KFF

Employer Health Benefits

2022

Annual Survey

KFF

Primary Authors:

KFF

Gary Claxton
Matthew Rae
Emma Wager
Gregory Young

NORC AT THE UNIVERSITY OF CHICAGO

Heidi Whitmore

DAVIS RESEARCH

Jason Kerns
Greg Shmavonian

INDEPENDENT CONSULTANT

Anthony Damico

The authors would like to thank Tricia Neuman, Karen Pollitz, Krutika Amin, Cynthia Cox, Ashley Kirzinger, Jeannie Fuglesten Biniek, Kaye Pestaina, Carene Clark, Larry Levitt, Craig Palosky, Rashida Hamm, Robin Sidel, Vicki Brewington and Drew Altman for their many contributions in making this report possible.

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

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

Printed in the United States of America.

KFF

Employer Health Benefits

2022

Annual Survey

KFF

Table of Contents

Abstract

This is the 24th annual Employer Health Benefit Survey. As in years past the survey examines trends in employer-sponsored health coverage, including premiums, employee contributions, cost-sharing provisions, offer rates, wellness programs, and employer practices. This year we asked employers detailed questions about their provider networks, programs to meet the mental health needs of their employees and coverage for services delivered through telehealth. The 2022 survey includes 2,188 interviews with non-federal public and private firms.

Annual premiums for employer-sponsored family health coverage reached $22,463 this year,1% higher but statistically similar to last year ($22,221). On average workers contributed $6,106 toward the cost of family coverage. The average deductible among covered workers in a plan with a general annual deductible is $1,763 for single coverage. Fifty 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 51%.

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. Additional resources including a technical supplement, an interactive graphic, and a deidentified public use data set are available at ehbs.kff.org

Summary of Findings

Employer-sponsored insurance covers almost 159 million nonelderly people.[1] To provide a current snapshot of 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-fourth Employer Health Benefits Survey (EHBS) and reflects employer-sponsored health benefits in 2022.

The survey was fielded from February to July of 2022. We made several revisions to the survey for 2022, including adding an online response option that 43% of respondents used to complete the survey. This change and others discussed in the methods section helped increase the number of employers completing the 2022 survey by 30% from last year.

HEALTH INSURANCE PREMIUMS AND WORKER CONTRIBUTIONS

In 2022, the average annual premiums for employer-sponsored health insurance are $7,911 for single coverage and $22,463 for family coverage. These amounts are each similar to the average premiums in 2021. In contrast to the lack of premium growth in 2022, workers' wages increased 6.7% and inflation increased 8%.[2] This difference may be due to the fact that many of the premiums for 2022 were finalized in the fall of 2021, before the extent of rising prices became clear. As inflation continues to grow at relatively high levels, we could potentially observe a higher increase in average premiums for 2023 than we have seen in recent years.

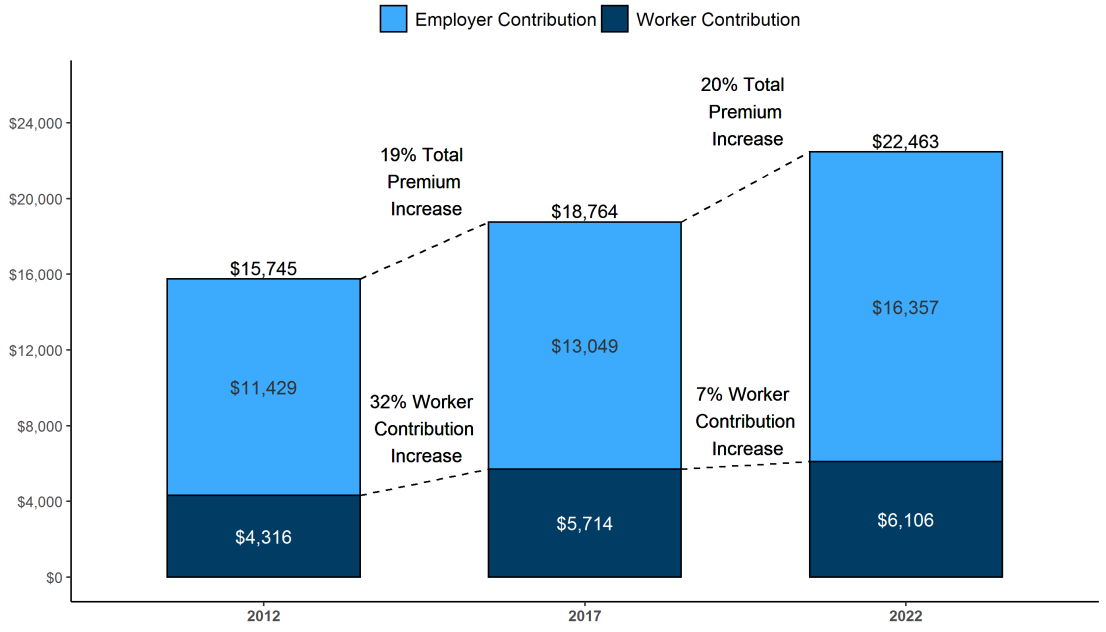
The average premium for family coverage has increased 20% over the last five years and 43% over the last ten years [Figure A].

Covered workers at small and large firms have similar premiums for single coverage ($8,012 vs. $7,873) and family coverage ($22,186 vs. $22,564). The average premiums for covered workers in high-deductible health plans with a savings option (HDHP/SO) are lower than the overall average premiums for single coverage ($7,288) and family coverage ($21,136) [Figure B]. In contrast, the average premiums for covered workers enrolled in PPOs are higher than the overall average premiums for single ($8,272) and family coverage ($23,426). Average premiums for both single coverage and family coverage are relatively high for covered workers in the Northeast and relatively low for covered workers in the South.

[1] Estimate from KFF's analysis of American Community Survey. Health insurance coverage of the nonelderly 0–64 [Internet]. San Francisco (CA): KFF; 2019 [cited 2022 Sep 12]. Available from: https://www.kff.org/other/state-indicator/nonelderly-0-64/

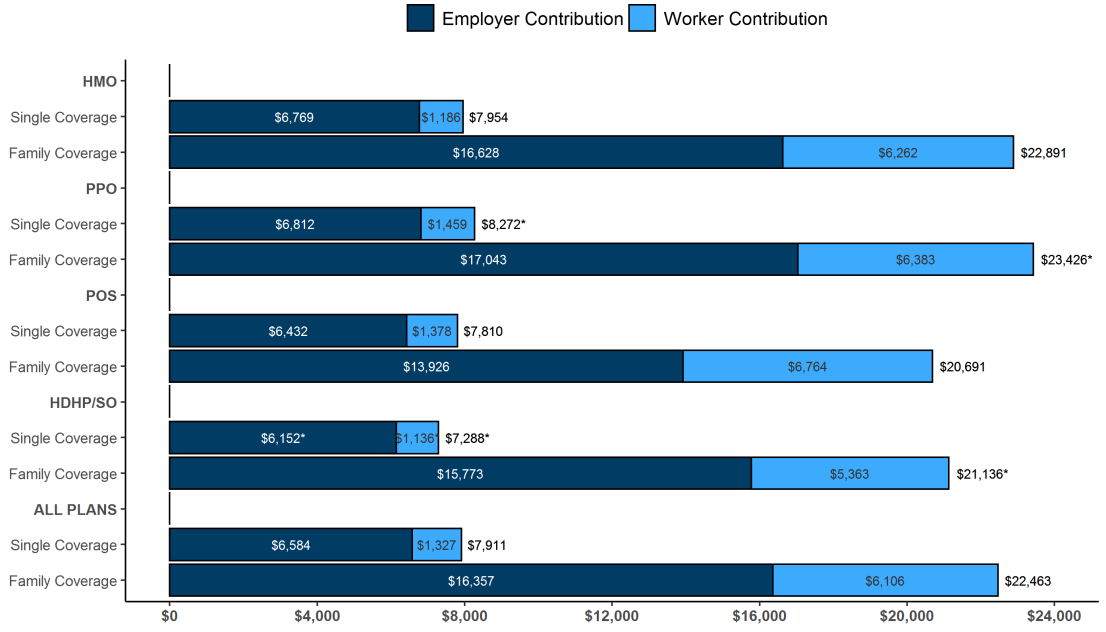
[2] Bureau of Labor Statistics, Mid-Atlantic Information Office. Consumer Price Index historical tables for, U.S. city average (1967 = 100) of annual inflation [Internet]. Washington (DC): BLS; [cited 2022 Sep 12]. Available from: https://www.bls.gov/regions/mid-atlantic/data/consumerpriceindexhistorical1967base_us_table.htm Seasonally adjusted data from the Current Employment Statistics Survey. Bureau of Labor Statistics. Current Employment Statistics—CES (national) [Internet]. Washington (DC): BLS; [cited 2022 Sep 12]. Available from: https://www.bls.gov/ces/publications/highlights/highlights-archive.htm

Figure A
Average Annual Worker and Employer Premium Contributions for Family Coverage, 2012, 2017, and 2022



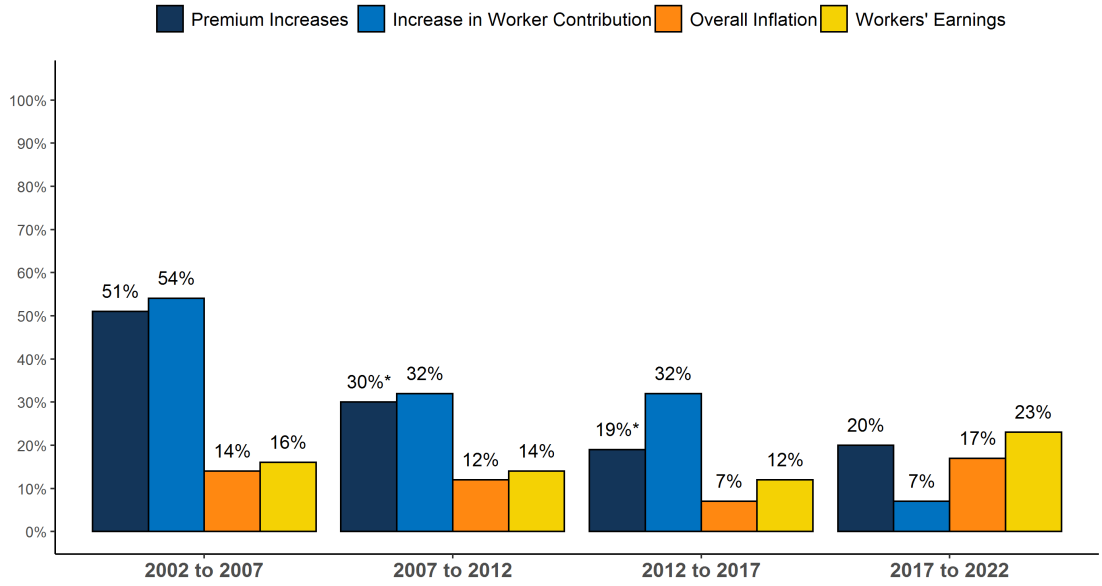
SOURCE: KFF Employer Health Benefits Survey, 2022; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2012 and 2017

Figure B
Average Annual Worker and Employer Premium Contributions for Single and Family Coverage, by Plan Type, 2022



* Estimate is statistically different from All Plans estimate within coverage type ($p < .05$).
SOURCE: KFF Employer Health Benefits Survey, 2022

Figure C
Cumulative Premium Increases, Inflation, and Earnings for Covered Workers with Family Coverage, 2002-2022



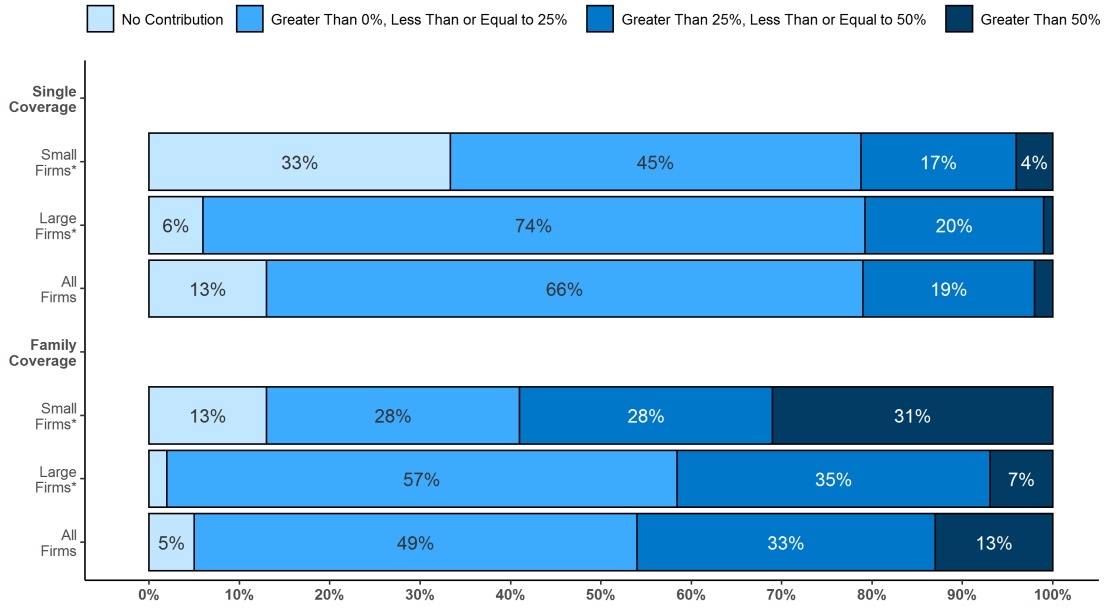
* Percentage change in family premium is statistically different from previous five year period shown ($p < .05$).
SOURCE: KFF Employer Health Benefits Survey, 2018-2022; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2002-2017. Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation, 2002-2022; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 2002-2022.

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, similar to the percentages in 2021. Covered workers at small firms contribute, on average, a higher percentage of the premium for family coverage than those at large firms (36% vs. 26%). As a result, the average contribution amount for covered workers in small firms ($7,556) is higher than the average contribution amount for covered workers in large firms ($5,580). Covered workers at private for-profit firms contribute a higher percentage of the premium for both single and family coverage than those at other firms, on average, while covered workers at public firms contribute a lower percentage of the premium for both single and family coverage.

Thirty-three percent of covered workers at small firms are enrolled in a plan where the employer pays the entire premium for single coverage. This is the case for only 6% of covered workers at large firms. However, 31% of covered workers at small firms are in a plan where they must contribute more than half of the premium for family coverage, compared to 7% of covered workers at large firms [Figure D].

The average annual dollar amounts contributed by covered workers in 2022 are $1,327 for single coverage and $6,106 for family coverage, similar to the amounts last year. Nine percent of covered workers, including 21% of covered workers at small firms, are in a plan with a worker contribution of $12,000 or more for family coverage.

Figure D
Distribution of Percentage of Premium Paid by Covered Workers for Single and Family Coverage, by Firm Size, 2022

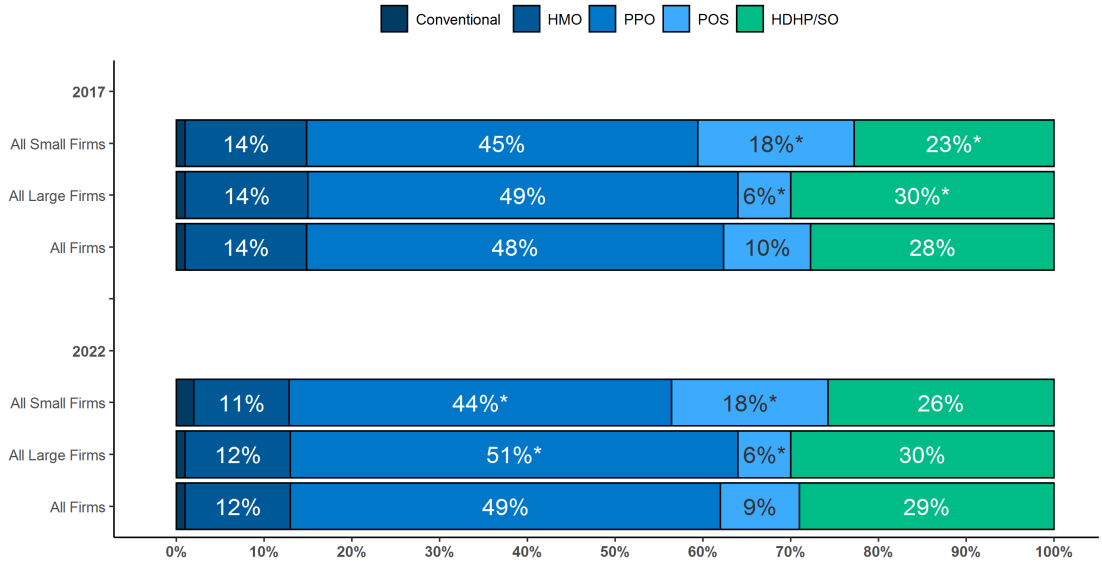


* Distributions are statistically different between Small Firms and Large Firms within coverage type ($p < 0.05$).
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2022

PLAN ENROLLMENT

PPOs remain the most common plan type. In 2022, 49% of covered workers are enrolled in a PPO, Twenty-nine percent in a high-deductible plan with a savings option (HDHP/SO), 12% in an HMO, 9% in a POS plan, and 1% in a conventional (also known as an indemnity) plan [Figure E]. This distribution of covered workers in plan types is similar to the distribution of covered workers in plan types last year.

Figure E
Distribution of Health Plan Enrollment for Covered Workers, by Plan Type and Firm Size, 2017 and 2022



* 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, 2022; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2017

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 through the purchase of health insurance. Sixty-five percent of covered workers, including 20% of covered workers at small firms and 82% in large firms are enrolled in plans that are self-funded. The percentage of covered workers in self-funded plans in 2022 is similar to the percentage last year.

Thirty-eight percent of small firms offering health benefits report that they have a level-funded plan, similar to the percentage in 2021 but much higher than preceding years. Level-funded arrangements combine a relatively small self-funded component with stop-loss insurance, which limits the employer's liability and transfers a substantial share of the risk to insurers. These plans have the potential to meaningfully affect competition in the small group market because, unlike insured plans, they use health status as a factor in rating and underwriting, and are not required to provide all of the essential health benefits that are mandatory for other plans.

EMPLOYEE COST SHARING

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

Among workers with single coverage and a general annual deductible, the average deductible amount is $1,763, similar to last year. The average deductible for covered workers is much higher at small firms than large firms ($2,543 vs. $1,493). Among workers with single coverage and any deductible, the average deductible amount has increased 17% over the last five years and 61% over the last ten years. In five years, the percentage of covered

workers with a general annual deductible of $2,000 or more for single coverage has grown from 22% to 32% [Figure F].

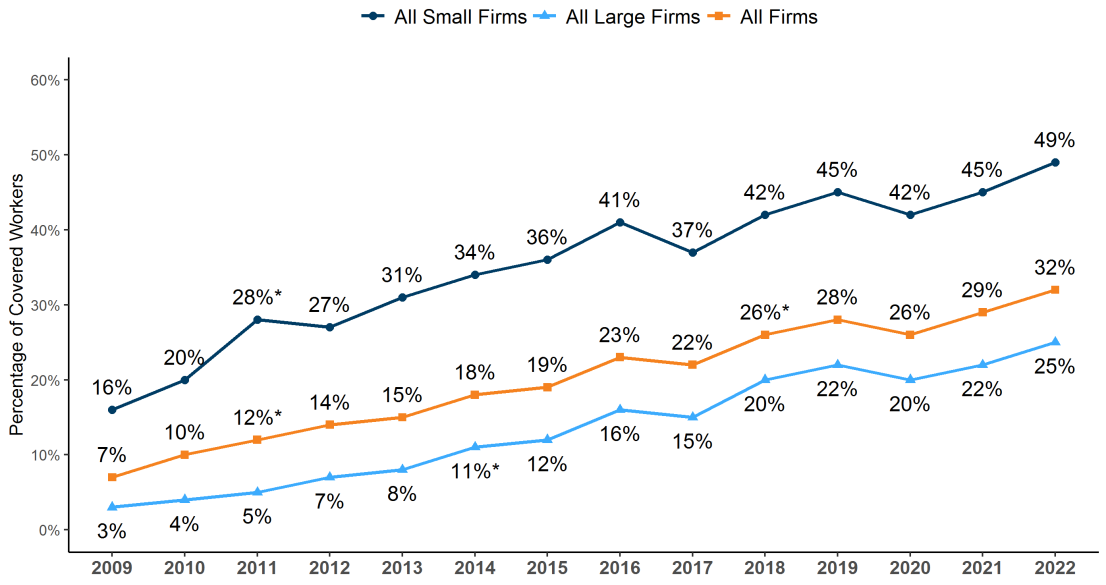
Some workers in health plans with high deductibles also receive contributions to savings accounts from their employers, which can be used to reduce cost sharing amounts. Fourteen percent of covered workers in an HDHP with a Health Reimbursement Arrangement (HRA), and 3% of covered workers in a Health Savings Account (HSA)-qualified HDHP receive an account contribution for single coverage greater than or equal to their deductible amount. Additionally, 30% 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 personal annual liability to less than $1,000.

Regardless of their deductible, most covered workers also pay a portion of the cost when they visit an in-network physician. Many covered workers face a copayment (a fixed dollar amount) when they visit a doctor, although some workers instead have coinsurance requirements (a percentage of the covered amount). Average copayments are $27 for primary care and $44 for specialty care physician appointments, while average coinsurance rates are 19% for primary care and 20% for specialty care. These amounts are similar to those observed in 2021.

Most workers also face additional cost sharing for a hospital admission or outpatient surgery. Sixty-eight percent of covered workers have coinsurance requirements and 13% have a copayment for hospital admissions. The average coinsurance rate for a hospital admission is 20% and the average copayment amount is $344 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 an annual limit on in-network cost sharing (called an out-of-pocket maximum) for single coverage, though these limits vary significantly. Among covered workers in plans with an out-of-pocket maximum for single coverage, 8% are in a plan with an out-of-pocket limit less than $2,000, while 26% are in a plan with a limit of $6,000 or more.

Figure F
Percentage of Covered Workers Enrolled in a Plan with a General Annual Deductible of $2,000 or More for Single Coverage, by Firm Size, 2009-2022



* 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, 2018-2022; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2009-2017

AVAILABILITY OF EMPLOYER-SPONSORED COVERAGE

While nearly all large firms (firms with 200 or more workers) offer health benefits to at least some workers, small firms (3-199 workers) are significantly less likely to do so. In 2022, 51% of all firms offered some health benefits. This is lower than the the percentage of firms offering health benefits last year (59%) but similar to the percentage five years ago (53%).

Most firms are very small, leading to fluctuations in the overall offer rate, as the offer rates of small firms can vary widely from year to year. Most workers, however, work for larger firms, where offer rates are high and much more stable. Over ninety percent (93%) of firms with 50 or more workers offer health benefits in 2022. This percentage has remained consistent over the last 10 years. Overall, 89% of workers employed at firms with 3 or more workers are employed at 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 employers. 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 may feel the coverage is too expensive or they may be covered through another source). Overall, at firms that offer coverage, 78% of workers are eligible. Among eligible workers, 77% take up the firm's offer. The end result is 60% of workers at firms that offer health benefits enrolling in coverage. All of these percentages are similar to those in 2021. 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 (49% vs. 62%). [3]

Among all workers, across firms that offer health benefits and firms that do not, 54% are covered by health plans offered by their employer. This is similar to the percentage last year.

HEALTH PROMOTION AND WELLNESS PROGRAMS

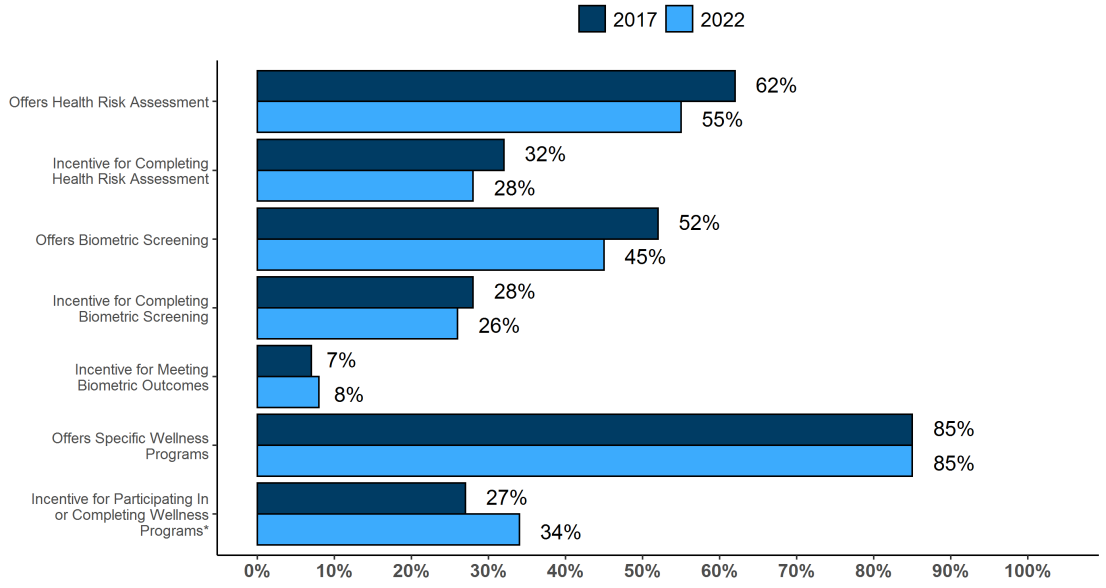
Many firms have programs that help workers identify health issues and manage chronic conditions, including health risk assessments, biometric screenings, and health promotion programs [Figure G]. However, disruptions caused by the COVID-19 pandemic, including job changes, remote work, and social distancing have challenged workers' abilities to participate. In the 2021 EHBS, we focused on the changes employers made to these programs in response to the pandemic. For the 2022 EHBS, we look at the shares of employers offering these programs and make comparison to pre-COVID-19 levels in 2019 where appropriate.

Health Risk Assessments. Among firms offering health benefits, 40% of small firms and 55% of large firms provide workers the opportunity to complete a health risk assessment. The percentage of large firms with a health risk assessment program is lower than in 2019 (41%). Among large firms that offer a health risk assessment, 50% use incentives or penalties to encourage workers to complete the assessment, similar to the percentage (50%) in 2019.

Biometric Screenings. Among firms offering health benefits, 24% of small firms and 45% of large firms provide workers the opportunity to complete a biometric screening. The percentage of large firms with a biometric screening program is higher than the percentage in 2021 (38%). This suggests that some large employers are reinstating or revamping programs that were discontinued or suspended during the pandemic. Among large firms with a biometric screening program, 57% use incentives or penalties to encourage workers to complete the assessment, similar to the percentage (58%) in 2019.

[3] This threshold is based on the twenty-fifth percentile of workers' earnings ($30,000 in 2022). Seasonally adjusted data from the Current Employment Statistics Survey. Bureau of Labor Statistics. Current Employment Statistics—CES (national) [Internet]. Washington (DC): BLS; [cited 2022 Sep 12]. Available from: https://www.bls.gov/ces/publications/highlights/highlights-archive.htm

Figure G
Among Large Firms Offering Health Benefits, Percentage of Firms Offering Various Wellness and Health Promotion Activities and Incentives, by Firm Size, 2017-2022



* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
NOTE: 'Specific Wellness Programs' include 'Programs to Help Workers Stop Smoking', 'Programs to Help Workers Lose Weight', or 'Other Lifestyle or Behavioral Coaching'. Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2022

Health and Wellness Promotion Programs. Most firms offering health benefits offer programs to help workers identify and address health risks and unhealthy behaviors. Fifty-four percent of small firms and 85% of large firms offer a program in at least one of these areas: smoking cessation, weight management, and behavioral or lifestyle coaching. The percentage of large firms offering one of these programs is similar to the percentages last year (83%) and in 2019 (84%).

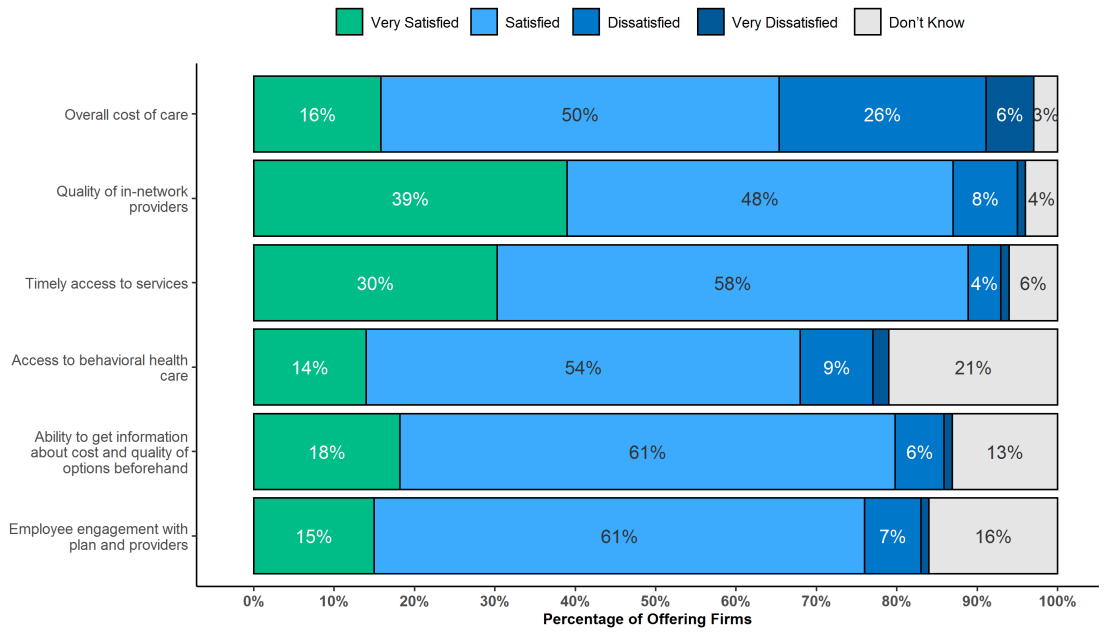
EMPLOYER SATISFACTION WITH HEALTH BENEFIT OFFERINGS

Employers offering health benefits were asked about their level of satisfaction with several aspects of their health plan offerings, including the overall costs for employees, access to care, including access to mental health services, quality of care, and adequacy of plan networks [Figure H]. Among firms offering health benefits:

- A large share (66%) is “very satisfied” or “satisfied” with the overall cost of care for their employees. Large firms are more likely to be at least “satisfied” with the overall cost of care than small firms (79% vs. 65%).
- Thirty-nine percent is “very satisfied” and another 48% is “satisfied” with the quality of the health care providers participating in their health plan networks. These percentages are similar for large and small firms.
- Thirty percent is “very satisfied” and another 58% is “satisfied” with the timely access to services for plan enrollees. These percentages are similar for large and small firms.
- Fourteen percent is “very satisfied” and another 54% is “satisfied” with access to behavioral health care in their health plans for enrollees who need it. Large firms are more likely than small firms to be “very satisfied” with access to behavioral health care in their health plans (25% vs. 13%), while small firms are more likely to say that they do not know (22% vs. 7%).

- Fifteen percent is "very satisfied" and another 61% is "satisfied" with the level of employee engagement with the plan and providers. These percentages are similar for large and small firms.

Figure H
Among Firms Offering Health Benefits, Firm's Satisfaction With Aspects of Firm's Health Plans, 2022



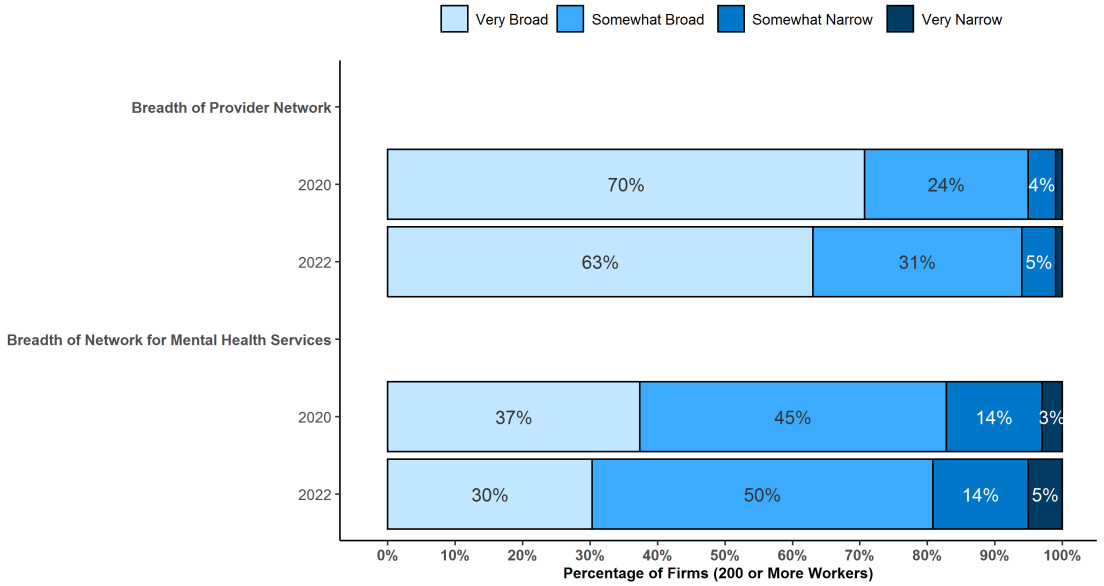
SOURCE: KFF Employer Health Benefits Survey, 2022

HEALTH PLAN PROVIDER NETWORKS

We asked employers to characterize the breadth of the provider network in their largest health plan, as well as whether the networks had a sufficient number of providers to assure timely access to certain services [Figure I]. Among employers offering health benefits:

- Fifty percent say that the network in their plan with the largest enrollment is "very broad," 37% say it is "somewhat broad," and 12% say it is "somewhat narrow." Large firms are more likely than small firms to characterize the network in their largest health plan as "very broad" (63% vs. 50%).
- Twenty percent of firms say that the network for mental health and substance use in their plan with the largest enrollment is "very broad," 51% say it is "somewhat broad," 21% say it is "somewhat narrow," and 8% say it is "very narrow." Large firms are more likely than small firms to characterize the network for mental health and substance use services in their largest health plan as "very broad" (30% vs. 19%).
- Over four in five (82%) of firms believe that there is a sufficient number of primary care providers in the plan networks to provide timely access to services for workers and their family members. In contrast, only 44% believe that there is a sufficient number of behavioral health providers in the plan networks to provide timely access to services for workers and their family members. Thirty-three percent of small firms and 18% of large firms say that they do not know the answer to this question.

Figure I
Among Large Firms Offering Health Benefits, How Broad the Firm Considers Their Largest Plan's Provider Network, by Firm Size, 2020-2022



NOTE: A broad network includes most doctors and hospitals in the area, a narrow network is one which is limited to a small number of providers. Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2022

TELEMEDICINE

Access to telemedicine benefits, which had been growing steadily before the COVID-19 pandemic, skyrocketed during the lockdown period as people refrained from seeking non-emergency health care. We asked employers about their telemedicine benefit offerings, as well as whether they view these benefits as an important source of access to health care in the future [Figure J].

For this survey, 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. We note that during the COVID-19 pandemic, some plans have eased their definitions to allow more types of digital communication to be reimbursed.

Among firms with 50 or more workers offering health benefits, 87% of small firms and 96% of large firms cover the provision of some health care services through telemedicine in their largest health plan. 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 (87% vs. 65% for small firms and 96% vs. 82% for large firms).

Among firms with 50 or more employees offering telemedicine services:

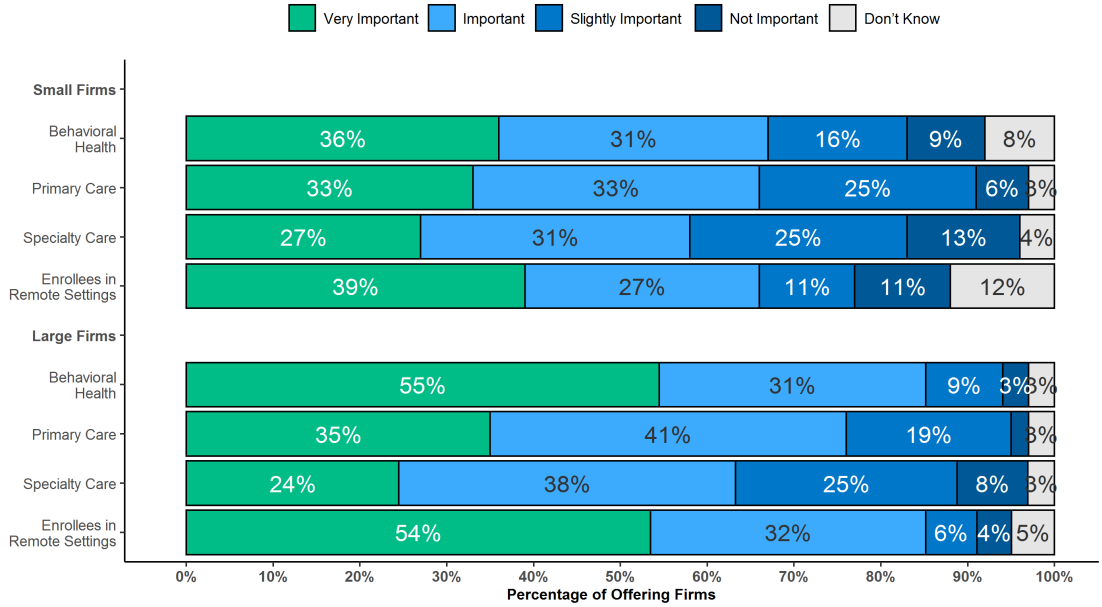
- Twenty-four percent offer telemedicine services through a specialized telemedicine service provider, such as Teledoc, Doctor on Demand, OR MDLIVE, while 59% offer services through their health plan, 14% offer services through both a specialized telemedicine provider and their health plan, and 3% provide services through some other arrangement. Small firms are more likely than larger firms to provide telemedicine services only through their health plan (63% vs. 46%), while large firms are more likely than smaller firms to use a specialized telemedicine provider (32% vs. 21%) or both a specialized telemedicine provider and their health plan (20% vs. 13%).

- Thirty-four percent expect the use of telemedicine to increase in 2022 when compared to last year, 14% expect it to decrease, and 42% expect it to stay about the same.
- Four percent say that their costs have increased as a result of telemedicine, 6% say that costs have decreased, 63% say that costs have stayed about the same, and 27% say that they do not know.

Firms with 50 or more employees offering telemedicine benefits were also asked how important they felt telemedicine would be in providing employees access to certain types of services in the coming years. Among these firms:

- Behavioral Health Services. Thirty-six percent say that telemedicine will be "very important" in providing access to behavioral health services in the future, and another 31% say that it will be "important" in providing access to these services. Large firms are more likely than small firms to say that telemedicine will be "very important" to providing access to behavioral health services. (55% vs. 36%).
- Primary Care. Thirty-three percent say that telemedicine will be "very important" in providing access to primary care in the future, and another 33% say that it will be "important" to providing access primary care.
- Specialty Care. Twenty-seven percent say that telemedicine will be "very important" in providing access to specialty care in the future, and another 31% say that it will be "important" to providing access to specialty care.
- Enrollees in Remote Areas. Forty percent say that telemedicine will be "very important" in providing future access to care for enrollees in remote areas, and another 27% say that it will be "important" to providing future access for remote enrollees. Large firms are more likely than small firms to say that telemedicine will be "very important" to providing access for enrollees in remote areas (54% vs. 39%) while small firms are more likely than large firms to say that telemedicine will be "not important" in providing access for remote enrollees (11% vs. 4%) or to say that they do not know.

Figure J
Among Firms Offering Health Benefits, How Important Will Telemedicine Be in Providing Access to Various Groups Going Forward, 2022



NOTE: Small Firms have 50-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2022

ASSISTANCE FOR LOWER-WAGE WORKERS

Some employers provide assistance to their lower-wage employees to help them with the costs of participating in their health plans. We asked large firms whether they provided assistance to help lower-wage workers with contributions or cost sharing.

- Ten percent of large firms offering health benefits have a program to lower the premium contributions of lower-wage workers, similar to the percentage in 2018 (11%). Firms with 5,000 or more workers are more likely to have a program to lower premium contributions than smaller firms.
- Only 5% of large firms offering health benefits have a program to lower cost sharing of lower-wage workers, similar to the percentage seen in 2020 (6%).

DISCUSSION

This year's average annual premiums for single coverage ($7,911) and family coverage ($22,463) are similar to last year's. The absence of a premium increases this year may reflect the low levels of utilization during the fall of 2021, when many employers were setting their premiums [4]. The inflation experienced throughout the economy in 2022 may push prices up, leading to premium increases in the upcoming year. Despite these concerns, this year continues a period of relatively low premium growth. Family premiums increased 20% over the last five years, compared to 30% between 2007 and 2012 and 51% between 2002 and 2007. Over the last five-year period, family coverage premiums grew at a rate comparable to inflation (17%) and workers earnings (23%). Additionally, the past few years have not seen significant increases in many measures of employee cost. Over the last five years, the average worker contribution to premiums for family coverage grew by 7%, slower than premiums overall, and slower than the average contribution made by employers to the premium (25%). Following a period of rapid increases, deductibles are growing at a slower pace; among all covered workers, the average deductible increased 28% over the last five years, compared to 52% between 2012 and 2017. Affordability issues linger for many with employer coverage, particularly for those at small firms who typically face high general annual deductibles, and for lower-wage workers who may find premiums unaffordable [5]. However, recent years have been a reprieve from the rapid increases in premiums and deductibles throughout the 2000s and 2010s.

There are important differences in coverage offered by small and large firms. On average, workers at small firms contribute more to the cost of family coverage ($7,556 vs $5,580) and face larger general annual deductibles. Among covered workers with a general annual deductible, the average deductible for single coverage is $2,543 at small firms, compared to $1,493 at large firms. Workers in small firms are considerably more likely to have a general annual deductible of $2,000 or more for single coverage than workers in large firms (49% vs. 25%).

Many employers continue to be concerned about meeting the mental health needs of their employees and their dependents. In 2022, 45% of large employers saw an increase in the share of employees seeking mental health services, and 43% were at least somewhat concerned with the growth of substance use conditions among their employees. In response to this need, many employers, particularly large employers, offer self-care apps (51%) or an employee assistance program (85%). Overall, employers expressed concern about the breadth of their provider networks for those with mental health conditions. Only 52% of large employers believe that there were a sufficient number of behavioral health providers in their networks to allow timely access to services compared to 89% for primary care providers. Additionally, only three-in-ten employers described their provider network as "very broad" for mental health services compared to 63% for their networks overall. Many employers indicated

[4] Gallagher K, Gerhart J, Amin K, Rae M, Cox C. Early 2021 data show no rebound in health care [Internet]. San Francisco (CA): Peterson-KFF Health System Tracker; 2022 Aug 17 [cited 2022 Oct 7]. Available from: https://www.healthsystemtracker.org/brief/early-2021-data-show-no-rebound-in-health-care-utilization/

[5] Claxton G, Rae M, Kurani N, Ortaliza J. How affordability of employer coverage varies by family income [Internet]. San Francisco (CA): Peterson-KFF Health System Tracker; 2022 Mar 10 [cited 2022 Oct 7]. Available from: https://www.healthsystemtracker.org/brief/how-affordability-of-health-care-varies-by-income-among-people-with-employer-coverage/

that they were trying to bolster their provider networks through alternative modes, such as adding new virtual providers.

Employers remain optimistic about the future of telemedicine, with over half of large employers indicating they believe it will be "very important" to provide access to behavioral health services, and care to enrollees in remote settings, going forward. Even as pandemic restrictions ease, over a third of large employers expected telemedicine use to increase this year.

Many employers expressed satisfaction with key elements of their plans. Over three-quarters of employers responded that they were either "very satisfied" or "satisfied" with the components of their plans we asked about, including cost of care, quality of providers, and enrollees' timely access to services. Despite challenges, this high level of satisfaction may help explain the stability we have witnessed in employer coverage, despite the considerable turmoil over the last two years.

METHODOLOGY

The KFF 2022 Employer Health Benefits Survey reports findings from a survey of 2,188 randomly selected non-federal public and private employers with three or more workers. Davis Research, LLC conducted the field work between Febuary and July 2022. In 2022, the overall response rate is 14%, 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. For more information 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

2022 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 Febuary to July 2022, Davis interviewed business owners as well as human resource and benefits managers at 2,188 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).[6] 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 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 Febuar, many respondents may have a plan whose 2022 plan year lags behind the calendar year. In some cases, plans may report the attributes of their 2021 plans and some plan attributes (such as HSA deductible limits) may not meet the calendar year regulatory requirements. Decisions concerning plan features and costs may have taken place months before the interview.

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' 2018 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 2021), 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 2019 SUSB). We determine the sample size based on the number of firms needed to ensure a target number of completes in six size categories.

[6] 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.

We attempted to repeat interviews with prior years' survey respondents (with at least ten employees) who participated in either the 2020 or the 2021 survey, or both. Firms with 3-9 employees are not included in the panel to minimize the potential of panel effects. As explained below, this year we also included firms which had participated in either 2018 or 2020 California Health Benefit Survey, sponsored by the California Health Care Foundation. As a result, 1,066 of the 2,188 firms that completed the full survey also participated in either the 2020 or 2021 surveys, or both. In total, 231 firms participated in 2020, 330 firms participated in 2021, and 505 firms participated in both 2020 and 2021. 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 14% [Figure M.1].[7] 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 1,759 of the 2,188 responding firms indicated they offered health benefits. This year we have more completes than in previous years (502 more respondents). This decrease may be attributed to a combination of factors including the introduction of the mixed-modal data collection, incorporating the CHBS and return-to-work accompany lower COVID-19 infection rates.

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 5,105 firms responded to this question (including 2,188 who responded to the full survey and 2,917 who responded to this one question). These responses are included in our estimates of the percentage of firms offering health benefits.[8] The response rate for this question is 32% [Figure M.1].

[7] 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.

[8] Estimates presented in [Figure 2.1], [Figure 2.2], [Figure 2.3], [Figure 2.4], [Figure 2.5], [Figure 2.6], and [Figure 2.7] 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.

Figure M.1

Response Rates for Various Subsets of the Sample, 2022

	Response Rate for Full Survey	Response Rate for Firms Answering A6
Small Firms (3-9 Workers)	13%	34%
Small Firms (3-199 Workers)	18%	39%
Large Firms (200 or More Workers)	11%	28%
Panel Firms (Completed Survey in at Least One of the Past Two Years)	38%	58%
Non Panel Firms	9%	28%
ALL FIRMS	**14%**	**32%**

SOURCE: KFF Employer Health Benefits Survey, 2022

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. As in years past the majority of firms are very small, so the considerable fluctuation we see across years in the offer rate for these small firms drives the overall offer rate.

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.2] 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.3]. 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.2

Selected Characteristics of Firms in the Survey Sample, 2022

	Sample Size	Sample Distribution After Weighting	Percentage of Total for Weighted Sample
FIRM SIZE			
3-9 Workers	225	1,937,974	59.1%
10-24 Workers	298	791,639	24.2
25-49 Workers	211	289,954	8.8
50-199 Workers	314	200,102	6.1
200-999 Workers	549	46,870	1.4
1,000-4,999 Workers	385	8,808	0.3
5,000 or More Workers	206	2,368	0.1
CALIFORNIA			
Firms Without California Employees	1,403	2,866,029	87.4%
Firms With Any California Employees	785	411,686	12.6
INDUSTRY			
Agriculture/Mining/Construction	142	373,729	11.4%
Manufacturing	191	173,849	5.3
Transportation/Communications/Utilities	130	126,847	3.9
Wholesale	122	157,171	4.8
Retail	204	369,163	11.3
Finance	122	206,342	6.3
Service	823	1,411,571	43.1
State/Local Government	114	48,567	1.5
Health Care	340	410,474	12.5
ALL FIRMS	**2,188**	**3,277,715**	**100%**

SOURCE: KFF Employer Health Benefits Survey, 2022

Figure M.3
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.4] 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.

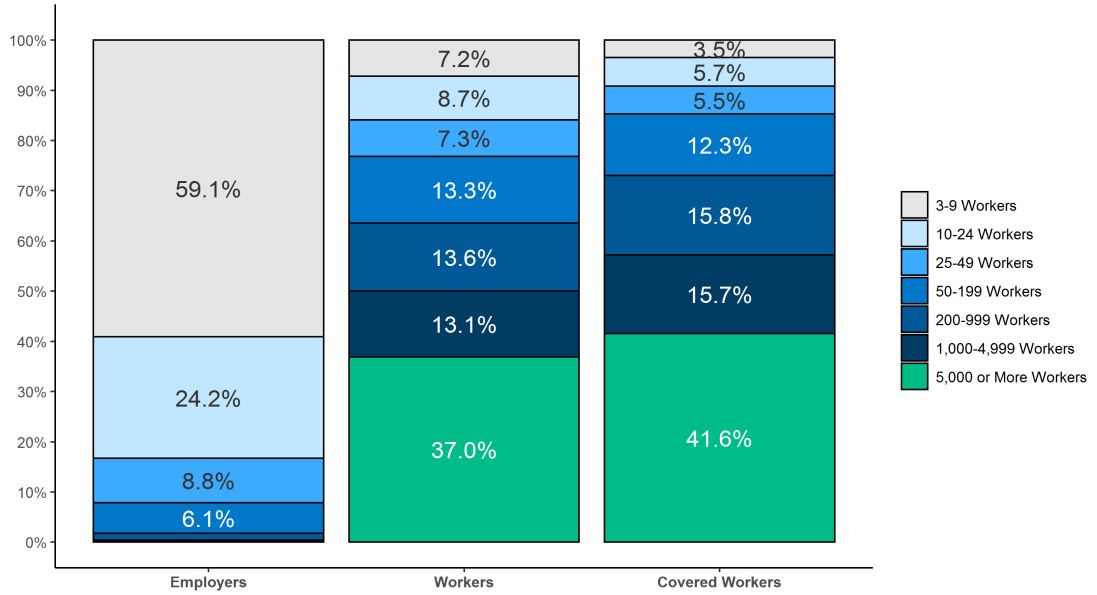
Figure M.4
States by Region, 2022

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, 2022. 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.5] 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 7.2% of workers, and 3.5% of workers covered by health insurance. In contrast, less than one percent of firms employ 5,000 or more workers; these firms employ 37% of workers and 41.6% 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.5
Distribution of Employers, Workers, and Workers Covered by Health Benefits, by Firm Size, 2022



NOTE: Data are based on a data request to the U.S. Census Bureau for their most recent (2020) 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, 2022

Although most firms in the United States are small, most workers covered by health benefits are employed at large firms: 73% 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 $30,000 Or Less or less per year for lower-wage workers and Categorized Percent Of Workforce Earning $70,000 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) (2020).[9] 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 8.0%.[10] 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

[9] General information on the OES can be found at http://www.bls.gov/oes/oes_emp.htm#scope.
[10] Bureau of Labor Statistics, Mid-Atlantic Information Office. Consumer Price Index historical tables for, U.S. city average (1967 = 100) of annual inflation [Internet]. Washington (DC): BLS; [cited 2022 Sep 12]. 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, 14% 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 2022, there were sixty-nine 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.6

Imputation Rates of Premiums, Worker Contributions, and Deductibles, by Plan Type, 2018-2022

	2018	2019	2020	2021	2022
HMO					
Single Premium	1.6%	3.9%	5.1%	6.1%	10.7%
Single Contribution	2.3	2.5	3.7	2.9	7.4*
Single Deductible	1.6	1.5	2.7	2	9*
Family Premium	3.9	5.2	5.7	8.3	13.5
Family Contribution	5.5	5	6.4	9.1	10.2
Family Deductible	3	2.5	4.7	5.4	8.5
PPO					
Single Premium	3.7%	4.4%	7%*	5.6%	8.4%*
Single Contribution	2.5	2.5	3.6	2.5	5.2*
Single Deductible	1	0.8	2.7*	1.2*	4.9*
Family Premium	4.6	5.3	9.1*	6.9	10*
Family Contribution	4.3	4.4	6.4*	5	7.9*
Family Deductible	3.3	2.8	5.4*	4	5.9
POS					
Single Premium	3.9%	10%*	15.5%	10.3%	16%
Single Contribution	1.9	7.4*	10	4.9	7.8
Single Deductible	2.9	2.6	8.2*	7.6	11.3
Family Premium	8.3	11.6	21.3*	16.4	21.7
Family Contribution	7.3	11.6	21.3*	13.1*	14.5
Family Deductible	2.9	5.8	15.7*	13.1	15.7
HDHP/SO					
Single Premium	3.9%	4%	4.9%	6.5%	7.1%
Single Contribution	2.3	2.4	3.3	2	3
Single Deductible	0.6	0.8	1.6	1.1	4.6*
Family Premium	4.1	4.6	6	6	7.4
Family Contribution	3	3.6	4.8	2.9	4.4
Family Deductible	1.6	1.8	3.4	4.5	4.9

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

SOURCE: KFF Employer Health Benefits Survey, 2018-2022;

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.

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 2019 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 4.2.1 (2022-06-23 ucrt) and the library "survey" version 4.1.1 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.

2022 SURVEY

In 2022, we incorporated the California Employer Health Benefits Survey (CHBS) from the California Health Care Foundation (CHCF) into EHBS by oversampling firms with any presence in California and including new questions into the main EHBS instrument to determine firms with any employment in the state of California. Unlike other years, the 2022 EHBS used as its panel both respondents to either of the prior two years of EHBS (2020 and 2021) and also respondents to either of the prior two years of CHBS (2018 and 2020). Since many larger firms operate across state lines, the integration of CHBS with EHBS aimed to reduce survey burden among firms that had previously responded to both surveys. Among the N=1,140 large firms responding to the 2022 EHBS, 419 of those responding firms (37%) had any presence in California, highlighting the overlap across these two projects. Given the size of the California oversample needed to assure statistical reliability both nationally and within California, firm weights were calibrated to California-specific targets from the SUSB.

In 2022, Davis extended computer assisted web interview (CAWI) capacity, offering most respondents the opportunity to complete the survey using an online questionnaire rather a telephone interview. Although only 1% of respondents used this survey mode during the initial 2021 attempt, 43% of 2022 survey respondents answered EHBS via CAWI. Neither premiums nor worker contributions differed across the two response modes.

OTHER RESOURCES

Additional information on the 2022 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.

Published: October 2022. Last Updated: October 23, 2022.

Employer Health Benefits

2022 Annual Survey

Cost of Health Insurance

SECTION

1

Section 1

Cost of Health Insurance

The average annual premiums in 2022 are $7,911 for single coverage and $22,463 for family coverage. These amounts are similar to the premiums in 2021 ($7,739 for single coverage and $22,221 for family coverage). The average family premium has increased 20% since 2017 and 43% since 2012.

