicine services. While some of these actions may change when the pandemic ends, employers appear convinced that telemedicine will continue to be important in the future. Almost half (47%) of employers with 50 or more employees offering health benefits agree that telemedicine will be very important in providing access in the future, while only 4% said that telemedicine would be unimportant in the future.

Another issue that has received a good deal of attention during the pandemic is mental health. The significant economic and social dislocations have placed unprecedented stresses on workers and their families, and some employers took steps to enhance benefits and access to services. Thirty-one percent of employers with 50 or more employees expanded the ways through which enrollees could get mental health or substance abuse services, such as through telemedicine, and sixteen percent developed new resources, such as an employee assistance program. These enhancements were timely, as 12% of employers with at least 50 employees, including 46% of firms with 5,000 or more employees, saw an increase in the share of employees using mental health services since the COVID-19 pandemic began.

Employers also made changes to their health promotion and wellness programs to adapt to the circumstances their workers faced during the pandemic, such as remote work. Fifty-five percent of firms with 50 or more employees made some type of change to their health promotion and wellness programs in response to the COVID-19 pandemic, including 17% that added a new digital program or digital content to their program and 43% that provided or expanded on-line counseling services for emotional or financial distress, relationship issues, or other stressful situations.

Looking ahead to 2022, the pandemic has not ended but the uncertainties seem fewer than at the beginning of 2021. One issue for both employment and health benefits is whether some of the changes brought about by the pandemic will endure. It was already apparent before the pandemic that more of the workforce could do their jobs remotely, but the pandemic proved the point. Whether and how employers structure benefits to support a potentially more far-flung workforce will be an important topic for the next few years. Similarly, it remains to be seen whether telemedicine will continue to grow as a source of access to care, or fade back to a more specialized option that is primarily available in difficult situations and hard to reach locations. During the pandemic, it has been a particularly important source for mental and behavioral heath care, an area of health care where provider access, at least within network, has been a longer-standing issue. This will be an area of particular interest going forward because enhanced access to these benefits may well increase costs. Another issue to watch will be the increase in level-funded premium plans among smaller employers. These plans use health status in underwriting and setting premiums in plans even for very small employers. We saw a large jump in the share of small employers with these plans in 2021, and if this continues, it could disrupt the community-rated pricing structure for ACA compliant small group plans.

The COVID pandemic has asked many questions of employers about their roles in assuring the health of their workers, their customers, and the public at large. Perhaps the most pressing issue currently is how to implement the federal vaccine requirement for employees of large employers, including policies about exceptions and whether or not to have incentives in addition to the requirement. Other complex issues have involved masking requirements, remote work, quarantines, assuring worker safety in interactions with coworkers and the public. Employers also have been challenged to make changes to their benefit plans to address the many health and social issues that have arisen during the pandemic, and many have done so. We can expect that employers will need to continue to adapt their programs as the pandemic continues into 2022.

[4] McDermott, D., Cox, C., Rudowitz, R., & Garfield, R. (2020, December 9). How Has the Pandemic Affected Health Coverage in the U.S.? KFF. Keisler-Starkey, K., & Mykyta, L. (2021, September 14). Private Health Coverage of Working-Age Adults Drops From Early 2019 to Early 2021. The United States Census Bureau. https://www.census.gov/america-counts/current-health-insurance-coverage https://www.kff.org/policy-watch/how-has-the-pandemic-affected-health-coverage-in-the-u-s/

METHODOLOGY

The KFF 2021 Employer Health Benefits Survey reports findings from a survey of 1,686 randomly selected non-federal public and private employers with three or more workers. Researchers at NORC at the University of Chicago and KFF designed and analyzed the survey. Davis Research, LLC conducted the field work between January and July 2021. In 2021, the overall response rate is 15%, which includes firms that offer and do not offer health benefits. 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 unless otherwise noted. Values below 3% are not shown on graphical figures to improve the readability of those graphs. Some distributions may not sum due to rounding. This year, we made several changes to the survey questionnaire in order to reduce the length and burden of the survey. For more information on this change and other information on the survey methodology, see the Survey Design and Methods section at http://ehbs.kff.org/.

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

Employer Health Benefits

2021 Annual Survey

Survey Design and Methods

Survey Design and Methods

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 2021, Davis interviewed business owners as well as human resource and benefits managers at 1,686 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).[5] 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). 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. Throughout this report, we use the term "in-network" to refer to services received from a preferred provider.

To reduce survey burden, questions on cost sharing for office visits, hospitalization, outpatient surgery and prescription drugs were only asked about the firm's largest plan type. Firms with sponsoring multiple plan types, were asked for their premiums, worker contribution and deductibles for their two largest plan types. Within each plan type, respondents are asked about the plan with the most enrollment.

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 2021 plan year lags behind the calendar year [Figure M.1]. In some cases, plans may report the attributes of their 2020 plans and some plan attributes (such as HSA deductible limits) may not meet the calendar year regulatory requirements. Many employers continued to experience significant disruptions from the COVID-19 pandemic. Approximately 60% of the responses (composing 56% of the covered worker weight) were collected between January and March.

[5] 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, 2021

	Percentage of Covered Workers	Percentage of Firms
January	73%	30%
February	1	4
March	1	3
April	3	6
May	2	7
June	2	5
July	6	5
August	2	5
September	3	10
October	3	5
November	1	6
December	4%	14%

SOURCE: KFF Employer Health Benefits Survey, 2021

SAMPLE DESIGN

The sample for the annual KFF 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' 2017 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 2020), 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 2018 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 2019 or the 2020 survey, or both. Firms with 3-9 employees are not included in the panel to minimize the potential of panel effects. As a result, 955 of the 1,686 firms that completed the full survey also participated in either the 2019 or 2020 surveys, or both. In total, 140 firms participated in 2019, 192 firms participated in 2020, and 623 firms participated in both 2019 and 2020. 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 extended methods at http://ehbs.kff.org/

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 15% [Figure M.2].[6] 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. Over the last two years, we have seen a larger decrease in response rates, in part a result of workplace disruptions accompanying the pandemic.

The vast majority of questions are asked only of firms that offer health benefits. A total of 1,418 of the 1,686 responding firms indicated they offered health benefits. This year we have a smaller number of completes than in previous years (326 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 4,099 firms responded to this question (including 1,686 who responded to the full survey and 2,413 who responded to this one question). These responses are included in our estimates of the percentage of firms offering health benefits.[7] The response rate for this question is 36% [Figure M.2].

Figure M.2

Response Rates for Various Subsets of the Sample, 2021

	Response Rate for Full Survey	Response Rate for Firms Answering A6
Small Firms (3-9 Workers)	12%	32%
Small Firms (3-199 Workers)	19%	41%
Large Firms (200 or More Workers)	13%	34%
Panel Firms (Completed Survey in at Least One of the Past Two Years)	44%	67%
Non Panel Firms	8%	30%
ALL FIRMS	**15%**	**36%**

SOURCE: KFF Employer Health Benefits Survey, 2021

While response rates have decreased, elements of the survey design limit the potential impact of a response bias. Most major statistics are weighted by the percentage of covered workers at a firm. 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]

[6] 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.

[7] 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.

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, 2021

	Sample Size	Sample Distribution After Weighting	Percentage of Total for Weighted Sample
FIRM SIZE			
3-9 Workers	121	1,938,122	59.1%
10-24 Workers	223	795,949	24.3
25-49 Workers	166	288,039	8.8
50-199 Workers	236	197,519	6
200-999 Workers	424	46,289	1.4
1,000-4,999 Workers	312	8,638	0.3
5,000 or More Workers	204	2,336	0.1
REGION			
Northeast	280	648,541	19.8%
Midwest	523	673,368	20.5
South	544	1,135,657	34.7
West	339	819,325	25
INDUSTRY			
Agriculture/Mining/Construction	111	369,031	11.3%
Manufacturing	164	175,343	5.4
Transportation/Communications/Utilities	95	126,464	3.9
Wholesale	75	160,888	4.9
Retail	113	373,208	11.4
Finance	102	207,793	6.3
Service	638	1,403,893	42.8
State/Local Government	132	48,567	1.5
Health Care	256	411,705	12.6
ALL FIRMS	**1,686**	**3,276,892**	**100%**

SOURCE: KFF Employer Health Benefits Survey, 2021

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.

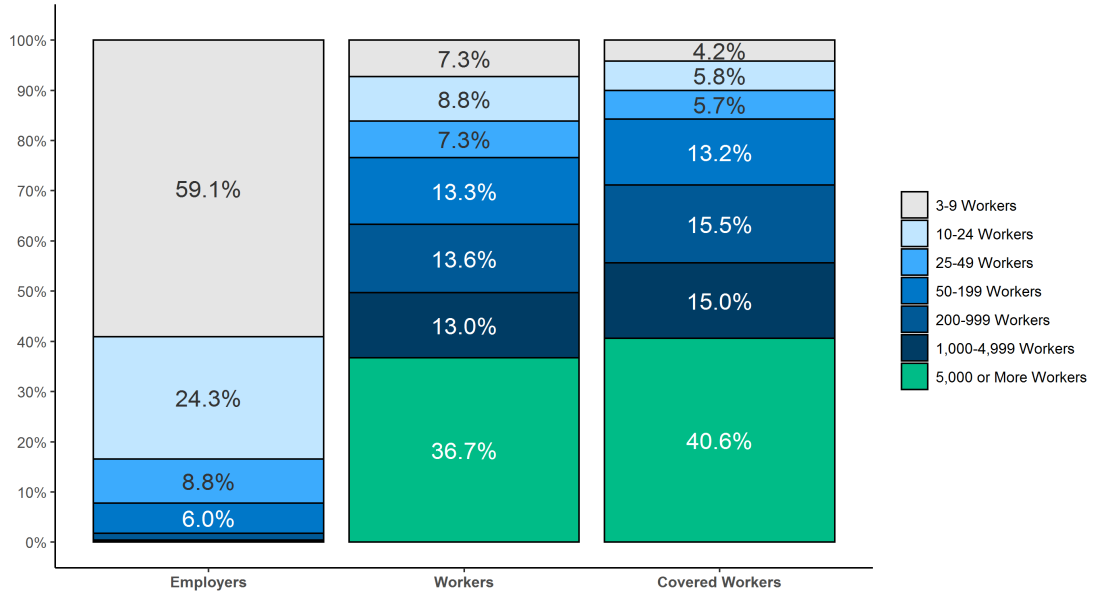
Figure M.5
States by Region, 2021

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, 2021. 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 59.1% employ 3 to 9 workers; such firms employ 7.3% of workers, and 4.2% of workers covered by health insurance. In contrast, less than one percent of firms employ 5,000 or more workers; these firms employ 36.7% 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, 2021



NOTE: Data are based on a data request to the U.S. Census Bureau for their most recent (2018) Statistics of U.S. Businesses data on private sector firms. State and local government data are from the Census Bureau's 2017 Census of Governments.
SOURCE: KFF Employer Health Benefits Survey, 2021

Although most firms in the United States are small, most workers covered by health benefits are employed at large firms: 71% 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 Categorized Percent Of Workforce Earning $28,000 Or Less or less per year for lower-wage workers and Categorized Percent Of Workforce Earning $66,000 Or More 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) (2019).[8] 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 1.9%.[9] 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

[8]General information on the OES can be found at http://www.bls.gov/oes/oes_emp.htm#scope.
[9]Bureau of Labor Statistics, Mid-Atlantic Information Office. Consumer Price Index historical tables for, U.S. City Average (1967 = 100) of Annual Inflation. Washington (DC): BLS; (cited 2021 Aug 21). Available from: https://www.bls.gov/regions/mid-atlantic/data/consumerpriceindexhistorical1967base_us_table.htm

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 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, 8% 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 2021, 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.

Figure M.7

Imputation Rates of Premiums, Worker Contributions, and Deductibles, by Plan Type, 2017-2021

	2017	2018	2019	2020	2021
HMO					
Single Premium	4.3%	1.6%*	3.9%	5.1%	6.1%
Single Contribution	2.1	2.3	2.5	3.7	2.9
Single Deductible	3.3	1.6	1.5	2.7	2
Family Premium	6	3.9	5.2	5.7	8.3
Family Contribution	4.8	5.5	5	6.4	9.1
Family Deductible	5.3	3	2.5	4.7	5.4
PPO					
Single Premium	4%	3.7%	4.4%	7%*	5.6%
Single Contribution	2.3	2.5	2.5	3.6	2.5
Single Deductible	1.5	1	0.8	2.7*	1.2*
Family Premium	5.6	4.6	5.3	9.1*	6.9
Family Contribution	4.4	4.3	4.4	6.4*	5
Family Deductible	4.5	3.3	2.8	5.4*	4
POS					
Single Premium	8.4%	3.9%	10%*	15.5%	10.3%
Single Contribution	4	1.9	7.4*	10	4.9
Single Deductible	3.1	2.9	2.6	8.2*	7.6
Family Premium	12.2	8.3	11.6	21.3*	16.4
Family Contribution	9.5	7.3	11.6	21.3*	13.1*
Family Deductible	9	2.9*	5.8	15.7*	13.1
HDHP/SO					
Single Premium	4.6%	3.9%	4%	4.9%	6.5%
Single Contribution	1.8	2.3	2.4	3.3	2
Single Deductible	0.5	0.6	0.8	1.6	1.1
Family Premium	5.6	4.1	4.6	6	6
Family Contribution	3.6	3	3.6	4.8	2.9
Family Deductible	2.5	1.6	1.8	3.4	4.5

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

SOURCE: KFF Employer Health Benefits Survey, 2018-2021; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2017

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 2018 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.

To account for design effects, the statistical computing package R version 4.1.1 (2021-08-10) 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 are tested against all other firm sizes not included in that subgroup: 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.

2021 SURVEY

This year we made several changes to the survey questionnaire in order to reduce the length and burden of the survey; rather than asking benefit managers about the characteristics of up to four plan types, we asked for the premiums and deductibles of the largest two plan types and other cost information for only the largest. We now only about cost-sharing for prescription drugs, hospitalizations, outpatient surgery and office visits for the plan type with the most enrollment. This change mostly impacts the largest firms which are more likely to sponsor multiple plan types. As in prior years, if a firm sponsors multiple plans, of the same plan type, for example, several PPOs across the country, we ask about only the one with the largest enrollment. In 2021, 13% respondents offered three or more plan types - in total the largest plan type accounts for 82% of workers covered by health benefits and the largest two plan types represents 98%. For this reason, this change will only have a minimal impact on most estimates. Furthermore, in prior years we observed no systematic bias in key metrics across the plan type rank at each firm. For example, in 2020, among firms with three or more plan types, the third-largest plan had statistically similar premiums and deductibles to the larger plan types on average. This change did not require a change in how many of the the all firm variables are calculated. To determine the all plan value for categorical variables describing plans, we continue to use the largest type as a proxy. To do so, we identify the plan type that has the largest enrollment within the observation and use data from that plan as a proxy for the all-plan aggregate for that firm. For example, in previous years, we would ask an employer whether their HMO, PPO, POS and HDHP/SO were self-funded, and then report the response from largest plan type as the all firm response.

For the first time, a subset of employers were invited to complete the survey online, though in total 99% of the interviews were completed through computer-assisted telephone interviewing.

OTHER RESOURCES

Additional information on the 2021 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.

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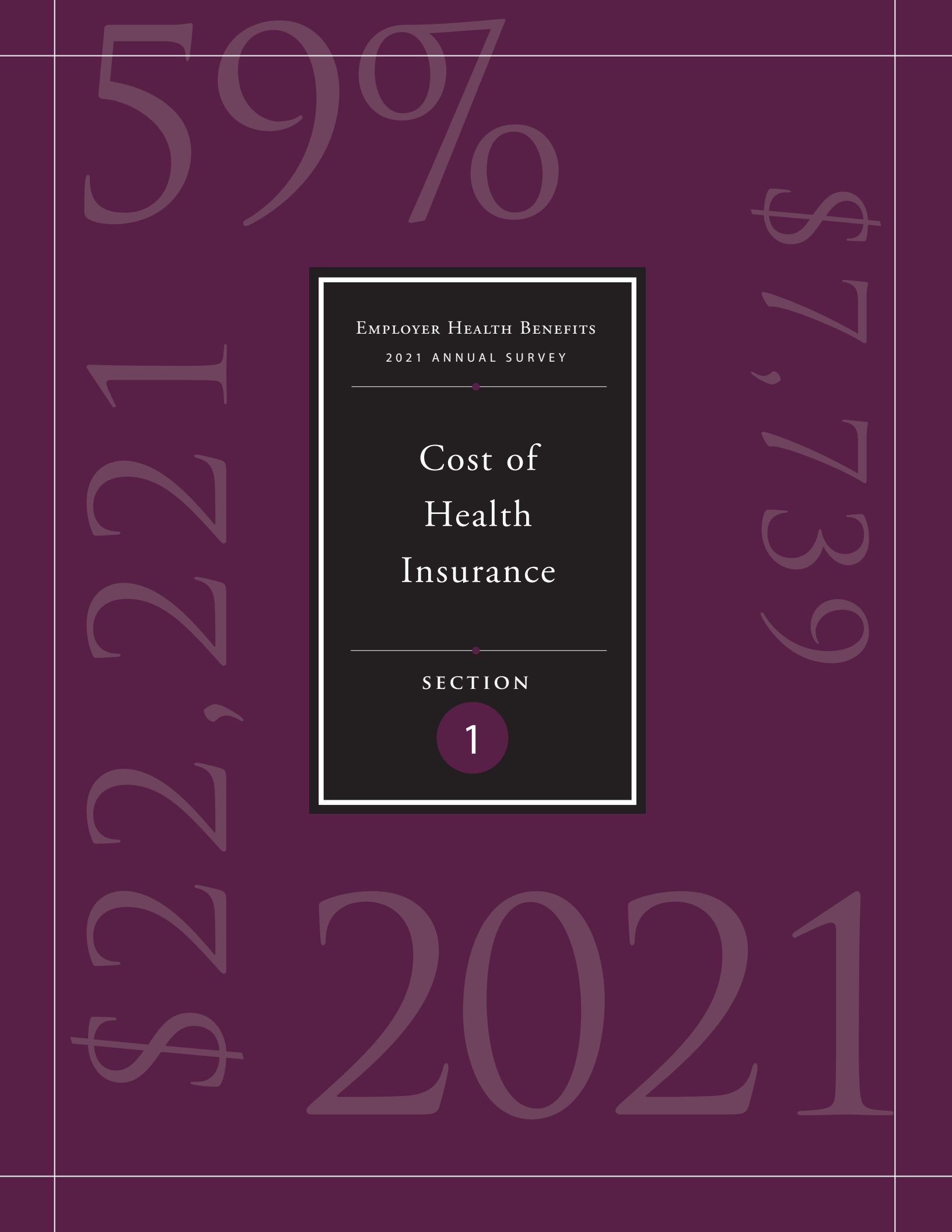


Employer Health Benefits

2021 ANNUAL SURVEY

Cost of Health Insurance

SECTION

1

Section 1

Cost of Health Insurance

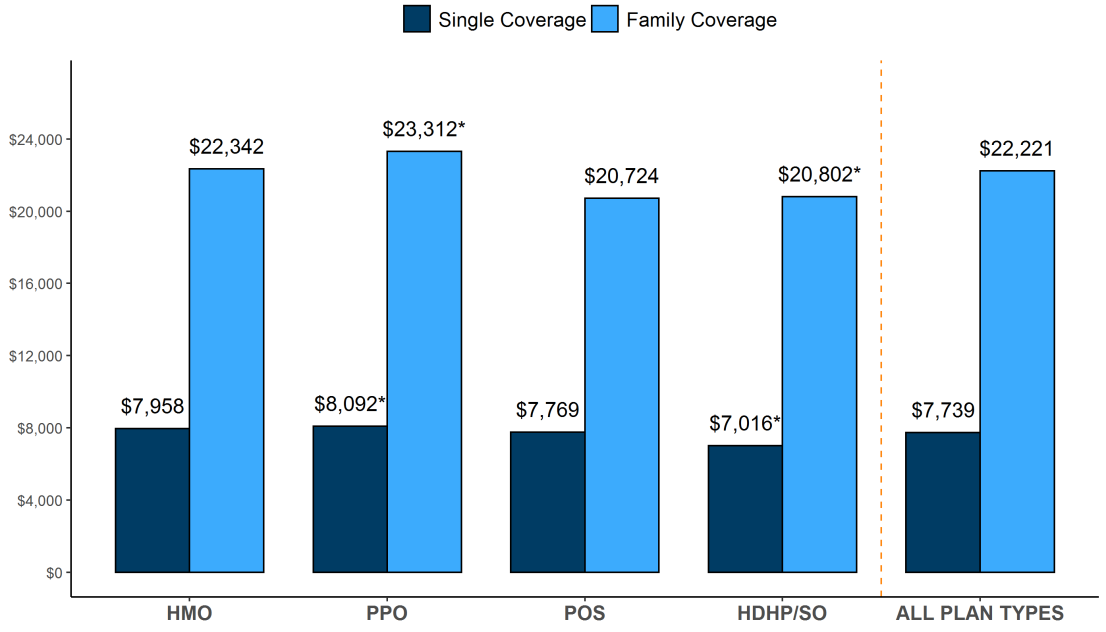
The average annual premiums in 2021, are $7,739 for single coverage and $22,221 for family coverage. Over the last year, the average premium for single coverage increased by 4% and the average premium for family coverage increased by 4%. The average family premium has increased 47% since 2011 and 22% since 2016.

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

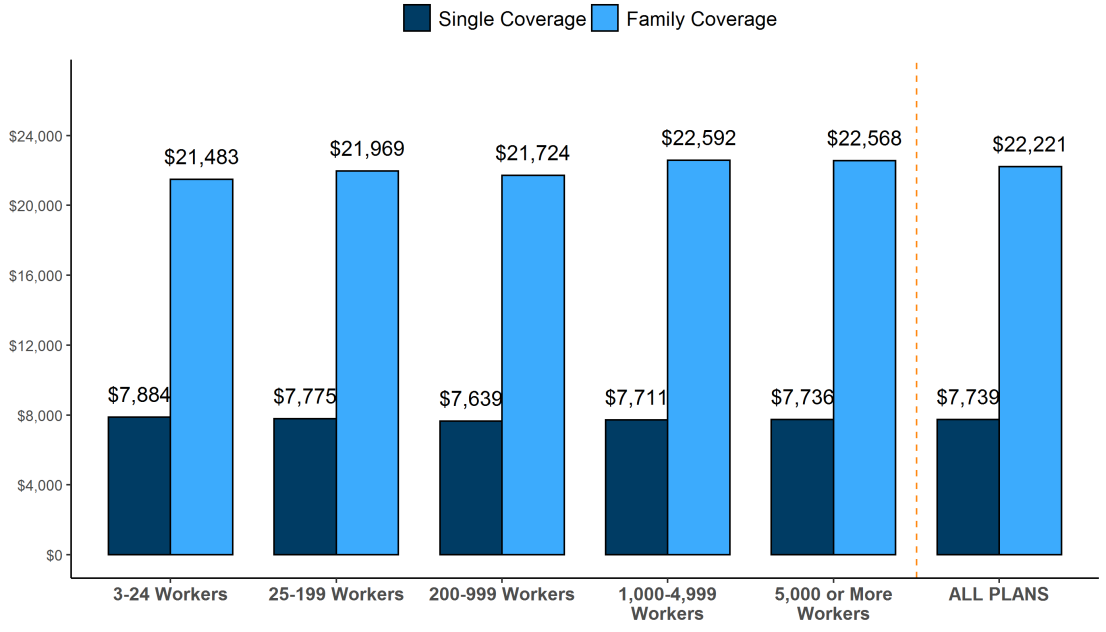
- The average premium for single coverage in 2021 is $7,739 per year. The average premium for family coverage is $22,221 per year [Figure 1.1].
- The average annual premium for single coverage for covered workers in small firms ($7,813) is similar to the average premium for covered workers in large firms ($7,709). The average annual premium for family coverage for covered workers in small firms ($21,804) is similar to the average premium for covered workers in large firms ($22,389). [Figure 1.3].
- The average annual premiums for covered workers in HDHP/SOs are lower than the average premiums for coverage overall for both single coverage ($7,016 v. $7,739) and family coverage ($20,802 vs. $22,221). The average premiums for covered workers enrolled in PPOs are higher than the overall average premiums for both single coverage ($8,092 v. $7,739) and family coverage ($23,312 vs. $22,221) [Figure 1.1].
- The average premiums for covered workers with single coverage are relatively high in the Northeast. The average premiums for covered workers with family coverage are relatively high in the Northeast and relatively low in the South [Figure 1.4].
- 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, and in the Agriculture/Mining/Construction categories are relatively low and the average premium for Health Care workers is relatively high [Figure 1.5].
- The average premiums for covered workers in firms with a relatively large share of lower-wage workers (where at least 35% of the workers earn $28,000 annually or less) are lower than the average premium for covered workers in firms with a smaller share of lower-wage workers for both single coverage ($7,156 vs. $7,796) and family coverage ($20,315 vs. $22,407) [Figures 1.6 and 1.7].
- The average annual premiums for covered workers in private for-profit firms are lower than average annual premiums for covered workers in other firms for both single and family coverage. Average annual premiums for covered workers in private not-for-profit firms are higher than average annual premiums for covered workers in other firms for both single and family coverage [Figures 1.6 and 1.7].
- The average annual premiums for covered workers in firms with at least some union workers are higher than the average premiums for workers in firms with no union workers for both single coverage ($8,014 vs. $7,590) and family coverage ($23,095 vs. $21,747) [Figure 1.8].

Figure 1.1
Average Annual Premiums for Covered Workers, Single and Family Coverage, by Plan Type, 2021



* Estimate is statistically different from All Plans estimate ($p < .05$).
SOURCE: KFF Employer Health Benefits Survey, 2021

Figure 1.2
Average Annual Premiums for Covered Workers, Single and Family Coverage, by Firm Size, 2021



Tests found no statistical difference from All Plans estimate ($p < .05$).
SOURCE: KFF Employer Health Benefits Survey, 2021

Figure 1.3

Average Monthly and Annual Premiums for Covered Workers, by Plan Type and Firm Size, 2021

	Monthly		Annual	
	Single Coverage	Family Coverage	Single Coverage	Family Coverage
HMO				
All Small Firms	$630	$1,792	$7,560	$21,503
All Large Firms	674	1,883	8,082	22,595
ALL FIRM SIZES	**$663**	**$1,862**	**$7,958**	**$22,342**
PPO				
All Small Firms	$678	$1,938	$8,134	$23,259
All Large Firms	673	1,944	8,074	23,333
ALL FIRM SIZES	**$674**	**$1,943**	**$8,092**	**$23,312**
POS				
All Small Firms	$642	$1,677	$7,702	$20,123
All Large Firms	655	1,791	7,856	21,497
ALL FIRM SIZES	**$647**	**$1,727**	**$7,769**	**$20,724**
HDHP/SO				
All Small Firms	$614	$1,685	$7,371	$20,219
All Large Firms	576	1,748	6,909	20,979
ALL FIRM SIZES	**$585**	**$1,734**	**$7,016**	**$20,802**
ALL PLANS				
All Small Firms	$651	$1,817	$7,813	$21,804
All Large Firms	642	1,866	7,709	22,389
ALL FIRM SIZES	**$645**	**$1,852**	**$7,739**	**$22,221**

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

Tests found no statistical difference within plan and coverage types between All Small Firms and All Large Firms ($p < .05$).

SOURCE: KFF Employer Health Benefits Survey, 2021

Figure 1.4

Average Monthly and Annual Premiums for Covered Workers, by Plan Type and Region, 2021

	Monthly		Annual	
	Single Coverage	Family Coverage	Single Coverage	Family Coverage
HMO				
Northeast	$681	$1,953	$8,175	$23,433
Midwest	636	1,667	7,630	20,005
South	668	1,938	8,018	23,253
West	657	1,820	7,879	21,844
ALL REGIONS	**$663**	**$1,862**	**$7,958**	**$22,342**
PPO				
Northeast	$738*	$2,152*	$8,857*	$25,819*
Midwest	681	1,979	8,168	23,743
South	639*	1,823*	7,674*	21,871*
West	672	1,927	8,068	23,120
ALL REGIONS	**$674**	**$1,943**	**$8,092**	**$23,312**
POS				
Northeast	$676	$1,795	$8,108	$21,543
Midwest	720*	1,864	8,640*	22,369
South	606	1,618	7,268	19,422
West	628	1,739	7,530	20,866
ALL REGIONS	**$647**	**$1,727**	**$7,769**	**$20,724**
HDHP/SO				
Northeast	$588	$1,742	$7,057	$20,901
Midwest	582	1,772	6,982	21,264
South	595	1,740	7,142	20,880
West	565	1,599	6,786	19,190
ALL REGIONS	**$585**	**$1,734**	**$7,016**	**$20,802**
ALL PLANS				
Northeast	$678*	$1,966*	$8,134*	$23,596*
Midwest	641	1,867	7,697	22,401
South	627	1,790*	7,530	21,477*
West	644	1,815	7,725	21,778
ALL REGIONS	**$645**	**$1,852**	**$7,739**	**$22,221**

* 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, 2021

Figure 1.5

Average Monthly and Annual Premiums for Covered Workers, by Plan Type and Industry, 2021

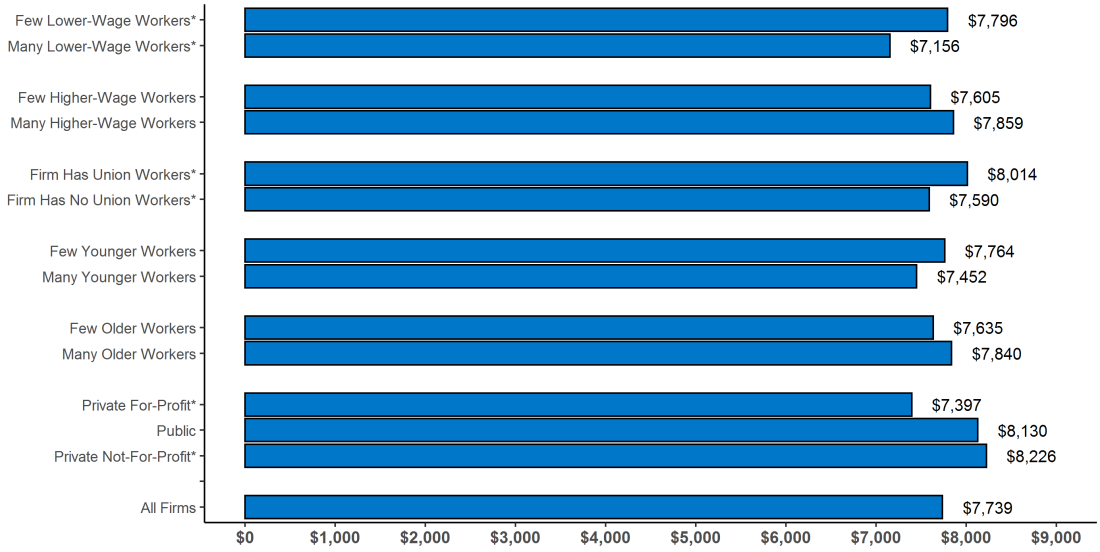
	Monthly		Annual	
	Single Coverage	Family Coverage	Single Coverage	Family Coverage
PPO				
Agriculture/Mining/Construction	$630	$1,894	$7,560	$22,724
Manufacturing	664	1,983	7,970	23,795
Transportation/Communications/Utilities	662	1,954	7,942	23,452
Wholesale	663	1,898	7,955	22,780
Retail	667	1,965	8,003	23,582
Finance	681	1,937	8,167	23,243
Service	674	1,928	8,093	23,141
State/Local Government	666	1,784	7,992	21,407
Health Care	710	2,046	8,521	24,558
ALL INDUSTRIES	**$674**	**$1,943**	**$8,092**	**$23,312**
HDHP/SO				
Agriculture/Mining/Construction	$547	$1,607	$6,564	$19,281
Manufacturing	520*	1,627	6,238*	19,521
Transportation/Communications/Utilities	589	1,823	7,068	21,872
Wholesale	NSD	NSD	NSD	NSD
Retail	558	1,716	6,692	20,593
Finance	607	1,775	7,289	21,305
Service	601	1,807	7,211	21,688
State/Local Government	599	1,554	7,184	18,653
Health Care	611	1,719	7,336	20,634
ALL INDUSTRIES	**$585**	**$1,734**	**$7,016**	**$20,802**
ALL PLANS				
Agriculture/Mining/Construction	$586*	$1,713	$7,026*	$20,559
Manufacturing	601*	1,818	7,210*	21,820
Transportation/Communications/Utilities	659	1,910	7,911	22,920
Wholesale	604	1,717*	7,251	20,606*
Retail	641	1,857	7,695	22,284
Finance	640	1,830	7,682	21,964
Service	651	1,867	7,811	22,403
State/Local Government	664	1,778	7,963	21,341
Health Care	684*	1,943*	8,205*	23,313*
ALL INDUSTRIES	**$645**	**$1,852**	**$7,739**	**$22,221**

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

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

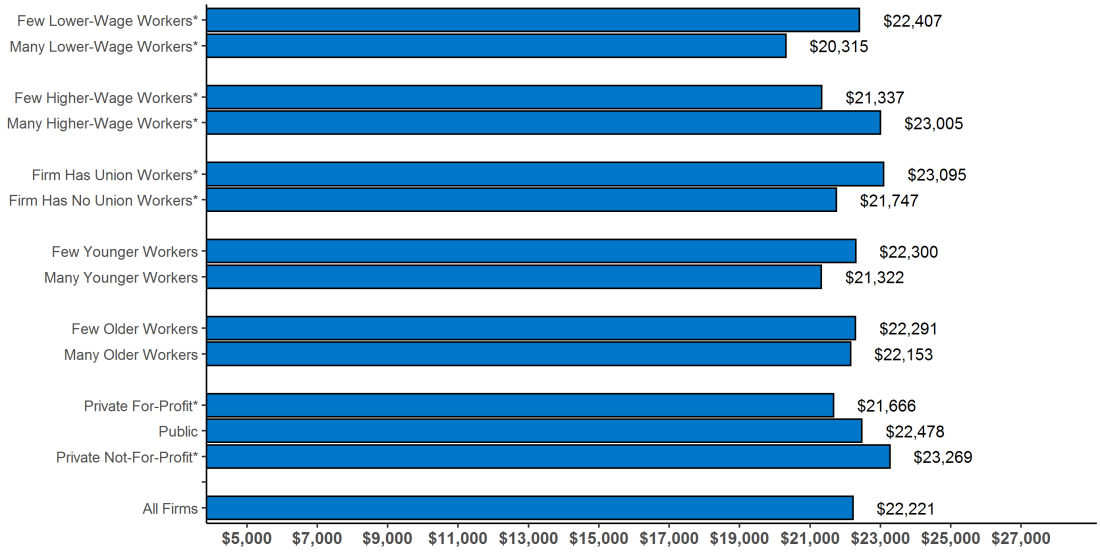
SOURCE: KFF Employer Health Benefits Survey, 2021

Figure 1.6
Average Annual Premiums for Covered Workers with Single Coverage, by Firm Characteristics, 2021



* 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 ($28,000 in 2021). Firms with many higher-wage workers are those where at least 35% earn the 75th percentile or more than of national earnings ($66,000 in 2021). 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, 2021

Figure 1.7
Average Annual Premiums for Covered Workers with Family Coverage, by Firm Characteristics, 2021



* 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 ($28,000 in 2021). Firms with many higher-wage workers are those where at least 35% earn the 75th percentile or more than of national earnings ($66,000 in 2021). 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, 2021

Figure 1.8

Average Annual Premiums for Covered Workers, by Firm Characteristics and Firm Size, 2021

	Single Coverage		Family Coverage	
	All Small Firms	All Large Firms	All Small Firms	All Large Firms
LOWER WAGE LEVEL				
Few Lower-Wage Workers	$7,849	$7,774*	$21,878	$22,625*
Many Lower-Wage Workers	$7,350	$7,096*	$20,855	$20,150*
HIGHER WAGE LEVEL				
Few Higher-Wage Workers	$7,651	$7,579	$20,907*	$21,575*
Many Higher-Wage Workers	$8,041	$7,806	$23,064*	$22,988*
UNIONS				
Firm Has Union Workers	$8,099	$8,008*	$23,182	$23,088*
Firm Has No Union Workers	$7,784	$7,458*	$21,668	$21,800*
YOUNGER WORKERS				
Few Younger Workers	$7,844	$7,731	$21,894	$22,467
Many Younger Workers	$7,369	$7,477	$20,530	$21,565
OLDER WORKERS				
Few Older Workers	$7,251*	$7,779	$20,951	$22,791
Many Older Workers	$8,302*	$7,639	$22,555	$21,980
FUNDING ARRANGEMENT				
Fully Insured	$7,758	$7,675	$21,832	$21,852
Self-Funded	$8,017	$7,717	$21,701	$22,510
FIRM OWNERSHIP				
Private For-Profit	$7,420*	$7,385*	$21,007*	$22,014
Public	$9,426*	$7,988	$24,713	$22,242
Private Not-For-Profit	$8,469*	$8,126*	$23,264	$23,271*
ALL FIRMS	**$7,813**	**$7,709**	**$21,804**	**$22,389**

NOTE: Firms with many lower-wage workers are those where at least 35% earn the 25th percentile or less of national earnings ($28,000 in 2021). Firms with many higher-wage workers are those where at least 35% earn the 75th percentile or more than of national earnings ($66,000 in 2021). 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.

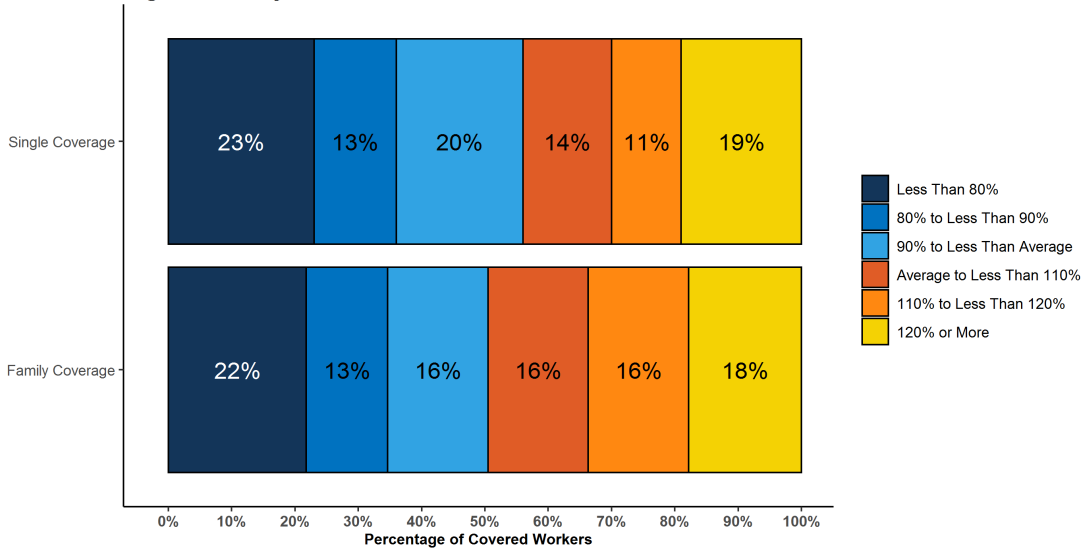
* Estimates are statistically different from estimate for all other firms not in the indicated category within each firm size ($p < .05$).

SOURCE: KFF Employer Health Benefits Survey, 2021

PREMIUM DISTRIBUTION

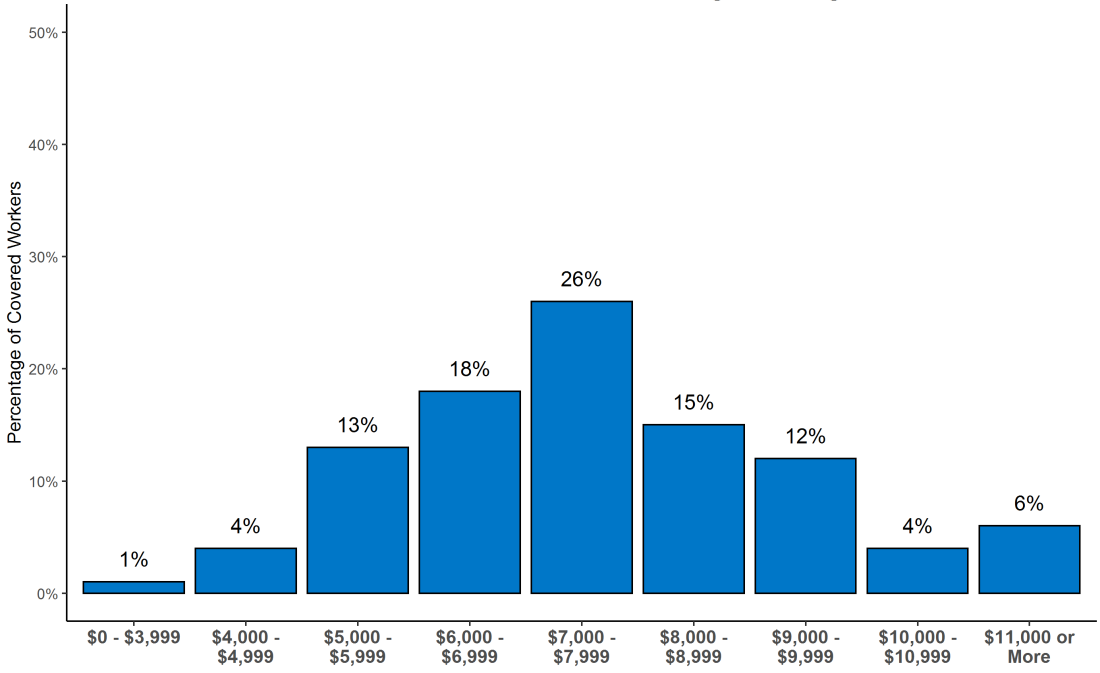
- There remains considerable variation in premiums for both single and family coverage.
  - Nineteen percent of covered workers are employed in a firm with a single premium at least 20% higher than the average single premium, while 23% of covered workers are in firms with a single premium less than 80% of the average single premium [Figure 1.9].
  - 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 22% of covered workers are in firms with a family premium less than 80% of the average family premium [Figure 1.9].
- Ten percent of covered workers are in a firm with an average annual premium of at least $10,000 for single coverage [Figure 1.10]. Ten percent of covered workers are in a firm with an average annual premium of at least $29,000 for family coverage [Figure 1.11].

Figure 1.9
Distribution of Annual Premiums for Single and Family Coverage Relative to the Average Annual Single or Family Premium, 2021



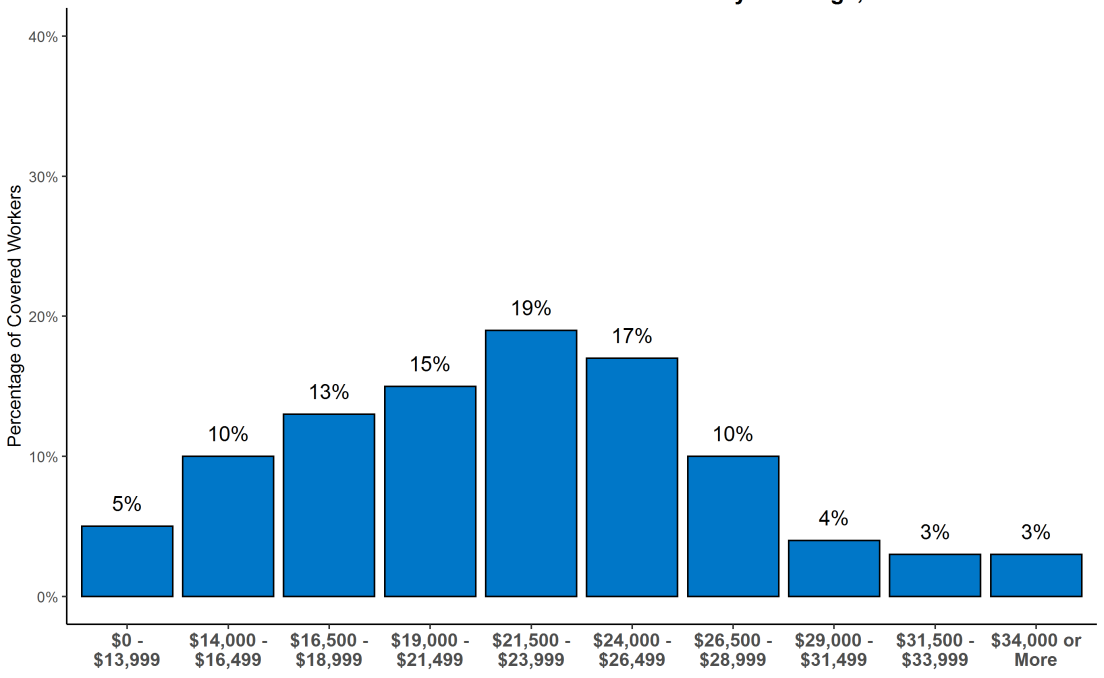
NOTE: The average annual premium is $7,739 for single coverage and $22,221 for family coverage. The premium distribution is relative to the average single or family premium. For example, $6,191 is 80% of the average single premium, $6,965 is 90% of the average single premium, $8,513 is 110% of the average single premium, and $9,287 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, 2021

Figure 1.10
Distribution of Annual Premiums for Covered Workers with Single Coverage, 2021



SOURCE: KFF Employer Health Benefits Survey, 2021

Figure 1.11
Distribution of Annual Premiums for Covered Workers with Family Coverage, 2021

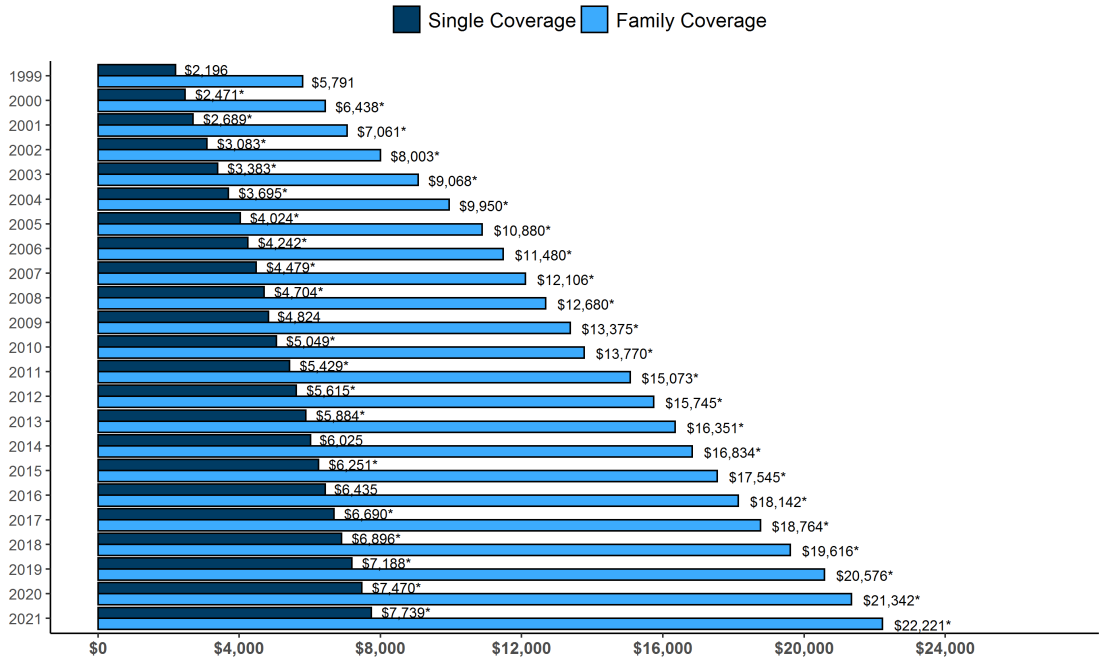


SOURCE: KFF Employer Health Benefits Survey, 2021

PREMIUM CHANGES OVER TIME

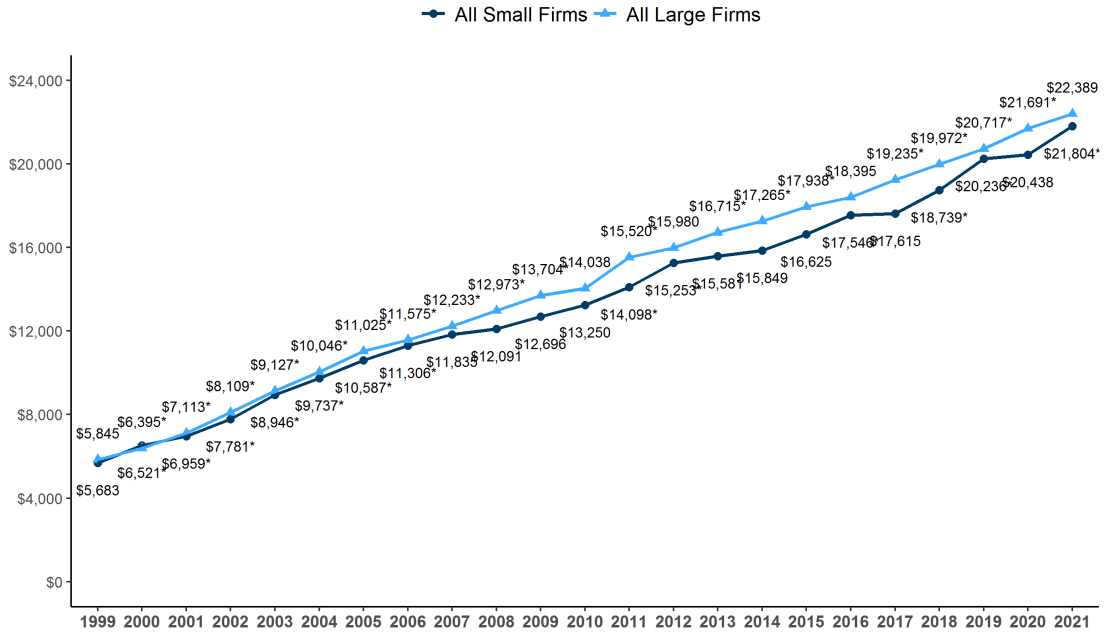
- The average premium for single coverage is 4% higher than the single premium last year, and the average premium for family coverage is 4% higher than the average family premium last year [Figure 1.12].
  - The average premium for single coverage has grown 20% since 2016, similar to the growth in the average premium for family coverage (22%) over the same period [Figure 1.12].
  - The $22,221 average family premium in 2021 is 22% higher than the average family premium in 2016 and 47% higher than the average family premium in 2011. The 22% family premium growth in the past five years is similar to the 20% growth between 2011 and 2016 [Figure 1.12].
  - The average family premiums for both small and large firms have increased at similar rates since 2016 (24% for small firms and 22% for large firms). For small firms, the average family premium rose from $17,546 in 2016 to $21,804 in 2021. For large firms, the average family premium rose from $18,395 in 2016 to $22,389 in 2021 [Figure 1.13].
  - The average family premium has grown faster since 2011 for covered workers in small as compared to covered workers in large firms (55% in small firms and 44% in large firms). In small firms, the average family premium rose from $14,098 in 2011 to $21,804 in 2021. In large firms, the average family premium rose from $15,520 in 2011 to $22,389 in 2021 [Figures 1.13].
- 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 (16% for fully insured plans and 23% for self-funded firms) [Figure 1.14].
- The average premiums for family coverage have risen faster than inflation over the last 5 years (22% vs. 11%) and the last 10 years (47% vs. 19%) [Figure 1.15].

Figure 1.12
Average Annual Premiums for Single and Family Coverage, 1999-2021



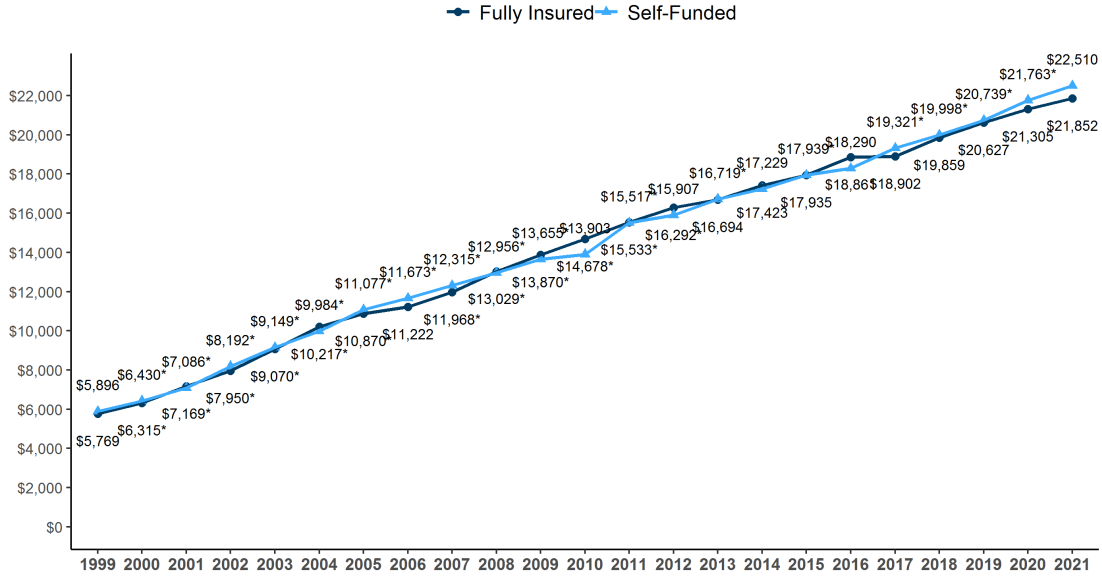
* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
SOURCE: KFF Employer Health Benefits Survey, 2018-2021; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

Figure 1.13
Average Annual Premiums for Covered Workers with Family Coverage, by Firm Size, 1999-2021



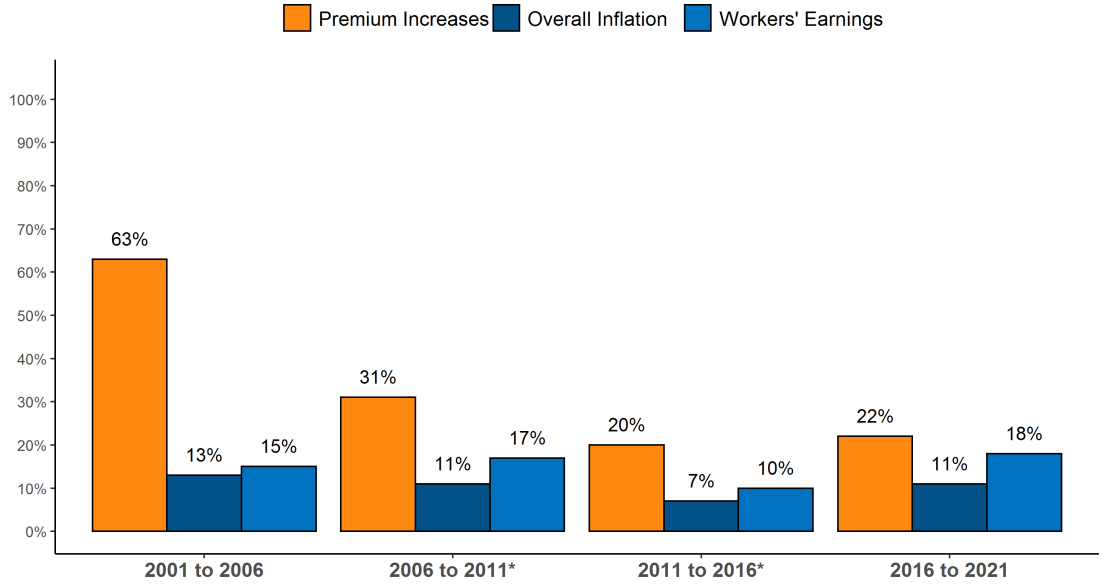
* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2018-2021; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

Figure 1.14
Among Workers in Large Firms, Average Annual Premiums for Family Coverage, by Funding Arrangement, 1999-2021



* 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, 2018-2021; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

Figure 1.15
Cumulative Premium Increases, Inflation, and Earnings for Covered Workers with Family Coverage, 2001-2021



* Percentage change in family premium is statistically different from previous five year period shown (p < .05).
SOURCE: KFF Employer Health Benefits Survey, 2018-2021; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2001-2017. Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation, 2001-2021; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 2001-2021.

Employer Health Benefits
2021 Annual Survey

Health Benefits Offer Rates

SECTION 2

Section 2

Health Benefits Offer Rates

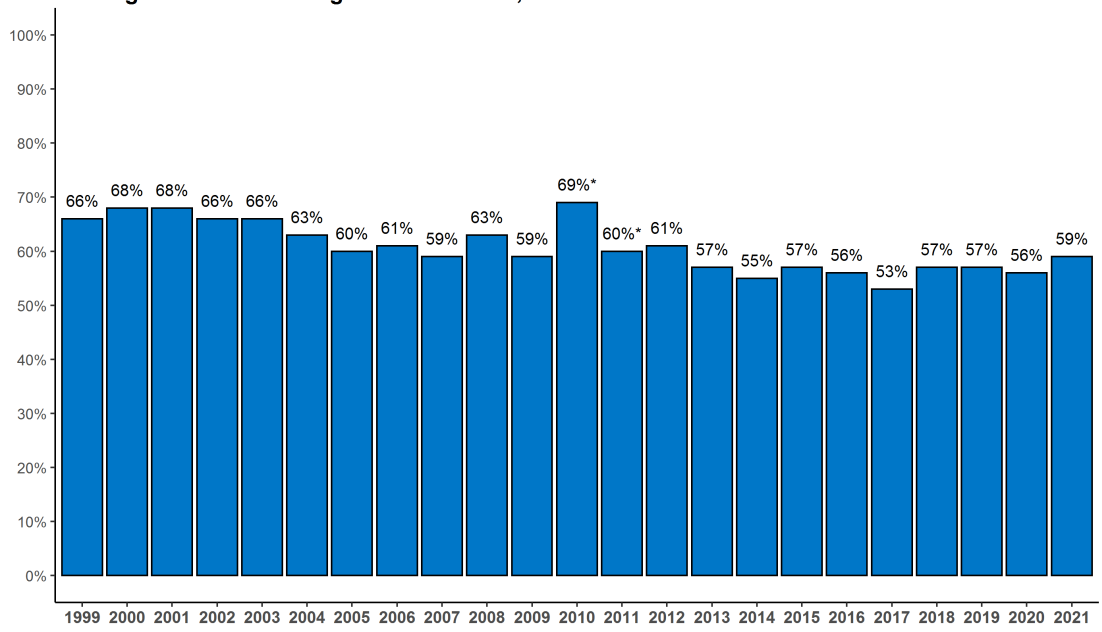
While nearly all large firms (200 or more workers) offer health benefits to at least some workers, small firms (3-199 workers) are significantly less likely to do so. The percentage of all firms offering health benefits in 2021 (59%) is similar to the percentages of firms offering health benefits last year (56%) and five years ago (56%).

Firms not offering health benefits continue to cite cost as the most important reason they do not do so. Almost all (96%) firms that offer coverage offer both single and family coverage.