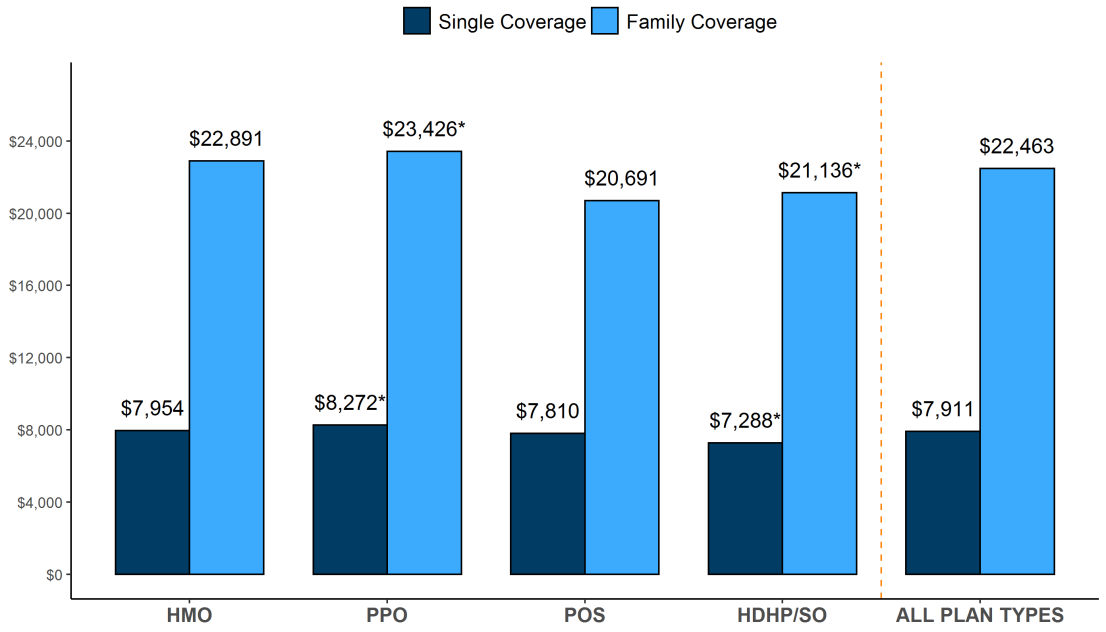
This graphing tool allows users to look at changes in premiums and worker contributions for covered workers at different types of firms over time: https://www.kff.org/interactive/premiums-and-worker-contributions/

PREMIUMS FOR SINGLE AND FAMILY COVERAGE

- The average premium for single coverage in 2022 is $7,911 per year. The average premium for family coverage is $22,463 per year [Figure 1.1].
- The average annual premium for single coverage for covered workers in small firms ($8,012) is similar to the average premium for covered workers in large firms ($7,873). The average annual premium for family coverage for covered workers in small firms ($22,186) is similar to the average premium for covered workers in large firms ($22,564). [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 ($7,288 vs. $7,911) and family coverage ($21,136 vs. $22,463). The average premiums for covered workers in PPOs are higher than the overall average premiums for both single coverage ($8,272 vs. $7,911) and family coverage ($23,426 vs. $22,463) [Figure 1.1].
- The average premiums for covered workers with either single or family coverage are relatively higher in the Northeast and relatively lower in the South [Figure 1.4].
- The average premium for family coverage for covered workers in the the Transportation/Communications/Utilities categories is higher than the average single premium for covered workers in other industries [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 $30,000 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 ($7,267 vs. $7,973) and family coverage ($20,211 vs. $22,681) [Figure 1.6] and [Figure 1.7].
- The average annual premium for single coverage for covered workers in private for-profit firms is lower than the average annual premium for covered workers in other firms. The average annual premium for covered workers in private not-for-profit firms is higher than average annual premium for covered workers in other firms [Figure 1.6] and [Figure 1.7].
- Average premiums vary with the distribution of ages of workers within firms.
  - The average annual premiums for covered workers in firms with a relatively large share of younger workers (where at least 35% of the workers are age 26 or younger) are lower than the average premium for covered workers in firms with a smaller share of younger workers for single coverage ($7,341 vs. $7,978) [Figure 1.6] and [Figure 1.7].

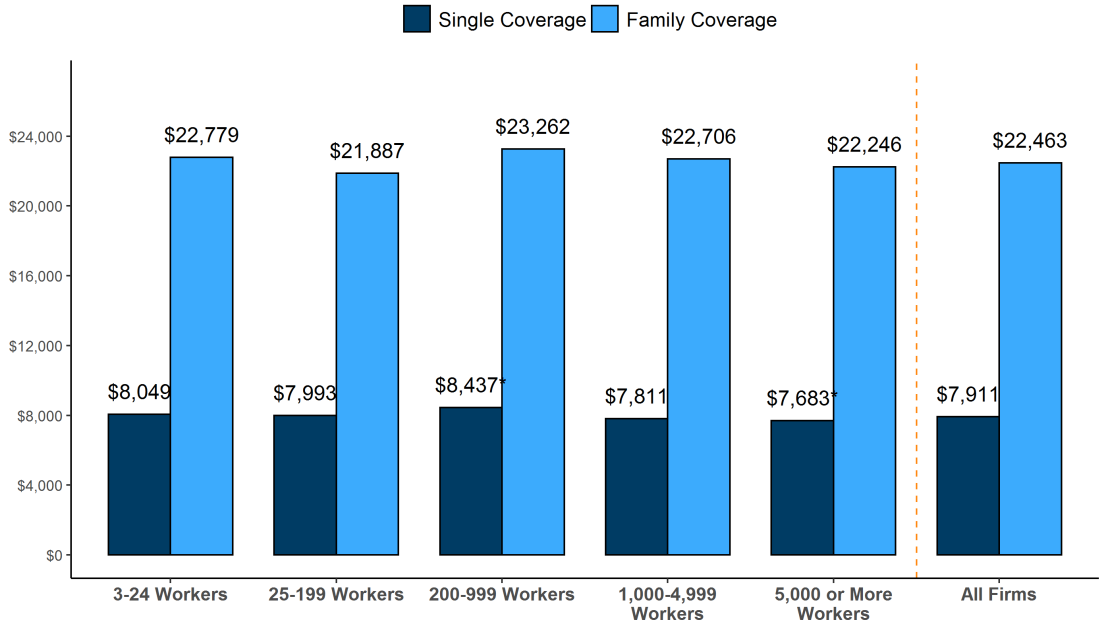
– The average annual premiums for covered workers in firms with a relatively large share of older workers (where at least 35% of the workers are age 50 or older) are higher than the average premium for covered workers in firms with a smaller share of older workers for both single coverage ($8,252 vs. $7,579) and family coverage ($23,197 vs. $21,748). [Figure 1.6] and [Figure 1.7].

Figure 1.1
Average Annual Premiums for Covered Workers, Single and Family Coverage, by Plan Type, 2022



* Estimate is statistically different from All Plans estimate (p < .05).
SOURCE: KFF Employer Health Benefits Survey, 2022

Figure 1.2
Average Annual Premiums for Covered Workers, Single and Family Coverage, by Firm Size, 2022



* Estimate is statistically different from All Plans estimate ($p < .05$).
SOURCE: KFF Employer Health Benefits Survey, 2022

Figure 1.3

Average Monthly and Annual Premiums for Covered Workers, by Plan Type and Firm Size, 2022

	Monthly		Annual	
	Single Coverage	Family Coverage	Single Coverage	Family Coverage
HMO				
All Small Firms	$616	$1,761	$7,391	$21,136
All Large Firms	679	1,959	8,154	23,503
ALL FIRM SIZES	**$663**	**$1,908**	**$7,954**	**$22,891**
PPO				
All Small Firms	$701	$1,929	$8,409	$23,147
All Large Firms	686	1,960	8,227	23,516
ALL FIRM SIZES	**$689**	**$1,952**	**$8,272**	**$23,426**
POS				
All Small Firms	$650	$1,726	$7,804	$20,706
All Large Firms	651	1,723	7,817	20,674
ALL FIRM SIZES	**$651**	**$1,724**	**$7,810**	**$20,691**
HDHP/SO				
All Small Firms	$642	$1,824	$7,707	$21,888
All Large Firms	597	1,742	7,158	20,905
ALL FIRM SIZES	**$607**	**$1,761**	**$7,288**	**$21,136**
ALL PLANS				
All Small Firms	$668	$1,849	$8,012	$22,186
All Large Firms	656	1,880	7,873	22,564
ALL FIRM SIZES	**$659**	**$1,872**	**$7,911**	**$22,463**

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, 2022

Figure 1.4

Average Monthly and Annual Premiums for Covered Workers, by Plan Type and Region, 2022

	Monthly		Annual	
	Single Coverage	Family Coverage	Single Coverage	Family Coverage
HMO				
Northeast	$801*	$2,353*	$9,609*	$28,230*
Midwest	580	1,609*	6,962	19,307*
South	662	1,925	7,943	23,102
West	636	1,817	7,629	21,807
ALL REGIONS	**$663**	**$1,908**	**$7,954**	**$22,891**
PPO				
Northeast	$702	$2,020	$8,419	$24,239
Midwest	714*	2,018	8,566*	24,220
South	667	1,872*	8,000	22,462*
West	679	1,925	8,143	23,105
ALL REGIONS	**$689**	**$1,952**	**$8,272**	**$23,426**
POS				
Northeast	$695	$1,833	$8,336	$21,992
Midwest	716	1,993*	8,597	23,920*
South	538*	1,341*	6,459*	16,091*
West	684	1,796	8,213	21,554
ALL REGIONS	**$651**	**$1,724**	**$7,810**	**$20,691**
HDHP/SO				
Northeast	$647	$1,893	$7,765	$22,712
Midwest	599	1,716	7,190	20,593
South	594	1,729	7,124	20,747
West	613	1,807	7,361	21,690
ALL REGIONS	**$607**	**$1,761**	**$7,288**	**$21,136**
ALL PLANS				
Northeast	$698*	$2,011*	$8,379*	$24,126*
Midwest	664	1,881	7,967	22,572
South	636*	1,794*	7,631*	21,530*
West	655	1,863	7,865	22,352
ALL REGIONS	**$659**	**$1,872**	**$7,911**	**$22,463**

* 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, 2022

Figure 1.5

Average Monthly and Annual Premiums for Covered Workers, by Plan Type and Industry, 2022

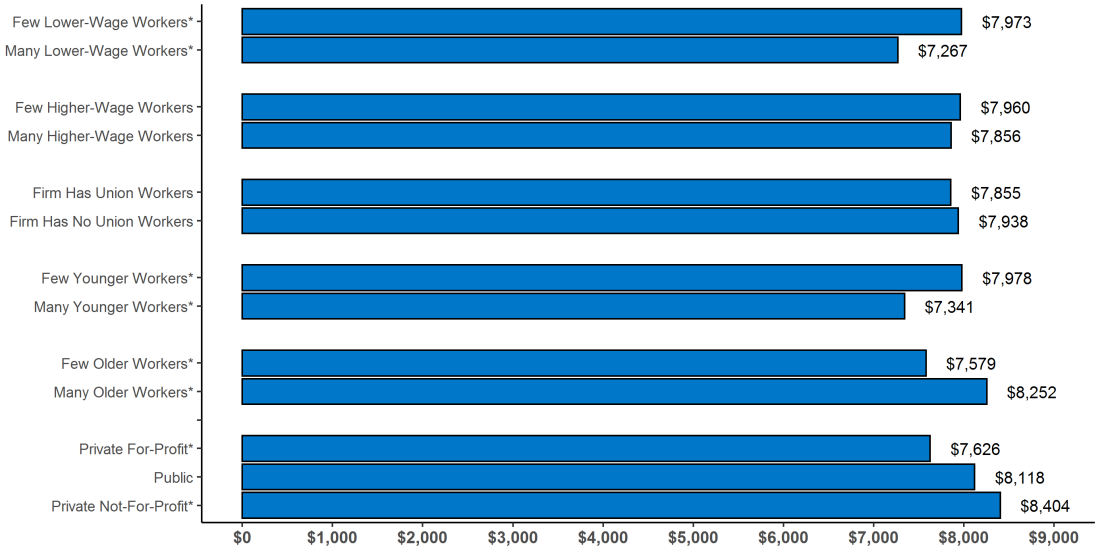
	Monthly		Annual	
	Single Coverage	Family Coverage	Single Coverage	Family Coverage
PPO				
Agriculture/Mining/Construction	$627	$1,812	$7,527	$21,748
Manufacturing	703	1,986	8,437	23,835
Transportation/Communications/Utilities	674	1,997	8,085	23,966
Wholesale	710	2,061	8,515	24,726
Retail	643*	1,942	7,716*	23,303
Finance	698	1,905	8,376	22,862
Service	710	2,031*	8,516	24,369*
State/Local Government	657	1,749	7,887	20,988
Health Care	697	1,892	8,363	22,710
ALL INDUSTRIES	**$689**	**$1,952**	**$8,272**	**$23,426**
HDHP/SO				
Agriculture/Mining/Construction	$599	$1,831	$7,187	$21,977
Manufacturing	567	1,693	6,802	20,315
Transportation/Communications/Utilities	614	1,896	7,368	22,746
Wholesale	597	1,788	7,160	21,456
Retail	584	1,698	7,013	20,379
Finance	659	1,893	7,912	22,712
Service	589	1,716	7,069	20,590
State/Local Government	610	1,467	7,319	17,601
Health Care	687*	1,836	8,243*	22,026
ALL INDUSTRIES	**$607**	**$1,761**	**$7,288**	**$21,136**
ALL PLANS				
Agriculture/Mining/Construction	$618	$1,821	$7,421	$21,851
Manufacturing	633	1,821	7,593	21,852
Transportation/Communications/Utilities	674	2,010*	8,088	24,116*
Wholesale	669	1,942	8,026	23,303
Retail	628	1,846	7,539	22,150
Finance	651	1,773	7,808	21,274
Service	664	1,903	7,967	22,831
State/Local Government	666	1,761	7,997	21,134
Health Care	685	1,869	8,225	22,432
ALL INDUSTRIES	**$659**	**$1,872**	**$7,911**	**$22,463**

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.

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

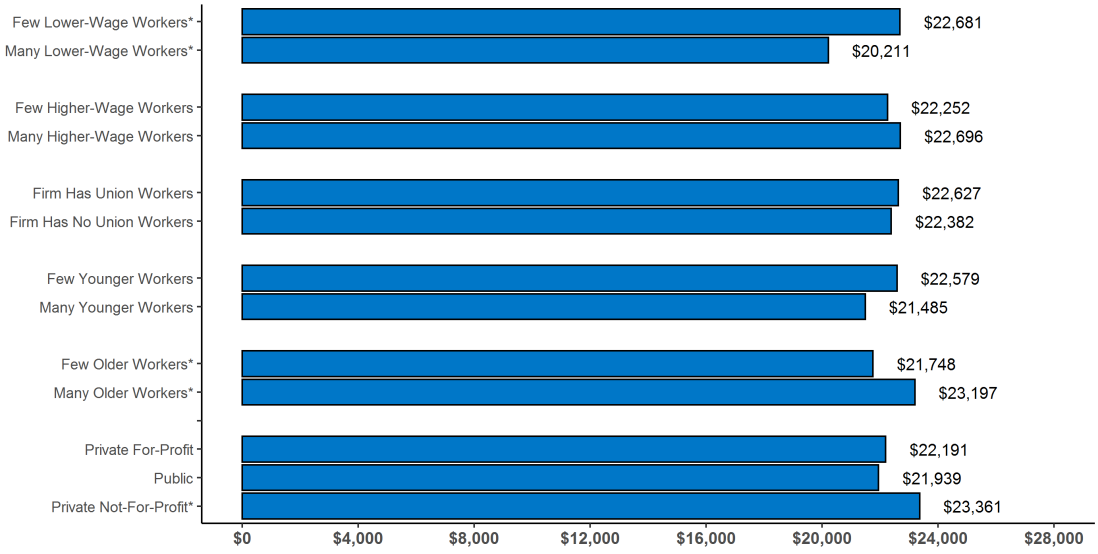
SOURCE: KFF Employer Health Benefits Survey, 2022

Figure 1.6
Average Annual Premiums for Covered Workers with Single Coverage, by Firm Characteristics, 2022



* 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 ($30,000 in 2022). Firms with many higher-wage workers are those where at least 35% earn the 75th percentile or more than of national earnings ($70,000 in 2022). 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, 2022

Figure 1.7
Average Annual Premiums for Covered Workers with Family Coverage, by Firm Characteristics, 2022



* 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 ($30,000 in 2022). Firms with many higher-wage workers are those where at least 35% earn the 75th percentile or more than of national earnings ($70,000 in 2022). 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, 2022

Figure 1.8

Average Annual Premiums for Covered Workers, by Firm Characteristics and Firm Size, 2022

	Single Coverage		Family Coverage	
	All Small Firms	All Large Firms	All Small Firms	All Large Firms
LOWER WAGE LEVEL				
Few Lower-Wage Workers	$8,146*	$7,911	$22,602*	$22,709
Many Lower-Wage Workers	$6,910*	$7,444	$18,753*	$20,919
HIGHER WAGE LEVEL				
Few Higher-Wage Workers	$7,708*	$8,081*	$21,432*	$22,638
Many Higher-Wage Workers	$8,534*	$7,677*	$23,466*	$22,494
UNIONS				
Firm Has Union Workers	$7,939	$7,849	$22,213	$22,659
Firm Has No Union Workers	$8,019	$7,892	$22,183	$22,495
YOUNGER WORKERS				
Few Younger Workers	$8,181*	$7,905	$22,616*	$22,566
Many Younger Workers	$6,871*	$7,574	$19,337*	$22,544
OLDER WORKERS				
Few Older Workers	$7,340*	$7,676	$20,692*	$22,163
Many Older Workers	$8,801*	$8,068	$23,915*	$22,958
FUNDING ARRANGEMENT				
Fully Insured	$7,830*	$7,721	$21,876	$21,434
Self-Funded	$8,741*	$7,907	$23,438	$22,814
FIRM OWNERSHIP				
Private For-Profit	$7,809	$7,557*	$21,803	$22,333
Public	$8,286	$8,091	$22,762	$21,810
Private Not-For-Profit	$8,298	$8,459*	$22,699	$23,702
ALL FIRMS	**$8,012**	**$7,873**	**$22,186**	**$22,564**

NOTE: Firms with many lower-wage workers are those where at least 35% earn the 25th percentile or less of national earnings ($30,000 in 2022). Firms with many higher-wage workers are those where at least 35% earn the 75th percentile or more than of national earnings ($70,000 in 2022). 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.

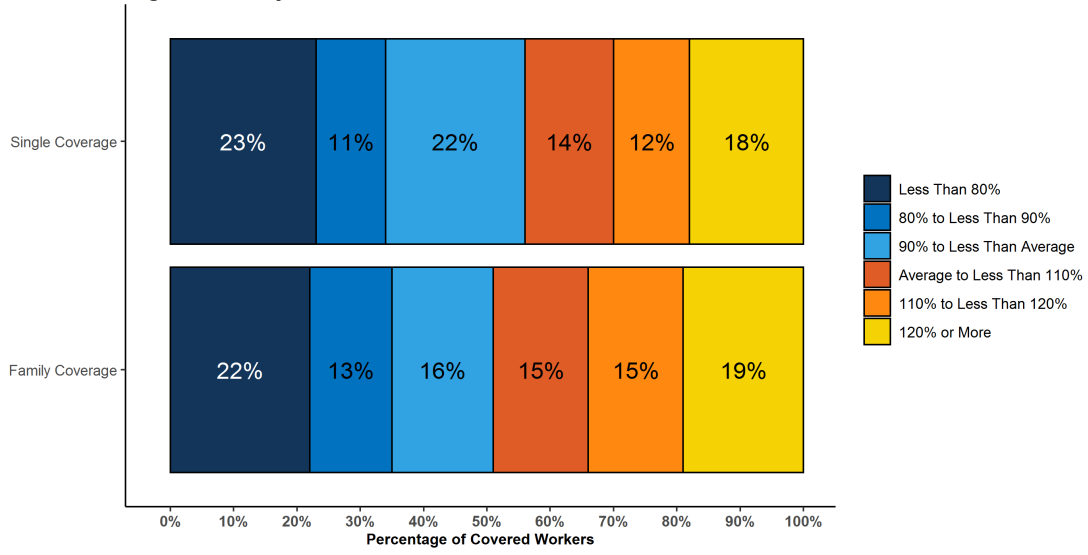
* Estimates are statistically different from estimate for all other firms not in the indicated category within each firm size ($p < .05$).

SOURCE: KFF Employer Health Benefits Survey, 2022

PREMIUM DISTRIBUTION

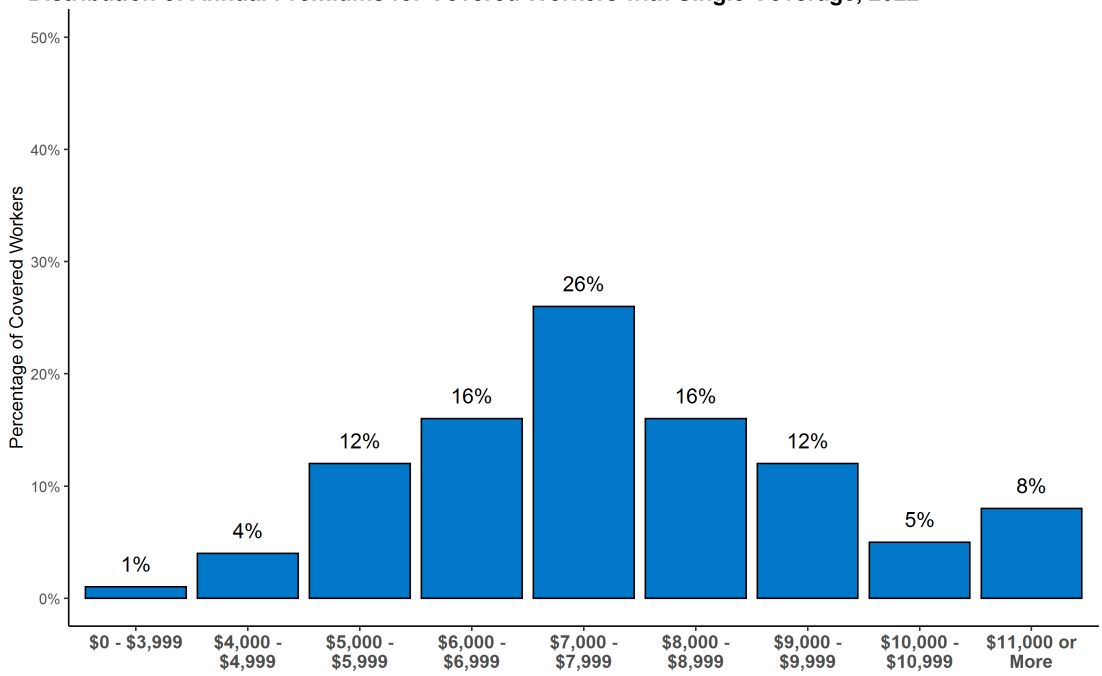
- There remains considerable variation in premiums for both single and family coverage.
  - Eighteen percent of covered workers are employed in a firm with a single premium at least 20% higher than the average single premium, while 23% of covered workers are in firms with a single premium less than 80% of the average single premium [Figure 1.9].
  - For family coverage, 19% 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].
- Thirteen percent of covered workers are in a firm with an average annual premium of at least $10,000 for single coverage [Figure 1.10]. Eleven 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, 2022



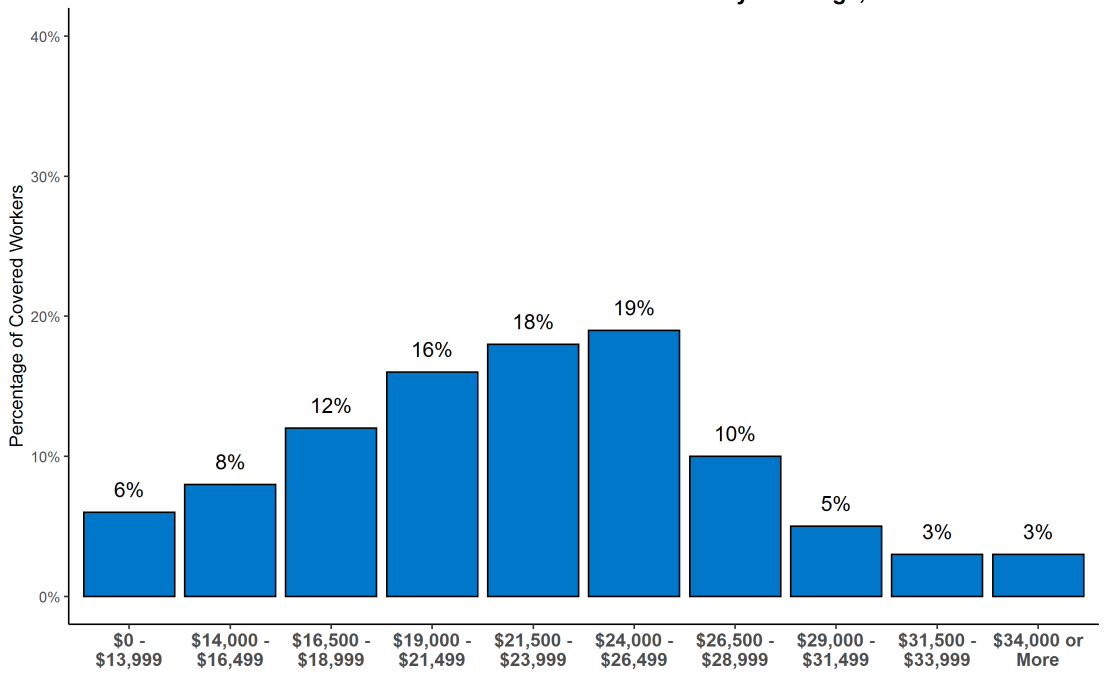
NOTE: The average annual premium is $7,911 for single coverage and $22,463 for family coverage. The premium distribution is relative to the average single or family premium. For example, $6,329 is 80% of the average single premium, $7,120 is 90% of the average single premium, $8,702 is 110% of the average single premium, and $9,493 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, 2022

Figure 1.10
Distribution of Annual Premiums for Covered Workers with Single Coverage, 2022



SOURCE: KFF Employer Health Benefits Survey, 2022

Figure 1.11
Distribution of Annual Premiums for Covered Workers with Family Coverage, 2022



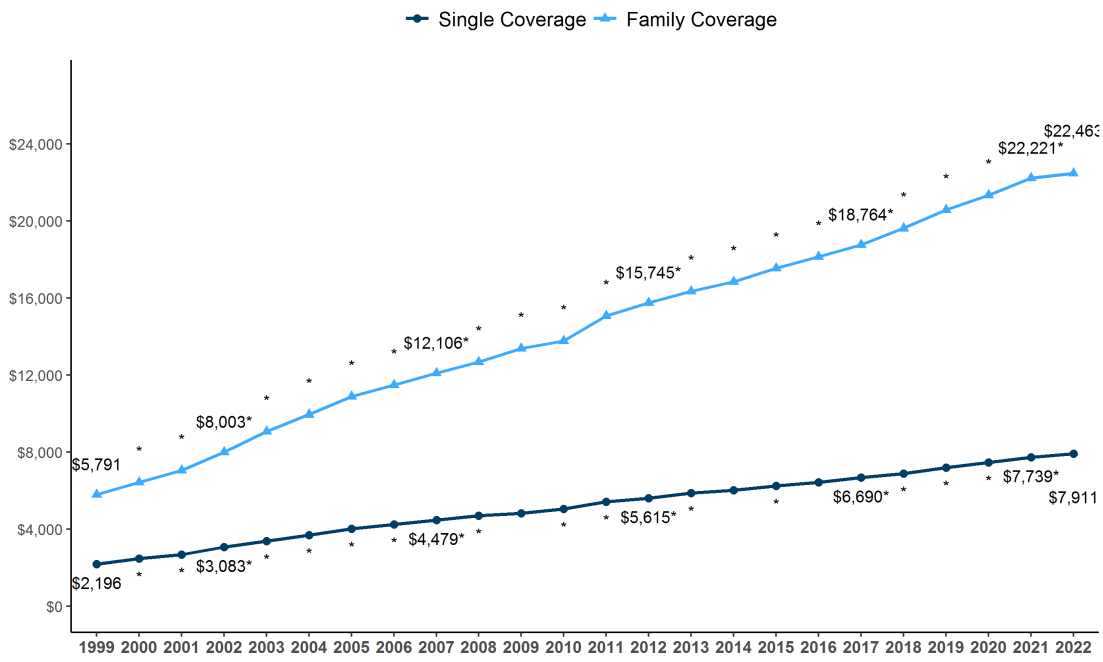
SOURCE: KFF Employer Health Benefits Survey, 2022

PREMIUM CHANGES OVER TIME

- The average premiums for single and family coverage are similar to the premiums from last year [Figure 1.12].
  - The average premium for single coverage has grown 18% since 2017, similar to the growth in the average premium for family coverage (20%) over the same period [Figure 1.12].
  - The $22,463 average family premium in 2022 is 20% higher than the average family premium in 2017 and 43% higher than the average family premium in 2012. The 20% family premium growth in the past five years is similar to the 19% growth between 2012 and 2017 [Figure 1.15].
  - The average family premium has grown faster since 2017 for covered workers in small firms as compared to covered workers in large firms (26% for small firms and 17% for large firms). For small firms, the average family premium rose from $17,615 in 2017 to $22,186 in 2022. For large firms, the average family premium rose from $19,235 in 2017 to $22,564 in 2022 [Figure 1.13].
  - The average family premium has grown at a similar rate since 2012 for covered workers in small firms as compared to covered workers in large firms (45% in small firms and 41% in large firms). In small firms, the average family premium rose from $15,253 in 2012 to $22,186 in 2022. In large firms, the average family premium rose from $15,980 in 2012 to $22,564 in 2022 [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 (13% for fully insured plans and 18% for self-funded firms) [Figure 1.14].
- The average family premium in 2022 is similar to the average family premium in 2021, which compares to a substantial jump in inflation between the first three months of 2021 and the same period in 2022, 8%. This

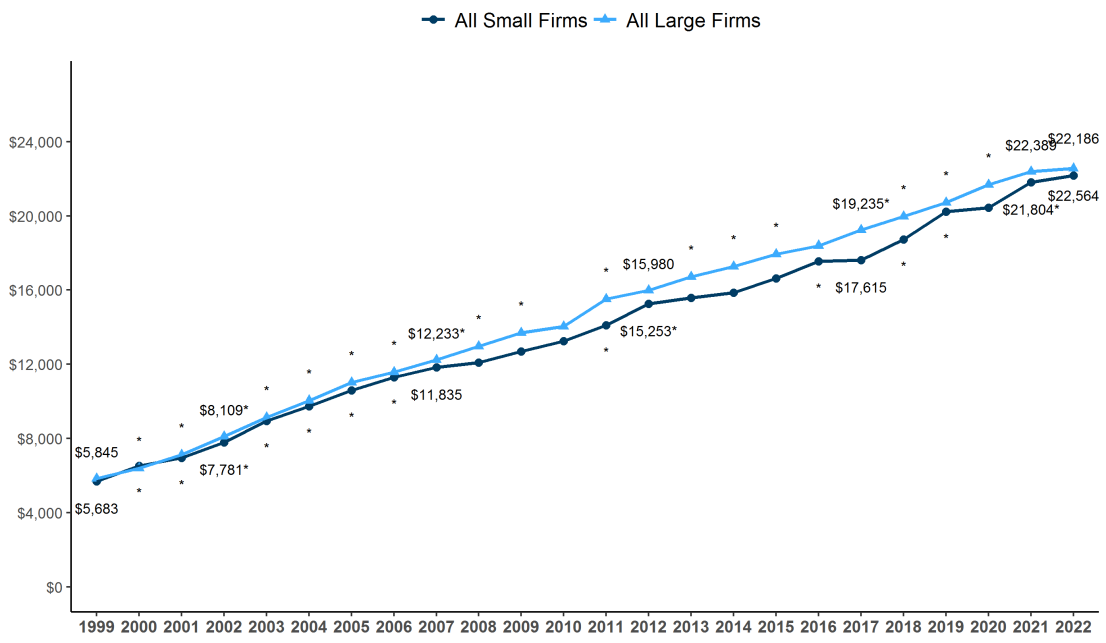
significant jump in inflation brings the growth in the average premium for family coverage over the last 5 years much closer to the rate of inflation over the same period (20% vs. 17%). The growth in the average premium for family coverage still outpaces the rate of inflation over the last ten years (43% vs. 25%) [Figure 1.15].

Figure 1.12
Average Annual Premiums for Single and Family Coverage, 1999-2022



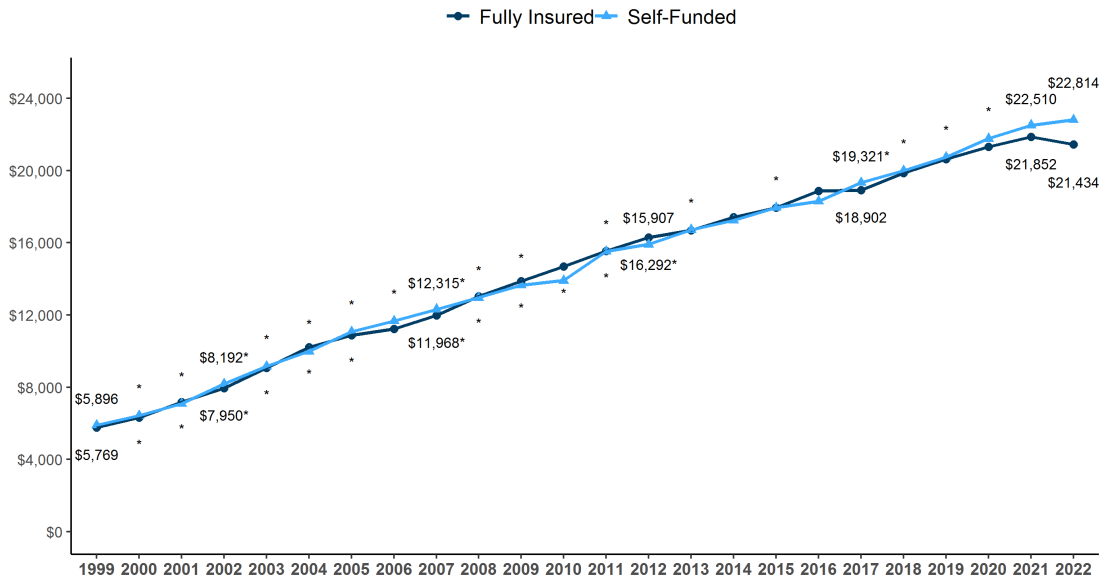
* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
SOURCE: KFF Employer Health Benefits Survey, 2018-2022; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

Figure 1.13
Average Annual Premiums for Covered Workers with Family Coverage, by Firm Size, 1999-2022



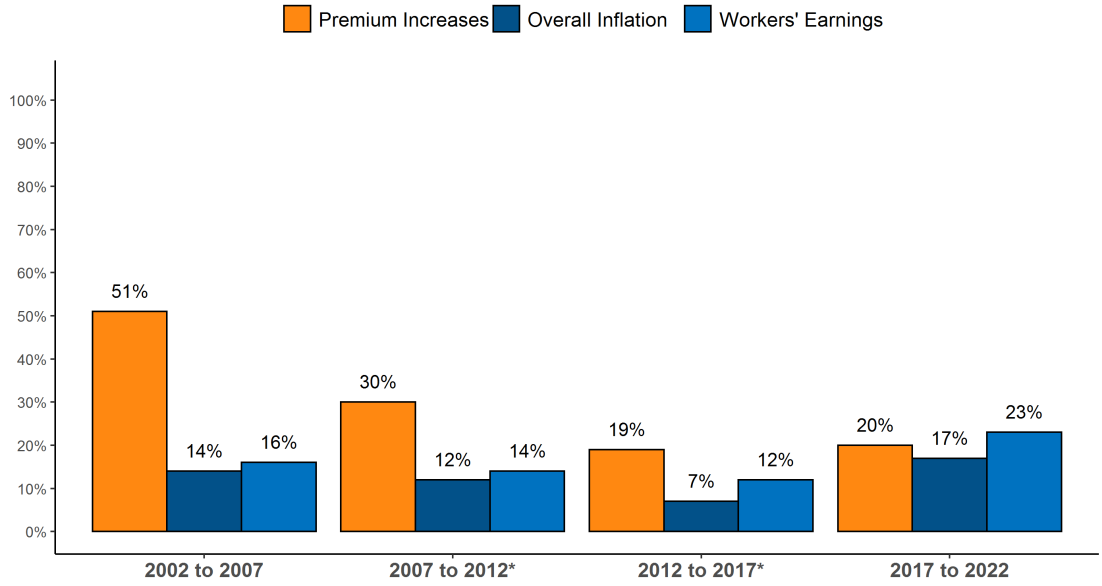
* Estimate is statistically different from estimate for the previous year shown (p < .05).
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2018-2022; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

Figure 1.14
Among Workers in Large Firms, Average Annual Premiums for Family Coverage, by Funding Arrangement, 1999-2022



* 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, 2018-2022; 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, 2002-2022



* Percentage change in family premium is statistically different from previous five year period shown ($p < .05$).
SOURCE: KFF Employer Health Benefits Survey, 2018-2022; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2002-2017. Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation, 2002-2022; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 2002-2022.

Employer Health Benefits
2022 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 2022 (51%) is lower than the the percentage of firms offering health benefits last year (59%) but similar to the percentage five years ago (53%).

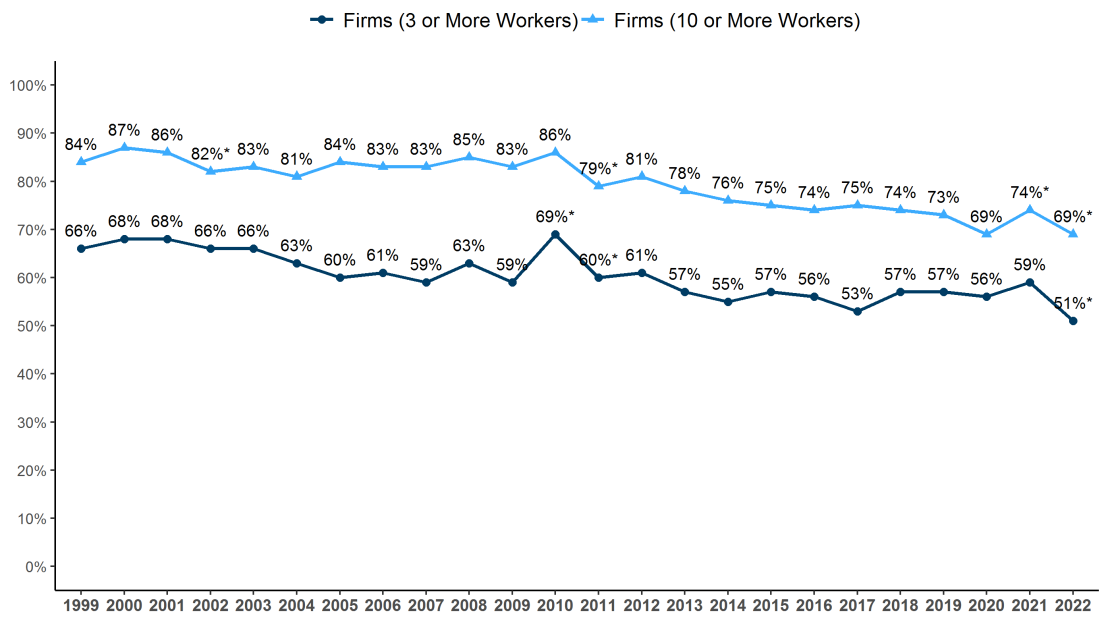
A majority of firms are very small, so the considerable fluctuation we see across years in the offer rate for these small firms drives the overall offer rate. Most workers, however, work for larger firms, where offer rates are high and much more stable. Over ninety percent (93%) of firms with 50 or more workers offers health benefits in 2022; this percentage has remained consistent over the last 10 years. Overall, 89% of workers employed in firms with 3 or more workers are employed at a firm that offers healh benefits to at least some of its workers.

Small firms not offering health benefits say that "the cost of insurance is too high" and that "the firm is too small" are the most important reasons they do not offer coverage. Almost all (95%) firms that offer coverage offer both single and family coverage.

FIRM OFFER RATES

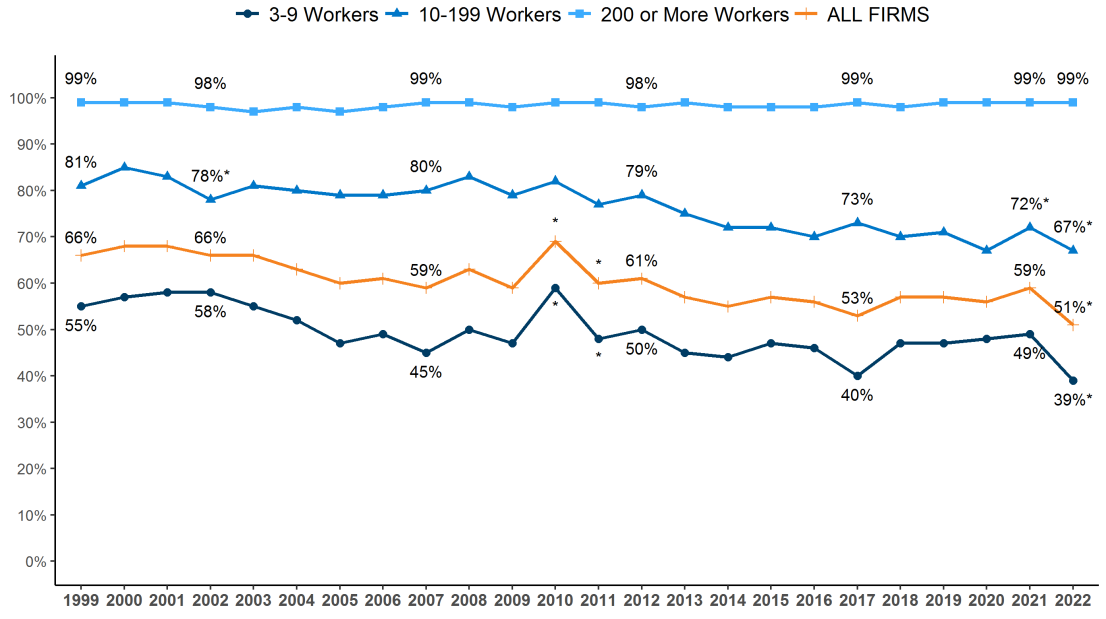
- In 2022, 51% of firms offer health benefits, lower than the percentage last year [Figure 2.1].
  - The smallest-sized firms are least likely to offer health insurance: 39% of firms with 3-9 workers offer coverage, compared to 58% of firms with 10-24 workers, 73% of firms with 25-49 workers, and 91% 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.5].
  - Only 47% of firms with 3-49 workers offer health benefits to at least some of their workers, compared to 93% 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. Eighty-nine percent of all workers are employed by a firm that offers health benefits to at least some of its workers [Figure 2.6].

Figure 2.1
Percentage of Firms Offering Health Benefits, 1999-2022



* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
NOTE: Estimates are based on both the sample of firms that completed the entire survey and those that answered just one question about whether they offer health benefits (See Methods).
SOURCE: KFF Employer Health Benefits Survey, 2018-2022; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

Figure 2.2
Percentage of Firms Offering Health Benefits, by Firm Size, 1999-2022



* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
NOTE: Estimates are based on both the sample of firms that completed the entire survey and those that answered just one question about whether they offer health benefits (See Methods).
SOURCE: KFF Employer Health Benefits Survey, 2018-2022; 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, 2022

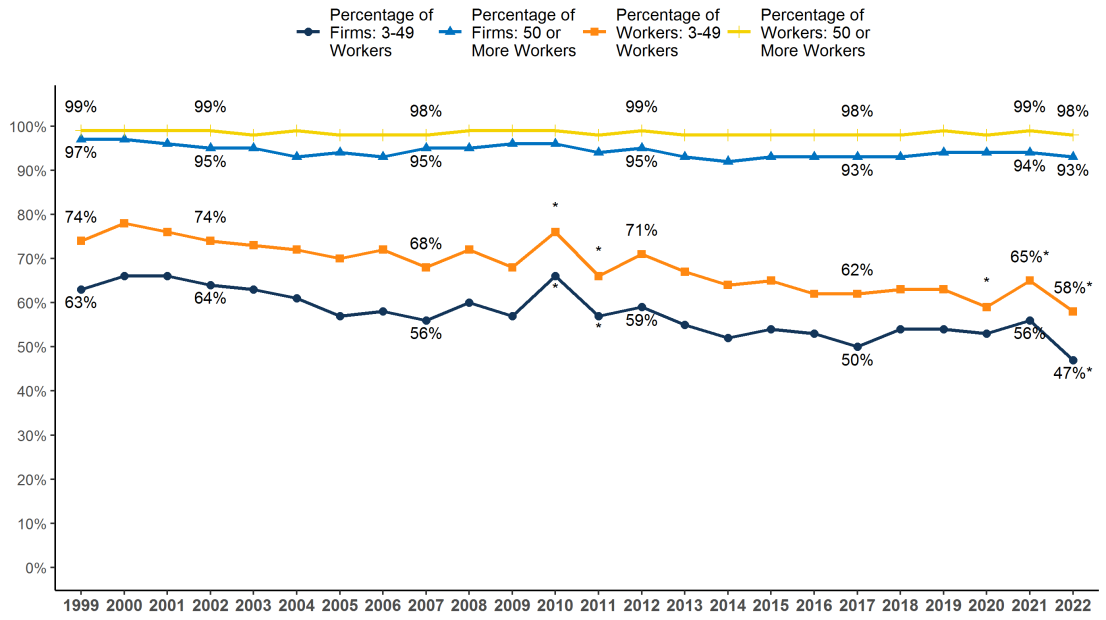
	Percentage of Firms Offering Health Benefits
FIRM SIZE	
3-9 Workers	39%*
10-24 Workers	58*
25-49 Workers	73*
50-199 Workers	91*
200-999 Workers	99*
1,000-4,999 Workers	99*
5,000 or More Workers	99*
All Small Firms (3-199 Workers)	**50%***
All Large Firms (200 or More Workers)	**99%***
REGION	
Northeast	56%
Midwest	51
South	43*
West	57*
INDUSTRY	
Agriculture/Mining/Construction	54%
Manufacturing	70*
Transportation/Communications/Utilities	38*
Wholesale	54
Retail	39*
Finance	46
Service	54
State/Local Government	45
Health Care	45
ALL FIRMS	**51%**

NOTE: Estimates are based on both the sample of firms that completed the entire survey and those that answered just one question about whether they offer health benefits (See Methods).

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

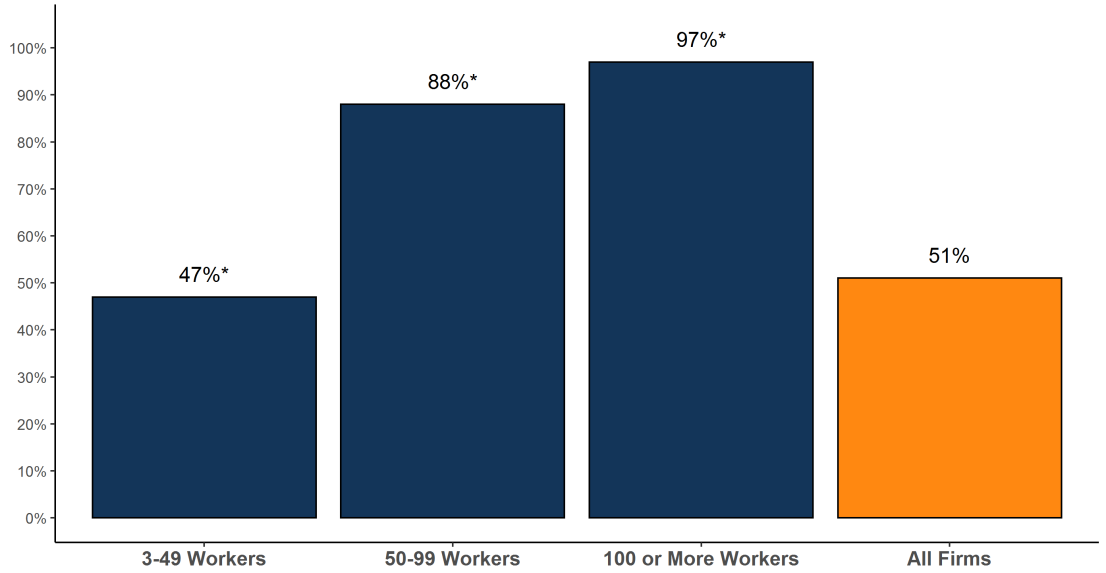
SOURCE: KFF Employer Health Benefits Survey, 2022

Figure 2.4
Percentage of Firms and Workers Offering Health Benefits, by Firm Size, 1999-2022



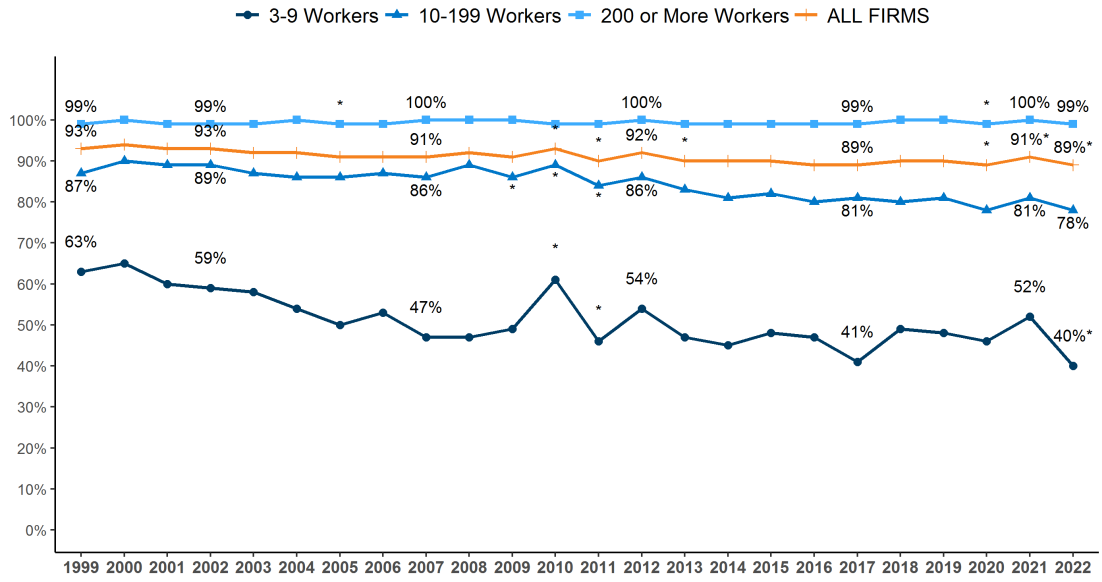
* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
NOTE: Estimates are based on both the sample of firms that completed the entire survey and those that answered just one question about whether they offer health benefits (See Methods). Not all workers at a firm offering benefits are eligible or enrolled in their firm's health benefits.
SOURCE: KFF Employer Health Benefits Survey, 2018-2022; 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, 2022



* Estimate is statistically different from estimate for all other firms not in the indicated size category ($p < .05$).
NOTE: Estimates are based on both the sample of firms that completed the entire survey and those that answered just one question about whether they offer health benefits (See Methods). 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, 2022

Figure 2.6
Percentage of Workers at Firms That Offer Health Benefits to at Least Some Workers, by Firm Size, 1999-2022



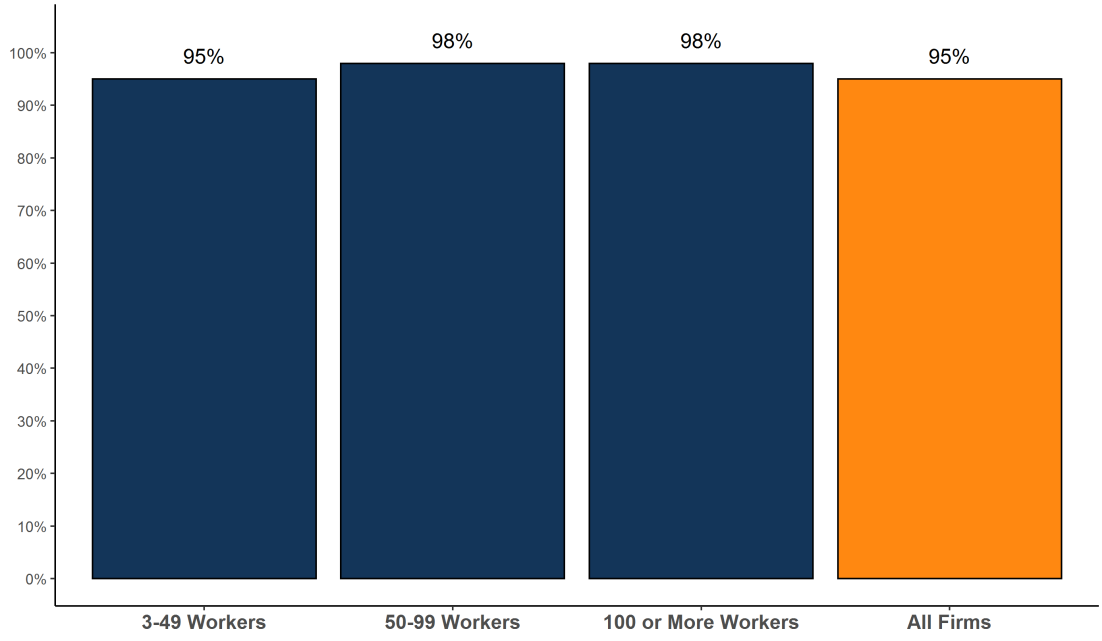
* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
NOTE: Estimates are based on both the sample of firms that completed the entire survey and those that answered just one question about whether they offer health benefits (See Methods). Not all workers at a firm offering benefits are eligible or enrolled in their firm's health benefits.
SOURCE: KFF Employer Health Benefits Survey, 2018-2022; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

SPOUSAL SURCHARGES

Among firms offering health benefits, the vast majority extend that offer to dependents [Figure 2.7]. Some employers place conditions on the ability of dependent spouses to enroll in a health plan if the spouse is offered health insurance from another source, such as his or her own place of work.