FIRM OFFER RATES

- In 2021, 59% of firms offer health benefits, similar to the percentage last year [Figure 2.1].
  - The overall percentage of firms offering health benefits in 2021 is similar to the percentages offering health benefits in 2016 (56%) and 2011 (60%) [Figure 2.1].
  - Ninety-nine percent of large firms offer health benefits to at least some of their workers. In contrast, only 58% of small firms offer health benefits [Figures 2.2 and 2.3]. The percentages of both small and large firms offering health benefits to at least some of their workers in 2021 are similar to those last year [Figure 2.2].
    - The smallest-sized firms are least likely to offer health insurance: 49% of firms with 3-9 workers offer coverage, compared to 65% of firms with 10-24 workers, 74% of firms with 25-49 workers, and 93% 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 [Figure 2.4]. For more information on the distribution of firms in the country, see the Survey Design and Methods Section and [Figure M.6].
    - Only 56% 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 2.5].
- 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. Ninety-one 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, 1999-2021



* 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, 2018-2021; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

Figure 2.2

Percentage of Firms Offering Health Benefits, by Firm Size, 1999-2021

	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%**
2021	49%	65%	74%	93%	58%	99%	**59%**

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, 2018-2021; 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, 2021

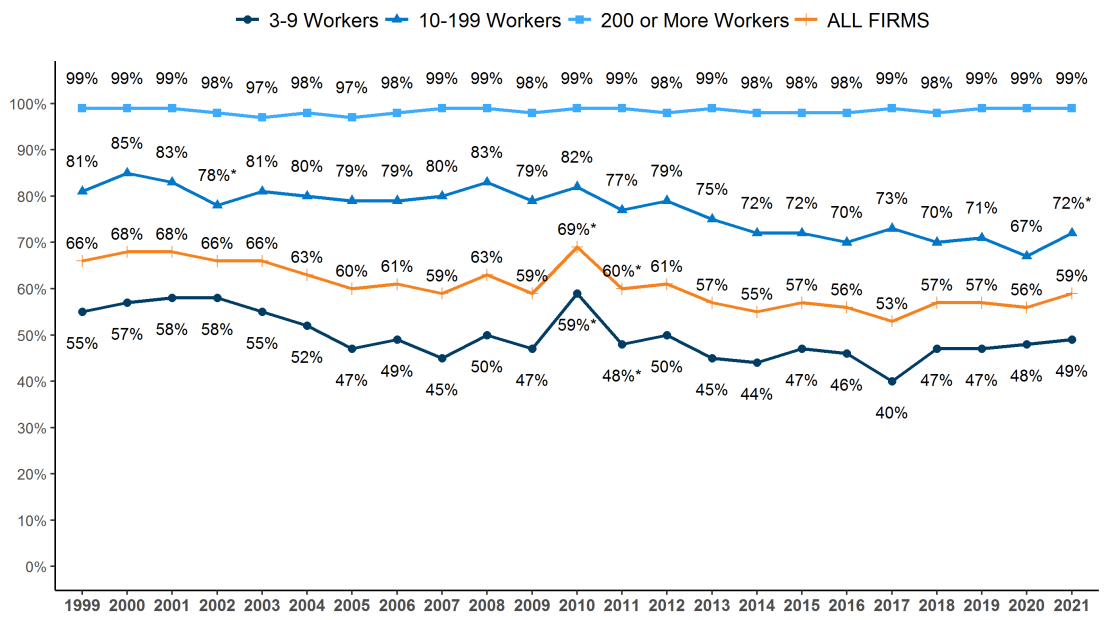
	Percentage of Firms Offering Health Benefits
FIRM SIZE	
3-9 Workers	49%*
10-24 Workers	65*
25-49 Workers	74*
50-199 Workers	93*
200-999 Workers	98*
1,000-4,999 Workers	99*
5,000 or More Workers	100*
All Small Firms (3-199 Workers)	**58%***
All Large Firms (200 or More Workers)	**99%***
REGION	
Northeast	57%
Midwest	59
South	54*
West	67*
INDUSTRY	
Agriculture/Mining/Construction	61%
Manufacturing	75*
Transportation/Communications/Utilities	60
Wholesale	77*
Retail	48*
Finance	59
Service	55*
State/Local Government	86*
Health Care	64
ALL FIRMS	**59%**

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 ($p < .05$).

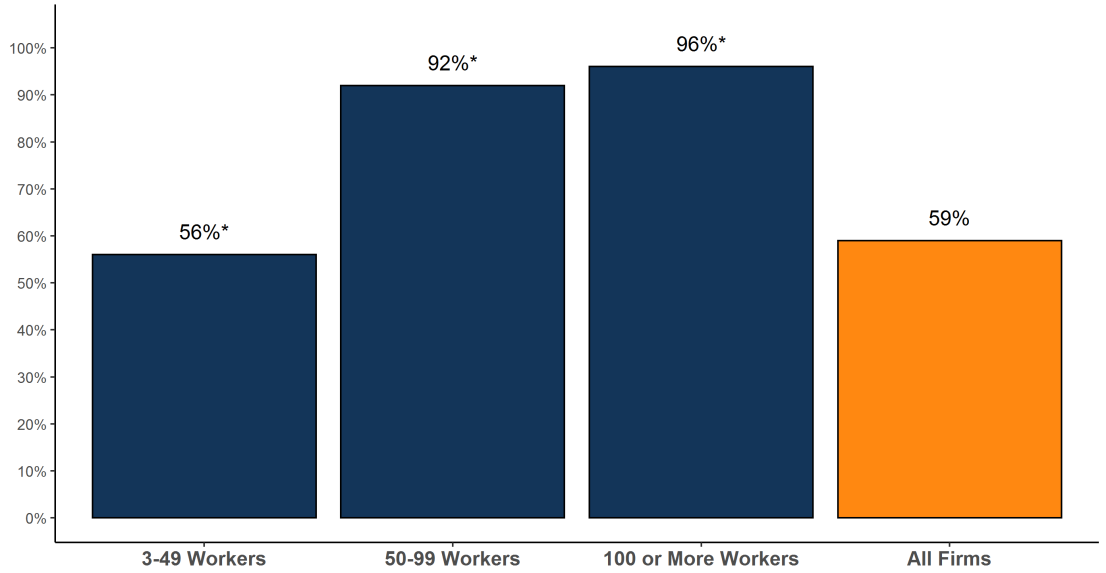
SOURCE: KFF Employer Health Benefits Survey, 2021

Figure 2.4
Percentage of Firms Offering Health Benefits, by Firm Size, 1999-2021



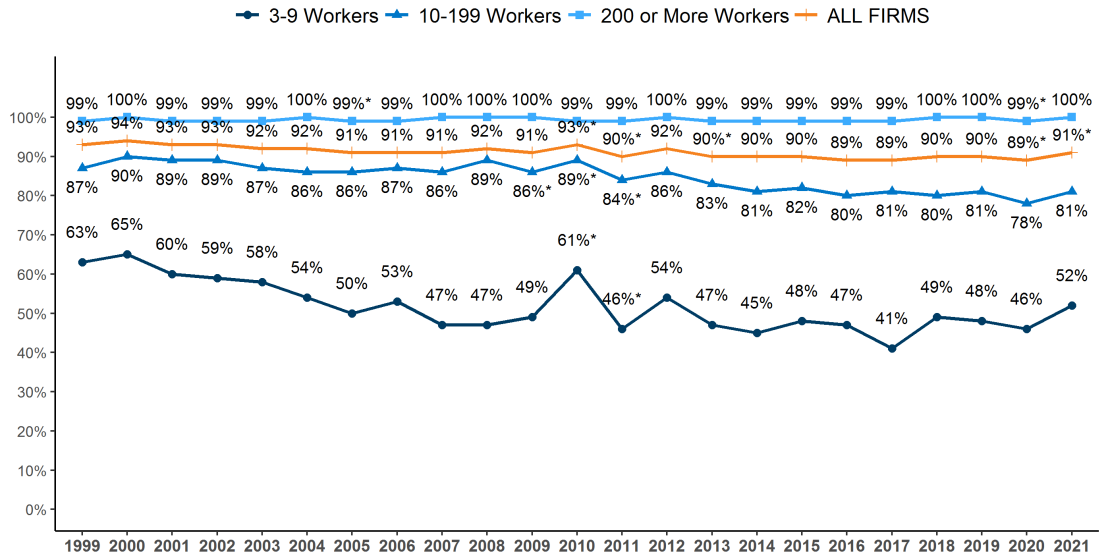
* Estimate is statistically different from estimate for the previous year shown (p < .05).
NOTE: As noted in the Survey Design and Methods section, estimates are based on the sample of both firms that completed the entire survey and those that answered just one question about whether they offer health benefits.
SOURCE: KFF Employer Health Benefits Survey, 2018-2021; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

Figure 2.5
Percentage of Firms Offering Health Benefits to At Least Some of Their Workers, by Firm Size, 2021



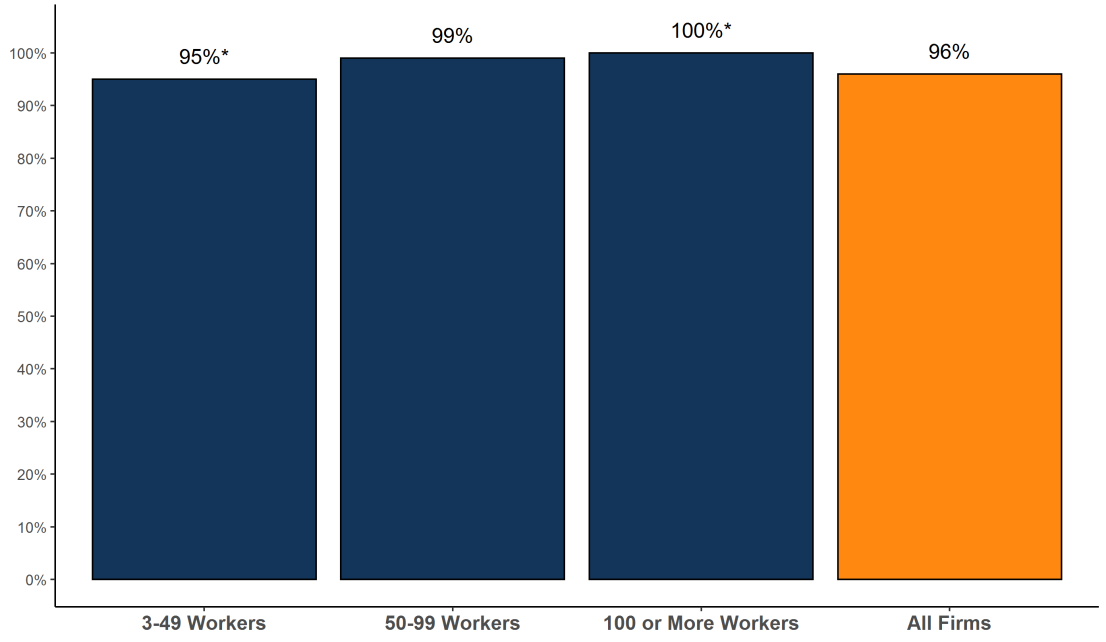
* Estimate is statistically different from estimate for all other firms not in the indicated size category (p < .05).
NOTE: As noted in the Survey Design and Methods section, estimates are based on the sample of both firms that completed the entire survey and those that answered just one question about 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, 2021

Figure 2.6
Percentage of Workers at Firms That Offer Health Benefits to at Least Some Workers, by Firm Size, 1999-2021



* 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, 2018-2021; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

Figure 2.7
Percentage of Firms Offering Health Benefits Which Offer Family Coverage, by Firm Size, 2021



* Estimate is statistically different from estimate for all other firms not in the indicated size category ($p < .05$).
SOURCE: KFF Employer Health Benefits Survey, 2021

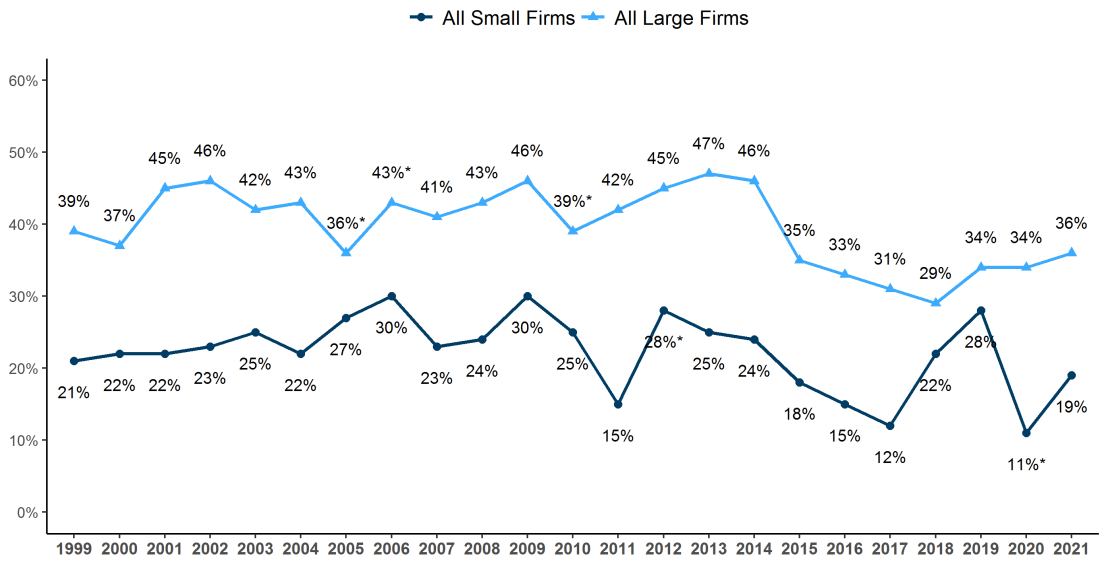
PART-TIME WORKERS

- 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-six percent of large firms that offer health benefits in 2021 offer health benefits to part-time workers, similar to the percentage in 2020 [Figure 2.8]. The share of large firms offering health benefits to part-time workers increases with firm size [Figure 2.9].

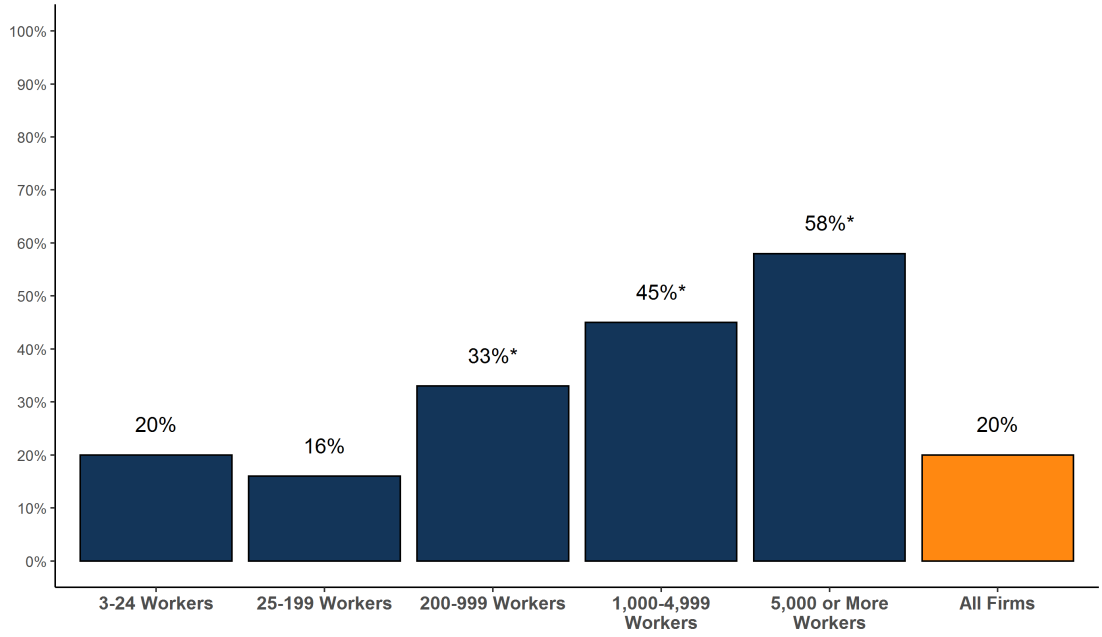
Figure 2.8
Among Firms Offering Health Benefits, Percentage That Offer to Part-Time Workers, by Firm Size, 1999-2021



* 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, 2018-2021; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

[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 2.9
Among Firms Offering Health Benefits, Percentage That Offer to Part-Time Workers, by Firm Size, 2021



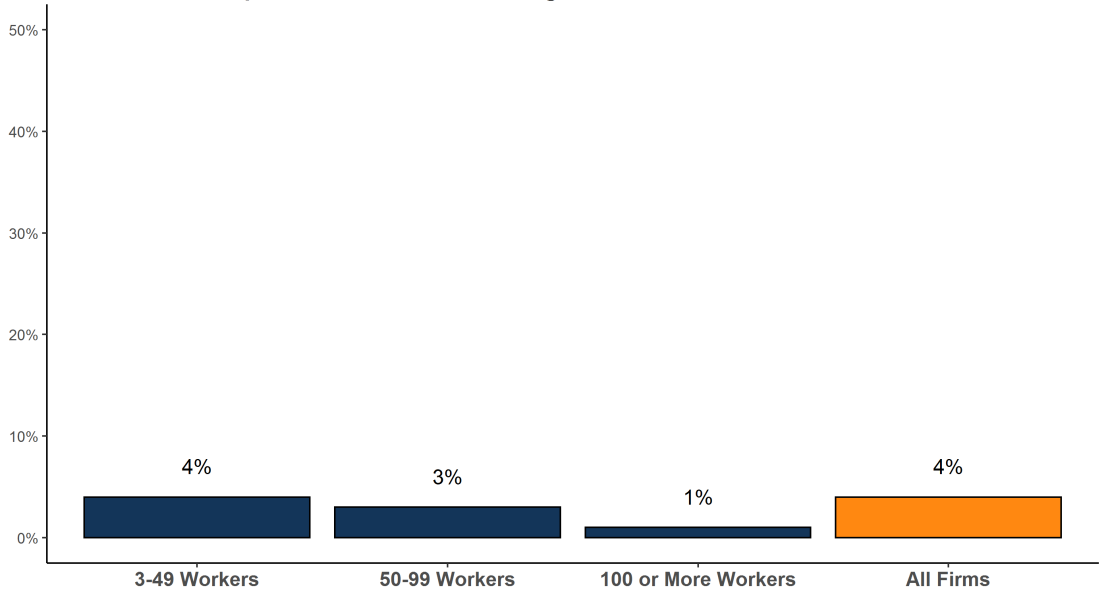
* Estimate is statistically different from estimate for all other firms not in the indicated size category ($p < .05$).
SOURCE: KFF Employer Health Benefits Survey, 2021

ASSISTING EMPLOYEES TO PURCHASE COVERAGE IN NON-GROUP MARKET

Some employers provide funds to some or all of their employees to help them purchase coverage in the individual ("non-group") market. Employers that do not otherwise offer health benefits may do this an alternative to offering a group plan, or employers that offer a group plan to some employees may use this approach for some types or classes of workers, such as part-time employees. One way an employer can provide tax-preferred assistance for employees to purchase non-group coverage is through an Individual Coverage Health Reimbursement Arrangement, or ICHRA. Both employers that offer and those that do not offer health benefits were asked if they provide funds to any employee to purchase non-group coverage.

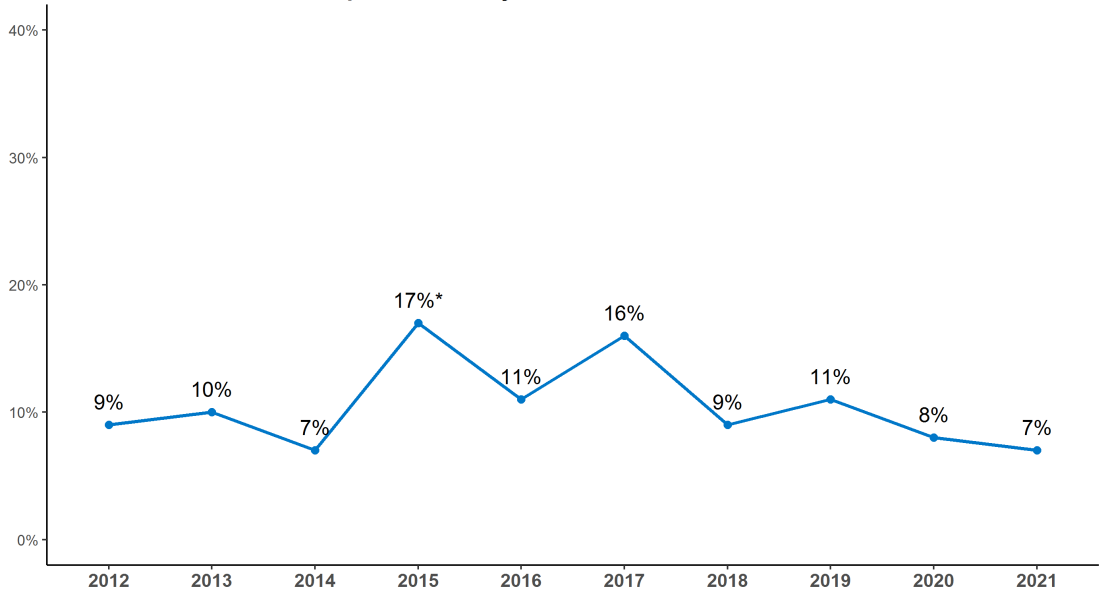
- Four percent of firms offering health benefits and 7% of firms not offering health benefits offer funds to one or more of their employees to purchase non-group coverage in 2021 [Figure 2.10].
  - Among small firms not offering health benefits, 7% offer funds to one or more of their employees to purchase non-group coverage, similar to the percentage (8%) last year [Figure 2.11].
- Among all firms (offering and not offering health benefits) that do not offer funds to any employees to purchase non-group coverage in 2021, only 1% are "very likely" and an additional 7% are "somewhat likely" to offer an ICHRA to at least some employees in the next two years.
  - Large firms that currently offer or intend to offer an ICHRA were asked about the types of employees that are or would be offered such an arrangement. Forty-four percent offer or intend to offer an ICHRA to all their employees, 16% offer or intend to offer to part-time or seasonal workers, 60% offer or intend to offer to low-wage workers, and 19% offer or intend to offer to some other group of employees, such as only full-time employees.

Figure 2.10
Among Firms Offering Health Benefits, Percentage of Firms That Provide Workers Funds to Purchase Non-Group Insurance, Such as Through an ICHRA, Firm Size, 2021



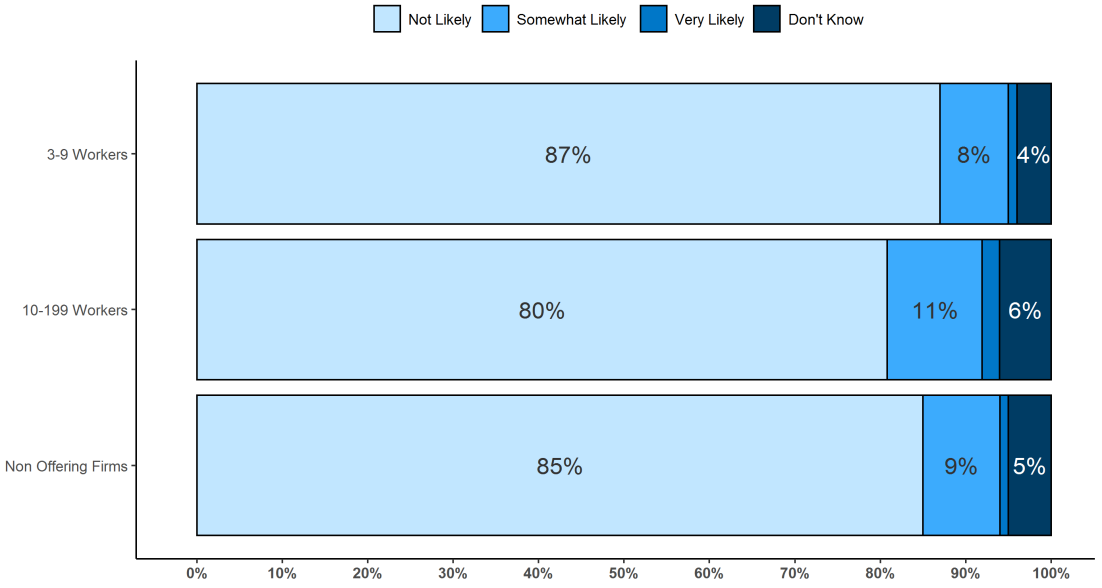
Tests found no statistical difference from estimate for all other firms not in the indicated size category ($p < .05$).
NOTE: Funds may be provided through an ICHRA. An Individual Coverage Health Reimbursement Arrangement (ICHRA) allows employers to reimburse their employees tax-free for premiums, cost-sharing as well as some other health services and equipment
SOURCE: KFF Employer Health Benefits Survey, 2021

Figure 2.11
Among Small Firms Not Offering Health Benefits, Percentage of Firms That Provide Workers Funds to Purchase Non-Group Insurance, by Firm Size, 2012-2021



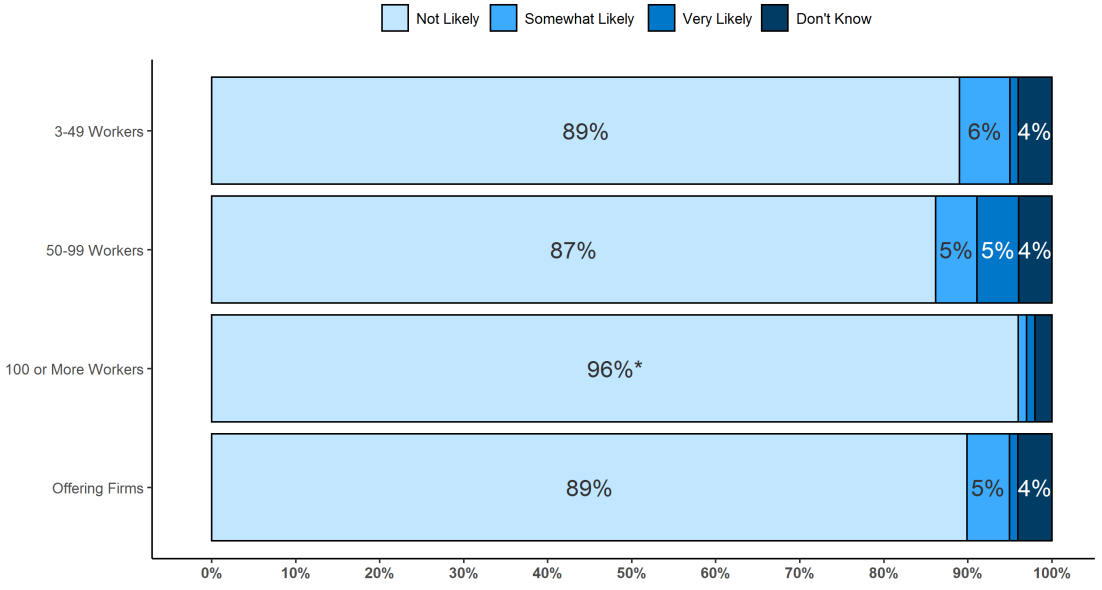
* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
NOTE: Small Firms have 3-199 workers. Funds may be provided through an ICHRA. An Individual Coverage Health Reimbursement Arrangement (ICHRA) allows employers to reimburse their employees tax-free for premiums, cost-sharing as well as some other health services and equipment
SOURCE: KFF Employer Health Benefits Survey, 2018-2021; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2012-2017

Figure 2.12
Among Small Firms Not Offering Health Benefits, How Likely is Firm to Offer an ICHRA in the Next Two Years, by Firm Size, 2021



Tests found no statistical difference from each other within category ($p < .05$).
NOTE: Small Firms have 3-199 workers. An Individual Coverage Health Reimbursement Arrangement (ICHRA) allows employers to reimburse their employees tax-free for premiums, cost-sharing as well as some other health services and equipment
SOURCE: KFF Employer Health Benefits Survey, 2021

Figure 2.13
Among Firms Offering Health Benefits, How Likely is Firm to Offer an ICHRA in the Next Two Years, by Firm Size, 2021



* Estimates are statistically different from each other within category ($p < .05$).
NOTE: An Individual Coverage Health Reimbursement Arrangement (ICHRA) allows employers to reimburse their employees tax-free for premiums, cost-sharing as well as some other health services and equipment
SOURCE: KFF Employer Health Benefits Survey, 2021

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, 30% cite high cost as "the most important reason" for not doing so. Other factors include employees are covered by another health plan (including a spouse's plan) (21%), "the firm is too small" (25%), and "most employees are part-time or temporary workers" (7%). Few small firms indicate that they do not offer because they believe employees will get a better deal on the health insurance exchanges (1%) [Figure 2.14].
- Some small non-offering firms have either offered health insurance in the past five years or shopped for health insurance in the past year.
  - Twelve percent of small non-offering firms have offered health benefits in the past five years, similar to than the percentage reported last year [Figure 2.15].
  - Ten percent of small non-offering firms have shopped for coverage in the past year, similar to the percentage last year (17%) [Figure 2.15].
- Among small non-offering firms that report they stopped offering coverage within the past five years, 16% stopped offering coverage within the past year.
- Seventy-four 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 2.14

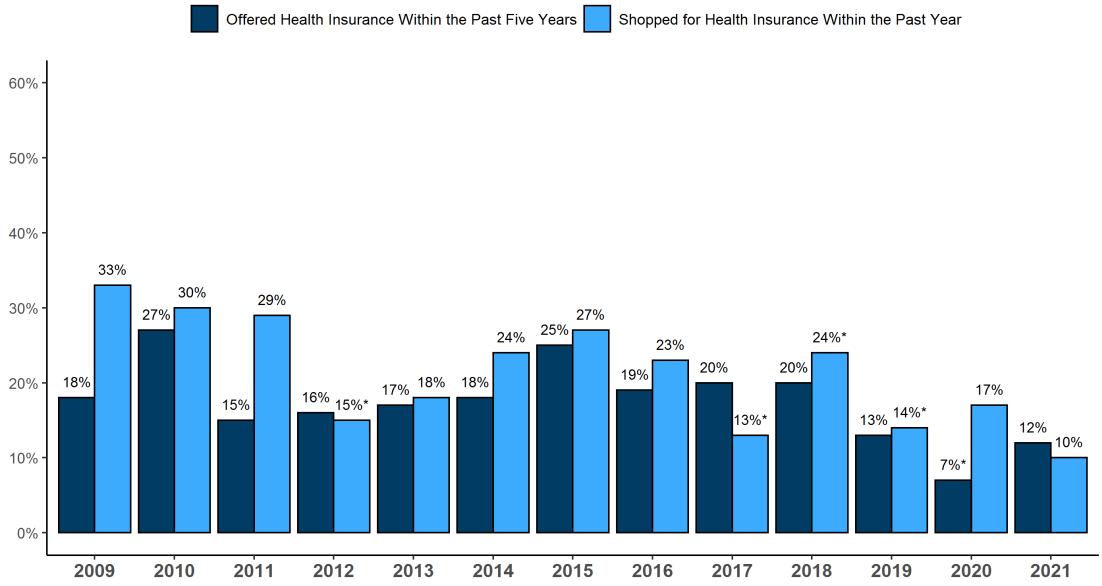
Among Small Firms Not Offering Health Benefits, Most Important Reason for Not Offering, 2021

	3-9 Workers	10-199 Workers	All Small Firms
Cost of Health Insurance Too High	29%	35%	**30%**
Firm Is Too Small	27	18	**25**
Employees Are Covered Under Another Plan, Including Spouse's	23	17	**21**
Employees Will Get a Better Deal On Health Insurance Exchanges	0	5	**1**
Employee Turnover Is Too Great	3	3	**3**
No Interest/Employees Do Not Want It	4	6	**4**
Most Employees Are Part-Time or Temporary Workers	7	8	**7**
Other	5	4	**5**
Don't Know	2%	5%	**3%**

NOTE: Small Firms have 3-199 workers.

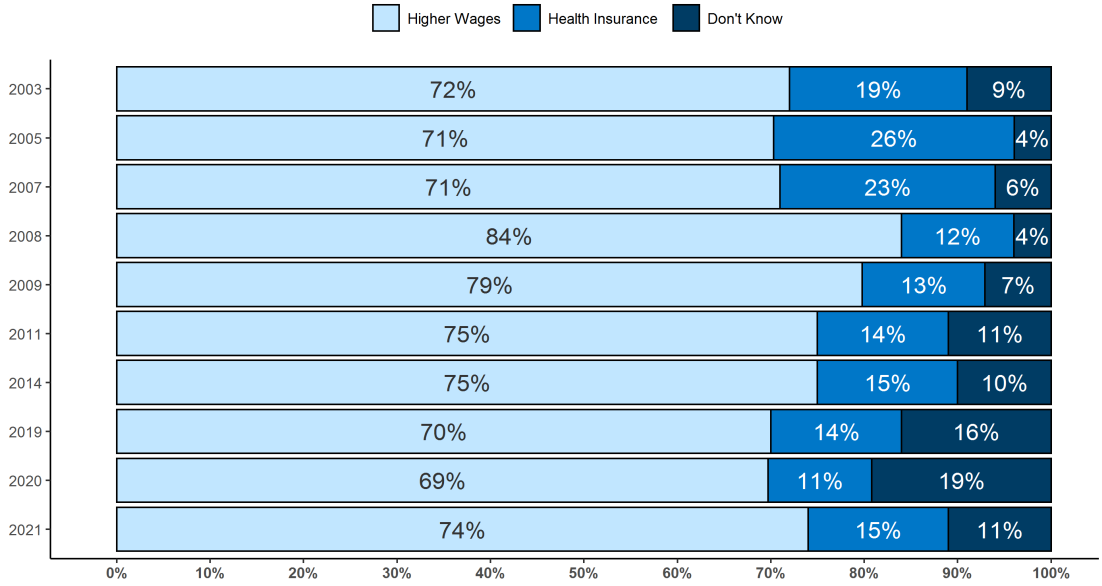
SOURCE: KFF Employer Health Benefits Survey, 2021

Figure 2.15
Among Small Firms Not Offering Health Benefits, Percentage of Firms That Report the Following Actions, 2009-2021



* Estimate is statistically different from estimate for the previous year shown (p < .05).
NOTE: Small Firms have 3-199 workers. 16% 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, 2018-2021; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2009-2017

Figure 2.16
Among Small Firms Not Offering Health Benefits, Firms' View of Employees' Preference for Higher Wages or Health Insurance Benefits, 2003-2021



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, 2019-2021; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2003-2014

Employer Health Benefits

2021 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 almost 155 million nonelderly 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 2021, 62% 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.

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 2021, 81% 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 [Figures 3.1 and 3.2].
  - 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 $28,000 a year or less) have a lower average eligibility rate than workers in firms with a smaller share of lower-wage workers (75% vs. 82%) [Figure 3.6].
  - Workers in firms with a relatively large share of higher-wage workers (where at least 35% earn $66,000 or more annually) have a higher average eligibility rate than workers in firms with a smaller share of higher-wage workers (87% vs. 75%) [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 (83% vs. 64%) [Figure 3.6].
  - Eligibility rates vary considerably for workers in different industries. The average eligibility rate remains particularly low for workers in retail firms (55%) [Figure 3.3].

[1] KFF. Health Insurance Coverage of the Nonelderly. San Francisco (CA): KFF; 2019 [cited 2021 Aug 19]. Available from: https://www.kff.org/other/state-indicator/nonelderly-0-64/ Estimate from the American Community Survey.
[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, 1999-2021

	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%
2021	81%	81%	81%	75%	78%	77%	60%	63%	62%

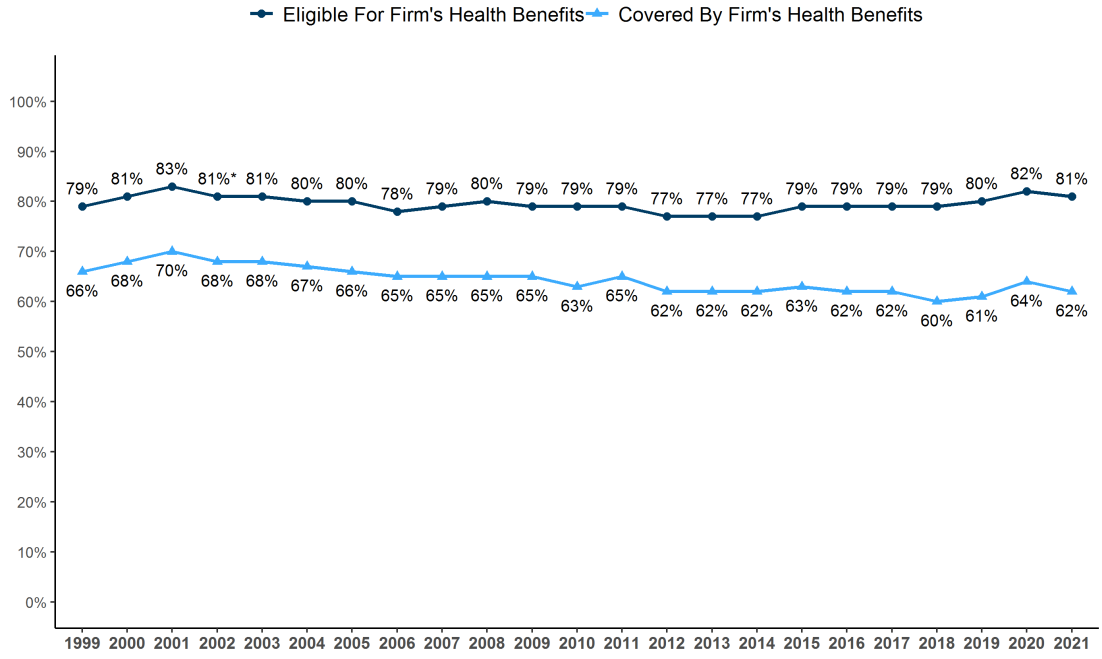
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers.

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

SOURCE: KFF Employer Health Benefits Survey, 2018-2021; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

Figure 3.2

Eligibility and Coverage Rates for Workers in Firms Offering Health Benefits, 1999-2021



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

SOURCE: KFF Employer Health Benefits Survey, 2018-2021; 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, 2021

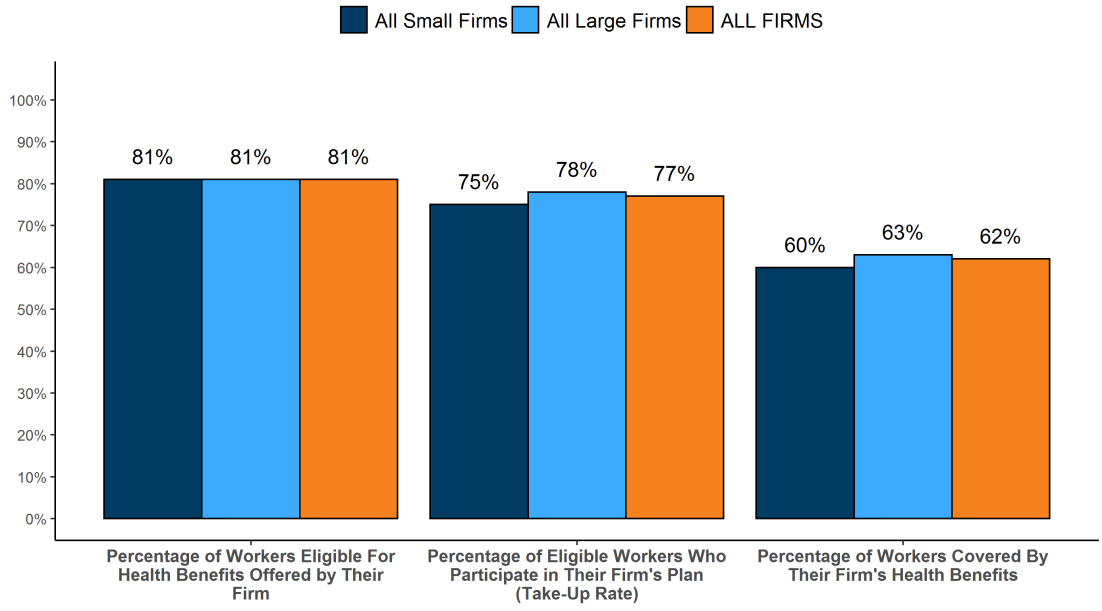
	Percentage of Workers Eligible for Health Benefits Offered by Their Firm	Percentage of Eligible Workers Who Participate in Their Firm's Plan (Take-Up Rate)	Percentage of Workers Covered by Their Firm's Health Benefits
FIRM SIZE			
3-24 Workers	77%	77%	59%
25-49 Workers	85	73	62
50-199 Workers	81	74*	60
200-999 Workers	83	77	64
1,000-4,999 Workers	84	77	65
5,000 or More Workers	79	79	62
All Small Firms (3-199 Workers)	**81%**	**75%**	**60%**
All Large Firms (200 or More Workers)	**81%**	**78%**	**63%**
REGION			
Northeast	82%	77%	63%
Midwest	78	78	61
South	83	75	62
West	80	80	64
INDUSTRY			
Agriculture/Mining/Construction	85%	75%	63%
Manufacturing	95*	77	73*
Transportation/Communications/Utilities	92*	87*	80*
Wholesale	87	81	71*
Retail	55*	72	40*
Finance	94*	82*	77*
Service	79	73*	57*
State/Local Government	91*	90*	81*
Health Care	80	76	61
ALL FIRMS	**81%**	**77%**	**62%**

* 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, 2021

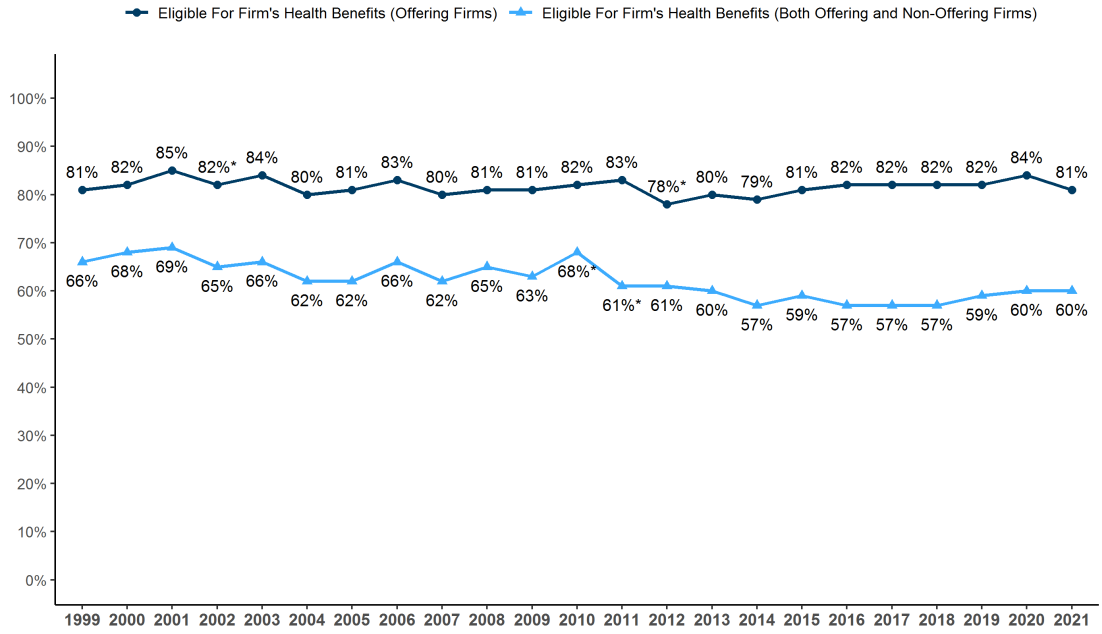
Figure 3.4

Eligibility, Take-Up, and Coverage Rates in Firms Offering Health Benefits, by Firm Size, 2021



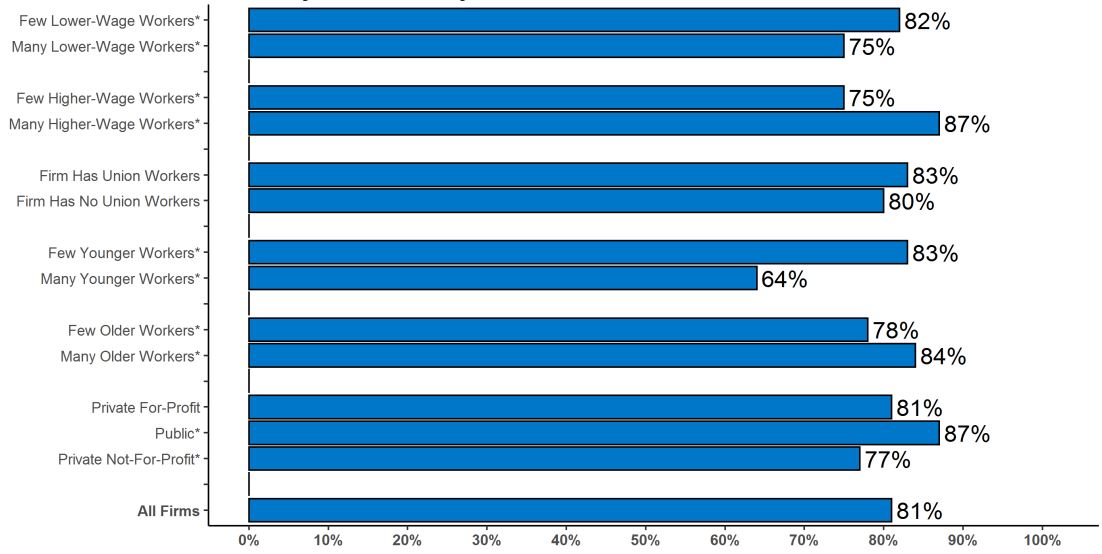
Tests found no statistical difference between large and small firms ($p < .05$).
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2021

Figure 3.5
Among Workers at Small Firms, Eligibility for Workers At Their Own Firms, 1999-2021



* 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, 2018-2021; 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, 2021

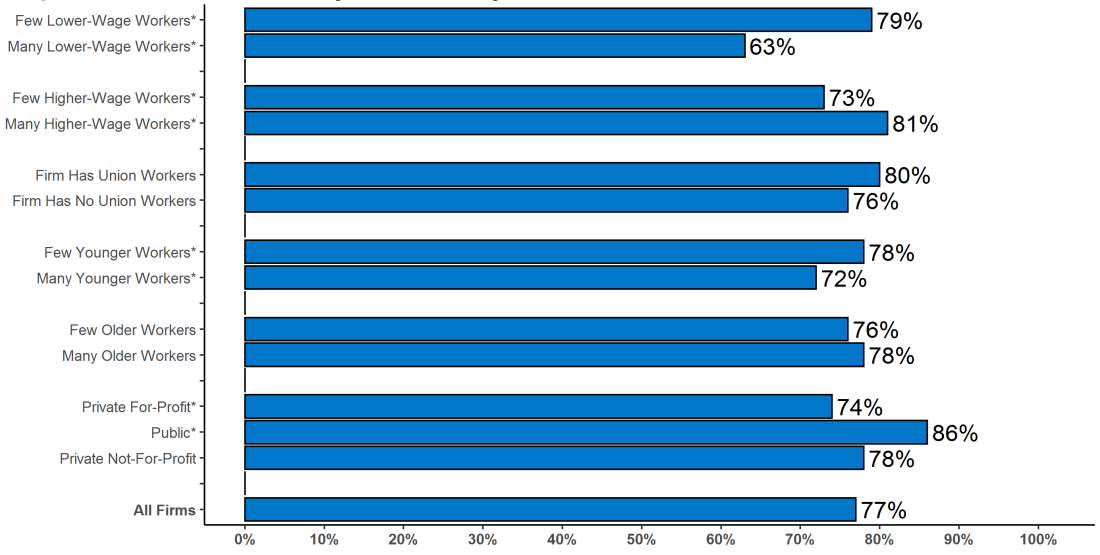


* Estimates are statistically different from each other within category ($p < .05$).
NOTE: Firms with many lower-wage workers are those where at least 35% earn the 25th percentile or less of national earnings ($28,000 in 2021). Firms with many higher-wage workers are those where at least 35% earn the 75th percentile or more than of national earnings ($66,000 in 2021). 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, 2021

TAKE-UP RATE

- Seventy-seven percent of eligible workers take up coverage when it is offered to them, similar to the percentage last year [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 (63% 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 (81% vs. 73%) [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 (72% vs. 78%) [Figure 3.7].
- Eligible workers in private, for-profit firms have a lower average take up rate (74%) and eligible workers in public firms have a higher average take up rate (86%) than workers in other firm types [Figure 3.7].
- 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 (77%) is similar to the shares in 2016 (79%) [Figure 3.1].

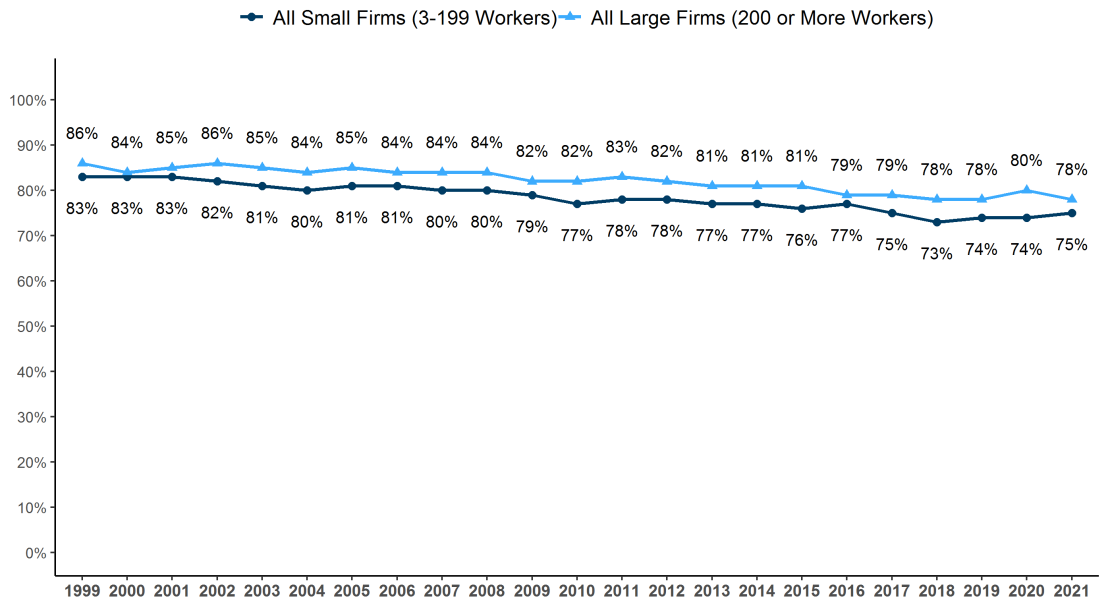
Figure 3.7
Among Workers in Firms Offering Health Benefits, Percentage of Eligible Workers Who Take Up Health Benefits Offered by Their Firm, by Firm Characteristics, 2021



* 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 ($28,000 in 2021). Firms with many higher-wage workers are those where at least 35% earn the 75th percentile or more than of national earnings ($66,000 in 2021). 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, 2021

[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.

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, 1999-2021



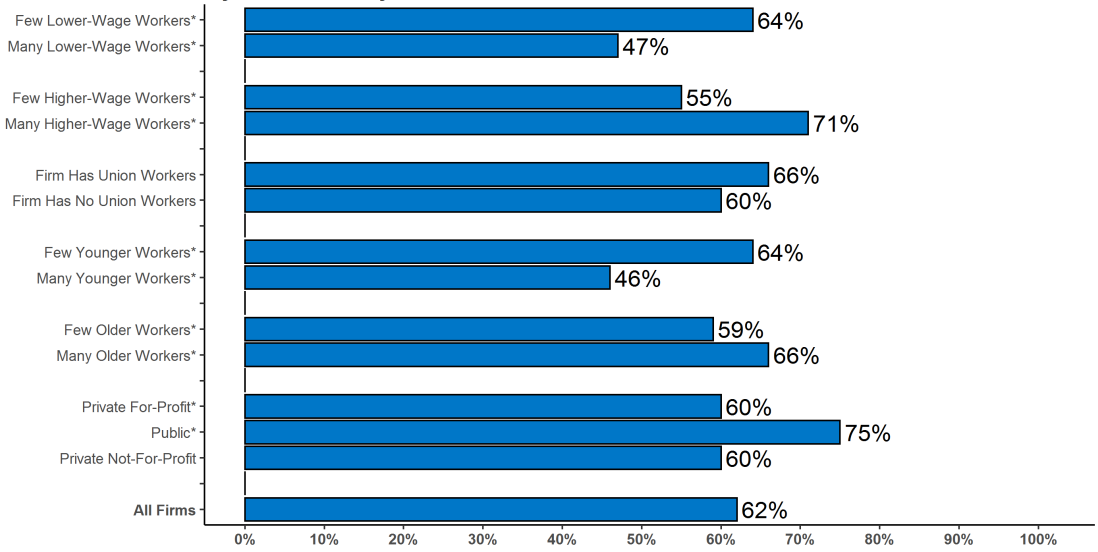
Tests found no statistical difference from estimate for the previous year shown ($p < .05$).
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2018-2021; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

COVERAGE

- In 2021, the percentage of workers at firms offering health benefits covered by their firm's health plan is 62%, 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 2021. 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. 64%). 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 (71% vs. 55%) [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 (64% vs. 46%). 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 (66% vs. 59%) [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, 56% are covered by health benefits offered by their employer, similar to the percentages last year, five years ago, and ten years ago [Figure 3.10].

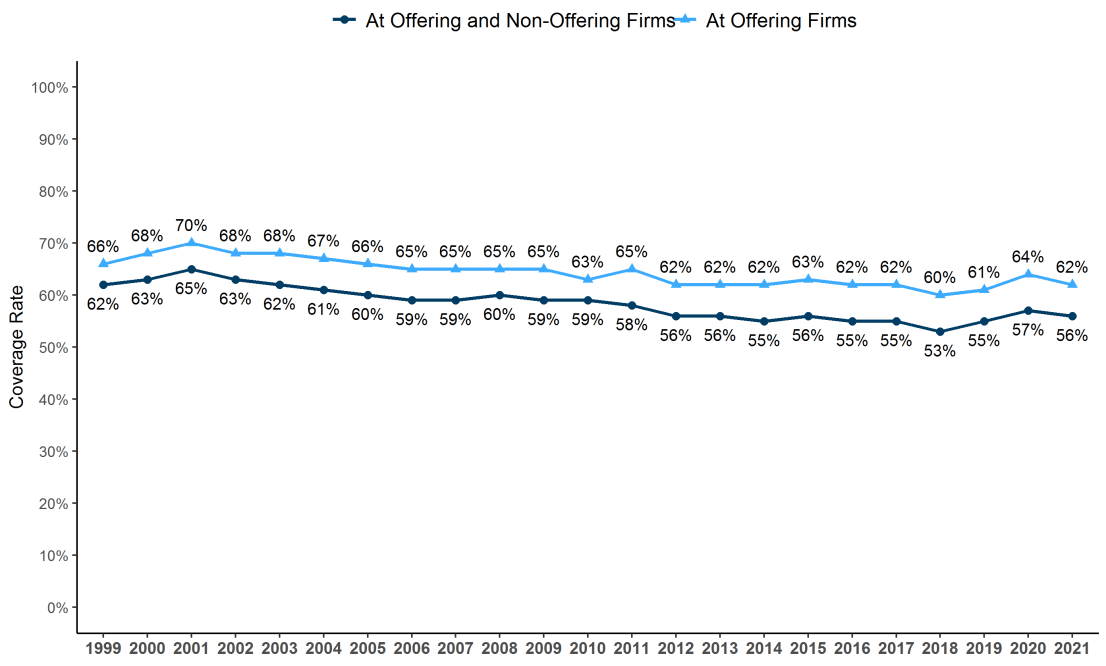
Figure 3.9
Among Workers in Firms Offering Health Benefits, Percentage of Workers Covered by Health Benefits Offered by Their Firm, by Firm Characteristics, 2021



* 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 ($28,000 in 2021). Firms with many higher-wage workers are those where at least 35% earn the 75th percentile or more than of national earnings ($66,000 in 2021). 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, 2021

Figure 3.10

Percentage of Workers Covered by Their Firm's Health Benefits, 1999-2021



Tests found no statistical difference from estimate for the previous year shown ($p < .05$).

SOURCE: KFF Employer Health Benefits Survey, 2018-2021; 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, 1999-2021

	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%**
2021	35%	47%	56%	63%	65%	62%	45%	63%	**56%**

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, 2018-2021; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

Types of Plans Offered

SECTION 4

Section 4

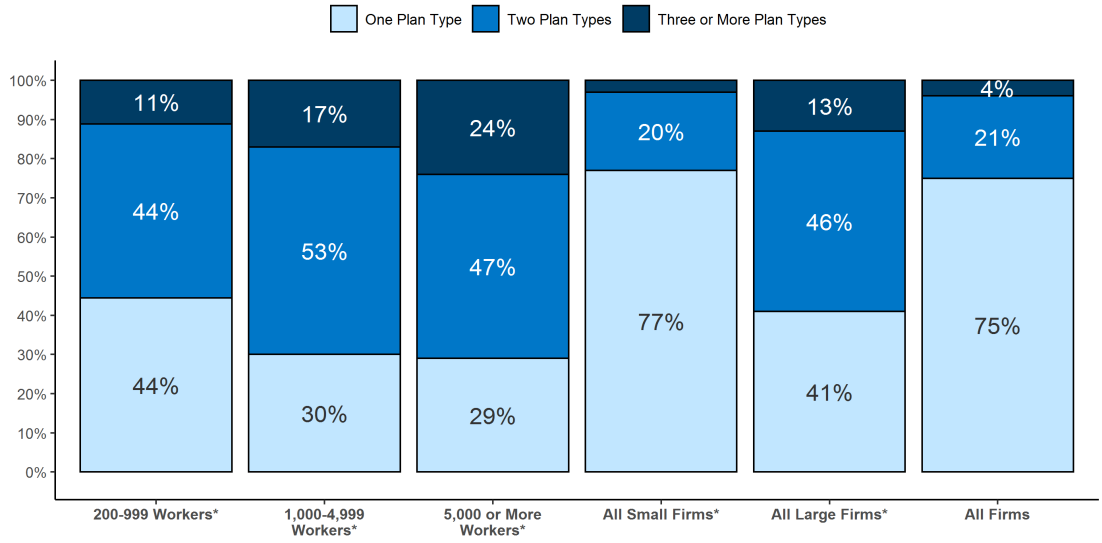
Types of Plans Offered

Most firms that offer health benefits offer only one type of health plan (75%). 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

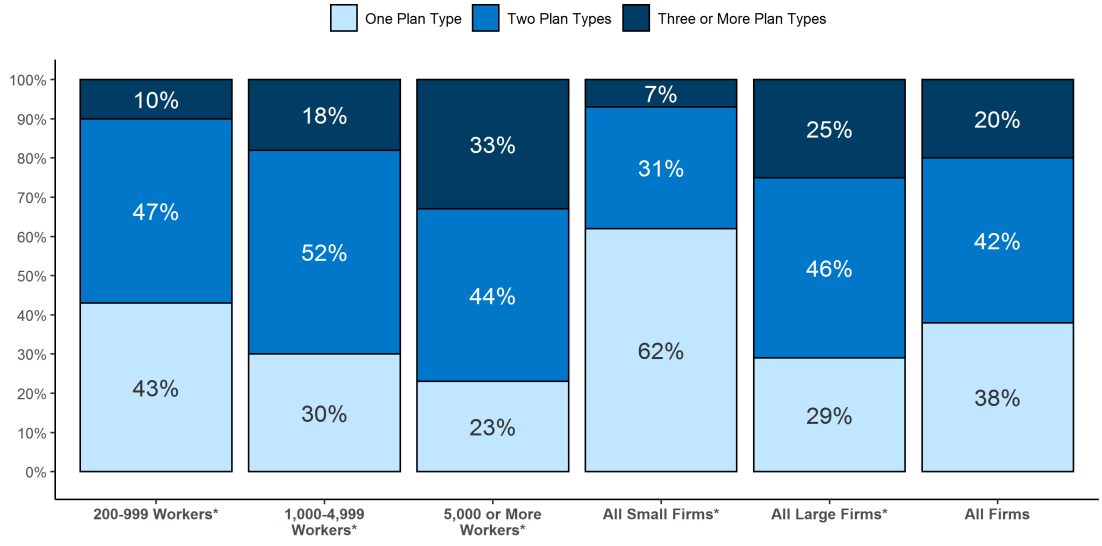
- In 2021, 75% of firms offering health benefits offer only one type of health plan. Large firms are more likely than small firms to offer more than one plan type (59% vs. 23%) [Figure 4.1].
- Sixty-two percent of covered workers are employed in a firm that offers more than one type of health plan. Seventy-one percent of covered workers in large firms are employed by a firm that offers more than one plan type, compared to 38% in small firms [Figure 4.2].
- Sixty-seven percent of covered workers in firms offering health benefits work in firms that offer one or more PPOs; 58% work in firms that offer one or more HDHP/SOs; 23% work in firms that offer one or more HMOs; 10% work in firms that offer one or more POS plans; and 2% 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, 54% are in firms that only offer one or more PPOs and 26% 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, 2021



* 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, 2021

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, 2021



* 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, 2021

Figure 4.3

Among Firms Offering Health Benefits, Percentage of Firms That Offer the Following Plan Types, by Firm Size, 2021

	Conventional	HMO	PPO	POS	HDHP/SO
FIRM SIZE					
3-24 Workers	1%	8%	23%*	12%	14%*
25-199 Workers	<1	11	37*	18	41*
200-999 Workers	2	17*	64*	11	56*
1,000-4,999 Workers	1	22*	73*	12	66*
5,000 or More Workers	2	22*	78*	8	66*
All Small Firms (3-199 Workers)	**1%**	**8%***	**25%***	**13%**	**20%***
All Large Firms (200 or More Workers)	**2%**	**18%***	**66%***	**11%**	**58%***
ALL FIRMS	**1%**	**8%**	**26%**	**13%**	**22%**

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, 2021

Figure 4.4

Among Firms Offering Health Benefits, Percentage of Covered Workers in Firms That Offer the Following Plan Types, by Firm Size, 2021

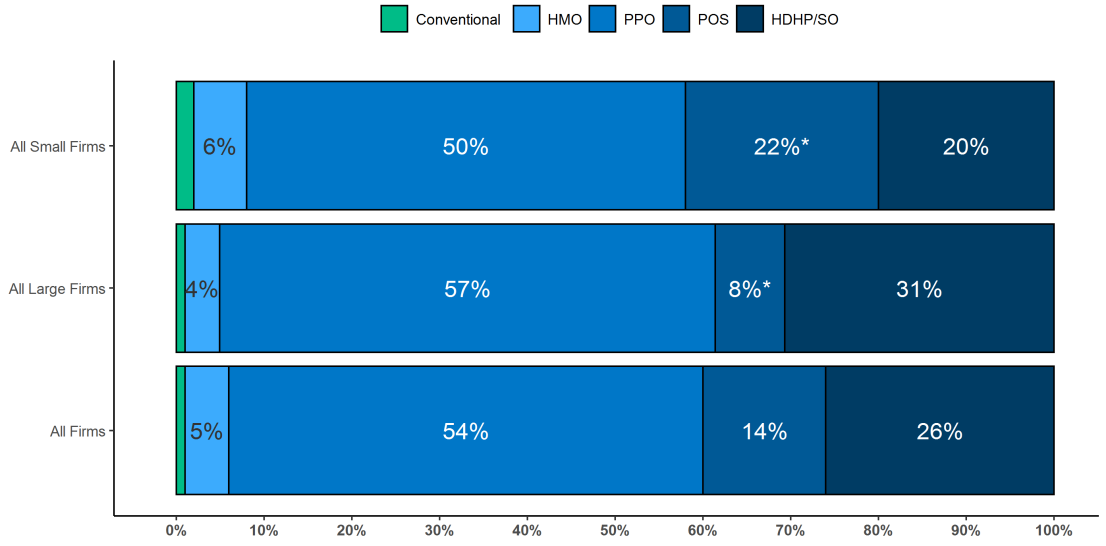
	Conventional	HMO	PPO	POS	HDHP/SO
FIRM SIZE					
200-999 Workers	2%	15%*	70%	8%	60%
1,000-4,999 Workers	1	18	76*	10	69*
5,000 or More Workers	3	34*	76*	6*	68*
All Small Firms (3-199 Workers)	**1%**	**15%***	**50%***	**18%***	**38%***
All Large Firms (200 or More Workers)	**2%**	**26%***	**74%***	**7%***	**67%***
ALL FIRMS	**2%**	**23%**	**67%**	**10%**	**58%**

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, 2021

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, 2021

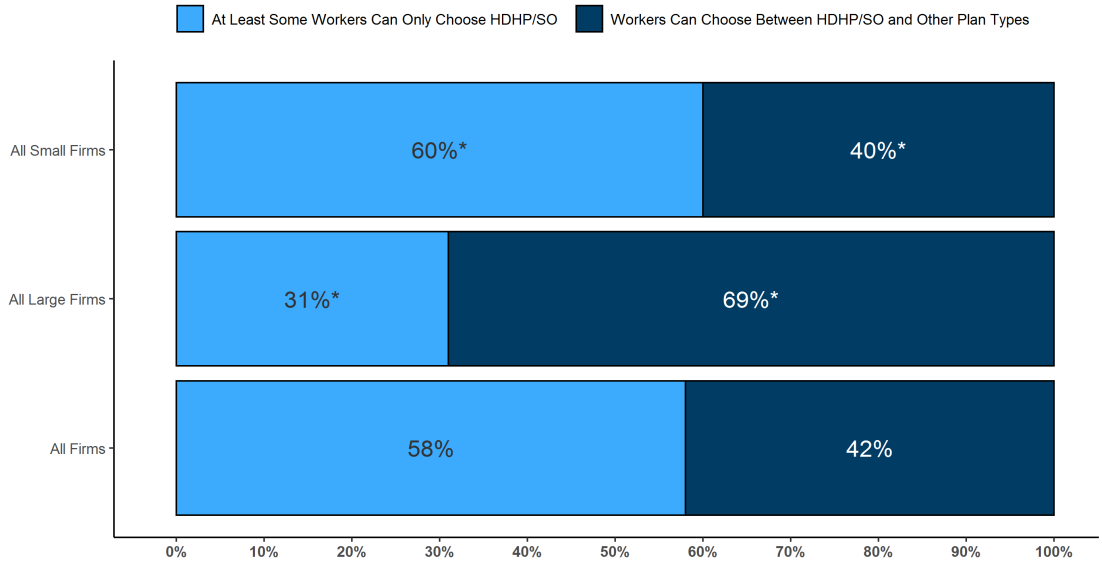


* Estimate is statistically different from estimate for all other firms not in the indicated size category ($p < .05$).
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers. The survey collects information on a firm's plan with the largest enrollment in each of the plan types. 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, 2021

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 58% of firms that offer an HDHP/SO, at least some workers can only choose an HDHP/SO, while 42% of firms that offer an HDHP/SO allow workers also 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, 2021



* 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, 8% 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, 2021

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.

Employer Health Benefits

2021 Annual Survey

Market Shares of Health Plans

SECTION

5

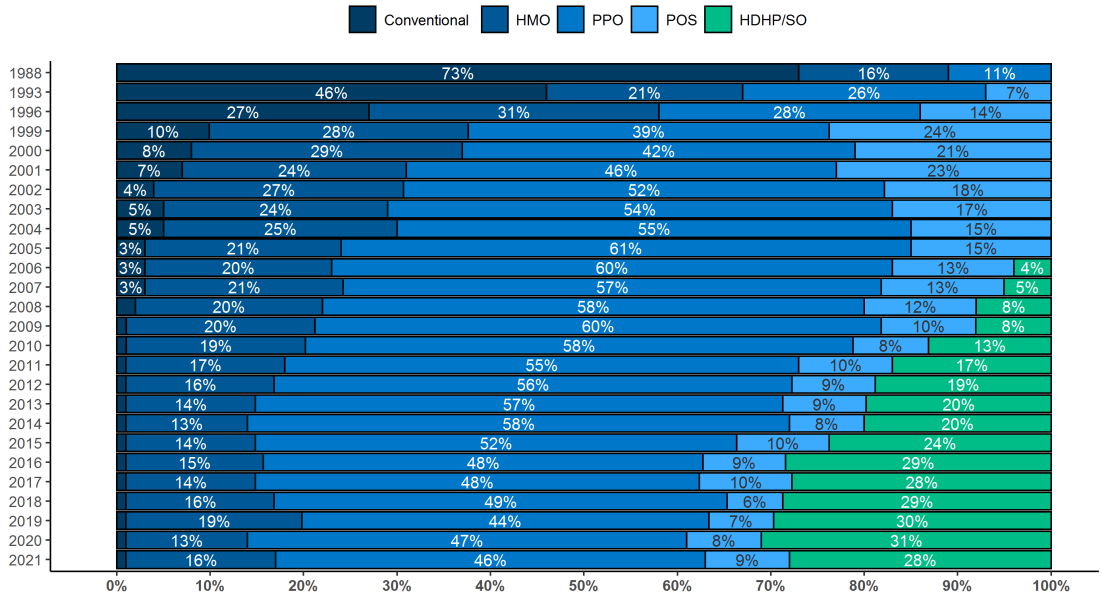
Section 5

Market Shares of Health Plans

PPOs are the most common plan type, covering 46% of covered workers, followed by HDHP/SOs, HMOs, POS plans, and conventional plans. All of these percentages are similar to the enrollment percentages in 2020.

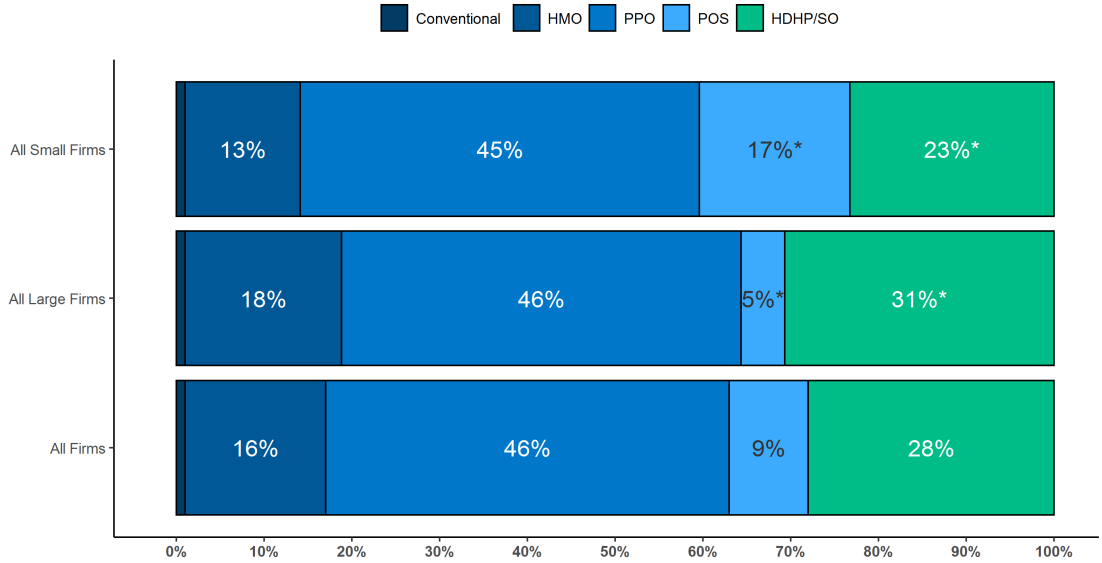
- Forty-six percent of covered workers are enrolled in PPOs, followed by HDHP/SOs (28%), HMOs (16%), POS plans (9%), and conventional plans (1%) [Figure 5.1].
- The percentage of covered workers enrolled in HDHP/SOs is similar to the percentages last year (31%) and five years ago (29%), but higher than the percentage 10 years ago (17%). The percentage of covered workers enrolled in PPOs decreased 9% over the past decade [Figure 5.1].
- The percentage of covered workers enrolled in HMOs (16%) is similar to the percentages last year (11%) and five years ago (15%). This percentage has moved around over the last few years and we are unsure as to why. 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 [Figure 5.2].
- Covered workers in large firms are more likely to be enrolled in HDHP/SOs than covered workers in small firms (30% vs. 23%) [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 (34%), and is significantly lower in the Midwest (8%) and in the South (10%) [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 (19%) 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, 1988-2021



NOTE: Information was not obtained for POS plans in 1988 or for HDHP/SO plans until 2006. See the Survey Design and Methods section from the 2005 Kaiser/HRET Survey and the 2021 KFF Survey for a discussion of weighting changes.
SOURCE: KFF Employer Health Benefits Survey, 2018-2021; 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, 2021



* 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, 2021

Figure 5.3

Distribution of Health Plan Enrollment for Covered Workers, by Firm Size, Region, and Industry, 2021

	Conventional	HMO	PPO	POS	HDHP/SO
FIRM SIZE					
3-24 Workers	3%	17%	42%	21%*	16%*
25-49 Workers	1	10	42	26*	21
50-199 Workers	0*	12	50	9	29
200-999 Workers	1	10*	50	6	33
1,000-4,999 Workers	<1*	11*	50	7	33
5,000 or More Workers	<1	23*	43	4*	29
All Small Firms (3-199 Workers)	**1%**	**13%**	**45%**	**17%***	**23%***
All Large Firms (200 or More Workers)	**1%**	**18%**	**46%**	**5%***	**31%***
REGION					
Northeast	<1%	21%	43%	7%	30%
Midwest	1	8*	44	8	39*
South	1	10*	54*	11	25
West	<1	34*	38*	9	19*
INDUSTRY					
Agriculture/Mining/Construction	0%*	8%*	44%	19%	28%
Manufacturing	<1*	9*	45	10	37*
Transportation/Communications/Utilities	1	22	47	5	25
Wholesale	0*	18	42	3*	36
Retail	1	26	44	4	25
Finance	0*	12	33*	6	49*
Service	1	18	44	9	27
State/Local Government	0*	11	61*	12	16*
Health Care	1	17	51	9	23
ALL FIRMS	**1%**	**16%**	**46%**	**9%**	**28%**

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, 2021

Employer Health Benefits

2021 Annual Survey

Worker and Employer Contributions for Premiums

SECTION

6

Section 6

Worker and Employer Contributions for Premiums

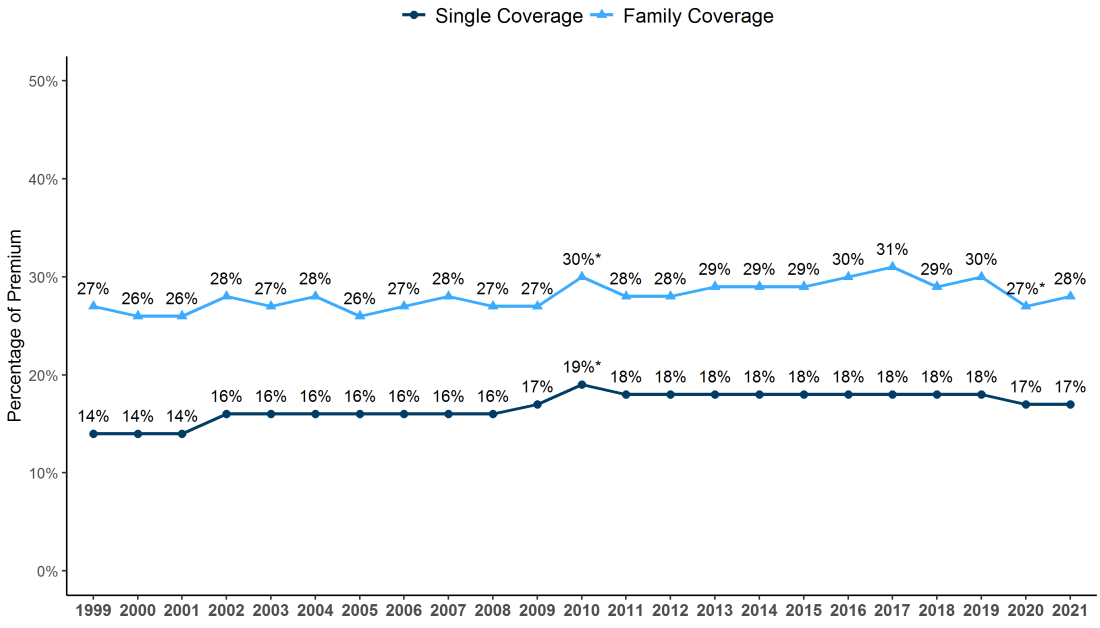
Covered workers on average contribute 17% of the premium for single coverage and 28% of the premium for family coverage in 2021.[1] The average monthly worker contributions are $108 for single coverage ($1,299 annually) and $497 for family coverage ($5,969 annually). The average contribution amount for family coverage is higher for covered workers in small firms (3-199 workers) than for covered workers in large firms (200 or more workers) ($7,710 vs. $5,269).

- In 2021, covered workers on average contribute 17% of the premium for single coverage and 28% 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 similar to the percentage (27%) last year [Figure 6.1].[2]
  - Covered workers in small firms on average contribute a much higher percentage of the premium for family coverage than covered workers in large firms (37% vs. 24%) [Figure 6.2].
- Workers with single coverage have an average contribution of $108 per month ($1,299 annually), and workers with family coverage have an average contribution of $497 per month ($5,969 annually) toward their health insurance premiums [Figure 6.3], [Figure 6.4], and [Figure 6.5].
  - The average worker contribution in HDHP/SOs for family coverage is lower than the overall average worker contribution for family coverage ($5,129 vs. $5,969) [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 ($7,710 vs. $5,269). 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.

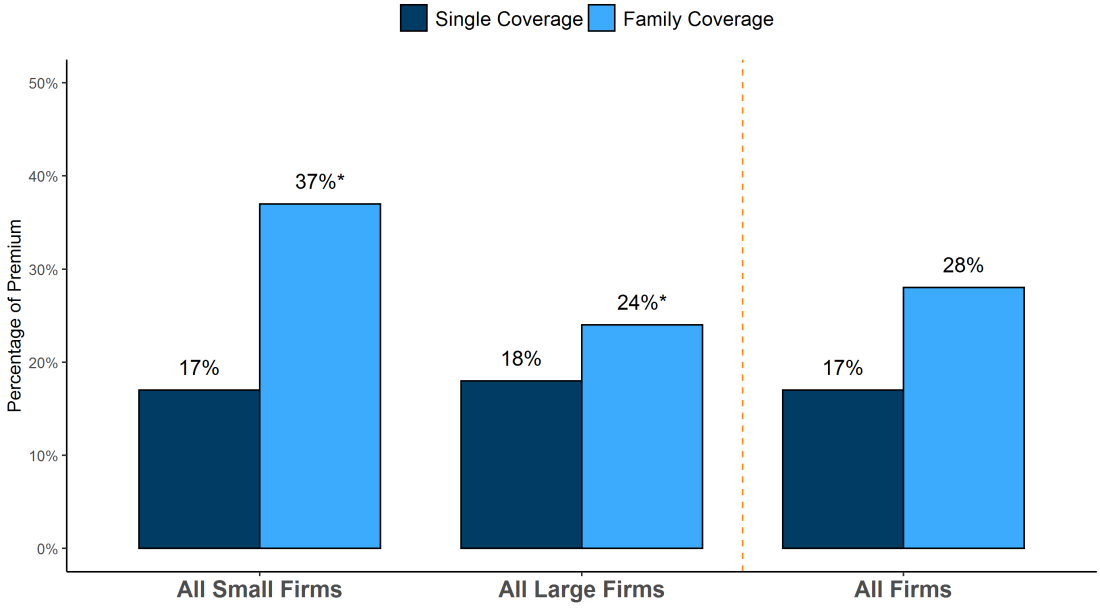
[2] The average percentage contribution is calculated as a weighted average of all a firm's plan types and may not necessarily equal the average worker contribution divided by the average premium.

Figure 6.1
Average Percentage of Premium Paid by Covered Workers for Single and Family Coverage, 1999-2021



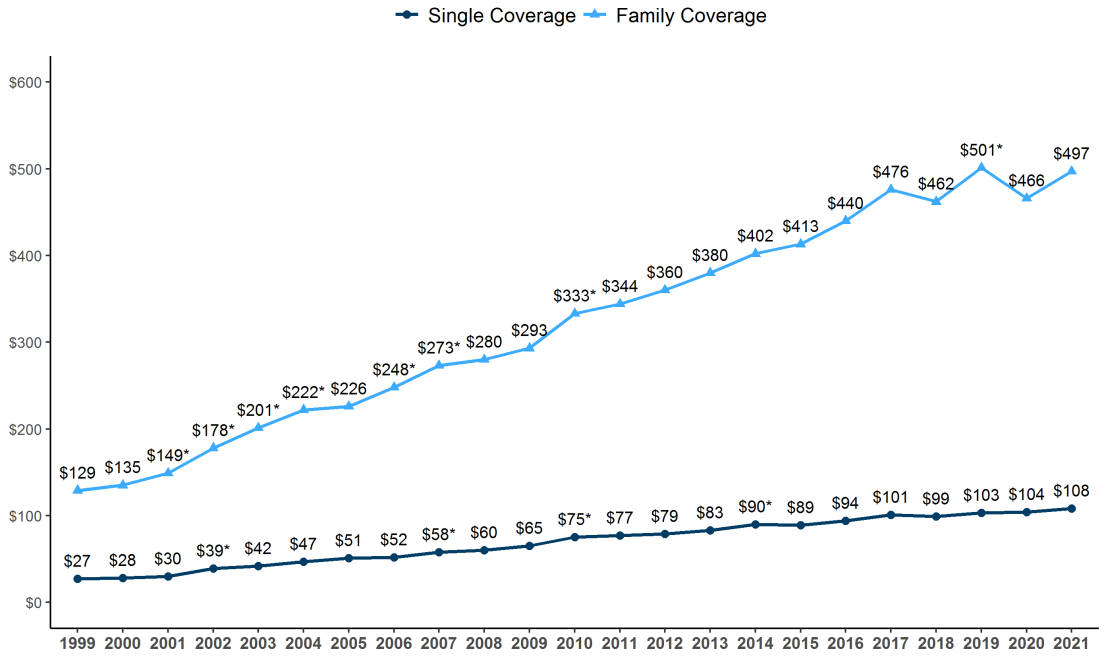
* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
SOURCE: KFF Employer Health Benefits Survey, 2018-2021; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

Figure 6.2
Average Percentage of Premium Paid by Covered Workers for Single and Family Coverage, by Firm Size, 2021



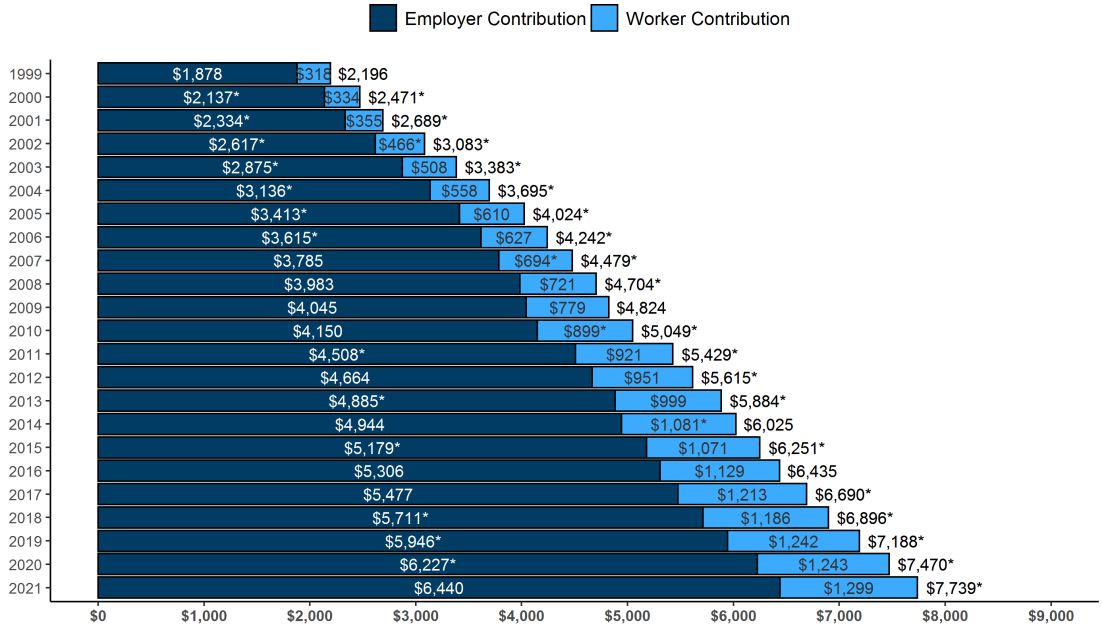
* Estimate is statistically different between All Small Firms and All Large Firms within coverage type ($p < .05$).
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2021

Figure 6.3
Average Monthly Worker Premium Contributions for Single and Family Coverage, 1999-2021



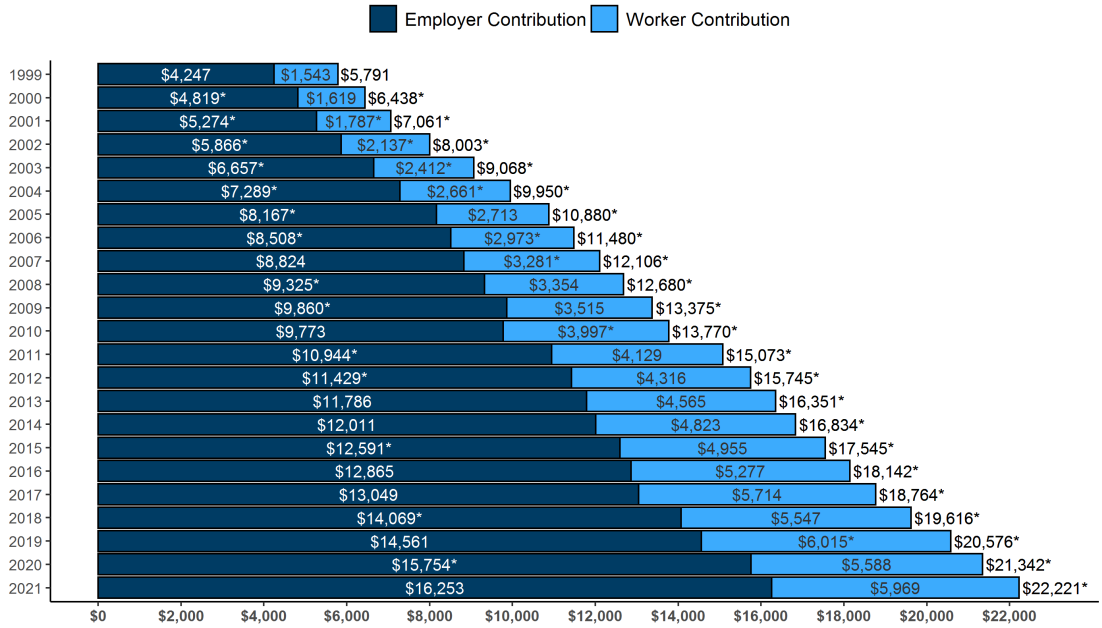
* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
SOURCE: KFF Employer Health Benefits Survey, 2018-2021; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

Figure 6.4
Average Annual Worker and Employer Contributions to Premiums and Total Premiums for Single Coverage, 1999-2021



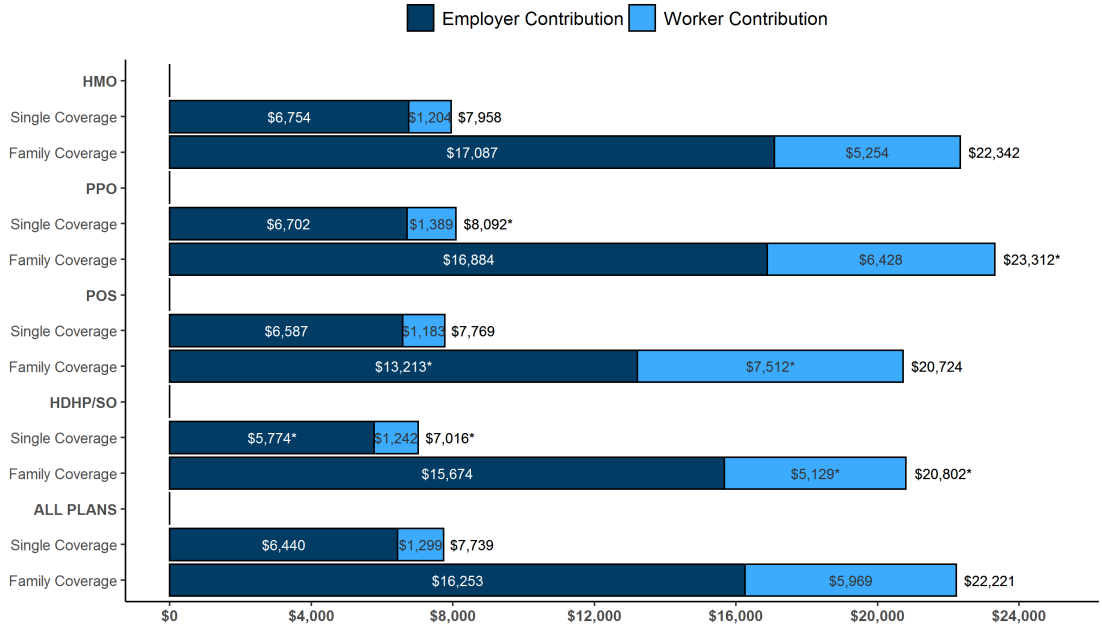
* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
SOURCE: KFF Employer Health Benefits Survey, 2018-2021; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

Figure 6.5
Average Annual Worker and Employer Contributions to Premiums and Total Premiums for Family Coverage, 1999-2021



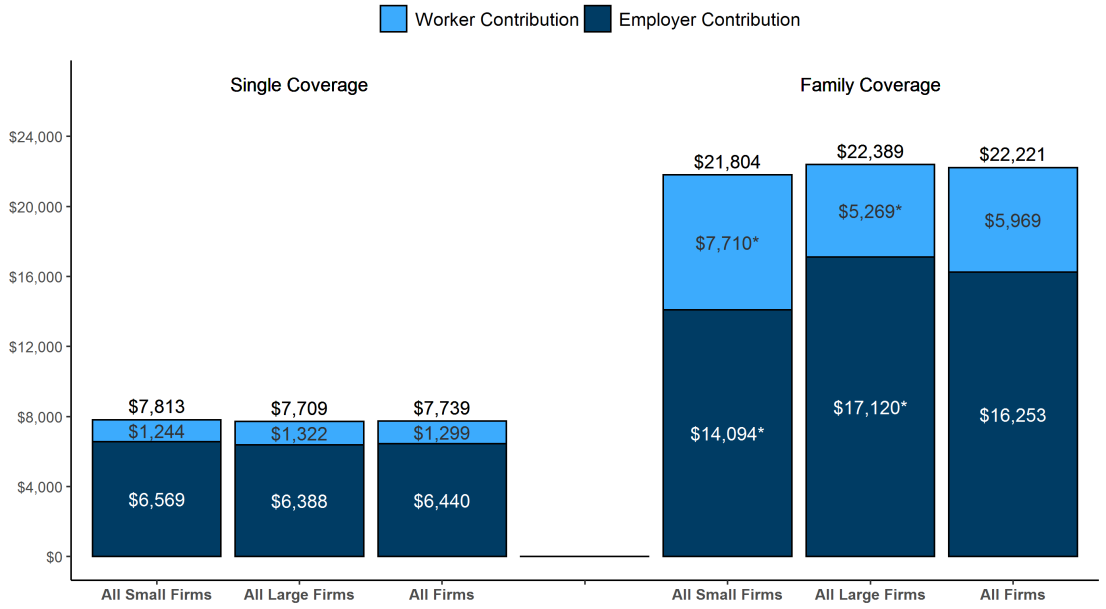
* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
SOURCE: KFF Employer Health Benefits Survey, 2018-2021; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

Figure 6.6
Average Annual Worker and Employer Premium Contributions and Total Premiums for Single and Family Coverage, by Plan Type, 2021



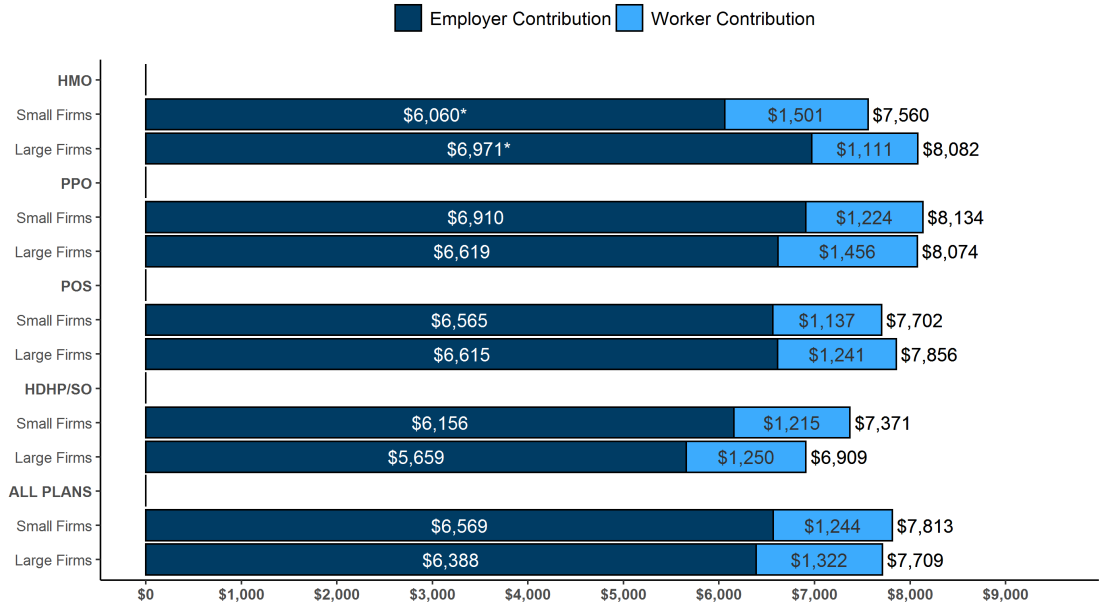
* Estimate is statistically different from All Plans estimate within coverage type ($p < .05$).
SOURCE: KFF Employer Health Benefits Survey, 2021

Figure 6.7
Average Annual Worker and Employer Premium Contributions and Total Premiums for Single and Family Coverage, by Firm Size, 2021



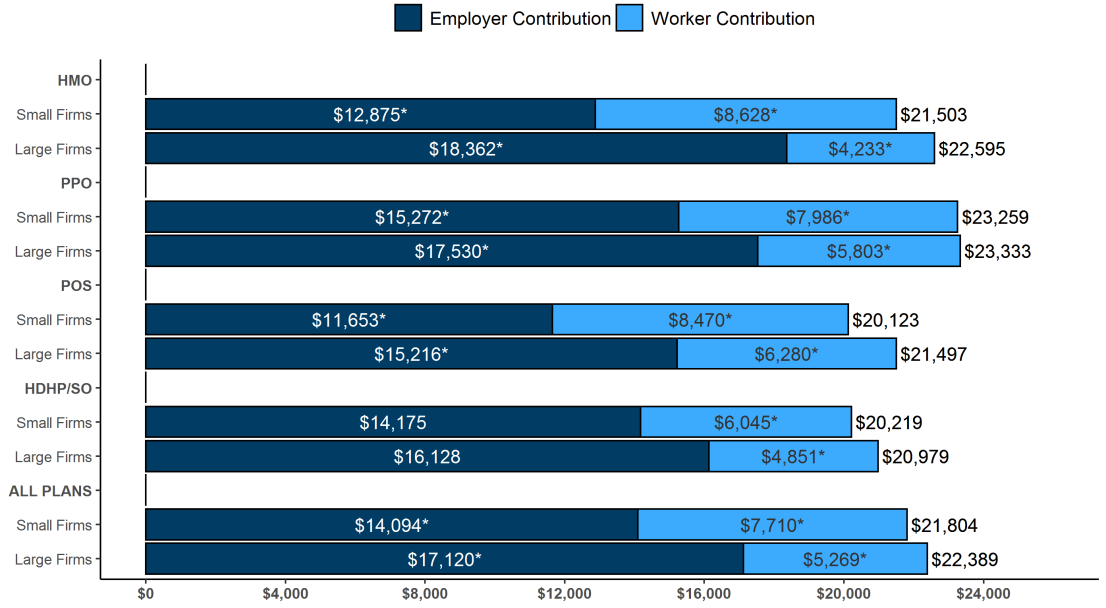
* Estimate is statistically different between All Small Firms and All Large Firms estimate ($p < .05$).
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2021

Figure 6.8
Average Annual Worker and Employer Premium Contributions and Total Premiums for Single Coverage, by Plan Type and Firm Size, 2021



* 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, 2021

Figure 6.9
Average Annual Employer and Worker Premium Contributions and Total Premiums for Family Coverage, by Plan Type and Firm Size, 2021



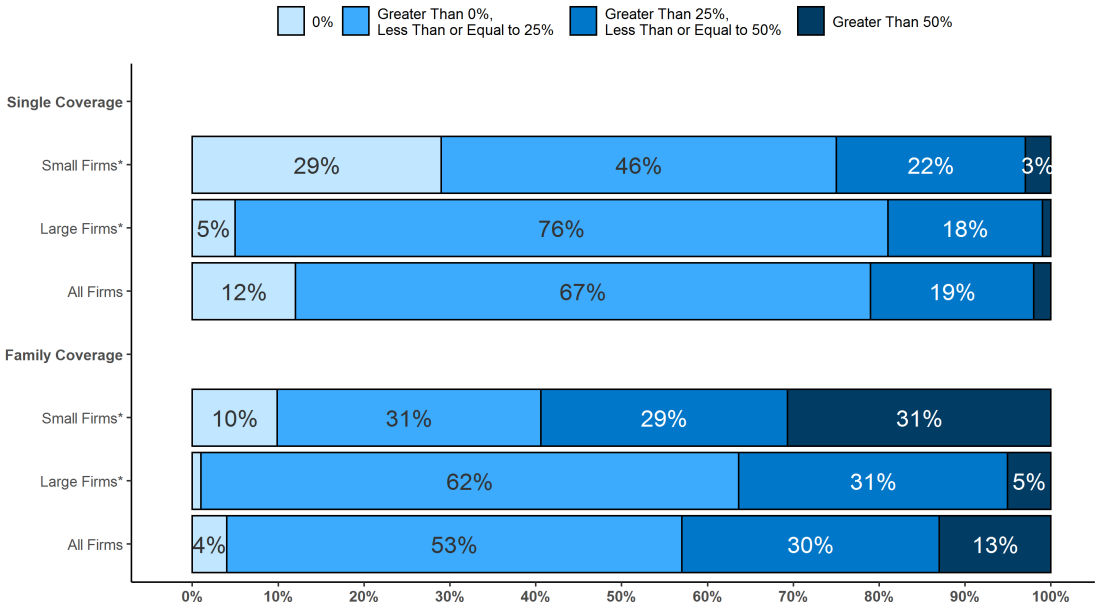
* Estimates are statistically different within plan type between All Small Firms and All Large Firms ($p < .05$).
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2021

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.
  - Twelve 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-nine percent of covered workers in small firms have an employer that pays the full premium for single coverage, compared to 5% 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].
- Thirteen 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].
  - Thirty-one 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 5% 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].

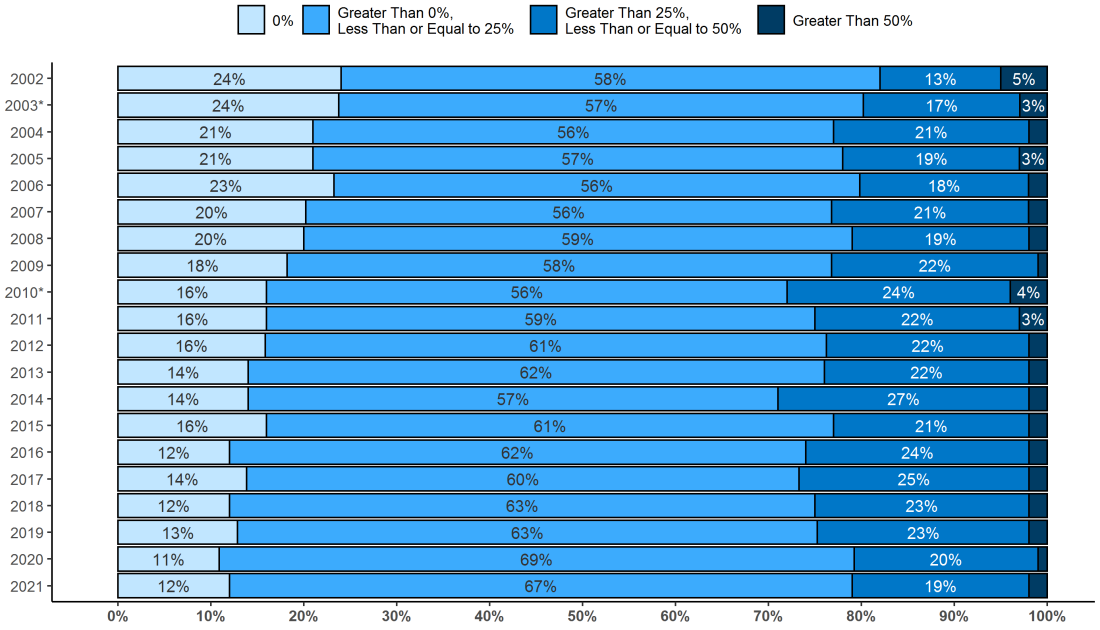
- There is substantial variation among workers in both small and large firms in the dollar amounts they must contribute.
  - Among covered workers in small firms, 34% have a contribution for single coverage of less than $500, while 20% have a contribution of $2,000 or more [Figure 6.13]. For family coverage, 13% have a contribution of less than $1,500, while 27% have a contribution of $10,500 or more [Figure 6.14].
  - Among covered workers in large firms, 12% have a contribution for single coverage of less than $500, while 16% have a contribution of $2,000 or more [Figure 6.13]. For family coverage, only 3% have a contribution of less than $1,500, while 5% have a contribution of $10,500 or more [Figure 6.14].

Figure 6.10
Distribution of Percentage of Premium Paid by Covered Workers for Single and Family Coverage, by Firm Size, 2021



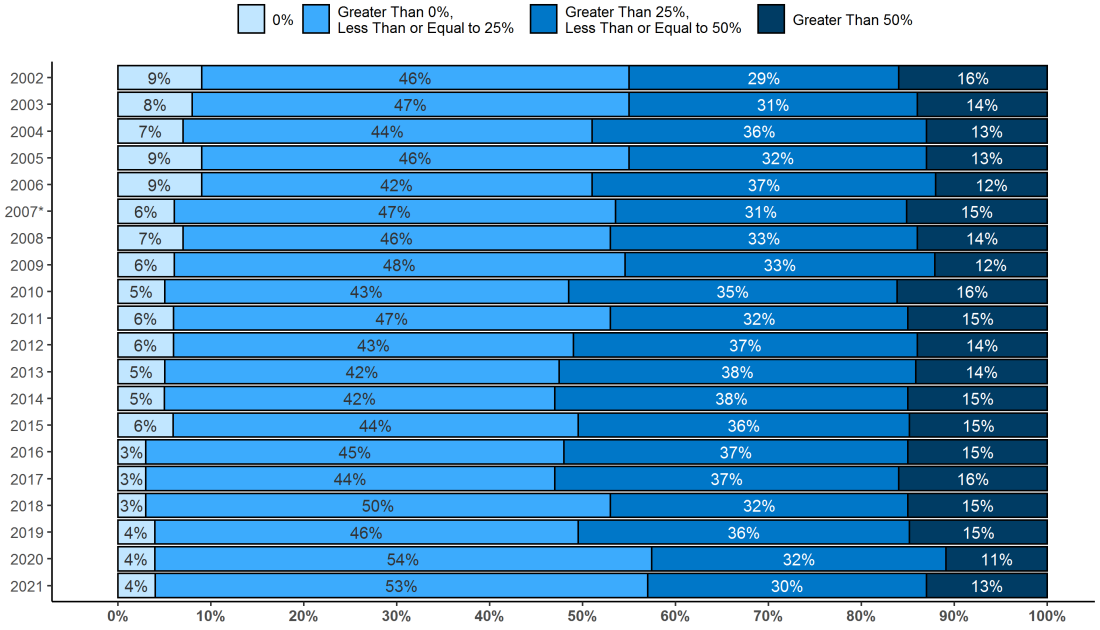
* Distributions are statistically different between All Small Firms and All Large Firms within coverage type ($p < 0.05$).
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2021

Figure 6.11
Distribution of Percentage of Premium Paid by Covered Workers for Single Coverage, 2002-2021



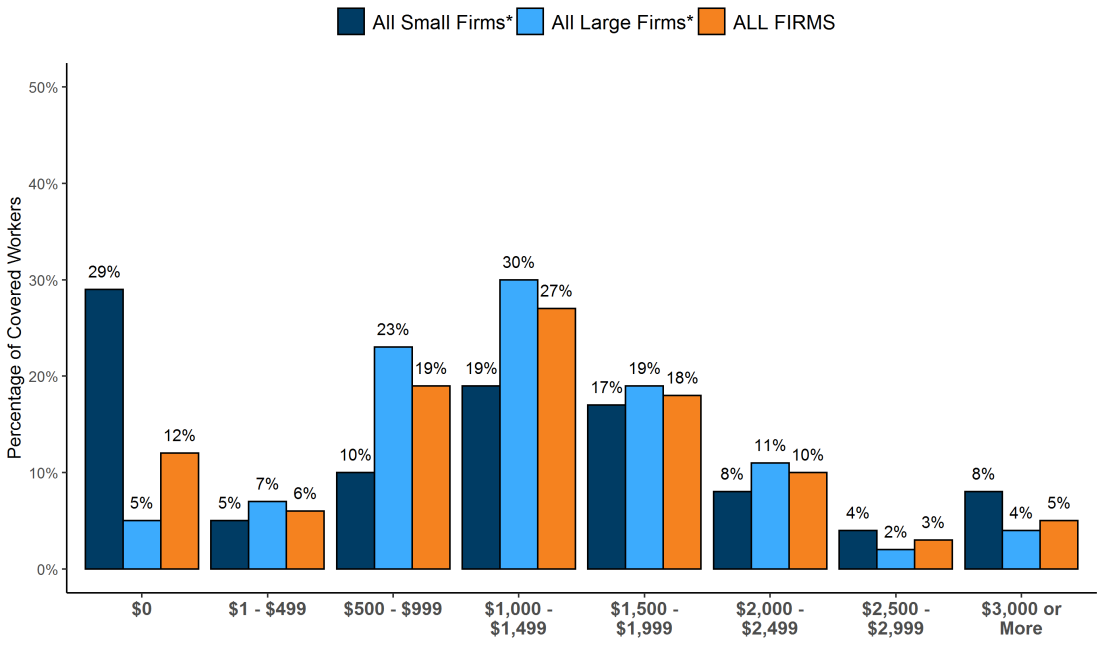
* Distribution is statistically different from distribution for the previous year shown ($p < .05$).
SOURCE: KFF Employer Health Benefits Survey, 2018-2021; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2002-2017

Figure 6.12
Distribution of Percentage of Premium Paid by Covered Workers for Family Coverage, 2002-2021



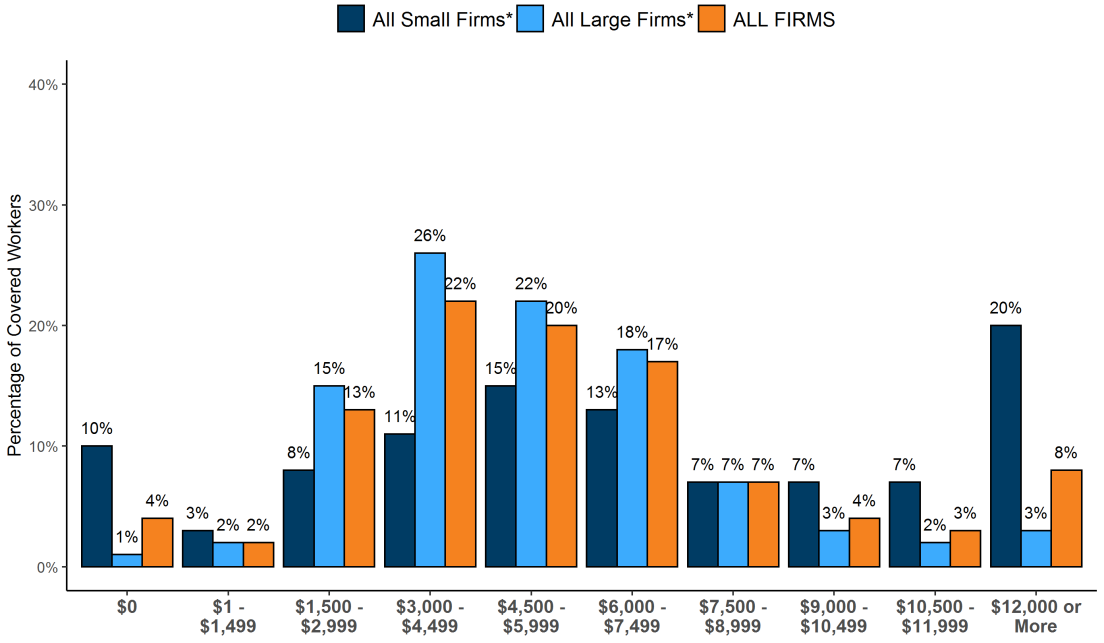
* Distribution is statistically different from distribution for the previous year shown ($p < .05$).
SOURCE: KFF Employer Health Benefits Survey, 2018-2021; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2002-2017

Figure 6.13
Distribution of Worker Contributions for Single Coverage, by Firm Size, 2021



* 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, 2021

Figure 6.14
Distribution of Worker Contributions for Family Coverage, by Firm Size, 2021

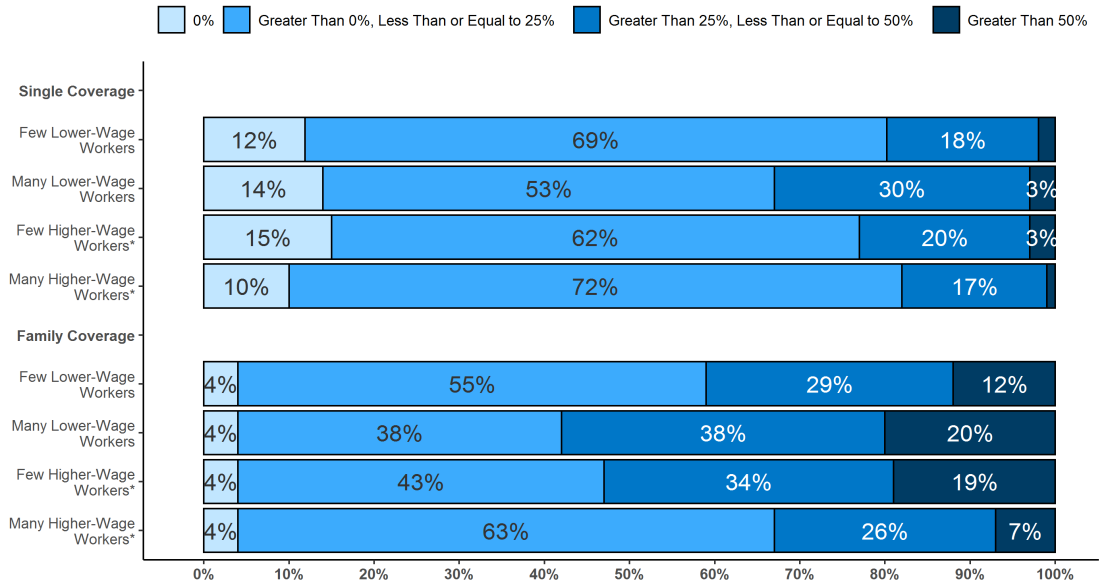


* Distribution is statistically different from distribution for all other firms not in the indicated size category ($p < .05$).
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2021

DIFFERENCES BY FIRM CHARACTERISTICS

- The percentage of the premium paid by covered workers varies by firm characteristics.
  - Covered workers in private, for-profit firms have relatively high premium contribution rates for single (20%) and family (30%) coverage. Covered workers in public firms and have relatively low premium contributions for single (11%) and family (23%) coverage. The average single coverage contribution rate for covered workers in private not-for-profit firms (16%) is also relatively low [Figure 6.17].
  - Covered workers in firms with a relatively large share of lower-wage workers (where at least 35% of workers earn $28,000 a year or less) have a higher average contribution rate for family coverage than those in firms with a smaller share of lower-wage workers (35% vs. 27%) [Figure 6.17].
  - Covered workers in firms with a relatively large share of higher-wage workers (where at least 35% earn $66,000 or more annually) have a lower average contribution rate for family coverage than those in firms with a smaller share of higher-wage workers (24% vs. 32%) [Figure 6.17].
  - Covered workers in firms with a relatively large share of younger workers (where at least 35% of workers are age 26 or younger) have higher average contribution rates for single coverage (23% vs. 17%) and for family coverage (35% vs. 28%) than those in firms with a smaller share of younger workers [Figure 6.17].
  - Covered workers in firms that have at least some union workers have a lower average contribution rate for family coverage (20% vs. 33%) than those in firms without any union workers [Figure 6.17].
  - Among covered workers in large firms, those that are in partially or completely self-funded plans on average have a lower average contribution rate for family coverage than workers in firms that are fully-insured (23% vs. 30%) [Figure 6.19].[3]

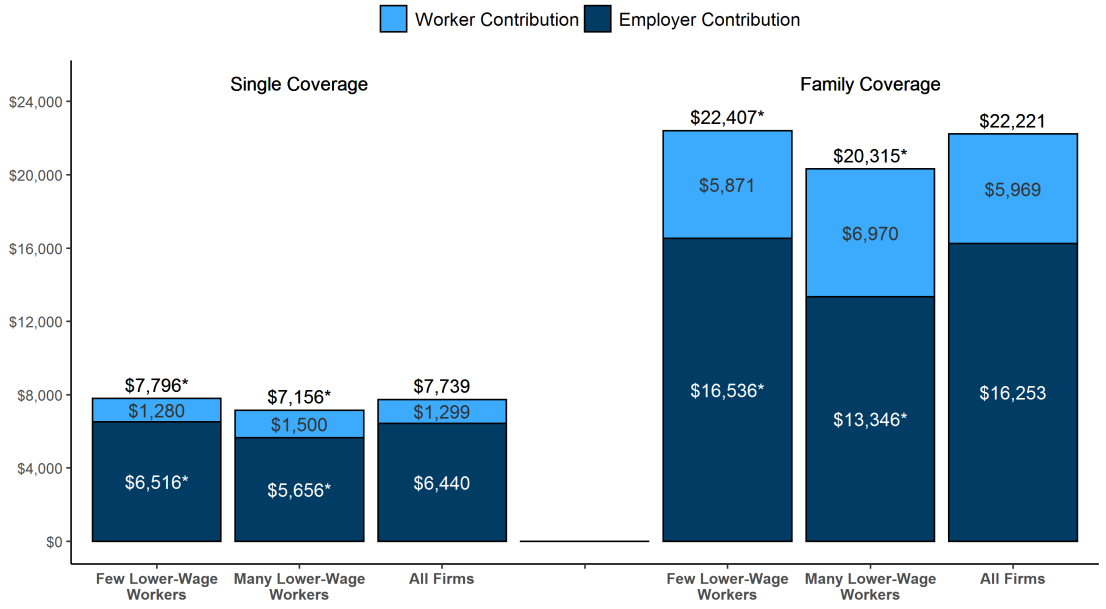
Figure 6.15
Distribution of the Percentage of Total Premium Paid by Covered Workers for Single and Family Coverage, by Firm Wage Level, 2021



*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 ($28,000 in 2021). Firms with many higher-wage workers are those where at least 35% earn the 75th percentile or more than of national earnings ($66,000 in 2021).
SOURCE: KFF Employer Health Benefits Survey, 2021

[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, 2021



* 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 ($28,000 in 2021).
SOURCE: KFF Employer Health Benefits Survey, 2021

Figure 6.17

Average Annual Premium Contributions Paid by Covered Workers for Single and Family Coverage, by Firm Characteristics, 2021

	Single Coverage		Family Coverage	
	Worker Contribution	Percent Contribution	Worker Contribution	Percent Contribution
LOWER WAGE LEVEL				
Few Lower-Wage Workers	$1,280	17%	$5,871	27%*
Many Lower-Wage Workers	$1,500	22%	$6,970	35%*
HIGHER WAGE LEVEL				
Few Higher-Wage Workers	$1,287	18%	$6,622*	32%*
Many Higher-Wage Workers	$1,310	17%	$5,390*	24%*
UNIONS				
Firm Has Union Workers	$1,245	16%	$4,559*	20%*
Firm Has No Union Workers	$1,328	18%	$6,733*	33%*
YOUNGER WORKERS				
Few Younger Workers	$1,271	17%*	$5,873*	28%*
Many Younger Workers	$1,618	23%*	$7,060*	35%*
OLDER WORKERS				
Few Older Workers	$1,319	18%	$6,244	30%
Many Older Workers	$1,280	17%	$5,700	27%
FUNDING ARRANGEMENT				
Fully Insured	$1,317	18%	$7,364*	35%*
Self-Funded	$1,289	17%	$5,193*	24%*
FIRM OWNERSHIP				
Private For-Profit	$1,430*	20%*	$6,332*	30%*
Public	$922*	11%*	$4,909*	23%*
Private Not-For-Profit	$1,267	16%*	$5,883	27%
ALL FIRMS	**$1,299**	**17%**	**$5,969**	**28%**

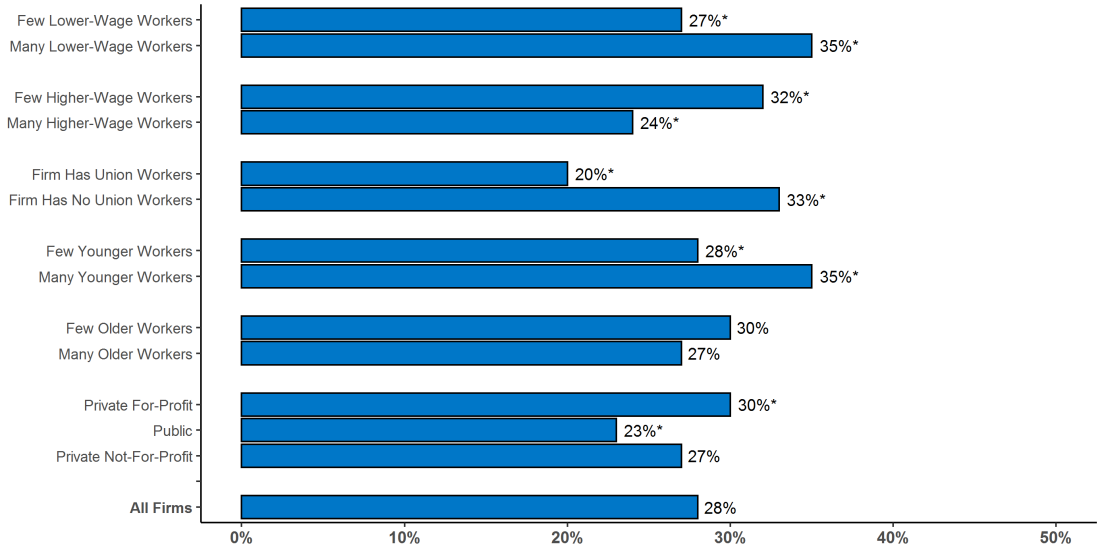
NOTE: Firms with many lower-wage workers are those where at least 35% earn the 25th percentile or less of national earnings ($28,000 in 2021). Firms with many higher-wage workers are those where at least 35% earn the 75th percentile or more than of national earnings ($66,000 in 2021). Firms with many 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, 2021

Figure 6.18

Average Percentage of Family Premium Paid by Covered Workers, by Firm Characteristics, 2021



* 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 ($28,000 in 2021). Firms with many higher-wage workers are those where at least 35% earn the 75th percentile or more than of national earnings ($66,000 in 2021). 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, 2021

Figure 6.19

Average Percentage of Premium Paid by Covered Workers, by Firm Characteristics and Size, 2021

	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%	36%*	24%*	27%*
Many Lower-Wage Workers	20%	23%	22%	49%*	31%*	35%*
HIGHER WAGE LEVEL						
Few Higher-Wage Workers	18%*	18%	18%	42%*	27%*	32%*
Many Higher-Wage Workers	15%*	18%	17%	31%*	22%*	24%*
UNIONS						
Firm Has Union Workers	15%	16%*	16%	19%*	20%*	20%*
Firm Has No Union Workers	17%	19%*	18%	39%*	28%*	33%*
YOUNGER WORKERS						
Few Younger Workers	16%	17%	17%*	37%	24%*	28%*
Many Younger Workers	21%	23%	23%*	45%	31%*	35%*
OLDER WORKERS						
Few Older Workers	17%	18%	18%	40%	26%	30%
Many Older Workers	16%	17%	17%	35%	23%	27%
FUNDING ARRANGEMENT						
Fully Insured	17%	19%	18%	39%*	30%*	35%*
Self-Funded	15%	17%	17%	31%*	23%*	24%*
FIRM OWNERSHIP						
Private For-Profit	19%*	21%*	20%*	39%	26%	30%*
Public	8%*	12%*	11%*	28%	22%	23%*
Private Not-For-Profit	14%*	16%	16%*	34%	24%	27%
ALL FIRMS	**17%**	**18%**	**17%**	**37%**	**24%**	**28%**

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 ($28,000 in 2021). Firms with many higher-wage workers are those where at least 35% earn the 75th percentile or more than of national earnings ($66,000 in 2021). 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, 2021

DIFFERENCES BY REGION AND INDUSTRY

- The average worker contribution rate for single coverage is relatively high in Northeast (20%) and relatively low in the West (14%) [Figure 6.20].
- The average worker contribution rate for family coverage is relatively low in the Northeast (24%) and the Midwest (25%) and relatively high in the South (33%) [Figure 6.20].
- There is considerable variation in average worker contribution rates across industries for single and family coverage [Figure 6.21].