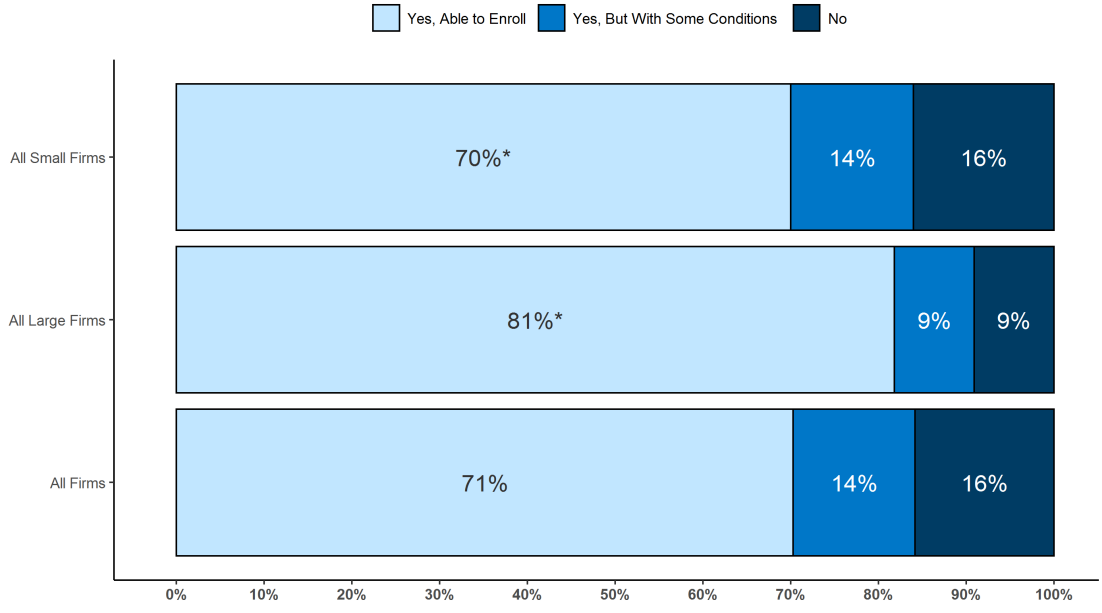
- Among firms offering health benefits to spouses, 71% say that an employee's spouse is able to enroll in the employee's health plan even if the spouse is offered coverage from another source, 14% say the spouse can enroll subject to some conditions (for example, the type of coverage offered), and 16% say that the spouse is not eligible to enroll [Figure 2.8].
- Among firms offering coverage (with or without conditions) to spouses with access to other coverage, 5% require such spouses to pay more if they enroll than spouses without access to other coverage, such as a higher premium contribution or higher cost sharing [Figure 2.10].
  - Firms with 1,000 or more employees are more likely to have restrictions or assess higher costs to spouses with access to other coverage [Figure 2.9].

Figure 2.7
Percentage of Firms Offering Health Benefits Which Offer Family Coverage, by Firm Size, 2022



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, 2022

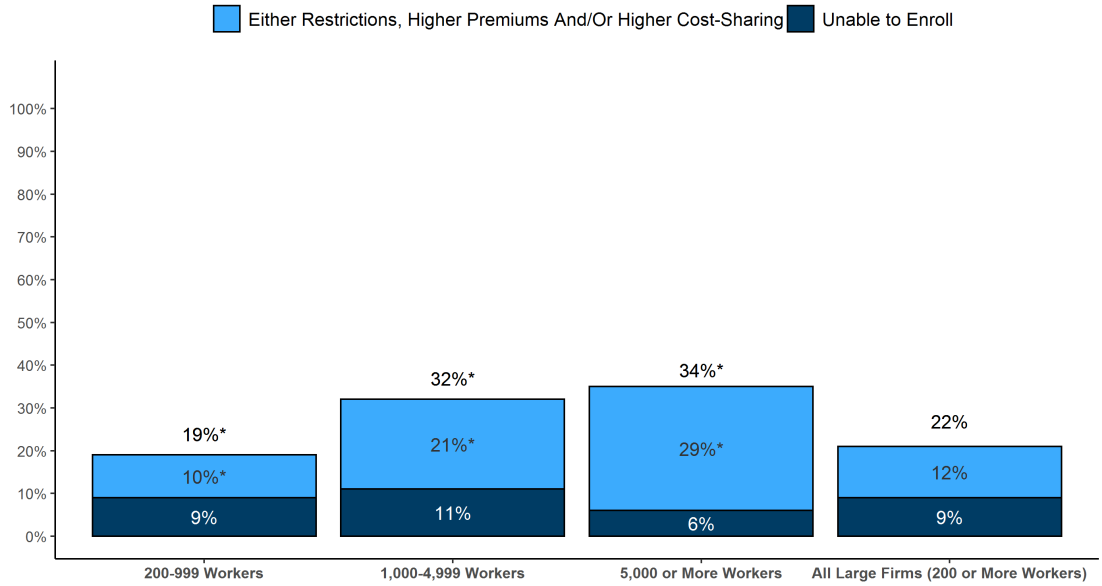
Figure 2.8
Percent of Firms Offering Spousal Coverage Which Restrict Spouses' Eligibility if They Have an Offer from Another Source, by Firm Size, 2022



* Estimate is statistically different between All Small Firms and All Large Firms estimate ($p < .05$).
NOTE: Other restrictions may include requirements on the work status of the spouse, or the type of coverage they have access to.
SOURCE: KFF Employer Health Benefits Survey, 2022

Figure 2.9

Among Large Firms that Offer Spousal Coverage, Spouses' Eligibility if They Have an Offer from Another Source, by Firm Size, 2022



* Estimate is statistically different from estimate for all other firms not in the indicated size category ($p < .05$).
NOTE: Large Firms have 200 or more workers. Other restrictions may include requirements on the work status of the spouse, or the type of coverage they have access to.
SOURCE: KFF Employer Health Benefits Survey, 2022

Figure 2.10

Among Firms Offering Health Benefits to Spouses, Firm's Approach to Spousal Coverage If Employee's Spouse Is Offered Coverage From Another Source, by Firm Size, 2014-2022

	2014	2016	2019	2020	2022
Spouse Not Eligible to Enroll					
All Small Firms (3-199 Workers)	9%	13%	12%	10%	16%
All Large Firms (200 or More Workers)	8%	5%	11%*	10%	9%
ALL FIRMS	9%	13%	12%	10%	16%
Spouse Required to Contribute More to Coverage					
All Small Firms (3-199 Workers)	5%	12%	3%*	2%	5%
All Large Firms (200 or More Workers)	9%	14%*	10%	13%	7%*
ALL FIRMS	5%	12%	3%*	3%	5%

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

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

SOURCE: KFF Employer Health Benefits Survey, 2019-2022; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2014-2016

PART-TIME WORKERS

Among firms offering health benefits, relatively few offer benefits to their part-time workers.

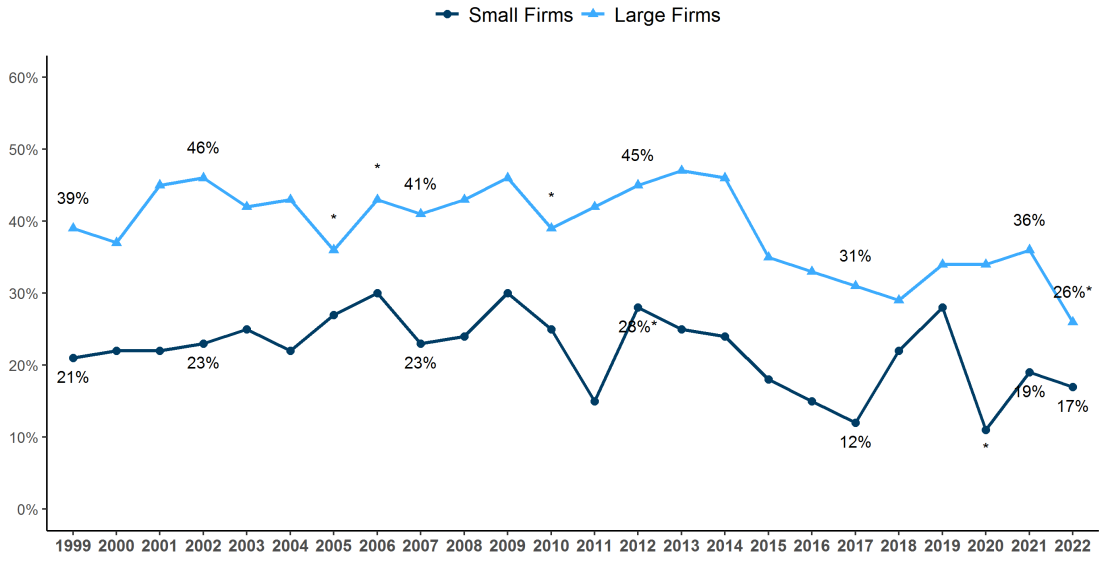
The Affordable Care Act (ACA) defines full-time workers as those who on average work at least 30 hours per week, and part-time workers as those who on average work fewer than 30 hours per week. The employer shared responsibility provision of the ACA requires that firms with at least 50 full-time equivalent 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.

- Twenty-six percent of large firms that offer health benefits in 2022 offer health benefits to part-time workers, lower than the percentage in 2021 [Figure 2.11]. The share of large firms offering health benefits to part-time workers increases with firm size [Figure 2.12].

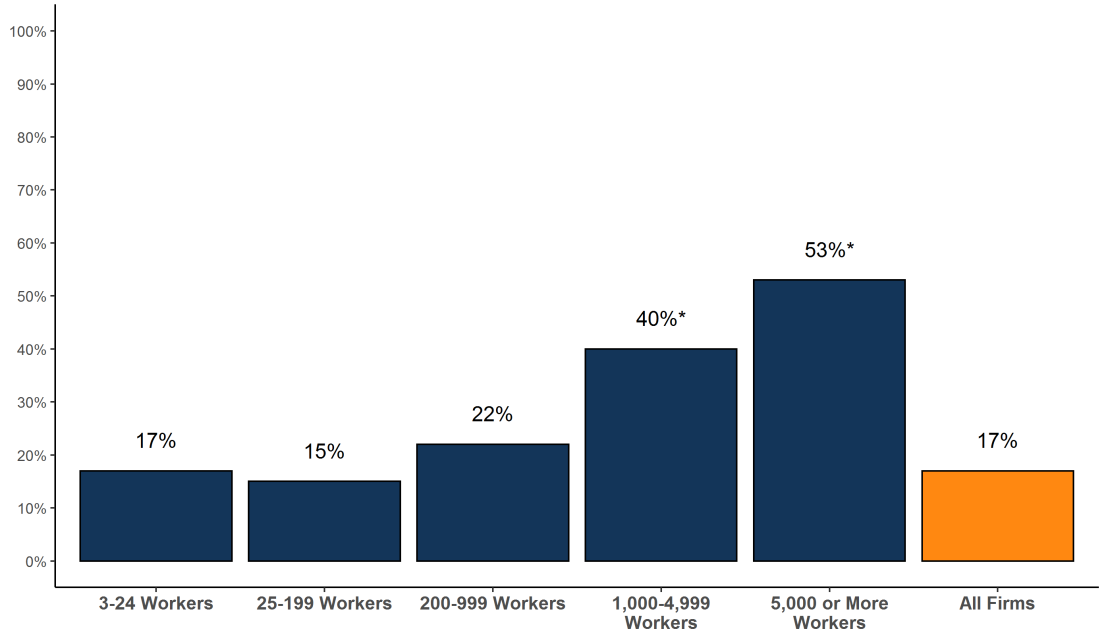
Figure 2.11
Among Firms Offering Health Benefits, Percentage That Offer to Part-Time Workers, by Firm Size, 1999-2022



* 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, 2018-2022; 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 2.12
Among Firms Offering Health Benefits, Percentage That Offer to Part-Time Workers, by Firm Size, 2022



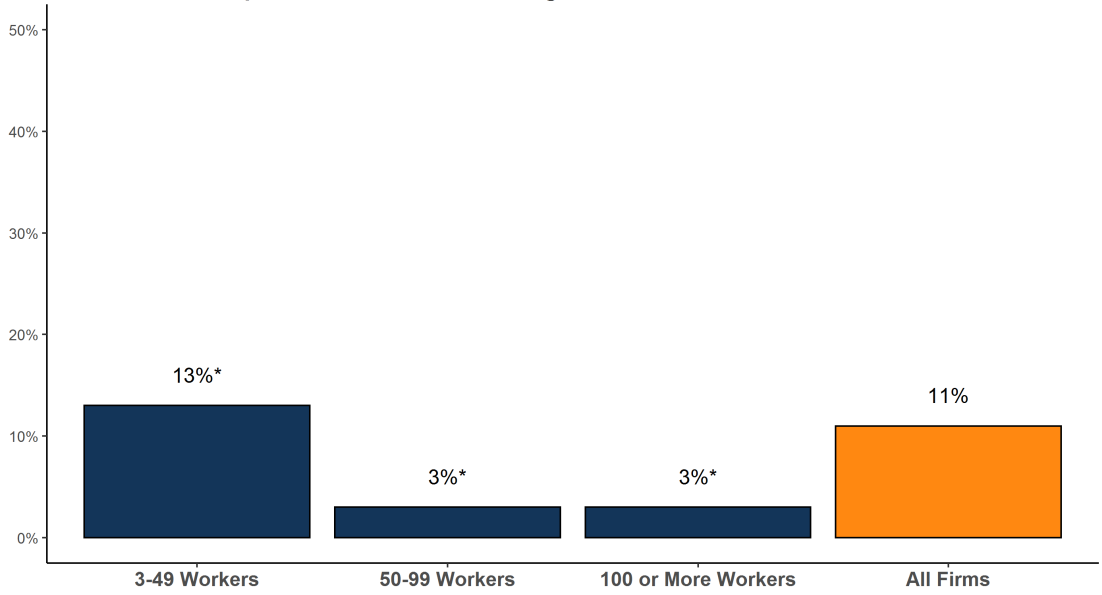
* Estimate is statistically different from estimate for all other firms not in the indicated size category ($p < .05$).
SOURCE: KFF Employer Health Benefits Survey, 2022

ASSISTING EMPLOYEES TO PURCHASE COVERAGE IN THE 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 as 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.

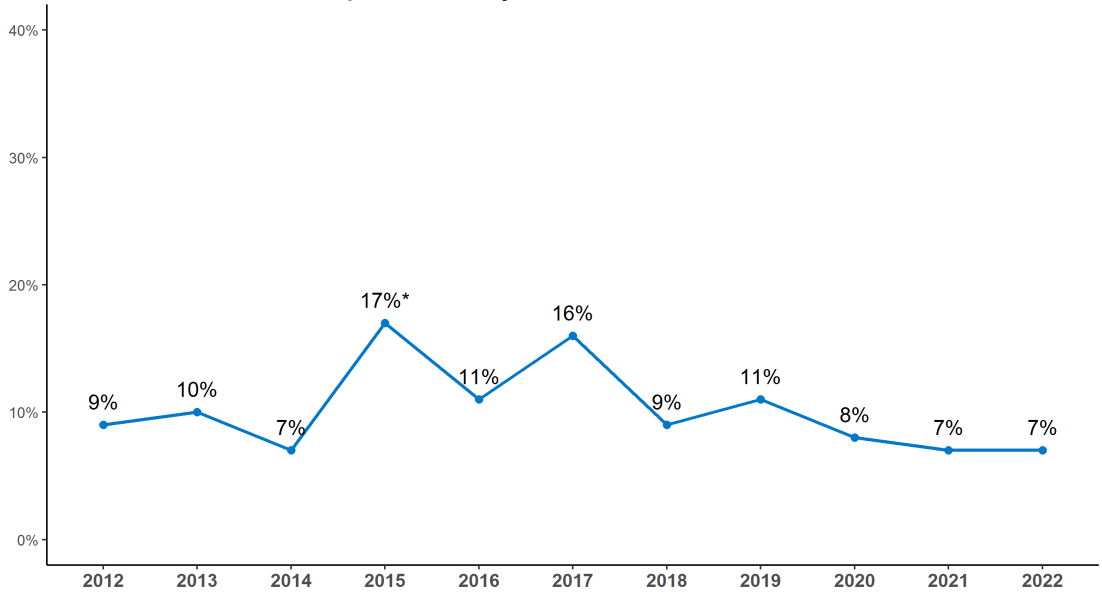
- Eleven percent of firms offering health benefits and 7% of firms not offering health benefits offer funds to one or more of their employees to purchase non-group coverage in 2022 [Figure 2.14] and [Figure 2.15].
  - Among small firms not offering health benefits, 7% offer funds to one or more of their employees to purchase non-group coverage, the same percentage (7%) as last year [Figure 2.14].
- Among all firms (offering and not offering health benefits) that do not offer funds to any employees to purchase non-group coverage in 2022, only 3% are "very likely" and an additional 9% are "somewhat likely" to offer an ICHRA to at least some employees in the next two years.

Figure 2.13
Among Firms Offering Health Benefits, Percentage of Firms That Provide Workers Funds to Purchase Non-Group Insurance, Such as Through an ICHRA, Firm Size, 2022



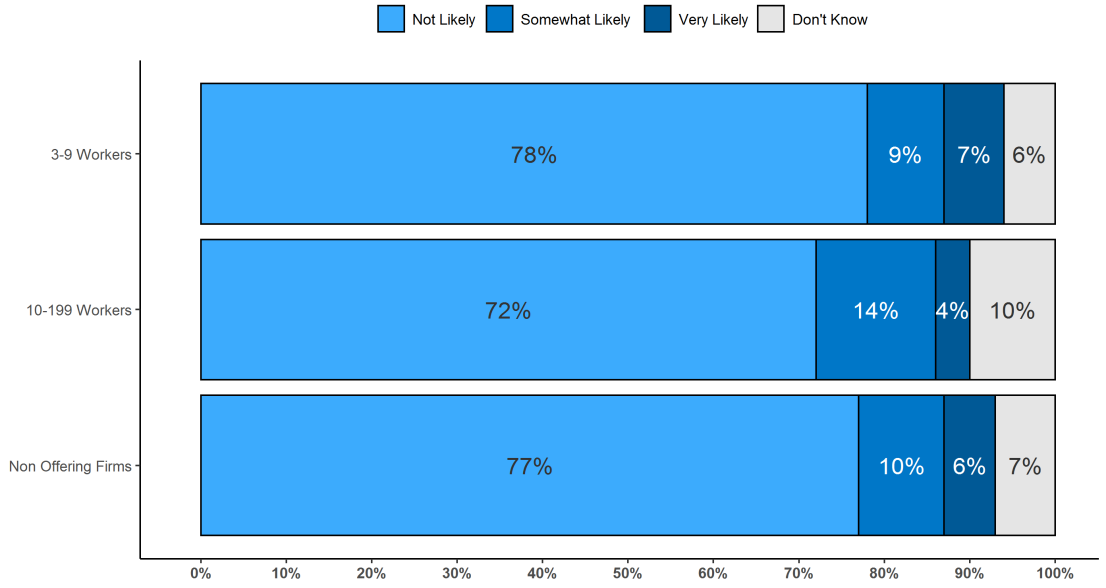
* Estimate is statistically different from estimate for all other firms not in the indicated size category (p < .05).
NOTE: Funds may be provided through an ICHRA. An Individual Coverage Health Reimbursement Arrangement (ICHRA) allows employers to reimburse their employees tax-free for premiums, cost-sharing as well as some other health services and equipment
SOURCE: KFF Employer Health Benefits Survey, 2022

Figure 2.14
Among Small Firms Not Offering Health Benefits, Percentage of Firms That Provide Workers Funds to Purchase Non-Group Insurance, by Firm Size, 2012-2022



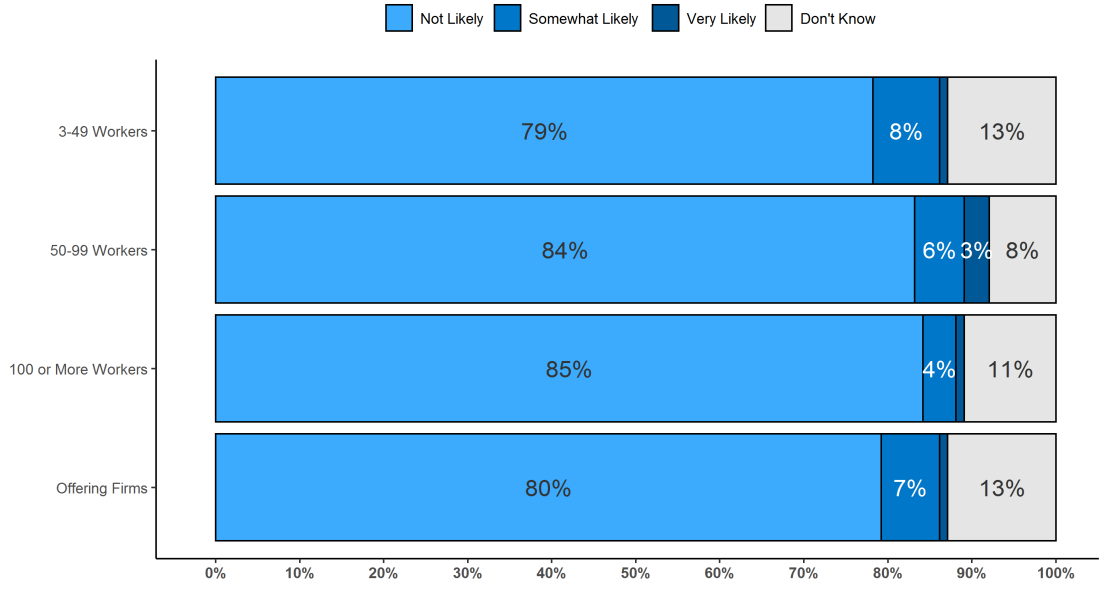
* Estimate is statistically different from estimate for the previous year shown (p < .05).
NOTE: Small Firms have 3-199 workers. Funds may be provided through an ICHRA. An Individual Coverage Health Reimbursement Arrangement (ICHRA) allows employers to reimburse their employees tax-free for premiums, cost-sharing as well as some other health services and equipment
SOURCE: KFF Employer Health Benefits Survey, 2018-2022; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2012-2017

Figure 2.15
Among Small Firms Not Offering Health Benefits, How Likely is Firm to Offer an ICHRA in the Next Two Years, by Firm Size, 2022



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, 2022

Figure 2.16
Among Firms Offering Health Benefits, How Likely is Firm to Offer an ICHRA in the Next Two Years, by Firm Size, 2022



Tests found no statistical difference 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, 2022

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 "firm is too small" and the "cost of insurance is too high" are the most common reasons small firms cite for not offering health benefits. Among small firms asked about the most important reason for not offering health benefits, 31% say the "firm is too small", 28% say the cost of insurance is too high, 18% say their "employees are covered under another plan, including coverage on a spouse's plan" and 6% say their employees are not intetested. Few small firms indicate that they do not offer because they believe employees will get a better deal on the health insurance exchanges (3%) [Figure 2.17].
- 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 2.18].
  - Thirteen percent of small non-offering firms have shopped for coverage in the past year, similar to the percentage last year (10%) [Figure 2.18].
- Among small non-offering firms that report they stopped offering coverage within the past five years, 20% stopped offering coverage within the past year.
- Seventy-nine percent of small firms not offering health benefits believed that their employees would prefer a two dollar per hour increase in wages rather than health insurance. [Figure 2.19].

Figure 2.17

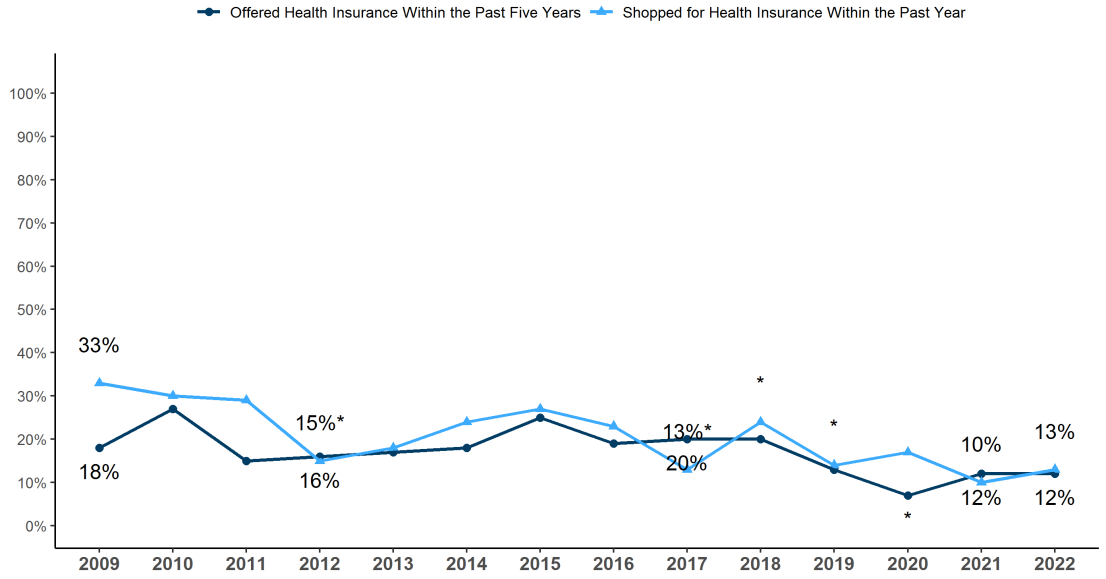
Among Small Firms Not Offering Health Benefits, Most Important Reason for Not Offering, 2022

	3-9 Workers	10-199 Workers	All Small Firms
Cost of Health Insurance Too High	24%	41%	**28%**
Firm Is Too Small	37	15	**31**
Employees Are Covered Under Another Plan, Including Spouse's	20	10	**18**
Employees Will Get a Better Deal On Health Insurance Exchanges	2	5	**3**
Employee Turnover Is Too Great	2	6	**3**
No Interest/Employees Do Not Want It	5	8	**6**
Most Employees Are Part-Time or Temporary Workers	5	11	**7**
Other	2	4	**2**
Don't Know	3%	1%	**2%**

NOTE: Small Firms have 3-199 workers.

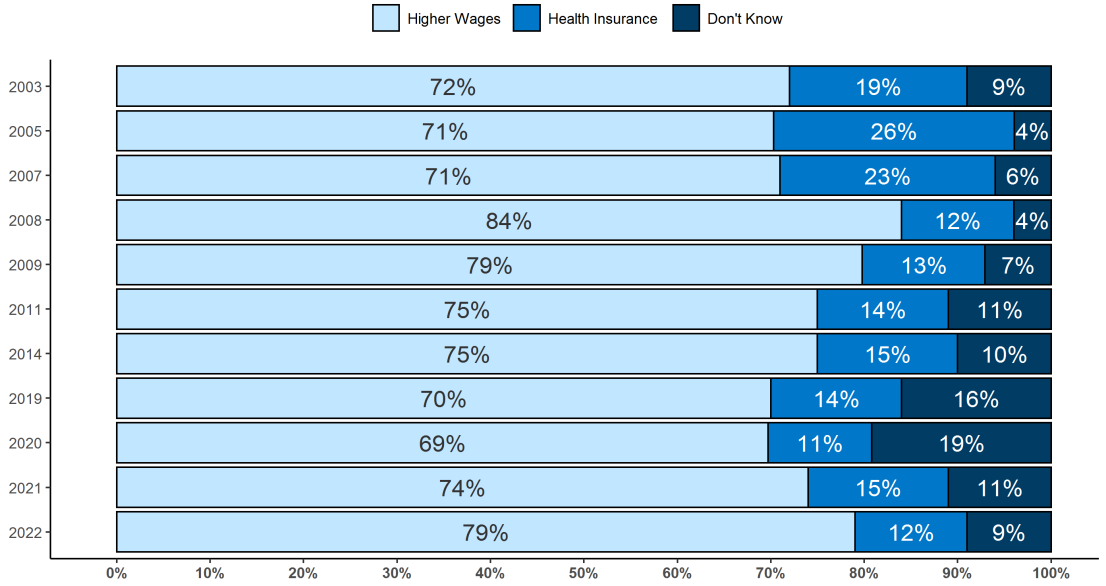
SOURCE: KFF Employer Health Benefits Survey, 2022

Figure 2.18
Among Small Firms Not Offering Health Benefits, Percentage of Firms That Report the Following Actions, 2009-2022



* Estimate is statistically different from estimate for the previous year shown (p < .05).
NOTE: Small Firms have 3-199 workers. 20% 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, 2018-2022; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2009-2017

Figure 2.19
Among Small Firms Not Offering Health Benefits, Firms' View of Employees' Preference for Higher Wages or Health Insurance Benefits, 2003-2022



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, 2019-2022; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2003-2014

Employer Health Benefits

2022 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 159 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 from another source (such as through their spouse's employer), or they may just refuse the offer of coverage from their firm. In 2022, 60% 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 2022, 78% 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 $30,000 a year or less) have a lower average eligibility rate than workers in firms with a smaller share of lower-wage workers (68% vs. 80%) [Figure 3.6].
  - Workers in firms with a relatively large share of higher-wage workers (where at least 35% earn $70,000 or more annually) have a higher average eligibility rate than workers in firms with a smaller share of higher-wage workers (87% vs. 72%) [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 (81% vs. 64%). Those in firms with a relatively large share of older workers (where more than 35% of the workers are age 50 or older) have a higher average eligibility rate than those in firms with a smaller share of older workers (83% vs. 75%) [Figure 3.6].
  - Workers in public firms have a higher average eligibility rate (83%) than workers in private for-profit firms (79%) and private not-forprofit firms (76%) [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] Estimate from KFF's analysis of American Community Survey. Health insurance coverage of the nonelderly 0–64 [Internet]. San Francisco (CA): KFF; 2019 [cited 2022 Sep 12]. Available from: https://www.kff.org/other/state-indicator/nonelderly-0-64/

[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, 1999-2022

	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%
2022	79%	78%	78%	73%	78%	77%	58%	61%	60%

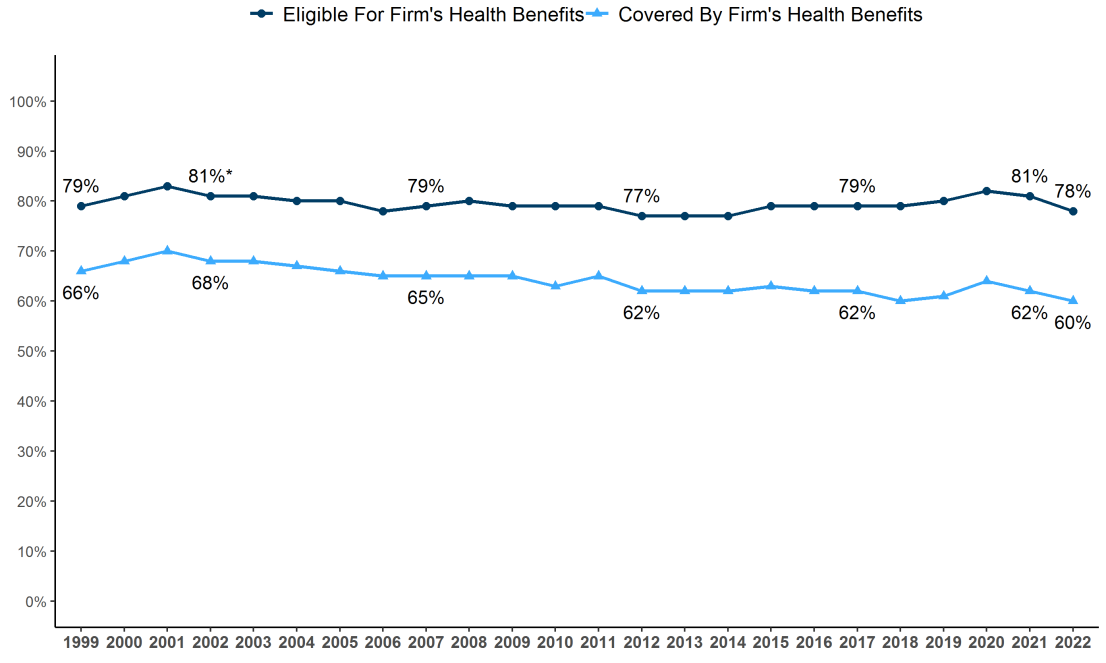
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers.

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

SOURCE: KFF Employer Health Benefits Survey, 2018-2022; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

Figure 3.2

Eligibility and Coverage Rates for Workers in Firms Offering Health Benefits, 1999-2022



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

SOURCE: KFF Employer Health Benefits Survey, 2018-2022; 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, 2022

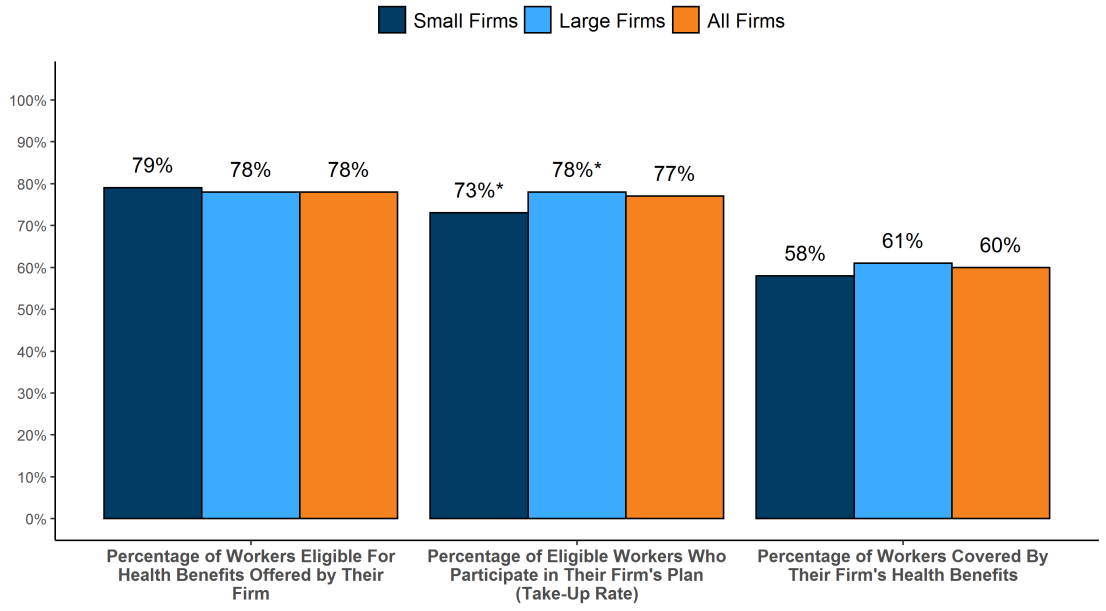
	Percentage of Workers Eligible for Health Benefits Offered by Their Firm	Percentage of Eligible Workers Who Participate in Their Firm's Plan (Take-Up Rate)	Percentage of Workers Covered by Their Firm's Health Benefits
FIRM SIZE			
3-24 Workers	82%	76%	62%
25-49 Workers	82	71*	58
50-199 Workers	75	73*	55*
200-999 Workers	80	77	62
1,000-4,999 Workers	81	79	64*
5,000 or More Workers	76	79*	60
All Small Firms (3-199 Workers)	**79%**	**73%***	**58%**
All Large Firms (200 or More Workers)	**78%**	**78%***	**61%**
REGION			
Northeast	78%	74%	58%
Midwest	79	77	60
South	81	77	63
West	74*	79	59
INDUSTRY			
Agriculture/Mining/Construction	78%	73%	58%
Manufacturing	91*	81*	74*
Transportation/Communications/Utilities	90*	85*	77*
Wholesale	86*	77	66
Retail	55*	65*	35*
Finance	91*	83*	76*
Service	76	74*	56*
State/Local Government	88*	89*	78*
Health Care	77	76	58
ALL FIRMS	**78%**	**77%**	**60%**

* 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, 2022

Figure 3.4

Eligibility, Take-Up, and Coverage Rates in Firms Offering Health Benefits, by Firm Size, 2022

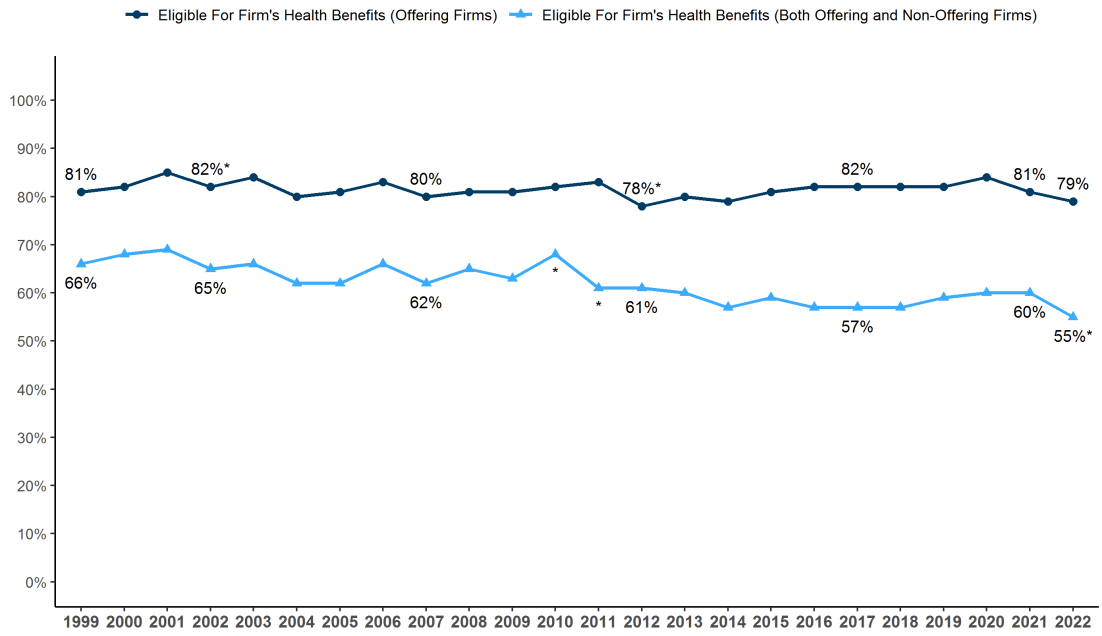


* Estimate for eligibility, take-up, or coverage rate is statistically different between large and small firms ($p < .05$).

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

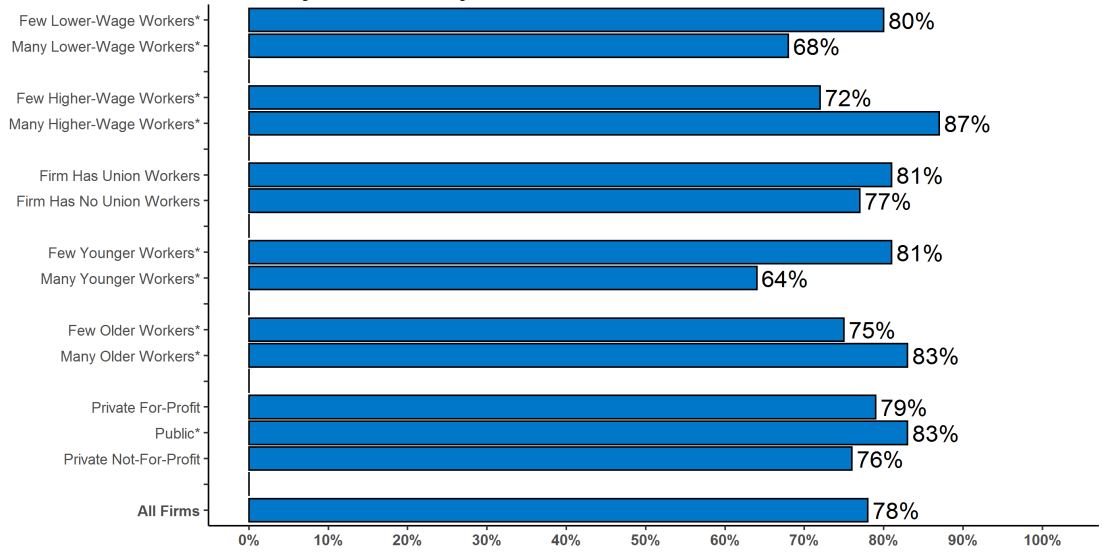
SOURCE: KFF Employer Health Benefits Survey, 2022

Figure 3.5
Among Workers at Small Firms, Eligibility for Workers At Their Own Firms, 1999-2022



* 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, 2018-2022; 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, 2022



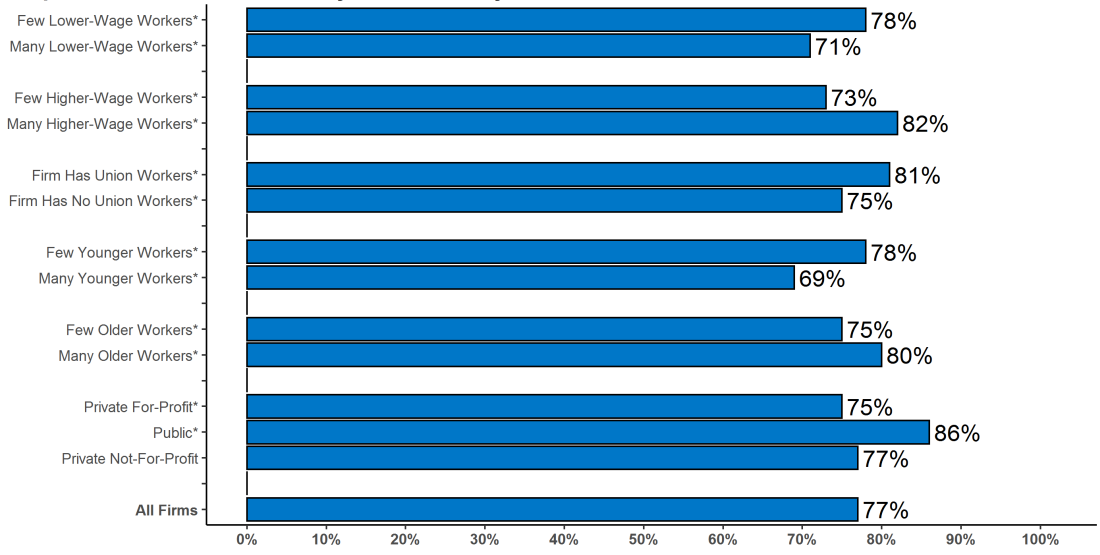
* Estimates are statistically different from each other within category ($p < .05$).
NOTE: Firms with many lower-wage workers are those where at least 35% earn the 25th percentile or less of national earnings ($30,000 in 2022). Firms with many higher-wage workers are those where at least 35% earn the 75th percentile or more than of national earnings ($70,000 in 2022). 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, 2022

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]
  - Eligible workers in small firms have a lower average take up rate than those in larger firms (73% vs. 78%) [Figure 3.8].
  - 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 (71% vs. 78%) [Figure 3.7].
  - Eligible workers in firms with a relatively large share of higher-wage workers have a higher average take up rate than those in firms with a smaller share of higher-wage workers (82% vs. 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 (69% vs. 78%) [Figure 3.7].
  - Eligible workers in private, for-profit firms have a lower average take up rate (75%) and eligible workers in public firms have a higher average take up rate (86%) than workers in other firm types [Figure 3.7].
  - Eligible workers in firms with some union workers have a higher average take up rate (81%) than eligible workers in firms with no union workers (75%) [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 share in 2017 (78%) but lower than the share in 2012 (81%) [Figure 3.1].

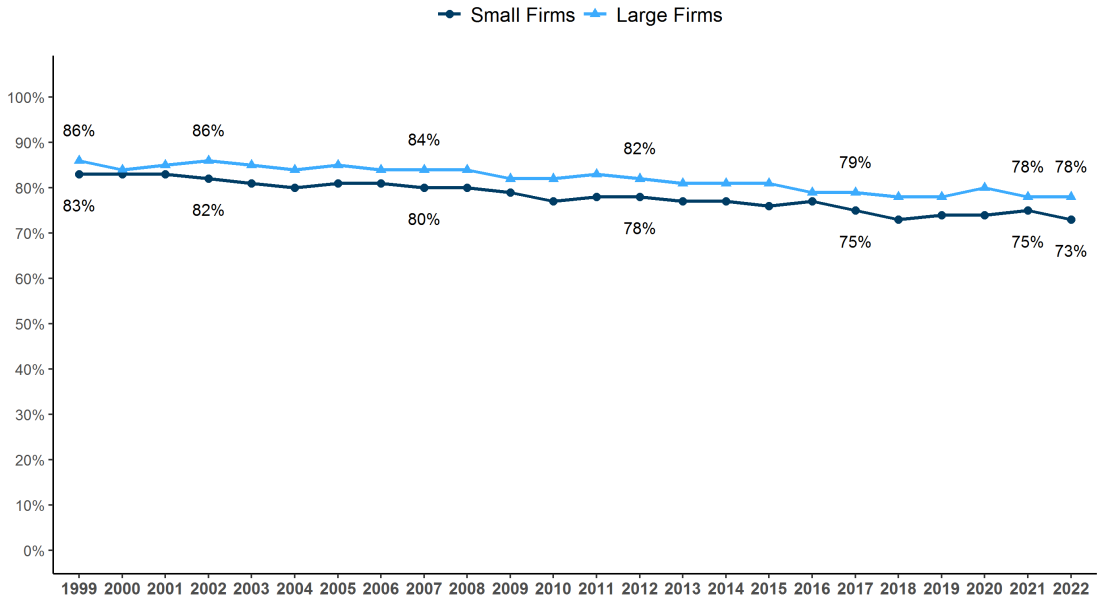
[3] In 2009, we began weighting the percentage of workers that take up coverage by the number of workers eligible for coverage. The historical take-up estimates have also been updated. See the Survey Design and Methods section for more information.

Figure 3.7
Among Workers in Firms Offering Health Benefits, Percentage of Eligible Workers Who Take Up Health Benefits Offered by Their Firm, by Firm Characteristics, 2022



* 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 ($30,000 in 2022). Firms with many higher-wage workers are those where at least 35% earn the 75th percentile or more than of national earnings ($70,000 in 2022). 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, 2022

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, 1999-2022

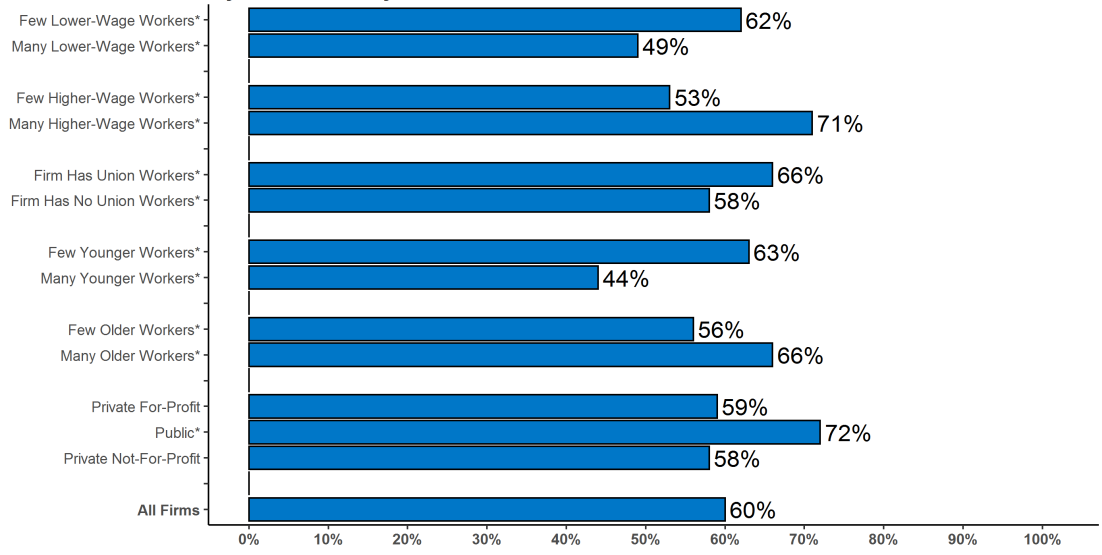


Tests found no statistical difference from estimate for the previous year shown (p < .05).
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2018-2022; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

COVERAGE

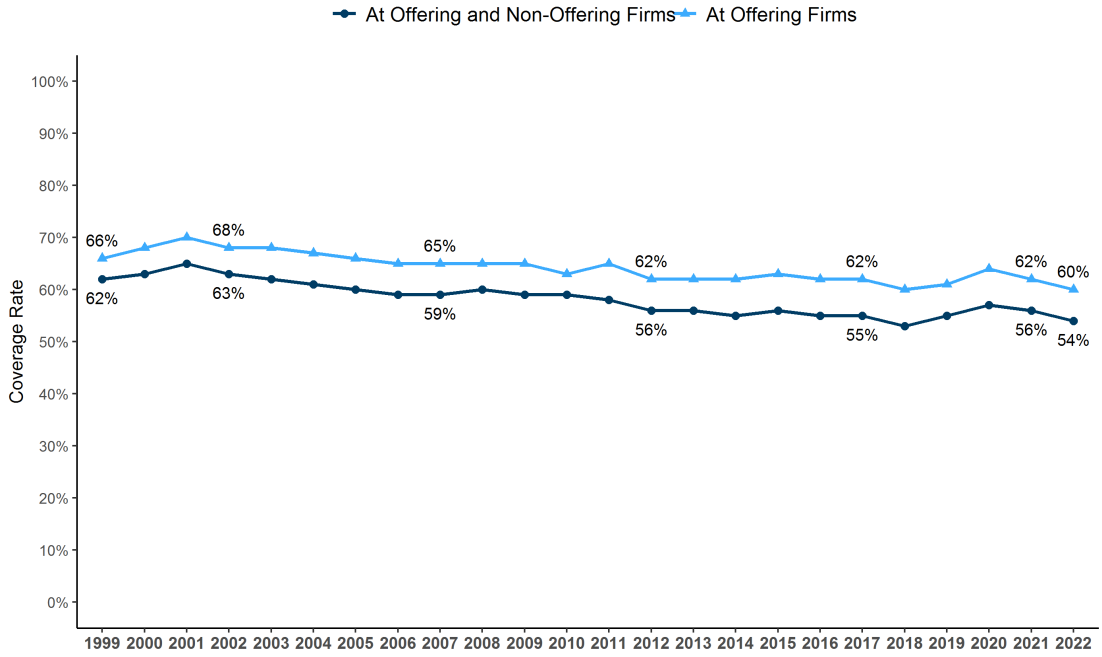
- In 2022, the percentage of workers at firms offering health benefits covered by their firm's health plan is 60%, similar to the percentage last year [Figure 3.1] and [Figure 3.2].
  - The coverage rate at firms offering health benefits is similar for small firms and large firms in 2022. These rates 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 (35%) [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 (49% vs. 62%). 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. 53%) [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 (63% vs. 44%). 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. 56%) [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, 54% are covered by health benefits offered by their employer, similar to the percentages last year (56%) and five years ago (55%) [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, 2022



* 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 ($30,000 in 2022). Firms with many higher-wage workers are those where at least 35% earn the 75th percentile or more than of national earnings ($70,000 in 2022). 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, 2022

Figure 3.10
Percentage of Workers Covered by Their Firm's Health Benefits, 1999-2022



Tests found no statistical difference from estimate for the previous year shown ($p < .05$).
SOURCE: KFF Employer Health Benefits Survey, 2018-2022; 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, 1999-2022

	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%**
2022	31%	42%	50%*	61%	63%	60%	40%*	61%	**54%**

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, 2018-2022; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

Types of Plans Offered

SECTION 4

Section 4

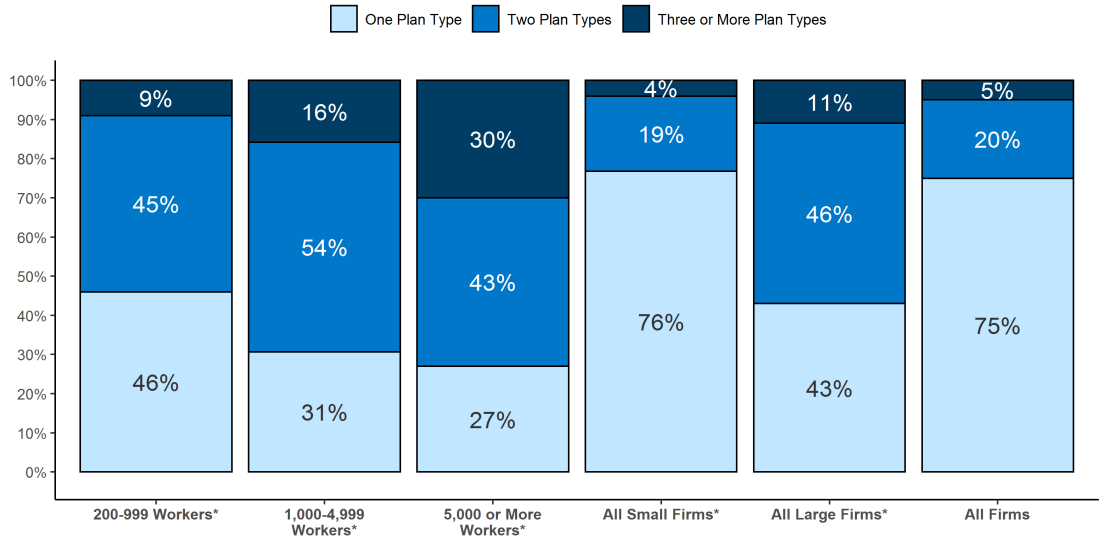
Types of Plans Offered

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 plan type.