Figure 6.20

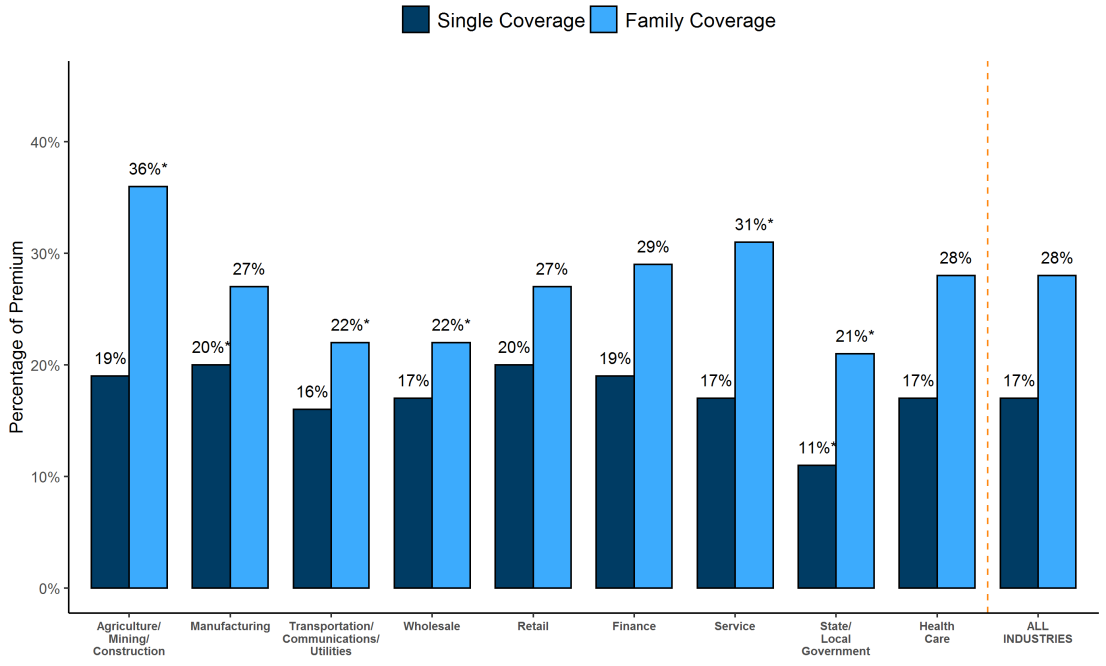
Average Premium Paid by Covered Workers for Single and Family Coverage, by Plan Type and Region, 2021

	Single Coverage		Family Coverage	
	Percent Contribution	Worker Contribution	Percent Contribution	Worker Contribution
HMO				
Northeast	19%*	$1,554*	21%	$4,912
Midwest	18	1,351	27	5,170
South	19	1,486	31	7,079*
West	11*	832*	22	4,688
ALL REGIONS	**15%**	**$1,204**	**24%**	**$5,254**
PPO				
Northeast	19%	$1,622*	22%*	$5,449*
Midwest	19	1,463	27	6,104
South	17	1,300	32*	6,855
West	15	1,221	31	7,039
ALL REGIONS	**18%**	**$1,389**	**29%**	**$6,428**
POS				
Northeast	24%	$1,972	38%	$7,183
Midwest	12	958	25*	5,122*
South	16	1,177	50*	9,321*
West	12	859	33	6,828
ALL REGIONS	**16%**	**$1,183**	**39%**	**$7,512**
HDHP/SO				
Northeast	22%*	$1,496	27%	$5,463
Midwest	17	1,122	22*	4,368*
South	17	1,180	29	5,745*
West	19	1,286	31	5,426
ALL REGIONS	**19%**	**$1,242**	**26%**	**$5,129**
ALL PLANS				
Northeast	20%*	$1,593*	24%*	$5,453
Midwest	18	1,280	25*	5,271*
South	17	1,272	33*	6,880*
West	14*	1,069*	28	5,933
ALL REGIONS	**17%**	**$1,299**	**28%**	**$5,969**

* 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, 2021

Figure 6.21
Average Percentage of Premium Paid by Covered Workers, by Industry, 2021

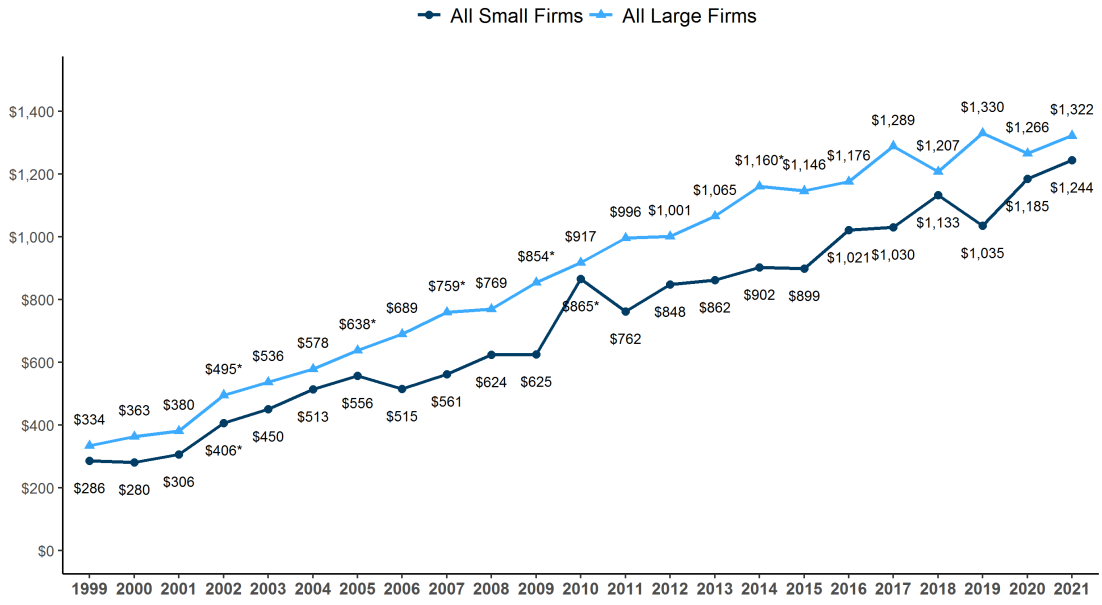


* Estimate is statistically different within coverage type from estimate for all other firms not in the indicated industry category ($p < .05$).
SOURCE: KFF Employer Health Benefits Survey, 2021

CHANGES OVER TIME

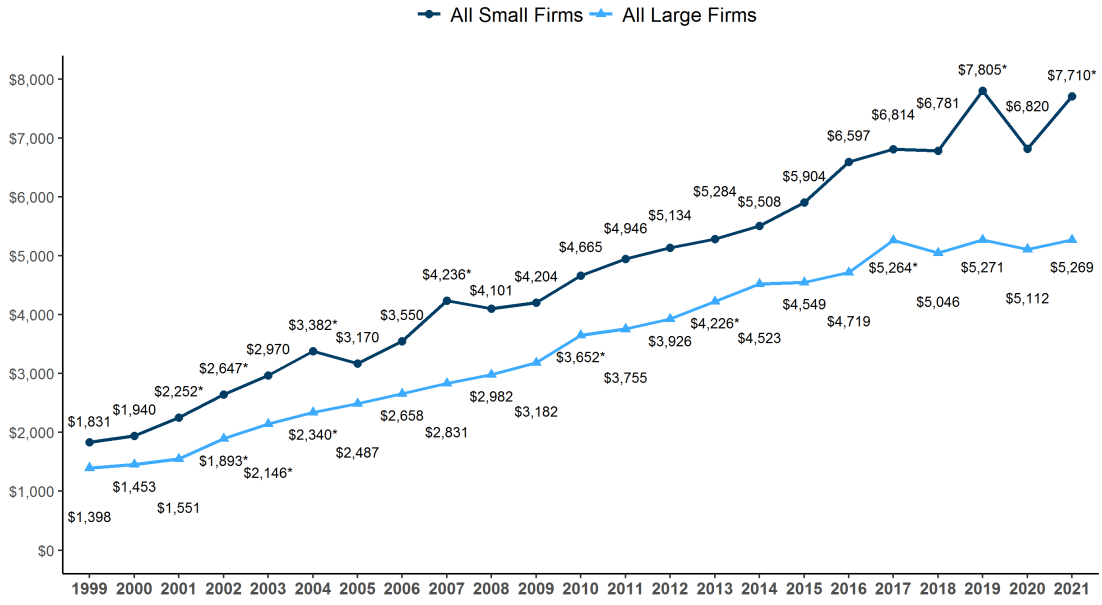
- The average worker contributions in 2021 for single coverage ($1,299) and for family coverage ($5,969) are similar to the average contribution levels last year [Figures 6.4 and 6.5].
- The average worker contributions for single and family coverage have increased over the last five years (15% and 13%, respectively) and over the last 10 years (41% and 45%, respectively) [Figures 6.4 and 6.5].

Figure 6.22
Average Annual Worker Contributions for Covered Workers with Single Coverage, by Firm Size, 1999-2021



* 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, 2018-2021; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

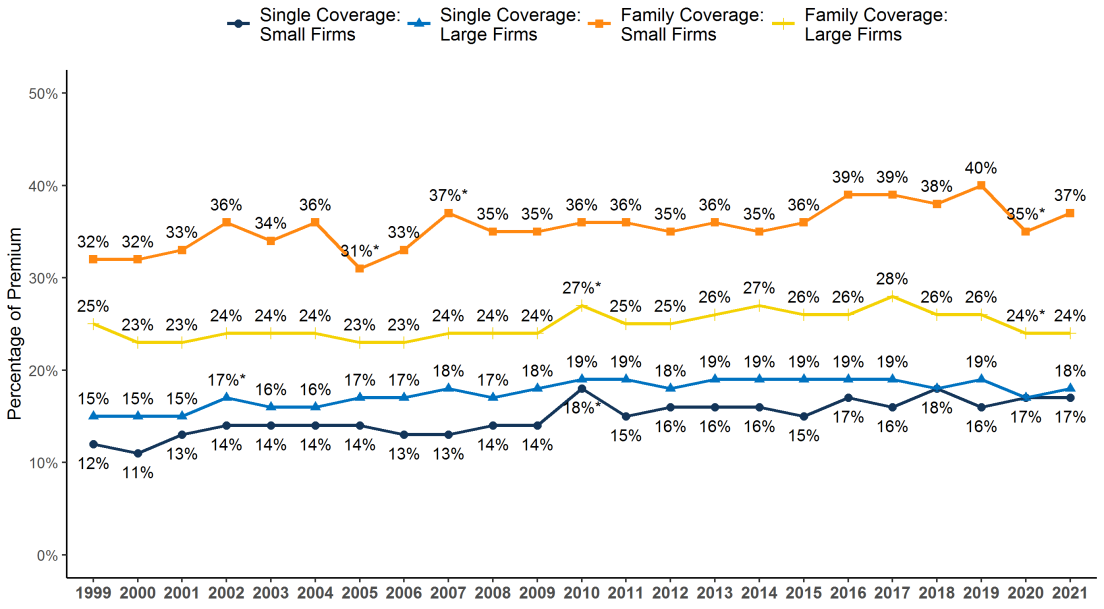
Figure 6.23
Average Annual Worker Contributions for Covered Workers with Family Coverage, by Firm Size, 1999-2021



* 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, 2018-2021; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

Figure 6.24

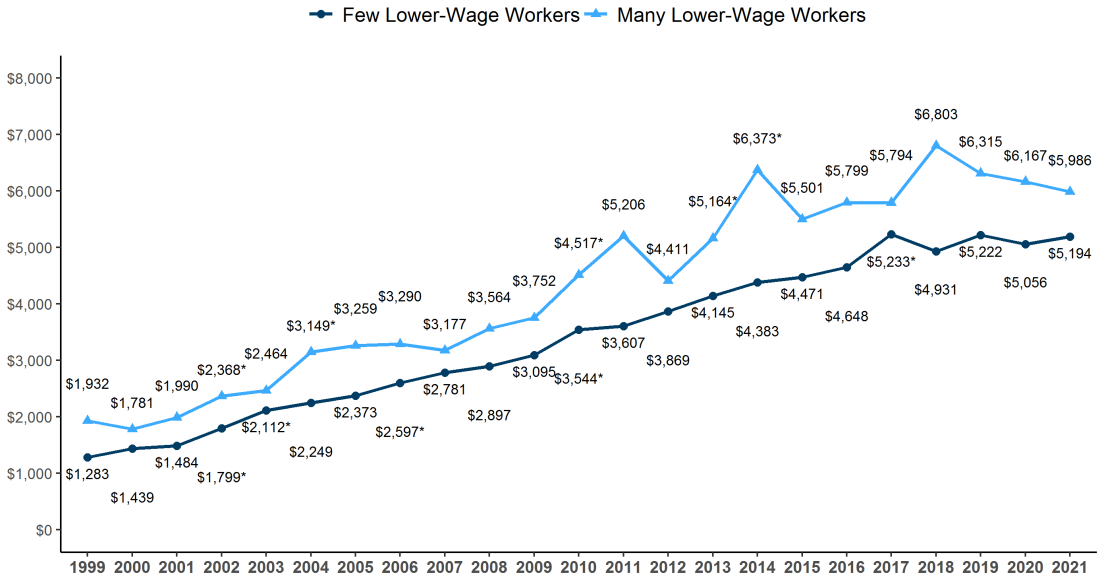
Average Percentage of Premium Paid by Covered Workers for Single and Family Coverage, by Firm Size, 1999-2021



* 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, 2018-2021; 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, 1999-2021



* 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 ($28,000 in 2021).
SOURCE: KFF Employer Health Benefits Survey, 2018-2021; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

Employer Health Benefits

2021 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 a copayment for a service, whichever is higher. The type and level of cost sharing may vary with 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.

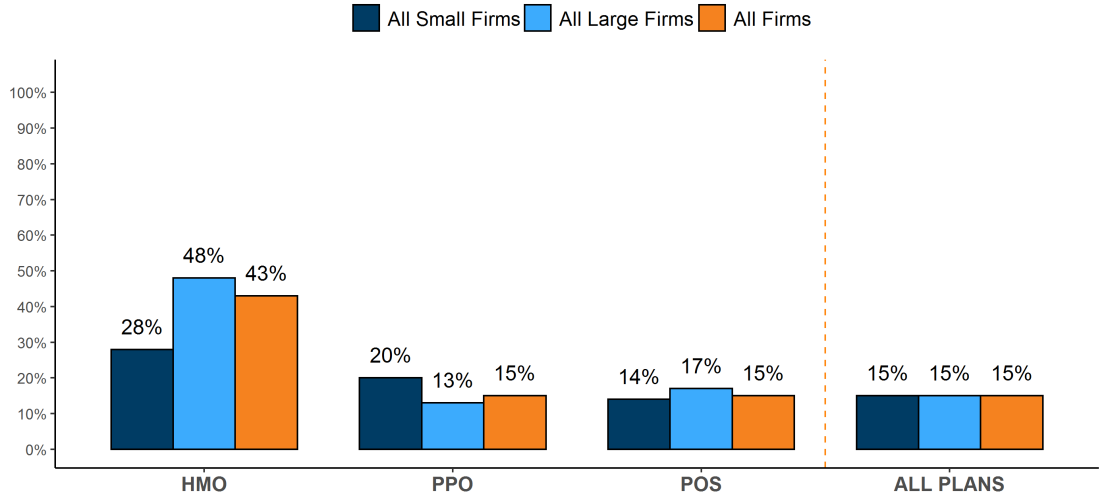
The cost-sharing amounts reported here are for covered workers using in-network services. Plan enrollees receiving services from providers that do not participate in plan networks often face higher cost sharing and may be responsible for charges that exceed the plan's allowable amounts. The framework 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.
  - Eighty-five percent of covered workers in 2021 are enrolled in a plan with a general annual deductible for single coverage, similar to the percentages last year (83%) and five years ago (83%) but higher than the percentage ten years ago (74%) [Figure 7.2].
  - The percentages of covered workers enrolled in a plan with a general annual deductible for single coverage are the same for small firms (3-199 workers) (85%) and large firms (200 or more workers) (85%) [Figure 7.2].
  - The likelihood of being in a plan with a general annual deductible varies by plan type. Forty-three percent of covered workers in HMOs do not have a general annual deductible for single coverage, compared to 15% of workers in POS plans and 15% 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 $1,669, similar to the average deductible ($1,644) 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 $1,271 in HMOs, $1,245 in PPOs, $1,852 in POS plans, and $2,424 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 ($1,972 vs. $976) [Figure 7.6]. Overall, for covered workers in plans with a general annual deductible, the average deductible for single coverage in small firms ($2,379) is higher than the average deductible in large firms ($1,397) [Figure 7.3].
- The average general annual deductible for single coverage for covered workers in plans with a general annual deductible has increased 13% over the past five years and 68% over the past ten years [Figure 7.8].

Figure 7.1
Percentage of Covered Workers with No General Annual Deductible for Single Coverage, by Plan Type and Firm Size, 2021



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 2021 is $1,400 for single coverage and $2,800 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, 2021

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, 2006-2021

	HMO			PPO			POS			ALL PLANS		
	All Small Firms	All Large Firms	All Firms	All Small Firms	All Large Firms	All Firms	All Small Firms	All Large Firms	All Firms	All Small Firms	All Large Firms	All Firms
2006	17%	10%	12%	69%	69%	69%	35%	28%	32%	56%	54%	55%
2007	14%	20%*	18%	72%	71%	71%	53%*	41%	48%*	60%	59%	59%*
2008	25%	18%	20%	73%	66%	68%	59%	41%	50%	65%	56%	59%
2009	27%	12%	16%	74%	74%	74%	63%	58%	62%	67%	61%	63%
2010	34%	25%*	28%*	80%	76%	77%	64%	70%	66%	73%	68%*	70%*
2011	38%	27%	29%	76%	83%	81%	68%	71%	69%	75%	74%	74%
2012	33%	29%	30%	76%	77%	77%	58%	63%	60%	72%	73%	72%
2013	44%	40%	41%	78%	82%	81%	78%*	49%	66%	77%	78%	78%*
2014	59%	28%	37%	83%	85%	85%	69%	72%*	70%	82%	80%	80%
2015	46%	40%	42%	85%	84%	85%	80%	61%	72%	82%	81%	81%
2016	44%	47%	46%	85%	84%	84%	81%	66%	76%	82%	83%	83%
2017	41%	37%	38%	78%	88%	86%	71%	58%	65%	77%	83%	81%
2018	56%	53%	54%*	86%	89%	88%	86%	63%	76%	85%*	85%	85%*
2019	58%	43%	48%	87%	84%	85%	75%	76%	76%	83%	81%	82%
2020	48%	49%	49%	78%	84%	82%	73%	79%	76%	79%	84%	83%
2021	72%*	52%	57%	80%	87%	85%	86%	83%	85%	85%	85%	85%

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, 2018-2021; 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, 2021

	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	84%	$2,384*
50-199 Workers	85	2,373*
200-999 Workers	86	1,985*
1,000-4,999 Workers	86	1,498*
5,000 or More Workers	84	1,140*
All Small Firms (3-199 Workers)	**85%**	**$2,379***
All Large Firms (200 or More Workers)	**85%**	**$1,397***
REGION		
Northeast	86%	$1,513
Midwest	96*	1,796
South	87	1,761
West	67*	1,482
ALL FIRMS	**85%**	**$1,669**

* 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, 2021

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, 2021

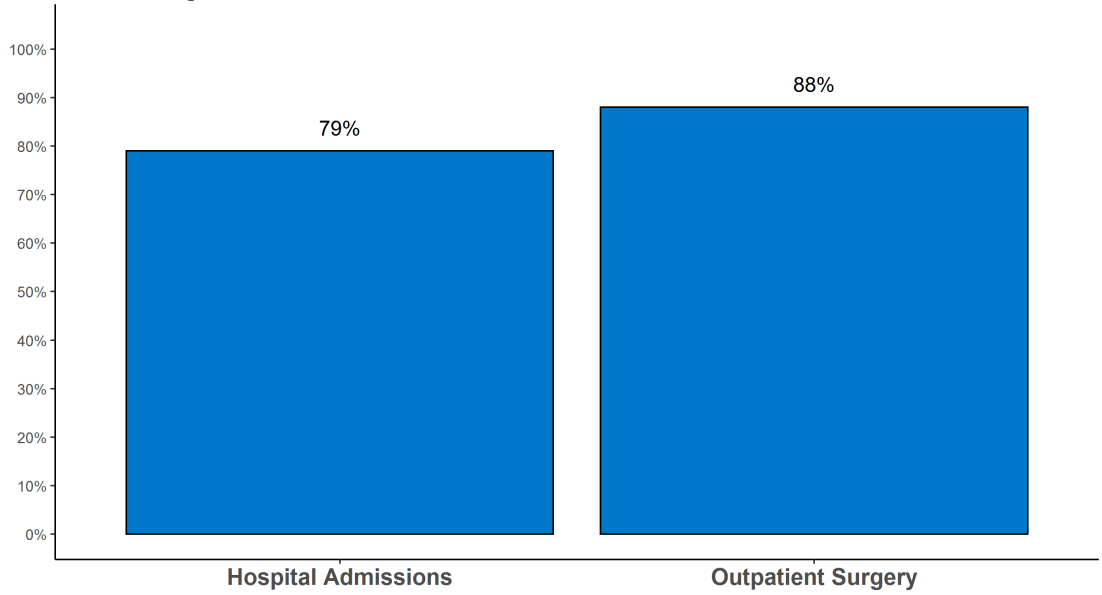
	Percentage of Covered Workers in a Plan With a General Annual Deductible	Among Covered Workers With a General Annual Deductible for Single Coverage, Average Deductible
LOWER WAGE LEVEL		
Few Lower-Wage Workers	84%*	$1,667
Many Lower-Wage Workers	93%*	$1,693
HIGHER WAGE LEVEL		
Few Higher-Wage Workers	86%	$1,888*
Many Higher-Wage Workers	84%	$1,467*
UNIONS		
Firm Has Union Workers	79%	$1,206*
Firm Has No Union Workers	88%	$1,916*
YOUNGER WORKERS		
Few Younger Workers	85%	$1,640
Many Younger Workers	82%	$2,001
OLDER WORKERS		
Few Older Workers	84%	$1,779*
Many Older Workers	85%	$1,566*
FIRM OWNERSHIP		
Private For-Profit	88%	$1,810*
Public	77%	$1,085*
Private Not-For-Profit	83%	$1,751
ALL FIRMS	**85%**	**$1,669**

NOTE: Firms with many lower-wage workers are those where at least 35% earn the 25th percentile or less of national earnings ($28,000 in 2021). Firms with many higher-wage workers are those where at least 35% earn the 75th percentile or more than of national earnings ($66,000 in 2021). 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 ($p < .05$).

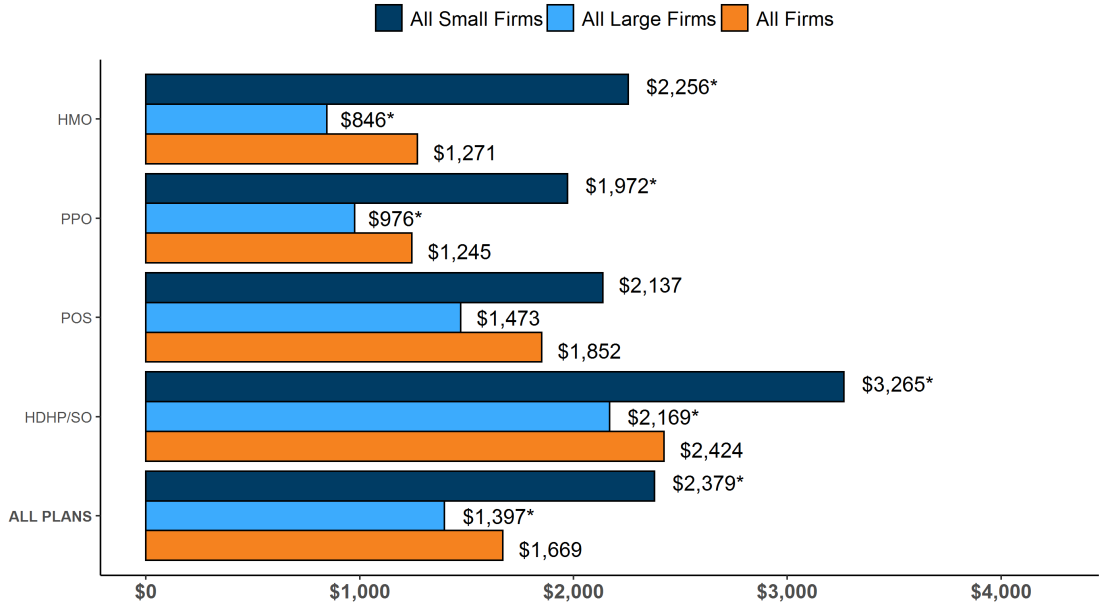
SOURCE: KFF Employer Health Benefits Survey, 2021

Figure 7.5
Among Covered Workers with No General Annual Deductible, Percentage Who Face Other Types of Cost Sharing, 2021



NOTE: Other cost sharing include a separate annual deductible, copayment, coinsurance or charge per day. Percentages are similar between single and family coverage.
SOURCE: KFF Employer Health Benefits Survey, 2021

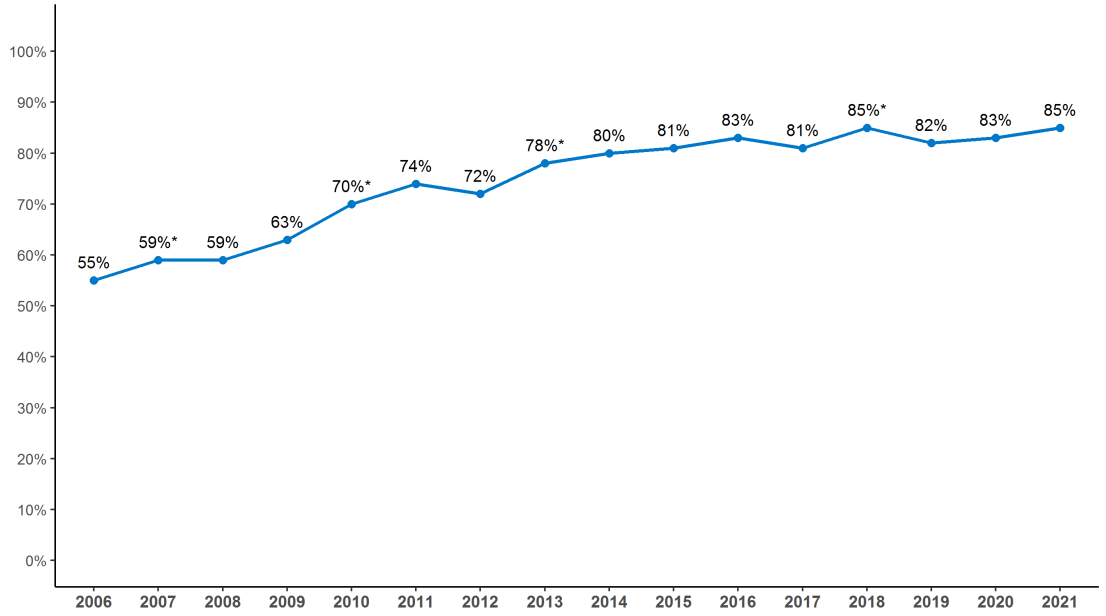
Figure 7.6
Among Covered Workers with a General Annual Deductible for Single Coverage, Average Deductible, by Plan Type and Firm Size, 2021



* 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, 2021

Figure 7.7

Percentage of Covered Workers with a General Annual Deductible for Single Coverage, 2006-2021



* 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, 2018-2021; 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, 2006-2021

	Family Coverage Deductible With Aggregate Structure				Family Coverage Deductible With Separate Per-Person Structure				Single Coverage				
	HMO	PPO	POS	HDHP/SO	HMO	PPO	POS	HDHP/SO	HMO	PPO	POS	HDHP/SO	All Plans
2006	$751	$1,034	$1,227	$3,511	NSD	$710	$992	NSD	352	$473	$553	$1,715	$584
2007	$759	$1,040	$1,359	$3,596	NSD	$492*	$592	NSD	$401	$461	$621	$1,729	$616
2008	$1,053	$1,344*	$1,860	$3,559	NSD	$514	$778	$2,334*	$503	$560*	$752	$1,812	$735*
2009	$1,524*	$1,488	$2,191	$3,626	$686	$633	$1,050	$2,091	$699*	$634*	$1,061	$1,838	$826*
2010	$1,321	$1,518	$2,253	$3,780	$500	$596	$1,164	$2,053	$601	$675	$1,048	$1,903	$917*
2011	$1,487	$1,521	$1,769	$3,666	$885	$646	$912	$2,149	$911	$675	$928	$1,908	$991
2012	$1,329	$1,770	$2,163	$3,924	$754	$632	$1,092	$2,821*	$691	$733	$1,014	$2,086	$1,097*
2013	$1,743	$1,854	$2,821	$4,079	$609	$782*	$1,080	$2,033*	$729	$799	$1,314	$2,003	$1,135
2014	$2,328	$1,947	$2,470	$4,522*	$870	$821	$1,153	$2,126	$1,032*	$843	$1,215	$2,215*	$1,217
2015	$2,758	$2,012	$2,467	$4,332	$852	$944	$1,153	$1,965	$1,025	$958	$1,230	$2,099	$1,318
2016	$2,245	$2,147	$3,769*	$4,343	$632	$1,052	$1,180	$2,411	$917	$1,028	$1,737*	$2,199	$1,478*
2017	$2,732	$2,503*	$2,697	$4,527	$1,045	$914	$1,128	$2,645	$1,175	$1,046	$1,301	$2,304	$1,505
2018	$2,317	$3,000*	$3,497	$4,676	$691	$1,005	$1,864*	$2,560	$870	$1,204*	$1,598	$2,349	$1,573
2019	$2,905	$2,883	$4,347	$4,779	$881	$1,091	$1,932	$3,078	$1,200	$1,206	$1,857	$2,486	$1,655
2020	$3,035	$2,716	$3,902	$4,552	NSD	$1,115	NSD	$2,523	$1,201	$1,204	$1,714	$2,303	$1,644
2021	$3,400	$3,000	$4,130	$4,705	$1,190	$1,126	$1,334	$2,748	$1,271	$1,245	$1,852	$2,424	$1,669

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, 2018-2021; 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 74% in 2011 to 85% in 2021 [Figure 7.9]. The average deductible amount for covered workers in plans with a deductible has also increased over the period, from $991 in 2011 to $1,669 in 2021 [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 2021 is $1,434, similar to the amount last year ($1,364) [Figure 7.10].
  - The 2021 value is 17% higher than the average general annual deductible of $1,221 in 2016 and 92% higher than the average general annual deductible of $747 in 2011 [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-eight 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 13%, from 51% to 58% [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 (72% vs. 52%) [Figure 7.12].
  - In 2021, 29% of covered workers are enrolled in a plan with a deductible of $2,000 or more, similar to the percentage last year (26%) [Figure 7.14]. This percentage is much higher for covered workers in small firms than large firms (45% vs. 22%) [Figure 7.12].

Figure 7.9

Prevalence and Value of General Annual Deductibles for Single Coverage, by Firm Size, 2006-2021

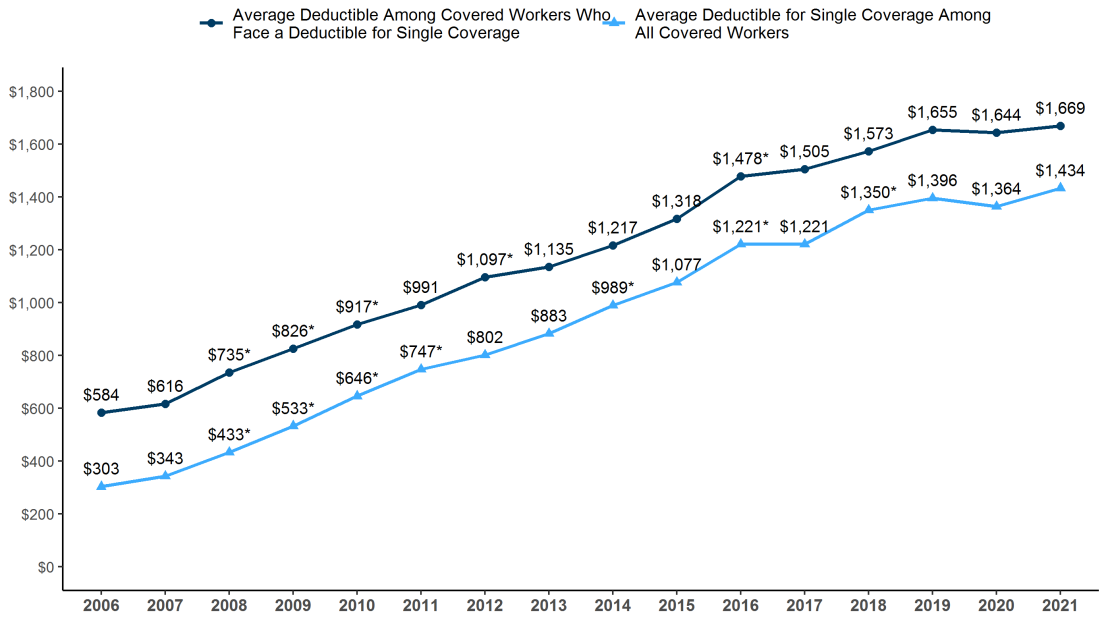
	Average General Annual Deductible Among Covered Workers Who Face A Deductible For Single Coverage			Percentage Of Covered Workers With A General Annual Deductible For Single Coverage			Average General Annual Deductible For Single Coverage Among All Covered Workers		
	All Small Firms	All Large Firms	All Firms	All Small Firms	All Large Firms	All Firms	All Small Firms	All Large Firms	All Firms
2006	$775	$496	$584	56%	54%	55%	$431	$234	$303
2007	$852	$519	$616	60%	59%	59%*	$494	$269	$343
2008	$1,124*	$553	$735*	65%	56%	59%	$727*	$284	$433*
2009	$1,254	$640*	$826*	67%	61%	63%	$851	$376*	$533*
2010	$1,391	$686	$917*	73%	68%*	70%*	$1,001	$456*	$646*
2011	$1,537	$757	$991	75%	74%	74%	$1,177	$546*	$747*
2012	$1,596	$875*	$1,097*	72%	73%	72%	$1,163	$629*	$802
2013	$1,715	$884	$1,135	77%	78%	78%*	$1,330	$670	$883
2014	$1,797	$971	$1,217	82%	80%	80%	$1,493	$765*	$989*
2015	$1,836	$1,105*	$1,318	82%	81%	81%	$1,507	$890*	$1,077
2016	$2,069	$1,238	$1,478*	82%	83%	83%	$1,669	$1,026	$1,221*
2017	$2,120	$1,276	$1,505	77%	83%	81%	$1,631	$1,049	$1,221
2018	$2,132	$1,355	$1,573	85%*	85%	85%*	$1,818	$1,159	$1,350*
2019	$2,271	$1,412	$1,655	83%	81%	82%	$1,896	$1,184	$1,396
2020	$2,295	$1,418	$1,644	79%	84%	83%	$1,819	$1,187	$1,364
2021	$2,379	$1,397	$1,669	85%	85%	85%	$2,009	$1,201	$1,434

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, 2018-2021; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006-2017

Figure 7.10
Average General Annual Deductibles for Single Coverage, 2006-2021

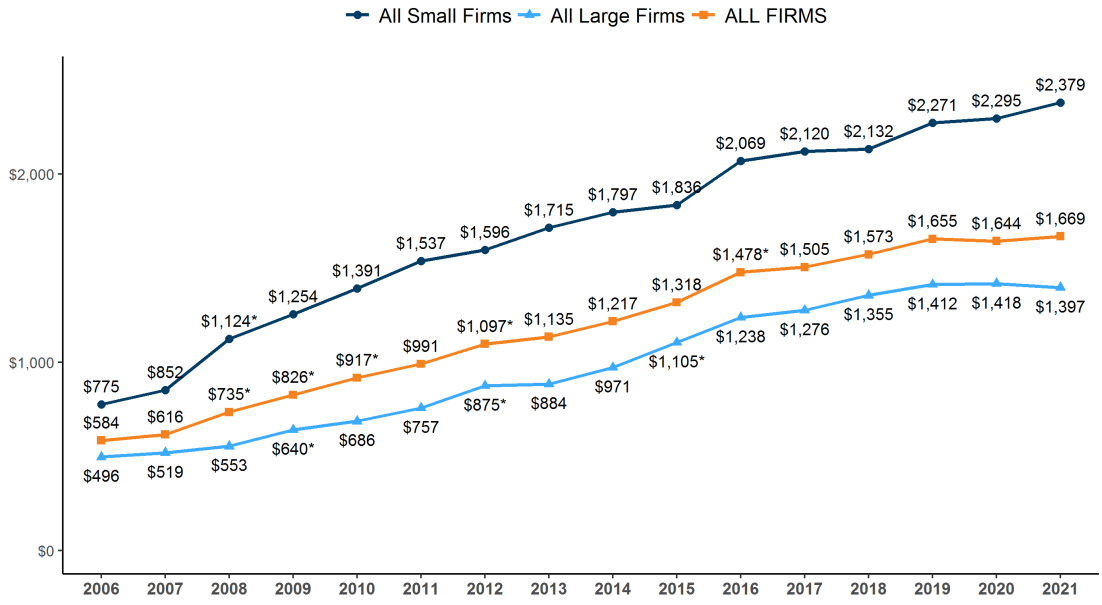


* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
NOTE: Average general annual deductibles are among all covered workers. Workers in plans without a general annual deductible for in-network services are assigned a value of zero.
SOURCE: KFF Employer Health Benefits Survey, 2018-2021; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006-2017

GENERAL ANNUAL DEDUCTIBLES AND ACCOUNT CONTRIBUTIONS

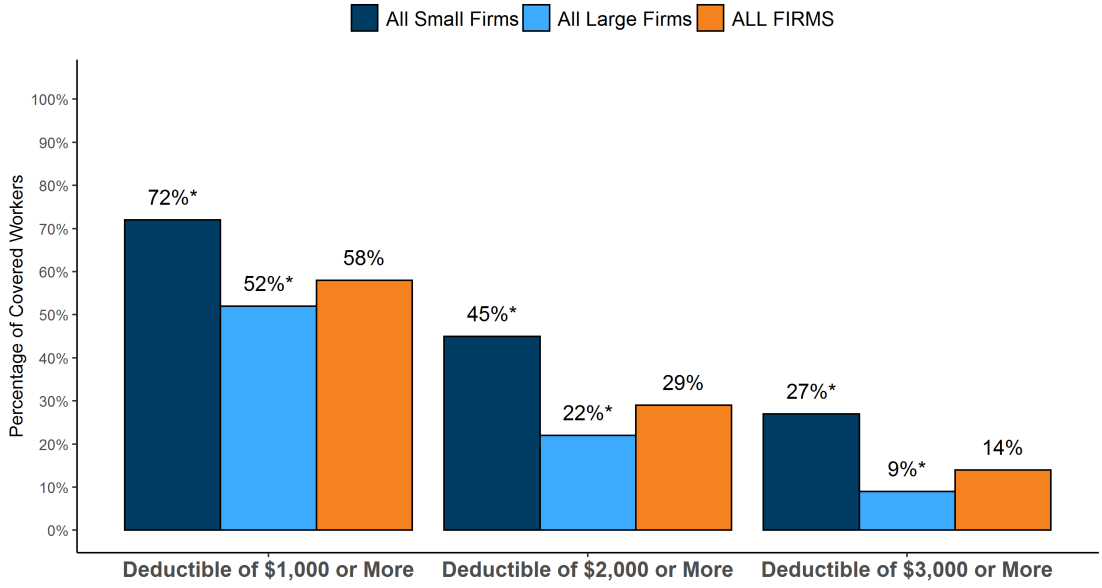
- One of the reasons for the growth in general annual deductibles has been the growth in enrollment in HDHP/SOs, which have higher deductibles than other plans. While higher deductibles in other plan types generally increases enrollee out-of-pocket liability, the shift in enrollment to HDHP/SOs does not necessarily do so because many HDHP/SO enrollees receive an account contribution from their employers, which in essence reduces the higher cost sharing in these plans.
  - Twenty-seven percent of covered workers in an HDHP with an HRA and 2% 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 20% of covered workers in an HDHP with an HRA and 17% 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 7.16].
  - 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 58% to 50% [Figure 7.13] and [Figure 7.15].

Figure 7.11
Among Covered Workers Who Face a Deductible for Single Coverage, Average General Annual Deductible for Single Coverage, by Firm Size, 2006-2021



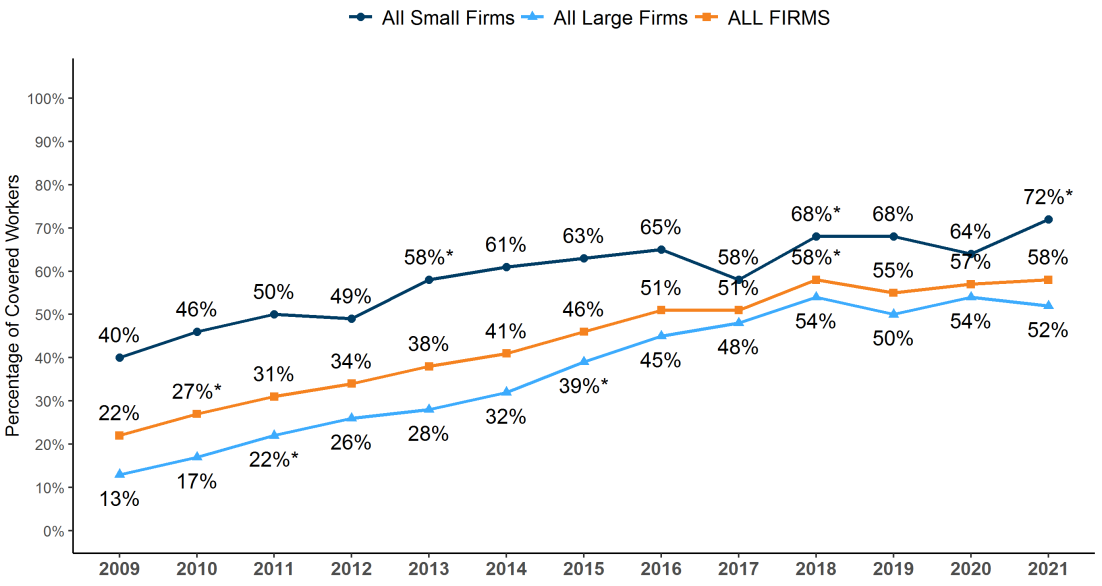
* Estimate is statistically different from estimate for the previous year shown (p < .05).
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers. Average general annual deductibles are for in-network providers.
SOURCE: KFF Employer Health Benefits Survey, 2018-2021; Kaiser/HRET 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, 2021



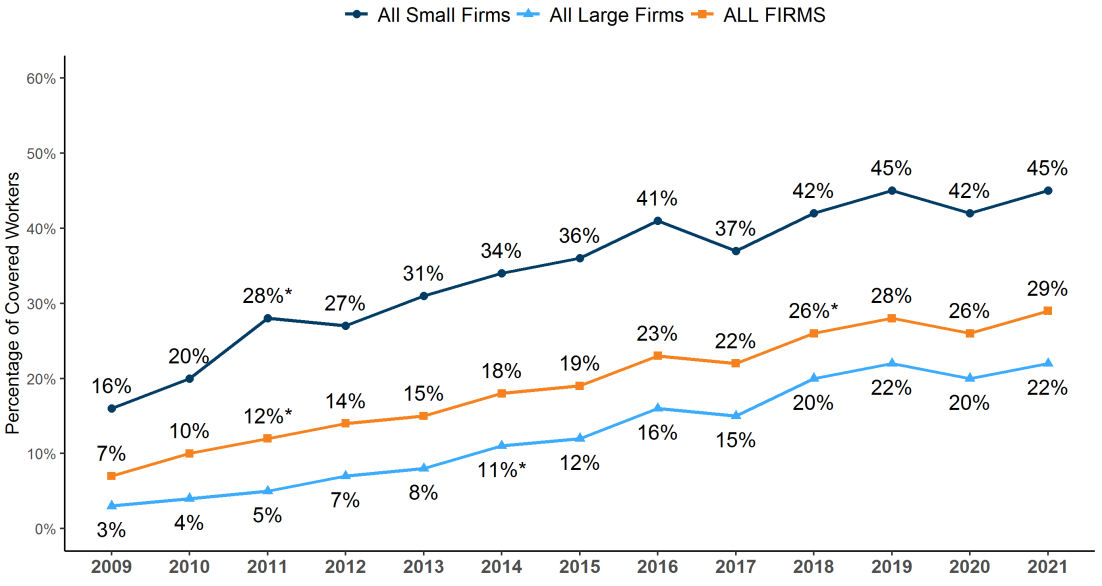
* Estimate is statistically different between All Small Firms and All Large Firms estimate (p < .05).
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers. These estimates include workers enrolled in HDHP/SOs and other plan types. Average general annual health plan deductibles for PPOs, POS plans, and HDHP/SOs are for in-network services.
SOURCE: KFF Employer Health Benefits Survey, 2021

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, 2009-2021



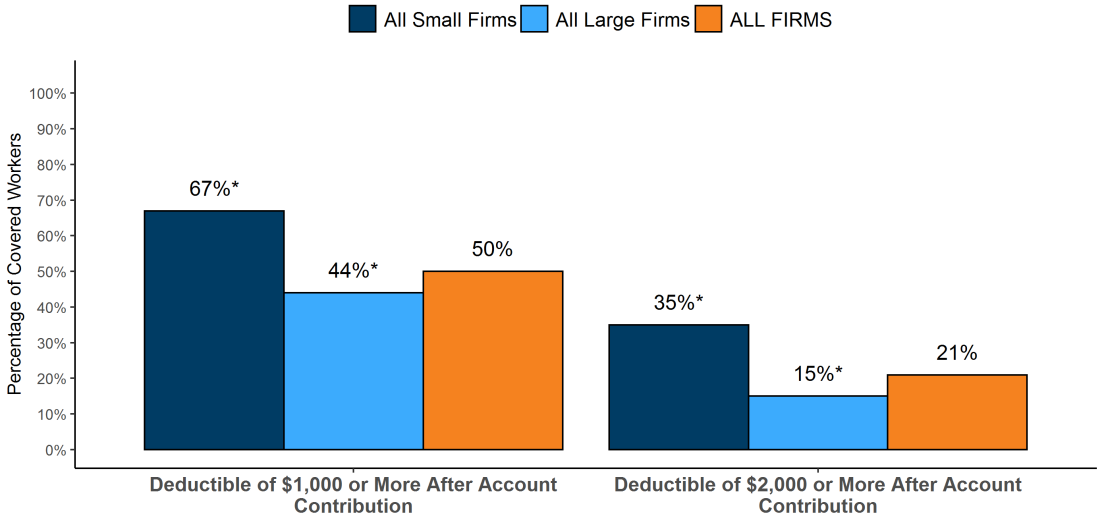
* Estimate is statistically different from estimate for the previous year shown (p < .05).
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers. These estimates include workers enrolled in HDHP/SOs and other plan types. Average general annual deductibles are for in-network providers.
SOURCE: KFF Employer Health Benefits Survey, 2018-2021; 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 $2,000 or More for Single Coverage, by Firm Size, 2009-2021



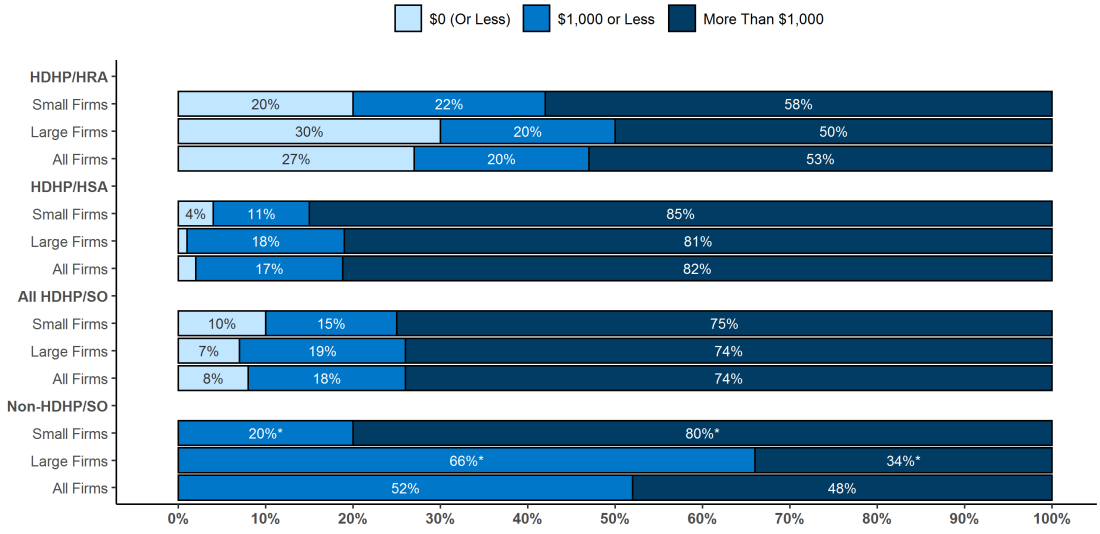
* Estimate is statistically different from estimate for the previous year shown (p < .05).
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers. These estimates include workers enrolled in HDHP/SOs and other plan types. Average general annual deductibles are for in-network providers.
SOURCE: KFF Employer Health Benefits Survey, 2018-2021; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2009-2017

Figure 7.15
Percentage of Covered Workers Enrolled in a Plan with a High General Annual Deductible for Single Coverage, Reduced by Any HRA/HSA Contributions, by Firm Size, 2021



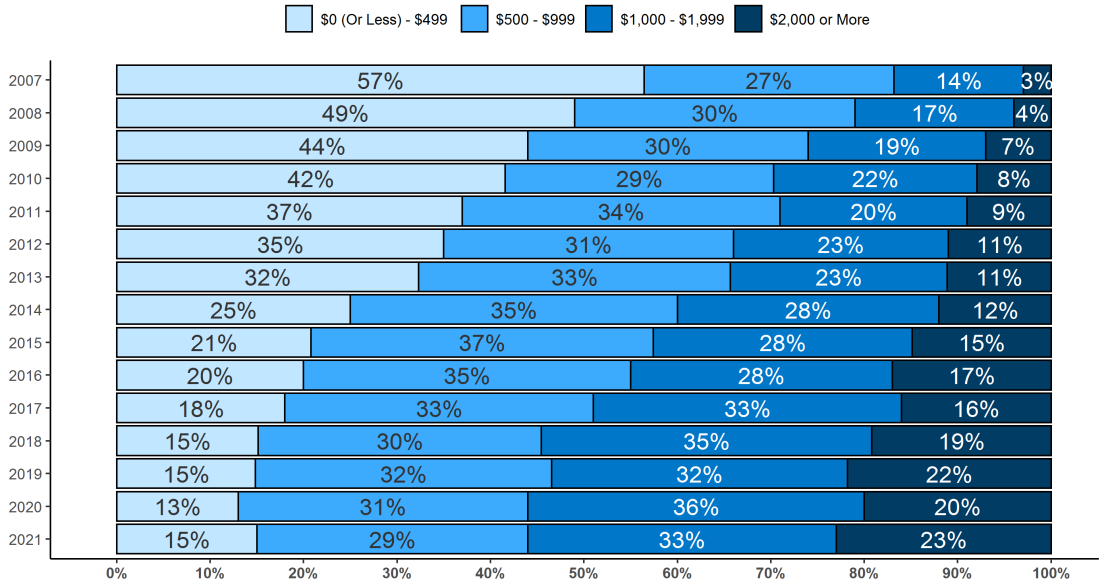
* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
NOTE: These estimates include workers enrolled in HDHP/SOs and other plan types. Average general annual health plan deductibles for PPOs, POS plans, and HDHP/SOs are for in-network services. These estimates include 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. Small Firms have 3-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2018-2021; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2009-2017

Figure 7.16
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, 2021



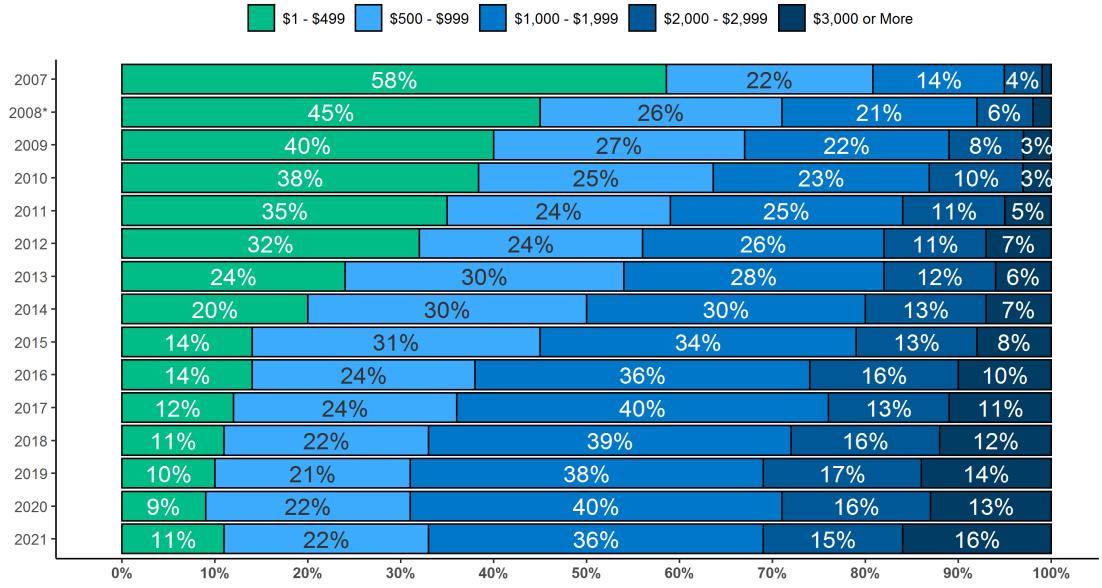
* Estimate is statistically different between All Small Firms and All Large Firms estimate ($p < .05$).
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers. The net liability for covered workers enrolled in a plan with an HSA or HRA is calculated by subtracting the account contribution 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, 2021

Figure 7.17
Among Covered Workers with a General Annual Deductible, Distribution of General Annual Deductibles for Single Coverage, Reduced by Any HRA/HSA Contributions, 2007-2021



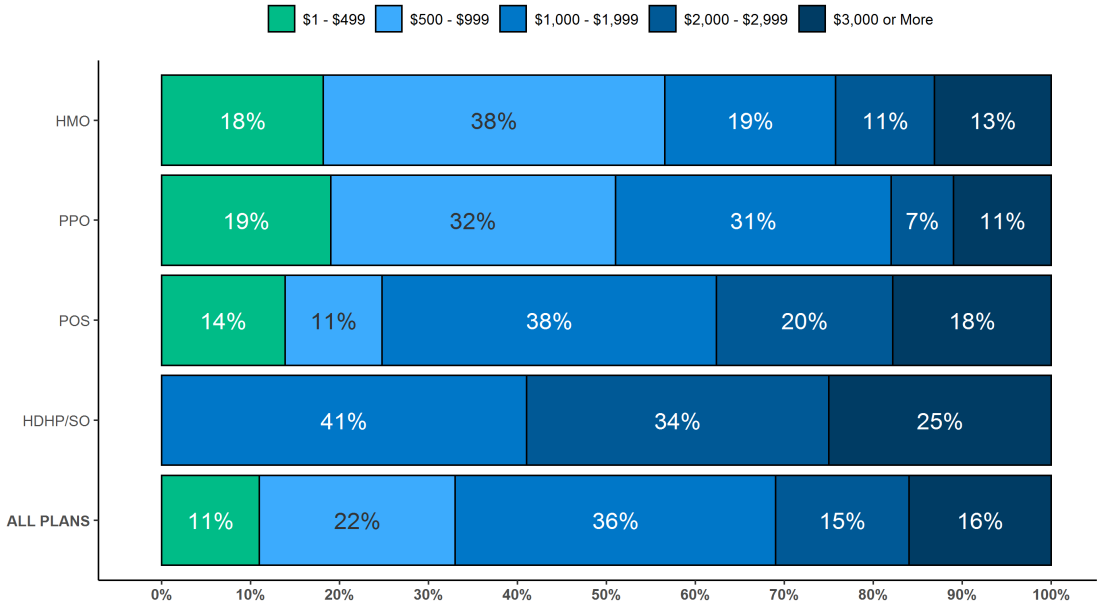
Tests found no statistical difference from distribution for the previous year shown ($p < .05$).
NOTE: Account contributions include an employer's contribution to an HSA or HRA. These estimates include workers enrolled in HDHP/SOs and other plan types. Average general annual deductibles are for in-network providers.
SOURCE: KFF Employer Health Benefits Survey, 2018-2021; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2007-2017

Figure 7.18
Among Covered Workers with a General Annual Deductible, Distribution of General Annual Deductible for Single Coverage, 2007-2021



* Distribution is statistically different from distribution for the previous year shown ($p < .05$).
NOTE: Average general annual deductibles are for in-network providers. In 2021, 85% of covered workers are enrolled in a plan with a general annual deductible.
SOURCE: KFF Employer Health Benefits Survey, 2018-2021; 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 Deductibles for Single Coverage, by Plan Type, 2021



NOTE: Average general annual deductibles are for in-network providers.
SOURCE: KFF Employer Health Benefits Survey, 2021

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]

- Forty-two percent of covered workers in HMOs are in plans without a general annual deductible for family coverage; the percentages in plans without family deductibles are lower for workers in PPOs (13%) and POS plans (13%). As defined, all covered workers in HDHP/SOs have a general annual deductible for family coverage [Figure 7.20].
- Among covered workers enrolled in family coverage, the percentages of covered workers in a plan with an aggregate general annual deductible are 28% for workers in HMOs; 50% for workers in PPOs; 72% for workers in POS plans; and 73% for workers in HDHP/SOs [Figure 7.20].

[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.

  - The average deductible amounts for covered workers in plans with an aggregate annual deductible for family coverage are $3,400 for HMOs; $3,000 for PPOs; $4,130 for POS plans; and $4,705 for HDHP/SOs [Figure 7.21]. The average deductible amounts for aggregate family deductibles are similar to last year for each plan type.

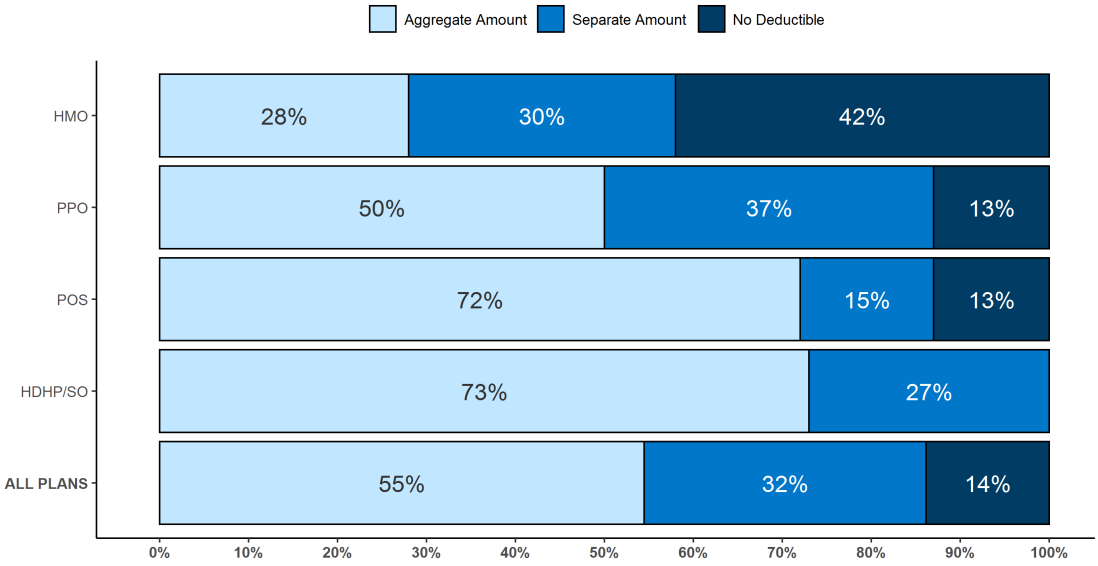
- For covered workers in plans with an aggregate deductible for family coverage, the average annual family deductibles in small firms are higher than the average annual family deductibles in large firms for covered workers in HMOs, PPOs and HDHP/SOs [Figure 7.21].

- 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 30% for workers in HMOs; 37% for workers in PPOs; 15% for workers in POS plans; and 27% for workers in HDHP/SOs [Figure 7.20].

  - The average deductible amounts for covered workers in plans with separate per-person annual deductibles for family coverage are $1,190 for HMOs, $1,126 for PPOs, and $2,748 for HDHP/SOs [Figure 7.21].

    * Forty-four percent of 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 7.24]. 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 7.25].

Figure 7.20
Distribution of Type of General Annual Deductible for Covered Workers with Family Coverage, by Plan Type, 2021



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 $2,000 for family coverage and either an HRA or HSA. 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, 2021

Figure 7.21

Among Covered Workers With a General Annual Deductible, Average Deductibles for Family Coverage, by Deductible Type, Plan Type, and Firm Size, 2021

	Aggregate Amount	Separate Per-Person Amount
HMO		
All Small Firms	$5,043*	NSD
All Large Firms	$1,867*	$1,108
ALL FIRM SIZES	**$3,400**	**$1,190**
PPO		
All Small Firms	$4,620*	$1,691*
All Large Firms	$2,234*	$972*
ALL FIRM SIZES	**$3,000**	**$1,126**
POS		
All Small Firms	$4,749	NSD
All Large Firms	$3,338	NSD
ALL FIRM SIZES	**$4,130**	**$1,334**
HDHP/SO		
All Small Firms	$6,142*	NSD
All Large Firms	$4,246*	$2,433
ALL FIRM SIZES	**$4,705**	**$2,748**

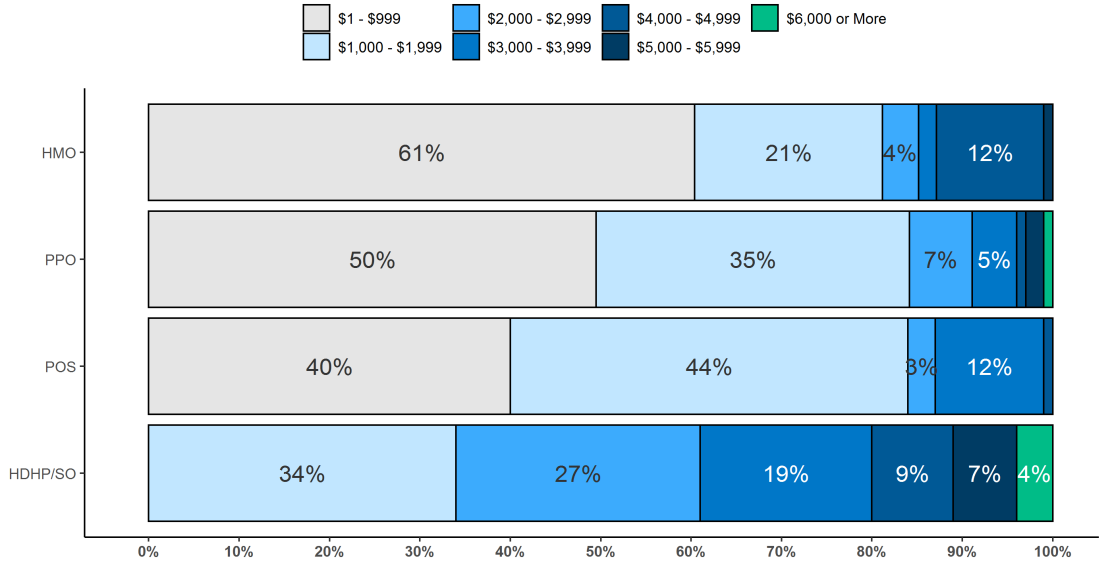
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers. Average general annual deductibles are for in-network providers. The survey distinguishes between plans that have an aggregate family deductible and plans that have a separate per-person deductible, typically with a limit 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, 2021

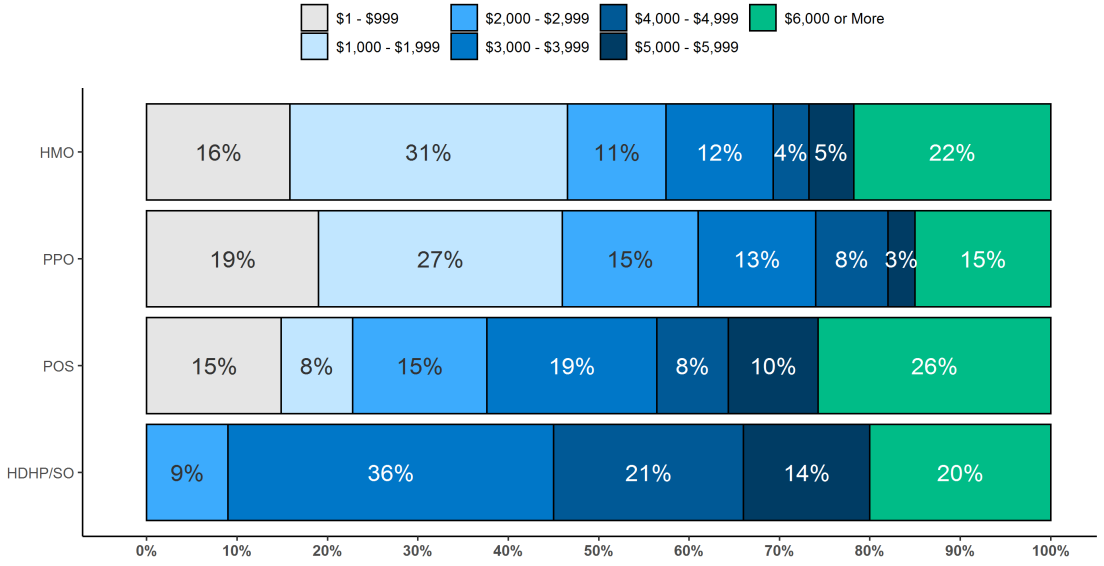
Figure 7.22

Among Covered Workers with a Separate Per-Person General Annual Deductible for Family Coverage, Distribution of Deductibles, by Plan Type, 2021



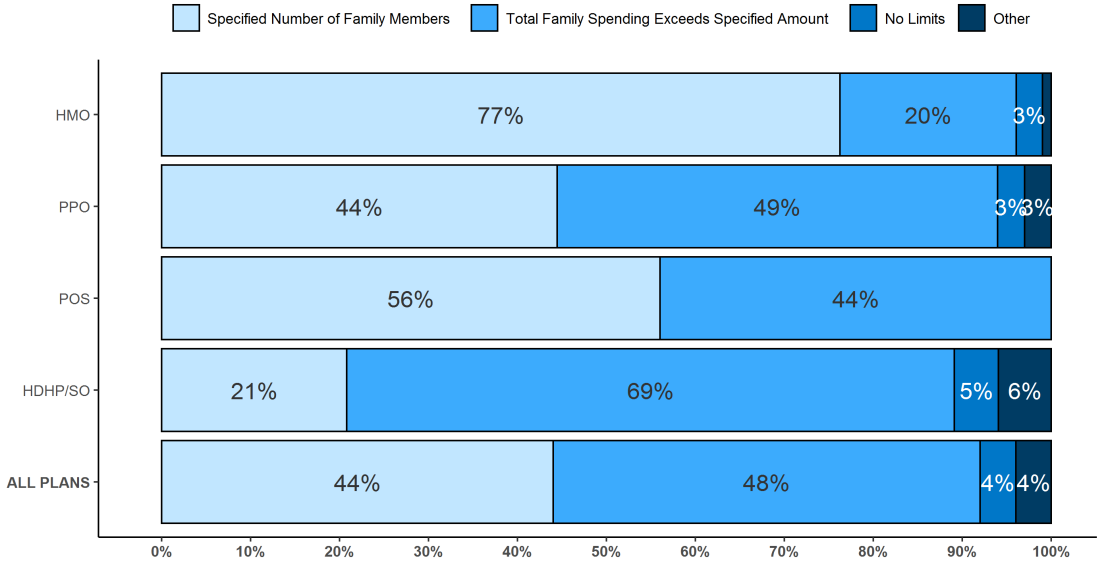
NOTE: Average general annual deductibles are for in-network providers. The survey distinguishes between plans that have an aggregate family deductible and plans that have a separate per-person deductible, typically with a limit on the number of family members required to reach that amount.
SOURCE: KFF Employer Health Benefits Survey, 2021

Figure 7.23
Among Covered Workers with an Aggregate General Annual Deductible for Family Coverage, Distribution of Deductibles, by Plan Type, 2021



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, 2021

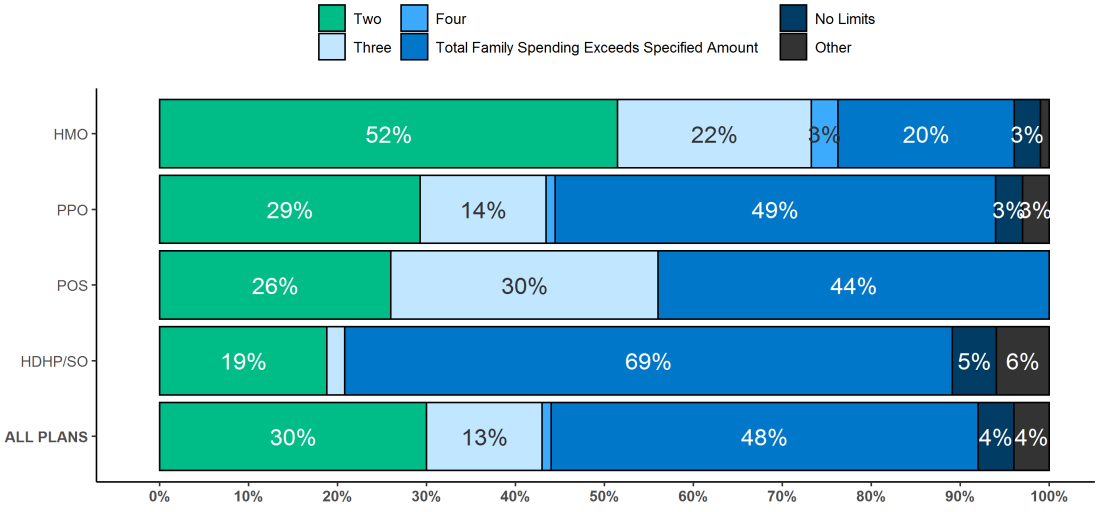
Figure 7.24
Among Covered Workers With a Separate Per-Person General Annual Deductible for Family Coverage, Structure of Deductible Limits, by Plan Type, 2021



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, 2021

Figure 7.25

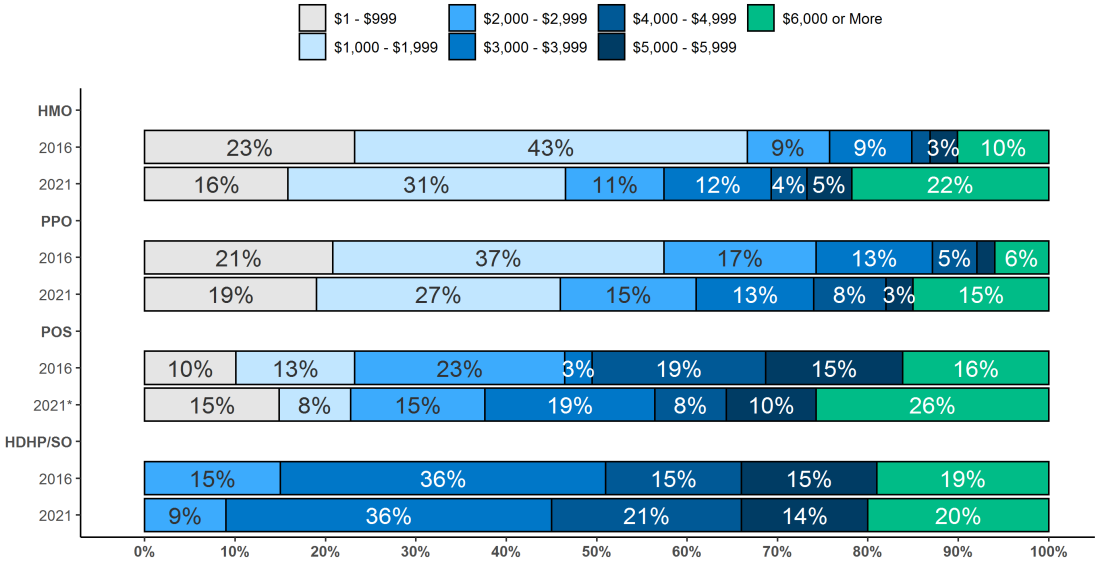
Among Covered Workers With a Separate Per-Person General Annual Deductible for Family Coverage and a Per-Person Limit, Distribution of Maximum Number of Family Members Required to Meet the Deductible, by Plan Type, 2021



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 with a separate family deductible were asked if they had a combined limit or if the limit was met when a specified number of family members reached their per-person limit. 'Other' category may include per-person limits with a total family dollar limit.
SOURCE: KFF Employer Health Benefits Survey, 2021

Figure 7.26

Among Covered Workers With an Aggregate General Annual Deductible for Family Coverage, Distribution of Aggregate Deductibles, by Plan Type, 2016 and 2021

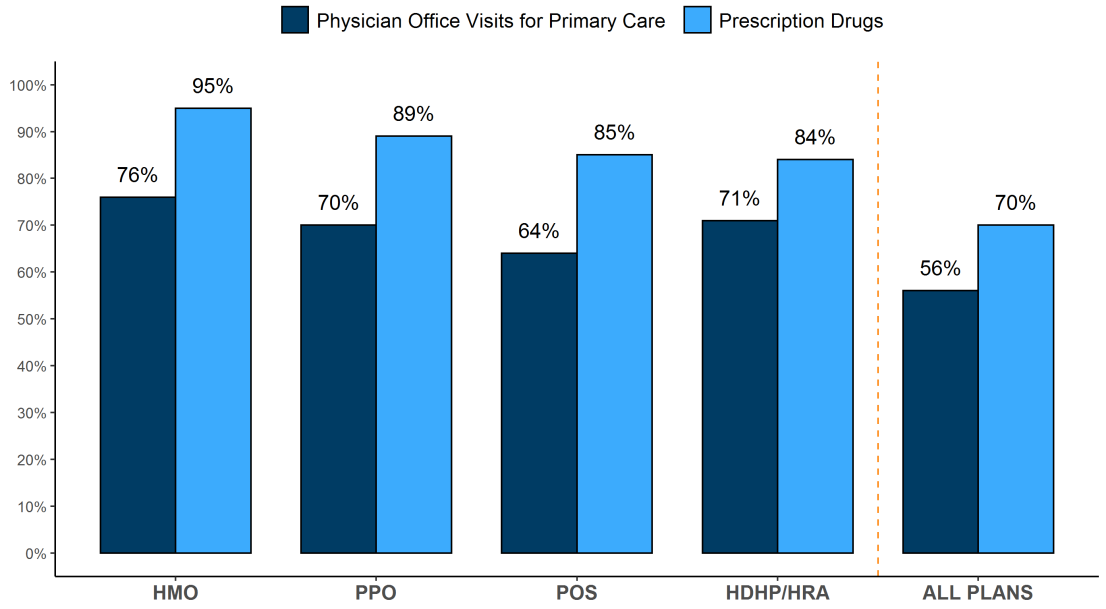


* Distribution is statistically different from distribution for the previous year shown ($p < .05$).
NOTE: By definition, 100% of covered workers in an HDHP/SO with an aggregate deductible have a family deductible of $2,000 or more. Average general annual deductibles are for in-network providers. The 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, 2021; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2016

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 (76% in HMOs, 70% in PPOs, 64% in POS plans, and 71% 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 7.27].
  - Similarly, among workers with a general annual deductible, large shares of covered workers in HMOs (95%), PPOs (89%), POS plans (85%), and HDHP/HRAs (84%) are enrolled in plans where the general annual deductible does not have to be met before prescription drugs are covered [Figure 7.27].

Figure 7.27
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, 2021



NOTE: These questions are asked of firms with a deductible. HSA-Qualified HDHPs are required by law to apply the deductible to most services.
SOURCE: KFF Employer Health Benefits Survey, 2021

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.
- In addition to any general annual deductible that may apply, 68% of covered workers have coinsurance and 12% have a copayment that apply to inpatient hospital admissions. Lower percentages of covered workers have per day (per diem) payments (5%), a separate hospital deductible (3%), or both a copayment

and coinsurance (9%), while 15% have no additional cost sharing for hospital admissions after any general annual deductible has been met [Figure 7.28].

  - For covered workers in HMOs, copayments are more common (23%) and coinsurance (37%) is less common than the average for all covered workers [Figure 7.28].
  - HDHP/SOs, on average, have a different cost-sharing structure than other plan types for hospital admissions. Only 2% of covered workers in HDHP/SOs have a copayment for hospital admissions, lower than the average for all covered workers [Figure 7.28].
  - The average coinsurance rate for a hospital admission is 20%, the average copayment is $321 per hospital admission, and the average per diem charge is $261 [Figure 7.31]. Seventy-one 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 7.32].

- The cost-sharing provisions for outpatient surgery are similar to those for hospital admissions, as most workers have coinsurance or copayments. In 2021, 16% of covered workers have a copayment and 68% have coinsurance for outpatient surgery. In addition, 7% have both a copayment and coinsurance, while 15% have no additional cost sharing after any general annual deductible has been met [Figures 7.29 and 7.30].

  - For covered workers with cost sharing for outpatient surgery, the average coinsurance rate is 20% and the average copayment is $162 [Figure 7.31].

Figure 7.28

Distribution of Covered Workers With Other Cost Sharing for Hospital Admissions, in Addition to Any General Annual Deductible, by Plan Type, 2021

Plan Type	Separate Annual Deductible for Hospital Admissions	Copayment	Coinsurance	Both Copayment and Coinsurance	Charge Per Day	None
HMO	3%	23%*	37%*	15%	8%	29%
PPO	3	11	78*	11	3	8*
POS	9	30*	46*	8	18*	14
HDHP/SO	<1*	2*	77*	3*	3*	19
ALL PLANS	**3%**	**12%**	**68%**	**9%**	**5%**	**15%**

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. 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, 2021

Figure 7.29

Distribution of Covered Workers With Other Cost Sharing for Outpatient Surgery, in Addition to Any General Annual Deductible, by Plan Type, 2021

Plan Type	Separate Annual Deductible for Outpatient Surgery	Copayment	Coinsurance	Both Copayment and Coinsurance	None
HMO	2%	40%*	34%*	13%	23%
PPO	1	11	78*	8	9*
POS	3	41*	42*	8	16
HDHP/SO	<1*	2*	77*	1*	21
ALL PLANS	**1%**	**16%**	**68%**	**7%**	**15%**

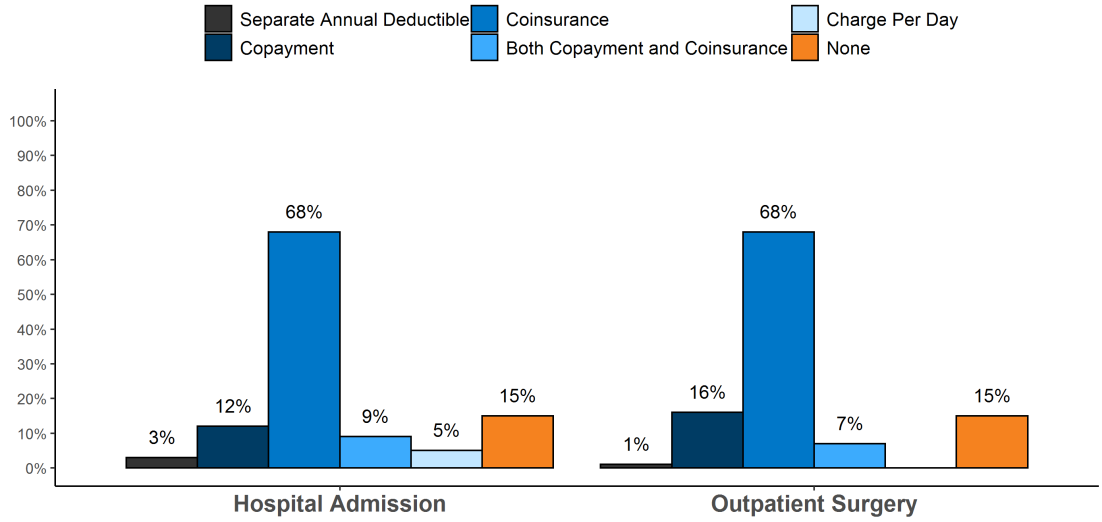
NOTE: We collect information on the cost-sharing provisions in addition to any general annual plan deductible. The distribution of workers with different types of cost sharing does not equal 100% because workers may face a combination of types of cost sharing. Less than one percent of covered workers 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.

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

SOURCE: KFF Employer Health Benefits Survey, 2021

Figure 7.30

Percentage of Covered Workers with the Following Types of Cost Sharing for Hospital Admissions and Outpatient Surgery, in Addition to Any General Annual Deductible, 2021



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. 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, 2021

Figure 7.31

Among Covered Workers With Separate Cost Sharing for Hospital Admissions or Outpatient Surgery, Average Cost Sharing, by Type, 2021

	Charge Per Day	Coinsurance	Copayment
Outpatient Surgery	N/A	20%	$162
Hospital Admission	$261	20%	$321

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, 2021

Figure 7.32

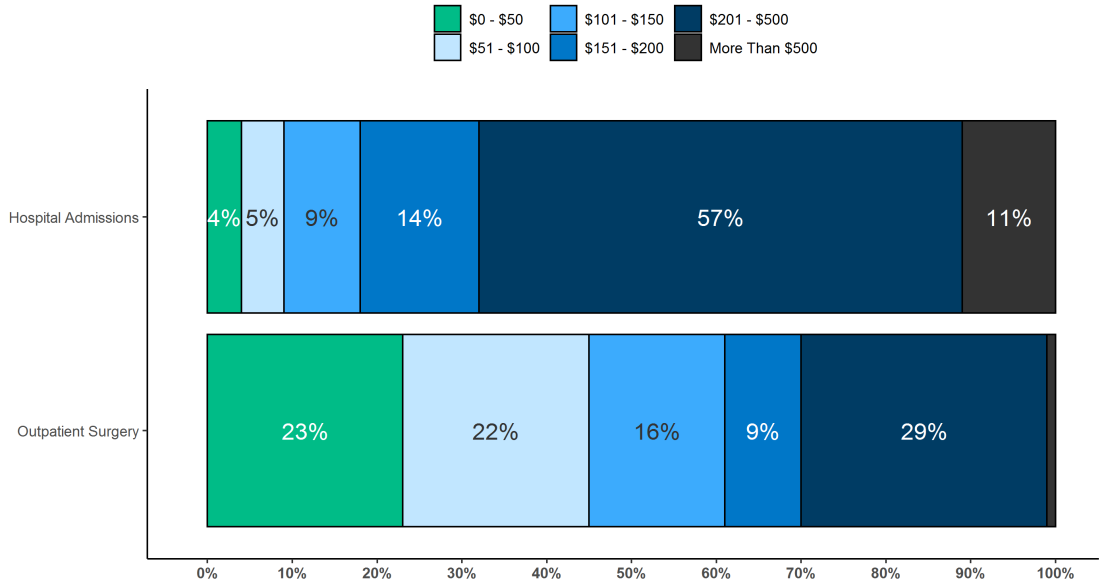
Among Covered Workers With a Charge Per Day for Hospital Admissions, Average Cost Sharing Features, 2021

	Among Covered Workers With a Charge Per Day for Hospital Admissions
Average Charge Per Day	$261
Percentage of Covered Workers With a Limit On the Number of Days a Worker Must Pay Per-Day Amount	71%

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.

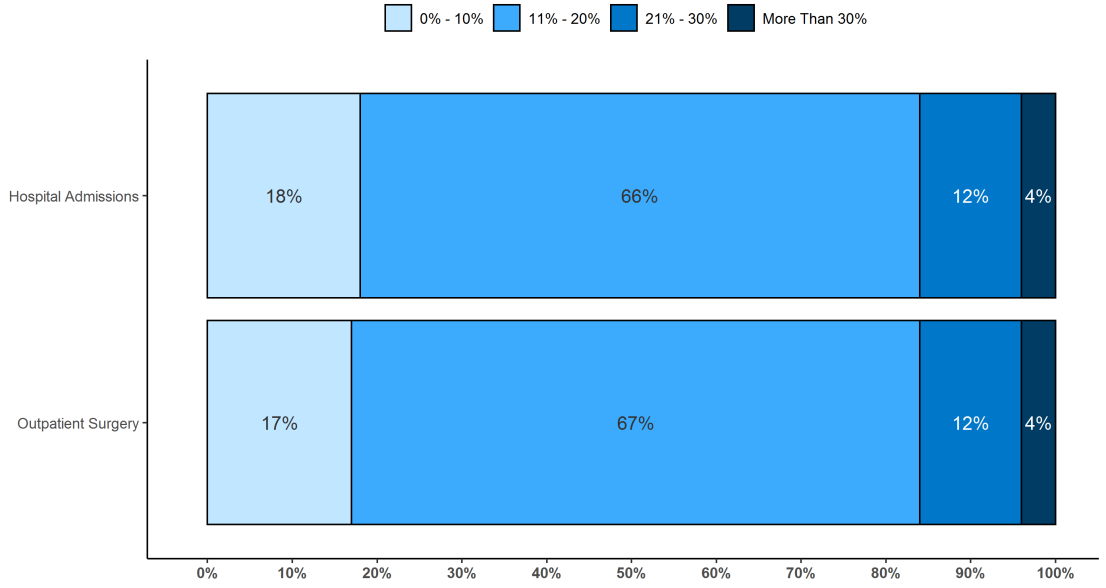
SOURCE: KFF Employer Health Benefits Survey, 2021

Figure 7.33
Among Covered Workers with a Copayment for Hospital Admissions or Outpatient Surgery, Distribution of Copayments, 2021



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, 2021

Figure 7.34
Among Covered Workers with Coinsurance for Hospital Admissions or Outpatient Surgery, Distribution of Coinsurance Rates, 2021

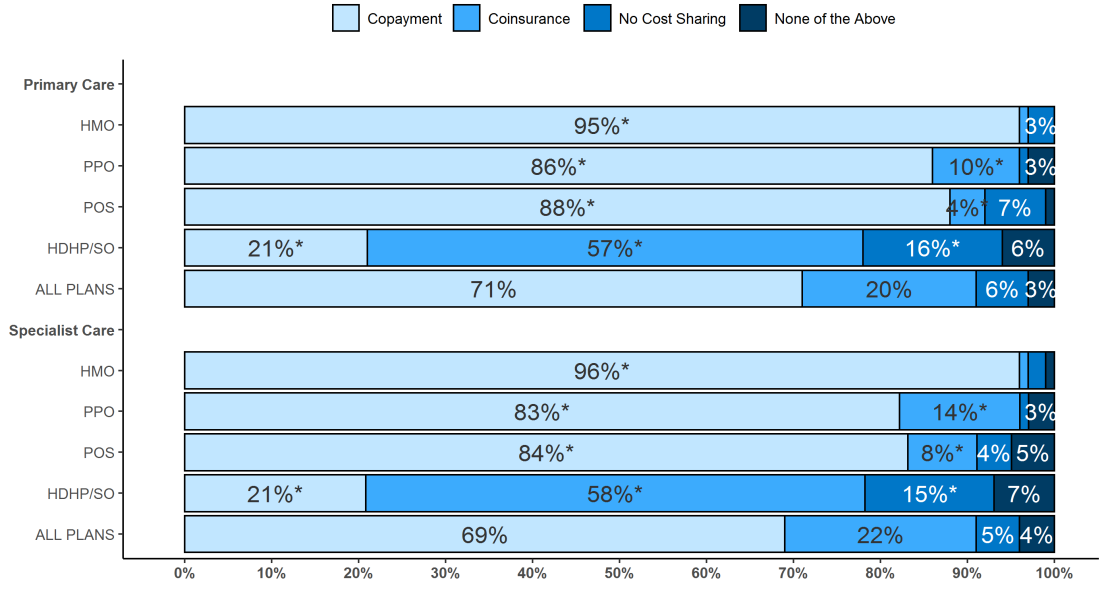


NOTE: Estimates represent cost sharing in addition to any general annual deductible. Distribution includes workers who may have a combination of types of cost sharing. Cost sharing amounts are for in-network providers.
SOURCE: KFF Employer Health Benefits Survey, 2021

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 cost sharing for an in-network physician office is a copayment. Seventy-one percent of covered workers have a copayment for a primary care physician office visit and 20% have coinsurance. For office visits with a specialty physician, 69% of covered workers have a copayment and 22% have coinsurance [Figure 7.35].
    - The form of cost sharing for physician office visits varies by firm size. For in-network primary care office visits, covered workers in small firms are more likely to have a copayment (78% vs. 68%) are are less likely to have coinsurance (9% vs. 25%). The pattern is similar for in-network office visits with specialists.
  - 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, 21% of covered workers in HDHP/SOs have a copayment, 57% have coinsurance, and 16% have no cost sharing after the general annual plan deductible is met [Figure 7.35].
  - Among covered workers with a copayment for in-network physician office visits, the average copayment is $25 for primary care and $42 for specialty physician office visits, similar to the amounts last year [Figure 7.36].
  - Among covered workers with coinsurance for in-network physician office visits, the average coinsurance rates are 19% for a visit with a primary care physician and 20% for a visit with a specialist, similar to the rates last year [Figure 7.36].

Figure 7.35
Percentage of Covered Workers with the Following Types of Cost Sharing for Physician Office Visits, by Plan Type, 2021



* 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, 2021

[2]For those enrolled in an HDHP/HSA, the out-of-pocket maximum may be no more than $7,000 for an individual plan and $14,000 for a family plan in 2021. See https://www.irs.gov/irb/2019-22_IRB#REV-PROC-2019-25

Figure 7.36

Among Covered Workers With Copayments And/Or Coinsurance for Physician Office Visits, Average Copayments and Coinsurance, by Plan Type, 2021

	HMO	PPO	POS	HDHP/SO	All Plans
Primary Care Office Visit					
Average Copayment ($)	$21*	$26	$29*	$26	**$25**
Average Coinsurance (%)	NSD	20%	NSD	18%	**19%**
Specialty Care Office Visit					
Average Copayment ($)	$36	$42	$49*	$49*	**$42**
Average Coinsurance (%)	NSD	21%	NSD	19%	**20%**

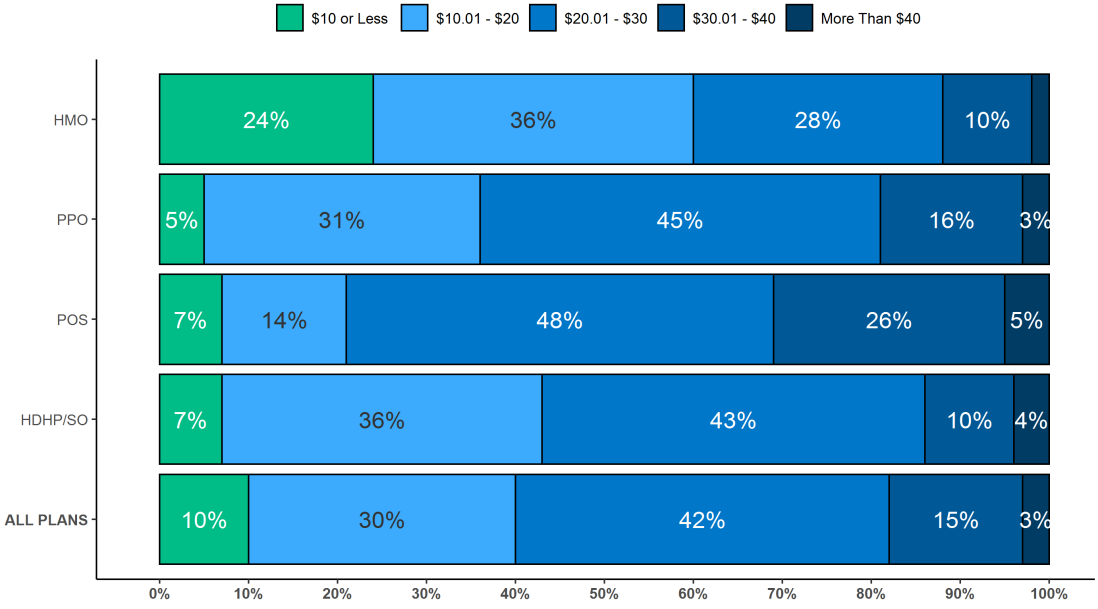
NOTE: Cost-sharing averages are for in-network visits.
NSD: Not Sufficient Data

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

SOURCE: KFF Employer Health Benefits Survey, 2021

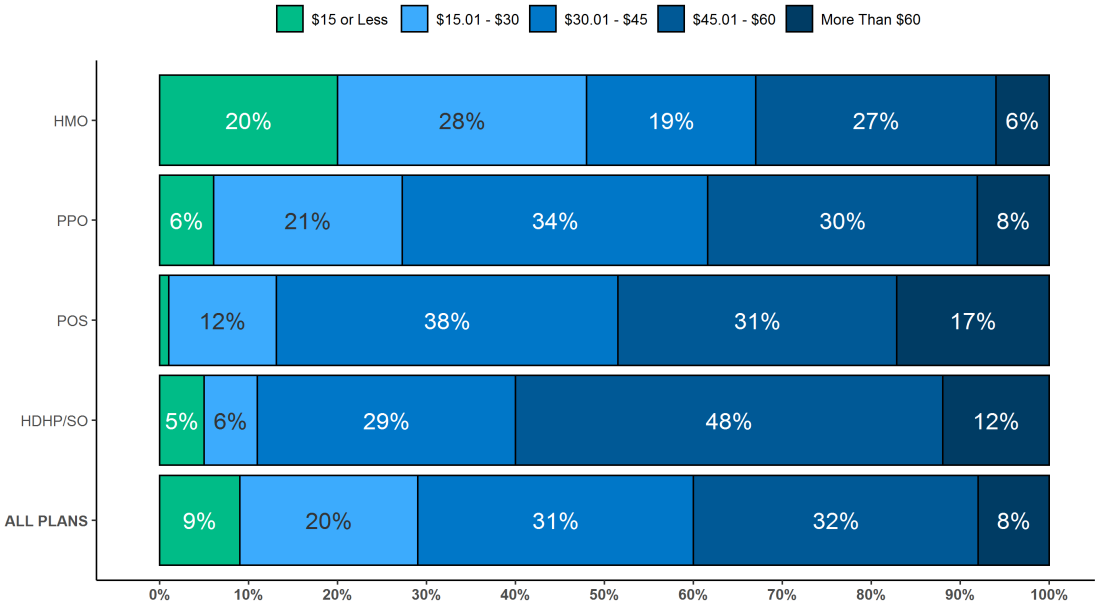
Figure 7.37

Among Covered Workers with a Copayment for a Primary Care Physician Office Visit, Distribution of Copayments, by Plan Type, 2021



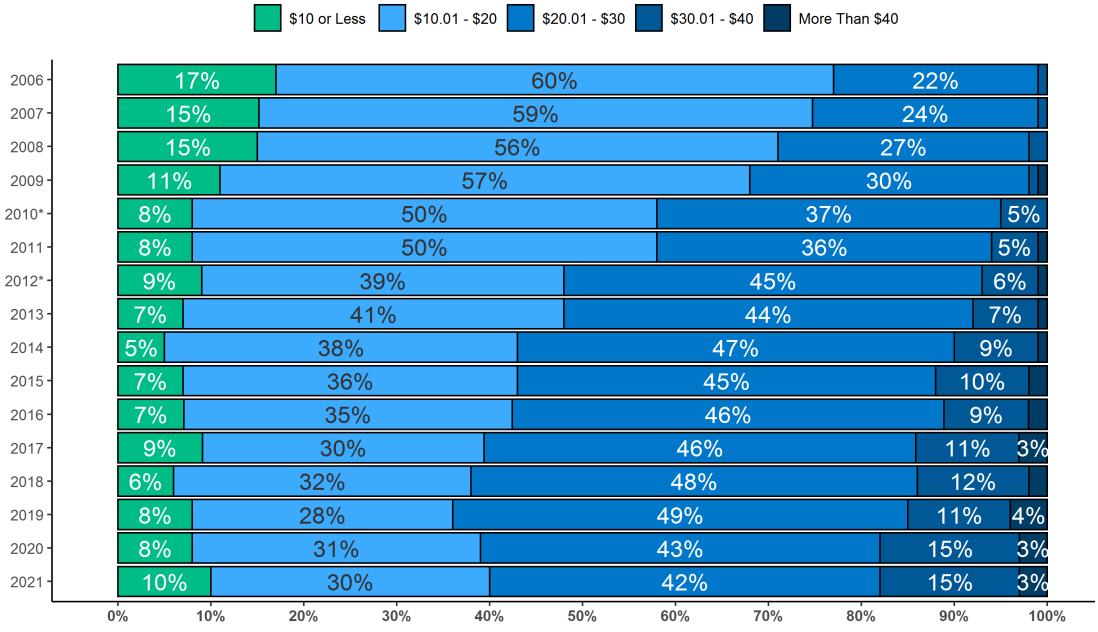
NOTE: Copayments are for in-network providers.
SOURCE: KFF Employer Health Benefits Survey, 2021

Figure 7.38
Among Covered Workers with a Copayment for a Specialist Physician Office Visit, Distribution of Copayments, by Plan Type, 2021



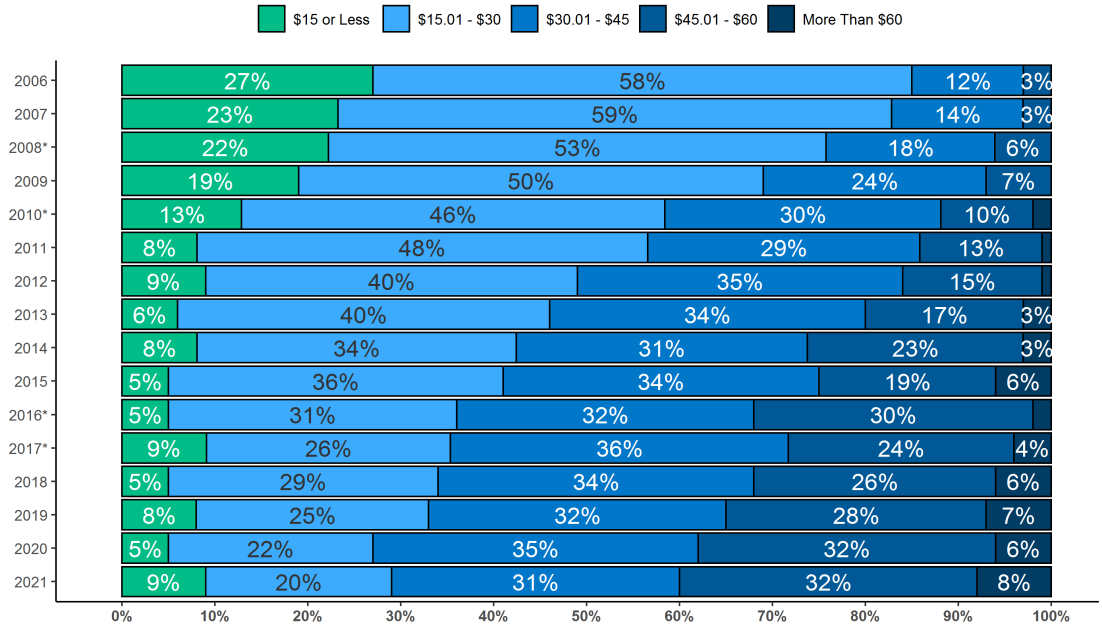
NOTE: Copayments are for in-network providers.
SOURCE: KFF Employer Health Benefits Survey, 2021

Figure 7.39
Among Covered Workers with a Copayment for a Primary Care Physician Office Visit, Distribution of Copayments, 2006-2021



* Distribution is statistically different from distribution for the previous year shown ($p < .05$).
SOURCE: KFF Employer Health Benefits Survey, 2018-2021; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006-2017

Figure 7.40
Among Covered Workers with a Copayment for a Specialist Physician Office Visit, Distribution of Copayments, 2006-2021



* Distribution is statistically different from distribution for the previous year shown ($p < .05$).
SOURCE: KFF Employer Health Benefits Survey, 2018-2021; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006-2017

Figure 7.41

Among Covered Workers With a Copayment And/Or Coinsurance for Physician Office Visits, Average Copayment and Coinsurance, 2006-2021

	Primary Care		Specialist Care	
	Copayment	Coinsurance	Copayment	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%
2021	$25	19%	$42	20%

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, 2018-2021; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006-2017

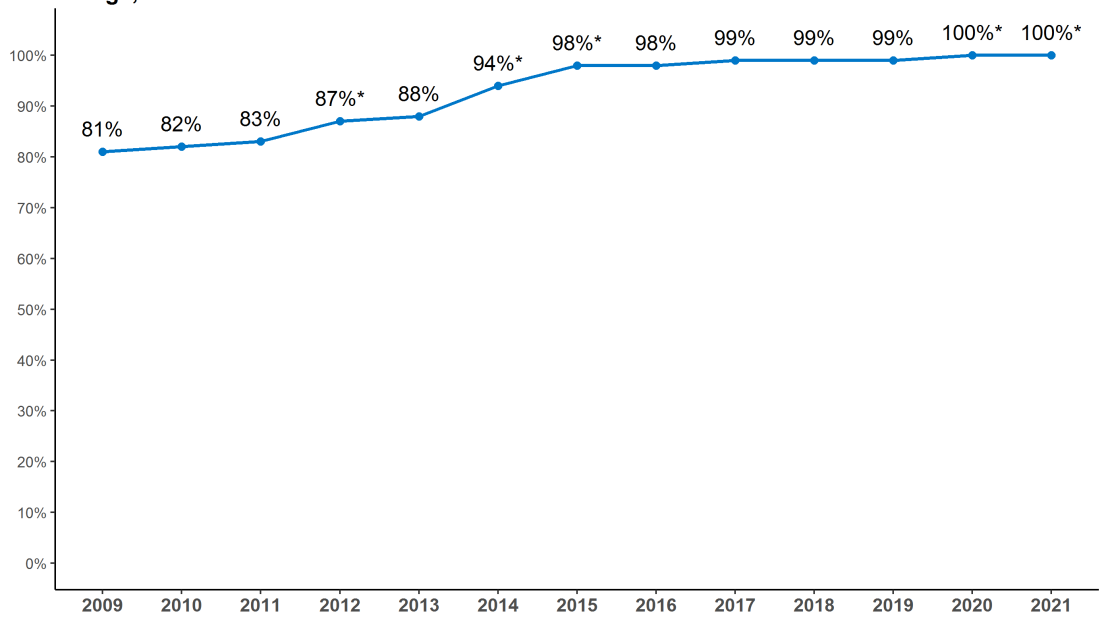
OUT-OF-POCKET MAXIMUMS

- Virtually all covered workers are in a plan that partially or totally limits the cost sharing that enrollees 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 $8,550 for single coverage and $17,100 for family coverage in 2021. 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.
- In 2021, more than 99% of covered workers are in a plan with an out-of-pocket maximum for single coverage. This is a significant increase from 98% in 2016 [Figure 7.42].

[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.

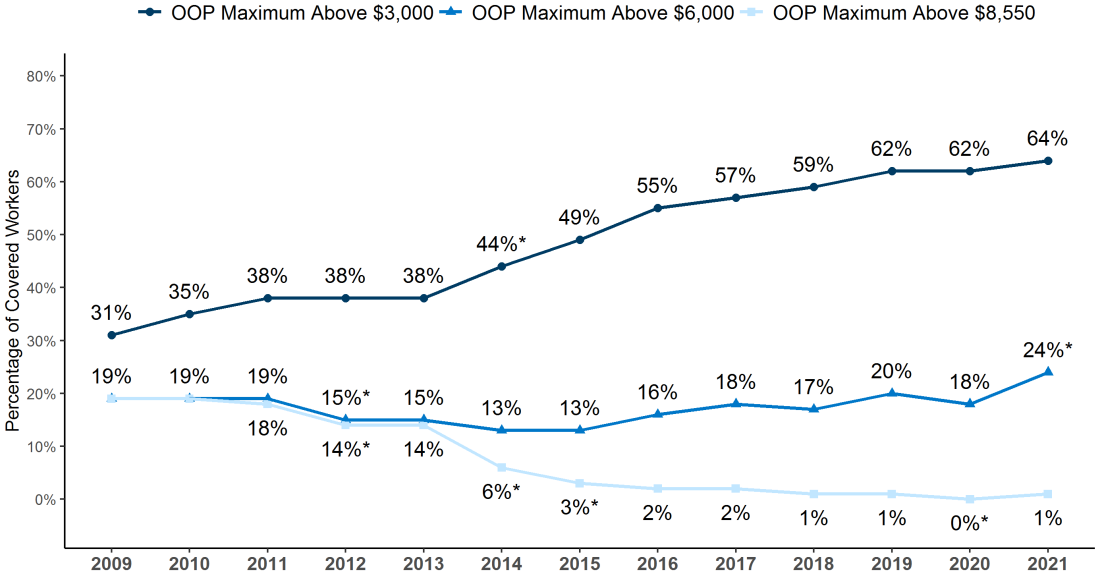
- For covered workers in plans with an out-of-pocket maximum for single coverage, there is wide variation in spending limits.
  - Thirteen percent of covered workers in plans with an out-of-pocket maximum for single coverage have an out-of-pocket maximum of less than $2,000, while 27% have an out-of-pocket maximum of $6,000 or more [Figure 7.44].

Figure 7.42
Percentage of Covered Workers in a Plan with an Out-of-Pocket Maximum for Single Coverage, 2009-2021



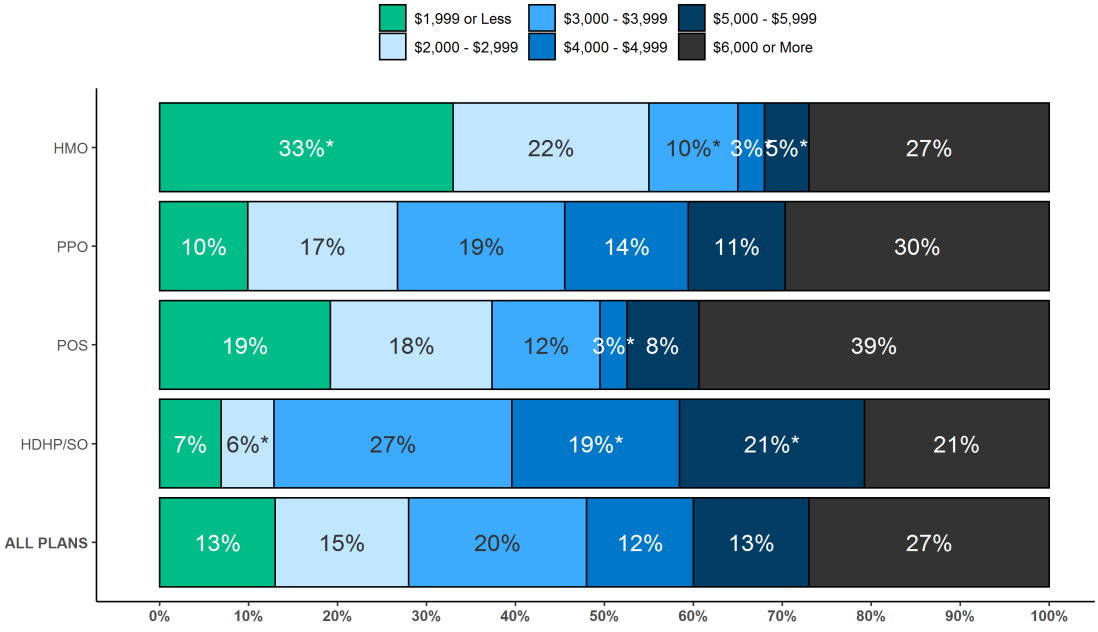
* Estimate is statistically different from estimate for the previous year shown (p < .05).
NOTE: Out-of-pocket maximums reported are for in-network services.
SOURCE: KFF Employer Health Benefits Survey, 2018-2021; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2009-2017

Figure 7.43
Percentage of Covered Workers in a Plan with an Out-of-Pocket Maximum Above Certain Thresholds for Single Coverage, 2009-2021



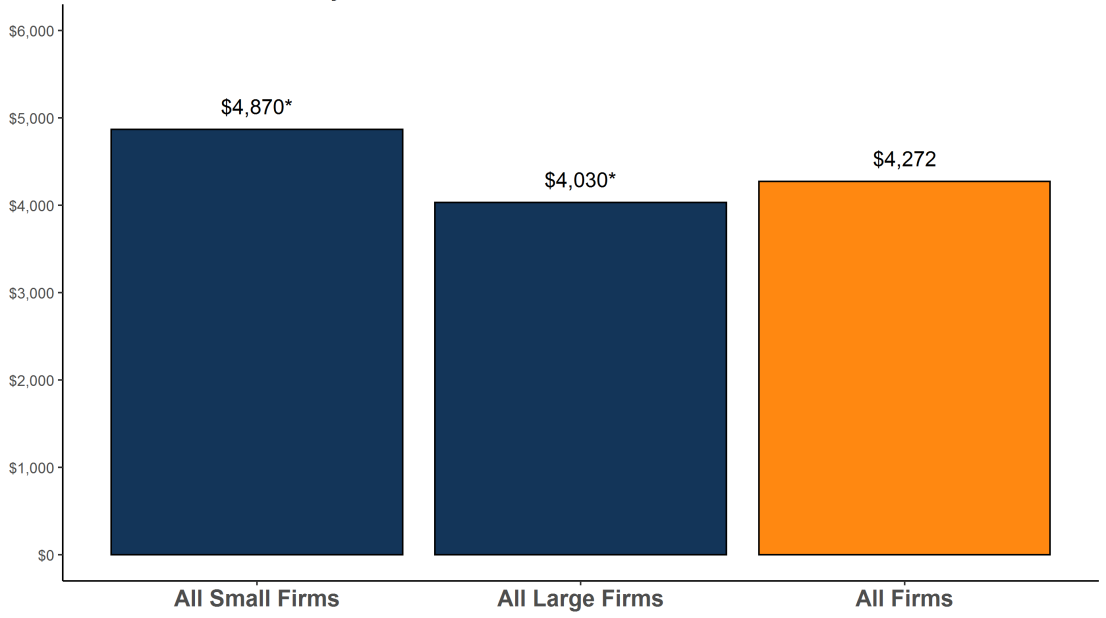
* Estimate is statistically different from estimate for the previous year shown (p < .05).
NOTE: OOP is 'out-of-pocket'. OOP maximums are for in-network services. Covered workers without an OOP maximum are considered to be exposed to at least the specified threshold. Some of these workers may be enrolled in plans whose cost-sharing structure has other limits.
SOURCE: KFF Employer Health Benefits Survey, 2018-2021; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2009-2017

Figure 7.44
Among Covered Workers with an Out-of-Pocket Maximum for Single Coverage, Distribution of Out-of-Pocket Maximums, by Plan Type, 2021



* Estimate is statistically different from All Plans estimate within plan type (p < .05).
SOURCE: KFF Employer Health Benefits Survey, 2021

Figure 7.45
Among Covered Workers with an Out-of-Pocket Maximum for Single Coverage, Average Out-of-Pocket Maximums, by Firm Size, 2021



* 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, 2021

Employer Health Benefits
2021 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]

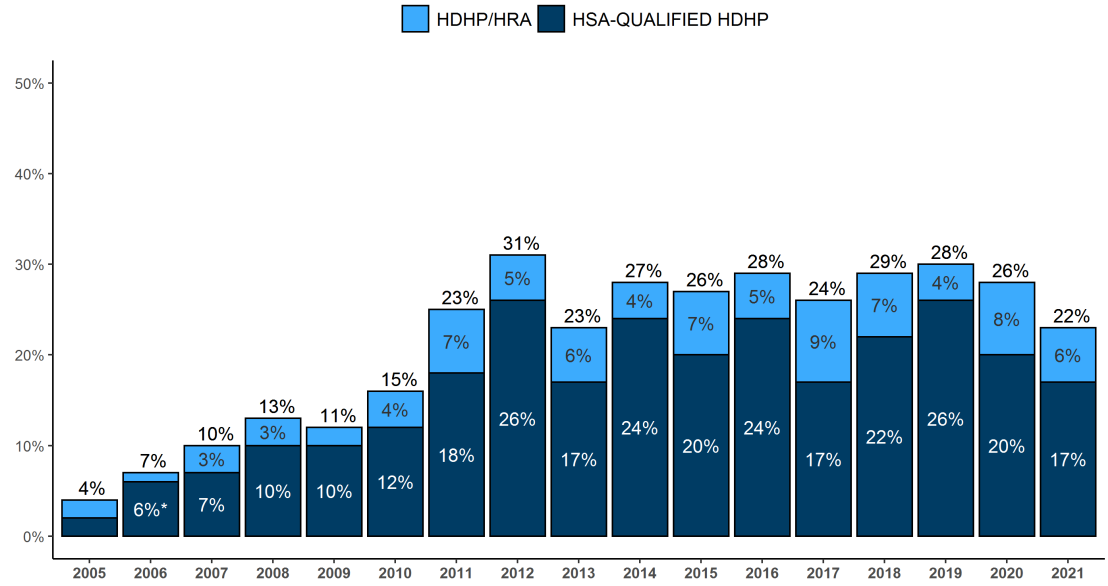
PERCENTAGE OF FIRMS OFFERING HDHP/HRAS AND HSA-QUALIFIED HDHPS

- Twenty-two percent of firms offering health benefits offer an HDHP/HRA, an HSA-qualified HDHP, or both. Among firms offering health benefits, 6% offer an HDHP/HRA and 17% 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 (58% vs. 20%) [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 2021 (or $1,400 and $2,800, respectively, for plans in their 2020 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.

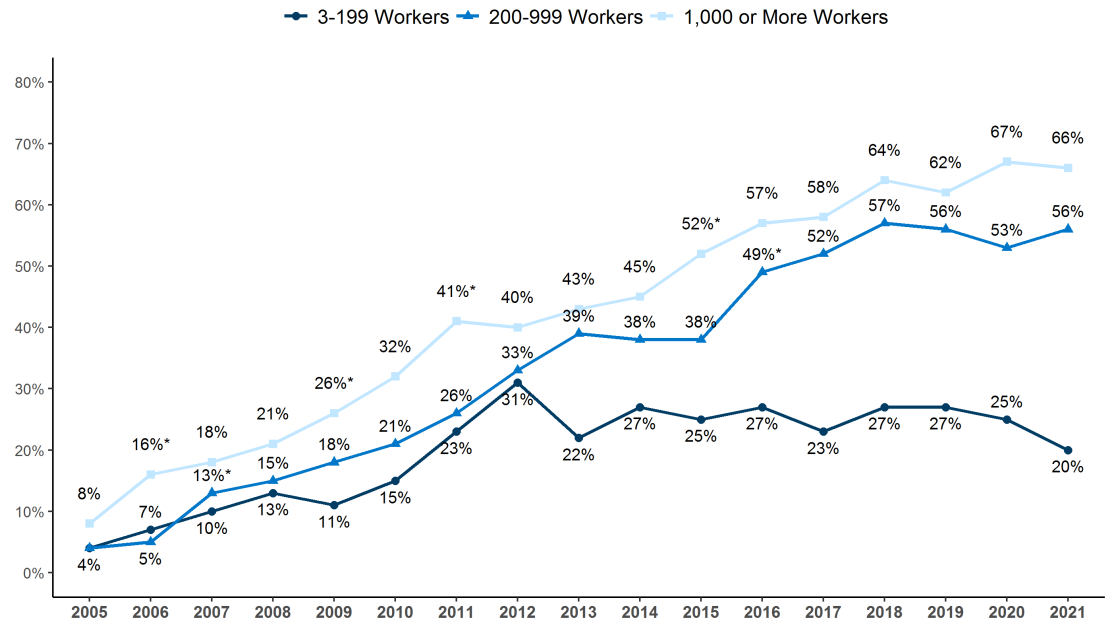
[2] The definitions of HDHP/SOs do not include other consumer-driven plan options, such as arrangements that combine an HRA with a lower-deductible health plan or arrangements in which an insurer (rather than the employer as in the case of HRAs or the enrollee as in the case of HSAs) establishes an account 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, 2005-2021



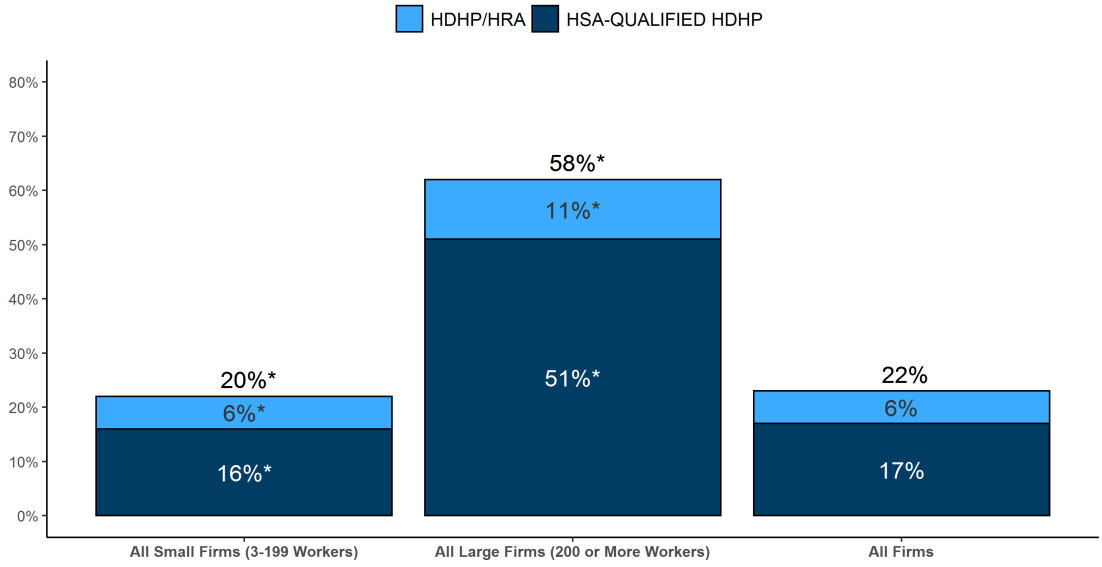
* Estimate is statistically different from estimate for the previous year shown (p < .05).
NOTE: Among all firms that offer health benefits, 1.3% offer both an HDHP/HRA and an HSA-qualified HDHP. Adding the percentage of firms offering HDHP/HRA and HSA-Qualified HDHPs may not sum to the percentage of firms offering HDHP/SOs because some firms offer both.
SOURCE: KFF Employer Health Benefits Survey, 2018-2021; 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, 2005-2021



* Estimate is statistically different from estimate for the previous year shown (p < .05).
SOURCE: KFF Employer Health Benefits Survey, 2018-2021; 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, 2021

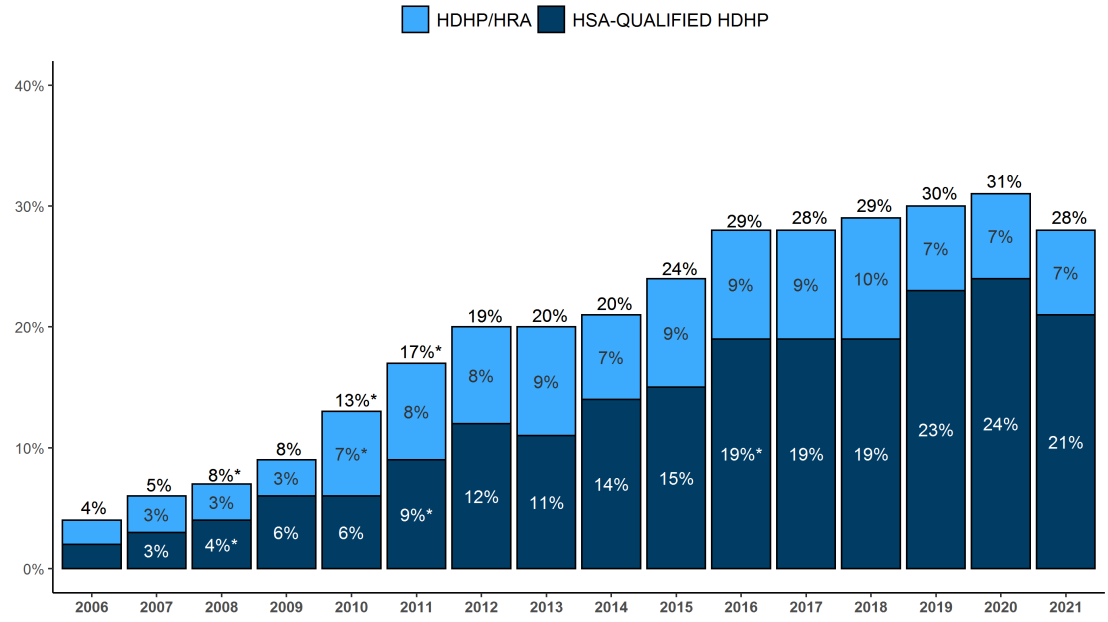


* Estimate is statistically different between All Small Firms and All Large Firms estimate ($p < .05$).
NOTE: Among all firms that offer health benefits, 1.3% offer both an HDHP/HRA and an HSA-qualified HDHP. Adding the percentage of firms offering HDHP/HRA and HSA-Qualified HDHPs may not sum to the 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, 2018-2021; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2005-2017

ENROLLMENT IN HDHP/HRAS AND HSA-QUALIFIED HDHPS

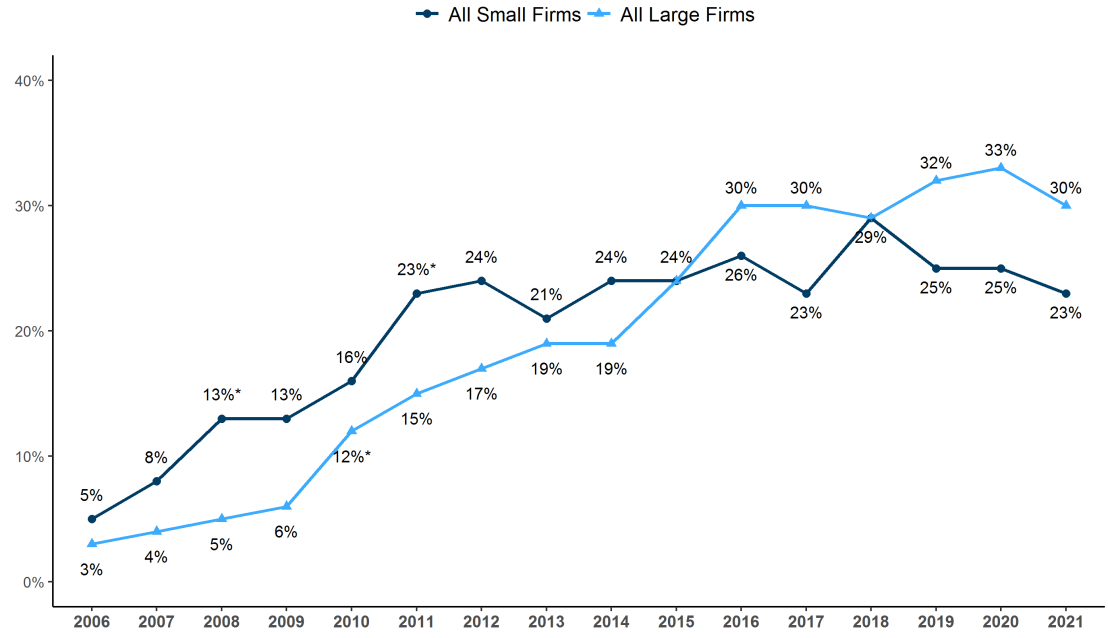
- Twenty-eight percent of covered workers are enrolled in an HDHP/SO in 2021, similar to the percentage last year (31%) [Figure 8.4].
- Enrollment in HDHP/SOs has increased over the past decade, from 17% of covered workers in 2011 to 28% in 2021 [Figure 8.4].
  - Seven percent of covered workers are enrolled in HDHP/HRAs and twenty-one percent of covered workers are enrolled in HSA-qualified HDHPs in 2021. These percentages are similar to the percentages last year [Figure 8.4].
  - The percentage of covered workers enrolled in HDHP/SOs is higher in large firms (30%) than in small firms (23%) [Figure 8.5].