NUMBER OF PLAN TYPES OFFERED

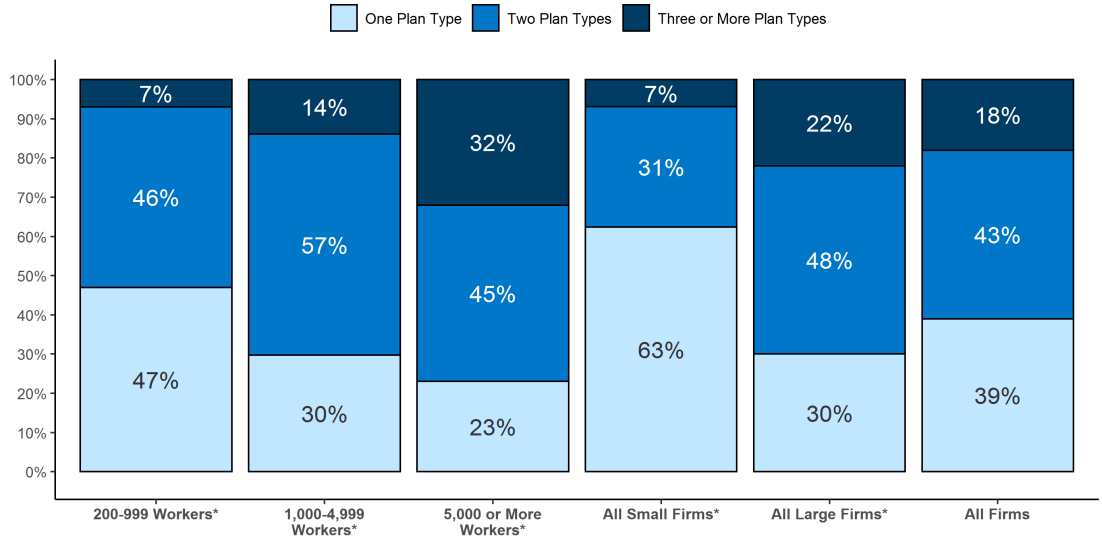
- In 2022, 75% of firms offering health benefits offer only one type of health plan. Large firms are more likely than small firms to offer more than one plan type (57% vs. 24%) [Figure 4.1].
- Sixty-one percent of covered workers are employed in a firm that offers more than one type of health plan. Seventy percent of covered workers in large firms are employed by a firm that offers more than one plan type, compared to 37% of covered workers in small firms [Figure 4.2].
- Sixty-eight percent of covered workers in firms offering health benefits work in firms that offer one or more PPOs; 59% work in firms that offer one or more HDHP/SOs; 19% 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, 55% are in firms that only offer PPOs and 24% are in firms that only offer 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, 2022



* 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, 2022

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, 2022



* 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, 2022

Figure 4.3

Among Firms Offering Health Benefits, Percentage of Firms That Offer the Following Plan Types, by Firm Size, 2022

	Conventional	HMO	PPO	POS	HDHP/SO
FIRM SIZE					
3-24 Workers	<1%	4%*	18%*	11%	22%*
25-199 Workers	2	11*	38*	12	40*
200-999 Workers	2	14*	63*	13	55*
1,000-4,999 Workers	1	18*	74*	12	64*
5,000 or More Workers	2	20*	76*	7	72*
All Small Firms (3-199 Workers)	**1%**	**5%***	**21%***	**12%**	**27%***
All Large Firms (200 or More Workers)	**2%**	**15%***	**65%***	**12%**	**57%***
ALL FIRMS	**1%**	**5%**	**22%**	**12%**	**28%**

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, 2022

Figure 4.4

Among Firms Offering Health Benefits, Percentage of Covered Workers in Firms That Offer the Following Plan Types, by Firm Size, 2022

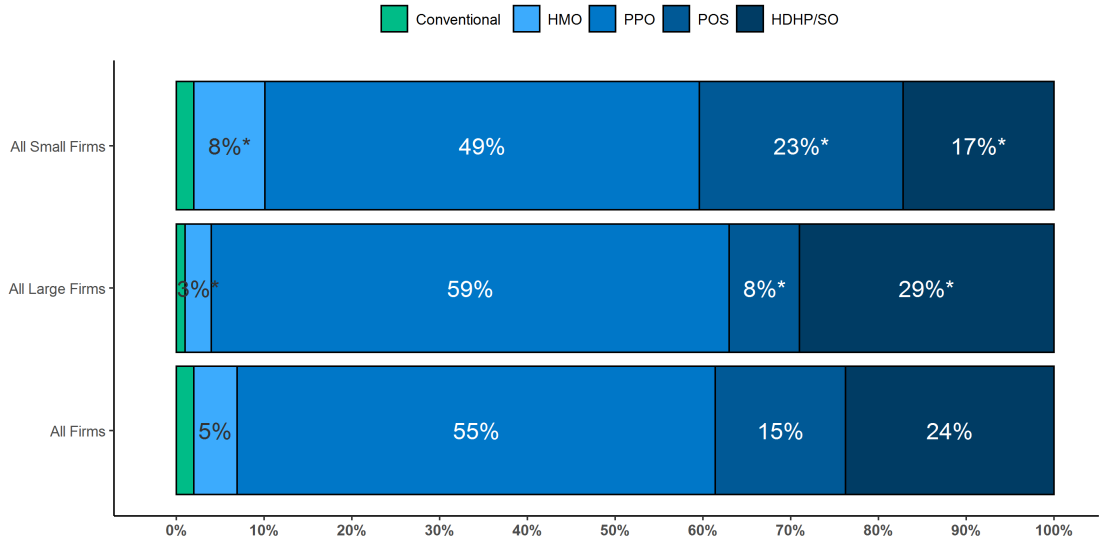
	Conventional	HMO	PPO	POS	HDHP/SO
FIRM SIZE					
200-999 Workers	2%	13%*	69%	11%	54%
1,000-4,999 Workers	1	16	77*	8	67*
5,000 or More Workers	2	26*	77*	6*	73*
All Small Firms (3-199 Workers)	**2%**	**13%***	**50%***	**18%***	**36%***
All Large Firms (200 or More Workers)	**2%**	**21%***	**75%***	**8%***	**67%***
ALL FIRMS	**2%**	**19%**	**68%**	**10%**	**59%**

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, 2022

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, 2022



* 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, 2022

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
2022 Annual Survey

Market Shares of Health Plans

SECTION

5

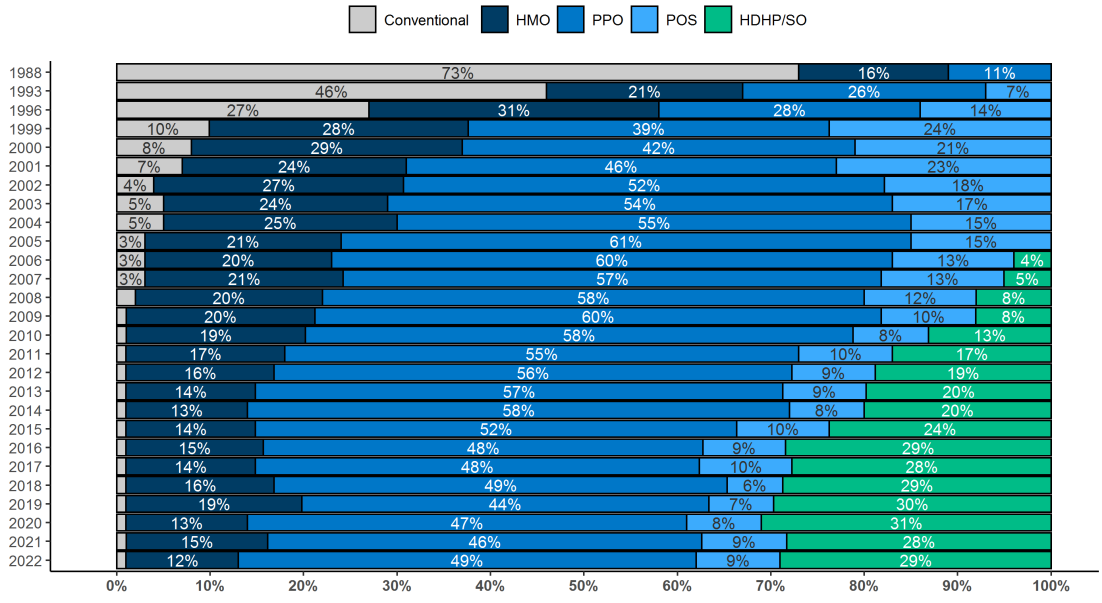
Section 5

Market Shares of Health Plans

PPOs are the most common plan type.

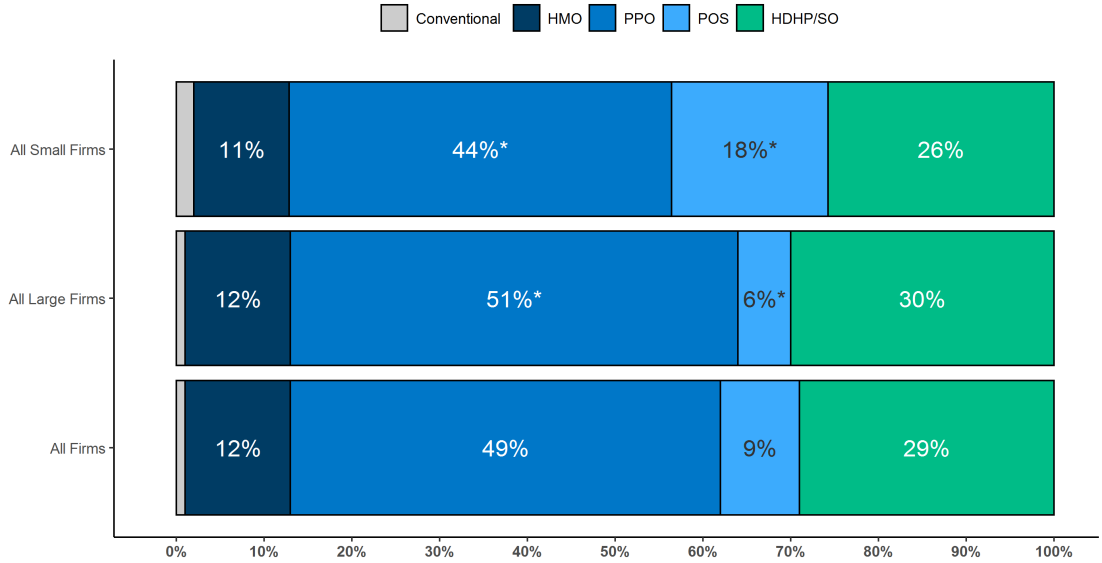
- Forty-nine percent of covered workers are enrolled in PPOs, followed by HDHP/SOs (29%), HMOs (12%), POS plans (9%), and conventional plans (1%) [Figure 5.1]. All of these percentages are similar to the enrollment percentages in 2021.
- The percentage of covered workers enrolled in HDHP/SOs is similar to last year (28%) and five years ago (28%), but higher than the percentage 10 years ago (19%). The percentage of covered workers enrolled in PPOs has decreased 7% over the past decade [Figure 5.1].
- The percentage of covered workers enrolled in HMOs (12%) is similar to the percentages last year (16%) and five years ago (14%).
- A larger share of covered workers are enrolled in HDHP/SOs than in HMOs in small and large firms [Figure 5.2].
- A similar share of covered workers in large firms and small firms are enrolled in HDHP/so plans (30% and 25%) [Figure 5.2]. Covered workers in small firms are more likely than covered workers in large firms to be enrolled in POS plans (18% vs. 6%) [Figure 5.2]. Covered workers in small firms are less likely than covered workers in large firms to be enrolled in PPO plans (44% vs. 51%)
- Plan enrollment patterns also differ across regions.
  - HMO enrollment is significantly higher in the West (23%), and significantly lower in the Midwest (6%) [Figure 5.3].
  - Covered workers in the Midwest (38%) are more likely to be enrolled in HDHP/SOs than workers in other regions, while covered workers in the West (22%) 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, 1988-2022



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, 2018-2022; 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, 2022



* 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, 2022

Figure 5.3

Distribution of Health Plan Enrollment for Covered Workers, by Firm Size, Region, and Industry, 2022

	Conventional	HMO	PPO	POS	HDHP/SO
FIRM SIZE					
3-24 Workers	2%	12%	43%	26%*	17%*
25-49 Workers	2	13	48	11	26
50-199 Workers	1	10	42	15*	32
200-999 Workers	2	8*	50	9	31
1,000-4,999 Workers	<1	10	52	5*	33
5,000 or More Workers	<1*	15	51	5*	29
All Small Firms (3-199 Workers)	**2%**	**11%**	**44%***	**18%***	**26%**
All Large Firms (200 or More Workers)	**1%**	**12%**	**51%***	**6%***	**30%**
REGION					
Northeast	<1%	12%	52%	9%	27%
Midwest	1	6*	47	9	38*
South	2	11	52	9	26
West	1	23*	45	10	22*
INDUSTRY					
Agriculture/Mining/Construction	1%	5%*	54%	7%	32%
Manufacturing	0*	9	46	6	39*
Transportation/Communications/Utilities	3	10	46	6	34
Wholesale	2	5*	53	5*	36
Retail	0*	8	56	13	22
Finance	0*	9	41	14	36
Service	1	15	45	11	28
State/Local Government	2	16	53	11	17*
Health Care	<1*	14	59*	6	21*
ALL FIRMS	**1%**	**12%**	**49%**	**9%**	**29%**

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, 2022

Employer Health Benefits

2022 Annual Survey

Worker and Employer Contributions for Premiums

SECTION

6

Section 6

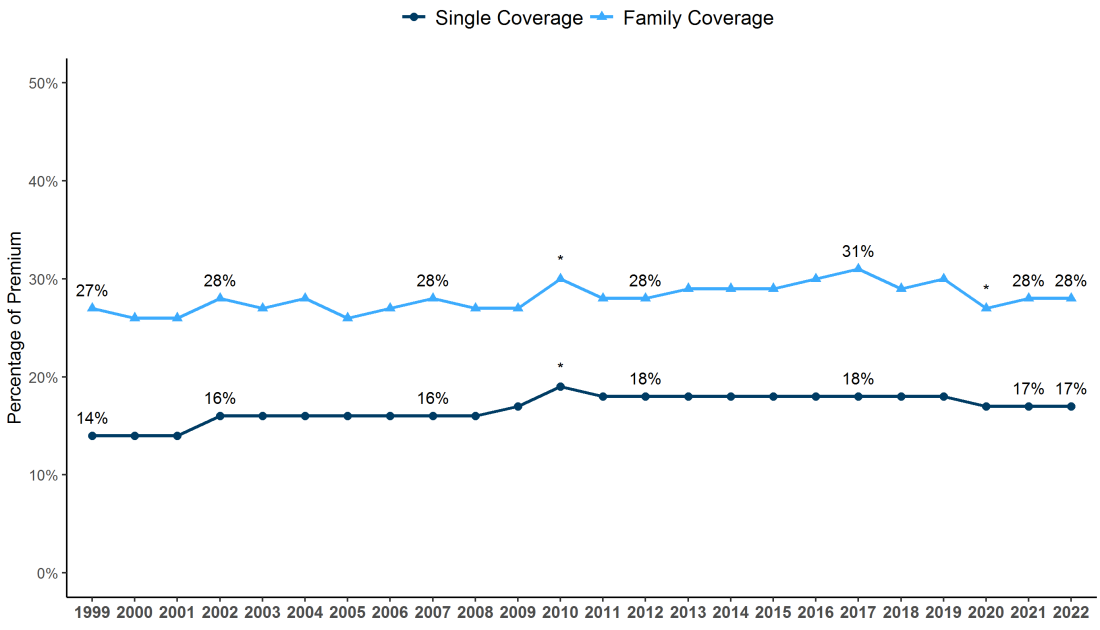
Worker and Employer Contributions for Premiums

The vast majority of covered workers make contributions towards the cost of thier coverage.

- In 2022, covered workers contribute, on average, 17% of the premium for single coverage and 28% of the premium for family coverage.
  - The average percentages contributed for single and family coverage have remained stable in recent years [Figure 6.1].[1]
  - Covered workers in small firms contribute, on average, a much higher percentage of the premium for family coverage than covered workers in large firms (36% vs. 26%) [Figure 6.2].
- Covered workers with single coverage have an average contribution of $111 per month ($1,327 annually), and covered workers with family coverage have an average contribution of $509 per month ($6,106 annually) toward their health insurance premiums [Figure 6.3], [Figure 6.4], and [Figure 6.5].
  - The average contribution for workers enrolled in HDHP/SOs for single coverage is lower than the overall average worker contribution for single coverage ($1,136 vs. $1,327) [Figure 6.6].
- Covered workers in small firms contribute, on average, significantly more annually for family coverage than covered workers in large firms ($7,556 vs. $5,580). The average contributions amounts for covered workers in small and large firms are similar for single coverage [Figure 6.7].

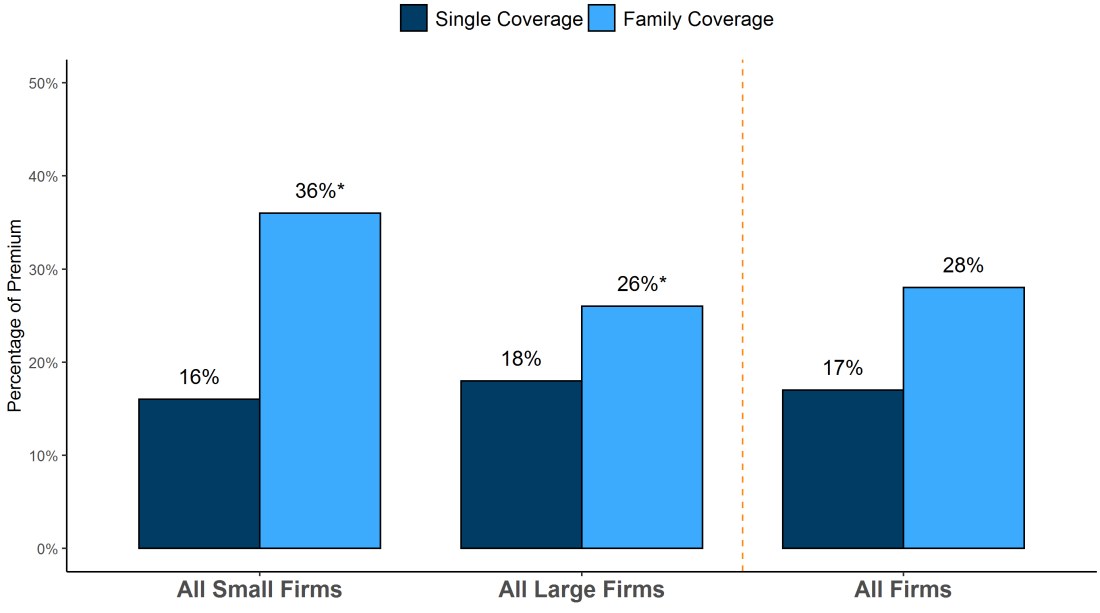
[1] The average percentage contribution is calculated as a weighted average of all a firm's plan types and may not necessarily equal the average worker contribution divided by the average premium.

Figure 6.1
Average Percentage of Premium Paid by Covered Workers for Single and Family Coverage, 1999-2022



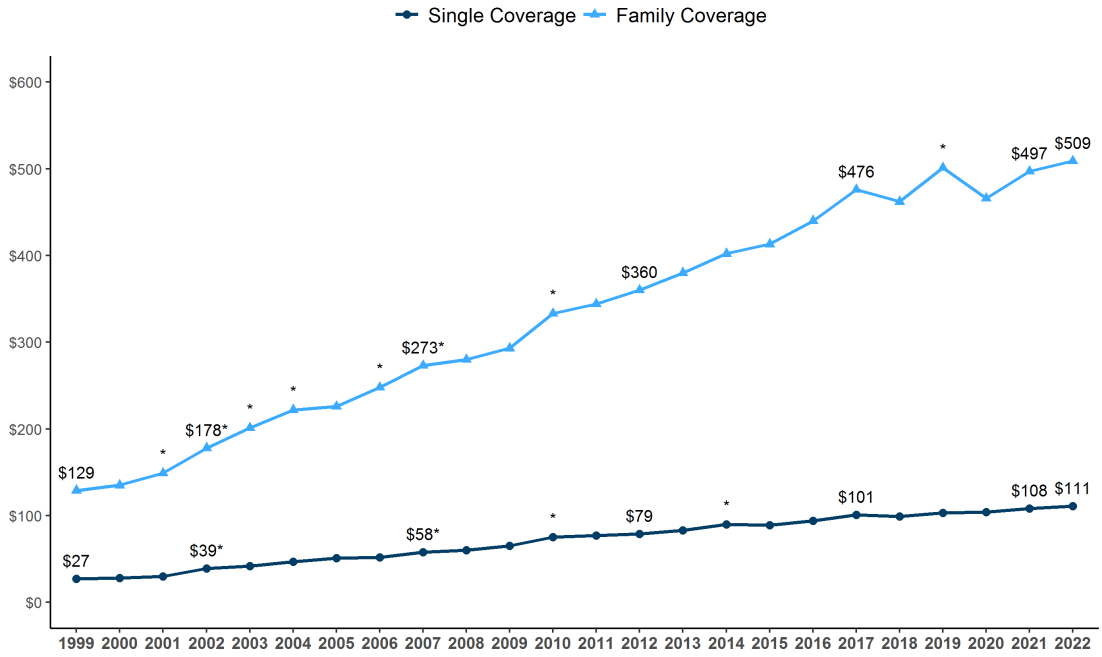
* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
SOURCE: KFF Employer Health Benefits Survey, 2018-2022; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

Figure 6.2
Average Percentage of Premium Paid by Covered Workers for Single and Family Coverage, by Firm Size, 2022



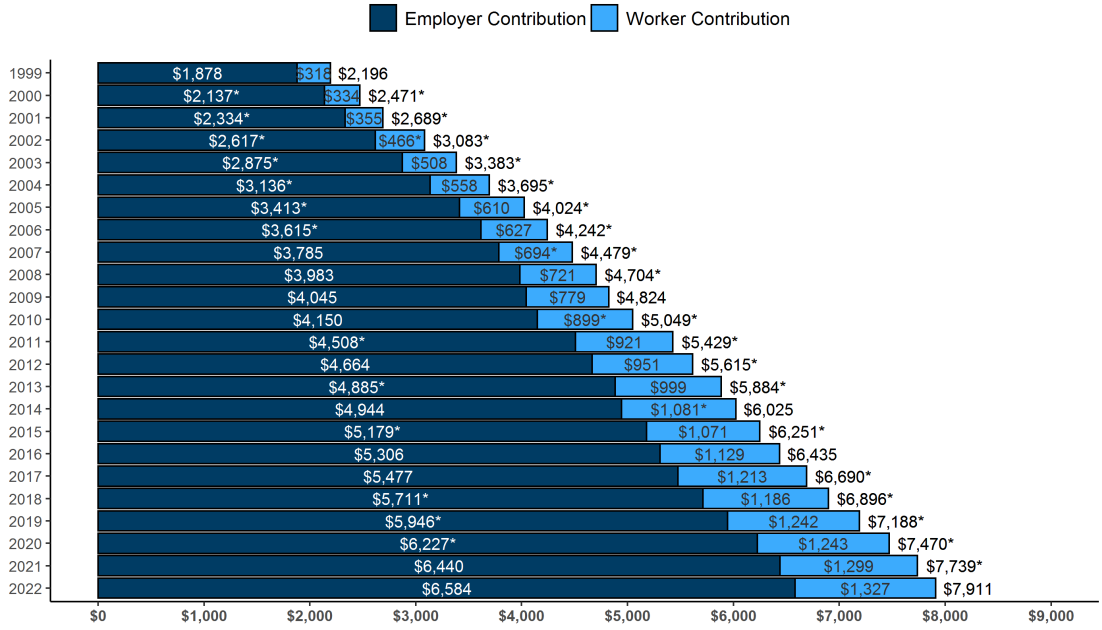
* Estimate is statistically different between All Small Firms and All Large Firms within coverage type ($p < .05$).
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2022

Figure 6.3
Average Monthly Worker Premium Contributions for Single and Family Coverage, 1999-2022



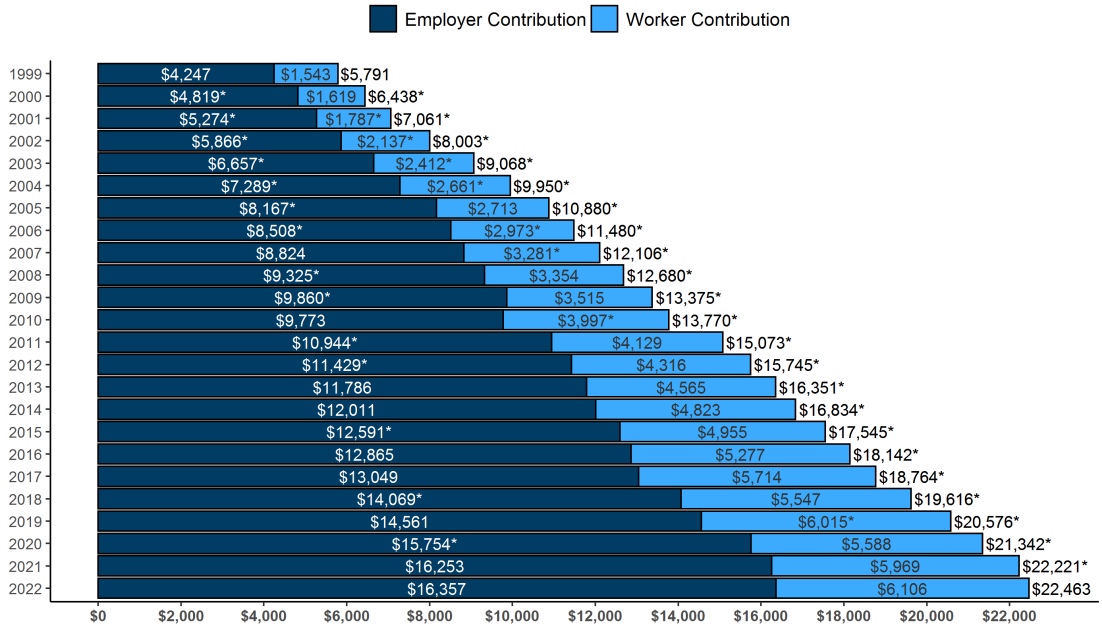
* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
SOURCE: KFF Employer Health Benefits Survey, 2018-2022; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

Figure 6.4
Average Annual Worker and Employer Contributions to Premiums and Total Premiums for Single Coverage, 1999-2022



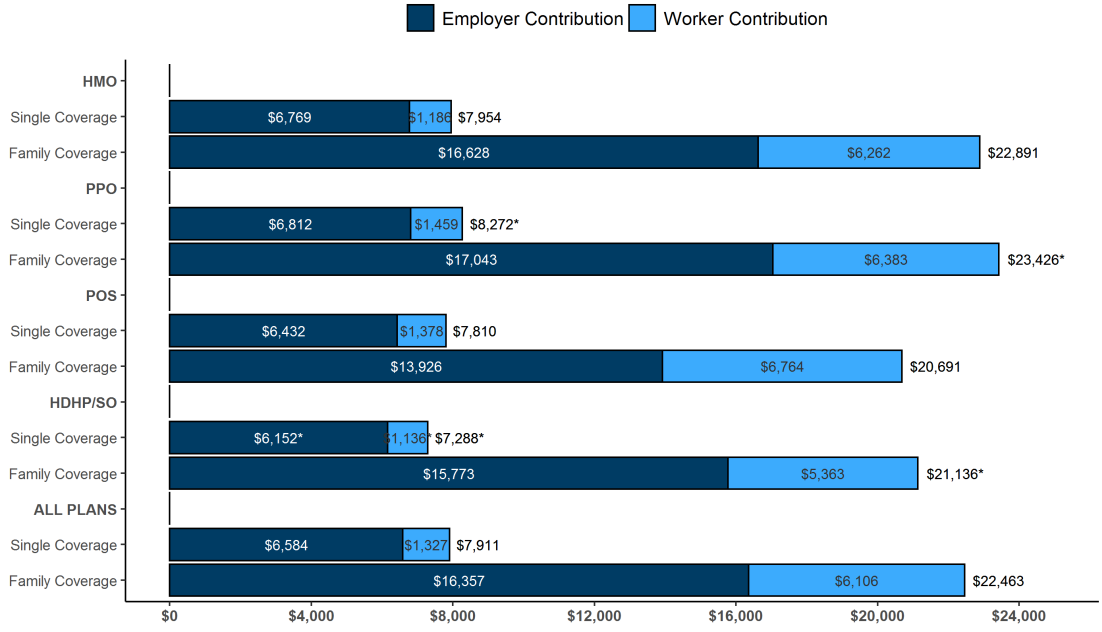
* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
SOURCE: KFF Employer Health Benefits Survey, 2018-2022; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

Figure 6.5
Average Annual Worker and Employer Contributions to Premiums and Total Premiums for Family Coverage, 1999-2022



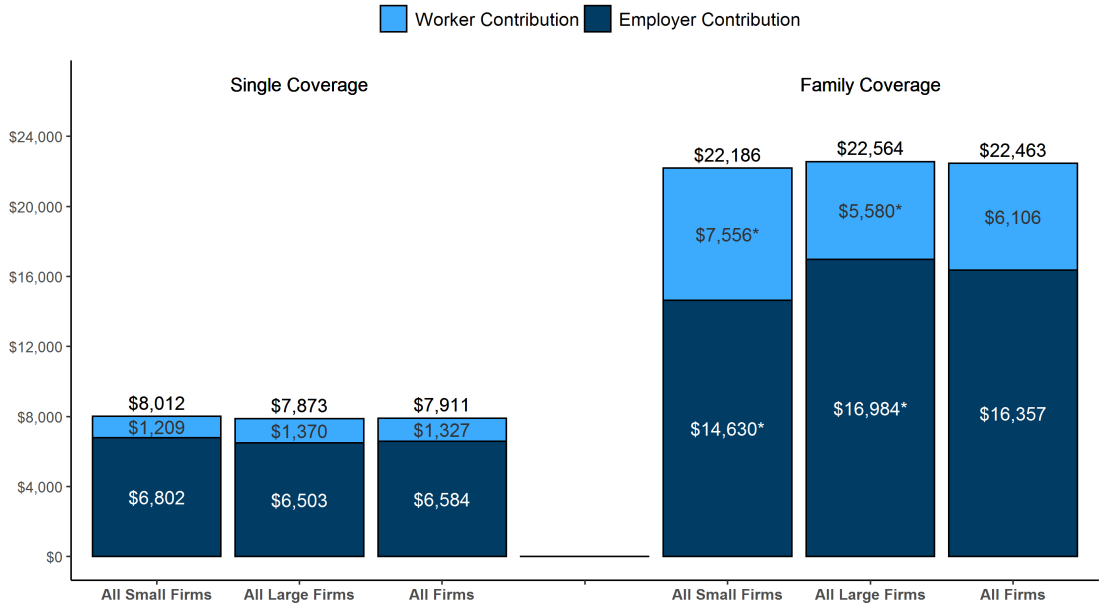
* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
SOURCE: KFF Employer Health Benefits Survey, 2018-2022; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

Figure 6.6
Average Annual Worker and Employer Premium Contributions and Total Premiums for Single and Family Coverage, by Plan Type, 2022



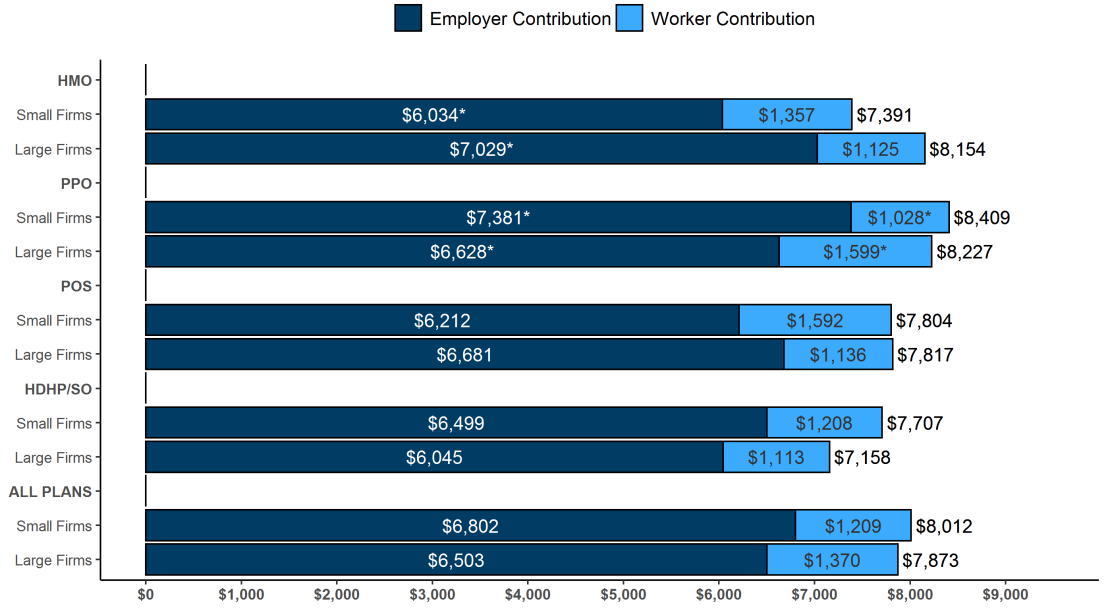
* Estimate is statistically different from All Plans estimate within coverage type ($p < .05$).
SOURCE: KFF Employer Health Benefits Survey, 2022

Figure 6.7
Average Annual Worker and Employer Premium Contributions and Total Premiums for Single and Family Coverage, by Firm Size, 2022



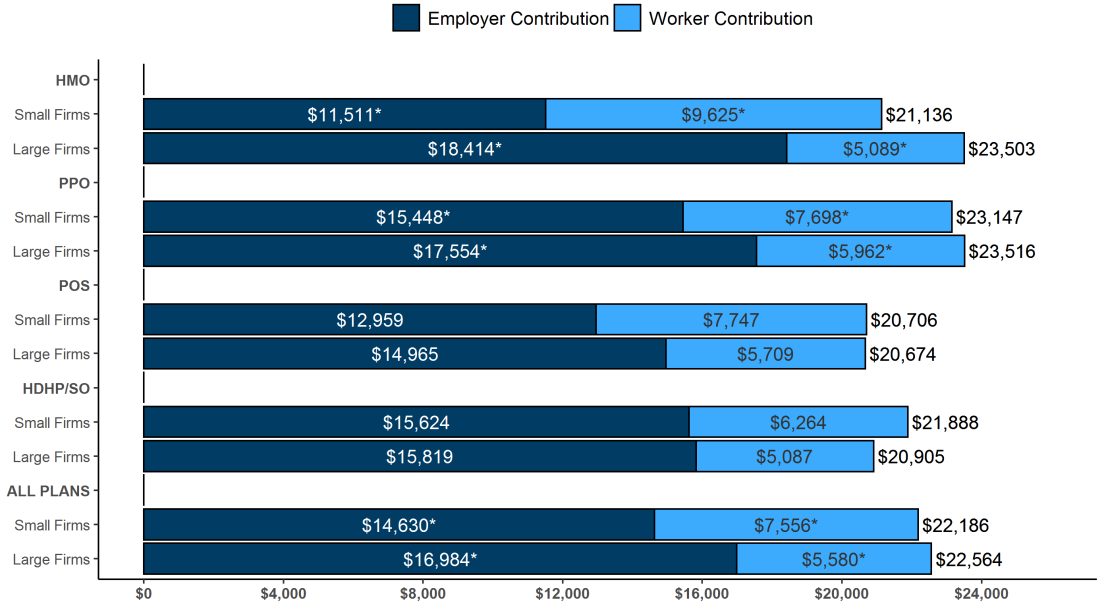
* Estimate is statistically different between All Small Firms and All Large Firms estimate ($p < .05$).
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2022

Figure 6.8
Average Annual Worker and Employer Premium Contributions and Total Premiums for Single Coverage, by Plan Type and Firm Size, 2022



* 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, 2022

Figure 6.9
Average Annual Employer and Worker Premium Contributions and Total Premiums for Family Coverage, by Plan Type and Firm Size, 2022



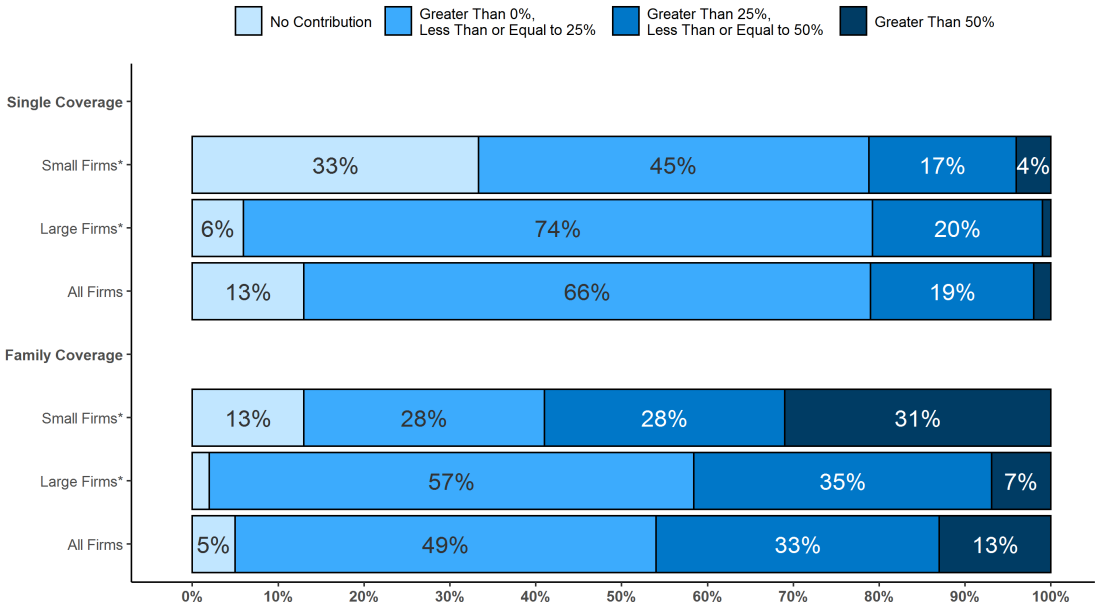
* Estimates are statistically different within plan type between All Small Firms and All Large Firms ($p < .05$).
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2022

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.
  - Thirteen percent of covered workers are in a plan where the employer pays the entire premium for single coverage, while only 5% 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.
  - Thirty-three percent of covered workers in small firms have an employer that pays the full premium for single coverage, compared to 6% of covered workers in large firms [Figure 6.10].
  - For family coverage, 13% of covered workers in small firms have an employer that pays the full premium, compared to 2% of covered workers in large firms [Figure 6.10].
- Thirteen percent of covered workers are in a plan where the worker contributes more than half of the premium for family coverage [Figure 6.10].
  - This percentage differs significantly with firm size. 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 7% of covered workers in large firms [Figure 6.10].
  - Small shares of covered workers in small firms (4%) and large firms (1%) must pay more than 50% of the premium for single coverage [Figure 6.10].

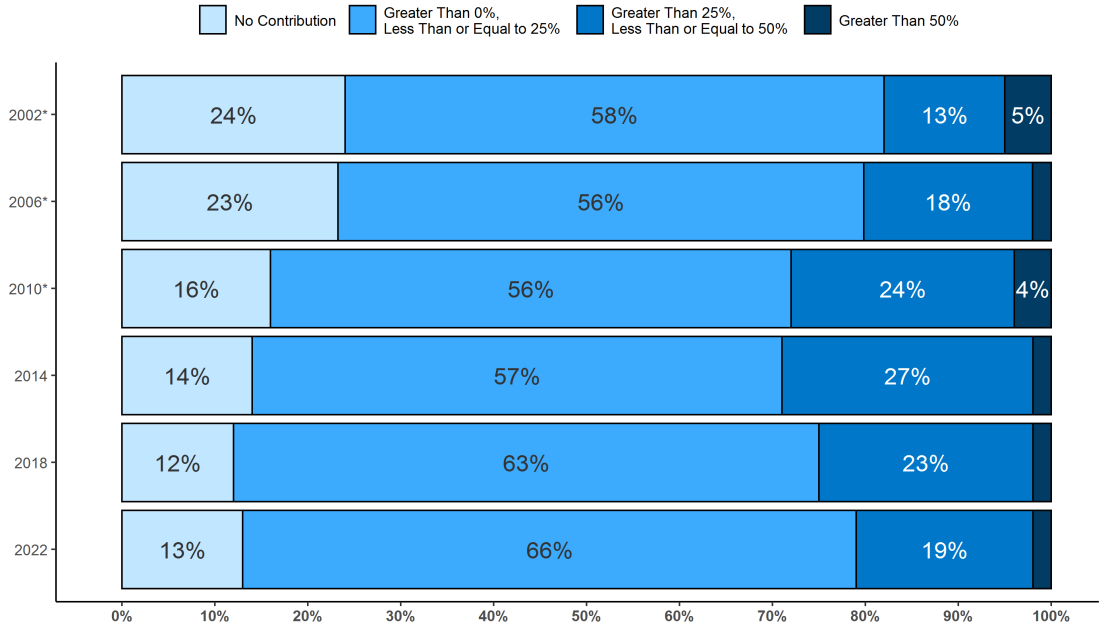
- There is substantial variation between small and large firms in the dollar amounts that covered workers must contribute.
  - Among covered workers in small firms, 37% have a contribution for single coverage of less than $500, while 19% have a contribution of $2,000 or more [Figure 6.13]. For family coverage, 15% have a contribution of less than $1,500, while 26% have a contribution of $10,500 or more [Figure 6.14].
  - Among covered workers in large firms, 14% contribute less than $500 for single coverage, while 18% have a contribution of $2,000 or more [Figure 6.13]. For family coverage, only 5% contribute less than $1,500, while 6% 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, 2022



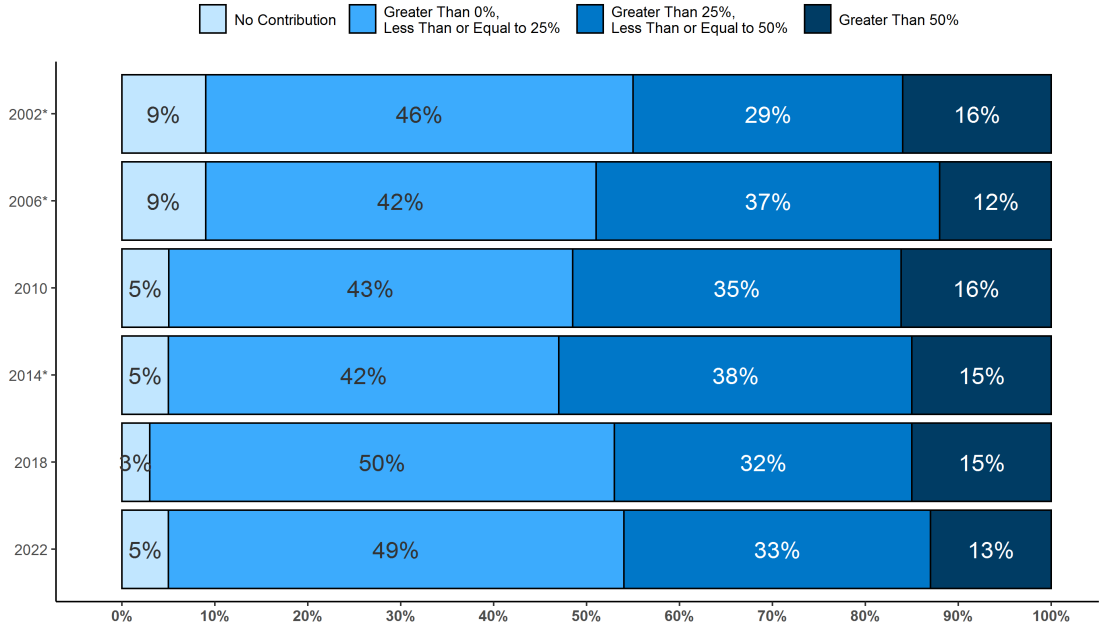
* Distributions are statistically different between All Small Firms and All Large Firms within coverage type ($p < 0.05$).
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2022

Figure 6.11
Distribution of Percentage of Premium Paid by Covered Workers for Single Coverage, 2002-2022



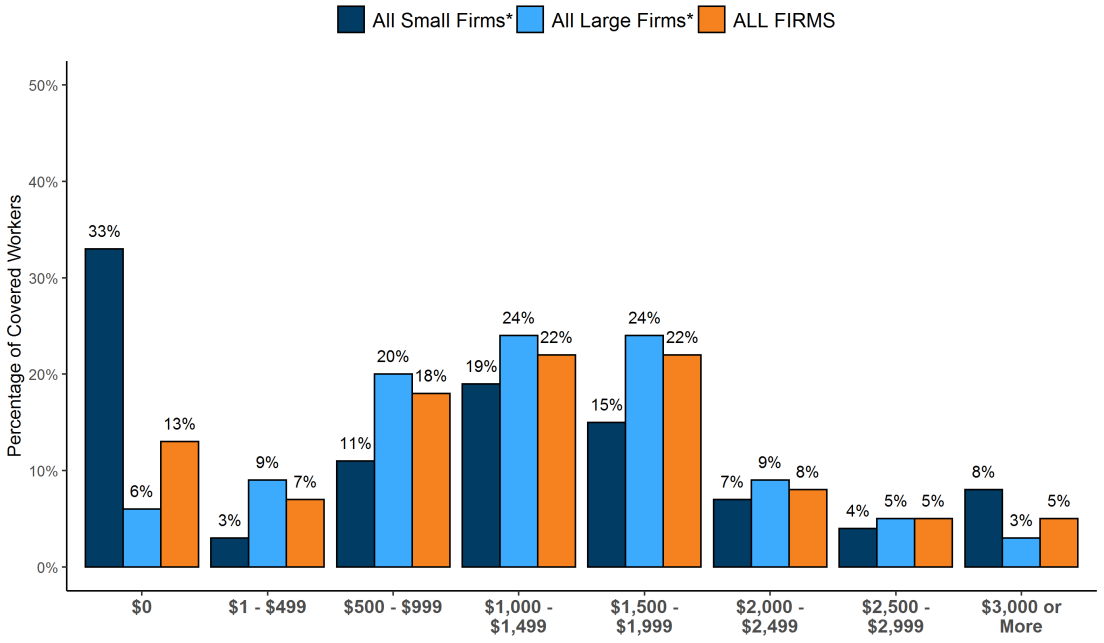
* Distribution is statistically different from distribution for the previous year shown (p < .05).
SOURCE: KFF Employer Health Benefits Survey, 2018-2022; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2002-2017

Figure 6.12
Distribution of Percentage of Premium Paid by Covered Workers for Family Coverage, 2002-2022



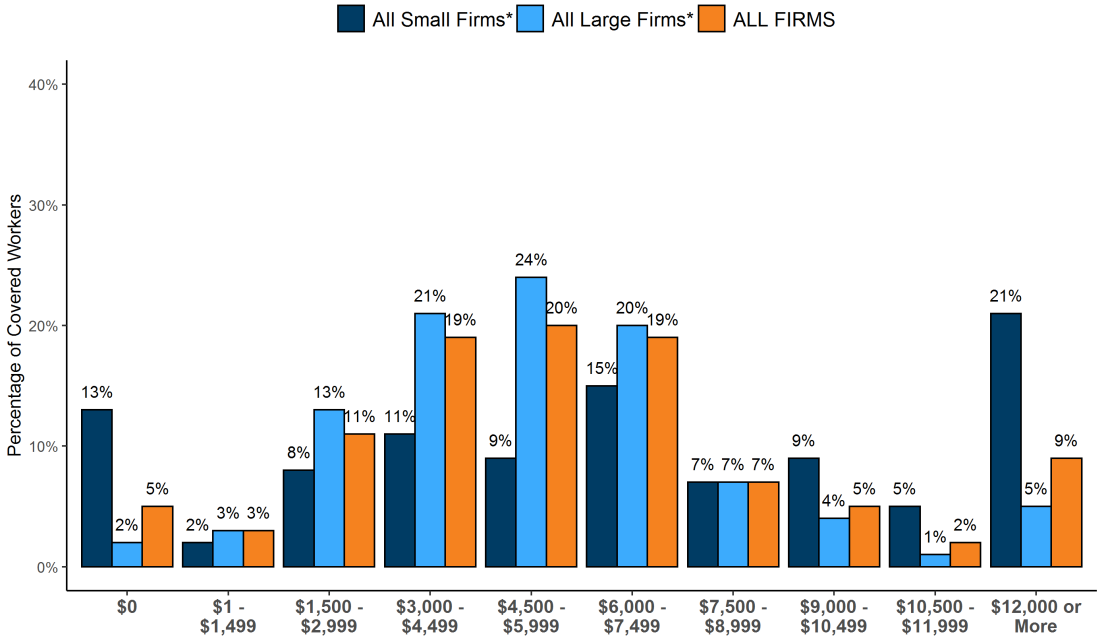
* Distribution is statistically different from distribution for the previous year shown (p < .05).
SOURCE: KFF Employer Health Benefits Survey, 2018-2022; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2002-2017

Figure 6.13
Distribution of Worker Contributions for Single Coverage, by Firm Size, 2022



* 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, 2022

Figure 6.14
Distribution of Worker Contributions for Family Coverage, by Firm Size, 2022

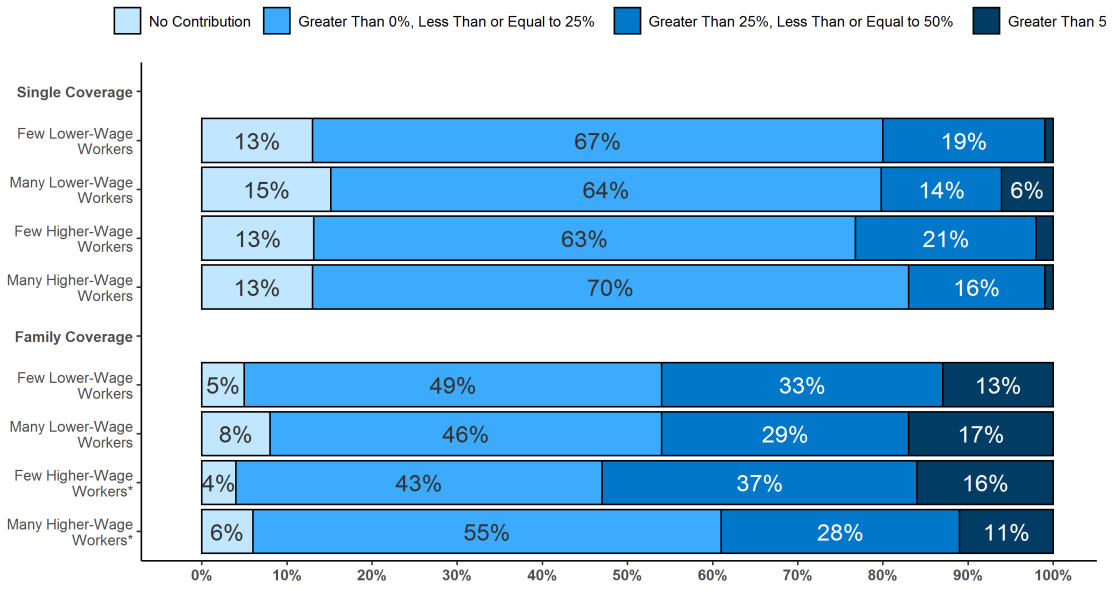


* Distribution is statistically different from distribution for all other firms not in the indicated size category ($p < .05$).
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2022

DIFFERENCES BY FIRM CHARACTERISTICS

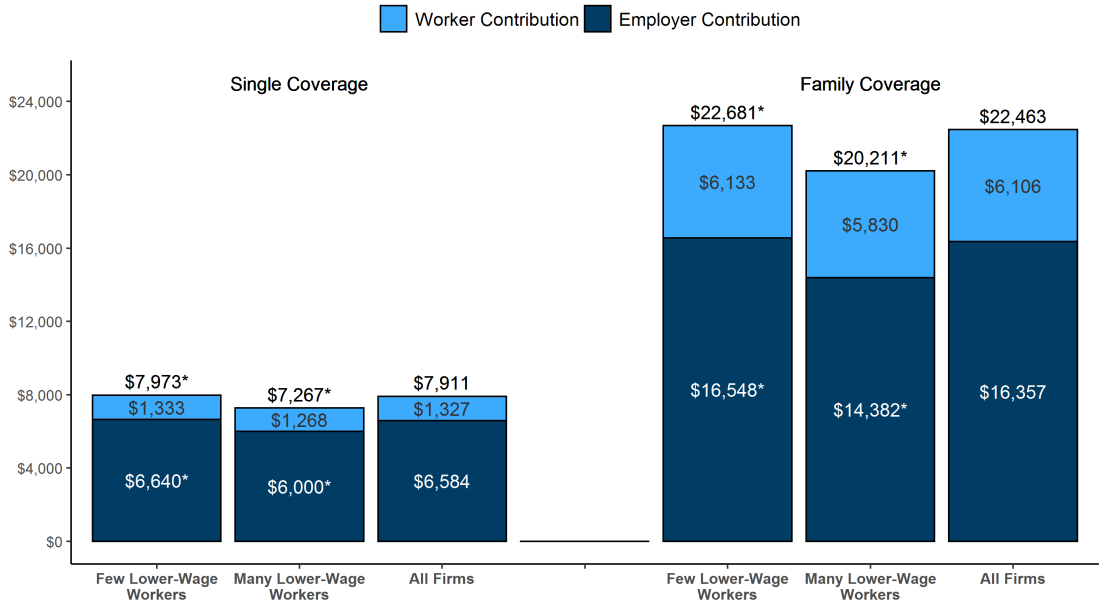
- The percentage of the premium paid by covered workers varies with firm characteristics.
  - Covered workers in private, for-profit firms have relatively high premium contribution rates for single (20%) and family (31%) coverage. On the other hand, covered workers in public firms have relatively low premium contributions for single (13%) and family (24%) coverage. The average single coverage contribution rate for covered workers in private not-for-profit firms (15%) is also relatively low [Figure 6.17].
  - Covered workers in firms with a relatively large share of higher-wage workers (where at least 35% earn $70,000 or more annually) have lower average contributions than those in firms with a smaller share of higher-wage workers for single coverage (16% vs. 19%) and for family coverage (25% vs. 31%) [Figure 6.16].
  - Covered workers in firms that have at least some union workers have a lower average contribution for family coverage (25% vs. 30%) than those in firms without any union workers [Figure 6.17].

Figure 6.15
Distribution of the Percentage of Total Premium Paid by Covered Workers for Single and Family Coverage, by Firm Wage Level, 2022



*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 ($30,000 in 2022). Firms with many higher-wage workers are those where at least 35% earn the 75th percentile or more than of national earnings ($70,000 in 2022).
SOURCE: KFF Employer Health Benefits Survey, 2022

Figure 6.16
Average Annual Worker and Employer Contributions to Premiums and Total Premiums for Single and Family Coverage, By Firm Wage Level, 2022



* 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 ($30,000 in 2022).
SOURCE: KFF Employer Health Benefits Survey, 2022

Figure 6.17

Average Annual Premium Contributions Paid by Covered Workers for Single and Family Coverage, by Firm Characteristics, 2022

	Single Coverage		Family Coverage	
	Worker Contribution	Percent Contribution	Worker Contribution	Percent Contribution
LOWER WAGE LEVEL				
Few Lower-Wage Workers	$1,333	17%	$6,133	28%
Many Lower-Wage Workers	$1,268	19%	$5,830	30%
HIGHER WAGE LEVEL				
Few Higher-Wage Workers	$1,425*	19%*	$6,573*	31%*
Many Higher-Wage Workers	$1,218*	16%*	$5,593*	25%*
UNIONS				
Firm Has Union Workers	$1,288	16%	$5,387*	25%*
Firm Has No Union Workers	$1,347	18%	$6,466*	30%*
YOUNGER WORKERS				
Few Younger Workers	$1,325	17%	$6,090	28%
Many Younger Workers	$1,342	20%	$6,244	31%
OLDER WORKERS				
Few Older Workers	$1,268	17%	$6,051	30%
Many Older Workers	$1,387	17%	$6,163	27%
FUNDING ARRANGEMENT				
Fully Insured	$1,190*	16%	$6,828*	34%*
Self-Funded	$1,400*	18%	$5,724*	26%*
FIRM OWNERSHIP				
Private For-Profit	$1,455*	20%*	$6,506*	31%*
Public	$985*	13%*	$4,930*	24%*
Private Not-For-Profit	$1,254	15%*	$5,949	26%
ALL FIRMS	**$1,327**	**17%**	**$6,106**	**28%**

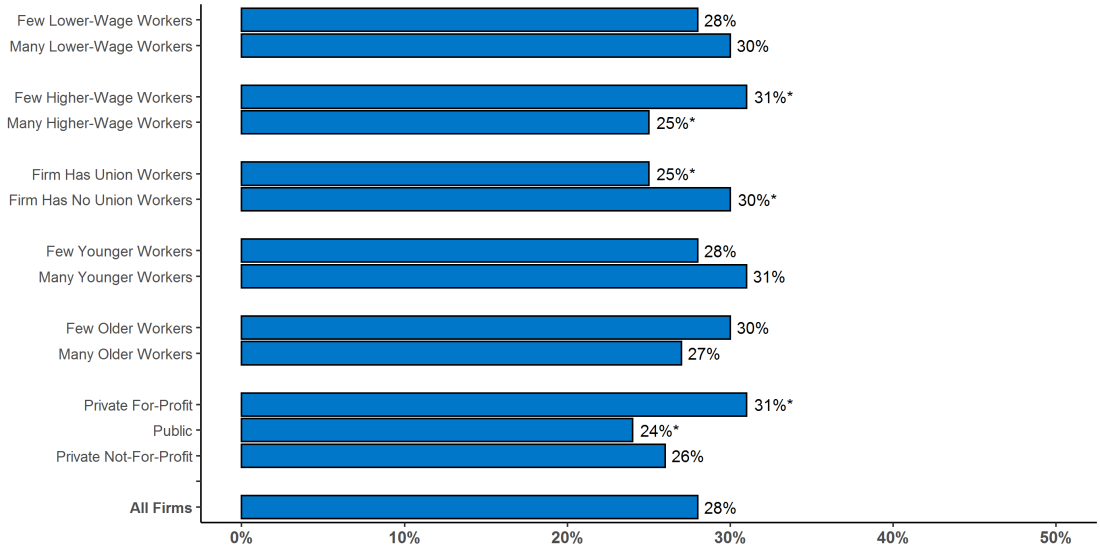
NOTE: Firms with many lower-wage workers are those where at least 35% earn the 25th percentile or less of national earnings ($30,000 in 2022). Firms with many higher-wage workers are those where at least 35% earn the 75th percentile or more than of national earnings ($70,000 in 2022). Firms with many 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, 2022

Figure 6.18

Average Percentage of Family Premium Paid by Covered Workers, by Firm Characteristics, 2022



* 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 ($30,000 in 2022). Firms with many higher-wage workers are those where at least 35% earn the 75th percentile or more than of national earnings ($70,000 in 2022). 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, 2022

Figure 6.19

Average Percentage of Premium Paid by Covered Workers, by Firm Characteristics and Size, 2022

	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	15%	18%	17%	36%	26%	28%
Many Lower-Wage Workers	21%	17%	19%	37%	27%	30%
HIGHER WAGE LEVEL						
Few Higher-Wage Workers	17%	19%*	19%*	40%*	27%	31%*
Many Higher-Wage Workers	14%	16%*	16%*	30%*	24%	25%*
UNIONS						
Firm Has Union Workers	11%*	17%	16%	23%*	25%	25%*
Firm Has No Union Workers	16%*	18%	18%	37%*	26%	30%*
YOUNGER WORKERS						
Few Younger Workers	15%	18%	17%	36%	25%	28%
Many Younger Workers	21%	19%	20%	37%	29%	31%
OLDER WORKERS						
Few Older Workers	17%	18%	17%	39%*	26%	30%
Many Older Workers	15%	18%	17%	32%*	25%	27%
FUNDING ARRANGEMENT						
Fully Insured	16%	16%	16%	36%	29%	34%*
Self-Funded	16%	18%	18%	35%	25%	26%*
FIRM OWNERSHIP						
Private For-Profit	18%	20%*	20%*	38%	28%*	31%*
Public	13%	13%*	13%*	34%	22%*	24%*
Private Not-For-Profit	14%	16%*	15%*	34%	22%*	26%
ALL FIRMS	**16%**	**18%**	**17%**	**36%**	**26%**	**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 ($30,000 in 2022). Firms with many higher-wage workers are those where at least 35% earn the 75th percentile or more than of national earnings ($70,000 in 2022). 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, 2022

DIFFERENCES BY REGION AND INDUSTRY

- The average worker contribution for single coverage is relatively high in Northeast (20%) and relatively low in the West (14%) [Figure 6.20].
- The average worker contribution for family coverage is relatively low in Midwest (25%) and relatively high in the South (34%) [Figure 6.20].
- Average worker contributions vary across industries for single and family coverage [Figure 6.21].

Figure 6.20

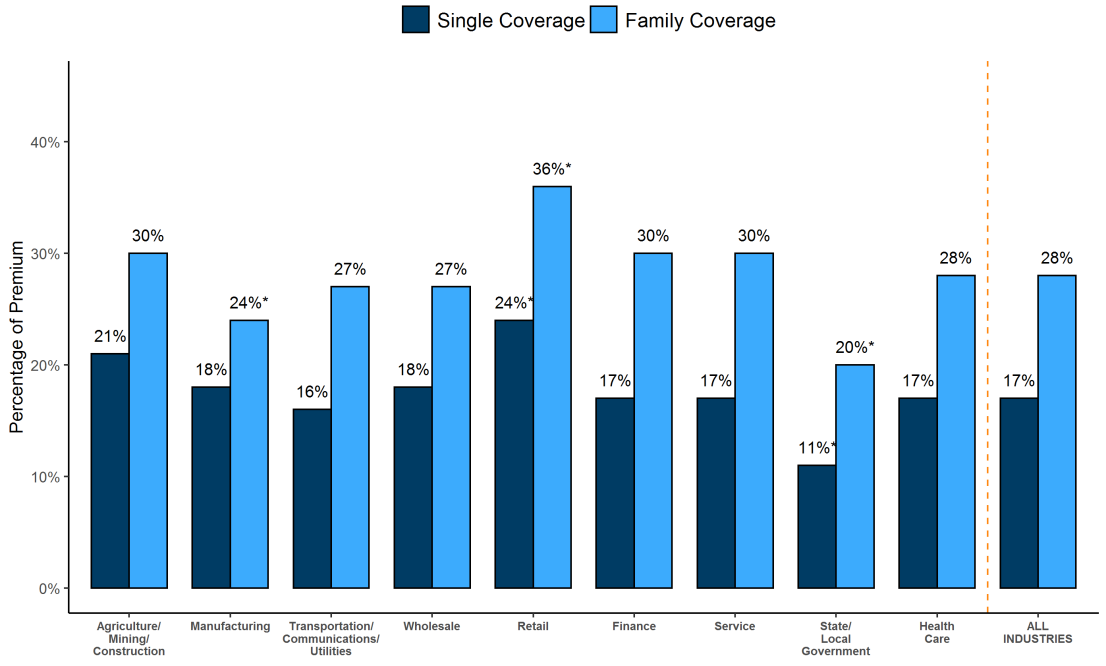
Average Premium Paid by Covered Workers for Single and Family Coverage, by Plan Type and Region, 2022

	Single Coverage		Family Coverage	
	Percent Contribution	Worker Contribution	Percent Contribution	Worker Contribution
HMO				
Northeast	18%	$1,644*	19%*	$4,984
Midwest	18*	1,264	26	4,802*
South	15	1,203	36*	8,182*
West	13*	956*	29	6,083
ALL REGIONS	**15%**	**$1,186**	**29%**	**$6,262**
PPO				
Northeast	21%	$1,662	26%	$5,886
Midwest	18	1,527	27	6,590
South	19	1,478	31*	6,768
West	14*	1,137*	26	5,817
ALL REGIONS	**18%**	**$1,459**	**28%**	**$6,383**
POS				
Northeast	18%	$1,716	33%	$7,201
Midwest	19	1,347	30	6,225
South	20	1,202	48	6,132
West	17	1,427	39	8,017
ALL REGIONS	**19%**	**$1,378**	**38%**	**$6,764**
HDHP/SO				
Northeast	19%*	$1,438*	25%	$5,414
Midwest	15	1,027	21*	4,175*
South	17	1,185	35*	7,421
West	14	1,043	23	4,888
ALL REGIONS	**16%**	**$1,136**	**26%**	**$5,363**
ALL PLANS				
Northeast	20%*	$1,603*	26%	$5,753
Midwest	17	1,309	25*	5,557*
South	18	1,350	34*	7,022*
West	14*	1,104*	27	5,887
ALL REGIONS	**17%**	**$1,327**	**28%**	**$6,106**

* 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, 2022

Figure 6.21
Average Percentage of Premium Paid by Covered Workers, by Industry, 2022

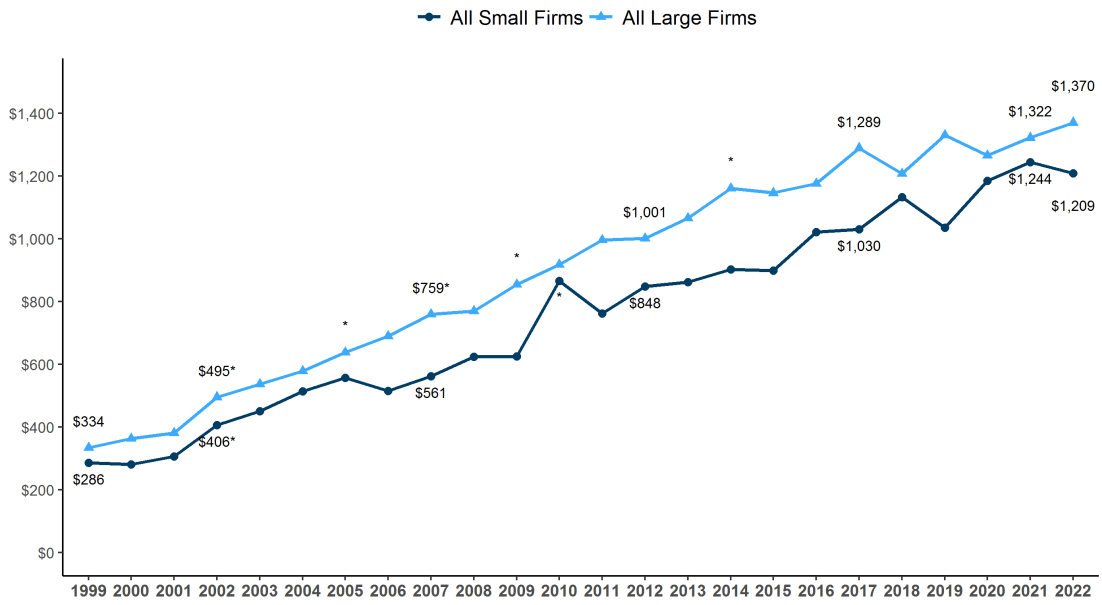


* Estimate is statistically different within coverage type from estimate for all other firms not in the indicated industry category ($p < .05$).
SOURCE: KFF Employer Health Benefits Survey, 2022

CHANGES OVER TIME

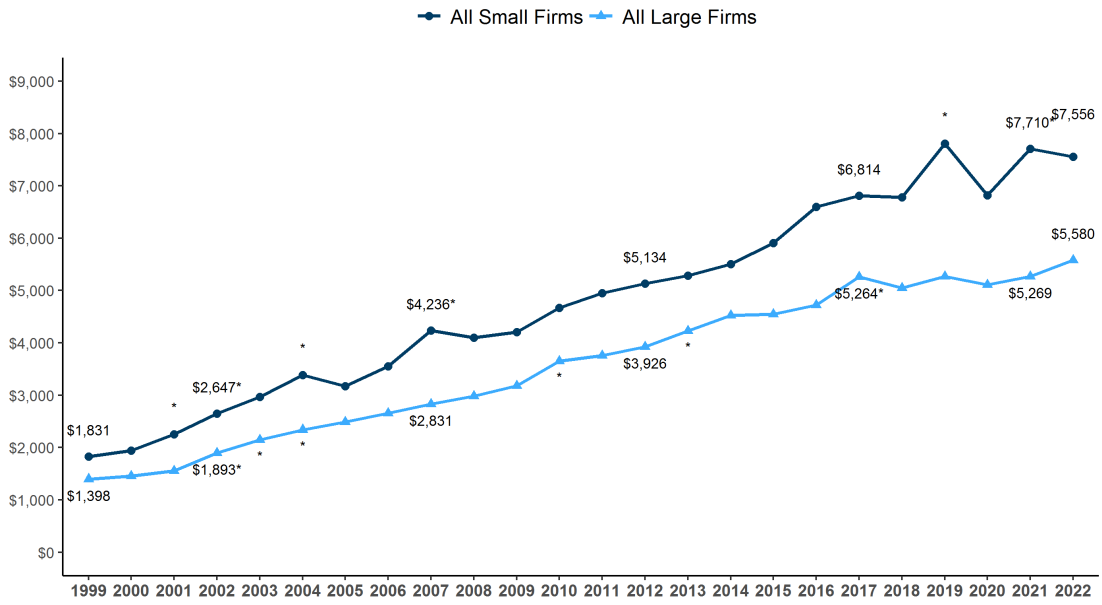
- The average worker contributions in 2022 for single coverage ($1,327) and for family coverage ($6,106) are similar to the average contribution levels last year [Figures 6.22 and 6.23].
- The average worker contribution for single coverage has increased 9% over the last five years. The average worker contributions for single and family coverage over the last 10 years have increased 39% and 41%, respectively [Figures 6.4 and 6.5].

Figure 6.22
Average Annual Worker Contributions for Covered Workers with Single Coverage, by Firm Size, 1999-2022



* 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, 2018-2022; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

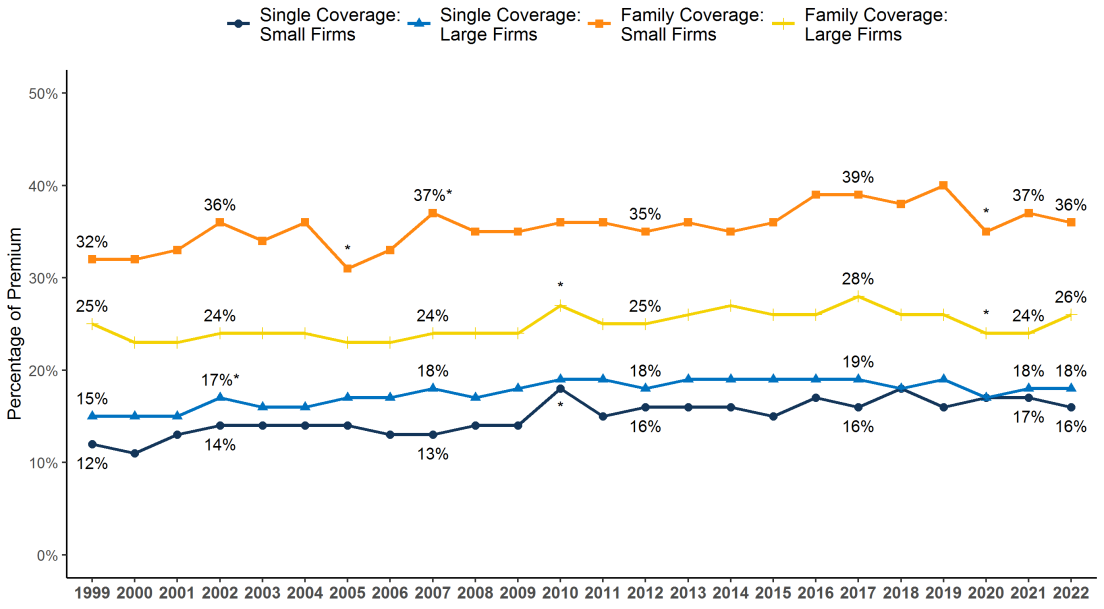
Figure 6.23
Average Annual Worker Contributions for Covered Workers with Family Coverage, by Firm Size, 1999-2022



* 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, 2018-2022; 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, 1999-2022



* 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, 2018-2022; 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, 1999-2022

* 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 ($30,000 in 2022).
SOURCE: KFF Employer Health Benefits Survey, 2018-2022; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

Employer Health Benefits

2022 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). Some plans combine cost-sharing forms, such as requiring coinsurance for a service up to a maximum amount, or assessing either 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, with separate classifications for office visits, hospitalizations, or prescription drugs.

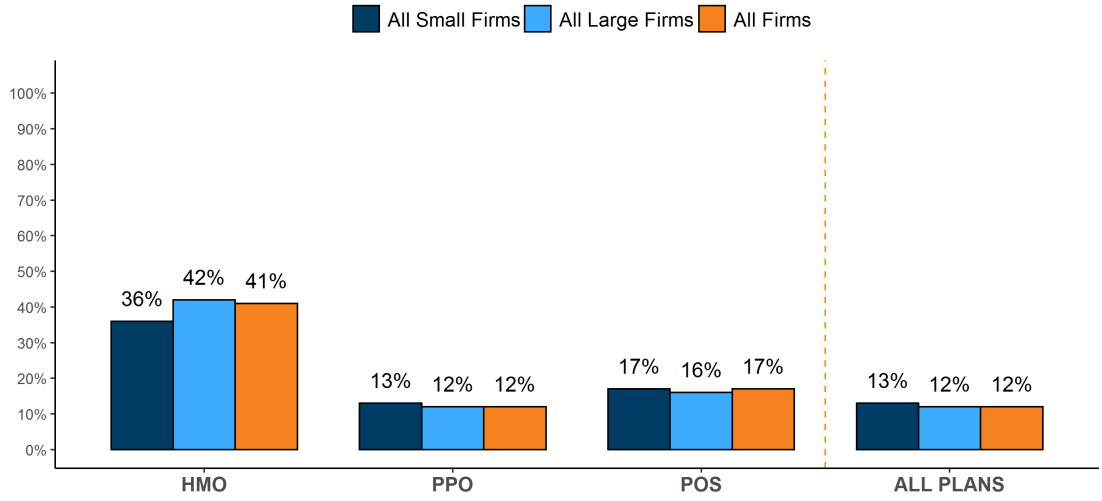
The cost-sharing amounts reported here are for covered workers using in-network services. Plan enrollees receiving services from providers that do not participate in plan networks often face higher cost sharing and may be responsible for charges that exceed the plan's allowable amounts. The framework of this survey does not allow us to capture all of the complex cost-sharing requirements in modern plans, including 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 specific deductible for certain services, like 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-eight percent of covered workers in 2022 are enrolled in a plan with a general annual deductible for single coverage, similar to the percentage last year (85%) but higher than the percentages five years ago (81%) or ten years ago (72%) [Figure 7.2].
  - The percent of covered workers enrolled in a plan with a general annual deductible for single coverage is similar for small firms (3-199 workers) (87%) and large firms (200 or more workers) (88%) [Figure 7.2].
  - The likelihood of a plan having a general annual deductible varies by plan type. Forty-one percent of covered workers in HMOs do not have a general annual deductible for single coverage, compared to 17% of workers in POS plans and 12% of workers in PPOs [Figure 7.1].
- For workers with single coverage in a plan with a general annual deductible, the average annual deductible is $1,763, similar to the average deductible last year ($1,669) [Figure 7.3] and [Figure 7.8].
  - For covered workers in plans with a general annual deductible, the average deductibles for single coverage are $1,451 in HMOs, $1,322 in PPOs, $1,907 in POS plans, and $2,539 in HDHP/SOs [Figure 7.6].

- In most plan types, the average deductibles for single coverage are higher for for covered workers in small firms than 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 in large firms ($2,248 vs. $1,023) [Figure 7.6]. Overall, for covered workers in plans with a general annual deductible, the average deductible for single coverage in small firms ($2,543) is higher than the average deductible in large firms ($1,493) [Figure 7.3].
- The average general annual deductible for single coverage for workers in plans with a deductible has increased 17% over the past five years and 61% 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, 2022



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 2022 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, 2022

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, 2006-2022

	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%
2022	64%	58%	59%	87%	88%	88%	83%	84%	83%	87%	88%	88%

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, 2018-2022; 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, 2022

	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	85%	$2,442*
50-199 Workers	89	2,656*
200-999 Workers	86	1,880
1,000-4,999 Workers	88	1,482*
5,000 or More Workers	89	1,357*
All Small Firms (3-199 Workers)	**87%**	**$2,543***
All Large Firms (200 or More Workers)	**88%**	**$1,493***
REGION		
Northeast	88%	$1,610
Midwest	96*	1,820
South	90	1,868
West	72*	1,623
ALL FIRMS	**88%**	**$1,763**

* 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, 2022

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, 2022

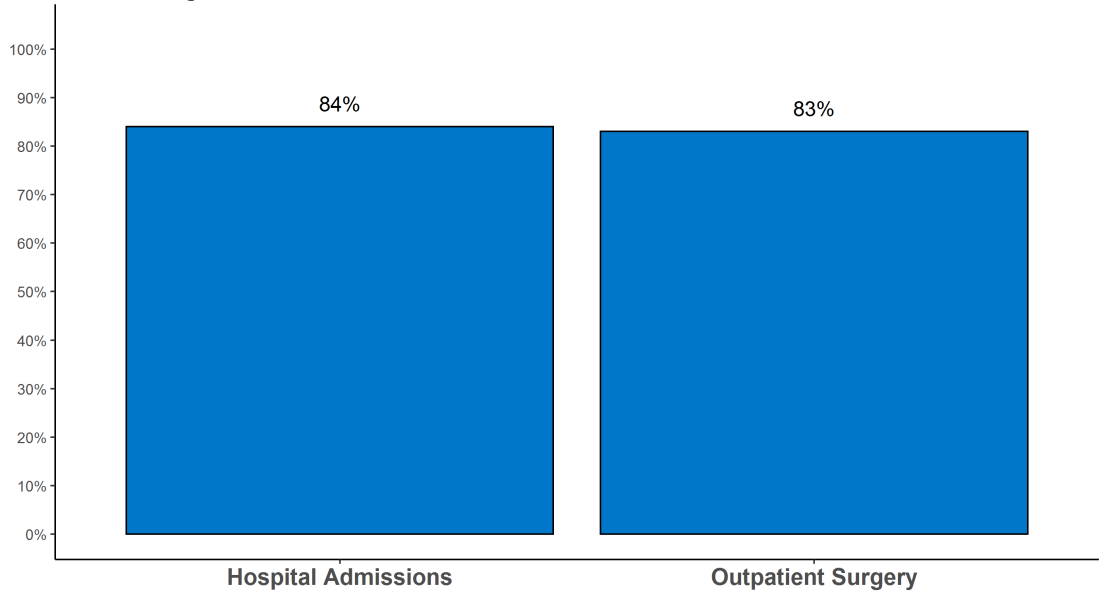
	Percentage of Covered Workers in a Plan With a General Annual Deductible	Among Covered Workers With a General Annual Deductible for Single Coverage, Average Deductible
LOWER WAGE LEVEL		
Few Lower-Wage Workers	88%	$1,771
Many Lower-Wage Workers	87%	$1,676
HIGHER WAGE LEVEL		
Few Higher-Wage Workers	88%	$1,900*
Many Higher-Wage Workers	88%	$1,616*
UNIONS		
Firm Has Union Workers	85%	$1,440*
Firm Has No Union Workers	89%	$1,930*
YOUNGER WORKERS		
Few Younger Workers	88%	$1,728
Many Younger Workers	84%	$2,088
OLDER WORKERS		
Few Older Workers	89%	$1,843
Many Older Workers	87%	$1,680
FIRM OWNERSHIP		
Private For-Profit	92%*	$1,862*
Public	79%*	$1,130*
Private Not-For-Profit	83%	$1,931
ALL FIRMS	**88%**	**$1,763**

NOTE: Firms with many lower-wage workers are those where at least 35% earn the 25th percentile or less of national earnings ($30,000 in 2022). Firms with many higher-wage workers are those where at least 35% earn the 75th percentile or more than of national earnings ($70,000 in 2022). 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 ($p < .05$).

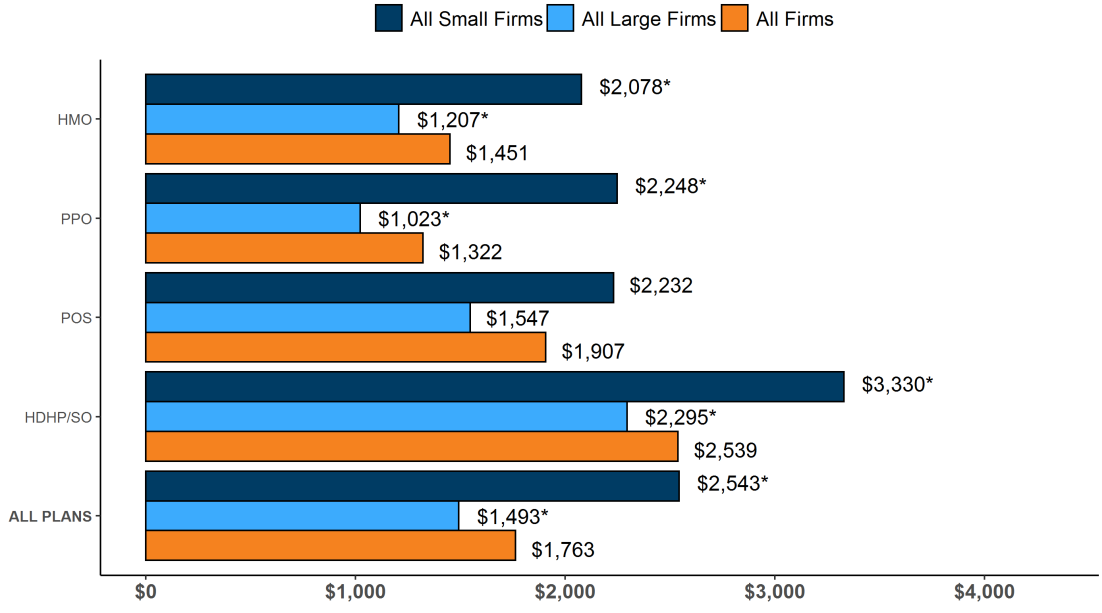
SOURCE: KFF Employer Health Benefits Survey, 2022

Figure 7.5
Among Covered Workers with No General Annual Deductible, Percentage Who Face Other Types of Cost Sharing, 2022



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, 2022

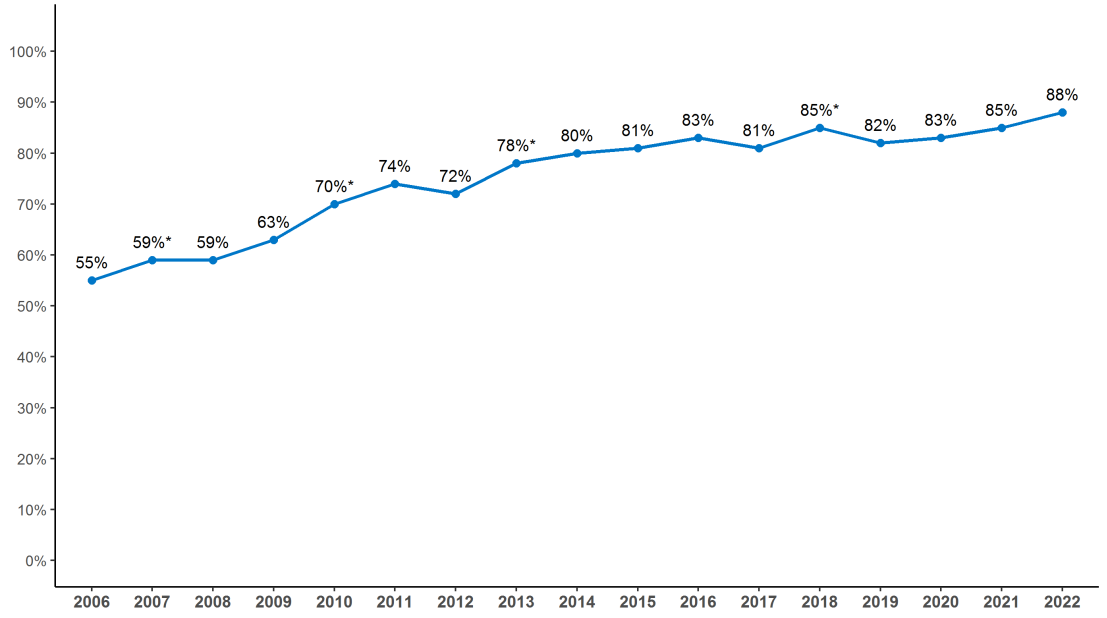
Figure 7.6
Among Covered Workers with a General Annual Deductible for Single Coverage, Average Deductible, by Plan Type and Firm Size, 2022



* 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, 2022

Figure 7.7

Percentage of Covered Workers with a General Annual Deductible for Single Coverage, 2006-2022



* 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, 2018-2022; 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, 2006-2022

	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
2022	$3,124	$2,908	$3,773	$4,766	$1,600	$1,506*	$2,468*	$3,325	$1,451	$1,322	$1,907	$2,539	$1,763

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, 2018-2022; 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 72% in 2012 to 88% in 2022 [Figure 7.9]. The average deductible amount for covered workers in plans with a deductible has also increased over this period, from $1,097 in 2012 to $1,763 in 2022 [Figure 7.10]. Neither trend by itself, however, captures the full impact that changes in deductibles have had on covered workers. We can look at the average impact of both trends together 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 higher deductible amounts, and the fact that more workers face them.
  - Using this approach, the average general annual deductible for single coverage for all covered workers in 2022 is $1,562, similar to the amount last year ($1,434) [Figure 7.10].
  - The 2022 value is 28% higher than the average general annual deductible in 2017 ($1,221) and 95% higher than in 2012 ($802) [Figure 7.10].
- Another way to examine the impact of deductibles on covered workers is to look at the percent of all covered workers who are in a plan with a deductible that exceeds a certain amount. Sixty-one 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 percent of covered workers with a general annual deductible of $1,000 or more for single coverage has grown, from 51% to 61% [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 (74% vs. 56%) [Figure 7.12].
- In 2022, 32% of covered workers are enrolled in a plan with a deductible of $2,000 or more, similar to the percentage last year (29%) [Figure 7.14]. This percentage is much higher for covered workers in small firms than in large firms (49% vs. 25%) [Figure 7.12].

Figure 7.9

Prevalence and Value of General Annual Deductibles for Single Coverage, by Firm Size, 2006-2022

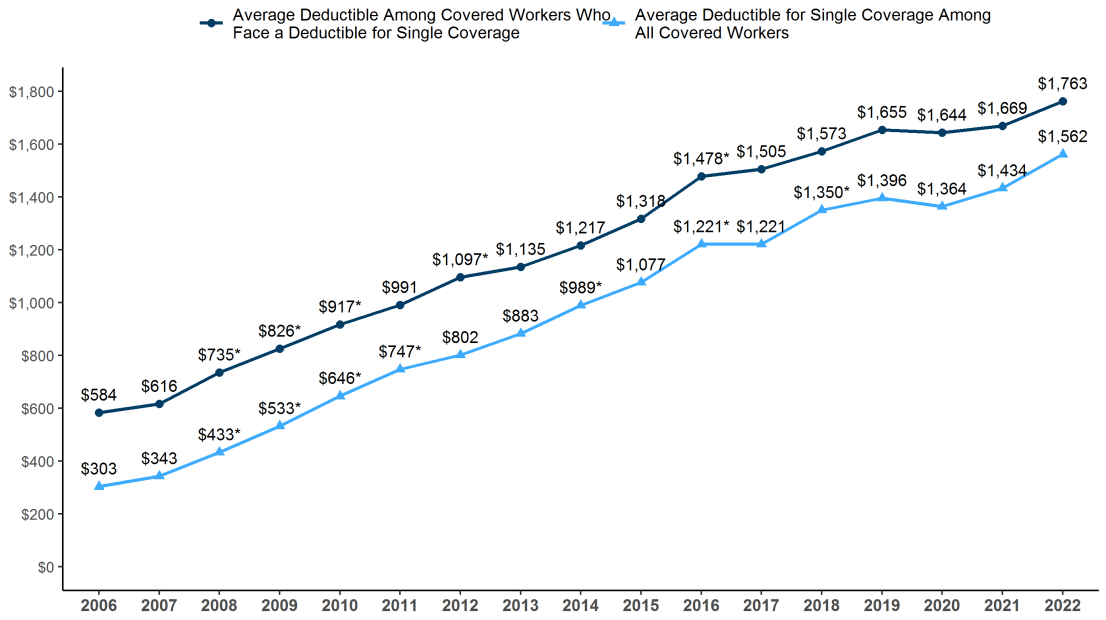
	Average General Annual Deductible Among Covered Workers Who Face A Deductible For Single Coverage			Percentage Of Covered Workers With A General Annual Deductible For Single Coverage			Average General Annual Deductible For Single Coverage Among All Covered Workers		
	All Small Firms	All Large Firms	All 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
2022	$2,543	$1,493	$1,763	87%	88%	88%	$2,218	$1,320	$1,562

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 ($p < .05$).

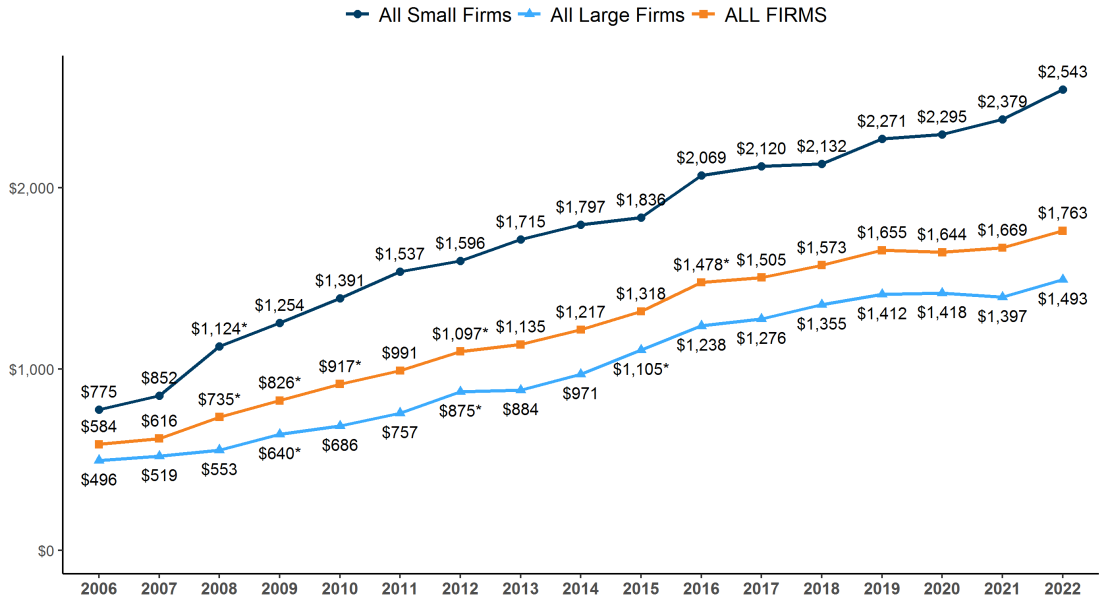
SOURCE: KFF Employer Health Benefits Survey, 2018-2022; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006-2017

Figure 7.10
Average General Annual Deductibles for Single Coverage, 2006-2022



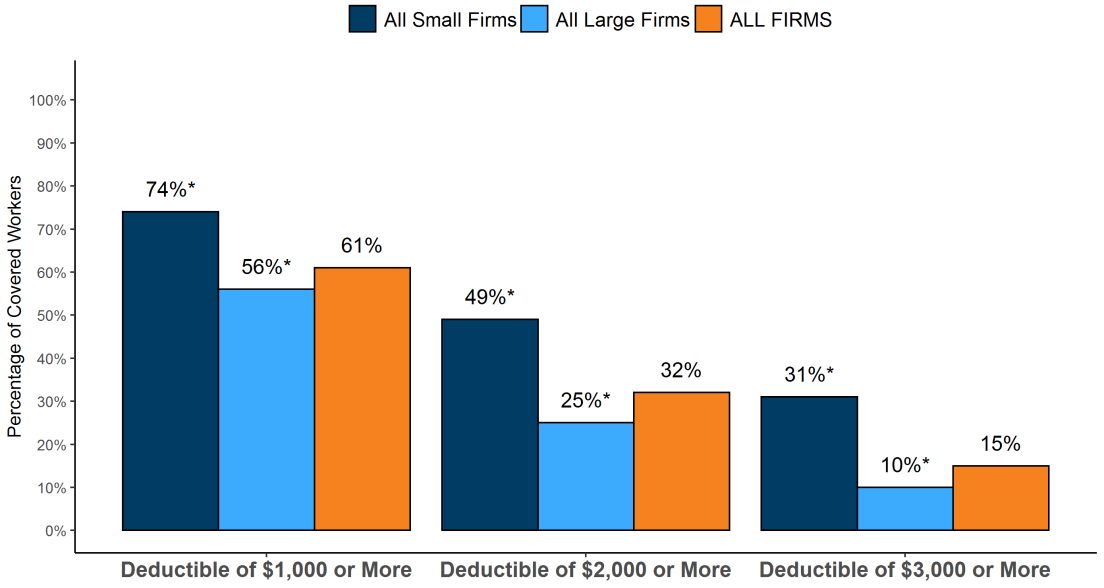
* Estimate is statistically different from estimate for the previous year shown (p < .05).
NOTE: Average general annual deductibles are among all covered workers. Workers in plans without a general annual deductible for in-network services are assigned a value of zero.
SOURCE: KFF Employer Health Benefits Survey, 2018-2022; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006-2017

Figure 7.11
Among Covered Workers Who Face a Deductible for Single Coverage, Average General Annual Deductible for Single Coverage, by Firm Size, 2006-2022



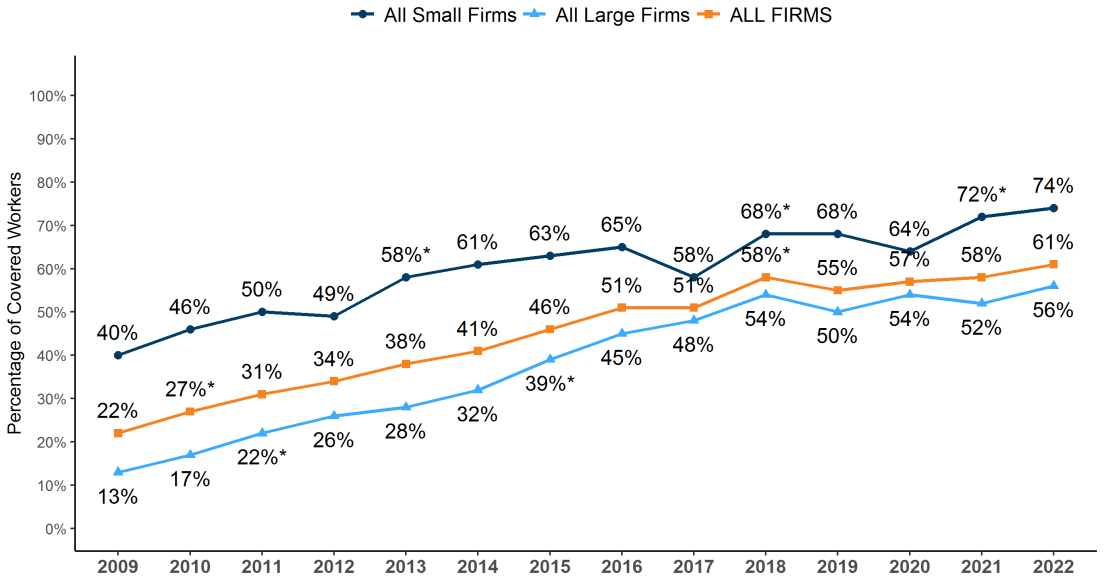
* Estimate is statistically different from estimate for the previous year shown (p < .05).
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers. Average general annual deductibles are for in-network providers.
SOURCE: KFF Employer Health Benefits Survey, 2018-2022; Kaiser/HRET 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, 2022



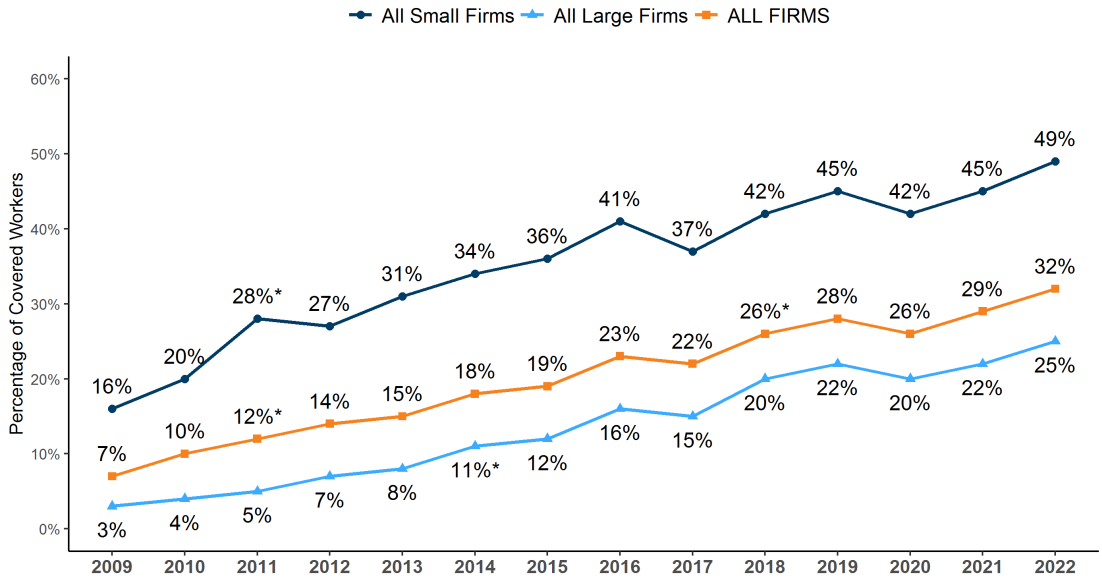
* Estimate is statistically different between All Small Firms and All Large Firms estimate ($p < .05$).
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers. These estimates include workers enrolled in HDHP/SOs and other plan types. Average general annual health plan deductibles for PPOs, POS plans, and HDHP/SOs are for in-network services.
SOURCE: KFF Employer Health Benefits Survey, 2022

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, 2009-2022



* 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, 2018-2022; 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, 2009-2022

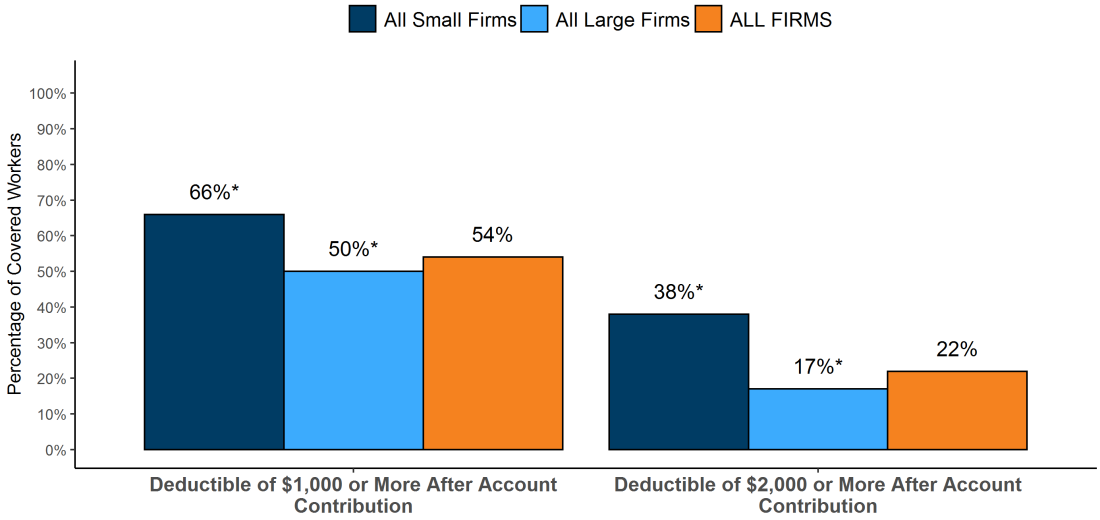


* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers. These estimates include workers enrolled in HDHP/SOs and other plan types. Average general annual deductibles are for in-network providers.
SOURCE: KFF Employer Health Benefits Survey, 2018-2022; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2009-2017

GENERAL ANNUAL DEDUCTIBLES AND ACCOUNT CONTRIBUTIONS

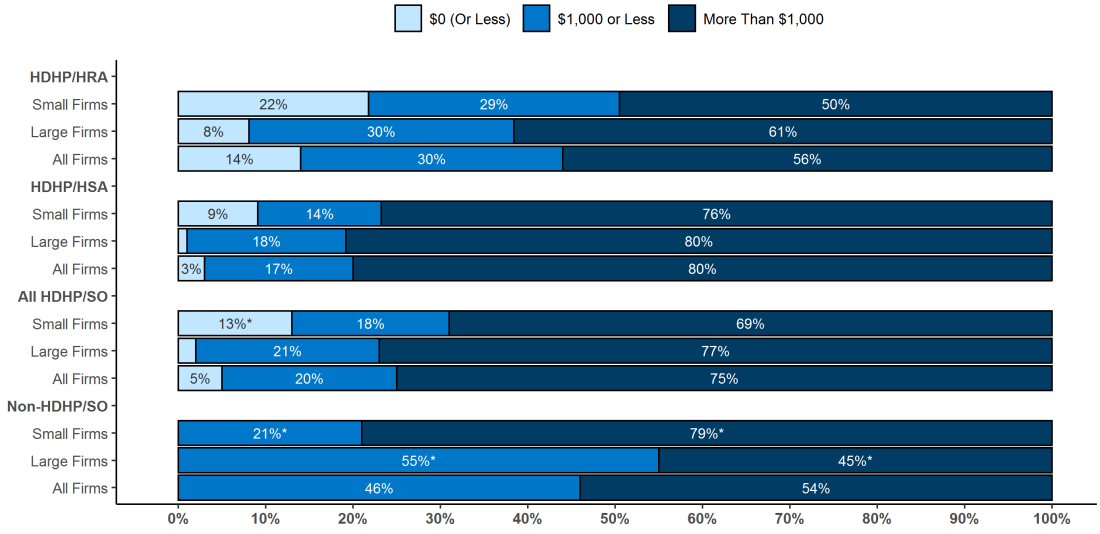
- One of the reasons for the growth in general annual deductibles is the growth in enrollment in HDHP/SOs, which have higher deductibles than other plans. While having a higher deductible in other plan types generally increases enrollee out-of-pocket liability, the shift in enrollment to HDHP/SOs does not necessarily do so, because many HDHP/SO enrollees receive an account contribution from their employers, reducing the higher cost sharing in these plans.
  - Fourteen percent of covered workers in an HDHP with an HRA and 3% of covered workers in an HSA-qualified HDHP receive an account contribution from their employer for single coverage that is at least equal to their deductible. Another 30% 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 subtract employer account contributions from the general annual deductibles, the percent of covered workers with a deductible of $1,000 or more would be reduced from 61% to 54% [Figure 7.13] and [Figure 7.15].

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, 2022



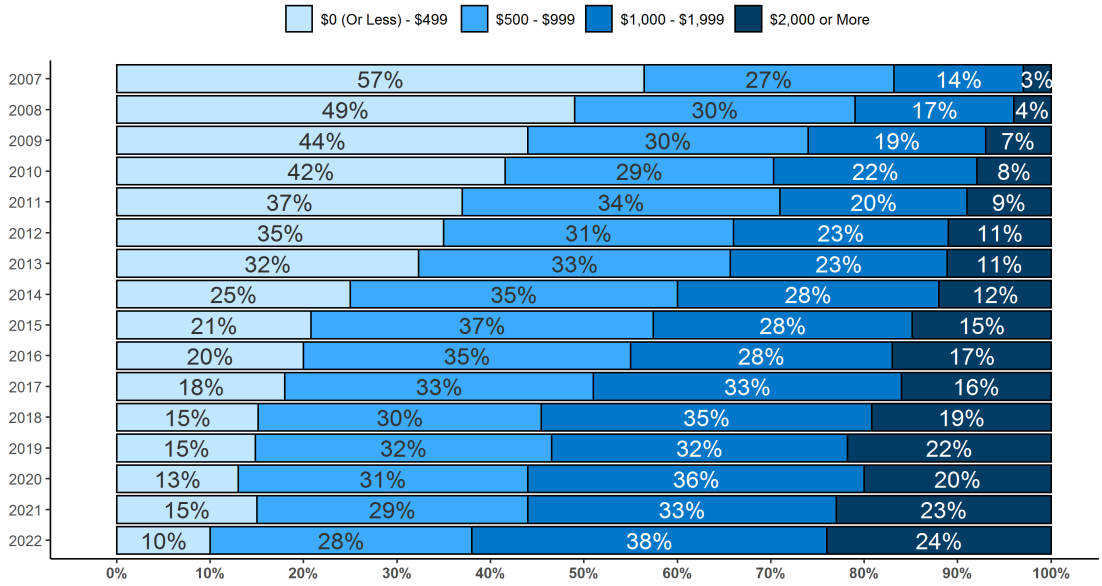
* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
NOTE: These estimates include workers enrolled in HDHP/SOs and other plan types. Average general annual health plan deductibles for PPOs, POS plans, and HDHP/SOs are for in-network services. These estimates include 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, 2018-2022; 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, 2022



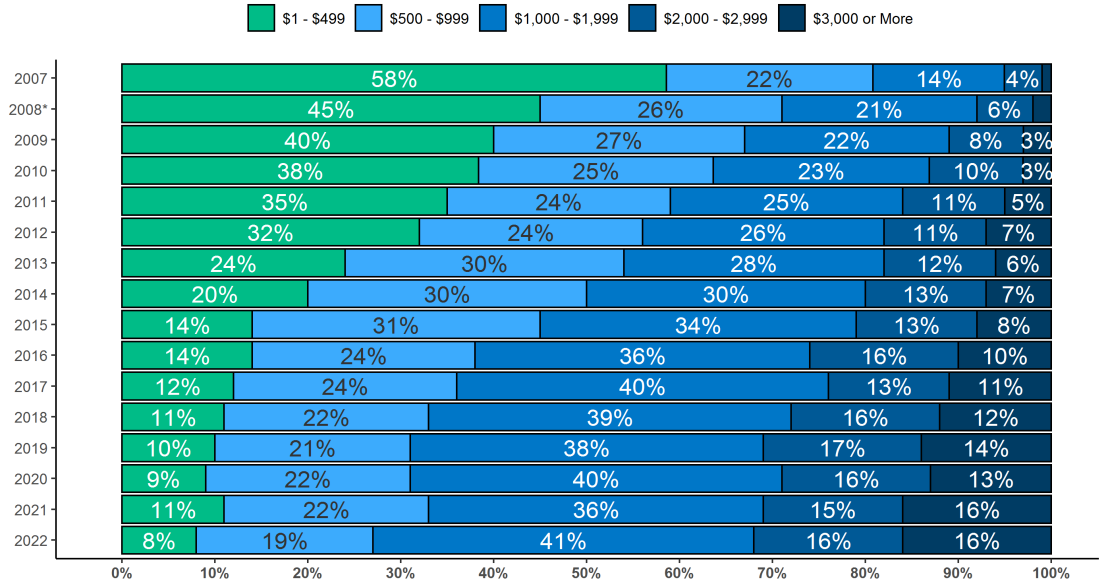
* Estimate is statistically different between All Small Firms and All Large Firms estimate ($p < .05$).
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers. The net liability for covered workers enrolled in a plan with an HSA or HRA is calculated by subtracting the account contribution 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, 2022

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, 2007-2022



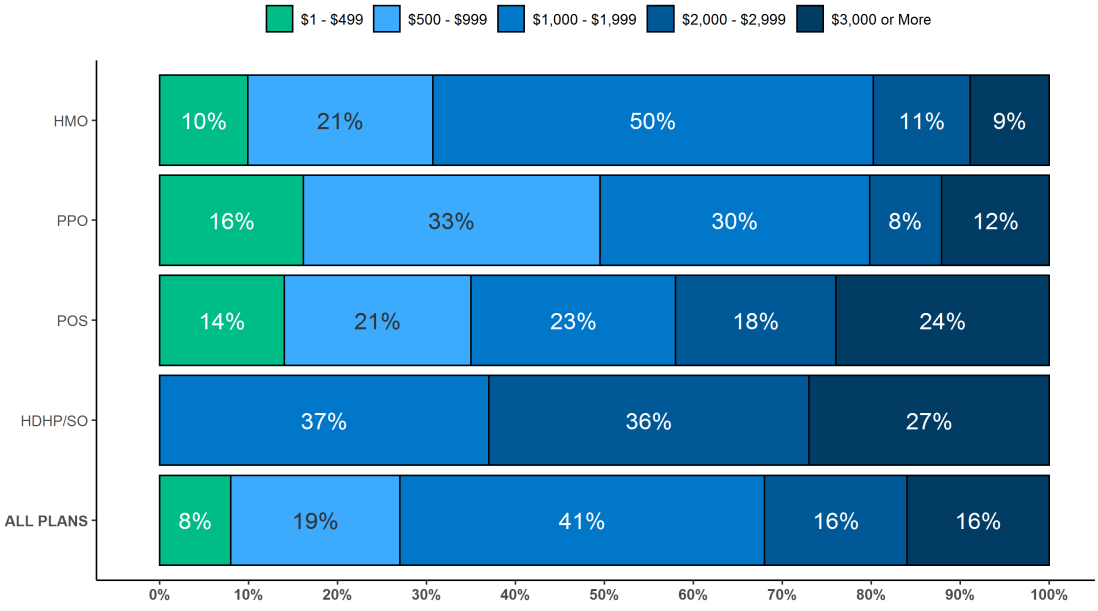
Tests found no statistical difference from distribution for the previous year shown ($p < .05$).
NOTE: Account contributions include an employer's contribution to an HSA or HRA. These estimates include workers enrolled in HDHP/SOs and other plan types. Average general annual deductibles are for in-network providers.
SOURCE: KFF Employer Health Benefits Survey, 2018-2022; 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, 2007-2022



* Distribution is statistically different from distribution for the previous year shown ($p < .05$).
NOTE: Average general annual deductibles are for in-network providers. In 2022, 88% of covered workers are enrolled in a plan with a general annual deductible.
SOURCE: KFF Employer Health Benefits Survey, 2018-2022; 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, 2022



NOTE: Average general annual deductibles are for in-network providers.
SOURCE: KFF Employer Health Benefits Survey, 2022

GENERAL ANNUAL DEDUCTIBLES FOR WORKERS ENROLLED IN FAMILY COVERGE

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

- Forty percent of covered workers in HMOs are in plans without a general annual deductible for family coverage. The percent of workers in plans without family deductibles are lower for workers in PPOs (12%) and POS plans (17%). 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 percent of covered workers in a plan with an aggregate general annual deductible is 44% for workers in HMOs, 53% for workers in PPOs, 68% for workers in POS plans, and 74% 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 $3,124 for HMOs, $2,908 for PPOs, $3,773 for POS plans, and $4,766 for HDHP/SOs [Figure 7.21]. The average deductible amounts for aggregate family deductibles are similar to last year for each plan type.