Figure 8.4
Percentage of Covered Workers Enrolled in an HDHP/HRA or HSA-Qualified HDHP, 2006-2021



* 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, 2018-2021; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006-2017

Figure 8.5
Percentage of Covered Workers Enrolled in an HDHP/SO, by Firm Size, 2006-2021



* 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, 2018-2021; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006-2017

PREMIUMS AND WORKER CONTRIBUTIONS

- In 2021, the average annual premiums for covered workers in HDHP/HRAs are $7,441 for single coverage and $21,662 for family coverage [Figure 8.6].
- The average annual premiums for workers in HSA-qualified HDHPs are $6,877 for single coverage and $20,507 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 8.7].
- The average annual worker contributions to premiums for workers enrolled in HDHP/HRAs are $1,569 for single coverage and $6,407 for family coverage [Figure 8.6]. 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 8.7].
- The average annual worker contributions to premiums for workers in HSA-qualified HDHPs are $1,134 for single coverage and $4,718 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 8.7].

Figure 8.6

HDHP/HRA and HSA-Qualified HDHP Features for Covered Workers, 2021

	HDHP/HRA		HSA-QUALIFIED HDHP	
Annual Plan Averages For:	Single Coverage	Family Coverage	Single Coverage	Family Coverage
Premium	$7,441	$21,662	$6,877	$20,507
Worker Contribution to Premium	$1,569	$6,407	$1,134	$4,718
General Annual Deductible	$2,349	$5,217	$2,454	$4,572
Out-Of-Pocket Maximum	$4,425	Not Available	$4,368	Not Available
Firm Contribution to the HRA or HSA	$1,410	$2,344	$575	$987

NOTE: Firms were not asked about out-of-pocket maximums for family coverage in 2021. Deductibles for family coverage are for covered workers with an aggregate amount. 43% of covered workers enrolled in an HDHP/HRA and 21% 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 (38% for single coverage and 42% for family coverage) are excluded, the average firm HSA contribution for covered workers is $743 for single coverage and $1,292 for family coverage. two 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 (two percent for single coverage and one percent for family coverage).

SOURCE: KFF Employer Health Benefits Survey, 2021

Figure 8.7

Average Annual Premiums and Contributions to Savings Accounts for Covered Workers in HDHP/HRAs or HSA-Qualified HDHPs, Compared to Non-HDHP/SOs, 2021

	Single Coverage			Family Coverage		
	HDHP/HRA	HSA-Qualified HDHP	Non-HDHP/SO Plans	HDHP/HRA	HSA-Qualified HDHP	Non-HDHP/SO Plans
Annual Premium	$7,441	$6,877*	$8,023	$21,662	$20,507*	$22,784
Worker Contribution to Premium	$1,569	$1,134*	$1,323	$6,407	$4,718*	$6,300
Firm Contribution to Premium	$5,872*	$5,743*	$6,700	$15,255	$15,789	$16,484
Annual Firm Contribution to HRA or HSA	$1,410	$575	Not Applicable	$2,344	$987	Not Applicable
Total Annual Firm Contribution (Firm Share of Premium Plus Firm Contribution to HRA or HSA)	$7,282	$6,304*	$6,700	$17,599	$16,808	$16,484
Total Annual Cost (Total Premium Plus Firm Contribution to HRA or HSA)	**$8,851***	**$7,437***	**$8,023**	**$24,006**	**$21,520***	**$22,784**

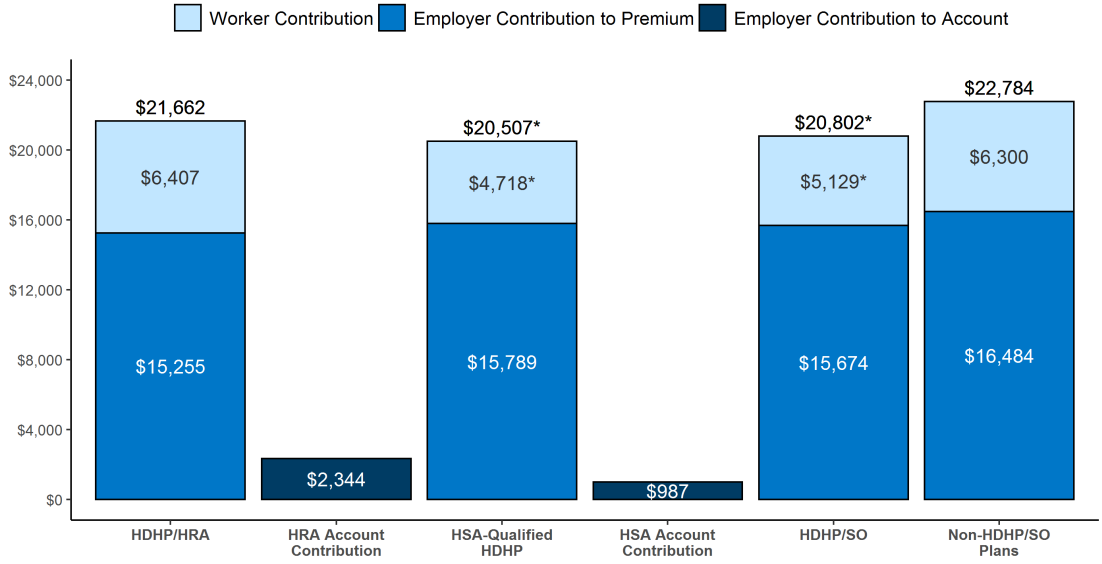
NOTE: Values shown in the table may not equal the sum of their component parts. The averages presented in the table are aggregated at the firm level and then averaged, which is methodologically more appropriate than adding the averages. See the note in Figure 8.6 for additional information on HSA and HRA contributions.

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

SOURCE: KFF Employer Health Benefits Survey, 2021

Figure 8.8

Average Annual Premiums and Contributions for Covered Workers in HDHP/SOs and Non-HDHP/SOs, for Family Coverage, 2021

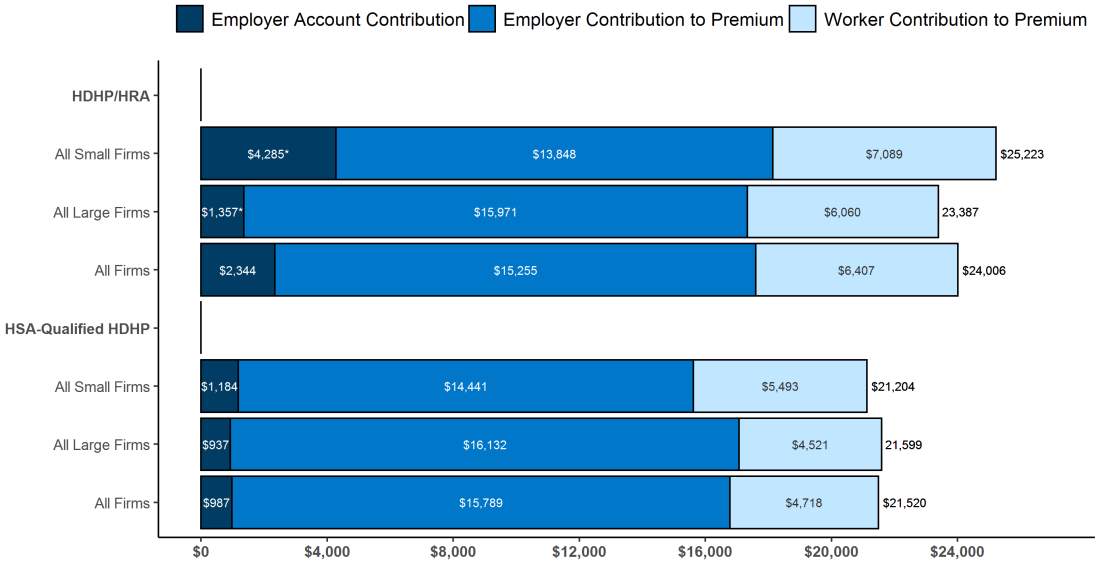


* Estimate is statistically different from estimate from Non-HDHP/SO plans ($p < .05$).

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 8.6 for additional information on HSA and HRA contributions.

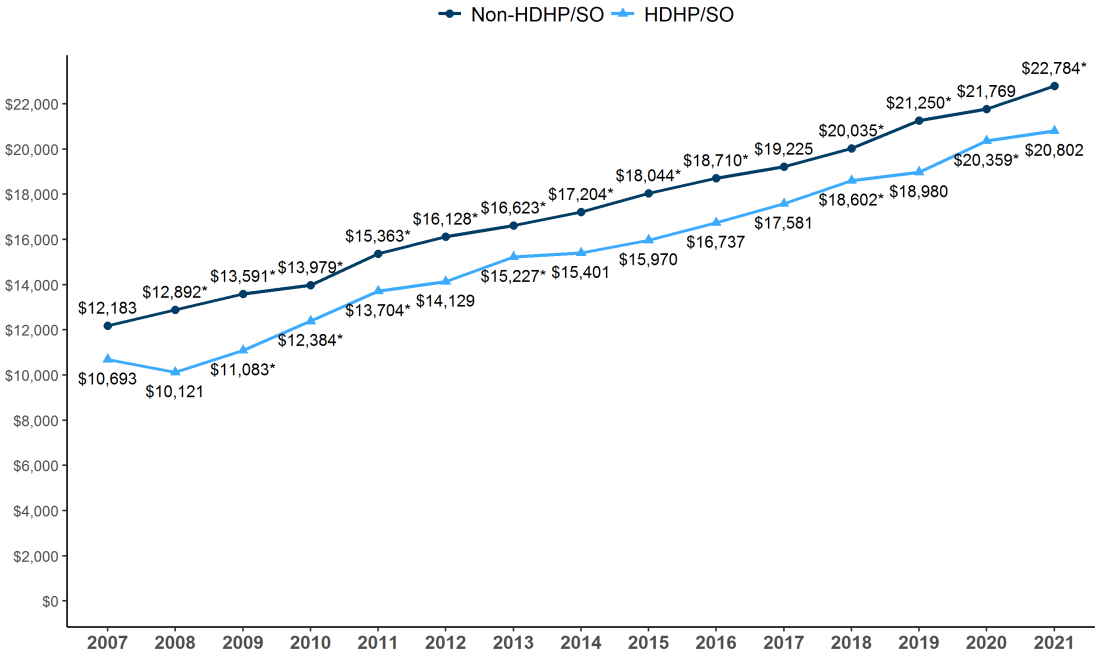
SOURCE: KFF Employer Health Benefits Survey, 2021

Figure 8.9
Total Annual Costs (Premiums and Account Contributions) for Covered Workers in HDHP/SOs, for Family Coverage, by Firm Size, 2021



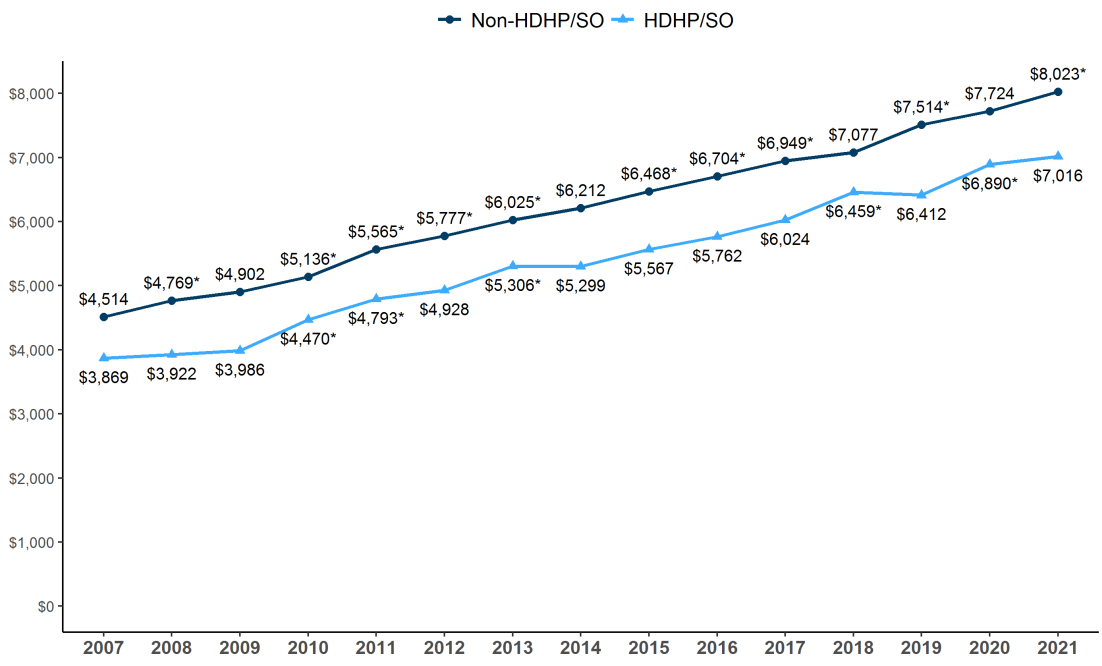
* Estimate is statistically different between All Small Firms and All Large Firms estimate ($p < .05$).
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers. Values shown in the table may not equal the sum of their component parts. The averages presented in the table are aggregated at the firm level and then averaged, which is methodologically more appropriate than adding the averages. See the note in Figure 8.6 for additional information on HSA and HRA contributions.
SOURCE: KFF Employer Health Benefits Survey, 2021

Figure 8.10
Average Annual Premiums for Covered Workers with Family Coverage, by Plan Type, 2007-2021



* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
SOURCE: KFF Employer Health Benefits Survey, 2018-2021; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2007-2017

Figure 8.11
Average Annual Premiums for Covered Workers with Single Coverage, by Plan Type, 2007-2021



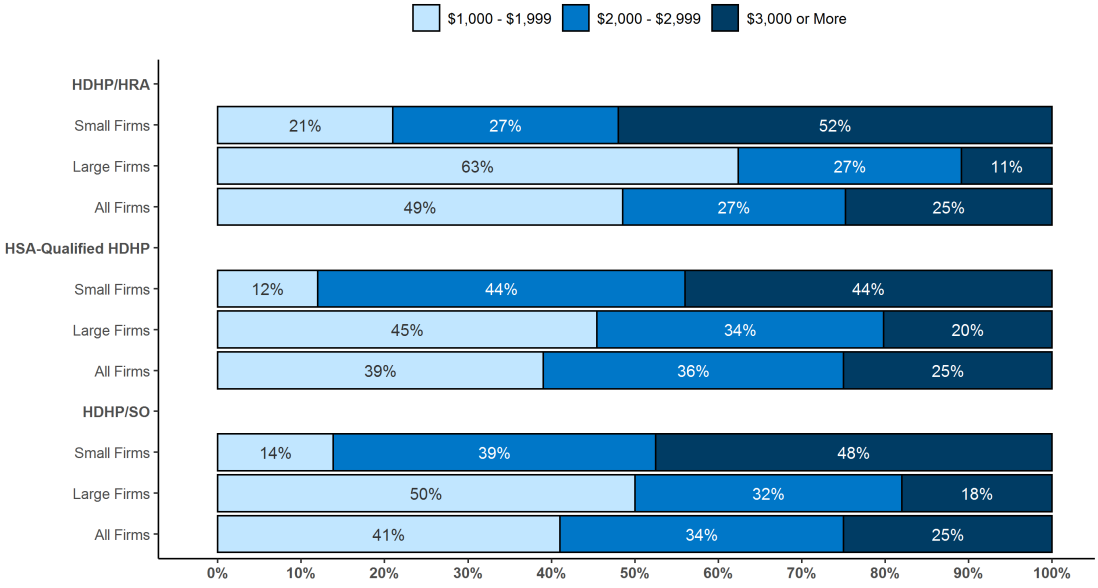
* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
SOURCE: KFF Employer Health Benefits Survey, 2018-2021; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2007-2017

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 $7,000 for single coverage and $14,000 for family coverage in 2021. Non-grandfathered HDHP/HRA plans are required to have out-of-pocket maximums of no more than $8,550 for single coverage and $17,100 for family coverage in 2021. Virtually all HDHP/HRA plans have an out-of-pocket maximum for single coverage in 2021.
  - The average annual out-of-pocket maximum for single coverage is $4,425 for HDHP/HRAs and $4,368 for HSA-qualified HDHPs [Figure 8.6].
- 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 $2,349 for HDHP/HRAs and $2,454 for HSA-qualified HDHPs [Figure 8.6]. These averages are similar to the amounts reported in recent years. There is wide variation around these averages: 41% 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 25% are in a plan with a deductible of $3,000 or more [Figure 8.12].
- 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 $5,217 for HDHP/HRAs and $4,572 for HSA-qualified HDHPs [Figure 8.6]. As with single coverage, there is wide variation around these averages for family coverage: 9% of covered workers enrolled in HDHP/SOs with an aggregate family deductible have a deductible of $2,000 to $2,999 while 20% have a deductible of $6,000 dollars or more [Figure 8.15].

Figure 8.12
Distribution of Covered Workers in HDHP/SOs with the Following General Annual Deductibles for Single Coverage, by Firm Size, 2021



NOTE: For HSA-qualified HDHPs, the legal minimum deductible for 2021 is $1,400 for single coverage and $2,800 for family coverage. Small Firms have 3-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2021

Figure 8.13

General Annual Deductible for Workers in HDHP/SOs After Any Employer Account Contributions for Single Coverage, by Firm Size, 2021

	HDHP/HRA	HSA-Qualified HDHP	HDHP/SO
General Annual Deductible			
All Small Firms	$3,389*	$3,175*	$3,265*
All Large Firms	1,820*	2,270*	2,169*
All Firms	**$2,349**	**$2,454**	**$2,424**
General Annual Deductible After Any HRA or HSA Contributions			
All Small Firms	$1,000	$2,454*	$1,957
All Large Firms	988	1,756*	1,584
All Firms	**$992**	**$1,895**	**$1,670**

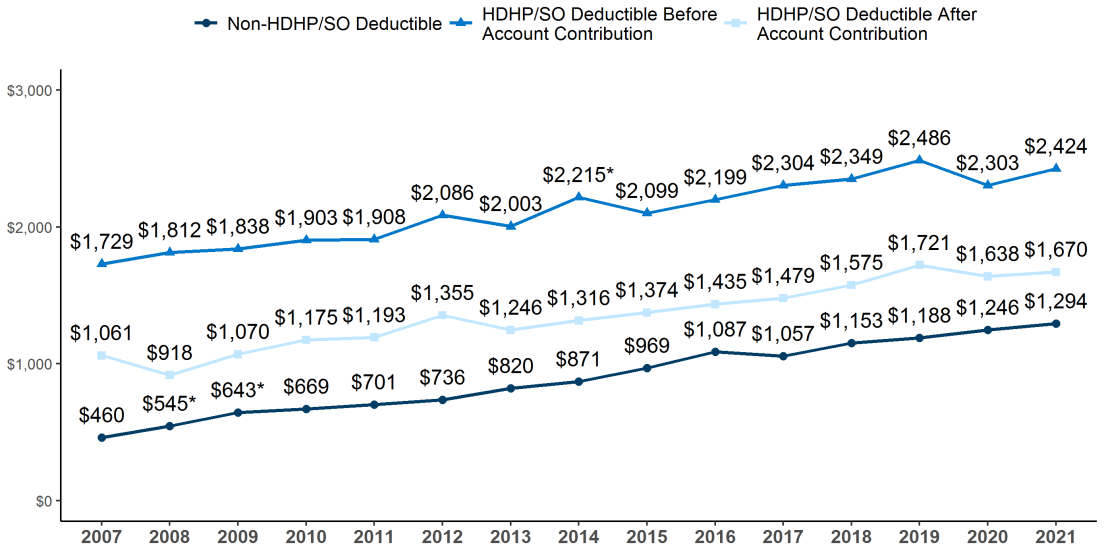
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers. The net liability for covered workers enrolled in a plan with an HSA or HRA is calculated by subtracting the account contribution from the single coverage deductible. HRAs are notional accounts, and employers are not required 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, 2021

Figure 8.14

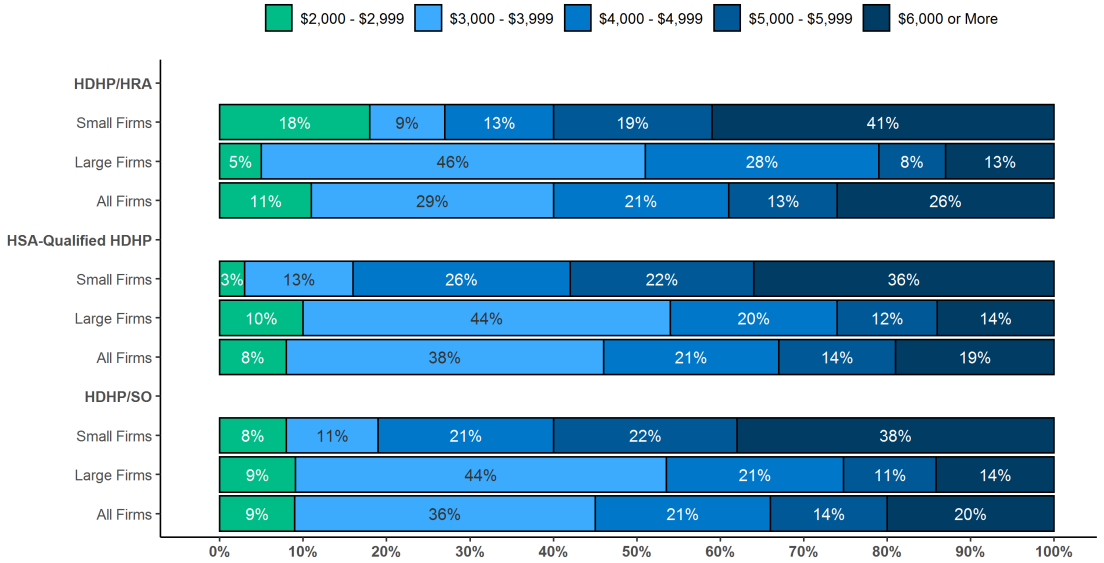
Among Covered Workers with a General Annual Deductible, Average Deductibles for Workers in Non-HDHP/SOs Compared to HDHP/SOs Before and After Any Employer Account Contributions, for Single Coverage, 2007-2021



* 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, 2018-2021; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2007-2017

Figure 8.15

Distribution of Covered Workers in HDHP/SOs with the Following Aggregate Family Deductibles, 2021



NOTE: Deductibles for family coverage are for covered workers with an aggregate amount. 43% of covered workers enrolled in an HDHP/HRA and 21% 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 2021 is $1,400 for single coverage and $2,800 for family coverage. Small Firms have 3-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2021

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 $5,872 for single coverage and $15,255 for family coverage [Figure 8.7]. These amounts are similar to the contribution amounts last year.
  - The average annual employer contributions to premiums for workers in HSA-qualified HDHPs are $5,743 for single coverage and $15,789 for family coverage. Both amounts are similar to the contribution amounts last year. The average employer contributions for covered workers in HSA-qualified HDHPs for single coverage is lower than the average contribution for covered workers in plans that are not HDHP/SOs [Figure 8.7].
- 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 $1,410 for single coverage and $2,344 for family coverage [Figure 8.7].
  - 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 $575 for single coverage and $987 for family coverage [Figure 8.7].
  - In many cases, employers that sponsor HSA-qualified HDHP/SOs do not make contributions to HSAs established by their employees. Thirty-eight percent of employers offering single coverage and 42% 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, 22% enrolled in single coverage and 24% enrolled in family coverage do not receive an account contribution from their employer [Figure 8.16] and [Figure 8.17].
  - 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 $744 for single coverage and $1,296 for family coverage.
    - The percentages of covered workers enrolled in a plan where the employer makes no HSA contribution (22% for single coverage and 24% for family coverage) are similar to the percentages in recent years [Figure 8.16] and [Figure 8.17].
- There is considerable variation in the amount that employers contribute to savings accounts.
  - Forty-two percent of covered workers in an HDHP/HRA receive an annual HRA contribution of less than $800 for single coverage, while 25% receive an annual HRA contribution of $1,600 or more [Figure 8.16].

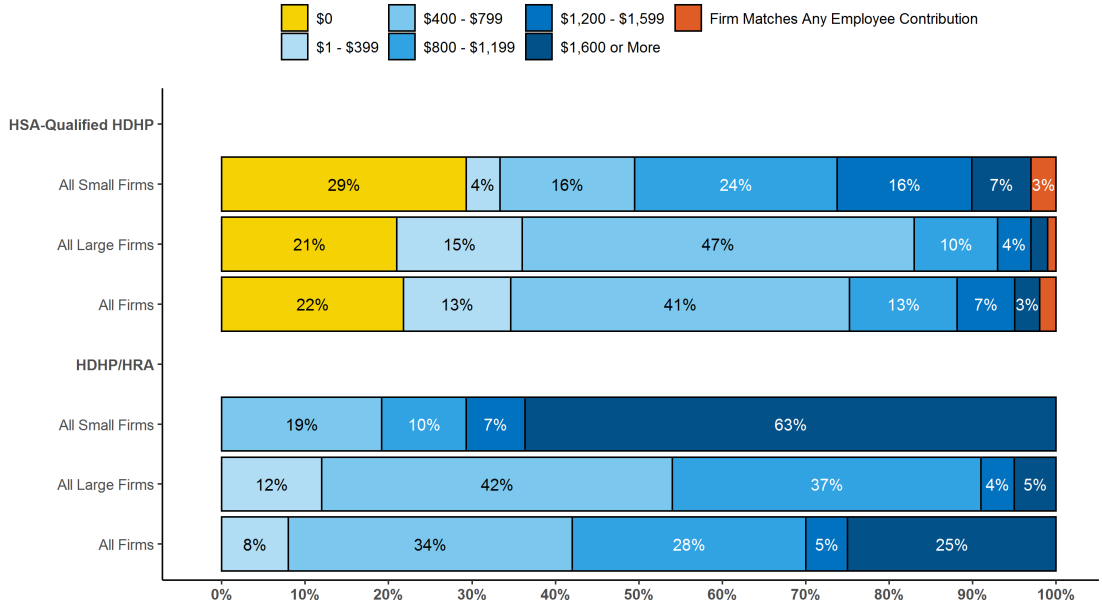
[3]The survey asks "Up to what dollar amount does your firm promise to contribute each year to an employee's HRA or health reimbursement arrangement for single coverage?" We refer to the amount that the employer commits to make available to an HRA as a contribution for ease of discussion. As discussed, 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.

- Thirty-five percent of covered workers in an HSA-qualified HDHP receive an annual HSA contribution of less than $400 for single coverage, including 22% that receive no HSA contribution from their employer [Figure 8.16]. In contrast, 9% of covered workers in an HSA-qualified HDHP receive an annual HSA contribution of $1,200 or more. Two 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 $7,282 for single coverage and $17,599 for family coverage. The average total employer contributions for covered workers for single coverage and family coverage in HDHP/HRAs are similar to the average firm contributions toward single and family coverage in plans that are not HDHP/SOs [Figure 8.7].
  - For HSA-qualified HDHPs, the average total annual firm contribution for covered workers is $6,304 for single coverage and $16,808 for workers with family coverage. The average total firm contribution amount for single coverage in HSA-qualified HDHPs is lower than the average firm contributions toward health plans that are not HDHP/SOs [Figure 8.7].

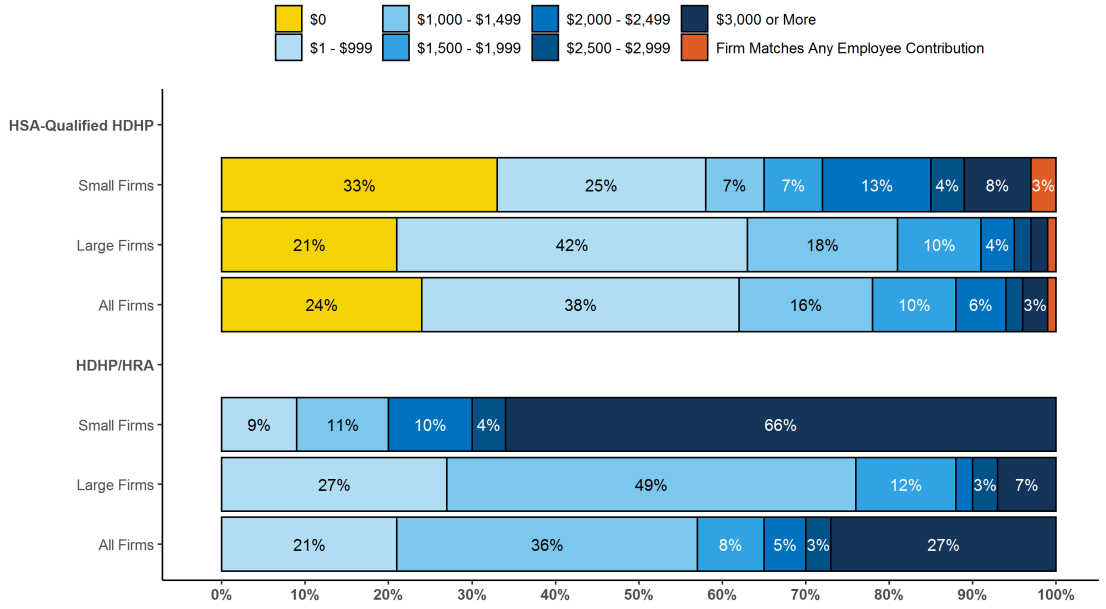
Figure 8.16
Distribution of Covered Workers with the Following Annual Employer Contributions to Their HRA or HSA, for Single Coverage, 2021



NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2021

Figure 8.17

Distribution of Covered Workers with the Following Annual Employer Contributions to Their HRA or HSA, for Family Coverage, 2021



NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2021

Figure 8.18

Average Annual Employer Contributions to HSA Accounts for Covered Workers Enrolled in an HSA-Qualified HDHP, 2009-2021

	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
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	$770
All Large Firms	450	567	446	402	547	544	481	563	535	531	530	496	527
All Firms	**$688**	**$558**	**$611**	**$609**	**$658**	**$769**	**$568***	**$686**	**$608**	**$603**	**$572**	**$550**	**$575**
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	$1,184
All Large Firms	815	1,087	864	760	992	976	923	1,084	999	981	1,031	949	936
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**	**$985**
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	$1,099
All Large Firms	619	748	641	618	737	707	657	707	670	645	658	636	666
All Firms	**$1,000**	**$858**	**$886**	**$919**	**$951**	**$1,006**	**$809**	**$916**	**$795**	**$790**	**$768**	**$741**	**$743**
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	$1,796
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	1,189
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**	**$1,292**

NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers. In 2021, 22% of workers in an HSA-qualified single coverage plan and 24% 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 (two percent for single coverage and one percent for family coverage).

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

SOURCE: KFF Employer Health Benefits Survey, 2018-2021; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2009-2017

Figure 8.19

Among Covered Workers in HDHP/HRAs and HSA-Qualified HDHPs, Average Annual Employer HSA and HRA Contributions, 2021

	Average Employer Account Contribution
HSA: Single Coverage	
All Small Firms	$770*
All Large Firms	526*
ALL FIRMS	**$575**
HSA: Family Coverage	
All Small Firms	$1,184
All Large Firms	937
ALL FIRMS	**$987**
HRA: Single Coverage	
All Small Firms	$2,537*
All Large Firms	837*
ALL FIRMS	**$1,410**
HRA: Family Coverage	
All Small Firms	$4,285*
All Large Firms	1,357*
ALL FIRMS	**$2,344**

NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers. See the note in Figure 8.6 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, 2021

COST SHARING FOR OFFICE VISITS

- The cost-sharing pattern for primary care office visits differs for workers enrolled in HDHP/SOs. Forty-six 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 8.20]. 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 8.20

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, 2021

	HDHP/HRA	HSA-Qualified HDHP	HDHP/SO	Non-HDHP/SO
Separate Cost Sharing for Primary Care Physician Office Visits				
Copayment	46%	9%*	21%	85%*
Coinsurance	44%	63%	57%	10%*
None	9%	19%*	16%	3%*
Other	1%	8%*	6%	2%*
Separate Cost Sharing for Specialty Care Physician Office Visits				
Copayment	46%	9%*	21%	83%*
Coinsurance	44%	64%	58%	13%*
None	9%	18%*	15%	2%*
Other	1%	9%*	7%	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, 2021

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 2021 or $1,400 and $2,800, respectively, in 2020) 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 $3,600 for single coverage and $7,200 for family coverage in 2021. 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

Employer Health Benefits

2021 Annual Survey

Prescription Drug Benefits

SECTION

9

Section 9

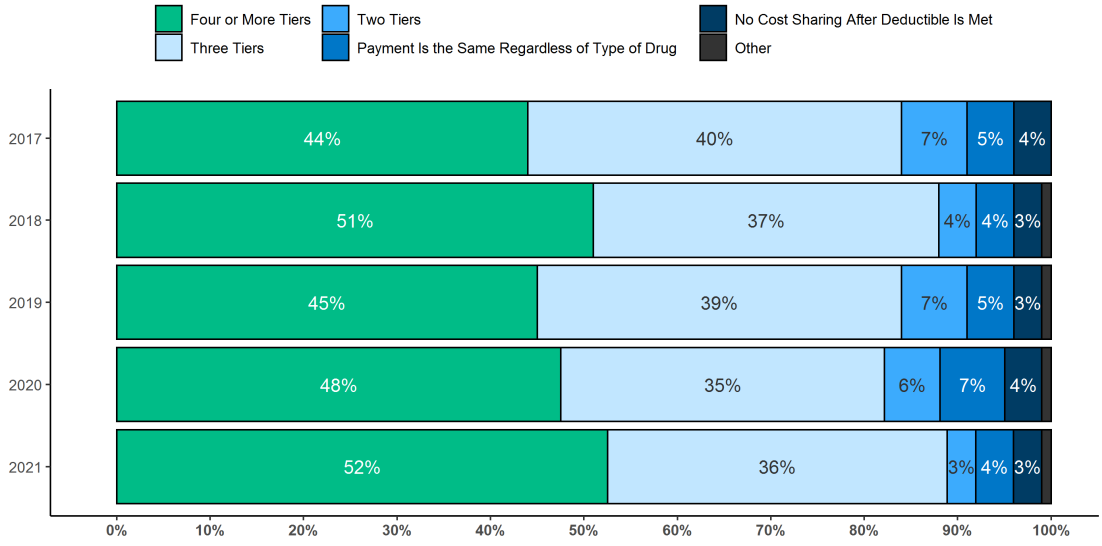
Prescription Drug Benefits

Nearly all (99%) covered workers are at a firm that provides prescription drug coverage in its largest health plan. Employer plans have over time incorporated more 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 other areas of variation in how plans structure their formularies.

DISTRIBUTION OF COST SHARING

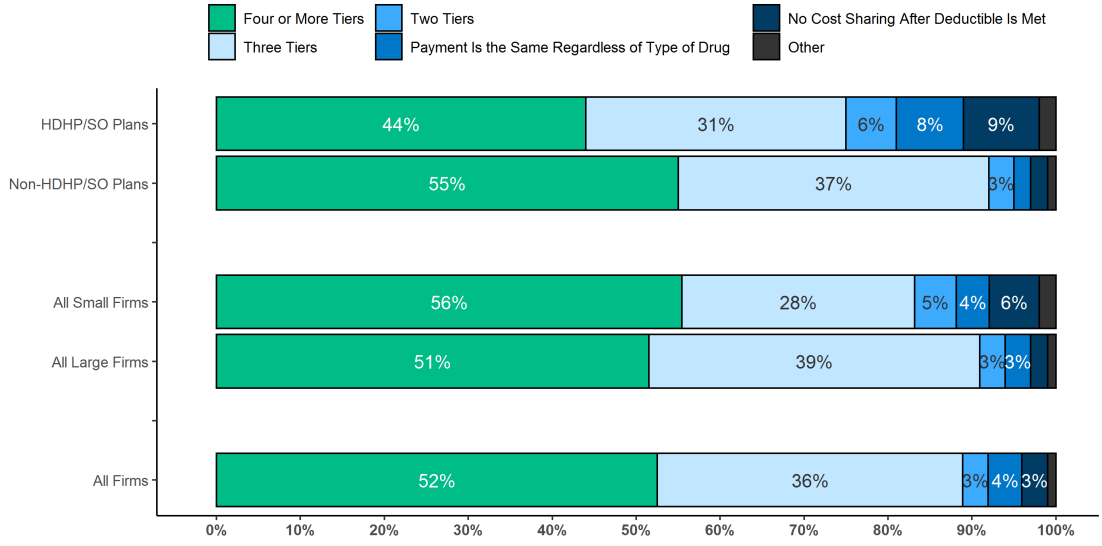
- The large majority of covered workers (92%) are in a plan with tiered cost sharing for prescription drugs [Figure 9.1]. Cost-sharing tiers generally refer to a health plan placing a drug on a formulary or preferred drug list that classifies drugs into categories that are subject to different cost sharing or management. It is common for there to be different tiers for generic, preferred and non-preferred drugs, and in recent years, plans have created additional tiers that may, for example, be used for specialty drugs or expensive drugs such as 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-eight 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 less likely to be in a plan with four or more tiers of cost sharing (44% vs. 55%) and are more likely to be 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, 2017-2021



Tests found no statistical difference from distribution for the previous year shown ($p < .05$).
NOTE: Number of tiers include any tiers specifically for specialty drugs. Excluding tiers specifically for specialty drugs, 23% of covered workers with prescription drug coverage are enrolled in a plan with four or more tiers, 60% have three tiers, 8% have two tiers, 4% have the same cost sharing regardless of the drug, and 4% 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, 2018-2021; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2017

Figure 9.2
Distribution of Covered Workers Facing Different Cost-Sharing Formulas for Prescription Drug Benefits, by Plan Type and Plan Size, 2021

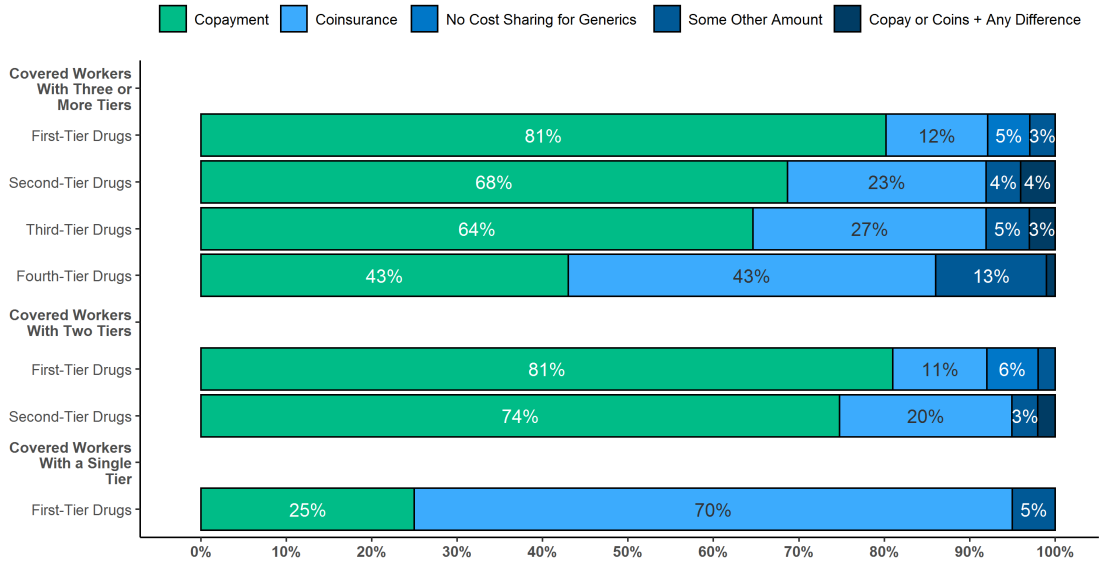


Tests found no statistical difference between HDHP/SO Plan and Non-HDHP/SO distributions or between Large and Small Firms ($p < .05$).
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers. Number of tiers include any tiers specifically for specialty drugs. Excluding tiers specifically for specialty drugs, 23% of covered workers with prescription drug coverage are enrolled in a plan with four or more tiers, 60% have three tiers, 8% have two tiers, 4% have the same cost sharing regardless of the drug, and 4% 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, 2021

TIERS NOT EXCLUSIVELY FOR SPECIALTY DRUGS

- Even when formulary tiers covering only specialty drugs are not counted, a large share (83%) 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 three 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 $12 for first-tier drugs, $36 second-tier drugs, $66 for third-tier drugs, and $124 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 20% for first-tier drugs, 25% second-tier drugs, 35% third-tier drugs, and 32% for fourth-tier drugs [Figure 9.6].
- Eight 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 $11 and the average copayment for the second tier is $32 [Figure 9.6].
- Four 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, 25% have copayments and 70% have coinsurance [Figure 9.3]. The average coinsurance rate is 25% [Figure 9.6].

Figure 9.3
Among Covered Workers with Prescription Drug Coverage, Distribution with the Following Types of Cost Sharing for Prescription Drugs, 2021



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, 2021

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, 2021

	Copayment	Coinsurance	No Cost Sharing for Generics	Some Other Amount
First-Tier Drugs, Often Called Generics				
All Small Firms	85%	4%*	8%	3%
All Large Firms	79	14*	4	2
ALL FIRMS	**81%**	**12%**	**5%**	**3%**
Second-Tier Drugs, Often Called Preferred Drugs			**Copayment or Coinsurance Plus Any Difference**	
All Small Firms	87%*	9%*	1%*	4%
All Large Firms	62*	28*	6*	4
ALL FIRMS	**68%**	**23%**	**4%**	**4%**
Third-Tier Drugs, Often Called Non-Preferred Drugs				
All Small Firms	82%*	12%*	<1%*	6%
All Large Firms	58*	33*	5*	5
ALL FIRMS	**64%**	**27%**	**3%**	**5%**
Fourth-Tier Drugs				
All Small Firms	52%	36%	0%	12%
All Large Firms	37	48	1	14
ALL FIRMS	**43%**	**43%**	**<1%**	**13%**

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, 2021

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, 2021

	Copayment	Coinsurance	No Cost Sharing for Generics	Some Other Amount
First-Tier Drugs, Often Called Generics				
HDHP/SO Plans	62%*	29%*	8%	1%
Non-HDHP/SO Plans	86*	7*	4	3
ALL PLANS	**81%**	**12%**	**5%**	**3%**
Second-Tier Drugs, Often Called Preferred Drugs			**Copayment or Coinsurance Plus Any Difference**	
HDHP/SO Plans	47%*	36%*	9%	8%
Non-HDHP/SO Plans	75*	20*	3	3
ALL PLANS	**68%**	**23%**	**4%**	**4%**
Third-Tier Drugs, Often Called Non-Preferred Drugs				
HDHP/SO Plans	45%*	42%*	8%	5%
Non-HDHP/SO Plans	70*	23*	2	5
ALL PLANS	**64%**	**27%**	**3%**	**5%**
Fourth-Tier Drugs				
HDHP/SO Plans	36%	48%	1%	15%
Non-HDHP/SO Plans	45	42	<1	13
ALL PLANS	**43%**	**43%**	**<1%**	**13%**

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, 2021

Figure 9.6

Among Covered Workers With Prescription Drug Coverage, Average Copayments and Coinsurance, 2021

	Average Copayment	Average Coinsurance
Plans With Three or More Tiers		
First Tier	$12	20%
Second Tier	$36	25%
Third Tier	$66	35%
Fourth Tier	$124	32%
Plans With Two Tiers		
First Tier	$11	NSD
Second Tier	$32	27%
Plans With the Same Cost Sharing For All Covered Drugs		
First Tier	NSD	25%

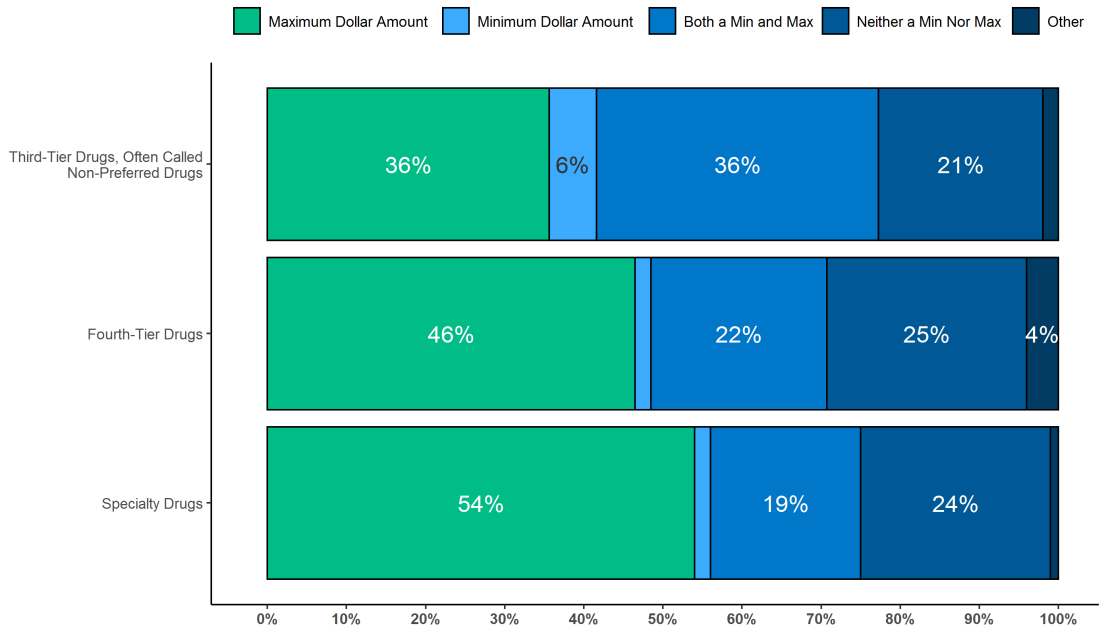
NOTE: Number of tiers refers to the number of tiers excluding those specifically for specialty drugs.
NSD: Not Sufficient Data

SOURCE: KFF Employer Health Benefits Survey, 2021

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 third cost-sharing tier, 36% have only a maximum dollar amount attached to the coinsurance rate, 6% have only a minimum dollar amount, 36% have both a minimum and maximum dollar amount, and 21% have neither. For those in a plan with coinsurance for the fourth cost-sharing tier, 46% have only a maximum dollar amount attached to the coinsurance rate, 2% have only a minimum dollar amount, 22% have both a minimum and maximum dollar amount, and 25% have neither [Figure 9.7].

Figure 9.7
Distribution of Coinsurance Structures for Covered Workers Facing a Coinsurance for Prescription Drugs, 2021



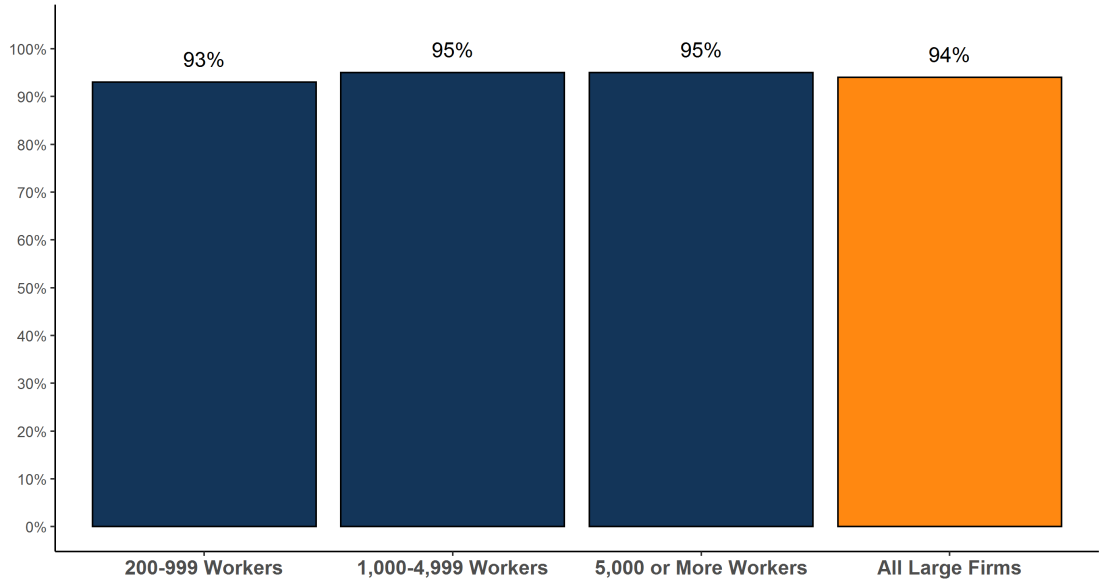
SOURCE: KFF Employer Health Benefits Survey, 2021

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.

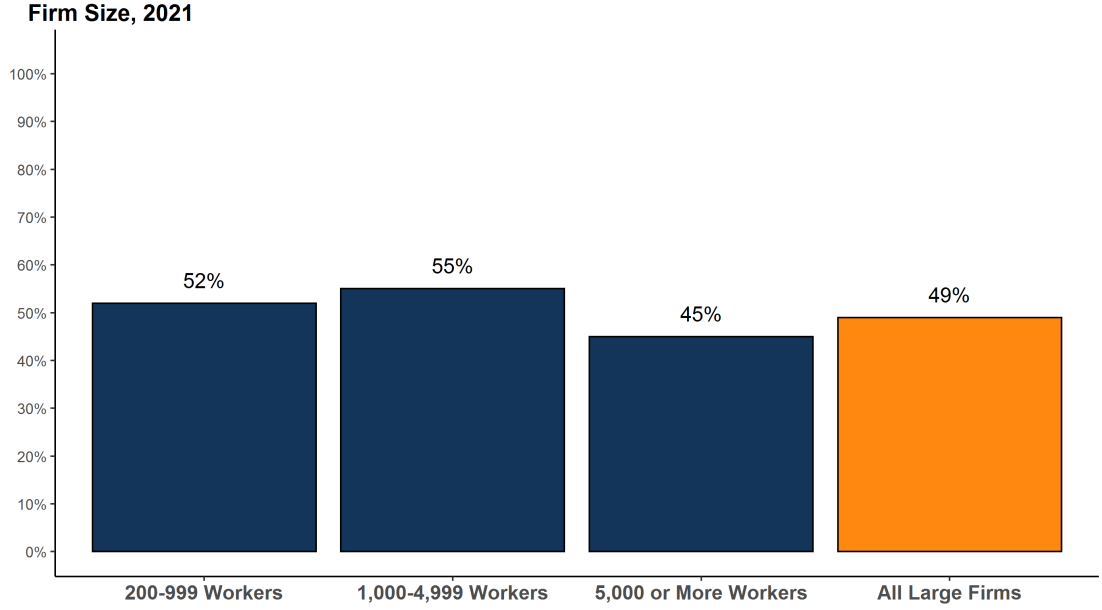
- Ninety-four percent of covered workers at large firms have coverage for specialty drugs [Figure 9.8]. Among these workers, 49% are in a plan with at least one cost-sharing tier just for specialty drugs [Figure 9.9].
- Among covered workers at large firms in a plan with at least one separate tier for specialty drugs, 44% have a copayment for specialty drugs and 42% have coinsurance [Figure 9.10]. The average copayment is $101 and the average coinsurance rate is 27% [Figure 9.11]. Seventy-four 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, 2021



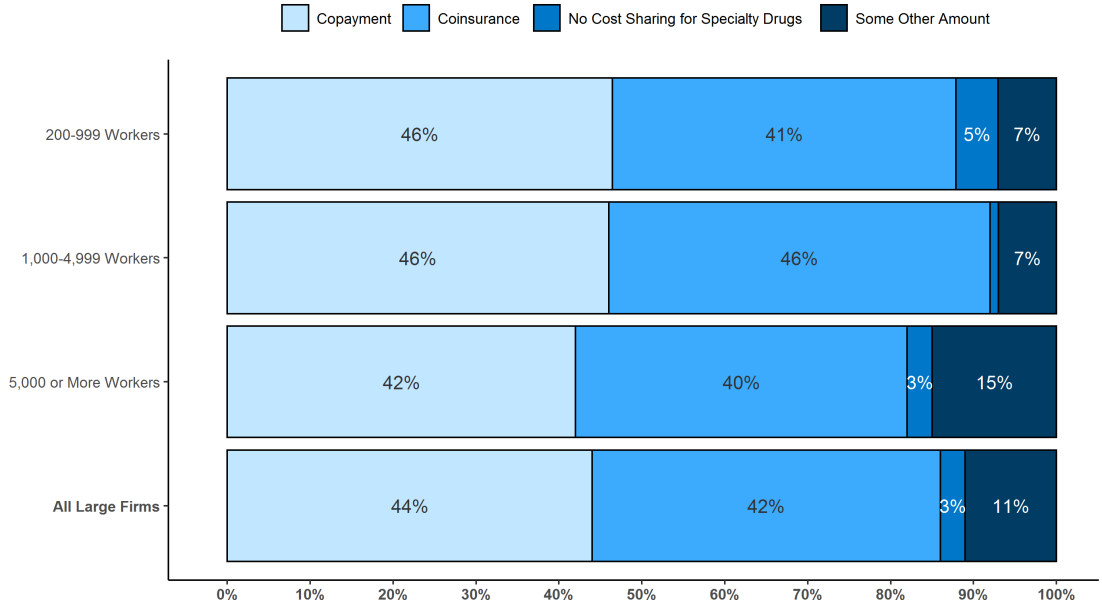
Tests found no statistical difference from estimate for all other firms not in the indicated size category ($p < .05$).
NOTE: Large Firms have 200 or more workers. Ninety-eight percent of firms offering health benefits offer prescription drug coverage.
SOURCE: KFF Employer Health Benefits Survey, 2021

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, 2021



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, 2021

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, 2021



Tests found no statistical difference 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, 2021

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, 2017 & 2021

	2017		2021	
	Average Copayment ($)	Average Coinsurance (%)	Average Copayment ($)	Average Coinsurance (%)
FIRM SIZE				
200-999 Workers	$90	24%	$100	27%
1,000-4,999 Workers	89	27	95	28
5,000 or More Workers	111*	28	104	26
All Large Firms (200 or More Workers)	**$101**	**27%**	**$101**	**27%**

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

SOURCE: KFF Employer Health Benefits Survey, 2021; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2017

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.

Plan Funding

SECTION 10

Section 10

Plan Funding

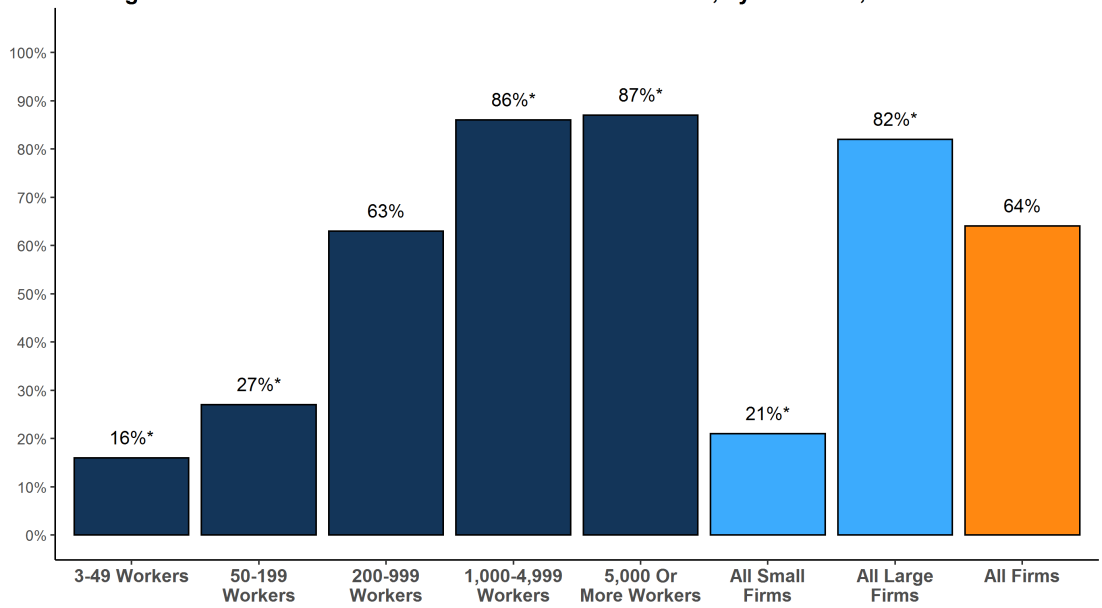
Many firms, particularly larger firms, choose to pay for some or all of the health services of their workers directly from their own funds rather than by purchasing health insurance for them. This is called self-funding. Both public and private employers use self-funding to provide health benefits. Federal 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-four percent of covered workers are in a self-funded health plan in 2021. 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. Thirty-eight percent of covered workers in small firms (3-199 workers) are in a level-funded plan.

SELF-FUNDED PLANS

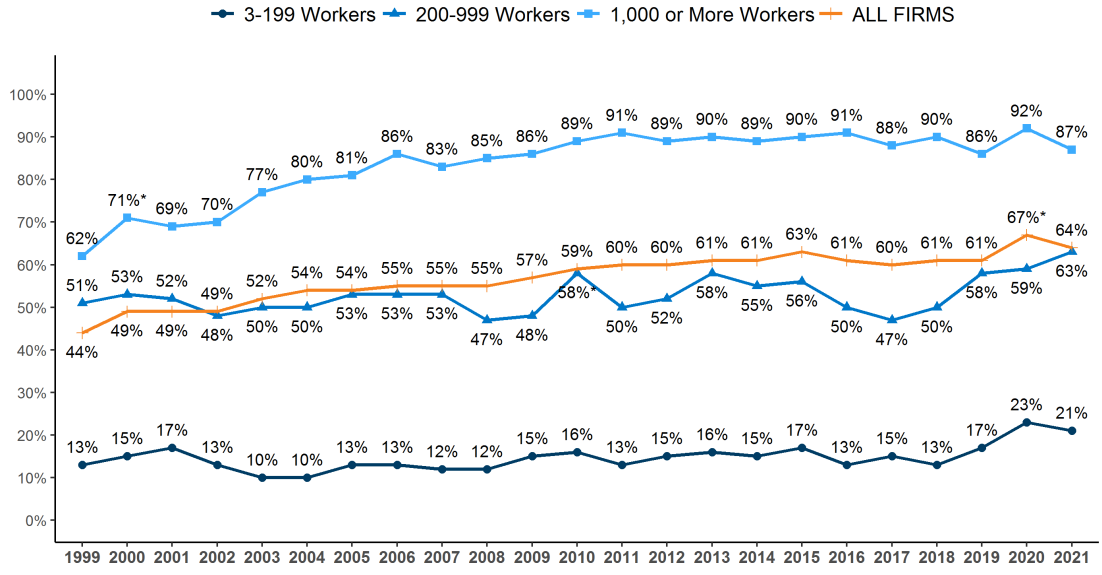
- Sixty-four percent of covered workers are in a plan that is self-funded, similar to the percentage (67%) last year [Figure 10.1] and [Figure 10.2].
  - The percentage of covered workers enrolled in self-funded plans is similar to the percentages five years ago (61%) and ten years ago (60%) [Figure 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 (82% vs. 21%) [Figure 10.1] and [Figure 10.3].

Figure 10.1
Percentage of Covered Workers Enrolled in a Self-Funded Plan, by Firm Size, 2021



* 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 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, 2021

Figure 10.2
Percentage of Covered Workers Enrolled in a Self-Funded Plan, by Firm Size, 1999-2021



* 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, 64% of covered workers are in a self-funded plan in 2021. 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 end of Section 10 for definitions of self-funded, fully-insured, and level-funded premium plans.
SOURCE: KFF Employer Health Benefits Survey, 2018-2021; 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, 2021

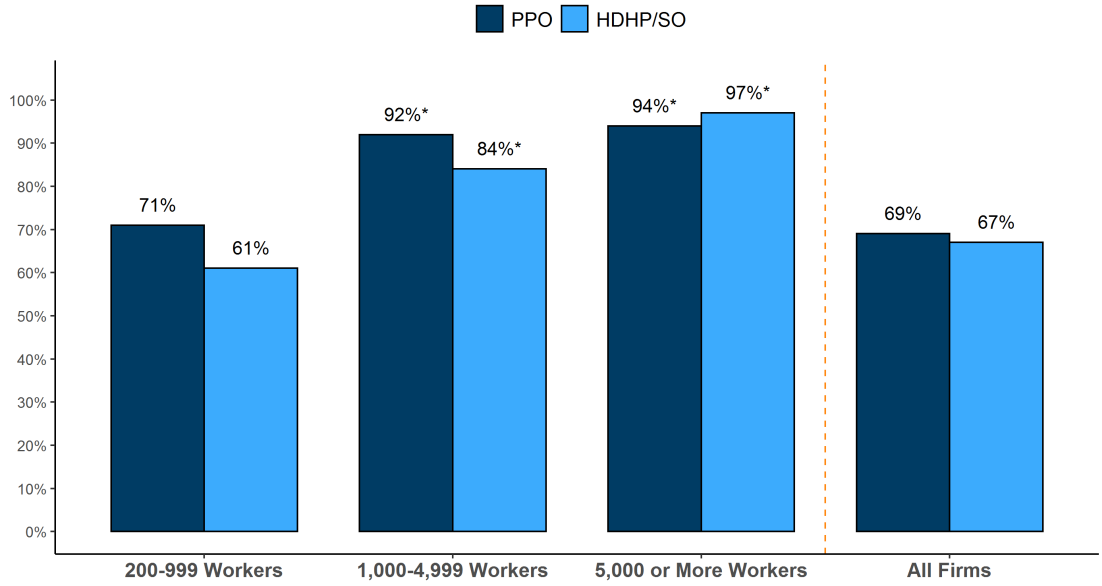
	Covered Workers in a Self-Funded Plan
FIRM SIZE	
200-999 Workers	63%
1,000-4,999 Workers	86*
5,000 or More Workers	87*
All Small Firms (3-199 Workers)	**21%***
All Large Firms (200 or More Workers)	**82%***
REGION	
Northeast	70%
Midwest	70
South	65
West	49*
INDUSTRY	
Agriculture/Mining/Construction	47%*
Manufacturing	59
Transportation/Communications/Utilities	75
Wholesale	67
Retail	82*
Finance	71
Service	49*
State/Local Government	74
Health Care	80*
ALL FIRMS	**64%**

NOTE: Includes covered workers enrolled in self-funded plans in which the firm's liability is limited through stoploss coverage. See 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 ($p < .05$).

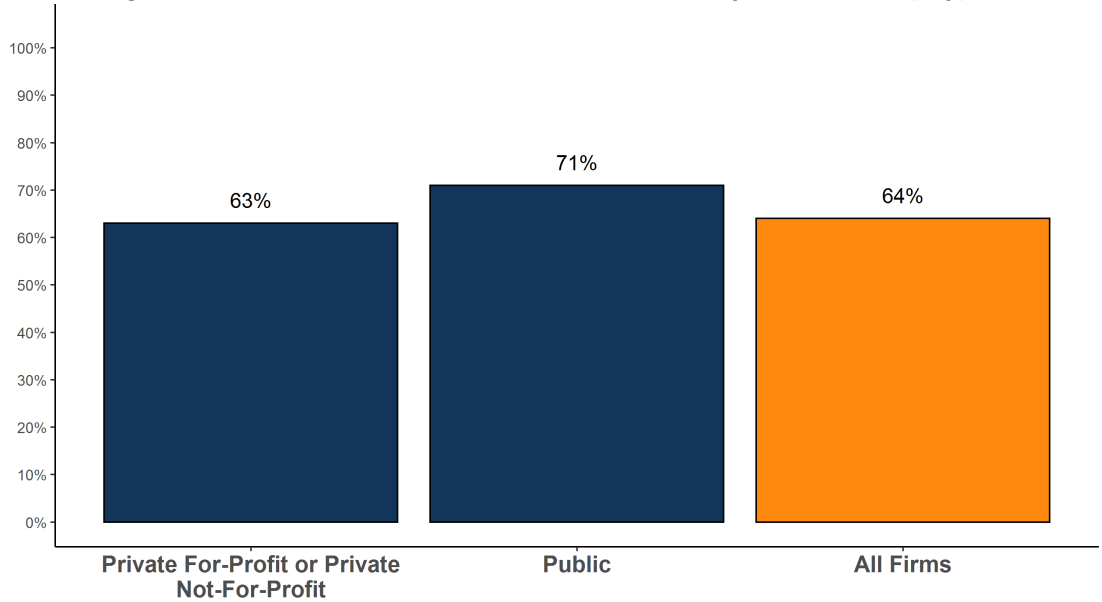
SOURCE: KFF Employer Health Benefits Survey, 2021

Figure 10.4
Percentage of Covered Workers Enrolled in a Self-Funded Plan, by Plan Type and Firm Size, 2021



* 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 end of Section 10 for definitions of self-funded, fully-insured, and level-funded premium plans.
SOURCE: KFF Employer Health Benefits Survey, 2021

Figure 10.5
Percentage of Covered Workers Enrolled in a Self-Funded Plan by Firm Ownership Type, 2021



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-four percent of covered workers in private for-profits and 60% of workers enrolled at private not-for-profits are self-funded
SOURCE: KFF Employer Health Benefits Survey, 2021

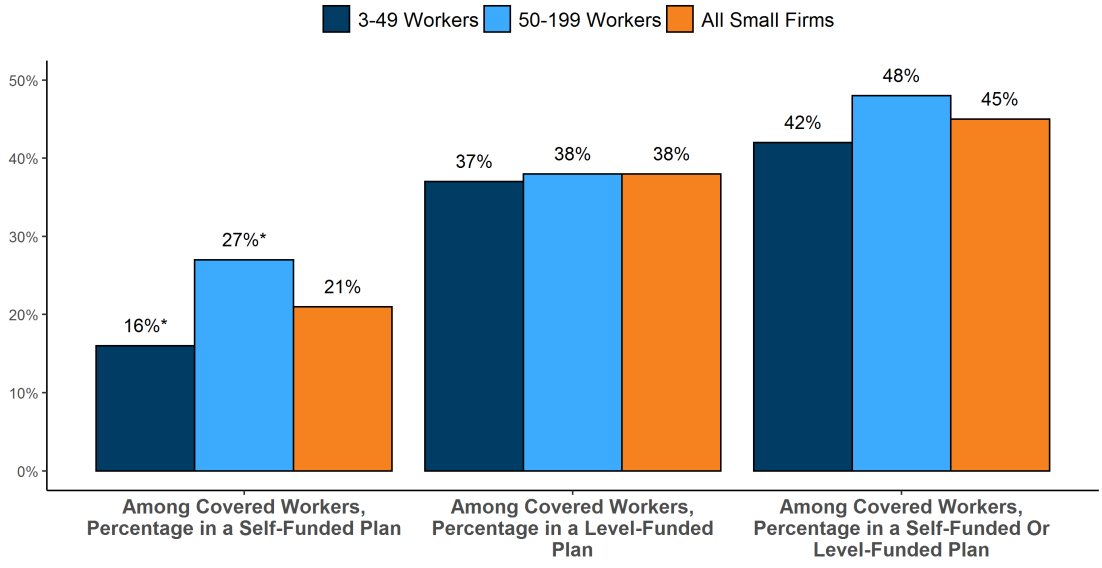
LEVEL-FUNDED PLANS

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.

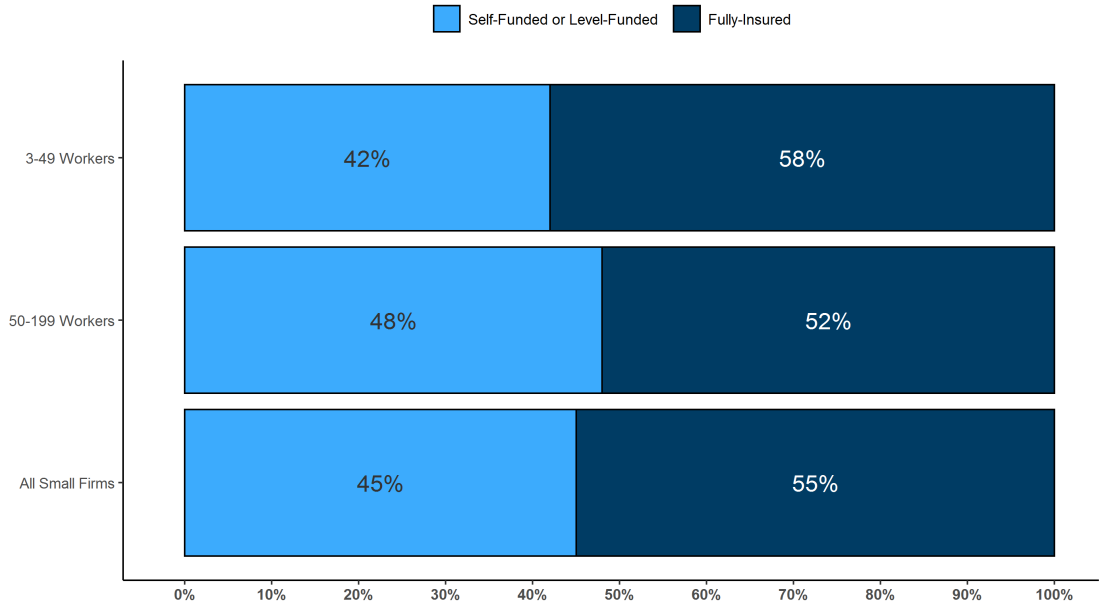
- Forty-two percent of small firms offering health benefits offer a level-funded plan in 2021, much higher than the percentage (13%) last year. The substantial increase for 2021 suggests that that there may be a significant shift in the small group market toward health-status-based rating, so it will be important to monitor this trend to see if continues over the next several years.

Figure 10.6
Among Covered Workers at Small Firms, Percentage Enrolled in a Level-Funded or Self-Funded Plan, by Firm Size, 2021



* Estimates are statistically different from estimate for all other firms not in the indicated category within each firm size ($p < .05$).
NOTE: See 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 2021, 42% 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, 2021

Figure 10.7
Among Covered Workers at Small Firms, Percentage Enrolled in a Level-Funded or Self-Insured Plan, by Firm Size, 2021



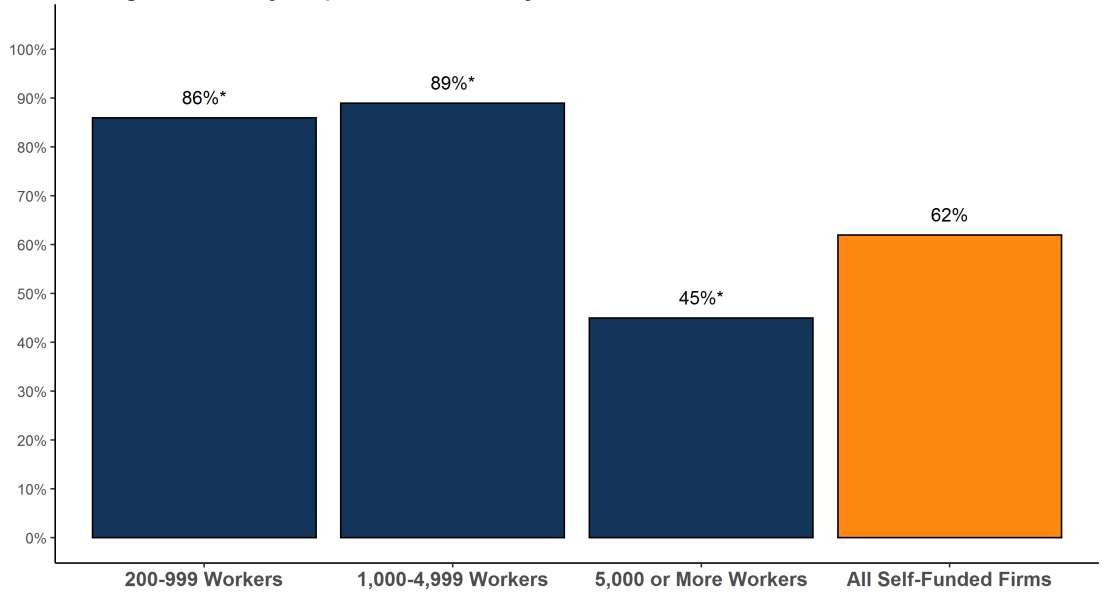
Tests found no statistical difference from estimate for all other firms not in the indicated size category ($p < .05$).
NOTE: See end of Section 10 for definitions of self-funded, fully-insured, and level-funded premium plans.
SOURCE: KFF Employer Health Benefits Survey, 2021

STOPLOSS COVERAGE

Employers purchase insurance, often referred to as "stoploss" coverage, to limit the amount that they may have to pay for claims in a self-funded plan. There are different types of stoploss; for example a stoploss policy may cover any amount that the plan sponsor must pay over a specified amount for each worker or enrollee (referred to as specific stoploss coverage) or it may limit the total amount the plan sponsor must pay for all claims in the plan over the plan year (referred to as aggregate stoploss coverage). Stoploss coverage also could be focused on particular types of claims. A firm may have more than one type of stoploss coverage.

- At large firms (200 or more workers), 62% of covered workers in self-funded health plans are in plans that have stoploss insurance, similar to percentages last year (61%) and in 2018 (59%) [Figure 10.8].
  - The percentage of covered workers in large firms in self-funded plans with stoploss insurance (62%) is similar to the value when the survey first asked about stoploss insurance in 2011 (57%).

Figure 10.8
Among Covered Workers Enrolled in a Self-Funded Plan (At Firms with 200 or More Workers), Percentage Covered by Stoploss Insurance, by Firm Size, 2021



* 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 end of Section 10 for definitions of self-funded, fully-insured, and level-funded premium plans.
SOURCE: KFF Employer Health Benefits Survey, 2021

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
2021 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.

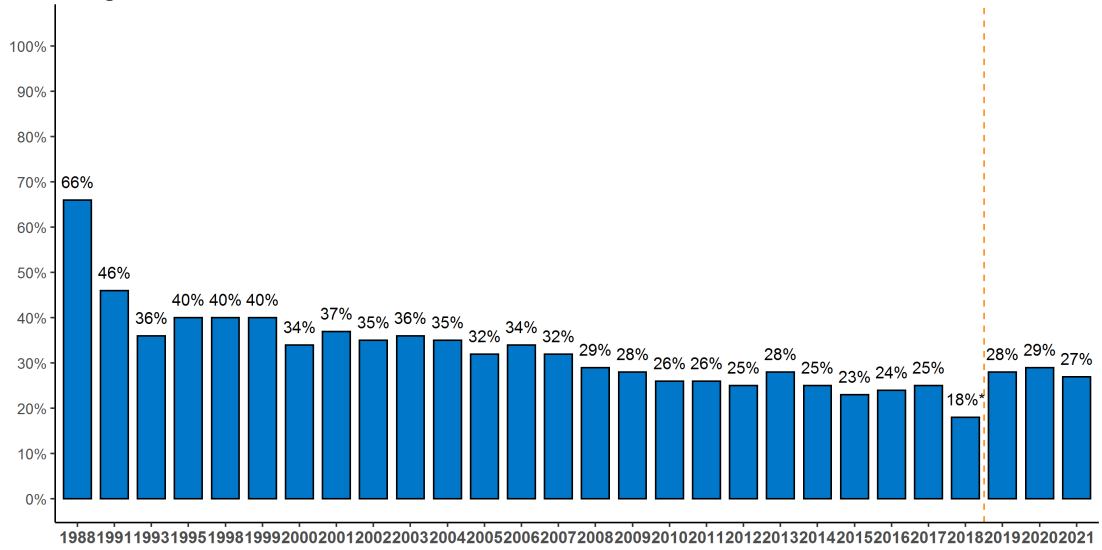
This year's survey finds that 27% of large firms offering health benefits offer retiree health benefits, similar to the percentage (29%) in 2020.

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

EMPLOYER RETIREE BENEFITS

- In 2021, 27% 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]. In 2019, we modified the question that we use to ask firms whether or not they provide retiree health benefits, to explicitly say "yes" if they still had some retirees getting coverage even if they terminated retiree health benefits (for current workers) or if they had current employees who will get retiree health coverage in the future. For this reason, estimates of retiree health benefits from 2019 and after are not comparable to prior survey estimates.
- 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 (56%) 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 (42% vs. 22%) [Figure 11.3].
- Large firms offering health benefits with a relatively large share of younger workers (where at least 35% of the workers are age 26 or younger) are less likely to offer retiree health benefits than large firms with a larger share of younger workers (12% vs. 29%) [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 (34% vs. 20%) [Figure 11.3].
- Large firms offering health benefits with a relatively large share of lower-wage workers (where at least 35% of workers earn $28,000 a year or less) are less likely to offer retiree health benefits than large firms with a smaller share of lower-wage workers (14% vs. 29%) [Figure 11.3].

Figure 11.1
Among Large Firms Offering Health Benefits to Active Workers, Percentage of Firms Offering Retiree Health Benefits, 1988-2021



* 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, 2018-2021; 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

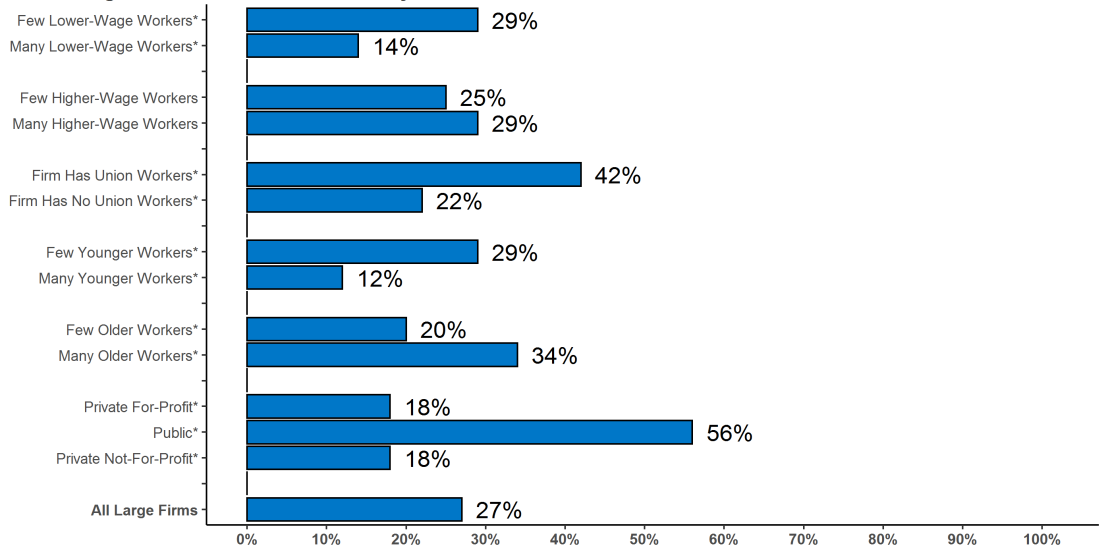
Among Large Firms Offering Health Benefits to Active Workers, Percentage of Firms Offering Retiree Health Benefits, by Firm Size, Region, and Industry, 2021

	Large Firms Offering Retiree Health Benefits
FIRM SIZE	
200-999 Workers	24%*
1,000-4,999 Workers	35*
5,000 or More Workers	49*
REGION	
Northeast	30%
Midwest	28
South	30
West	18*
INDUSTRY	
Agriculture/Mining/Construction	9%*
Manufacturing	13*
Transportation/Communications/Utilities	44*
Wholesale	14
Retail	15
Finance	40
Service	31
State/Local Government	69*
Health Care	12*
All Large Firms (200 or More Workers)	**27%**

* 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, 2021

Figure 11.3
Among Large Firms Offering Health Benefits to Active Workers, Percentage of Firms Offering Retiree Health Benefits, by Firm Characteristics, 2021

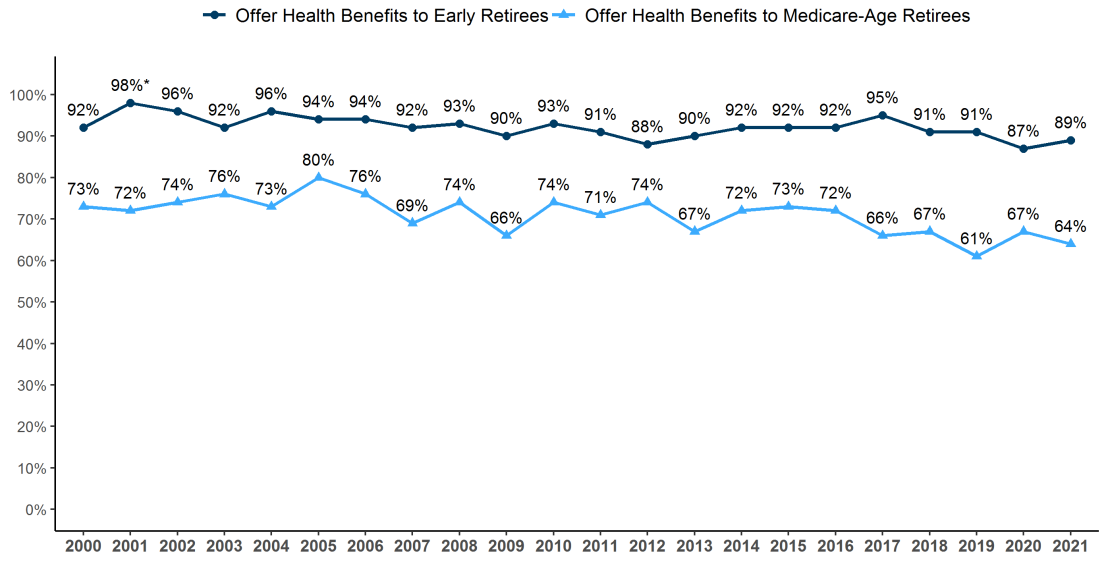


* Estimates are statistically different from each other within category ($p < .05$).
NOTE: Large Firms have 200 or more workers. Firms with many lower-wage workers are those where at least 35% earn the 25th percentile or less of national earnings ($28,000 in 2021). Firms with many higher-wage workers are those where at least 35% earn the 75th percentile or more than of national earnings ($66,000 in 2021). 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, 2021

COVERAGE FOR EARLY RETIREES AND MEDICARE-AGE RETIREES

- Among large firms offering retiree health benefits, 89% offer benefits to early retirees under the age of 65 and 64% offer them to Medicare-age retirees [Figure 11.4].
- Among all large firms offering health benefits to current workers, 17% offer retiree health benefits to Medicare-age retirees.
- Among large firms offering retiree health benefits, 57% offer benefits to both early and Medicare-age retirees.

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, 2000-2021

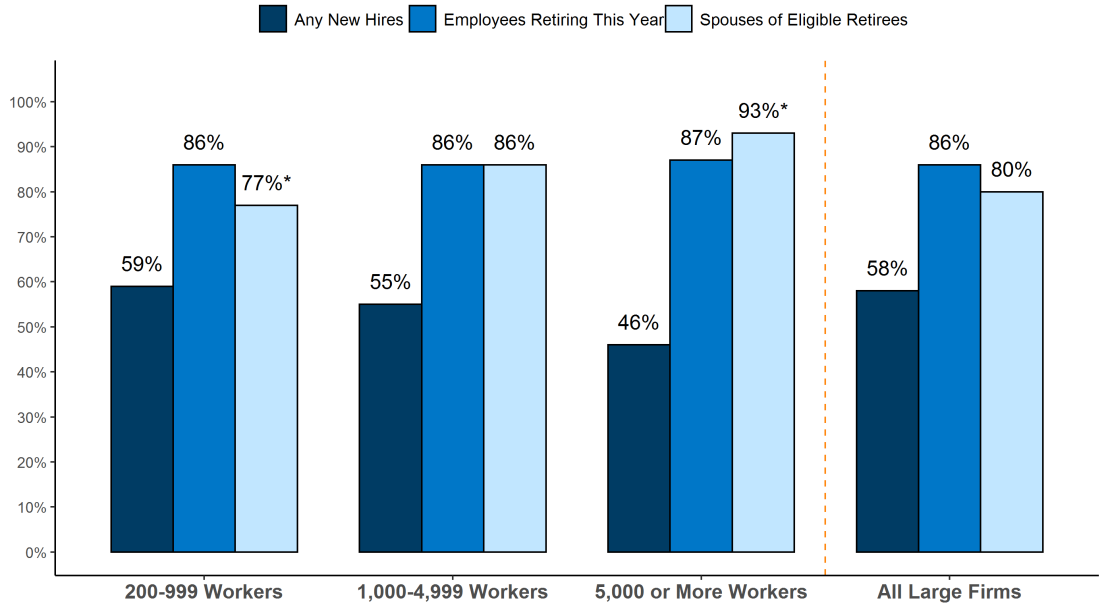


* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
NOTE: Among Large Firms offering health benefits to active workers and offering retiree coverage, 57% offer health benefits to both early and Medicare-age retirees. Large Firms have 200 or more workers. Early 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, 2018-2021; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2000-2017

BENEFIT ELIGIBILITY

- Among large firms offering retiree health benefits, 86% say that at least some current employees will be eligible for retiree health benefits after meeting any age and/or length of service requirements [Figure 11.5].
- Among large firms offering retiree health benefits, 58% say that new hires will be eligible for the firm's retiree health benefits after meeting any age and/or length of service requirements [Figure 11.5].
- Among large firms offering retiree benefits, a large share (80%) report offering health benefits to the spouses of retirees [Figure 11.5].

Figure 11.5
Among Large Firms Offering Health Benefits to Active Workers and Retirees, Percentage of Firms Offering Retiree Health Benefits to Various Groups of Workers, by Firm Size, 2021

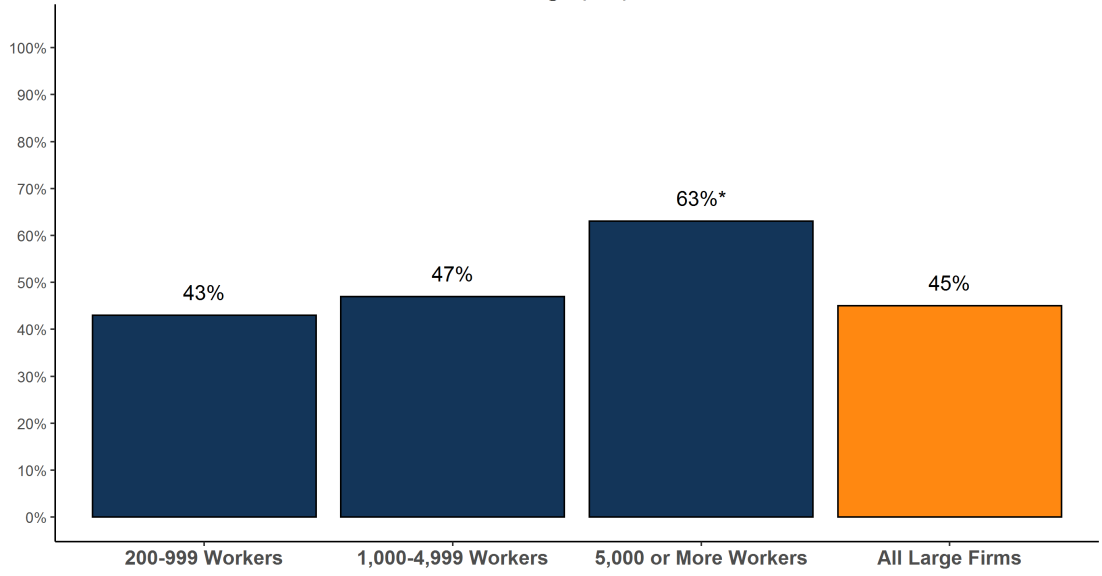


* Estimate is statistically different from estimate for all other firms not in the indicated size category ($p < .05$).
NOTE: Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2021

MEDICARE ADVANTAGE

- Forty-five 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, the same percentage as last year (45%) [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, 2021

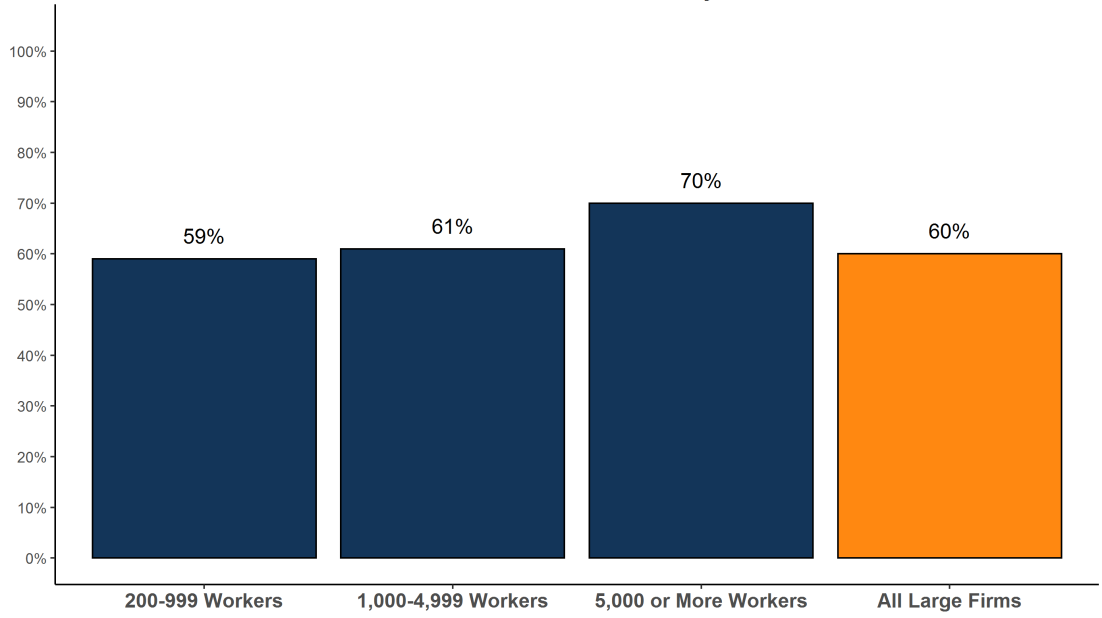


* Estimate is statistically different from estimate for all other firms not in the indicated size category ($p < .05$).
NOTE: MA refers to Medicare Advantage, an arrangement where private health plans receive capitated payments to provide all Medicare-covered services to enrollees. Sixty-four percent 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, 2021

PREMIUM CONTRIBUTIONS

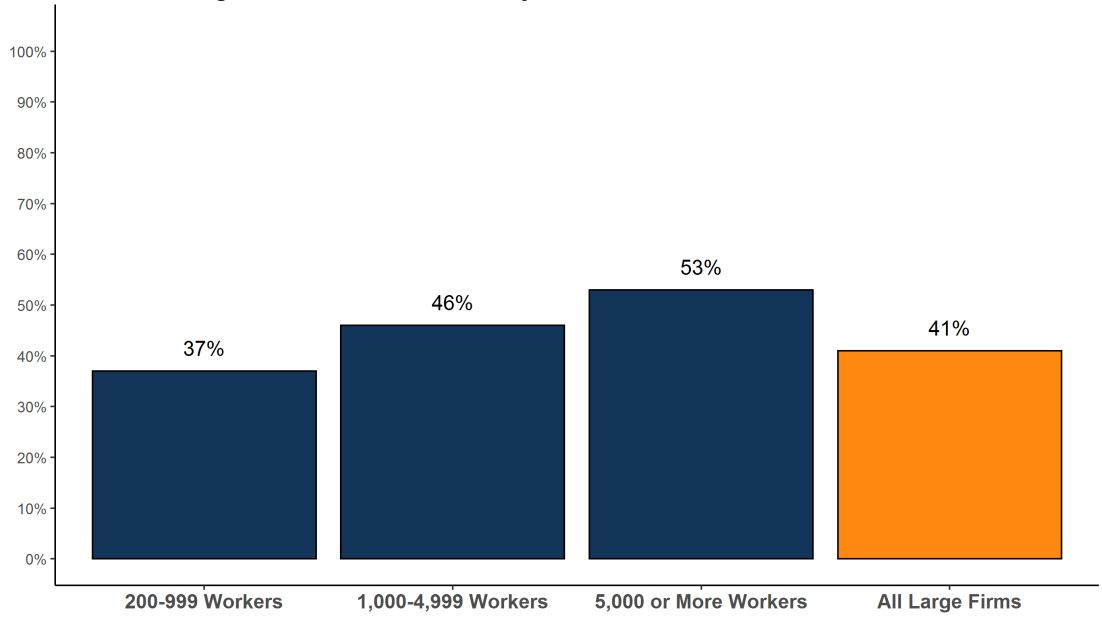
- Sixty percent of large firms offering retiree health benefits make a contribution toward the cost of benefits for at least some of their retirees [Figure 11.7].
  - A defined contribution is a set dollar amount that the retiree can use to purchase a health plan they choose. Among large firms that make a contribution toward the cost of retiree benefits, 41% report that they make a defined contribution for retiree health benefits [Figure 11.8].

Figure 11.7
Among Large Firms Offering Health Benefits to Active Workers and Retirees, Percentage of Firms That Contribute to the Cost of Retiree Health Benefits, by Firm Size, 2021



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, 2021

Figure 11.8
Among Large Firms That Contribute to Retiree Health Benefits, Percentage of Firms That Contribute Through a Defined Contribution, by Firm Size, 2021



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, 2021

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Health Screening, 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 families can improve morale and productivity, as well as reduce health care costs. Only firms offering health benefits were asked about their wellness and health promotion programs.

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 and to understand employee health risks. Some firms have incentive programs that reward or penalize workers for different activities, including participating in wellness programs or completing health screenings.

The COVID-19 pandemic placed stress on employer health promotion and wellness activities. Many employees worked remotely for large stretches of 2020, and many avoided public places, including medical offices and gyms. For these employees, achieving wellness goals or targets was a struggle, and some employers responded by modifying their health screening, health promotion and wellness programs in recognition of these challenges. This calendar year began with large shares of workers still working remotely and many people continuing to avoid unnecessary public contacts. Due to these uncertain circumstances, we modified our questions for 2021 about health screening and wellness to focus on changes that employers and payers made to accommodate the challenges workers had and may still have in achieving and maintaining good health.

Among firms with 50 or more employees offering a biometric screening opportunity both this year and last year, 32% of small firms (50-199 employees) and 43% of larger firms report making some change in their biometric screening programs since the start of the COVID-19 pandemic.

Among firms with 50 or more employees offering a health promotion or wellness program this year, 50% of smaller firms (50-199 employees) and 68% of larger firms reported making some change to their health promotion programs since the start of the COVID-19 pandemic.

BIOMETRIC SCREENING

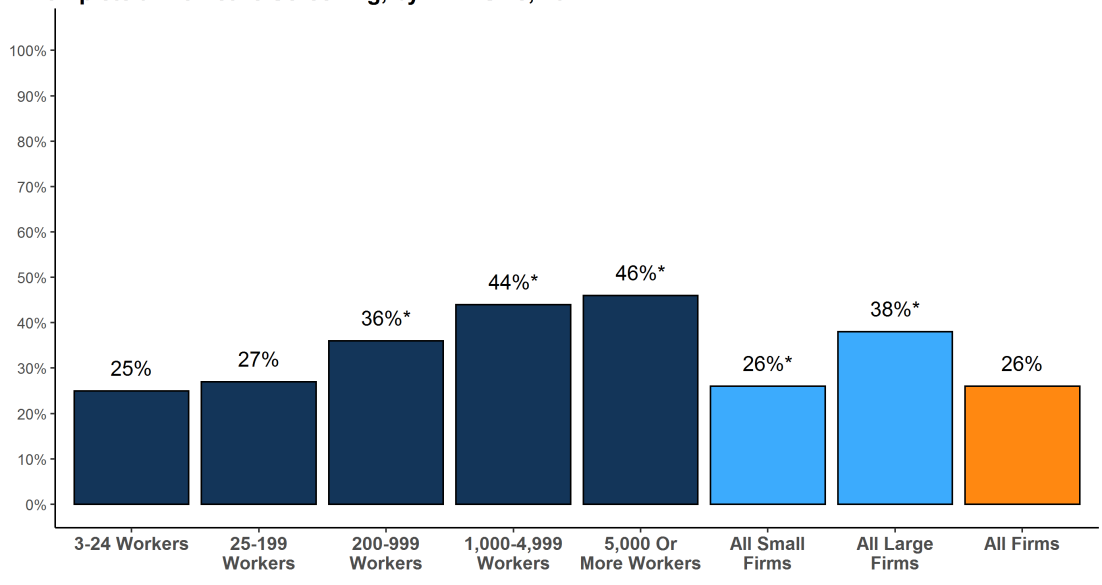
Biometric screening is a health examination that measures a person's risk factors (such as cholesterol, blood pressure, and body mass index (BMI)) for certain medical issues. A biometric outcome involves assessing whether the person meets specified health targets related to certain risk factors, such 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, 26% of small firms and 38% of large firms provide workers the opportunity to complete a biometric screening [Figure 12.1]. The percentage of large firms providing workers the opportunity to complete a biometric screening is lower than the percentage last year (50%) [Figure 12.2]. In fact, 45% of large firms offering health benefits in 2021, including 16% of large firms not

offering a biometric screening opportunity this year, report offering a biometric screening opportunity in 2020.

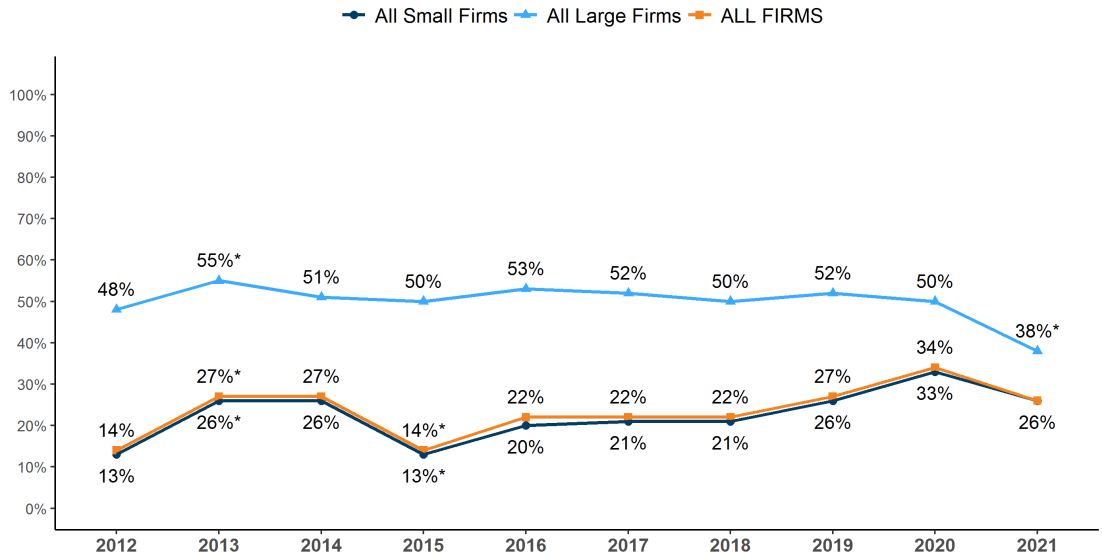
- Firms with at least 50 employees offering a biometric screening opportunity both this year and last year were asked about changes that they have made to their programs since the start of the COVID-19 pandemic. Overall, among firms offering a biometric screening opportunity both this year and last year, 32% of small firms (50-199 employees) and 43% of larger firms report making some change in their biometric screening programs since the start of the COVID-19 pandemic [Figure 12.3].
- Three percent of smaller firms and 5% of larger firms reduced or eliminated incentives for completing the screening.
- Thirteen percent of smaller firms and 23% of larger firms permitted screenings to be completed by a broader set of providers.
- Five percent of smaller firms and 15% of larger firms reduced the stringency of screening requirements.
- Nineteen percent of smaller firms and 18% of larger firms arranged for biometric screenings to be performed on a digital platform.
- Three percent of smaller firms and 5% of larger firms suspended or eliminated the program for some workers.

Figure 12.1
Among Firms Offering Health Benefits, Percentage of Firms That Provide an Opportunity to Complete a Biometric Screening, by Firm Size, 2021



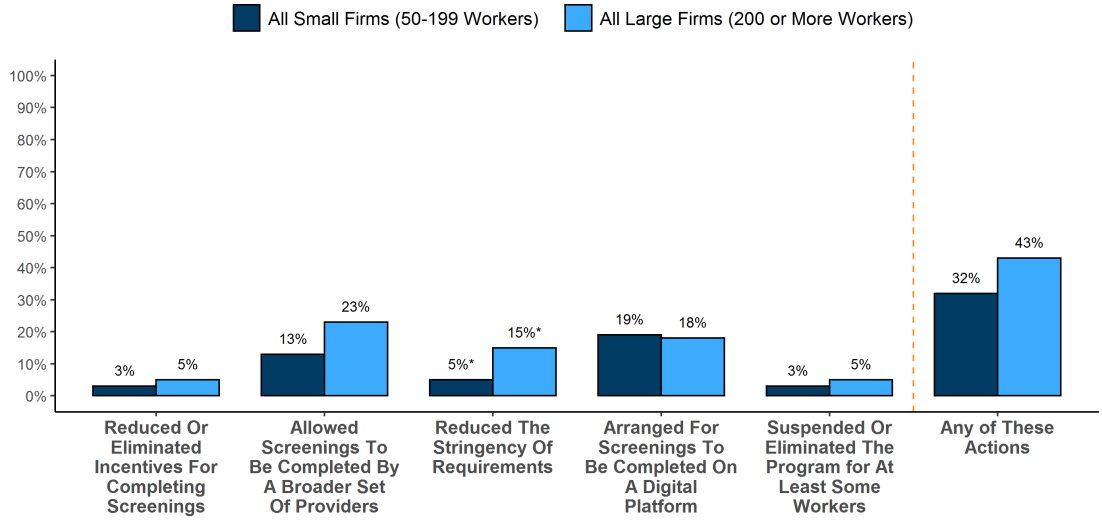
* Estimate is statistically different from estimate for all other firms not in the indicated size category ($p < .05$).
NOTE: Biometric screening is a health examination that measures a person's risk factors for certain medical issues. Biometric outcomes could include meeting a target body mass index (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, 2021

Figure 12.2
Among Firms Offering Health Benefits, Percentage of Firms That Provide an Opportunity to Complete Biometric Screening, by Firm Size, 2012-2021



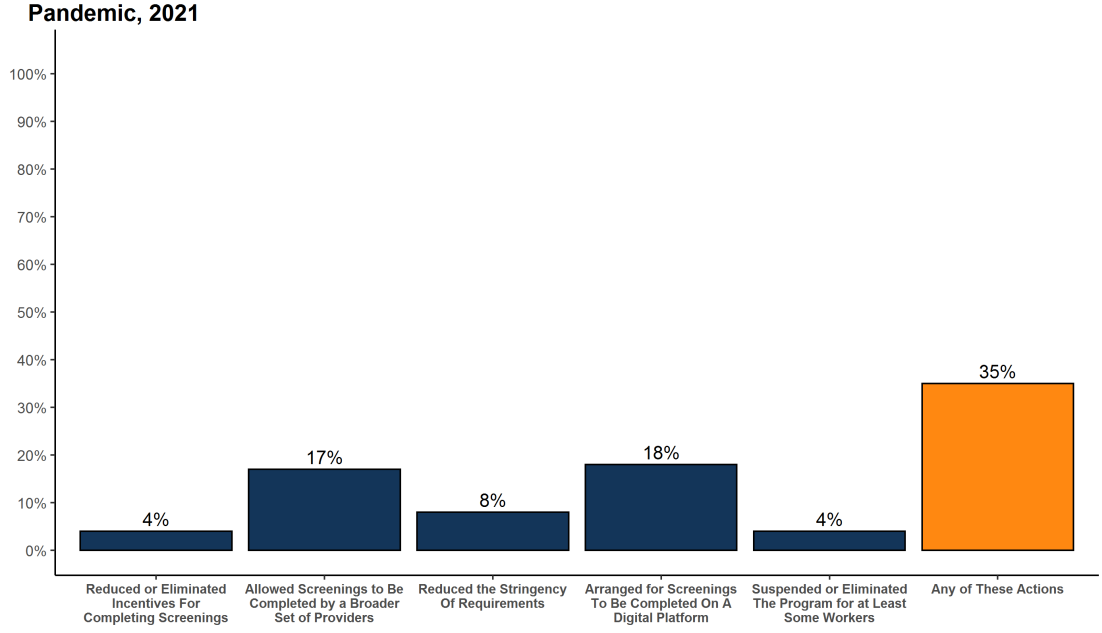
* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
NOTE: Biometric screening is a health examination that measures a person's risk factors for certain medical issues. Biometric outcomes could include meeting a target body mass index (BMI) or cholesterol level, 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, 2018-2021; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2012-2017

Figure 12.3
Among Firms Which Offered Biometric Screening This Year and Last Year, Changes Firm Made to Biometric Screening Programs Due to the COVID-19 Pandemic, by Firm Size, 2021



* Estimate is statistically different between All Small Firms and All Large Firms estimate ($p < .05$).
NOTE: 33% of firms with 50 or more workers offering health benefits reported that they offered employees the opportunity to complete a biometric screening program last year. 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. We asked respondents about changes they made due to the COVID-19 pandemic from January 2020 that were still in effect at the time of the interview. Small Firms have 50 to 199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2021

Figure 12.4
Among Firms with 50 or More Employees Which Offered Biometric Screening This Year and Last Year, Changes Firm Made to Biometric Screening Programs Due to the COVID-19 Pandemic, 2021



SOURCE: KFF Employer Health Benefits Survey, 2021

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. As with biometric and other screening programs, employers made changes for 2020 and 2021 in reaction to the COVID-19 pandemic.

- Among firms offering health benefits, 42% of small firms and 69% of large firms offer programs to help workers stop smoking or using tobacco, 44% of small firms and 63% of large firms offer programs to help workers lose weight, and 48% of small firms and 71% of large firms offer some other lifestyle or behavioral coaching program. Overall, 58% of small firms and 83% of large firms offering health benefits offer at least one of these three programs [Figure 12.6] and [Figure 12.7]. These percentages are similar to the percentages last year.

Figure 12.5

Among Firms Offering Health Benefits, Percentage of Firms Offering Specific Wellness Programs to Their Workers, by Firm Size and Region, 2021

	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	40%*	43%	47%*	57%*
50-199 Workers	58*	53	56	70
200-999 Workers	66*	59*	69*	80*
1,000-4,999 Workers	80*	76*	80*	92*
5,000 or More Workers	87*	77*	81*	94*
All Small Firms (3-199 Workers)	**42%***	**44%***	**48%***	**58%***
All Large Firms (200 or More Workers)	**69%***	**63%***	**71%***	**83%***
REGION				
Northeast	31%	36%	44%	52%
Midwest	38	48	47	61
South	39	39	44	49
West	59*	55	58	73*
ALL FIRMS	**43%**	**45%**	**49%**	**59%**

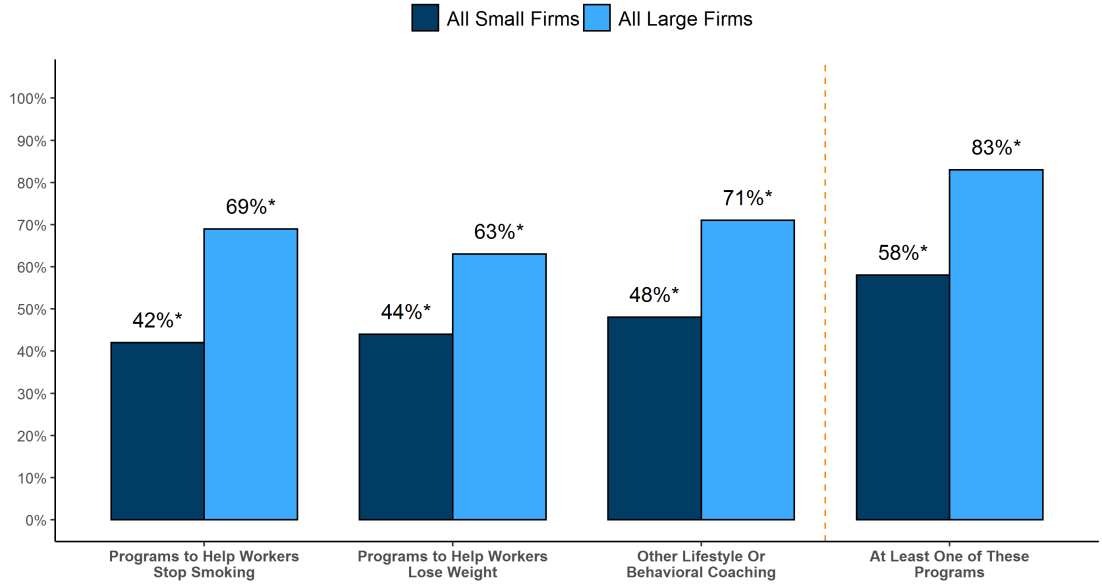
NOTE: 'Other Lifestyle or Behavioral Coaching' can include health education classes, stress management, or substance abuse counseling.

* 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, 2021

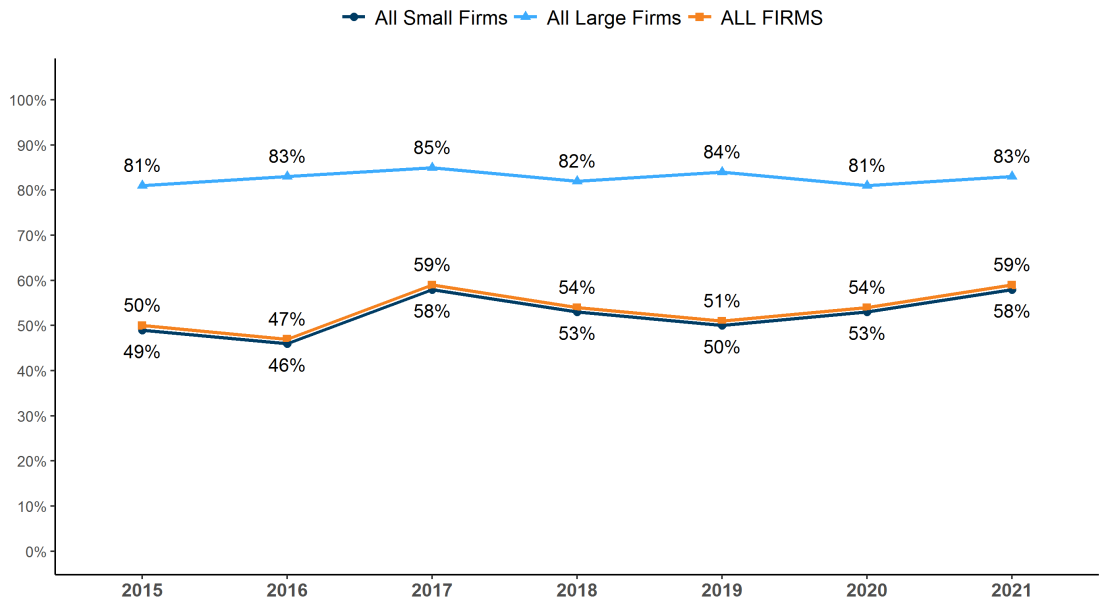
Figure 12.6

Among Firms Offering Health Benefits, Percentage of Firms Offering Specific Wellness Programs to Their Workers, by Firm Size, 2021



* 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, 2021

Figure 12.7
Among Firms Offering Health Benefits, Percentage of Firms Offering Wellness Programs, by Firm Size, 2015-2021

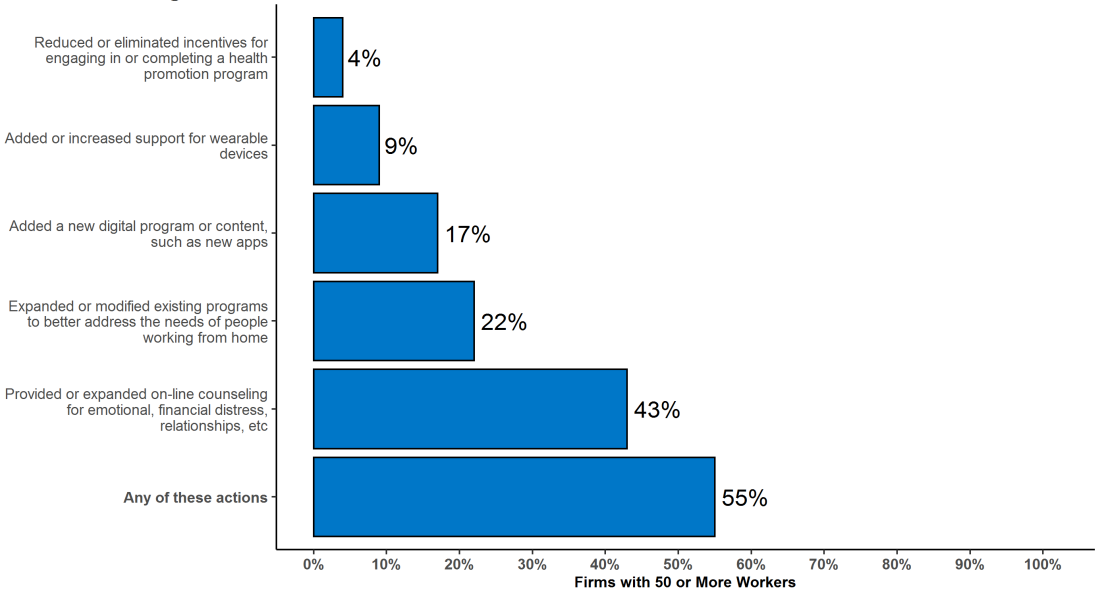


Tests found no statistical difference from estimate for the previous year shown ($p < .05$).
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2018-2021; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2015-2017

CHANGES TO WELLNESS AND HEALTH PROMOTION PROGRAMS

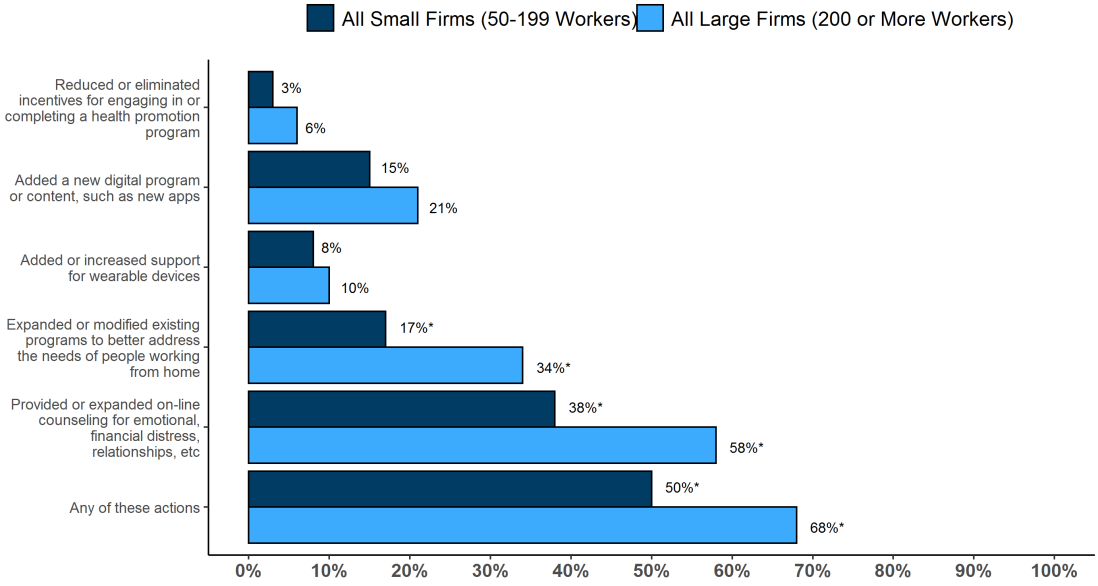
- Firms with 50 or more employees with a wellness or health promotion program were asked if they made changes to their programs since the beginning of the COVID-19 pandemic. Overall, 50% of smaller firms (50-199 employees) and 68% of larger firms reported some type of change.
- Three percent of smaller firms and 6% of larger firms reduced or eliminated incentives associated with their program [Figure 12.9].
- Fifteen percent of smaller firms and 21% of larger firms added a new digital program or digital content to their program.
- Eight percent of smaller firms and 10% of larger firms increased support for wearable devices.
- Seventeen percent of smaller firms and 34% of larger firms expanded or modified the content of their existing programs to better address the health needs of people working from home.
- Thirty-eight percent of smaller firms and 58% of larger firms provided or expanded on-line counseling services for emotional or financial distress, relationship issues, or other stressful situations.