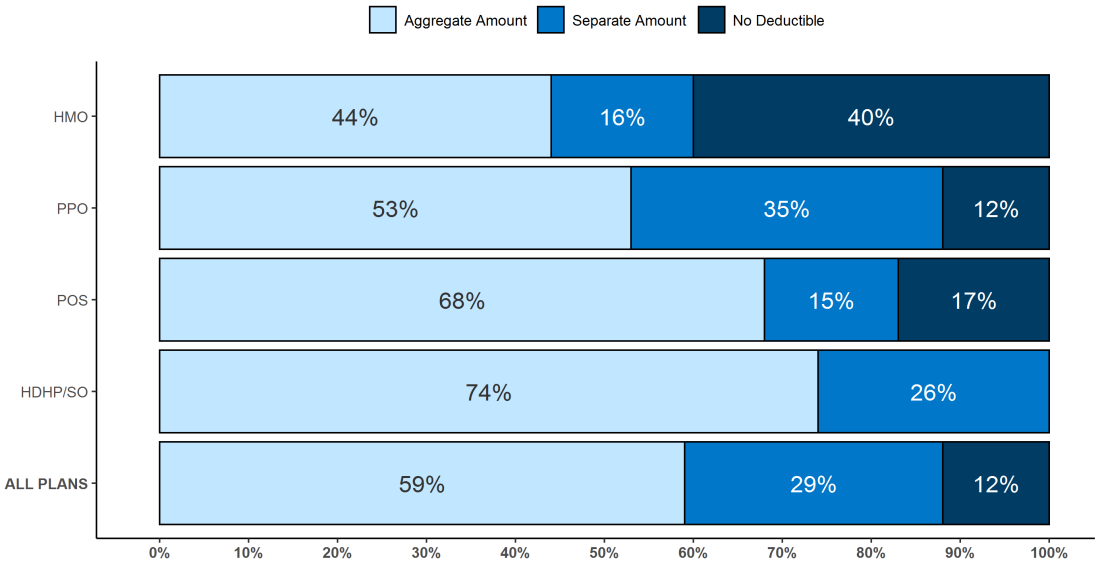
- For covered workers in plans with an aggregate deductible for family coverage, the average annual family deductibles in small firms are higher than in large firms for covered workers in HMOs, PPOs and HDHP/SOs [Figure 7.21].

- Among workers enrolled in family coverage, the percent of workers in plans with a separate per-person annual deductible for family coverage is 16% for workers in HMOs, 35% for workers in PPOs, 15% for workers in POS plans, and 26% 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 $1,600 for HMOs, $1,506 for PPOs, and $3,325 for HDHP/SOs [Figure 7.21].

- Thirty-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, the most frequent number of family members who are 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, 2022



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, 2022

Figure 7.21

Among Covered Workers With a General Annual Deductible, Average Deductibles for Family Coverage, by Deductible Type, Plan Type, and Firm Size, 2022

	Aggregate Amount	Separate Per-Person Amount
HMO		
All Small Firms	$4,035*	NSD
All Large Firms	$2,783*	$1,446
ALL FIRM SIZES	**$3,124**	**$1,600**
PPO		
All Small Firms	$4,373*	$3,070*
All Large Firms	$2,326*	$1,154*
ALL FIRM SIZES	**$2,908**	**$1,506**
POS		
All Small Firms	$4,251	NSD
All Large Firms	$3,282	NSD
ALL FIRM SIZES	**$3,773**	**$2,468**
HDHP/SO		
All Small Firms	$6,237*	$4,217*
All Large Firms	$4,317*	$3,046*
ALL FIRM SIZES	**$4,766**	**$3,325**

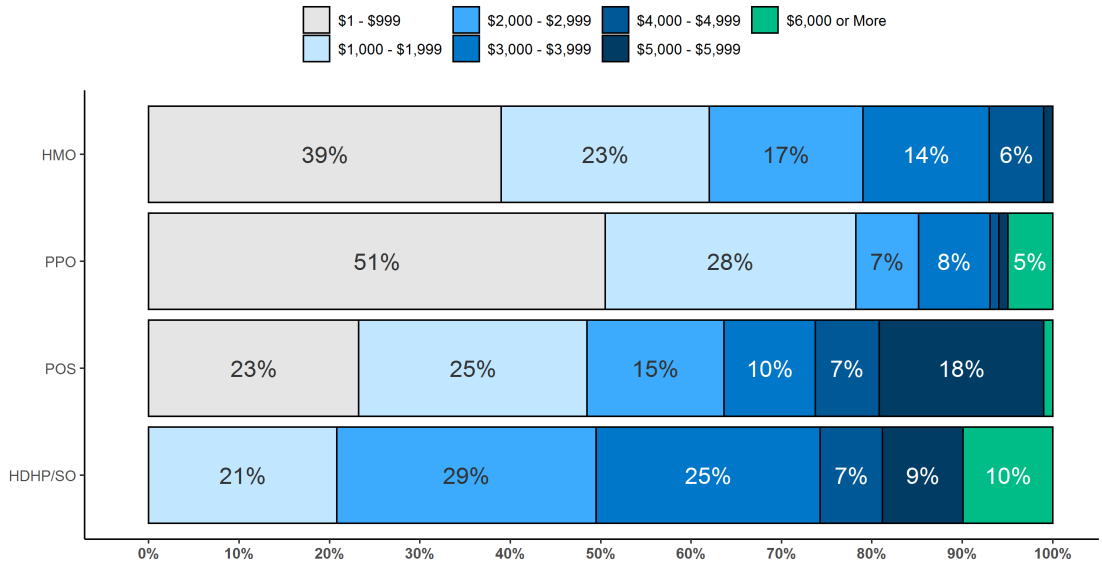
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers. Average general annual deductibles are for in-network providers. The survey distinguishes between plans that have an aggregate family deductible and plans that have a separate per-person deductible, typically with a limit 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, 2022

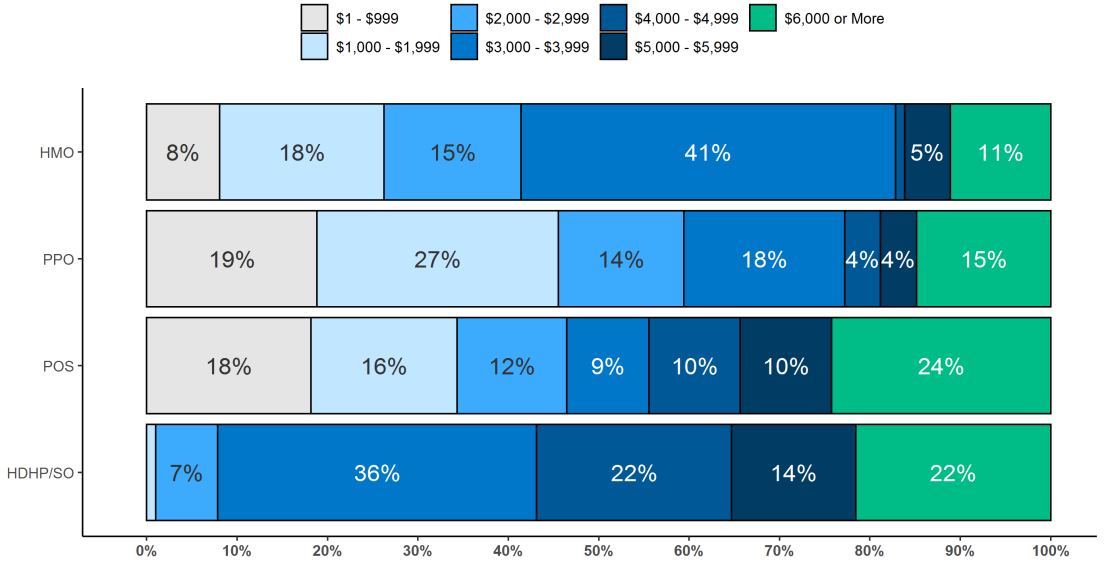
Figure 7.22

Among Covered Workers with a Separate Per-Person General Annual Deductible for Family Coverage, Distribution of Deductibles, by Plan Type, 2022



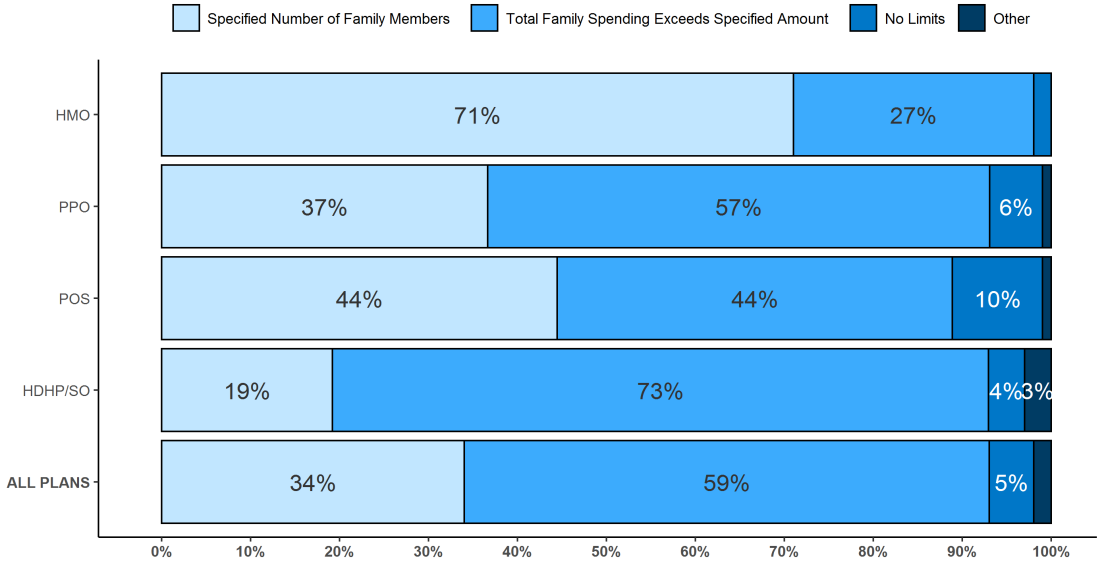
NOTE: Average general annual deductibles are for in-network providers. The survey distinguishes between plans that have an aggregate family deductible and plans that have a separate per-person deductible, typically with a limit on the number of family members required to reach that amount.
SOURCE: KFF Employer Health Benefits Survey, 2022

Figure 7.23
Among Covered Workers with an Aggregate General Annual Deductible for Family Coverage, Distribution of Deductibles, by Plan Type, 2022



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, 2022

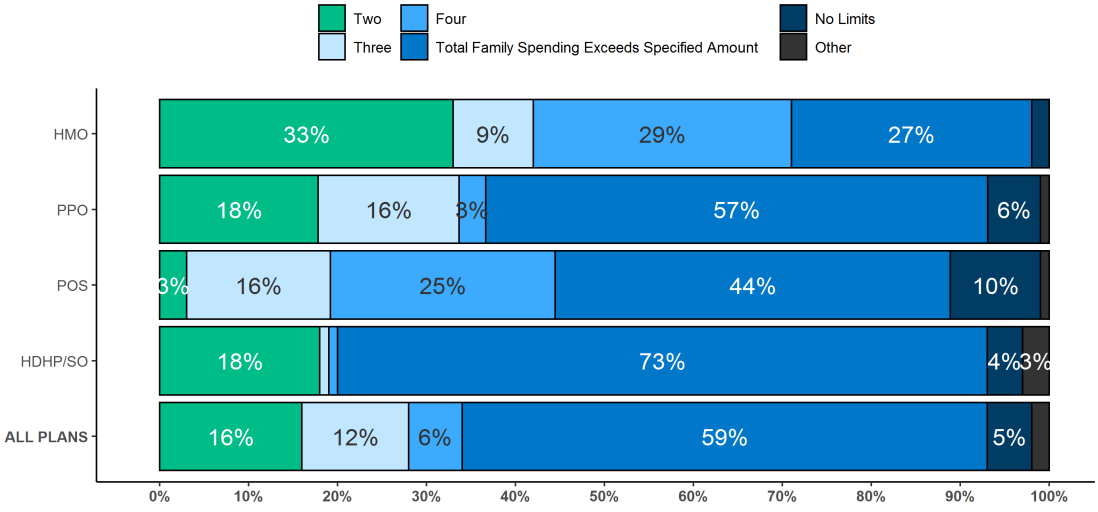
Figure 7.24
Among Covered Workers With a Separate Per-Person General Annual Deductible for Family Coverage, Structure of Deductible Limits, by Plan Type, 2022



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, 2022

Figure 7.25

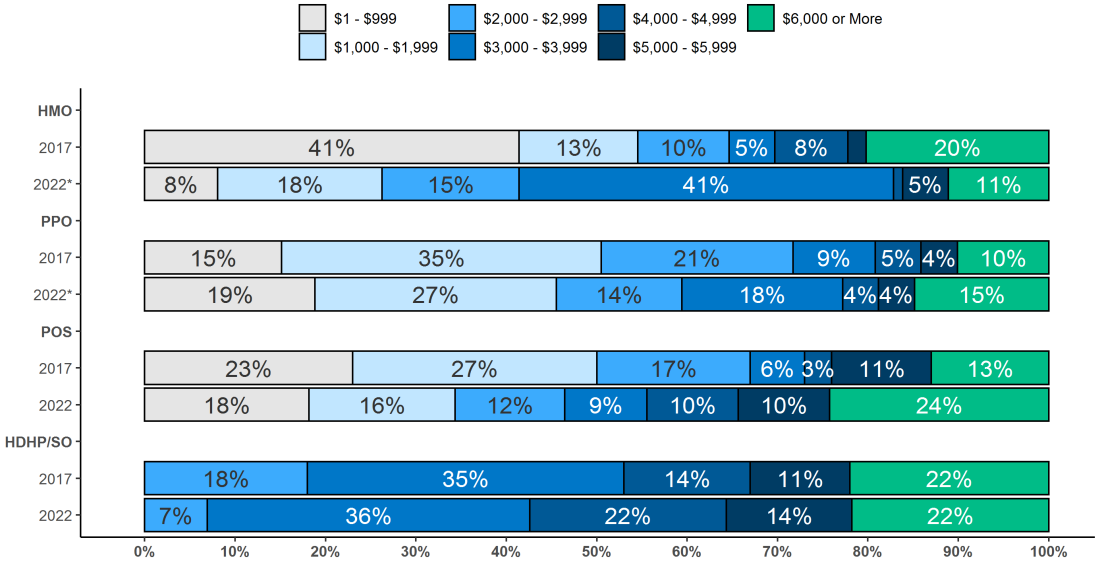
Among Covered Workers With a Separate Per-Person General Annual Deductible for Family Coverage and a Per-Person Limit, Distribution of Maximum Number of Family Members Required to Meet the Deductible, by Plan Type, 2022



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, 2022

Figure 7.26

Among Covered Workers With an Aggregate General Annual Deductible for Family Coverage, Distribution of Aggregate Deductibles, by Plan Type, 2017 and 2022

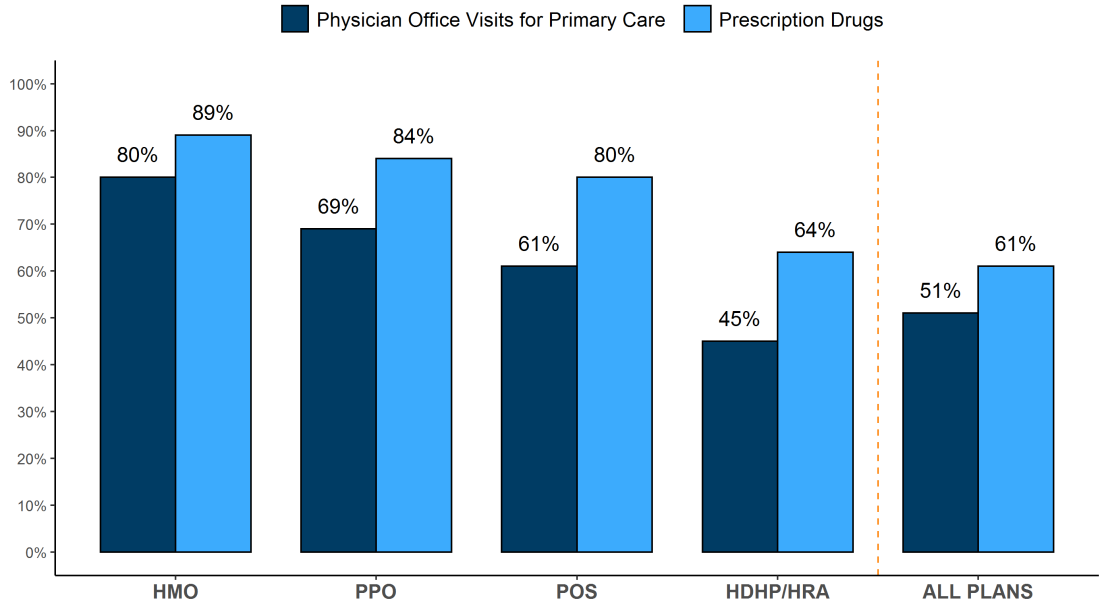


* Distribution is statistically different from distribution for the previous year shown ($p < .05$).
NOTE: By definition, 100% of covered workers in an HDHP/SO with an aggregate deductible have a family deductible of $2,000 or more. Average general annual deductibles are for in-network providers. The 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, 2022; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2017

COVERAGE OF SERVICES AND PRODUCTS BEFORE MEETING THE GENERAL ANNUAL DEDUCTIBLES

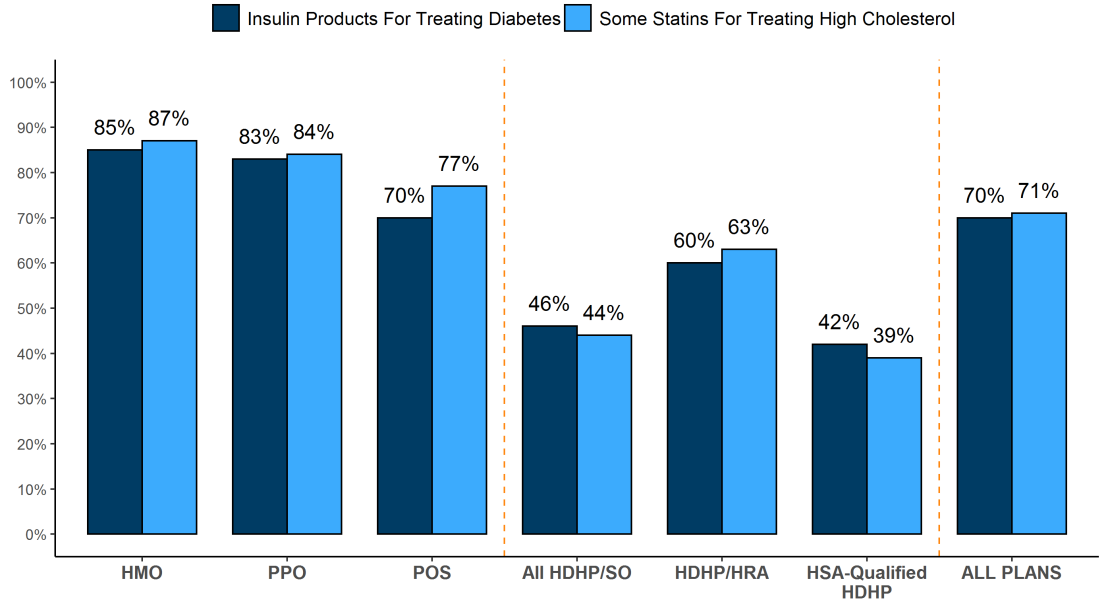
- The majority of covered workers with a general annual deductible are in plans where the deductible does not have to be met before certain services, such as physician office visits or prescription drugs, are covered. Covered workers in HSA qualified HDHP/SOs are not included in these estimates because HSA-qualified plans generally only pay for preventive services before the deductible is met.
  - The majority of covered workers (80% in HMOs, 69% in PPOs, and 61% in POS plans) 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 (89%), PPOs (84%), POS plans (80%), and HDHP/HRAs (64%) do not have to meet the general annual deductible before prescription drugs are covered [Figure 7.27].
- In 2019, the federal government issued new rules that expanded the number and types of items and services that may be considered preventive by HSA-qualified health plans. This means that plan sponsors may pay for part or all of these services before enrollees meet the plan deductibles in these plans. In 2022, we asked employers with all types of health plans, including HSA qualified HDHP/SOs, whether certain preventive services – specifically insulin products for treating diabetes and statins for treating high cholesterol – were paid for before the plan deductible is met.
  - The majority of covered workers (85% in HMOs, 83% in PPOs, and 70% in POS plans, and 46% in HPHD/SOs) are enrolled in plans where the general annual deductible does not have to be met before at least some insulin products are covered. Covered workers in HDHP/SOs are less likely than covered workers in PPOs and HMOs to be in a plan where insulin products are covered before the deductible is met [Figure 7.28].
  - Similarly, the majority of covered workers (87% in HMOs, 84% in PPOs, and 77% in POS plans, and 44% in HPHD/SOs) are enrolled in plans where the general annual deductible does not have to be met before at least some statins are covered. Covered workers in HDHP/SOs are less likely than covered workers in PPOs and HMOs to be in a plan where statins are covered before the deductible is met [Figure 7.28].

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, 2022



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, 2022

Figure 7.28
Among Covered Workers with a General Annual Deductible, Percentage with Coverage for the Following Drug Classes Without Having to First Meet the Deductible, by Plan Type, 2022



NOTE: Covered workers enrolled in an HDHP/SO are enrolled in either an HDHP/HRA or a HSA-Qualified HDHP.
SOURCE: KFF Employer Health Benefits Survey, 2022

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 13% have a copayment that applies to inpatient hospital admissions. A lower percent of covered workers have per day (per diem) payments (5%), a separate hospital deductible (2%), or both a copayment and coinsurance (10%), while 15% have no additional cost sharing for hospital admissions after any general annual deductible has been met [Figure 7.29].
  - On average, covered workers in HMOs and POS plans are more likely than workers in other plan types to have a copayment for hospital admissions, while workers in HDHP/SOs are less likely [Figure 7.29].
  - Covered workers in HMOs and POS plans are less likely, on average, than workers in other plan types to have a coinsurance requirement for hospital admissions [Figure 7.29].
  - The average coinsurance rate for a hospital admission is 20%, the average copayment is $344 per hospital admission, and the average per diem charge is $473 [Figure 7.32]. Sixty-seven percent of workers enrolled in a plan with a per diem for hospital admissions have a limit on the number of days for which a worker must pay the cost-sharing amount [Figure 7.33].
- The cost-sharing provisions for outpatient surgery are similar to those for hospital admissions, as most workers have coinsurance or copayments. In 2022, 13% of covered workers have a copayment and 69% have a coinsurance rate for outpatient surgery. In addition, 8% have both a copayment and a coinsurance rate, while 16% have no additional cost sharing after any general annual deductible has been met [Figures 7.30 and 7.31].
  - For covered workers with cost sharing for outpatient surgery, the average coinsurance rate is 20% and the average copayment is $179 [Figure 7.32].

Figure 7.29

Distribution of Covered Workers With Other Cost Sharing for Hospital Admissions, in Addition to Any General Annual Deductible, by Plan Type, 2022

Plan Type	Separate Annual Deductible for Hospital Admissions	Copayment	Coinsurance	Both Copayment and Coinsurance	Charge Per Day	None
HMO	5%	38%*	49%*	9%	15%*	7%*
PPO	2	9	74	14	3*	12
POS	6*	36*	39*	10	13*	19
HDHP/SO	<1*	3*	74	3*	2*	22*
ALL PLANS	**2%**	**13%**	**68%**	**10%**	**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. 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. One 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, 2022

Figure 7.30

Distribution of Covered Workers With Other Cost Sharing for Outpatient Surgery, in Addition to Any General Annual Deductible, by Plan Type, 2022

Plan Type	Separate Annual Deductible for Outpatient Surgery	Copayment	Coinsurance	Both Copayment and Coinsurance	None
HMO	5%*	41%*	48%*	5%	10%*
PPO	1	10	76*	10	11*
POS	3	26*	48*	13	22
HDHP/SO	1	3*	71	3	25*
ALL PLANS	**2%**	**13%**	**69%**	**8%**	**16%**

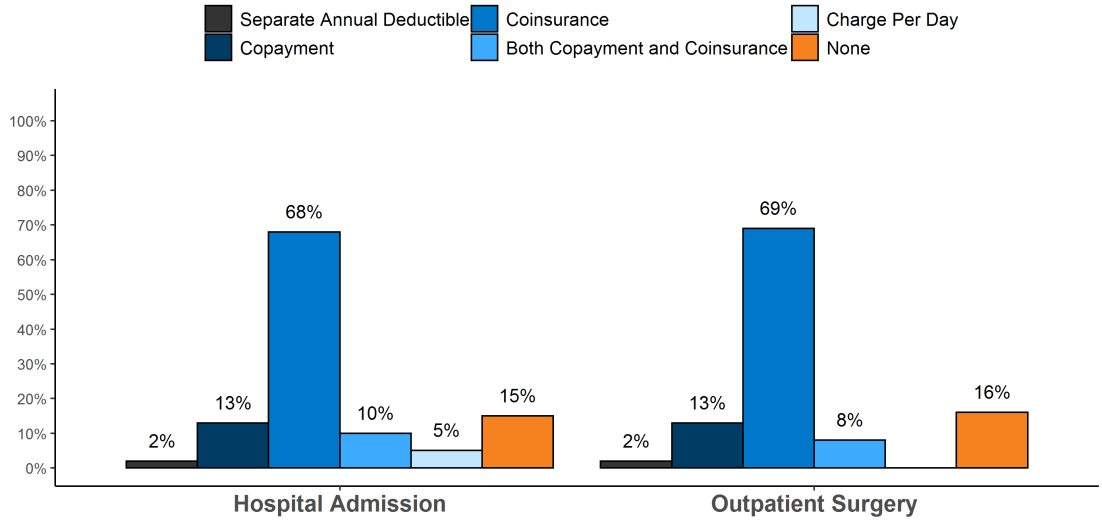
NOTE: We collect information on the cost-sharing provisions in addition to any general annual plan deductible. The distribution of workers with different types of cost sharing does not equal 100% because workers may face a combination of types of cost sharing. Less than one percent of covered workers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

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

SOURCE: KFF Employer Health Benefits Survey, 2022

Figure 7.31

Percentage of Covered Workers with the Following Types of Cost Sharing for Hospital Admissions and Outpatient Surgery, in Addition to Any General Annual Deductible, 2022



NOTE: We collect information on the cost-sharing provisions in addition to any general annual plan deductible. The distribution of workers with different types of cost sharing does not equal 100% because workers may face a combination of types of cost sharing. Less than one percent of covered workers have an 'Other' type of cost sharing. Information on separate deductibles for hospital admissions was collected only for HDHP/HRAs because federal regulations for HSA-qualified HDHPs make it unlikely these plans would have a separate deductible for specific services. 'Both Copayment and Coinsurance' category includes workers who are required to pay the higher amount of either the copayment or coinsurance under the plan.
SOURCE: KFF Employer Health Benefits Survey, 2022

Figure 7.32

Among Covered Workers With Separate Cost Sharing for Hospital Admissions or Outpatient Surgery, Average Cost Sharing, by Type, 2022

	Charge Per Day	Coinsurance	Copayment
Outpatient Surgery	N/A	20%	$179
Hospital Admission	$473	20%	$344

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, 2022

Figure 7.33

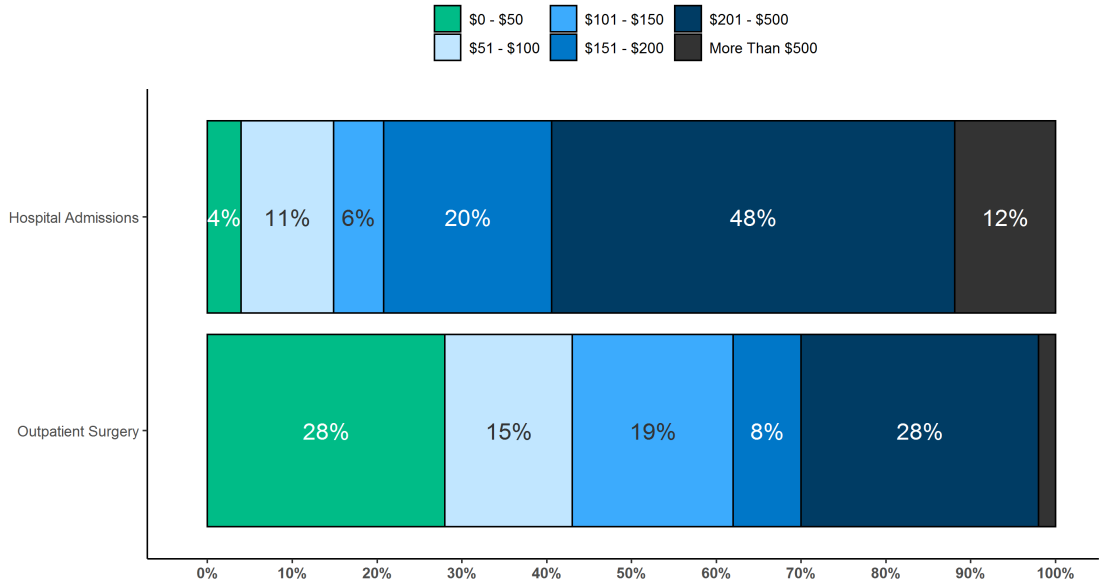
Among Covered Workers With a Charge Per Day for Hospital Admissions, Average Cost Sharing Features, 2022

	Among Covered Workers With a Charge Per Day for Hospital Admissions
Average Charge Per Day	$473
Percentage of Covered Workers With a Limit On the Number of Days a Worker Must Pay Per-Day Amount	67%

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.

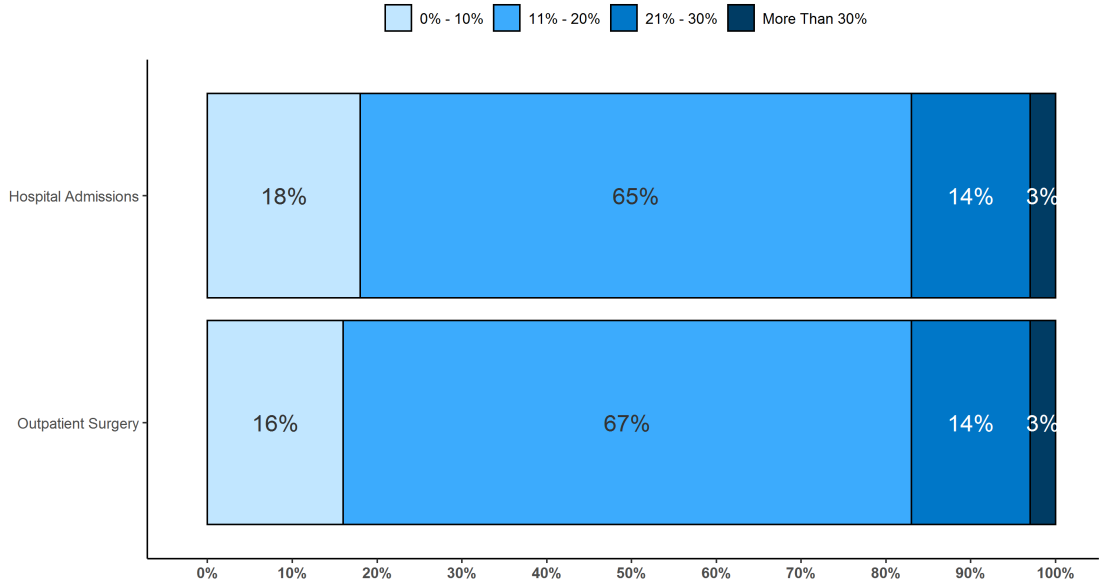
SOURCE: KFF Employer Health Benefits Survey, 2022

Figure 7.34
Among Covered Workers with a Copayment for Hospital Admissions or Outpatient Surgery, Distribution of Copayments, 2022



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, 2022

Figure 7.35
Among Covered Workers with Coinsurance for Hospital Admissions or Outpatient Surgery, Distribution of Coinsurance Rates, 2022



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, 2022

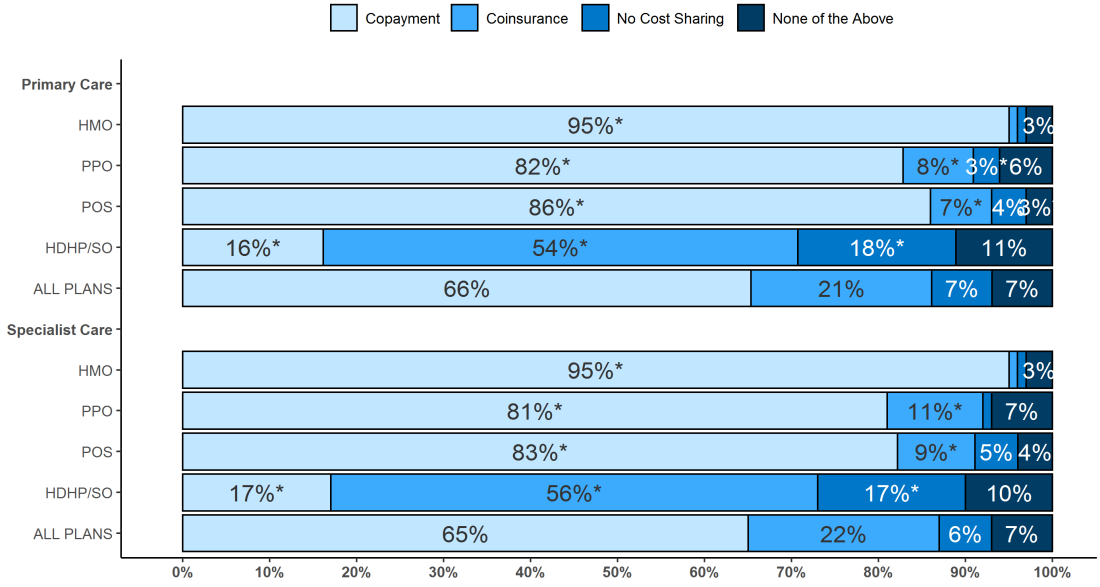
COST SHARING FOR PHYSICIAN OFFICE VISITS

- 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. Sixty-six percent of covered workers have a copayment for a primary care physician office visit and 21% have coinsurance. For office visits with a specialty physician, 65% of covered workers have a copayment and 22% have coinsurance [Figure 7.36].
  - The form of cost sharing for physician office visits varies by firm size. Covered workers in small firms are are less likely to have coinsurance than workers in large firms for in-network primary care office visits (10% vs. 24%), and for in-network office visits with specialists (11% vs. 26%).
  - Covered workers in HMOs, PPOs, and POS plans are much more likely to have copayments for both primary care and specialty care physician office visits than workers in HDHP/SOs. For primary care physician office visits, 16% of covered workers in HDHP/SOs have a copayment, 54% have coinsurance, and 18% have no cost sharing after the general annual plan deductible is met [Figure 7.36].
  - Among covered workers with a copayment for in-network physician office visits, the average copayment for primary care physician office visits is $27, similar to the average copayment last year ($25) [Figure 7.37].
  - Among covered workers with a copayment for in-network physician office visits, the average copayment for specialty physician office visits is $44, similar to the amount last year [Figure 7.37].
  - For covered workers with a copayment for physician office visits, average copayment amounts are higher for workers in small firms than those in large firms for both primary care physician office visits ($29 vs. $25) and specialty physician office visits ($50 vs. $41).
  - 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 7.37].

[2] 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.

Figure 7.36

Percentage of Covered Workers with the Following Types of Cost Sharing for Physician Office Visits, by Plan Type, 2022



* 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, 2022

Figure 7.37

Among Covered Workers With Copayments And/Or Coinsurance for Physician Office Visits, Average Copayments and Coinsurance, by Plan Type, 2022

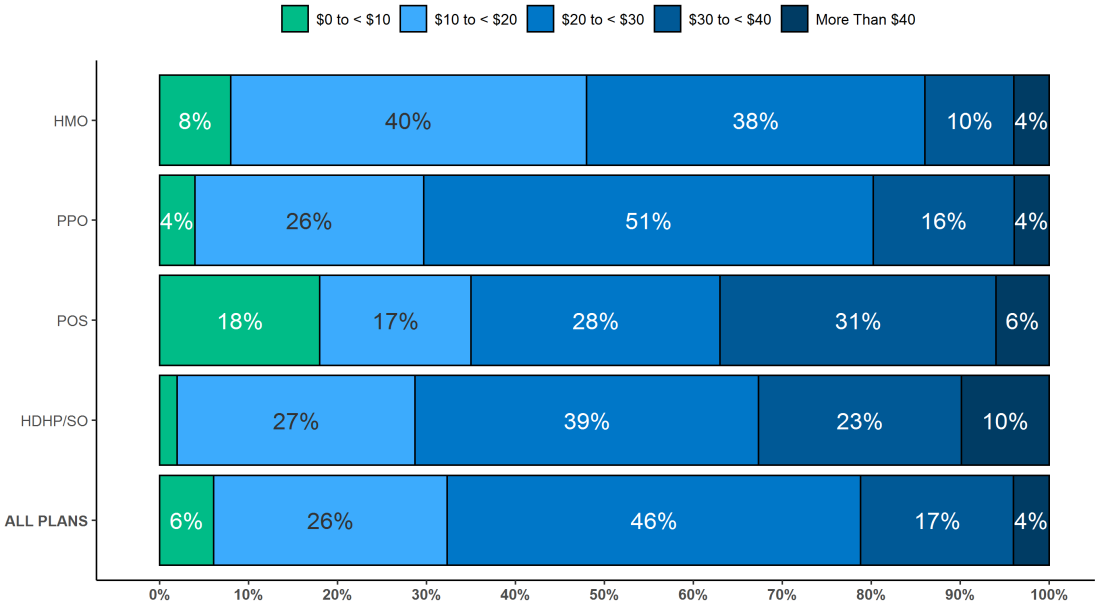
	HMO	PPO	POS	HDHP/SO	All Plans
Primary Care Office Visit					
Average Copayment ($)	$24*	$27	$27	$31	**$27**
Average Coinsurance (%)	NSD	22%	NSD	19%	**19%**
Specialty Care Office Visit					
Average Copayment ($)	$41	$44	$46	$49	**$44**
Average Coinsurance (%)	NSD	22%	NSD	19%	**20%**

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

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

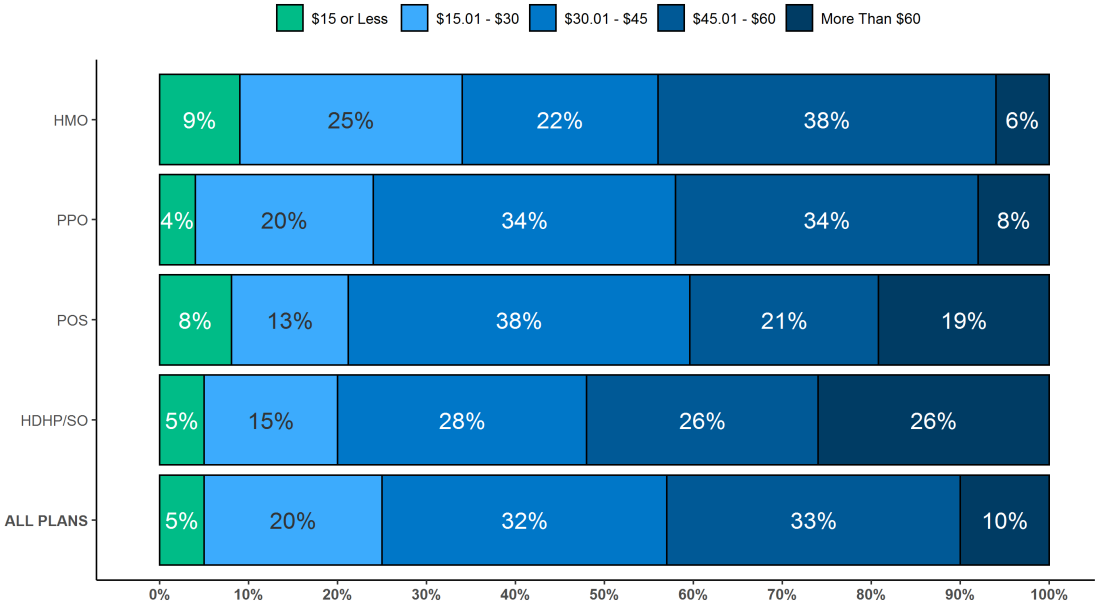
SOURCE: KFF Employer Health Benefits Survey, 2022

Figure 7.38
Among Covered Workers with a Copayment for a Primary Care Physician Office Visit, Distribution of Copayments, by Plan Type, 2022



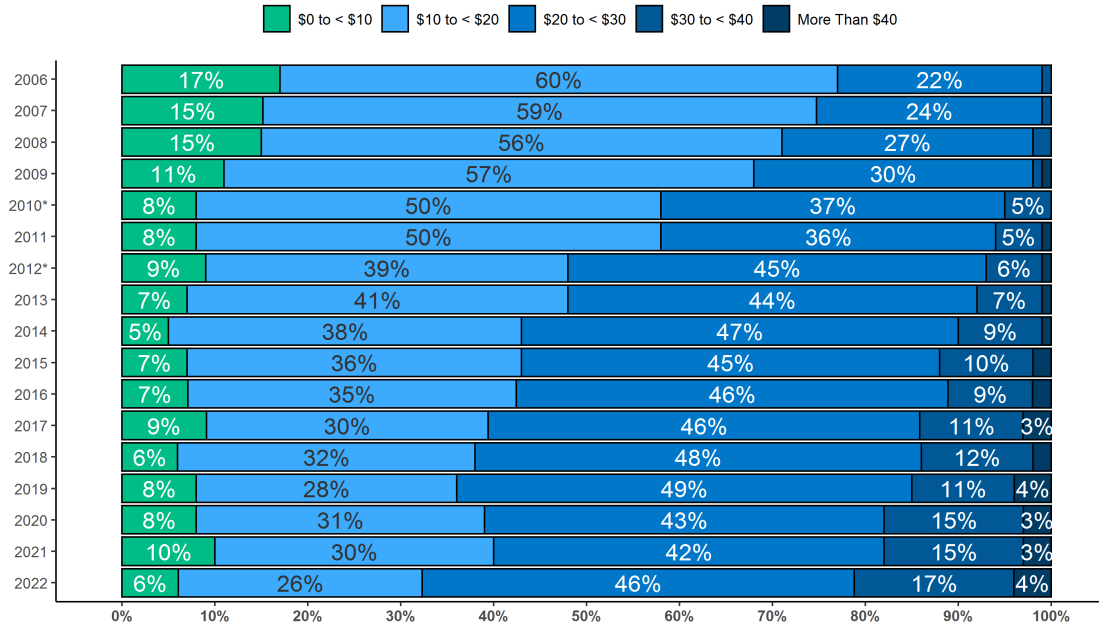
NOTE: Copayments are for in-network providers.
SOURCE: KFF Employer Health Benefits Survey, 2022

Figure 7.39
Among Covered Workers with a Copayment for a Specialist Physician Office Visit, Distribution of Copayments, by Plan Type, 2022



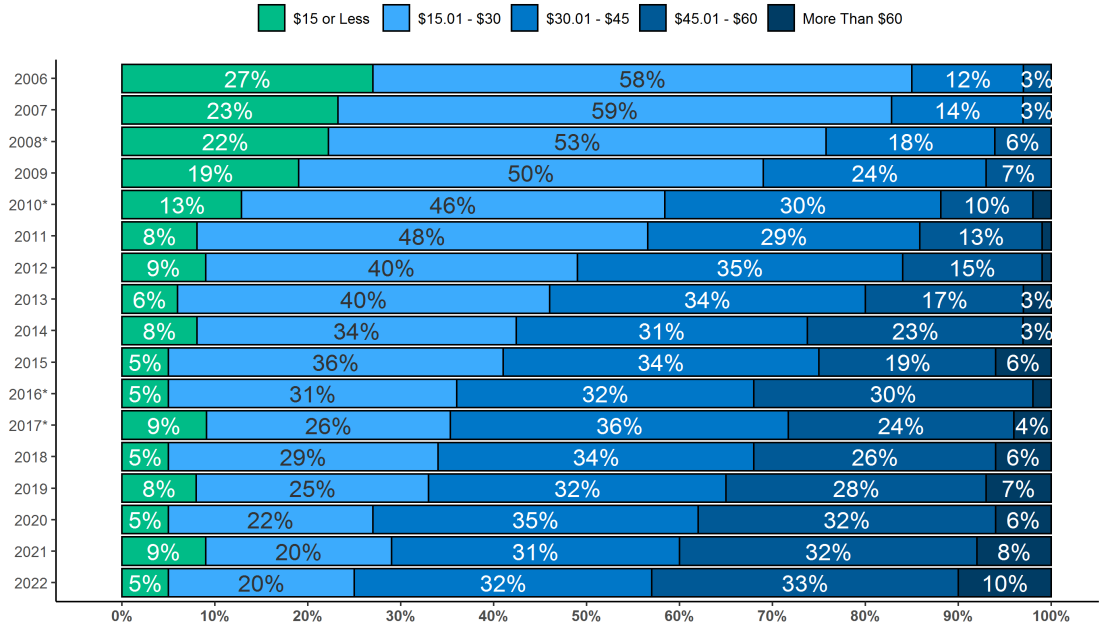
NOTE: Copayments are for in-network providers.
SOURCE: KFF Employer Health Benefits Survey, 2022

Figure 7.40
Among Covered Workers with a Copayment for a Primary Care Physician Office Visit, Distribution of Copayments, 2006-2022



* Distribution is statistically different from distribution for the previous year shown ($p < .05$).
SOURCE: KFF Employer Health Benefits Survey, 2018-2022; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006-2017

Figure 7.41
Among Covered Workers with a Copayment for a Specialist Physician Office Visit, Distribution of Copayments, 2006-2022



* Distribution is statistically different from distribution for the previous year shown ($p < .05$).
SOURCE: KFF Employer Health Benefits Survey, 2018-2022; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006-2017

Figure 7.42

Among Covered Workers With a Copayment And/Or Coinsurance for Physician Office Visits, Average Copayment and Coinsurance, 2006-2022

	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%
2022	$27	19%	$44	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, 2018-2022; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006-2017

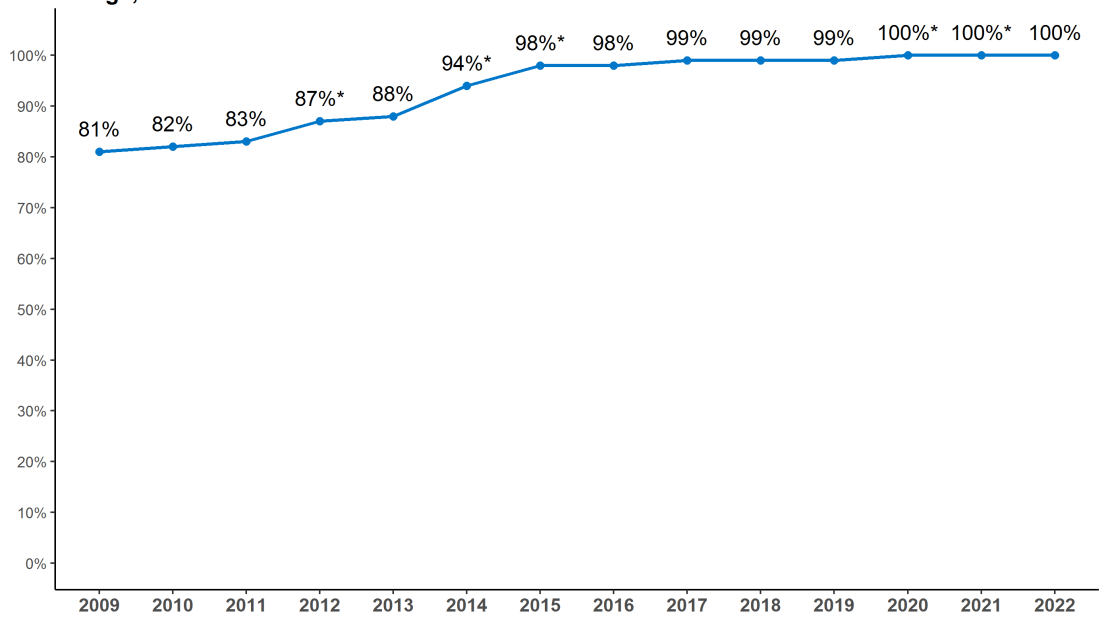
OUT-OF-POCKET MAXIMUMS

- 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 $8,700 for single coverage and $17,400 for family coverage in 2022. 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 2022, more than 99% of covered workers are in a plan that has an out-of-pocket maximum for single coverage [Figure 7.43].

[3]For those enrolled in an HDHP/HSA, the out-of-pocket maximum may be no more than $7,050 for an individual plan and $14,100 for a family plan in 2022. See https://www.irs.gov/irb/2019-22_IRB#REV-PROC-2019-25

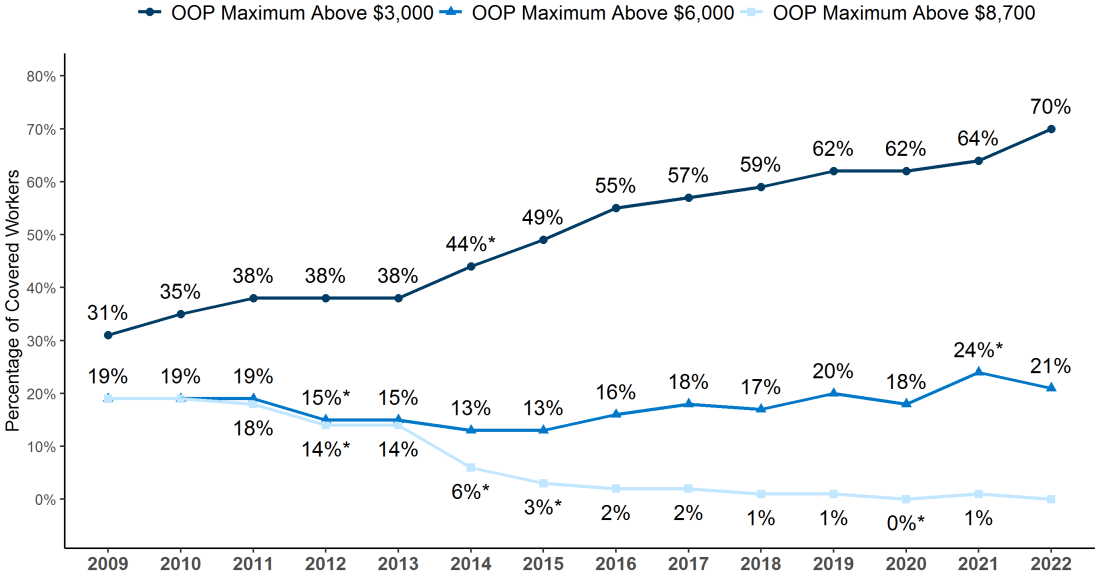
- For covered workers in plans with an out-of-pocket maximum for single coverage, there is wide variation in spending limits.
  - Eight percent of covered workers in plans with an out-of-pocket maximum have an out-of-pocket maximum of less than $2,000 for single coverage, while 26% of these workers have an out-of-pocket maximum of $6,000 or more [Figure 7.45].

Figure 7.43
Percentage of Covered Workers in a Plan with an Out-of-Pocket Maximum for Single Coverage, 2009-2022



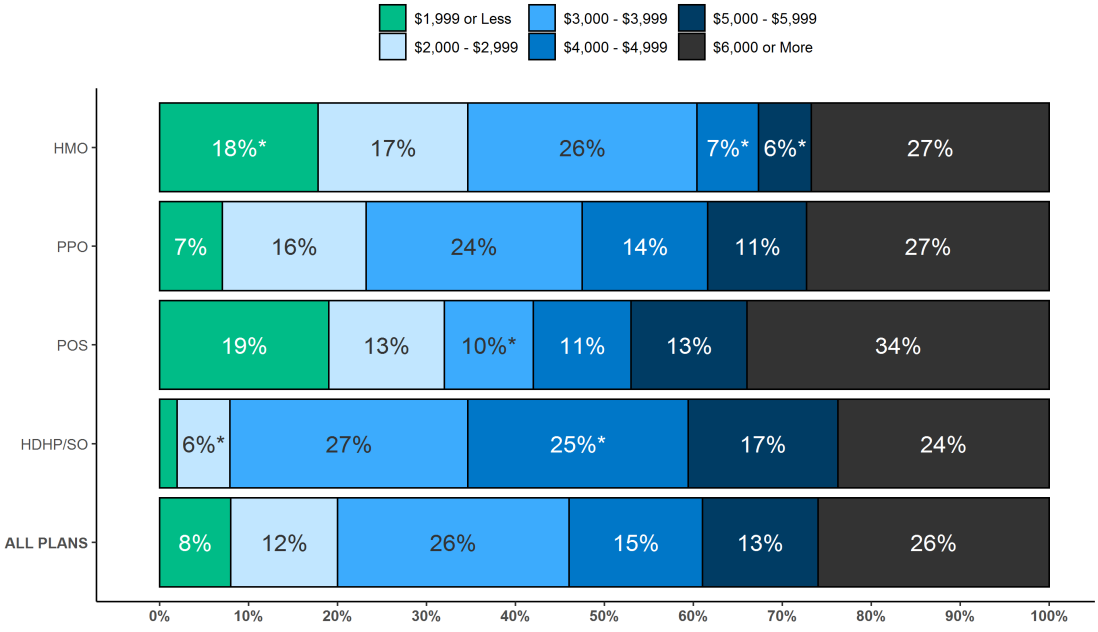
* Estimate is statistically different from estimate for the previous year shown (p < .05).
NOTE: Out-of-pocket maximums reported are for in-network services.
SOURCE: KFF Employer Health Benefits Survey, 2018-2022; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2009-2017

Figure 7.44
Percentage of Covered Workers in a Plan with an Out-of-Pocket Maximum Above Certain Thresholds for Single Coverage, 2009-2022



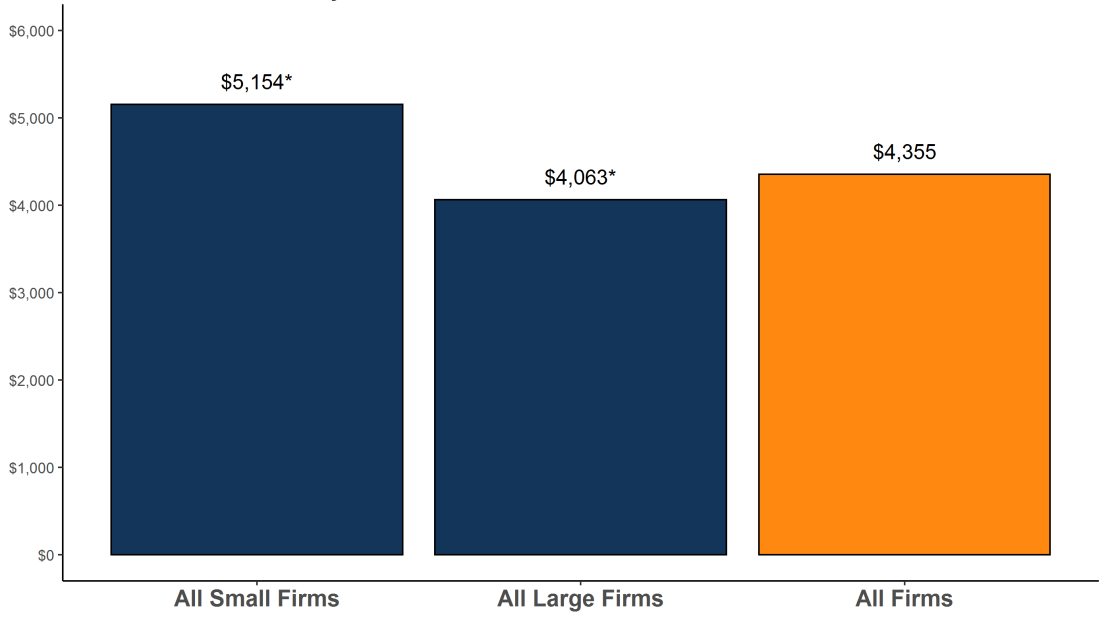
* Estimate is statistically different from estimate for the previous year shown (p < .05).
NOTE: OOP is 'out-of-pocket'. OOP maximums are for in-network services. Covered workers without an OOP maximum are considered to be exposed to at least the specified threshold. Some of these workers may be enrolled in plans whose cost-sharing structure has other limits.
SOURCE: KFF Employer Health Benefits Survey, 2018-2022; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2009-2017

Figure 7.45
Among Covered Workers with an Out-of-Pocket Maximum for Single Coverage, Distribution of Out-of-Pocket Maximums, by Plan Type, 2022



* Estimate is statistically different from All Plans estimate within plan type (p < .05).
SOURCE: KFF Employer Health Benefits Survey, 2022

Figure 7.46
Among Covered Workers with an Out-of-Pocket Maximum for Single Coverage, Average Out-of-Pocket Maximums, by Firm Size, 2022



* 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, 2022

Employer Health Benefits
2022 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 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 of accounts are health reimbursement arrangements (HRAs) and health savings accounts (HSAs). HRAs and HSAs are both 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. This 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]

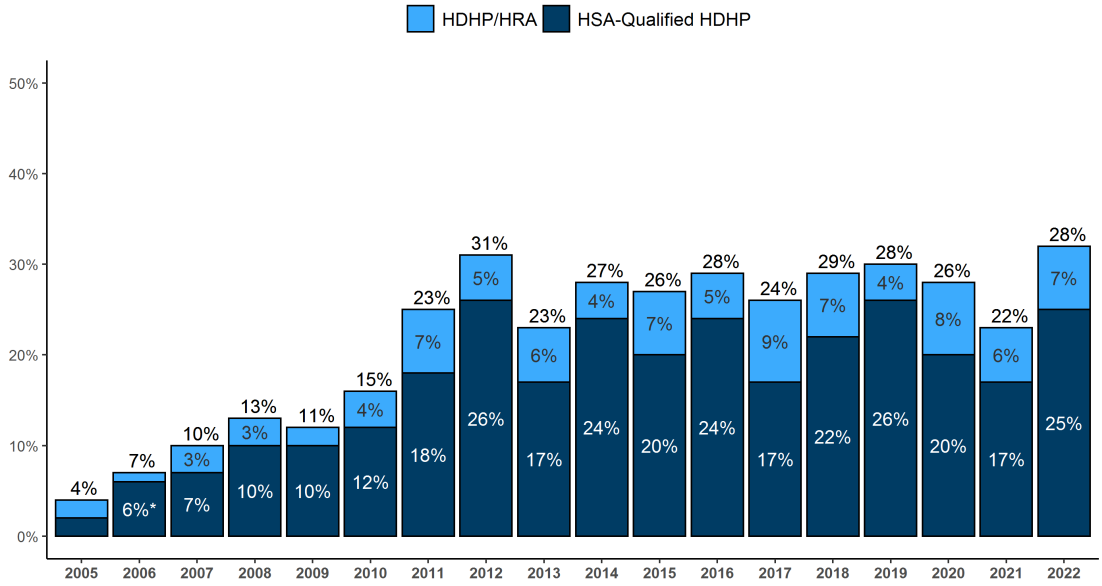
PERCENTAGE OF FIRMS OFFERING HDHP/HRAS AND HSA-QUALIFIED HDHPS

- Twenty-eight percent of firms offering health benefits offer an HDHP/HRA, an HSA-qualified HDHP, or both. Among firms offering health benefits, 7% offer an HDHP/HRA and 25% 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 to offer an HDHP/SO than small firms (3-199 workers) (57% vs. 27%) [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 2022 (or $1,400 and $2,800, respectively, for plans in their 2021 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.

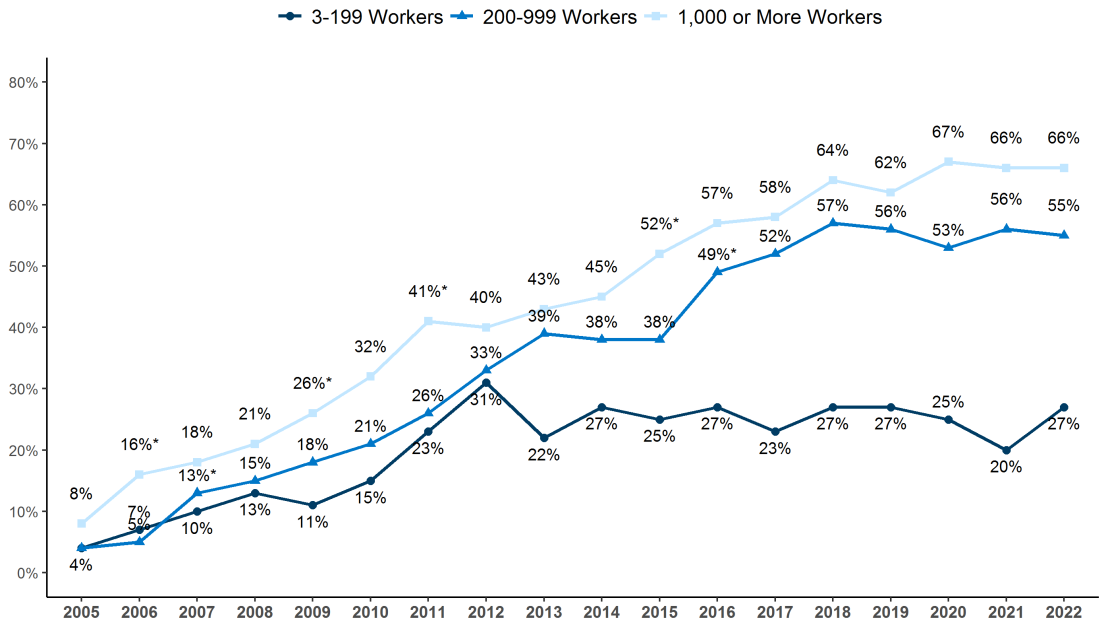
[2] The definitions of HDHP/SOs do not include other consumer-driven plan options, such as arrangements that combine an HRA with a lower-deductible health plan or arrangements in which an insurer (rather than the employer as in the case of HRAs or the enrollee as in the case of HSAs) establishes an account 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, 2005-2022



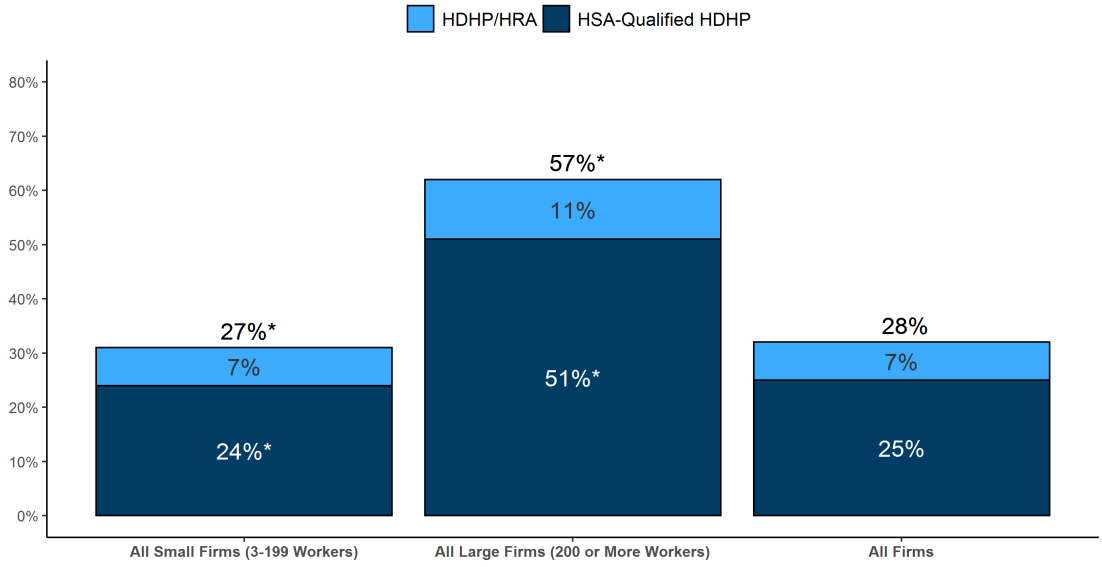
* Estimate is statistically different from estimate for the previous year shown (p < .05).
NOTE: Among all firms that offer health benefits, 3.7% offer both an HDHP/HRA and an HSA-Qualified HDHP. Adding the percentage of firms offering HDHP/HRA and HSA-Qualified HDHPs may not sum to the percentage of firms offering HDHP/SOs because some firms offer both.
SOURCE: KFF Employer Health Benefits Survey, 2018-2022; 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, 2005-2022



* Estimate is statistically different from estimate for the previous year shown (p < .05).
SOURCE: KFF Employer Health Benefits Survey, 2018-2022; 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, 2022

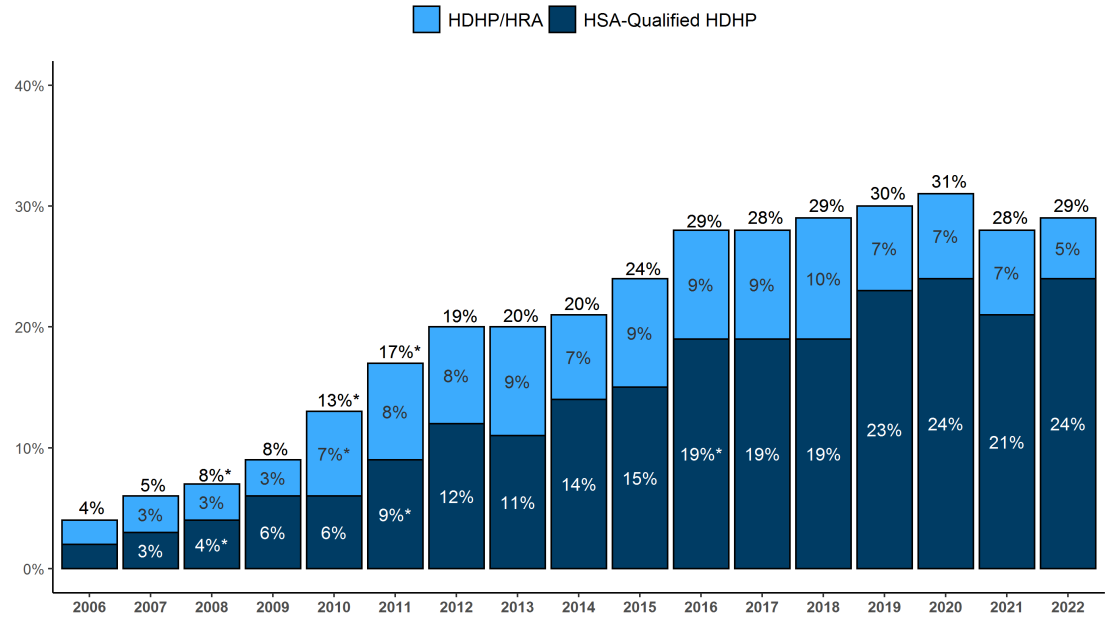


* Estimate is statistically different between All Small Firms and All Large Firms estimate ($p < .05$).
NOTE: Among all firms that offer health benefits, 3.7% offer both an HDHP/HRA and an HSA-Qualified HDHP. Adding the percentage of firms offering HDHP/HRA and HSA-Qualified HDHPs may not sum to the 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, 2018-2022; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2005-2017

ENROLLMENT IN HDHP/HRAS AND HSA-QUALIFIED HDHPS

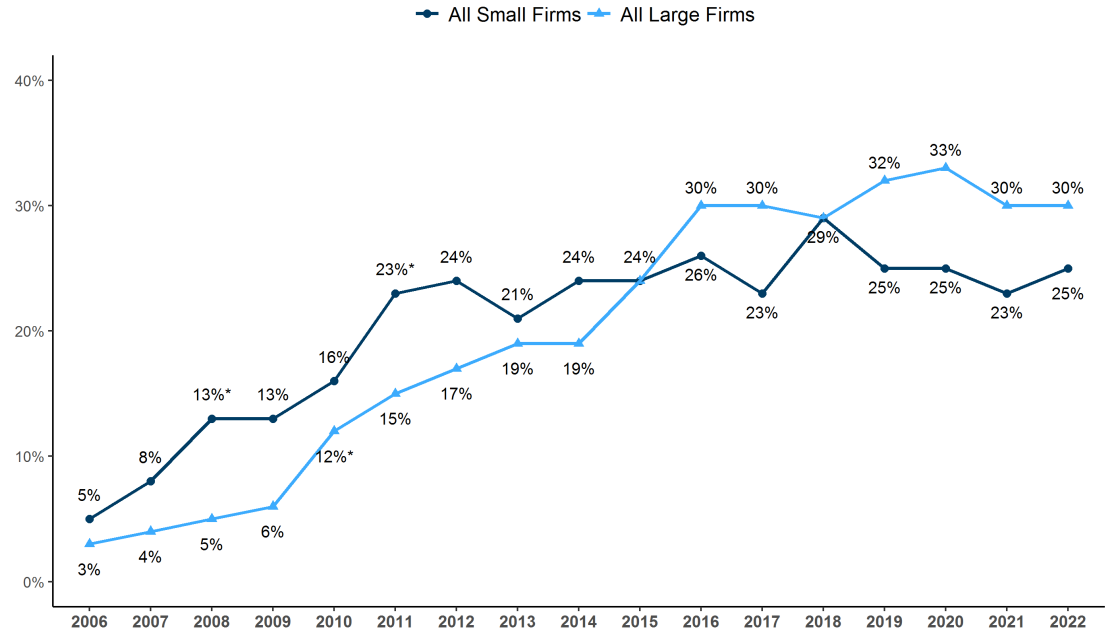
- Twenty-nine percent of covered workers are enrolled in an HDHP/SO in 2022, similar to the percentage last year (28%) [Figure 8.4].
- Enrollment in HDHP/SOs has increased over the past decade, from 19% of covered workers in 2012 to 29% in 2022 [Figure 8.4].
  - Five percent of covered workers are enrolled in HDHP/HRAs and 24% of covered workers are enrolled in HSA-qualified HDHPs in 2022. These percentages are similar to last year [Figure 8.4].
  - The percentage of covered workers enrolled in HDHP/SOs is similar in small firms and in large firms [Figure 8.5].

Figure 8.4
Percentage of Covered Workers Enrolled in an HDHP/HRA or HSA-Qualified HDHP, 2006-2022



* 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, 2018-2022; 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, 2006-2022



* 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, 2018-2022; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006-2017

PREMIUMS AND WORKER CONTRIBUTIONS

- In 2022, average annual premiums for covered workers in HDHP/HRAs are $7,832 for single coverage and $21,708 for family coverage [Figure 8.6].
- The average annual premiums for workers in HSA-qualified HDHPs are $7,170 for single coverage and $21,079 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 premium contribution for workers enrolled in HDHP/HRAs is $1,405 for single coverage and $6,241 for family coverage [Figure 8.6]. The average contribution for family coverage for workers in HDHP/HRAs is similar to the average premium contribution made by workers in plans that are not HDHP/SOs [Figure 8.7].
- The average annual worker premium contributions for workers in HSA-qualified HDHPs are $1,078 for single coverage and $5,188 for family coverage. The average contribution for single coverage for workers in HSA-qualified HDHPs is significantly less than in plans that are not HDHP/SOs [Figure 8.7].

Figure 8.6

HDHP/HRA and HSA-Qualified HDHP Features for Covered Workers, 2022

	HDHP/HRA		HSA-Qualified HDHP	
Annual Plan Averages For:	Single Coverage	Family Coverage	Single Coverage	Family Coverage
Premium	$7,832	$21,708	$7,170	$21,079
Worker Contribution to Premium	$1,405	$6,241	$1,078	$5,188
General Annual Deductible	$2,925	$6,013	$2,458	$4,533
Out-Of-Pocket Maximum	$5,328	Not Available	$4,422	Not Available
Firm Contribution to the HRA or HSA	$1,815	$3,322	$648	$1,117

NOTE: Firms were not asked about out-of-pocket maximums for family coverage in 2022. Deductibles for family coverage are for covered workers with an aggregate amount. 24% of covered workers enrolled in an HDHP/HRA and 26% 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 (39% for single coverage and 32% for family coverage) are excluded, the average firm HSA contribution for covered workers is $820 for single coverage and $1,413 for family coverage. four 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 (four percent for single coverage and four percent for family coverage).

SOURCE: KFF Employer Health Benefits Survey, 2022

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, 2022

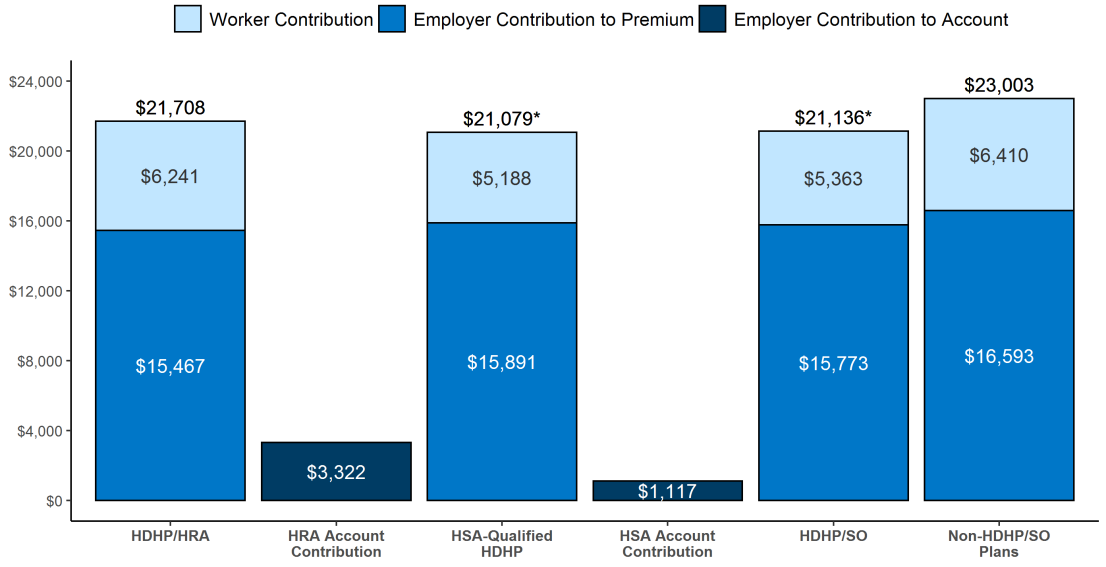
	Single Coverage			Family Coverage		
	HDHP/HRA	HSA-Qualified HDHP	Non-HDHP/SO Plans	HDHP/HRA	HSA-Qualified HDHP	Non-HDHP/SO Plans
Annual Premium	$7,832	$7,170*	$8,162	$21,708	$21,079*	$23,003
Worker Contribution to Premium	$1,405	$1,078*	$1,405	$6,241	$5,188	$6,410
Firm Contribution to Premium	$6,427	$6,092*	$6,757	$15,467	$15,891	$16,593
Annual Firm Contribution to HRA or HSA	$1,815	$648	Not Applicable	$3,322	$1,117	Not Applicable
Total Annual Firm Contribution (Firm Share of Premium Plus Firm Contribution to HRA or HSA)	$8,243*	$6,774	$6,757	$18,788*	$17,149	$16,593
Total Annual Cost (Total Premium Plus Firm Contribution to HRA or HSA)	**$9,647***	**$7,849**	**$8,162**	**$25,029***	**$22,304**	**$23,003**

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 ($p < .05$).

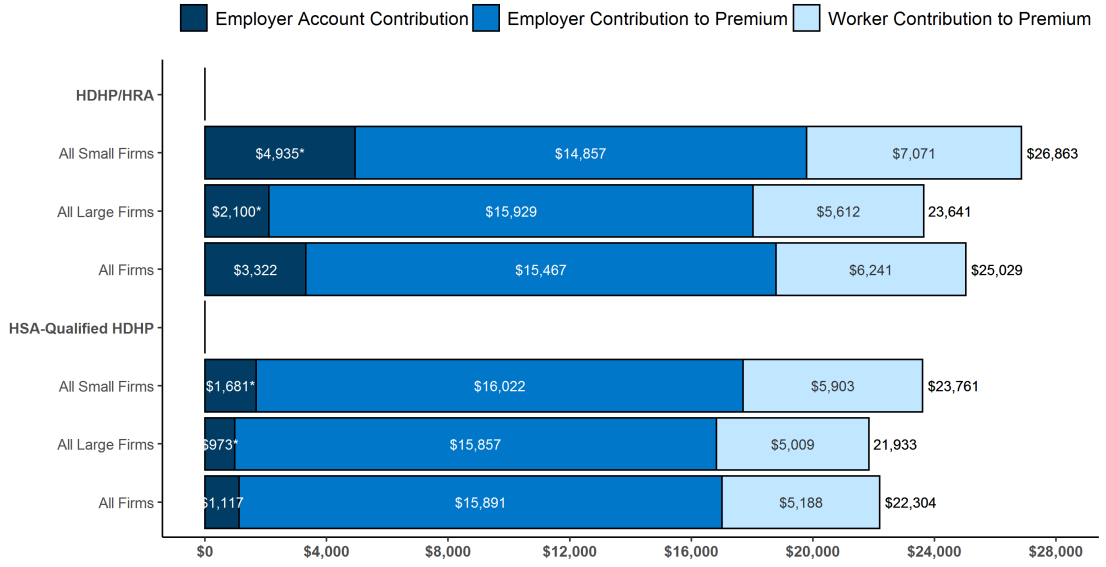
SOURCE: KFF Employer Health Benefits Survey, 2022

Figure 8.8
Average Annual Premiums and Contributions for Covered Workers in HDHP/SOs and Non-HDHP/SOs, for Family Coverage, 2022



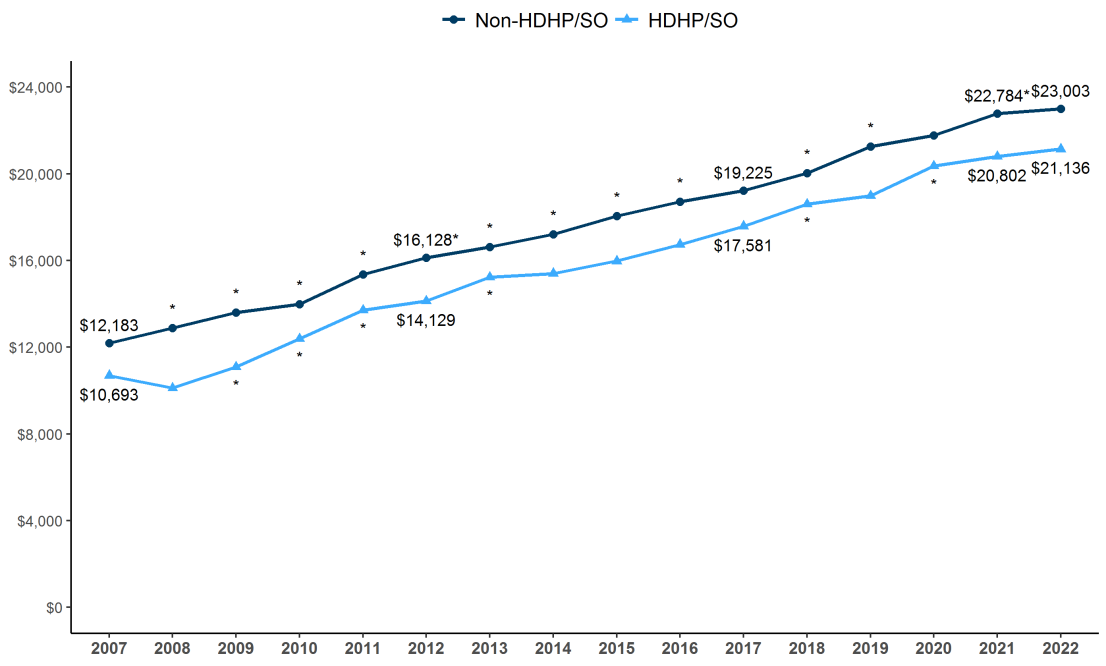
* Estimate is statistically different from estimate from Non-HDHP/SO plans ($p < .05$).
NOTE: Values shown in the table may not equal the sum of their component parts. The averages presented in the table are aggregated at the firm level and then averaged, which is methodologically more appropriate than adding the averages. See the note in Figure 8.6 for additional information on HSA and HRA contributions.
SOURCE: KFF Employer Health Benefits Survey, 2022

Figure 8.9
Total Annual Costs (Premiums and Account Contributions) for Covered Workers in HDHP/SOs, for Family Coverage, by Firm Size, 2022



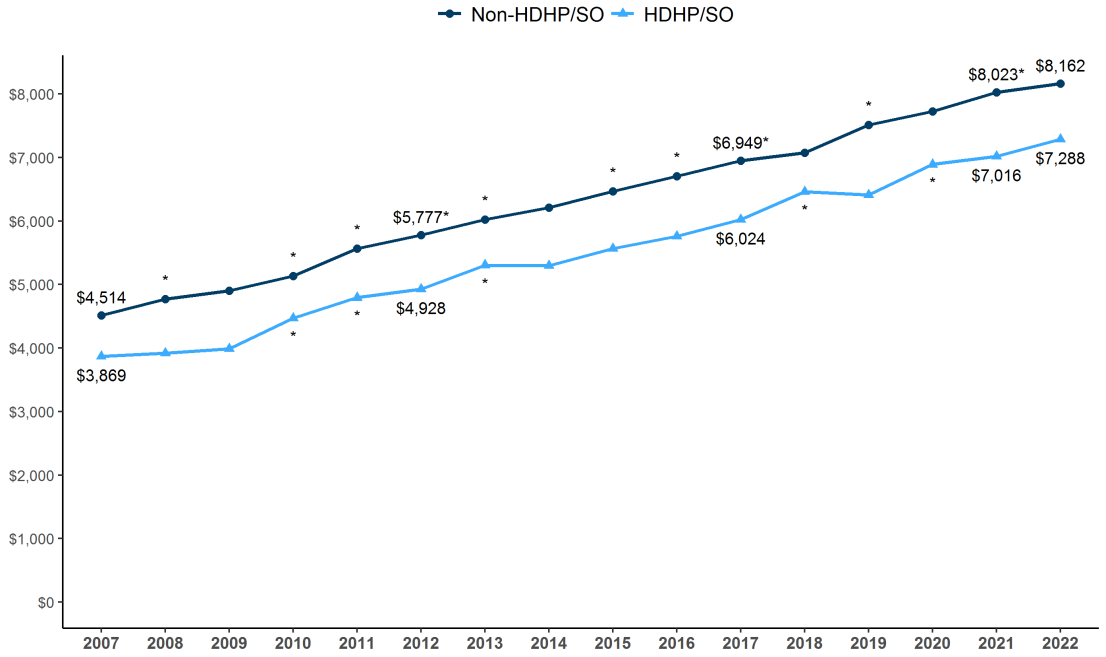
* Estimate is statistically different between All Small Firms and All Large Firms estimate ($p < .05$).
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers. Values shown in the table may not equal the sum of their component parts. The averages presented in the table are aggregated 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, 2022

Figure 8.10
Average Annual Premiums for Covered Workers with Family Coverage, by Plan Type, 2007-2022



* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
SOURCE: KFF Employer Health Benefits Survey, 2018-2022; 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, 2007-2022

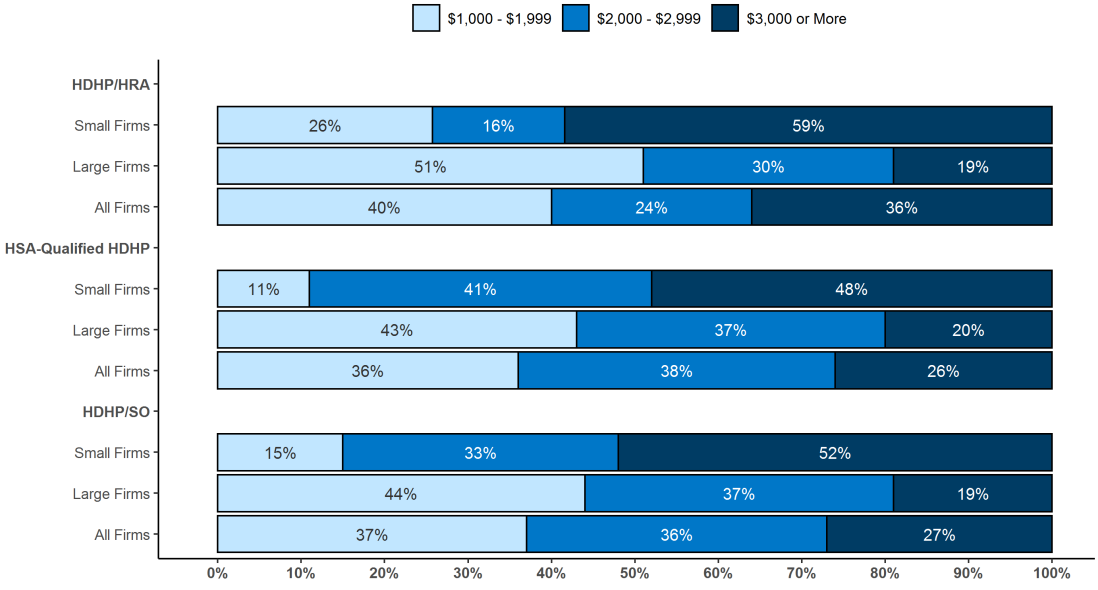


* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
SOURCE: KFF Employer Health Benefits Survey, 2018-2022; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2007-2017

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 $7,050 for single coverage and $14,100 for family coverage in 2022. Non-grandfathered HDHP/HRA plans are required to have out-of-pocket maximums of no more than $8,700 for single coverage and $17,400 for family coverage. Virtually all HDHP/HRA plans have an out-of-pocket maximum for single coverage in 2022.
  - The average annual out-of-pocket maximum for single coverage is $5,328 for HDHP/HRAs and $4,422 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 [Figure 8.14].
  - The average general annual deductible for single coverage is $2,925 for HDHP/HRAs and $2,458 for HSA-qualified HDHPs [Figure 8.6]. There is wide variation around these averages: 37% of covered workers enrolled in an HDHP/SO are in a plan with a deductible between $1,000 and $1,999 for single coverage while 27% have 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 $6,013 for HDHP/HRAs and $4,533 for HSA-qualified HDHPs [Figure 8.6]. As with single coverage, there is wide variation around these averages for family coverage: 7% of covered workers enrolled in HDHP/SOs with an aggregate family deductible have a deductible between $2,000 and $2,999 while 22% 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, 2022



NOTE: For HSA-qualified HDHPs, the legal minimum deductible for 2022 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, 2022

Figure 8.13

General Annual Deductible for Workers in HDHP/SOs After Any Employer Account Contributions for Single Coverage, by Firm Size, 2022

	HDHP/HRA	HSA-Qualified HDHP	HDHP/SO
General Annual Deductible			
All Small Firms	$3,757*	$3,088*	$3,330*
All Large Firms	2,290*	2,299*	2,295*
All Firms	**$2,925**	**$2,458**	**$2,539**
General Annual Deductible After Any HRA or HSA Contributions			
All Small Firms	$1,357	$2,029	$1,845
All Large Firms	1,220	1,776	1,698
All Firms	**$1,279**	**$1,827**	**$1,733**

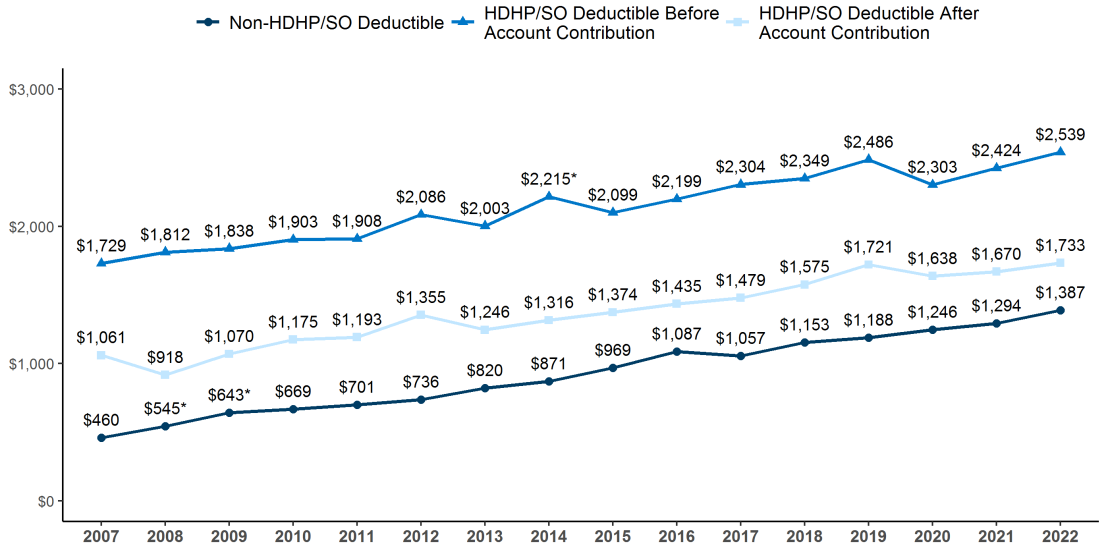
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers. The net liability for covered workers enrolled in a plan with an HSA or HRA is calculated by subtracting the account contribution from the single coverage deductible. HRAs are notional accounts, and employers are not required 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, 2022

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, 2007-2022

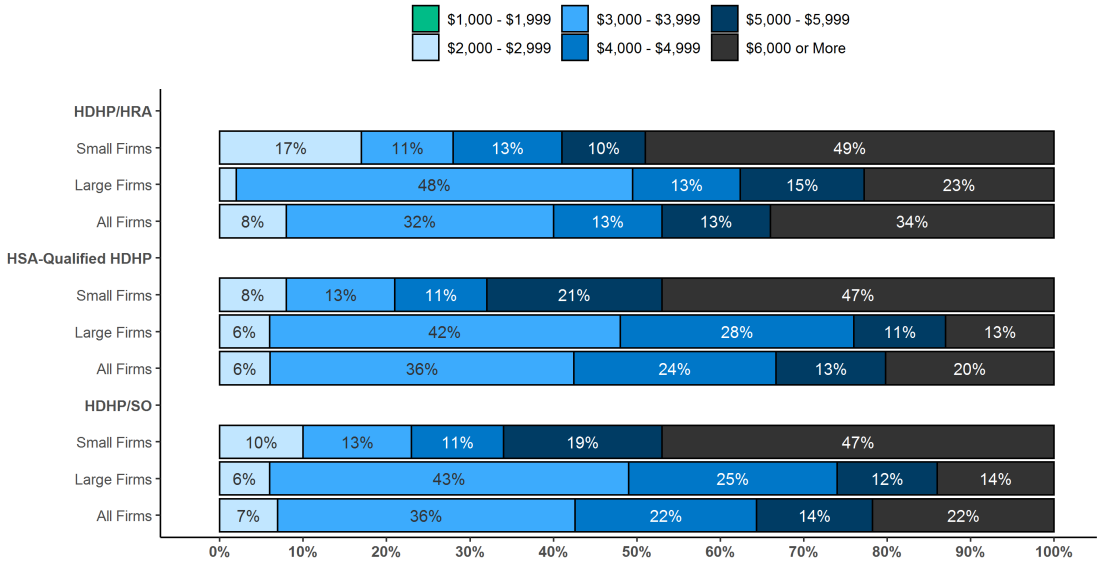


* Estimate is statistically different from estimate for the previous year shown ($p < .05$).

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, 2018-2022; 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, 2022



NOTE: Deductibles for family coverage are for covered workers with an aggregate amount. 24% of covered workers enrolled in an HDHP/HRA and 26% 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 2022 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, 2022

EMPLOYER ACCOUNT CONTRIBUTIONS

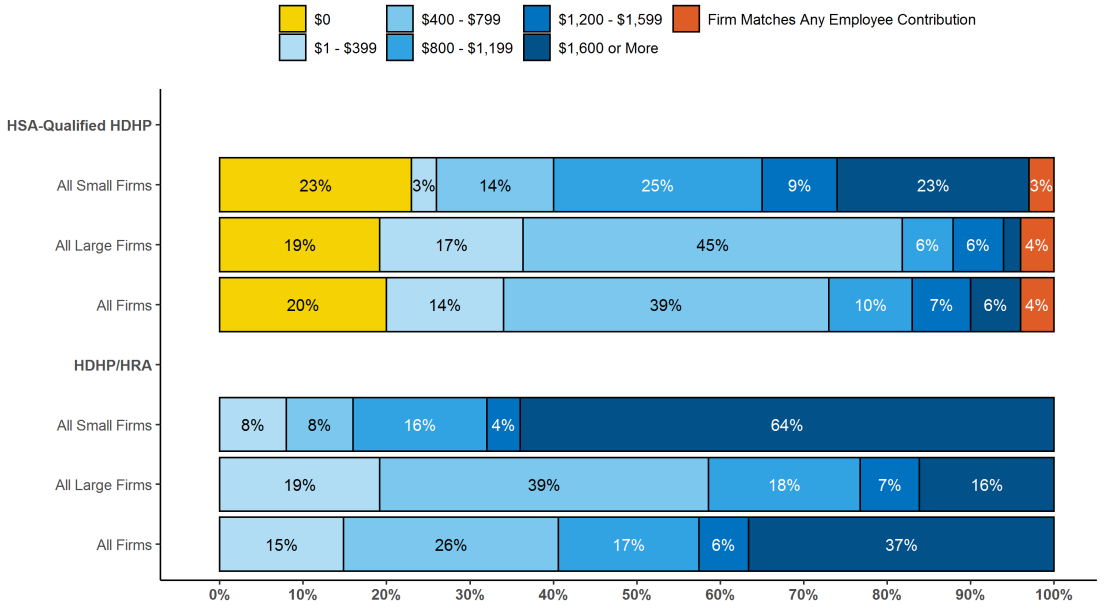
- Employers contribute to HDHP/SOs in two ways: through their contributions toward the premium for the health plan, and through their contributions (if any, in the case of HSAs) to the savings account option (the HRAs or HSAs themselves).
  - Covered workers in HDHP/HRAs receive premium contributions from their employers of $6,427 on average for single coverage and $15,467 for family coverage [Figure 8.7]. These amounts are similar to the contribution amounts last year.
  - The average annual employer contribution to premiums for workers in HSA-qualified HDHPs is $6,092 for single coverage and $15,891 for family coverage. The contribution for single coverage is higher than the amount last year ($6,092 vs. $5,743). The average employer contribution for single coverage for workers in HSA-qualified HDHPs is lower than for workers in plans that are not HDHP/SOs [Figure 8.7].
- Covered workers enrolled in HDHP/HRAs on average receive an annual employer contribution to their HRA of $1,815 for single coverage and $3,322 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

[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.

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.

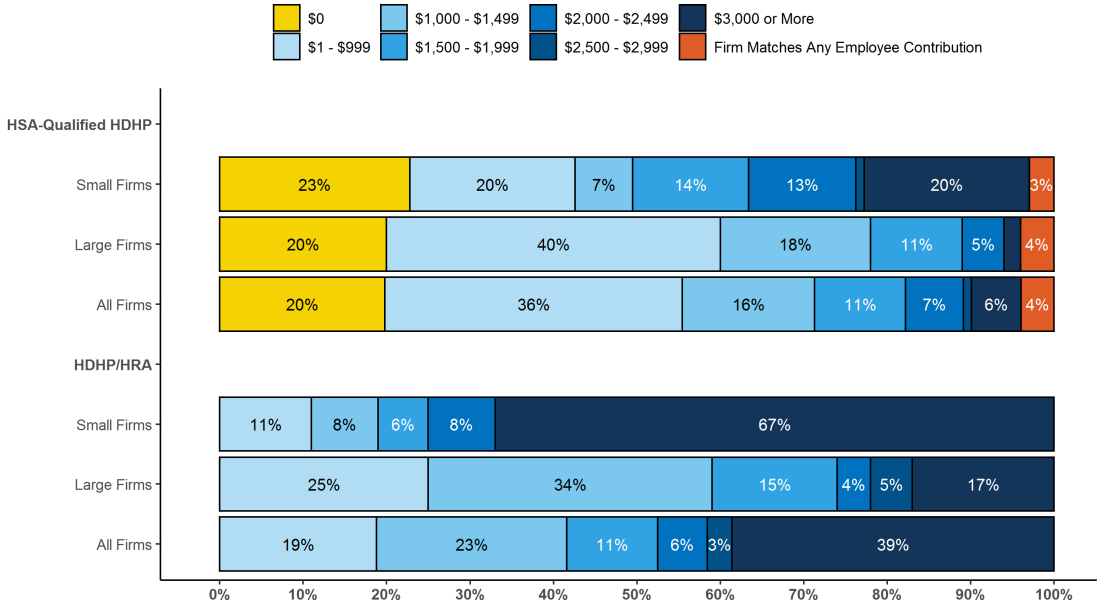
- Covered workers enrolled in HSA-qualified HDHPs receive an average annual employer HSA contribution of $648 for single coverage and $1,117 for family coverage [Figure 8.7].
  - In many cases, employers that sponsor HSA-qualified HDHP/SOs do not make contributions to HSAs established by their employees. Thirty-nine percent of employers offering single coverage and 32% 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, 20% enrolled in single coverage and 20% 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, the average employer contribution for covered workers is $820 for single coverage and $1,417 for family coverage.
  - The percentages of covered workers enrolled in a plan where the employer makes no HSA contribution, (20% for single coverage and 20% for family coverage), are similar to the percentages in recent years [Figure 8.16] and [Figure 8.17].
- The amount that employers contribute to savings accounts varies considerably.
  - Forty percent of covered workers in an HDHP/HRA receive an annual HRA contribution of less than $800 for single coverage, while 37% receive an annual HRA contribution of $1,600 or more [Figure 8.16].
  - Thirty-four percent of covered workers in an HSA-qualified HDHP receive an annual HSA contribution of less than $400 for single coverage, including 20% who receive no HSA contribution from their employer [Figure 8.16]. In contrast, 13% of covered workers in an HSA-qualified HDHP receive an annual HSA contribution of $1,200 or more. Four 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 $8,243 for single coverage and $18,788 for family coverage. The average total employer contributions for covered workers for single coverage and family coverage in HDHP/HRAs are higher than the average employer contributions toward single and family coverage in plans that are not HDHP/SOs [Figure 8.7].
  - For HSA-qualified HDHPs, the average total annual employer contribution for covered workers is $6,774 for single coverage and $17,149 for workers with family coverage. These amounts are similar to the average employer contributions for single and family coverage in 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, 2022



NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2022

Figure 8.17
Distribution of Covered Workers with the Following Annual Employer Contributions to Their HRA or HSA, for Family Coverage, 2022



NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2022

Figure 8.18

Average Annual Employer Contributions to HSA Accounts for Covered Workers Enrolled in an HSA-Qualified HDHP, 2009-2022

	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
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	$1,113
All Large Firms	450	567	446	402	547	544	481	563	535	531	530	496	527	530
All Firms	**$688**	**$558**	**$611**	**$609**	**$658**	**$769**	**$568***	**$686**	**$608**	**$603**	**$572**	**$550**	**$575**	**$648**
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	$1,685
All Large Firms	815	1,087	864	760	992	976	923	1,084	999	981	1,031	949	936	971
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**	**$1,115**
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	$1,450*
All Large Firms	619	748	641	618	737	707	657	707	670	645	658	636	666	665
All Firms	**$1,000**	**$858**	**$886**	**$919**	**$951**	**$1,006**	**$809**	**$916**	**$795**	**$790**	**$768**	**$741**	**$743**	**$820**
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	$2,198
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	1,221
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**	**$1,413**

NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers. In 2022, 20% of workers in an HSA-Qualified single coverage plan and 20% 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 (four percent for single coverage and four percent for family coverage).

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

SOURCE: KFF Employer Health Benefits Survey, 2018-2022; 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, 2022

	Average Employer Account Contribution
HSA: Single Coverage	
All Small Firms	$1,114*
All Large Firms	529*
ALL FIRMS	**$648**
HSA: Family Coverage	
All Small Firms	$1,681*
All Large Firms	973*
ALL FIRMS	**$1,117**
HRA: Single Coverage	
All Small Firms	$2,690*
All Large Firms	1,148*
ALL FIRMS	**$1,815**
HRA: Family Coverage	
All Small Firms	$4,935*
All Large Firms	2,100*
ALL FIRMS	**$3,322**

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, 2022

COST SHARING FOR OFFICE VISITS

- The cost-sharing pattern for primary care office visits varies for workers enrolled in HDHP/SOs. Fifty-eight percent of covered workers in HDHP/HRAs have a copayment for primary care physician office visits, compared to 6% 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, 2022

	HDHP/HRA	HSA-Qualified HDHP	HDHP/SO	Non-HDHP/SO
Separate Cost Sharing for Primary Care Physician Office Visits				
Copayment	58%	6%*	16%	80%*
Coinsurance	19%	62%*	54%	11%*
None	9%	21%*	18%	3%*
Other	15%	11%	11%	6%*
Separate Cost Sharing for Specialty Care Physician Office Visits				
Copayment	62%	6%*	17%	79%*
Coinsurance	20%	64%*	56%	13%*
None	6%	20%*	17%	2%*
Other	12%	10%	10%	6%

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, 2022

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 2022 or $1,400 and $2,800, respectively, in 2021) 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 $3,650 for single coverage and $7,300 for family coverage in 2022. 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
2022 Annual Survey

Prescription Drug Benefits

SECTION 9

Section 9

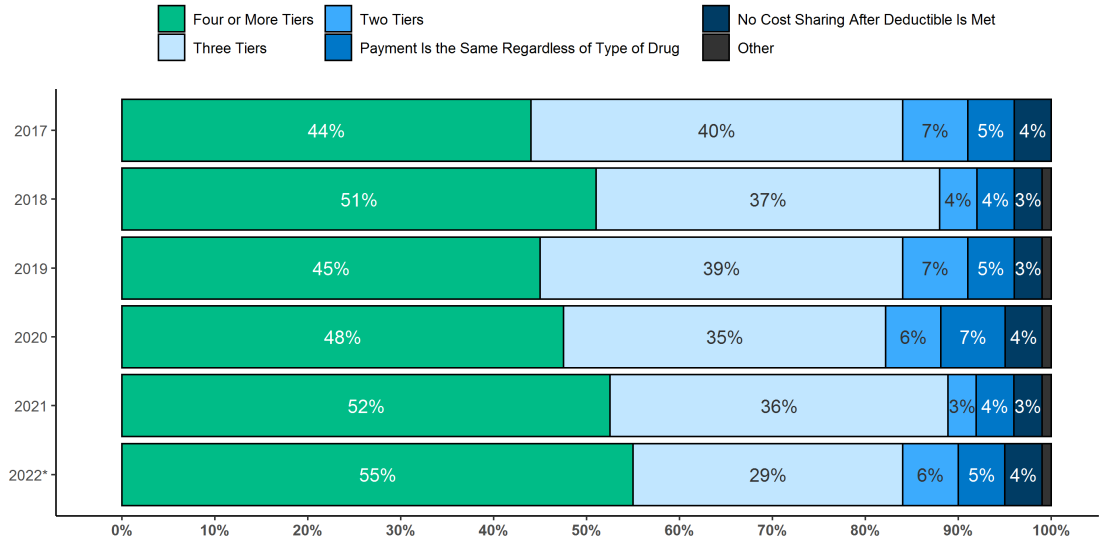
Prescription Drug Benefits

Nearly all (98%) covered workers are at a firm that provides prescription drug coverage in its largest health plan. Employer plans have incorporated more complex benefit designs for prescriptions drugs over time, 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 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

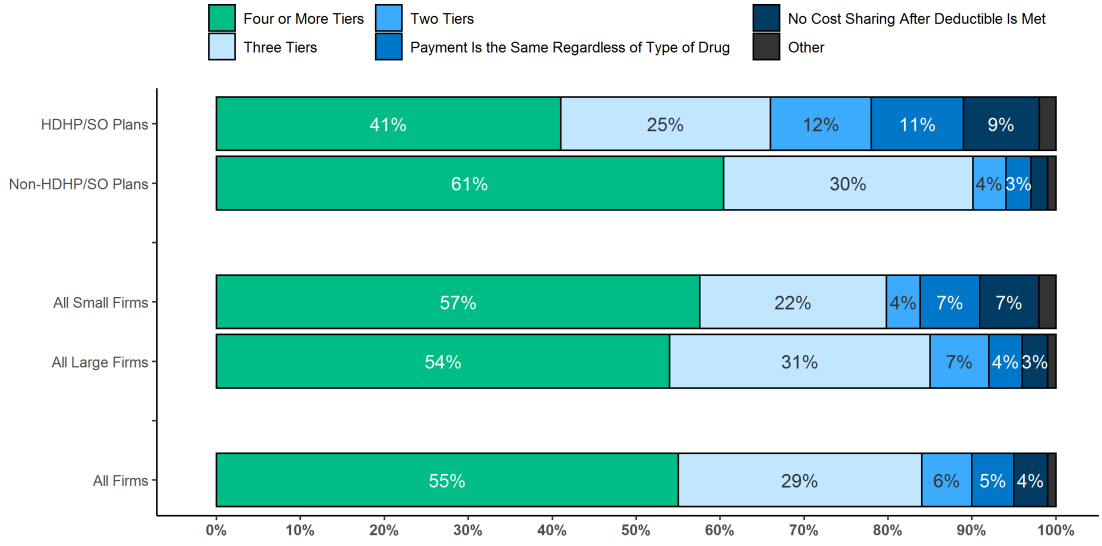
- The large majority of covered workers (90%) are in a plan with tiered cost sharing for prescription drugs [Figure 9.1]. Cost-sharing tiers generally refer to a health plan placing a drug on a formulary or preferred drug list that classifies drugs into categories that are subject to different cost sharing or management. Commonly, there are different tiers for generic, preferred and non-preferred drugs, and in recent years, plans have created additional tiers that may 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-four percent of covered workers are in a plan with three, four, or even 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.
    - HDHP/SO plans 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 (41% vs. 61%) 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, 2017-2022



* Distribution is statistically different 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, 56% have three tiers, 9% have two tiers, 7% have the same cost sharing regardless of the drug, and 6% 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, 2018-2022; 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, 2022

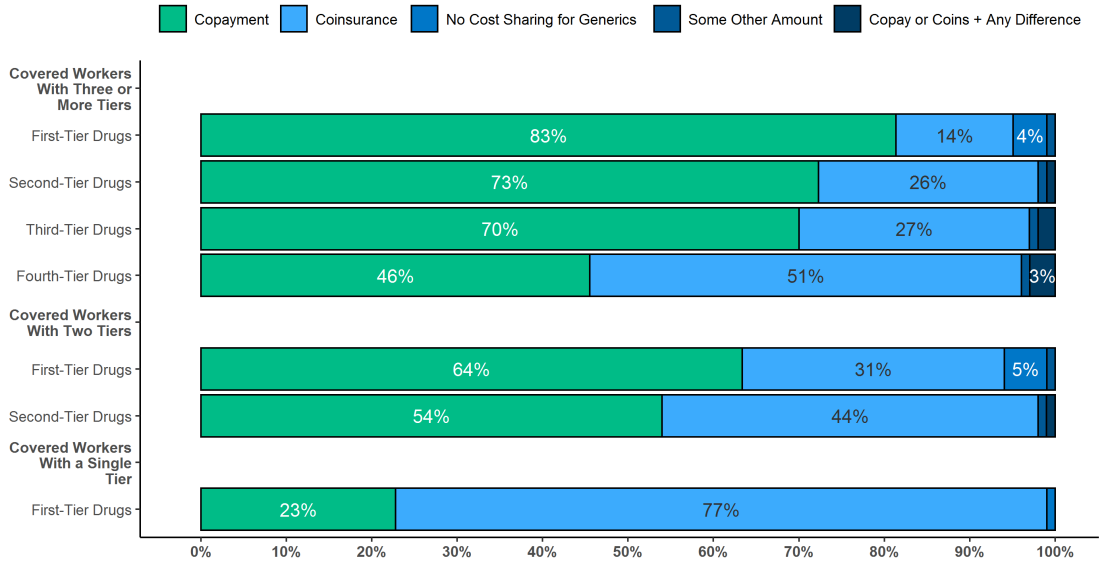


Tests found no statistical difference between HDHP/SO Plan and Non-HDHP/SO distributions or between Large and Small Firms ($p < .05$).
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers. Number of tiers include any tiers specifically for specialty drugs. Excluding tiers specifically for specialty drugs, 23% of covered workers with prescription drug coverage are enrolled in a plan with four or more tiers, 56% have three tiers, 9% have two tiers, 7% have the same cost sharing regardless of the drug, and 6% 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, 2022

TIERS NOT EXCLUSIVELY FOR SPECIALTY DRUGS

- Even when formulary tiers covering only specialty drugs are not counted, a large share (78%) 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 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 second-most common [Figure 9.3].
  - Among covered workers in plans with three or more tiers of cost sharing for prescription drugs, the average copayment is $11 for first-tier drugs, $37 second-tier drugs, $67 for third-tier drugs, and $116 for fourth-tier drugs [Figure 9.6].
  - Among covered workers in plans with three or more tiers of cost sharing for prescription drugs, the average coinsurance rate is 18% for first-tier drugs, 25% second-tier drugs, 37% third-tier drugs, and 27% for fourth-tier drugs [Figure 9.6].
- Nine 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 in the first-tier [Figure 9.3]. The average copayment is $12 for the first tier and $40 for the second tier. [Figure 9.6].
- Seven 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, 23% have copayments and 77% have a coinsurance rate [Figure 9.3].