Figure 12.8
Among Firms Offering a Specified Wellness Program, Percentage of Firms Which Changed Wellness Programs Due to the COVID-19 Pandemic, 2021



NOTE: We asked respondents about changes they made due to the COVID-19 pandemic from January 2020 that were still in effect at the time of the interview.
SOURCE: KFF Employer Health Benefits Survey, 2021

Figure 12.9
Among Firms Offering a Specified Wellness Program, Percentage of Firms Which Changed Wellness Programs Due to the COVID-19 Pandemic, by Firm Size, 2021



* Estimate is statistically different between All Small Firms and All Large Firms estimate ($p < .05$).
NOTE: Small Firms have 50 to 199 workers and Large Firms have 200 or more workers. We asked respondents about changes they made due to the COVID-19 pandemic from January 2020 that were still in effect at the time of the interview.
SOURCE: KFF Employer Health Benefits Survey, 2021

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Employer Practices, Telehealth and Employer Responses to the Pandemic

SECTION

13

Section 13

Employer Practices, Telehealth and Employer Responses to the Pandemic

Employers frequently review and modify their health plans to incorporate new options or adapt to new circumstances. We continue to monitor new options, such as telemedicine, and ask about changes in the health or policy environments.

This year employers continue to deal with the coronavirus pandemic, with the accompanying economic and social disruptions and the uncertainty about when "normality" may return. For many employers, this means that some or even all of their employees began the year working remotely, with no clear guidance about when that may change. The approval and rapid dissemination of vaccines for coronavirus provide hope that the worst parts of the pandemic may be in the past, although low levels of vaccinations in some parts of the country (and throughout much of the world) and the emergence of new and more dangerous variants are reasons to remain cautious about new outbreaks.

We modified the 2021 survey to gather information about changes that employers may have made to their health benefits in response to COVID-19. Two issues, in particular, that received attention over the last year are telemedicine and mental health. Telemedicine proved to be an important source of access to care, particularly during the early months of the pandemic as people sheltered at home and avoided public places, including physician offices and health facilities. The compound stresses from social isolation and economic and health uncertainties challenged many families, focusing attention on the adequacy of mental health supports.

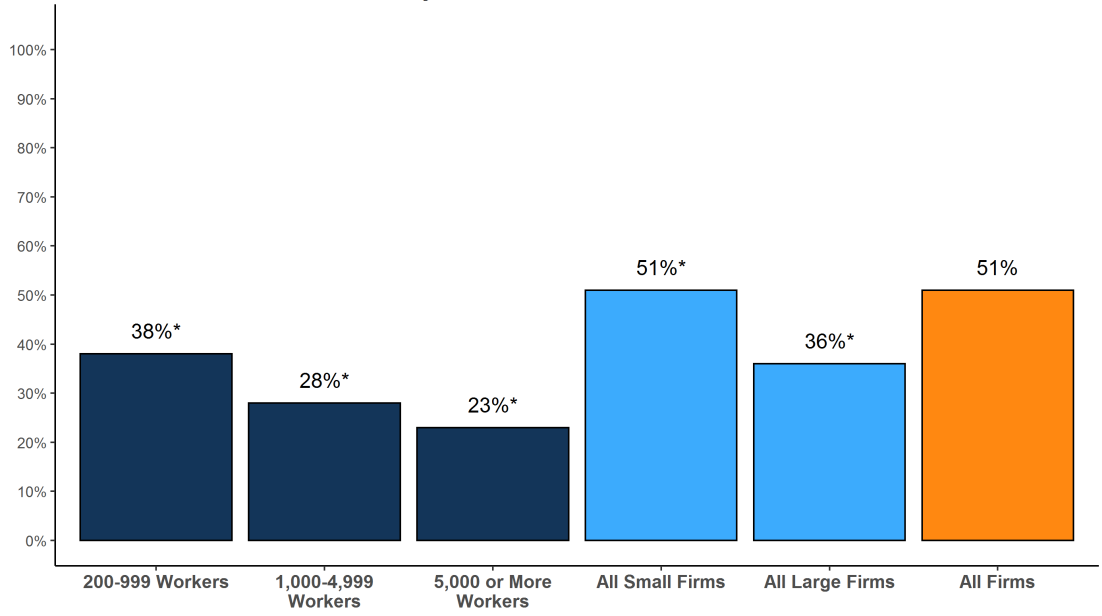
The share of employers covering health services through telemedicine continued to grow in 2021. In addition, many employers made changes in their telemedicine benefits after the COVID-19 pandemic began to broaden coverage or make the benefit easier to use. Many employers also made changes in their mental health coverage to make it easier for employees to access services.

SHOPPING FOR HEALTH COVERAGE

Fifty-one 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. The likelihood that a firm reported shopping for a new health plans or carrier decreased with firm size. [Figure 13.1].

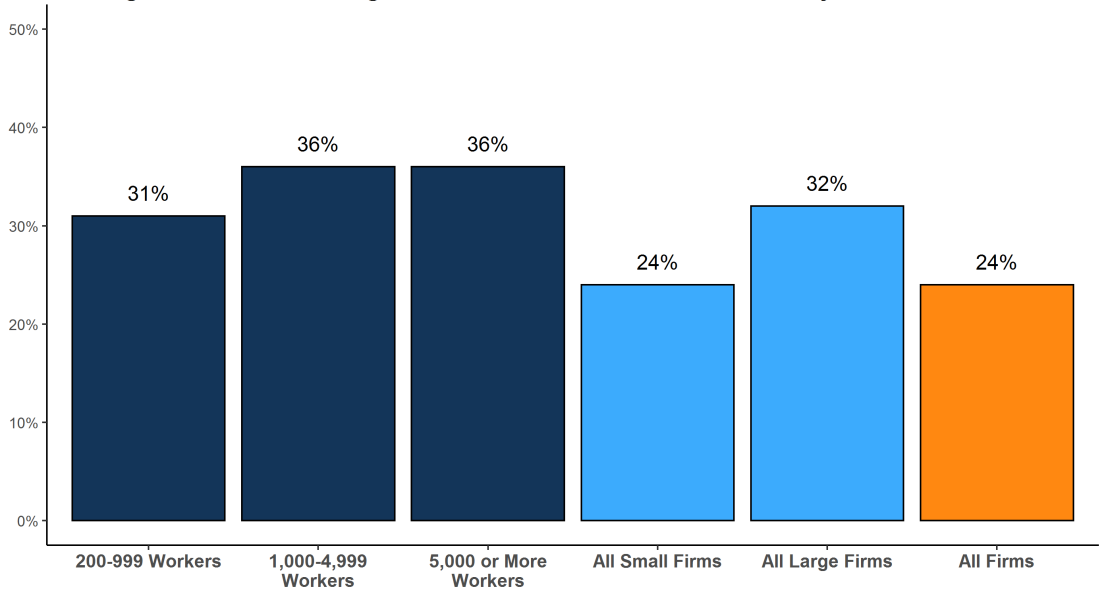
- Among firms that offer health benefits and who shopped for a new plan or carrier in the past year, 24% changed insurance carriers [Figure 13.2].

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, 2021



* 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, 2021

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, 2021



Tests found no statistical difference from estimate for all other firms not in the indicated size category ($p < .05$).
NOTE: In 2021, 51% of firms offering health benefits shopped for a new plan. Small Firms have 3-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2021

TELEMEDICINE

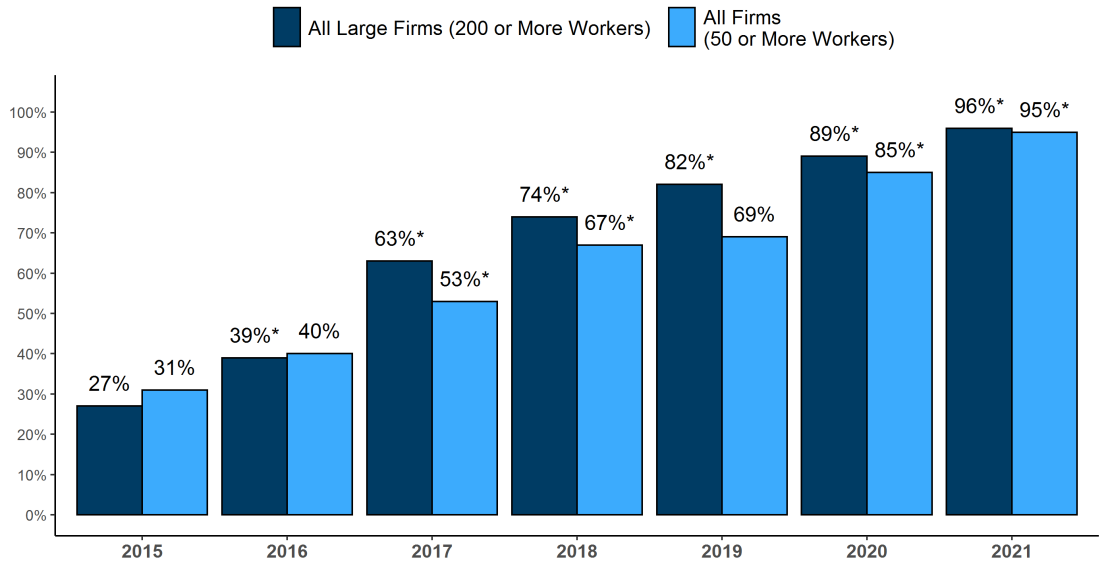
While telemedicine was becoming an increasingly popular benefit prior to the COVID-19 pandemic, its use skyrocketed during the pandemic as people sheltered at home and refrained from seeking non-emergency health care. Both state and federal policymakers took steps to reduce regulatory barriers to the provision of telemedicine services, while employers and insurers also took steps to make it easier for patients to use them. We expanded the telemedicine questions on the survey for 2021 to ask about changes employers made to their telemedicine benefits after the beginning the COVID-19 pandemic.

We define telemedicine as 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 does not include the mere exchange of information via email, exclusively web-based resources, or online information that 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.

- Ninety-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, higher than the percentage (85%) in 2020 [Figure 13.3].
  - The percentages of small firms (50-199 workers) and large firms reporting that they cover services through telemedicine are much higher than they were three years ago (94% v. 65% for small firms and 96% v. 74% for large firms) [Figure 13.3].
- Among firms with 50 or more employees offering telemedicine services, 20% offer telemedicine services through a specialized telemedicine service provider, such as Teledoc, Doctor on Demand, OR MDLIVE, 59% offer services through their health plan, 17% offer services through both a specialized telemedicine provider and their health plan, and 4% provide services through some other arrangement [Figure 13.5].
  - Small firms are more likely than larger firms to provide telemedicine services only through their health plan (63% v. 46%) while large firms are more likely than smaller firms to provide telemedicine services through both a specialized telemedicine provider and their health plan (24% v. 14%) [Figure 13.5].
- As noted above, telemedicine has became an important source of health care services during the COVID-19 pandemic. Employers with 50 or more employees offering telemedicine services were asked about changes they made to their programs after the beginning the COVID-19 pandemic [Section 13.6]. Among these firms:
  - Nineteen percent of smaller employers and 35% of large employers expanded the number of services covered through telemedicine [Section 13.7].
    - Nineteen percent of smaller employers and 33% of large employers expanded the number or type of providers that could provide telemedicine services [Section 13.7].
  - Fifteen percent of smaller employers and 27% of large employers reduced or eliminated cost sharing for telemedicine services [Section 13.7].
  - Twenty-four percent of employers expanded the settings or locations where enrollees may use telemedicine services [Section 13.6].
  - Thirty-one percent of employers expanded coverage for additional modes of delivering telemedicine, such as by telephone [Section 13.6].
  - Three percent of smaller employers and 10% contracted with a new telemedicine service provider, such as a specialized telemedicine vendor [Section 13.7].
  - Forty-seven percent of smaller employers and 66% of large employers increased promotion or employee communication of telemedicine resources [Section 13.7].

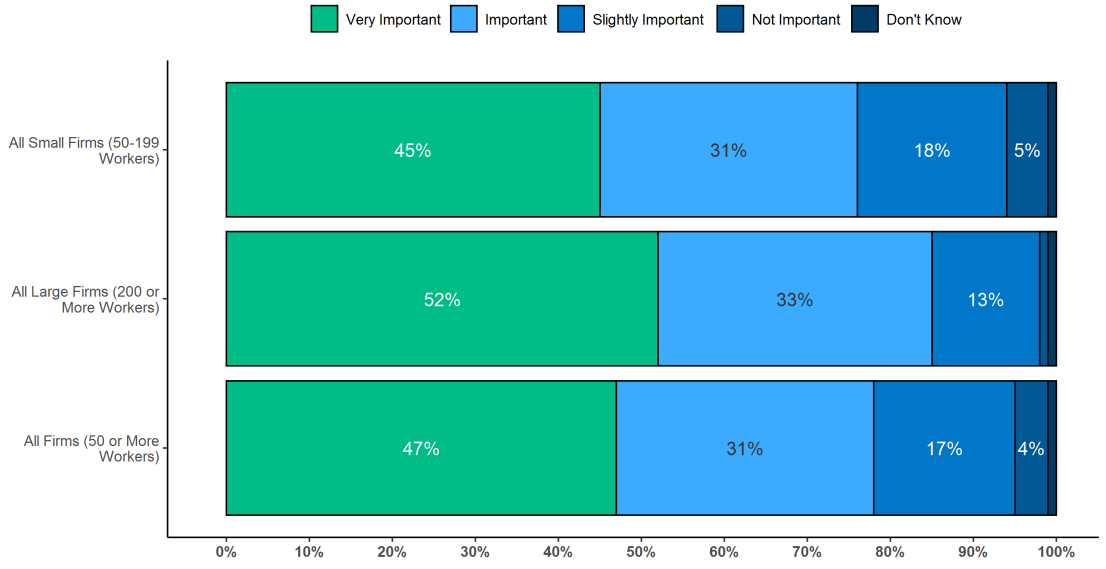
- Employers with 50 or more employees offering telemedicine services were asked how important they felt telemedicine would be in providing their employees with access to health care in the coming years. Almost half of these employers (47% felt telemedicine would be very important in providing access in the future, while only 4% said that telemedicine would be unimportant in providing access in the future [Figure 13.4].

Figure 13.3
Among Firms Offering Health Benefits, Percentage of Firms Whose Plan with the Largest Enrollment Covers Telemedicine, by Firm Size, 2015-2021



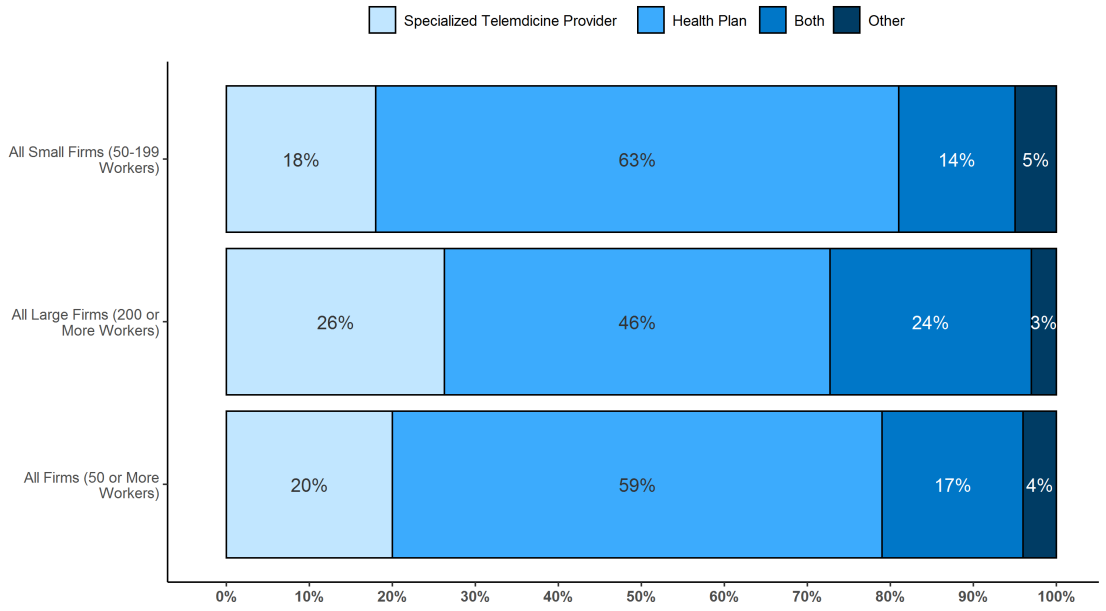
* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
NOTE: Telemedicine is health care services provided to a patient from a provider who is at a different location, including video chat and remote monitoring. We do not include email, exclusively web-based non-interactive 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, 2018-2021; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2015-2017

Figure 13.4
Among Firms Offering Health Benefits, How Important Firm Considers Telemedicine in Providing Access to Enrollees in The Coming Years, by Firm Size, 2021



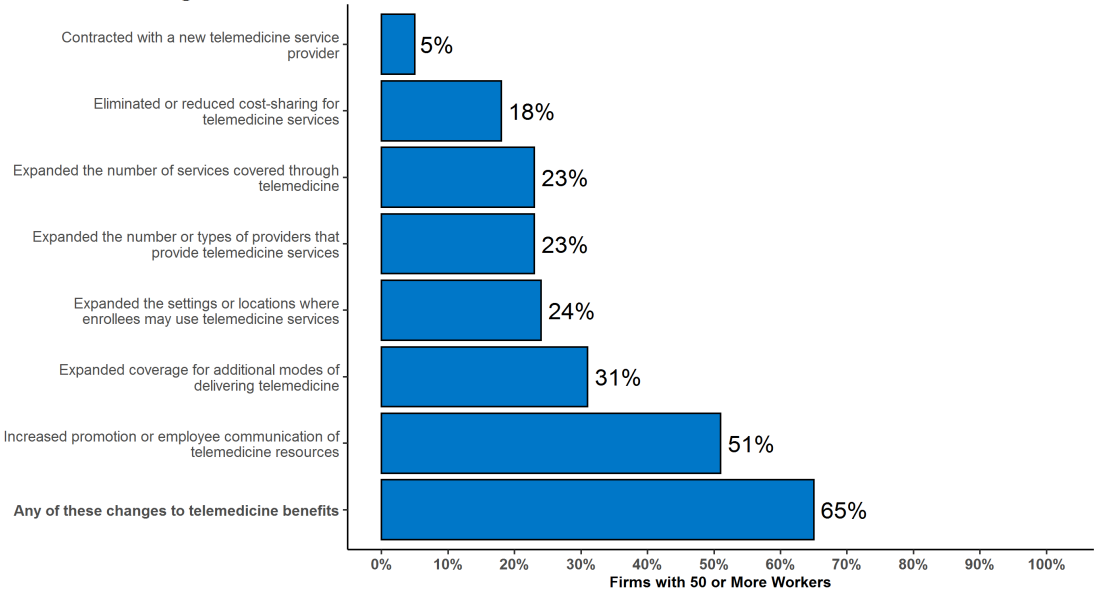
NOTE: Telemedicine is health care services provided to a patient from a provider who is at a different location, including video chat and remote monitoring. We do not include email, exclusively web-based non-interactive resources, or online information a plan may make available unless a health professional provides information specific to the enrollee's condition.
SOURCE: KFF Employer Health Benefits Survey, 2021

Figure 13.5
Among Firms Offering Telemedicine Health Benefits, Structure of the Firms Telemedicine Benefits, by Firm Size, 2021



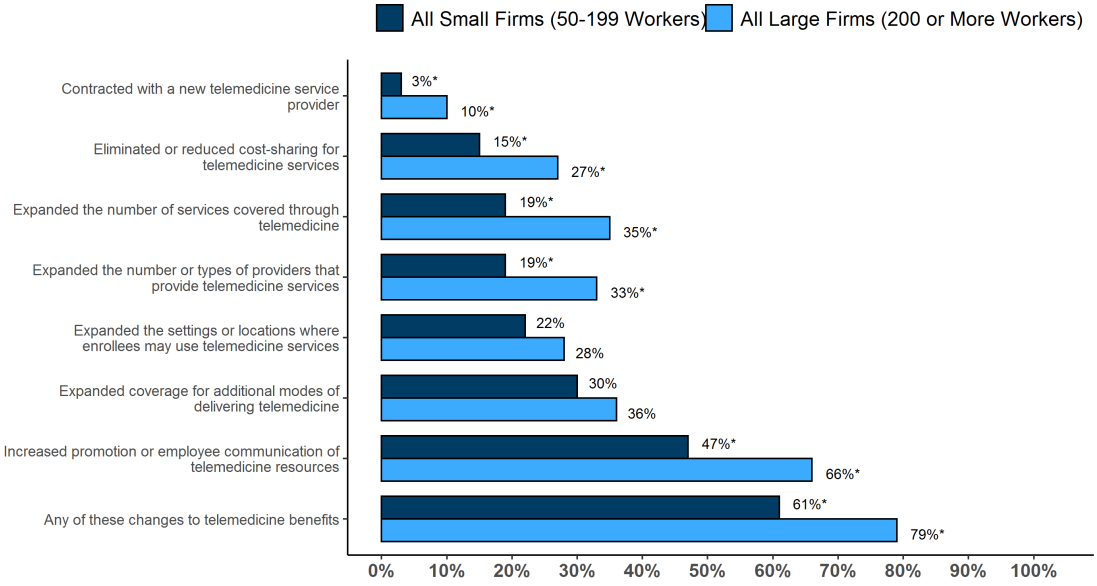
NOTE: A specialized telemedicine service provider, may include organizations such as Teledoc, Doctor on Demand, or MDLIVE
SOURCE: KFF Employer Health Benefits Survey, 2021

Figure 13.6
Among Firms Offering Telemedicine Benefits, Changes the Firm Made to Telemedicine Benefits During the COVID-19 Pandemic, 2021



NOTE: We asked respondents about changes they made due to the COVID-19 pandemic from January 2020 that were still in effect at the time of the interview.
SOURCE: KFF Employer Health Benefits Survey, 2021

Figure 13.7
Among Firms Offering Telemedicine Benefits, Changes the Firm Made to Telemedicine Benefits During the COVID-19 Pandemic, by Firm Size, 2021



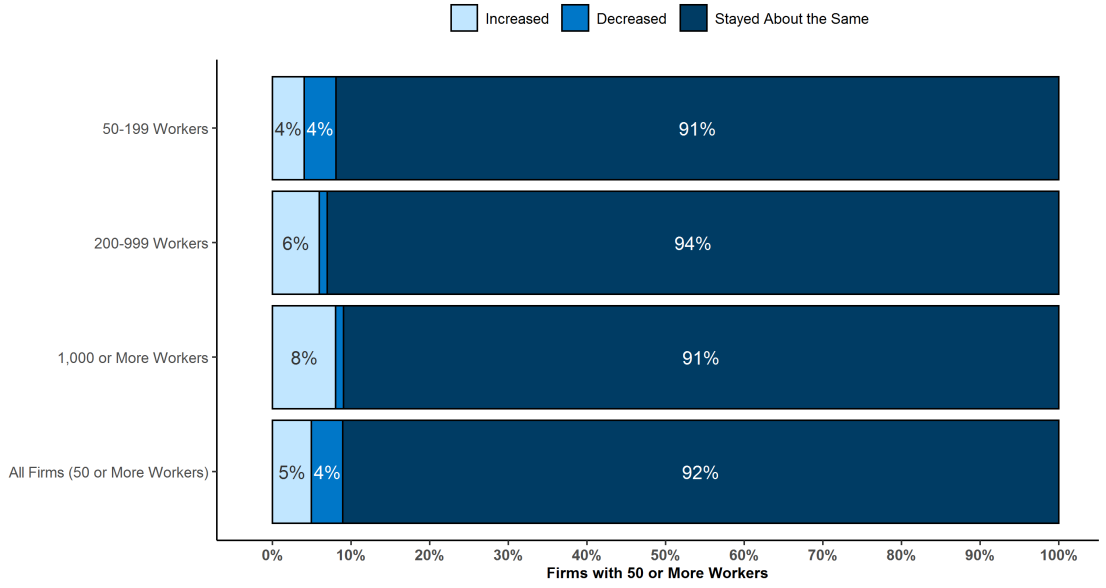
* Estimate is statistically different between All Small Firms and All Large Firms estimate ($p < .05$).
NOTE: Small Firms have 50 to 199 workers and Large Firms have 200 or more workers. We asked respondents about changes they made due to the COVID-19 pandemic from January 2020 that were still in effect at the time of the interview.
SOURCE: KFF Employer Health Benefits Survey, 2021

COVID-19 IMPACTS AND POLICIES

The COVID-19 pandemic and the associated social and financial disruptions have challenged employers in many ways. Employers have made changes to their employment policies and to their health plans, and have seen changes in enrollment and utilization of plan services.

Enrollment of Dependents. Only small shares of employers say that they saw an increase or decrease in the share of dependents enrolling in their health plans after the start of the COVID-19 pandemic. Among firms with 50 or more employees offering health benefits to dependents, 5% said that the share of dependents enrolling in their health plans increased, 4% said that the share of dependents enrolling in their health plans decreased, and 92% said that the share remained about the same. Small firms were more likely than large firms to say that the share of dependents in their health plan decreased [Figure 13.8].

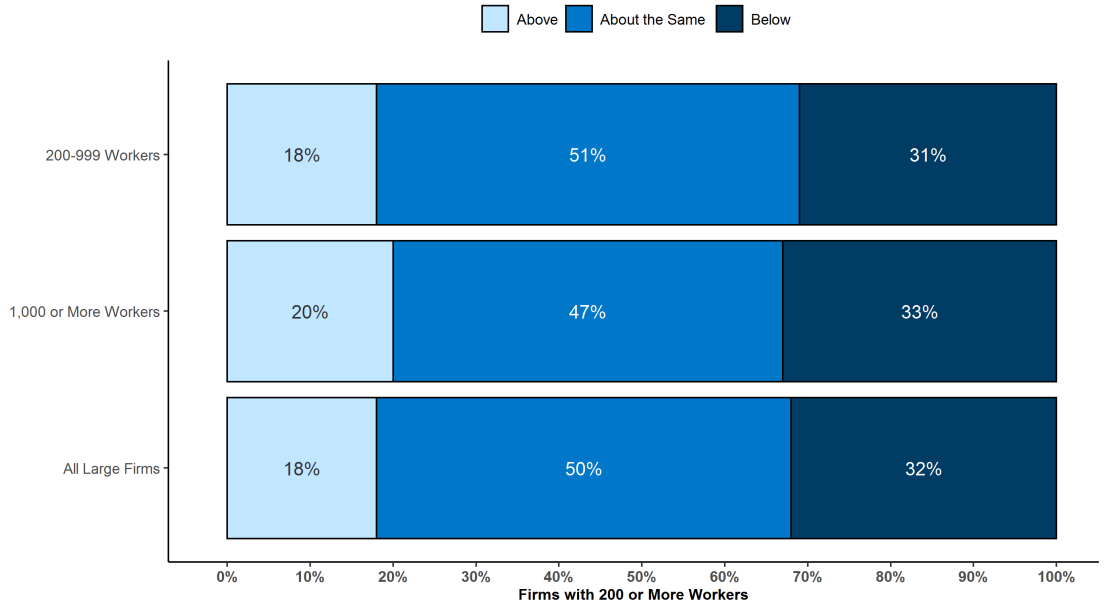
Figure 13.8
Among Firms Offering Health Benefits, Change in the Share of Dependents Enrolling in the Plan Since Start of the COVID-19 Pandemic, by Firm Size, 2021



NOTE: We asked respondents about changes they made due to the COVID-19 pandemic from January 2020 that were still in effect at the time of the interview.
SOURCE: KFF Employer Health Benefits Survey, 2021

Health Service Use. As was widely reported, the use of health care services fell significantly during 2020 as people sheltered at home and avoided health care settings. Entering into 2021, some of the questions for employers involved whether, and if so by how much, service use might rebound. We asked large employers (200 or more employees) offering health benefits how the level of service use in their health plans during the most recent quarter matched their expectations. Eighteen percent of these employers say that the level of service use in the last quarter was higher than expected, 50% say that the level was about what they expected, and 32% say that the level was below the level that they expected [Figure 13.9].

Figure 13.9
Among Large Firms Offering Health Benefits, Has the Amount of Health Care Utilization Been Above or Below Expectations During the Last Quarter, by Firm Size, 2021

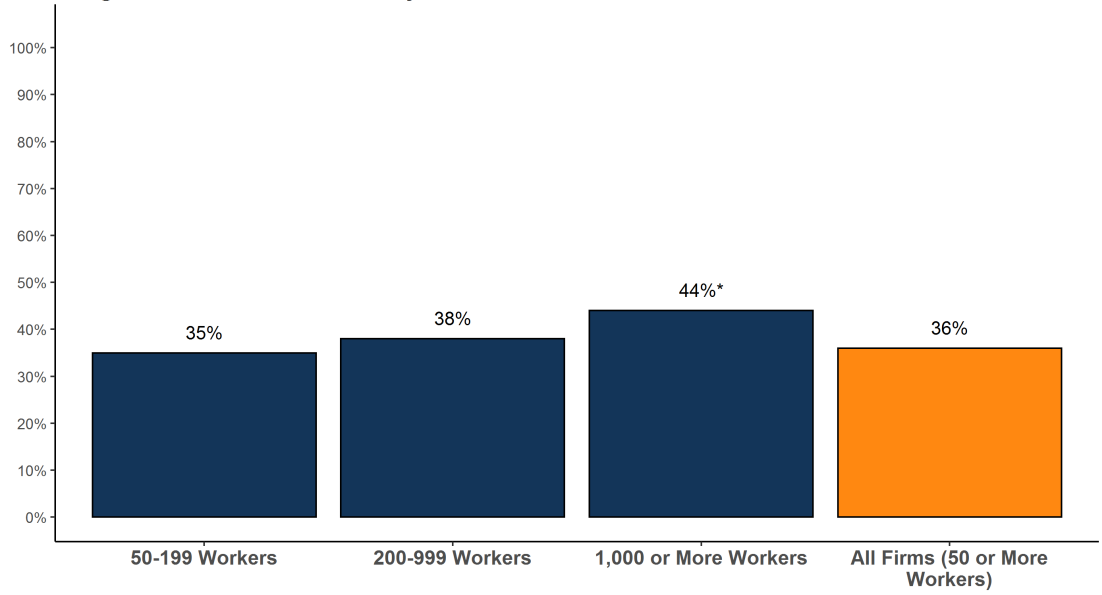


NOTE: Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2021

Cost Sharing for COVID Treatment. Many employers and health plans waived cost sharing last year for their enrollees who became infected with COVID-19. Employers with 50 or more employees were asked if they currently waive cost sharing for COVID-19 treatment.

- Thirty-five percent of employers with 50 to 199 workers and 45% of employers with 5,000 or more workers currently waive cost sharing for treatment of employees infected with COVID-19. Firms with 1,000 or more employees are more likely to waive cost sharing for COVID-19 treatment than smaller firms [Figure 13.10].

Figure 13.10
Among Firms Offering Health Benefits, Percentage of Firms Whose Largest Plan Waives Cost Sharing for COVID-19 Treatment, by Firm Size, 2021



* Estimate is statistically different from estimate for all other firms not in the indicated size category ($p < .05$).
NOTE: Respondents were asked their firm's policy at the point of the interview; the 2021 Employer Health Benefits Survey was fielded from January to July
SOURCE: KFF Employer Health Benefits Survey, 2021

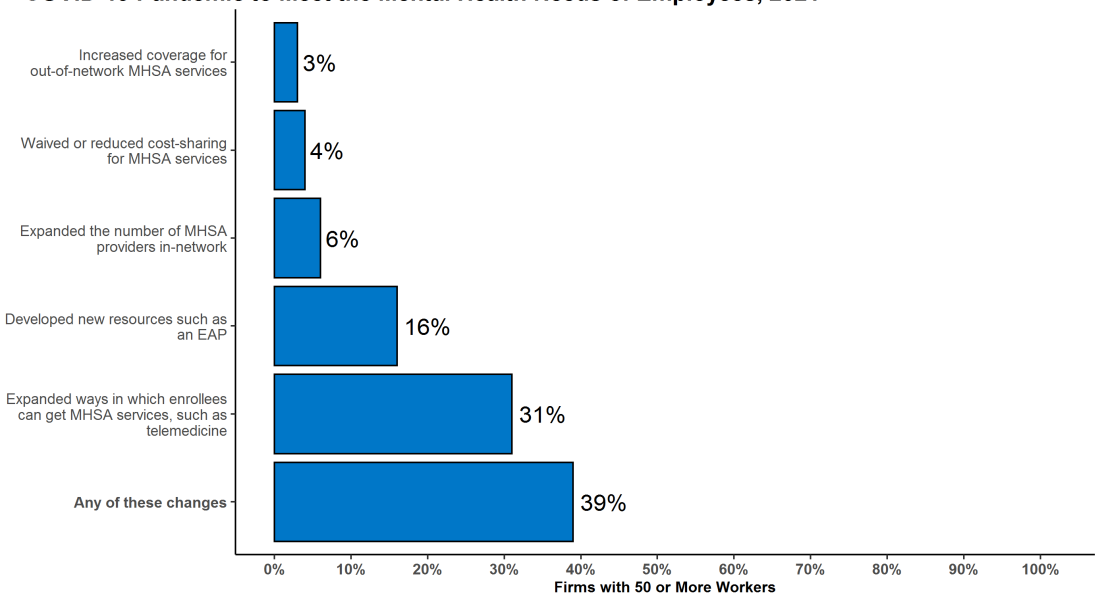
Mental and Behavioral Health. The COVID-19 pandemic and the accompanying social and economic disruptions have placed an unprecedented level of stress on people all over the world. Many employers took steps to assist employees and family members facing these stresses, such as providing information on assistance and resources that they make available through their health plans and employee assistance programs or by creating new programs to support employees and family members needing assistance.

- Employers with at least 50 employees offering health benefits were asked about changes they made to their health plans after the start of the COVID-19 pandemic to support the mental health of their employees. Sixteen percent of employers developed new resources, such as an employee assistance program [Figure 13.11].
- Three percent of employers increased coverage for out-of-network mental health or substance abuse services. Firms with 1,000 or more employees were more likely than smaller firms (50 to 199 employees) to increase coverage for out-of-network services (9% v. 3%) [Figure 13.11].
- Six percent of employers, including (16% of employers with 5,000 or more employees, expanded the number of mental health or substance abuse providers in their plans' networks [Figure 13.11].
- Four percent of employers waived or reduced cost-sharing for mental health or substance abuse services. The percentage of firms waiving or reducing cost sharing for these services increased with firm size [Figure 13.11].
- Thirty-one percent of employers expanded the ways through which enrollees could get mental health or substance abuse services, such as through telemedicine. The percentage of firms expanding the methods of access for these services increased with firm size [Figure 13.11].
- Twelve percent of employers with at least 50 employees offering health benefits reported seeing an increase in the share of employees using mental health services since the COVID-19 pandemic began.

This percentage increases with firm size, with 46% of firms with 5,000 or more employees seeing such an increase. We note that the percentage if firms reporting "don't know" to this question is relatively high (24%) [Figure 13.14].

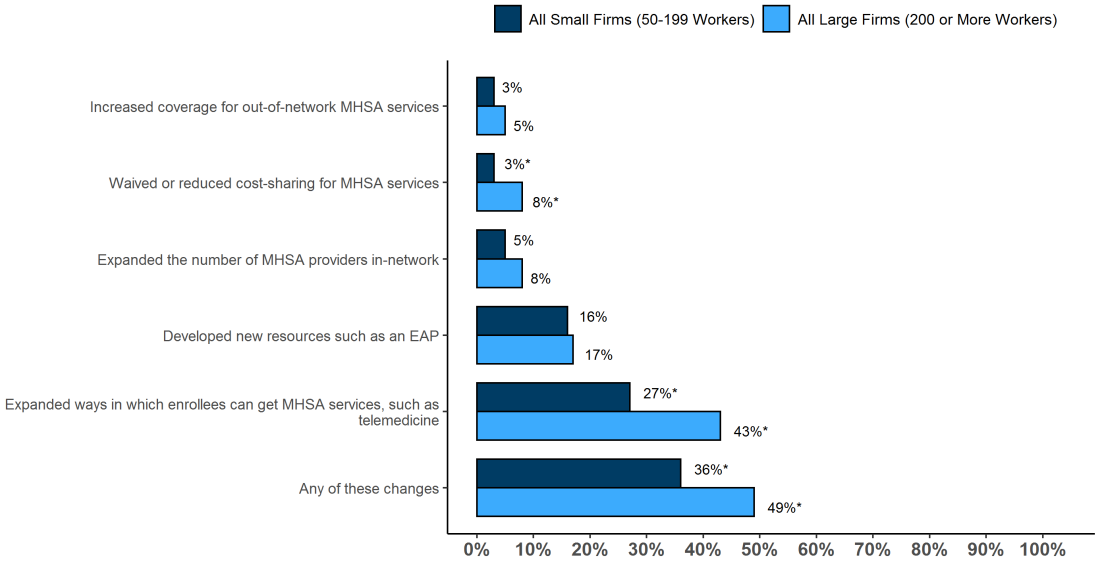
- A much smaller share of these employers (1%) reported seeing an increase in the share of employees using services for substance-abuse-related conditions since the COVID-19 pandemic began. This percentage increases with firm size, with 11% of firms with 5,000 or more employees seeing the share increase. We note that the percentage if firms reporting "don't know" to this question is relatively high (22%) [Figure 13.14].
- Despite the lower percentage of employers reporting that they saw an increase in the share of employees using services for substance-abuse-related conditions, there is concern among employers that substance abuse has grown among their employees since the COVID-19 pandemic began. Twenty-six percent of employers, including 59% of firms with 5,000 or more workers, say that they are concerned "a great deal" or are "somewhat" concerned that substance abuse conditions have increased among their employees [Figure 13.13].

Figure 13.11
Among Firms Offering Health Benefits, Changes the Firm Made Since the Beginning of the COVID-19 Pandemic to Meet the Mental Health Needs of Employees, 2021



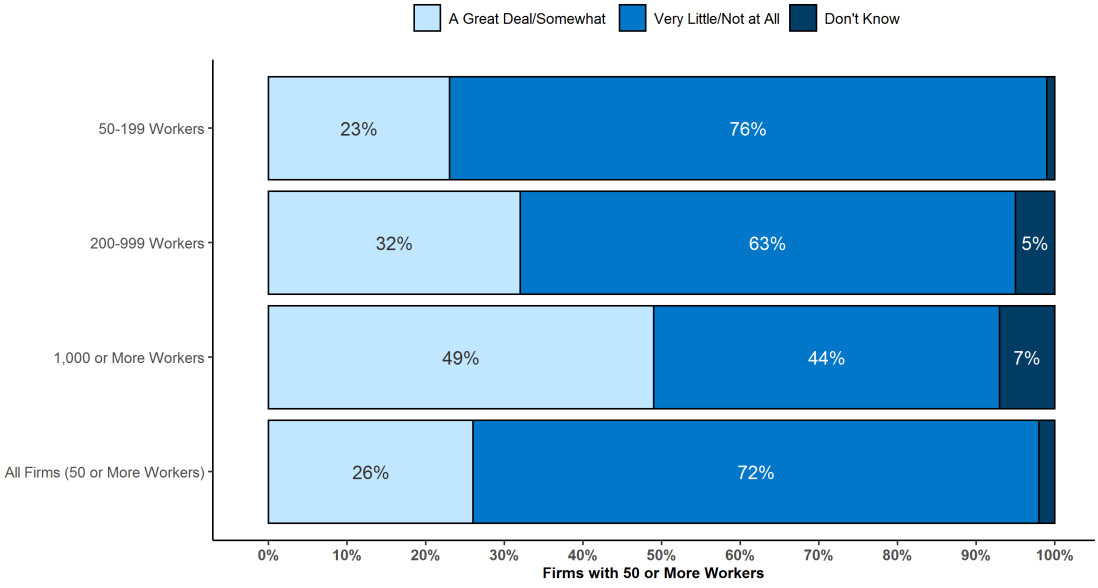
NOTE: We asked respondents about changes they made due to the COVID-19 pandemic from January 2020 that were still in effect at the time of the interview. MHSA refers to Mental Health and/or Substance Abuse. EAP refers to Employee Assistance Programs.
SOURCE: KFF Employer Health Benefits Survey, 2021

Figure 13.12
Among Firms Offering Health Benefits, Changes the Firm Made Since the Beginning of the COVID-19 Pandemic to Meet the Mental Health Needs of Employees, by Firm Size, 2021



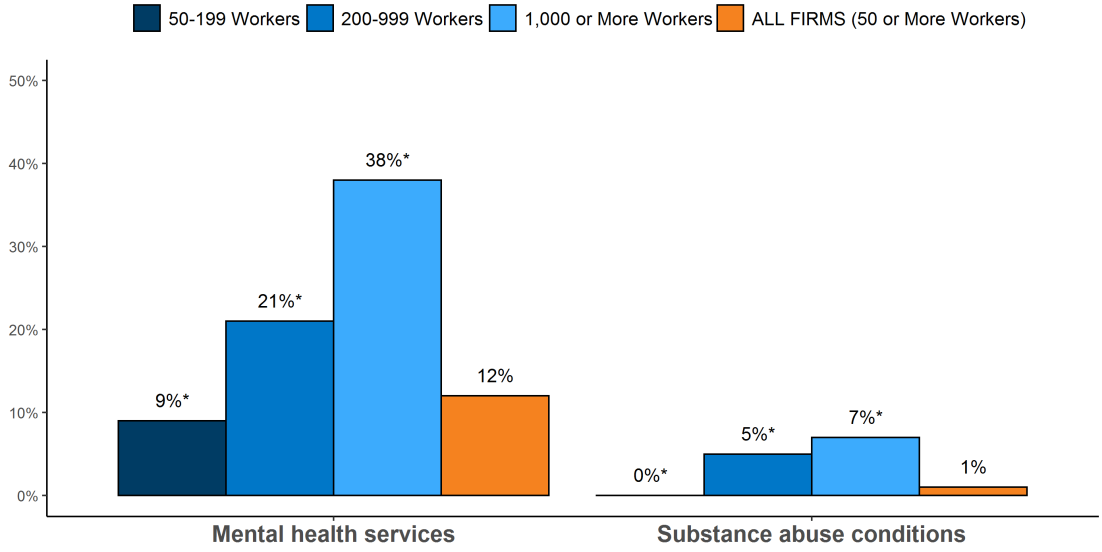
* Estimate is statistically different between All Small Firms and All Large Firms estimate ($p < .05$).
NOTE: Small Firms have 50 to 199 workers and Large Firms have 200 or more workers. MHSA refers to Mental Health and/or Substance Abuse. EAP refers to Employee Assistance Programs. We asked respondents about changes they made due to the COVID-19 pandemic from January 2020 that were still in effect at the time of the interview.
SOURCE: KFF Employer Health Benefits Survey, 2021

Figure 13.13
Among Firms Offering Health Benefits, Concern with Growth of Substance Abuse Conditions Among Employees, by Firm Size, 2021



NOTE: We asked respondents about changes they made due to the COVID-19 pandemic from January 2020 that were still in effect at the time of the interview.
SOURCE: KFF Employer Health Benefits Survey, 2021

Figure 13.14
Among Firms Offering Health Benefits, Percentage of Firms Which Have Seen an Increase in Employees Seeking Mental Health and Substance Abuse Services Since the COVID-19 Pandemic Began, by Firm Size, 2021



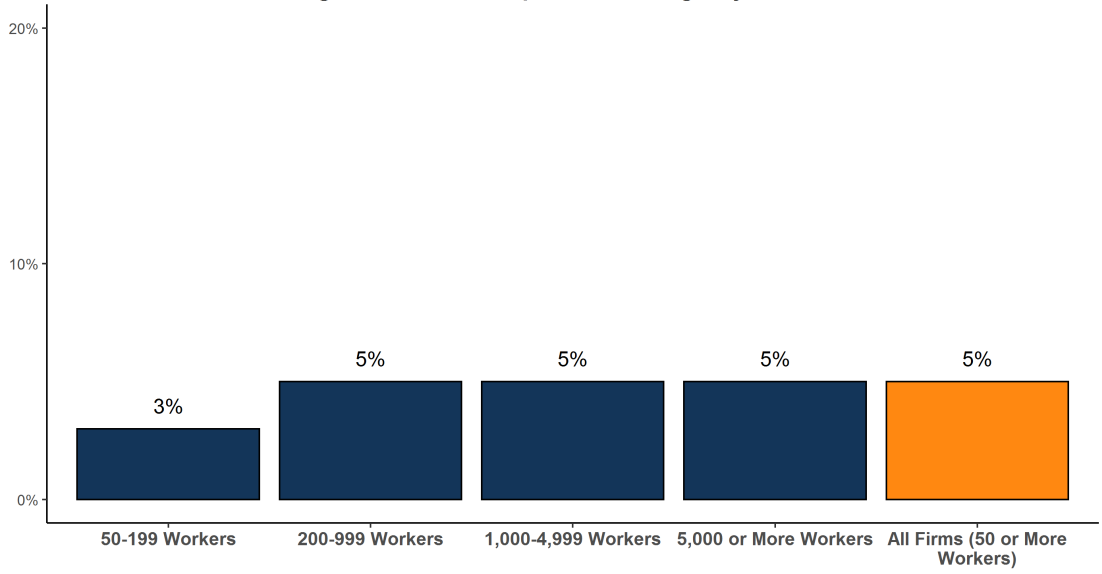
* Estimate is statistically different from estimate for all other firms not in the indicated size category ($p < .05$).
NOTE: A significant share of employers did not know whether there was an increase in employees seeking mental health (24%) and substance abuses services (22%) since the COVID-19 pandemic began.
SOURCE: KFF Employer Health Benefits Survey, 2021

PRIVATE EXCHANGES

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.

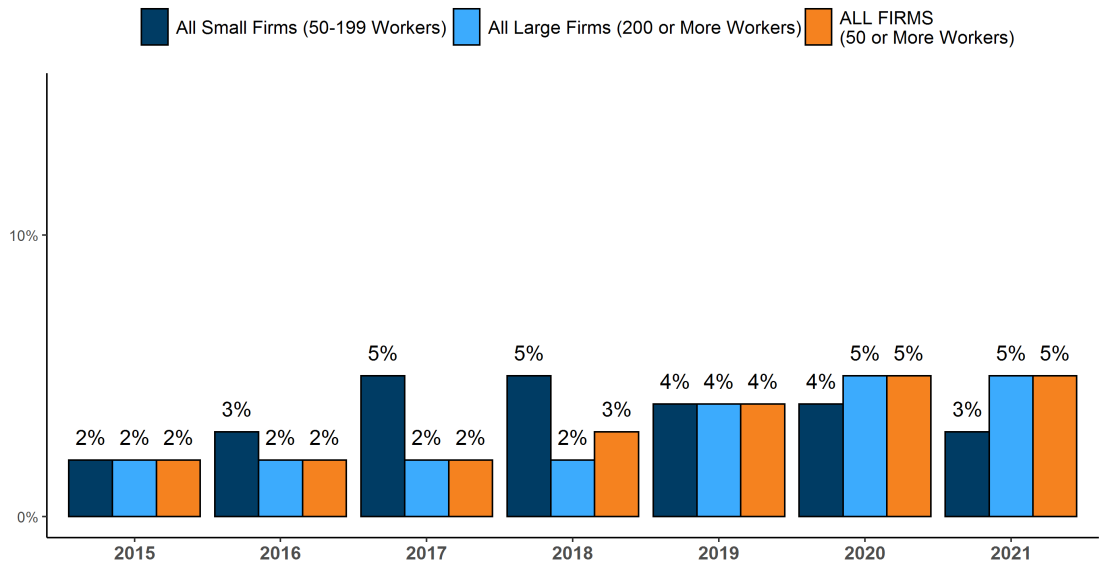
- Five percent of firms offering health benefits with 50 or more workers offer coverage through a private exchange. These firms provide coverage to 5% of covered workers in firms with 50 or more workers. These percentages are similar to those in the past few years.

Figure 13.15
Among Firms Offering Health Benefits, Percentage of Covered Workers Enrolled at a Firm That Offers Benefits Through a Private or Corporate Exchange, by Firm Size, 2021



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 2021, 5% of offering firms with 50 or more workers offered coverage through a private exchange.
SOURCE: KFF Employer Health Benefits Survey, 2021

Figure 13.16
Among Firms Offering Health Benefits, Percentage of Covered Workers Enrolled at a Firm That Offers Benefits Through a Private or Corporate Exchange, by Firm Size, 2015-2021



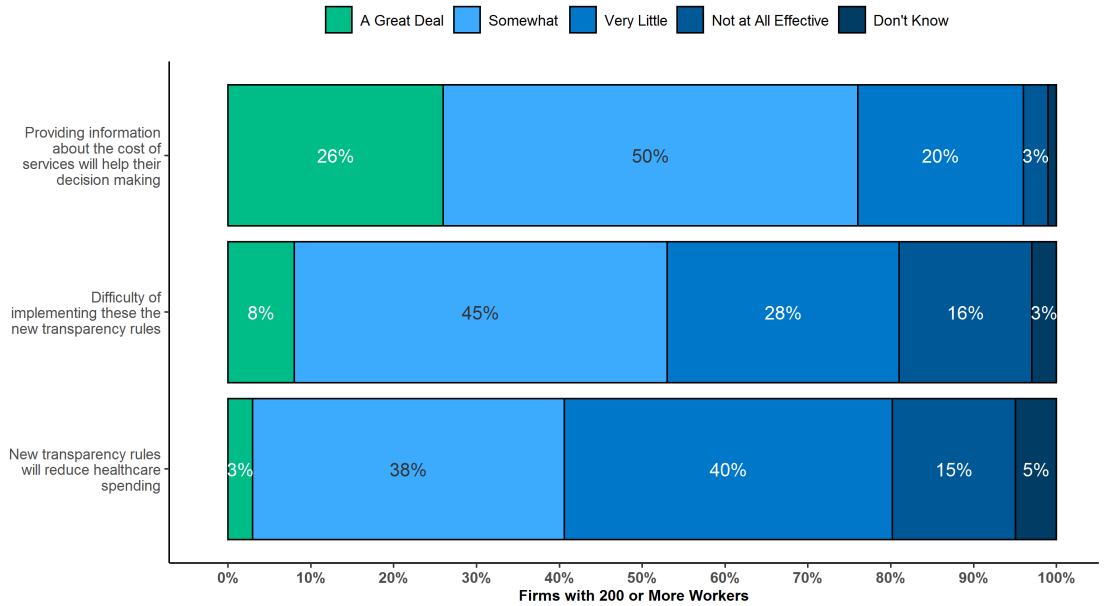
Tests found no statistical difference from estimate for the previous year shown ($p < .05$).
NOTE: A private exchange is one created by a consulting company; not by a federal or state government. Private exchanges allow employees to choose from several health benefit options offered on the exchange. In 2021, 5% of offering firms with 50 or more workers offered coverage through a private exchange.
SOURCE: KFF Employer Health Benefits Survey, 2018-2021; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2015-2017

HEALTH CARE PRICE TRANSPARENCY

New federal rules will require health plans (including self-funded plans) to make information available to enrollees about the estimated cost of services and cost-sharing on a "real-time" basis. Large employers (200 or more employees) were asked about the potential effectiveness and burdens of these new transparency requirements.

- Among large employers offering health benefits, 26% say that providing employees with additional information about the cost of services will help their health care decision making "a great deal" and an additional 50% say that it will help their decision making "somewhat" [Figure 13.17].
- Among large employers offering health benefits, 8% say that implementing the new transparency rules would involved "a great deal" of difficulty and an additional 45% say that it will be "somewhat" difficult [Figure 13.17]. Among firms with 5,000 or more employees, 21% say that implementing the new transparency rules would involved "a great deal" of difficulty.
- Among large employers offering health benefits, only 3% say that the new transparency rules will reduce health spending "a great deal", while 15% say that they will be reduce health spending "not at all." Thirty-eight percent of these firms say that the new rules will reduce spending "somewhat" and 40% say that they will reduce spending "very little" [Figure 13.17].

Figure 13.17
Among Large Firms Offering Health Benefits, Firms Opinions on Health Transparency Requirements, 2021



NOTE: Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2021

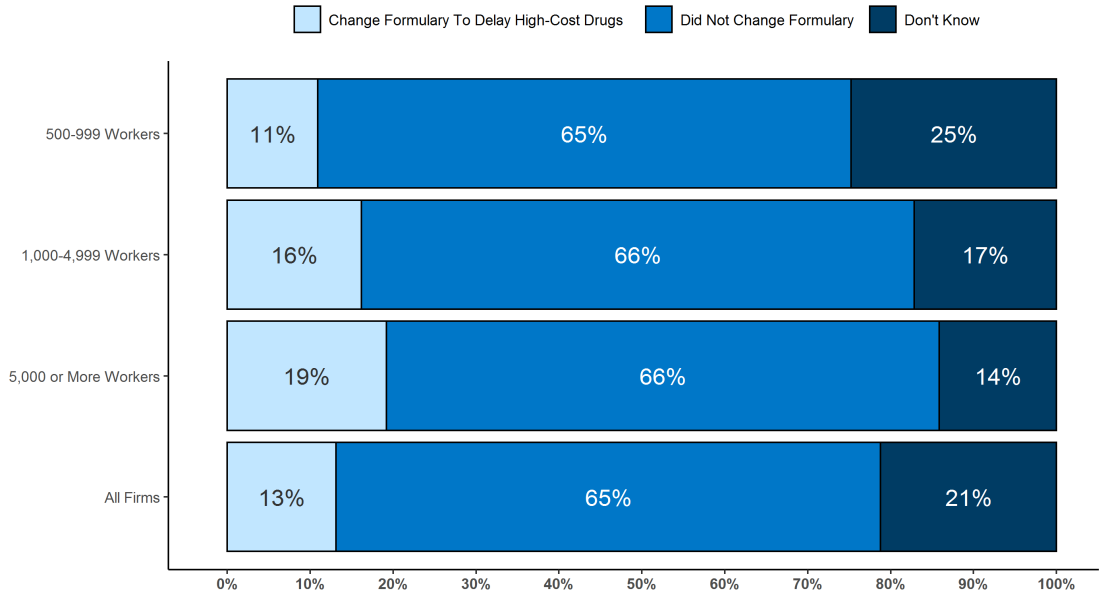
PRESCRIPTION DRUG MANAGEMENT

Employers, health plans and their prescription benefit managers continue to add new features to manage the costs of prescription drugs. This year we included questions for larger employers (500 or more workers) about

programs that exclude the value of pharmaceutical manufacturer subsidies (e.g., coupons) when determining if deductibles or out-of-pocket limits are met and programs that delay formulary placement for certain high-cost medications until they are proven effective.

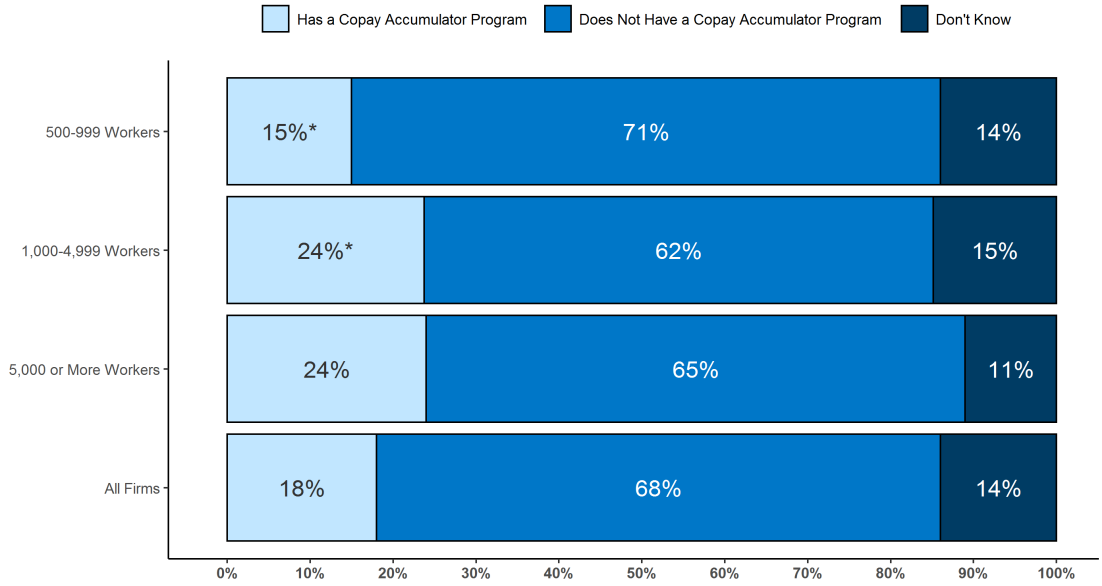
- Among employers with 500 or more employees offering prescription drug benefits in 2021, 13% have made a change to their prescription program in the last two years to delay the inclusion of new high-cost drug therapies until the therapy is proven effective. A fairly large share of employers with 500 or more workers (21%) did not know if they had made such a change to their programs [Figure 13.18].
- Among employers with 500 or more employees offering prescription drug benefits in 2021, 18% have a programs that excludes subsidies from prescription drug manufacturers, such as coupons, from counting towards an enrollee's deductible or out-of-pocket limit. About the same share of employers with 500 or more workers (14%) did not know if their programs included this feature [Figure 13.19].

Figure 13.18
Among Firms with 500 or More Employees Offering Drug Benefits, Percentage of Firms That Changed Their Formulary Over the Last Two Years to Delay the Inclusion of New High-Cost Drug Therapies Until They Are Proven Effective, 2021



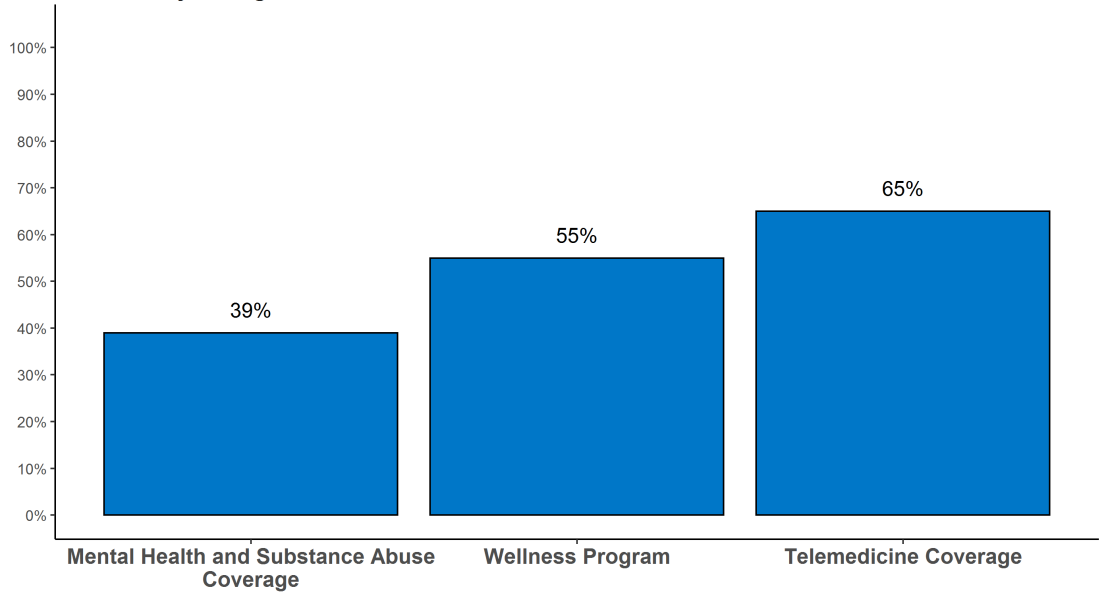
Tests found no statistical difference from estimate for all other firms not in the indicated size category ($p < .05$).
SOURCE: KFF Employer Health Benefits Survey, 2021

Figure 13.19
Among Firms with 500 or More Employees Offering Prescription Drug Coverage, Percentage of Firms That Have a Copay Accumulator Program, 2021



* Estimate is statistically different from estimate for all other firms not in the indicated size category ($p < .05$).
NOTE: Copay accumulator program do not count enrollees' spending from copay cards or drug manufacturer's coupons towards either the deductible or the out-of-pocket maximum
SOURCE: KFF Employer Health Benefits Survey, 2021

Figure 13.20
Among Firms with 50 or More Employees Offering Each of the Following Programs, Percentage That Made Any Change Due to COVID-19 Pandemic, 2021



NOTE: We asked respondents about changes they made due to the COVID-19 pandemic from January 2020 that were still in effect at the time of the interview.
SOURCE: KFF Employer Health Benefits Survey, 2021

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