Figure 9.3
Among Covered Workers with Prescription Drug Coverage, Distribution with the Following Types of Cost Sharing for Prescription Drugs, 2022



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, 2022

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, 2022

	Copayment	Coinsurance	No Cost Sharing for Generics	Some Other Amount
First-Tier Drugs, Often Called Generics				
All Small Firms	93%*	4%*	4%	<1%
All Large Firms	79*	17*	3	<1
ALL FIRMS	**83%**	**14%**	**4%**	**<1%**
Second-Tier Drugs, Often Called Preferred Drugs			**Copayment or Coinsurance Plus Any Difference**	
All Small Firms	92%*	8%*	<1%	<1%
All Large Firms	67*	32*	1	<1
ALL FIRMS	**73%**	**26%**	**1%**	**<1%**
Third-Tier Drugs, Often Called Non-Preferred Drugs				
All Small Firms	86%*	11%*	2%	1%
All Large Firms	64*	33*	2	1
ALL FIRMS	**70%**	**27%**	**2%**	**1%**
Fourth-Tier Drugs				
All Small Firms	62%*	38%*	0%	<1%
All Large Firms	34*	60*	5	1
ALL FIRMS	**46%**	**51%**	**3%**	**1%**

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

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

SOURCE: KFF Employer Health Benefits Survey, 2022

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, 2022

	Copayment	Coinsurance	No Cost Sharing for Generics	Some Other Amount
First-Tier Drugs, Often Called Generics				
HDHP/SO Plans	67%*	29%*	3%	<1%
Non-HDHP/SO Plans	87*	9*	4	<1
ALL PLANS	**83%**	**14%**	**4%**	**<1%**
Second-Tier Drugs, Often Called Preferred Drugs			**Copayment or Coinsurance Plus Any Difference**	
HDHP/SO Plans	58%*	41%*	1%	<1%
Non-HDHP/SO Plans	78*	21*	1	<1
ALL PLANS	**73%**	**26%**	**1%**	**<1%**
Third-Tier Drugs, Often Called Non-Preferred Drugs				
HDHP/SO Plans	53%*	43%*	3%	1%
Non-HDHP/SO Plans	75*	23*	2	1
ALL PLANS	**70%**	**27%**	**2%**	**1%**
Fourth-Tier Drugs				
HDHP/SO Plans	38%	61%	<1%	1%
Non-HDHP/SO Plans	48	48	4	<1
ALL PLANS	**46%**	**51%**	**3%**	**1%**

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

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

SOURCE: KFF Employer Health Benefits Survey, 2022

Figure 9.6

Among Covered Workers With Prescription Drug Coverage, Average Copayments and Coinsurance, 2022

	Average Copayment	Average Coinsurance
Plans With Three or More Tiers		
First Tier	$11	18%
Second Tier	$37	25%
Third Tier	$67	37%
Fourth Tier	$116	27%
Plans With Two Tiers		
First Tier	$12	NSD
Second Tier	$40	32%
Plans With the Same Cost Sharing For All Covered Drugs		
First Tier	$12	22%

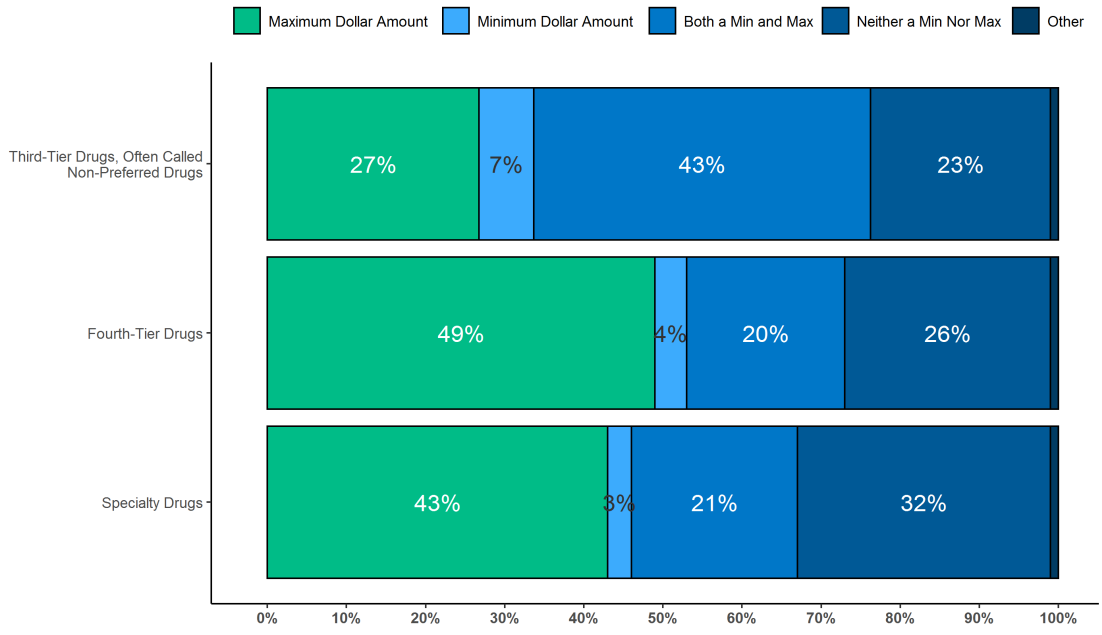
NOTE: Number of tiers refers to the number of tiers excluding those specifically for specialty drugs.
NSD: Not Sufficient Data

SOURCE: KFF Employer Health Benefits Survey, 2022

COINSURANCE MAXIMUMS

- Coinsurance rates for prescription drugs often include maximum and/or minimum dollar amounts. Depending on the plan design, coinsurance maximums can 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 tiers and plan designs.
  - For example, among covered workers in a plan with coinsurance for the third cost-sharing tier, 27% have only a maximum dollar amount attached to the coinsurance rate, 7% have only a minimum dollar amount, 43% have both a minimum and maximum dollar amount, and 23% have neither. For those in a plan with coinsurance for the fourth cost-sharing tier, 49% have only a maximum dollar amount attached to the coinsurance rate, 4% have only a minimum dollar amount, 20% have both a minimum and maximum dollar amount, and 26% have neither [Figure 9.7].

Figure 9.7
Distribution of Coinsurance Structures for Covered Workers Facing a Coinsurance for Prescription Drugs, 2022



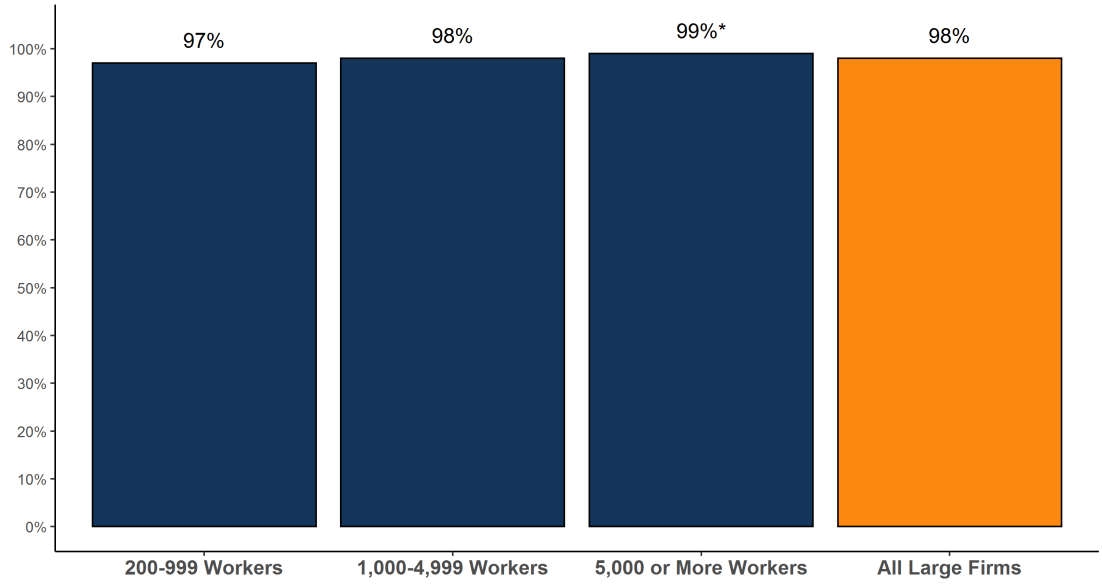
SOURCE: KFF Employer Health Benefits Survey, 2022

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.

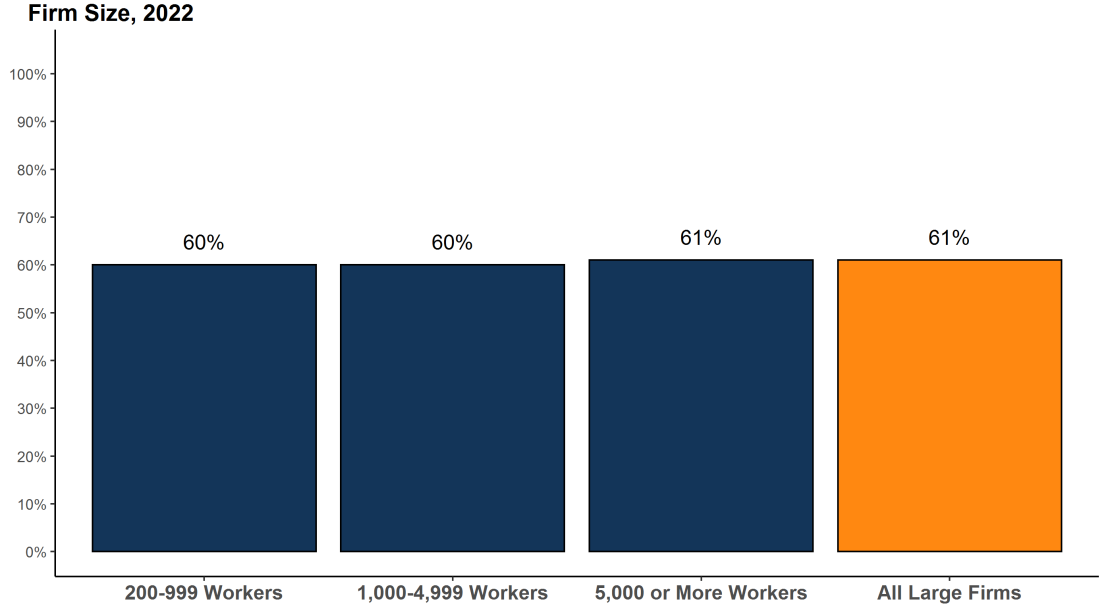
- Ninety-eight percent of covered workers at large firms have coverage for specialty drugs [Figure 9.8]. Among these workers, 61% are in a plan with at least one cost-sharing tier just for specialty drugs [Figure 9.9].
- Among covered workers at large firms in a plan with at least one separate tier for specialty drugs, 42% have a copayment for specialty drugs and 49% have coinsurance [Figure 9.10]. The average copayment is $103 and the average coinsurance rate is 25% [Figure 9.11]. Sixty-five 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, 2022



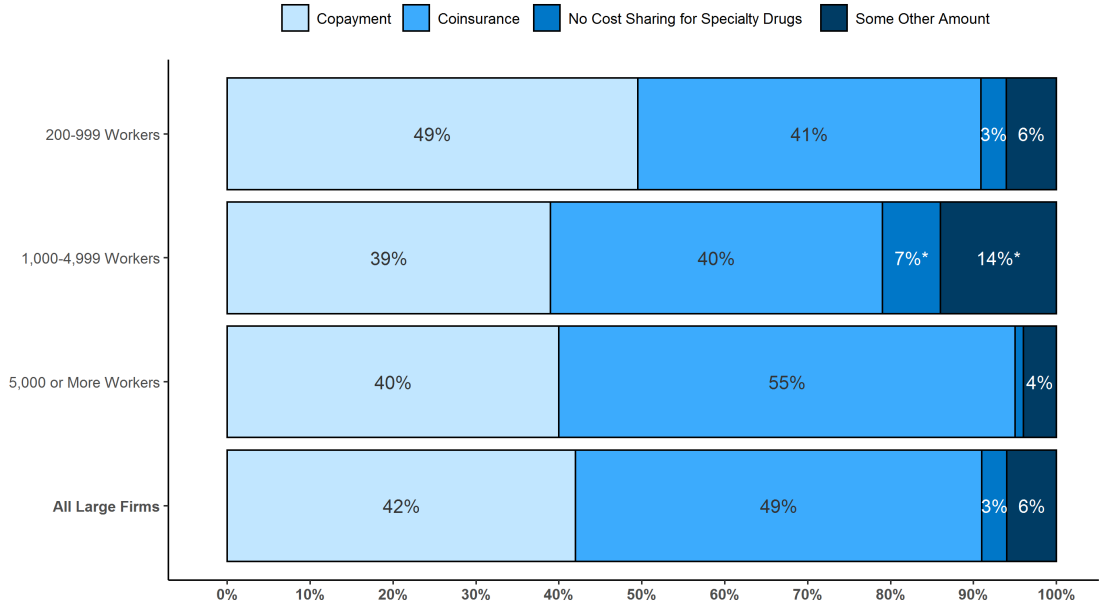
* Estimate is statistically different from estimate for all other firms not in the indicated size category ($p < .05$).
NOTE: Large Firms have 200 or more workers. Ninety-nine percent of firms offering health benefits offer prescription drug coverage.
SOURCE: KFF Employer Health Benefits Survey, 2022

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, 2022



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, 2022

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, 2022



* Estimates are statistically different from estimate for all other firms not in the indicated category within each firm size ($p < .05$).
NOTE: Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2022

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 & 2022

	2017		2022	
	Average Copayment ($)	Average Coinsurance (%)	Average Copayment ($)	Average Coinsurance (%)
FIRM SIZE				
200-999 Workers	$90	24%	$95	26%
1,000-4,999 Workers	89	27	98	25
5,000 or More Workers	111*	28	108	25
All Large Firms (200 or More Workers)	**$101**	**27%**	**$103**	**25%**

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

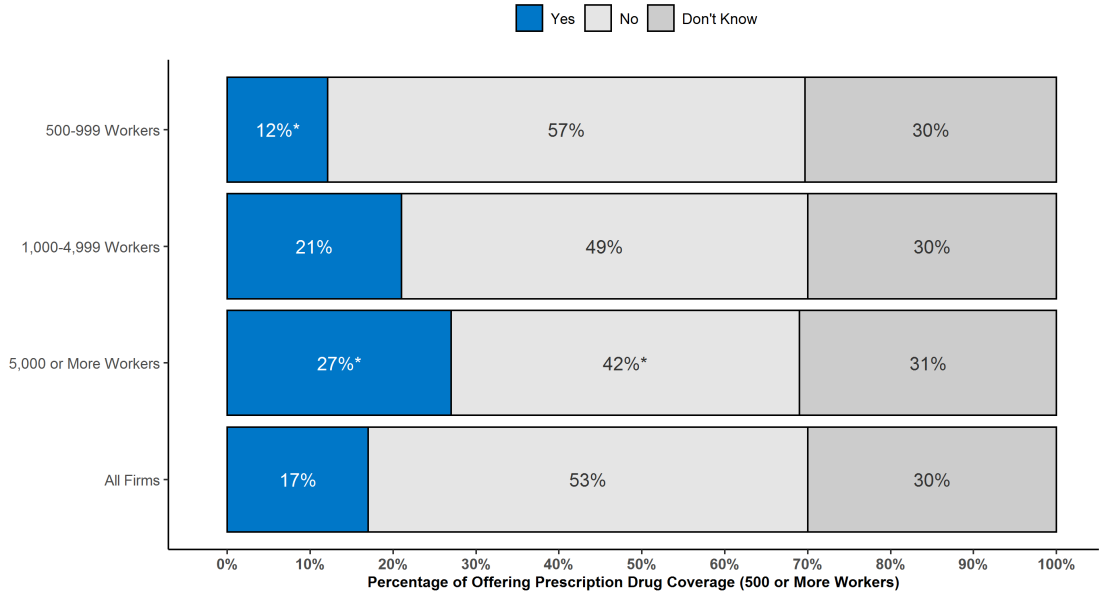
SOURCE: KFF Employer Health Benefits Survey, 2022; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2017

DELAYING FORMULARY CHANGES

Seventeen percent of firms with 500 or more employees with coverage for prescription drugs say that they or their Pharmacy Benefit Manager (PBM) made changes over the past two years to the formulary for their plan with the largest enrollment to delay the inclusion of new high-cost drug therapies until they are proven effective.

- Among these firms, those with 5,000 or more employees were more likely to make such a change (27%) and firms with 500 to 999 employees were less likely to (12%) [Figure 9.12].
- A meaningful share of these employers (30%) did not know the answer to this question.

Figure 9.12
Among Firms Offering Prescription Drug Coverage, Percentage of Firms Which Changed their Formulary to Delay the Inclusion of New High-cost Drug Therapies Until They are Proven Effective, by Firm Size, 2022



* 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, 2022

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.

Employer Health Benefits
2022 Annual Survey

Plan Funding

SECTION 10

Section 10

Plan Funding

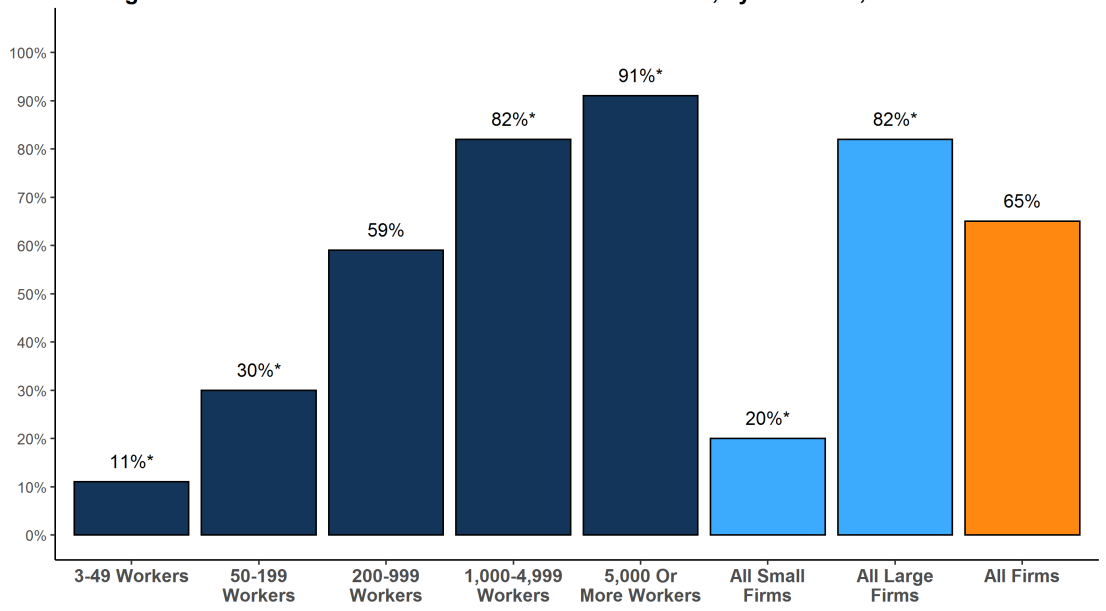
Many firms, particularly larger firms, choose to pay for some or all of the health services of their workers directly from their own funds rather than by purchasing health insurance for them. This is called self-funding. Both public and private employers can use self-funding to provide health benefits. 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-five percent of covered workers are in a self-funded health plan in 2022. 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-five percent of covered workers in small firms (3-199 workers) are in a level-funded plan.

SELF-FUNDED PLANS

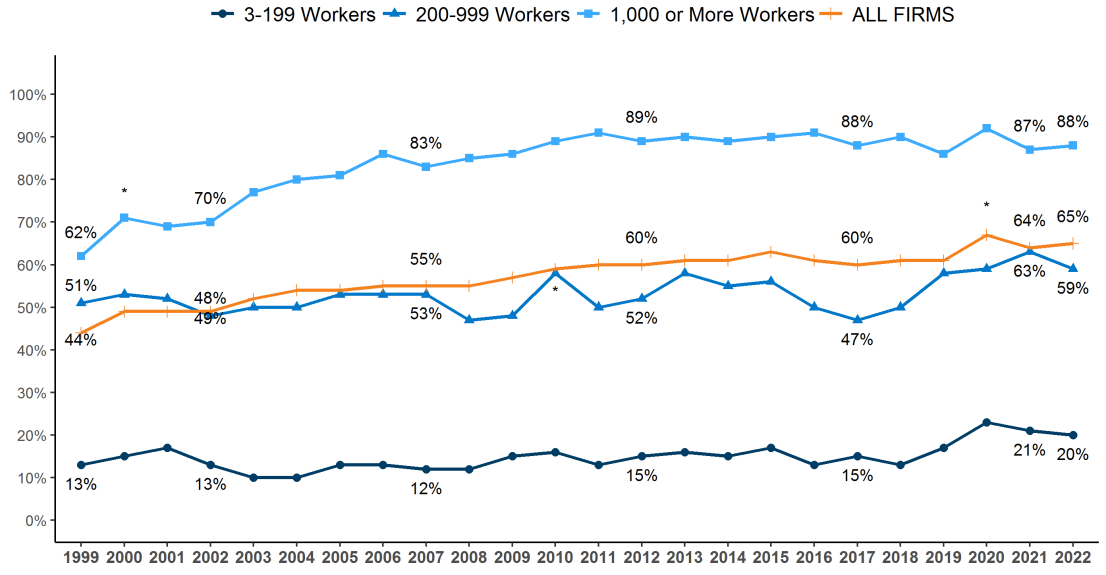
- Sixty-five percent of covered workers are in a plan that is self-funded, similar to the percentage (64%) last year [Figure 10.1] and [Figure 10.2].
  - The percentage of covered workers enrolled in self-funded plans is higher than the percentage ten years ago (60%) [Figure 10.2].
  - As expected, covered workers in large firms are significantly more likely to be in a self-funded plan than covered workers in small firms (82% vs. 20%) [Figure 10.1] and [Figure 10.3].

Figure 10.1
Percentage of Covered Workers Enrolled in a Self-Funded Plan, by Firm Size, 2022



* 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, 2022

Figure 10.2
Percentage of Covered Workers Enrolled in a Self-Funded Plan, by Firm Size, 1999-2022



* 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, 65% of covered workers are in a self-funded plan in 2022. 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, 2018-2022; 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, 2022

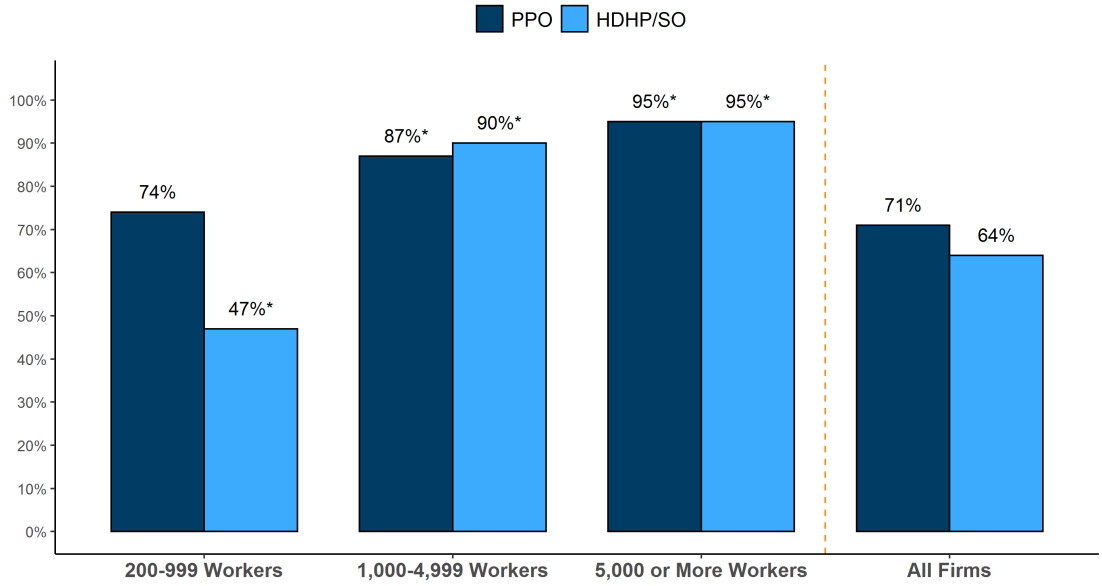
	Covered Workers in a Self-Funded Plan
FIRM SIZE	
200-999 Workers	59%
1,000-4,999 Workers	82*
5,000 or More Workers	91*
All Small Firms (3-199 Workers)	**20%***
All Large Firms (200 or More Workers)	**82%***
REGION	
Northeast	71%
Midwest	72*
South	67
West	47*
INDUSTRY	
Agriculture/Mining/Construction	60%
Manufacturing	70
Transportation/Communications/Utilities	80*
Wholesale	69
Retail	77*
Finance	61
Service	54*
State/Local Government	67
Health Care	74*
ALL FIRMS	**65%**

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 ($p < .05$).

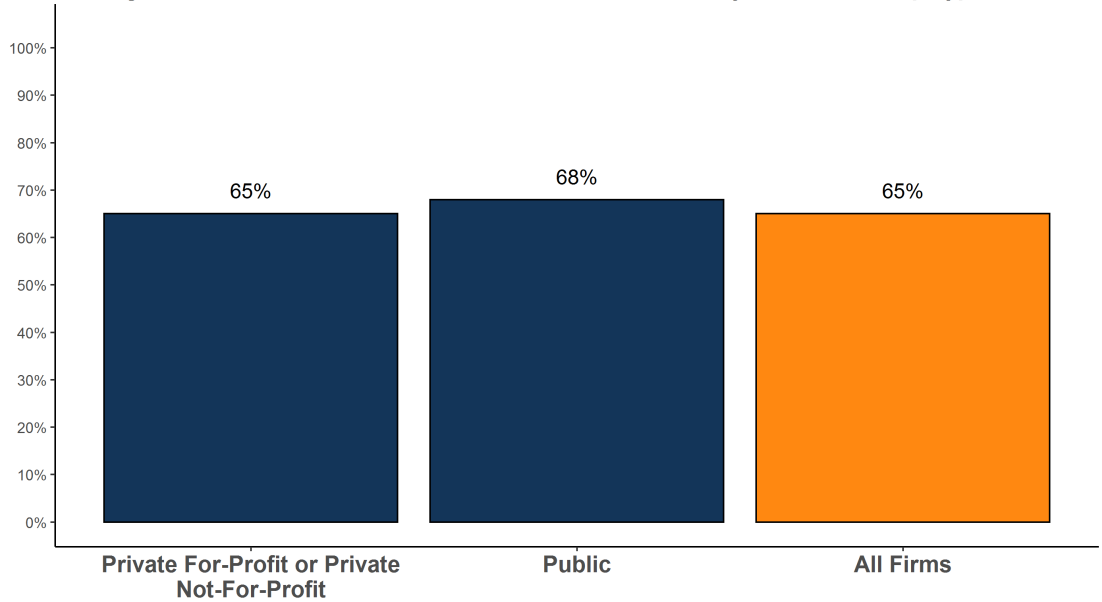
SOURCE: KFF Employer Health Benefits Survey, 2022

Figure 10.4
Percentage of Covered Workers Enrolled in a Self-Funded Plan, by Plan Type and Firm Size, 2022



* 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, 2022

Figure 10.5
Percentage of Covered Workers Enrolled in a Self-Funded Plan by Firm Ownership Type, 2022



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-six 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, 2022

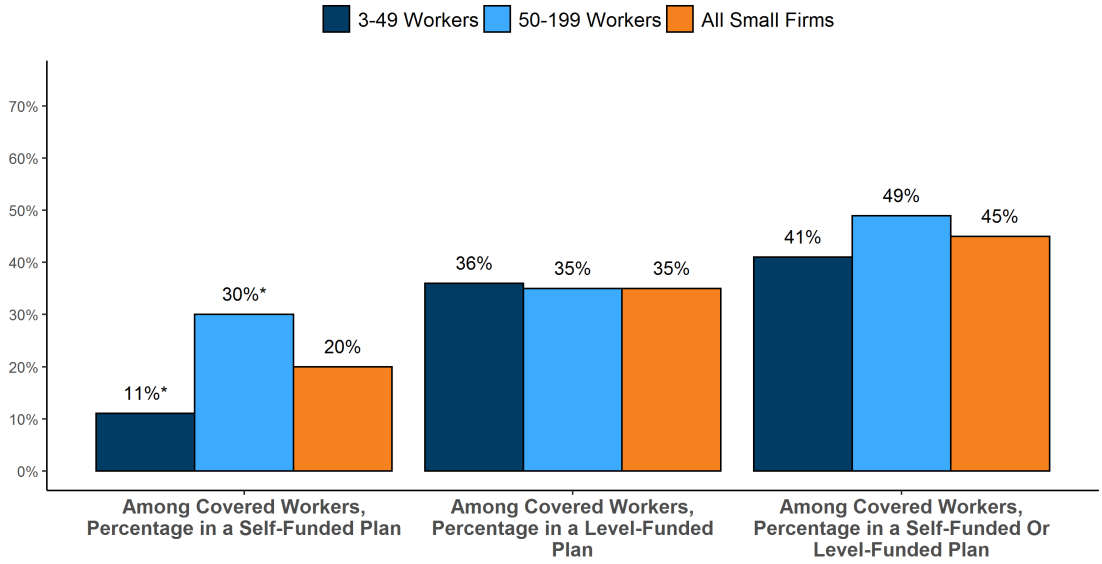
LEVEL-FUNDED PLANS

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.

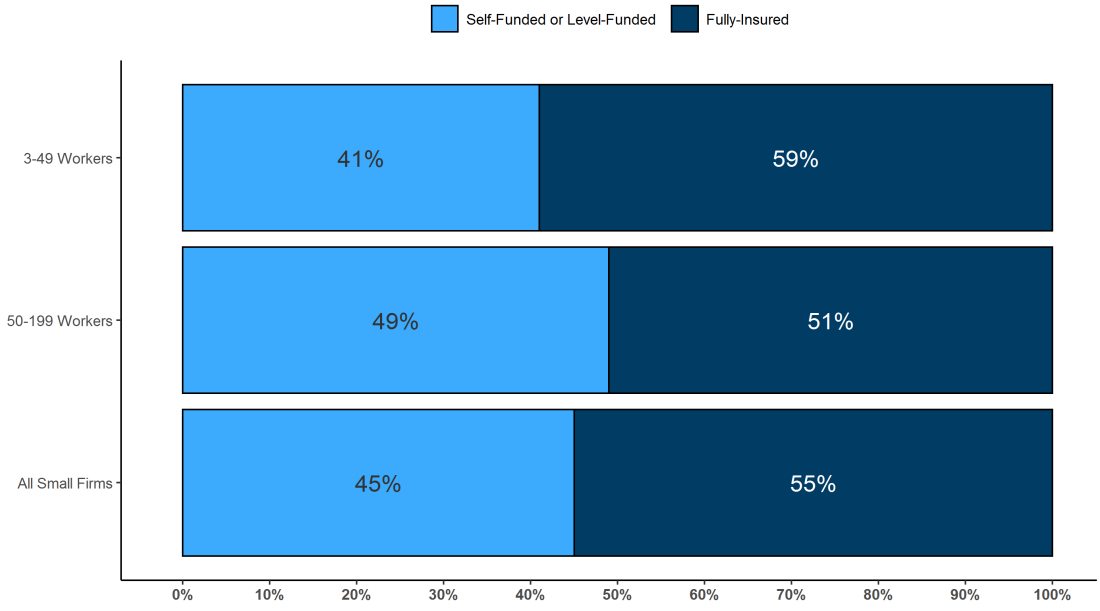
- Thirty-eight percent of small firms report offering health benefits offer a level-funded plan in 2022, similar to the percentage (42%) last year. Last year we reported a substantial increase from 2020, so it is possible that the instability reflects some uncertainty among respondents over the type of plan that they have. These arrangements are complex and are labeled differently by different carriers, so they are difficult to describe them accurately to respondents. We modified our survey question somewhat for 2022 to provide more examples of how these plans are labeled in the market, although we may have expected this to increase rather than decrease the reported prevalence. That said, this is an important development in the small group market so we will continue to monitor the prevalence of these plans [Figure 10.6].

Figure 10.6
Among Covered Workers at Small Firms, Percentage Enrolled in a Level-Funded or Self-Funded Plan, by Firm Size, 2022



* 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 2022, 38% 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, 2022

Figure 10.7
Among Covered Workers at Small Firms, Percentage Enrolled in a Level-Funded or Self-Insured Plan, by Firm Size, 2022



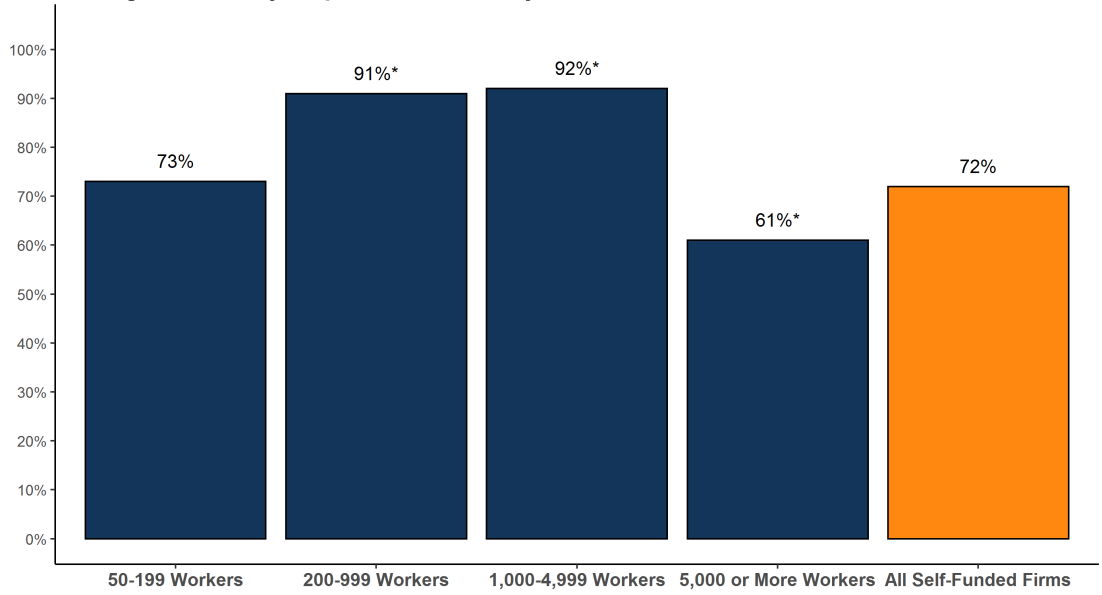
Tests found no statistical difference from estimate for all other firms not in the indicated size category ($p < .05$).
NOTE: See end of Section 10 for definitions of self-funded, fully-insured, and level-funded premium plans.
SOURCE: KFF Employer Health Benefits Survey, 2022

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.

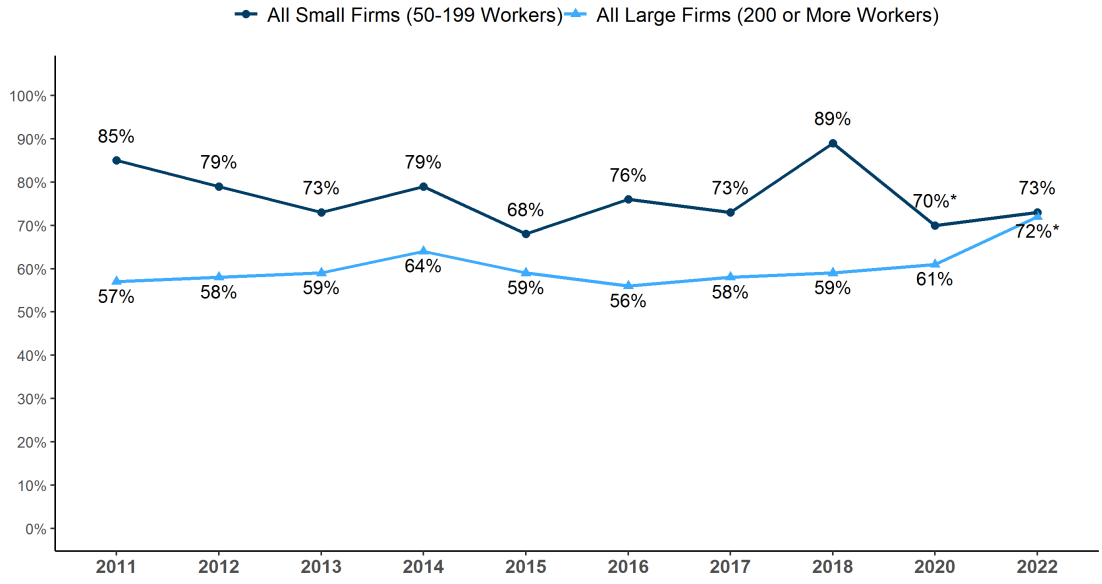
- At large firms (200 or more workers), 72% of covered workers in self-funded health plans are in plans that have stoploss insurance [Figure 10.8]. The percentage this year is not significantly higher than the percentage last year (62%) but is higher than the percentages in other recent years (61% in 2020) and (59% in 2018) [Figure 10.9].

Figure 10.8
Among Covered Workers Enrolled in a Self-Funded Plan (At Firms with 50 or More Workers), Percentage Covered by Stoploss Insurance, by Firm Size, 2022



* 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, 2022

Figure 10.9
Among Covered Workers Enrolled in a Self-Funded Plan, Percentage Covered by Stoploss Insurance (At Firms with 50 or More Workers), by Firm Size, 2011-2022



* 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. We did not ask about stoploss coverage in 2019 or for small firms in 2021.
SOURCE: KFF Employer Health Benefits Survey, 2018-2022; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2011-2017

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

2022 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.

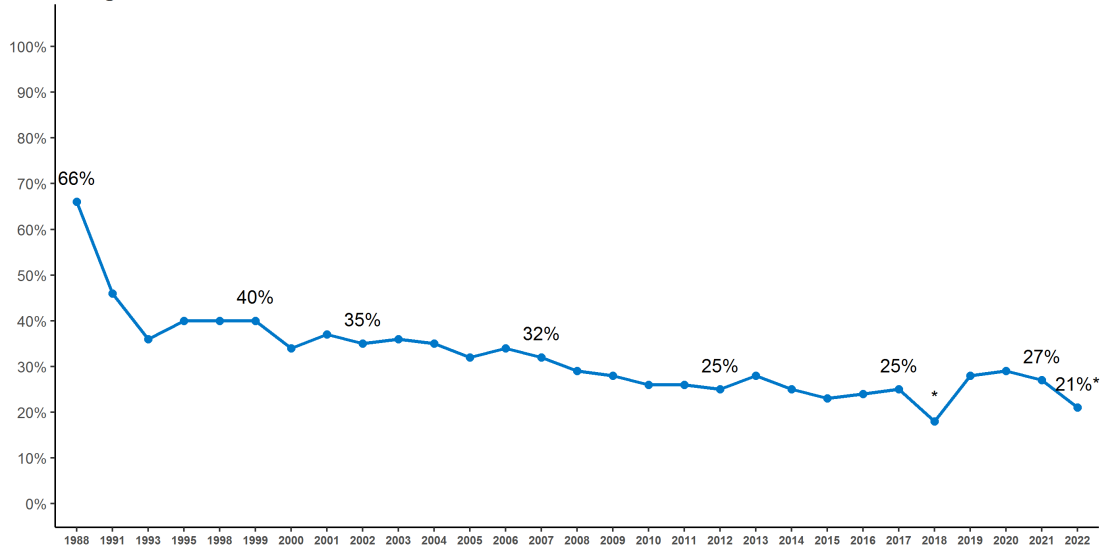
This year's survey finds that 21% of large firms offering health benefits offer retiree health benefits, a decrease from the percentage in 2021 (27%).

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

EMPLOYER RETIREE BENEFITS

- In 2022, 21% of large firms that offer health benefits offer retiree health benefits for at least some current workers or retirees, lower than 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 (63%) and private for-profit employers are less likely (14%) 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 (38% vs. 16%) [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 (27% vs. 15%) [Figure 11.3].

Figure 11.1
Among Large Firms Offering Health Benefits to Active Workers, Percentage of Firms Offering Retiree Health Benefits, 1988-2022



* 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, 2018-2022; 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

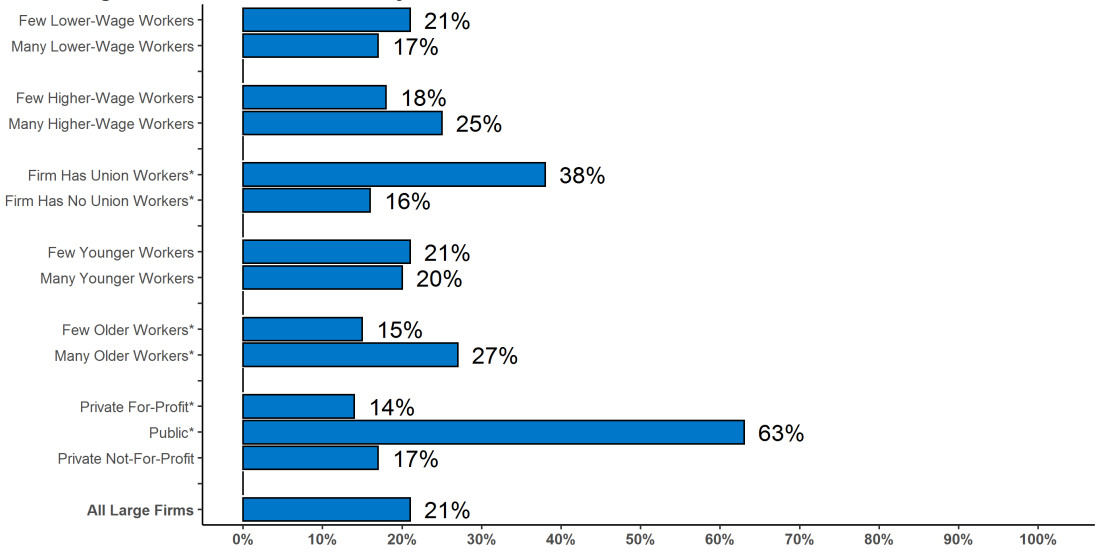
Among Large Firms Offering Health Benefits to Active Workers, Percentage of Firms Offering Retiree Health Benefits, by Firm Size, Region, and Industry, 2022

	Large Firms Offering Retiree Health Benefits
FIRM SIZE	
200-999 Workers	18%*
1,000-4,999 Workers	29*
5,000 or More Workers	41*
REGION	
Northeast	15%
Midwest	21
South	26
West	18
INDUSTRY	
Agriculture/Mining/Construction	12%
Manufacturing	15
Transportation/Communications/Utilities	36
Wholesale	20
Retail	7*
Finance	24
Service	20
State/Local Government	70*
Health Care	13*
All Large Firms (200 or More Workers)	**21%**

* 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, 2022

Figure 11.3
Among Large Firms Offering Health Benefits to Active Workers, Percentage of Firms Offering Retiree Health Benefits, by Firm Characteristics, 2022

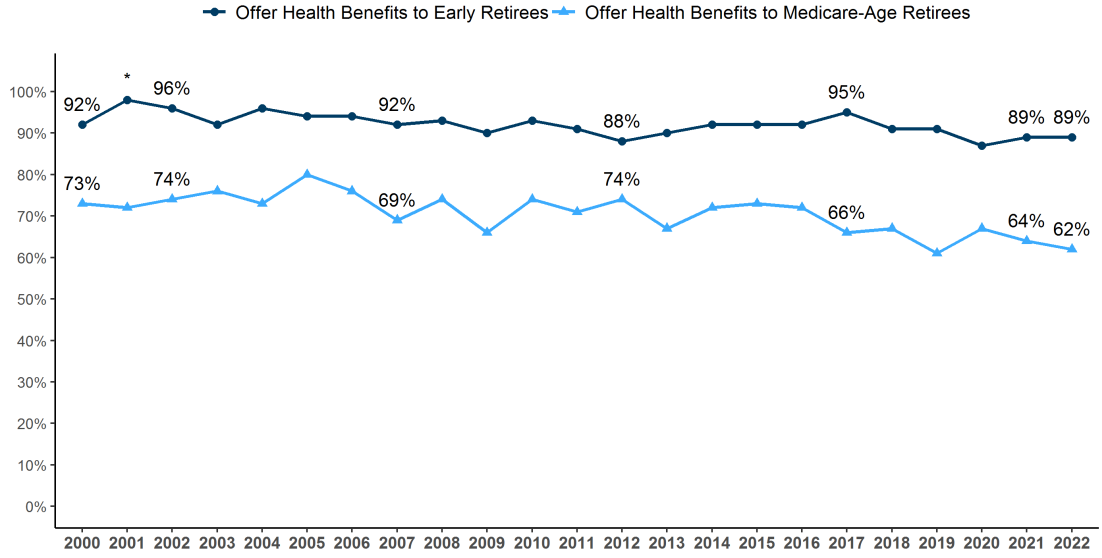


* Estimates are statistically different from each other within category ($p < .05$).
NOTE: Large Firms have 200 or more workers. Firms with many lower-wage workers are those where at least 35% earn the 25th percentile or less of national earnings ($30,000 in 2022). Firms with many higher-wage workers are those where at least 35% earn the 75th percentile or more than of national earnings ($70,000 in 2022). 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, 2022

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 62% offer them to Medicare-age retirees [Figure 11.4].
- Among all large firms offering health benefits to current workers, 13% 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, 2000-2022

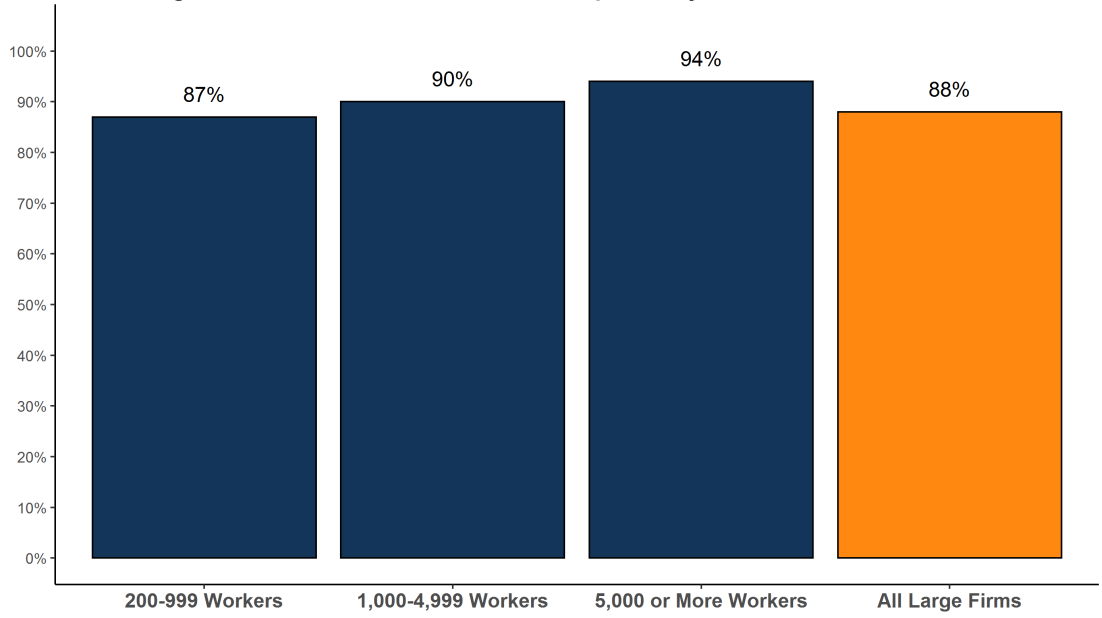


* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
NOTE: Among Large Firms offering health benefits to active workers and offering retiree coverage, 57% offer health benefits to both early and Medicare-age retirees. Large Firms have 200 or more workers. Early 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, 2018-2022; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2000-2017

BENEFIT ELIGIBILITY

- Among large firms offering retiree benefits, a large share (88%) 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 Retirees' Spouse, by Firm Size, 2022

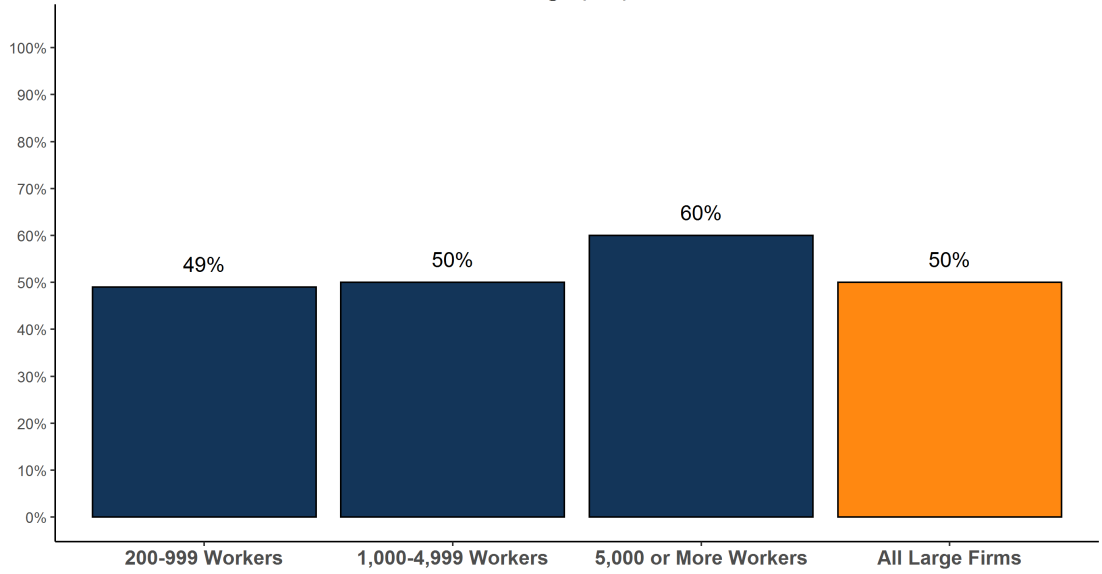


Tests found no statistical difference from estimate for all other firms not in the indicated size category ($p < .05$).
NOTE: Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2022

MEDICARE ADVANTAGE

- Fifty percent of large employers offering retiree health benefits to Medicare-age retirees offer coverage to at least some Medicare-age retirees through a contract with a Medicare Advantage plan, similar to 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, 2022



Tests found no statistical difference from estimate for all other firms not in the indicated size category ($p < .05$).
NOTE: MA refers to Medicare Advantage, an arrangement where private health plans receive capitated payments to provide all Medicare-covered services to enrollees. Sixty-two 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, 2022

Employer Health Benefits

2022 Annual Survey

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. Some employers believe that improving the health of their workers and their family members can improve wellbeing and productivity, as well as reduce health care spending

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

Among large firms offering health benefits in 2022, 55% offer workers the opportunity to complete a health risk assessment, 45% offer workers the opportunity to complete a biometric screening, and 85% offer workers one or more wellness programs, such as programs to help them stop smoking or lose weight, or programs that offer lifestyle and behavioral coaching. Substantial shares of these large firms provide incentives for workers to participate in or complete the programs.

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

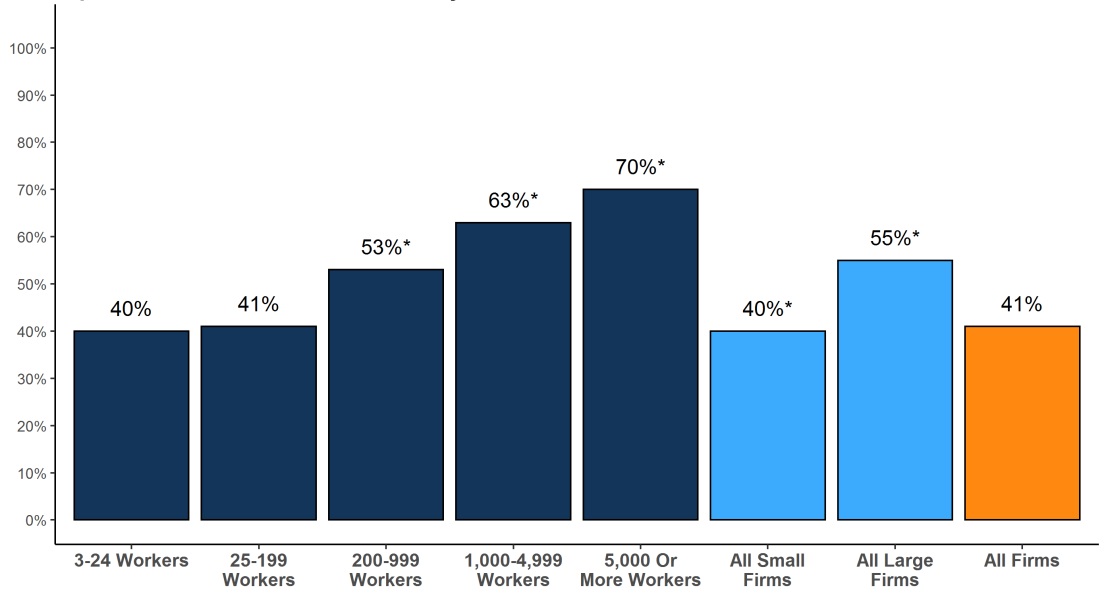
Due to the COVID-19 pandemic, we changed the focus of our questions in 2021 to look at how employers were modifying their health screening and health promotions in response to the COVID-19, in particular to address the large share of the workforce that was working remotely. For the 2022 survey we have reverted to our normal questions about these programs. Due to this break in continuity and because we know that some employers made changes to their screening and wellness programs as the pandemic intensified, we make comparisons to pre-pandemic findings from 2019.

HEALTH RISK ASSESSMENTS

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

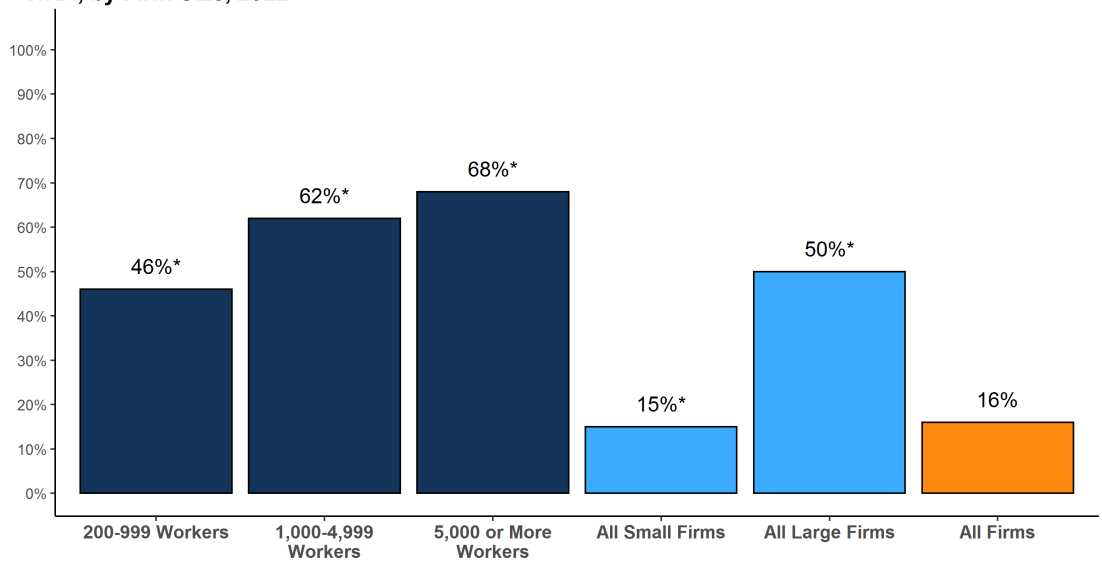
- Among firms offering health benefits, 40% of small firms and 55% of large firms provide workers the opportunity to complete a health risk assessment [Figure 12.1]. The percentage of large firms with a health risk assessment program is lower than the percentage in 2019 (65%).
- Some firms offer incentives to encourage workers to complete a health risk assessment.
  - Among large firms that offer a health risk assessment, 50% use incentives or penalties to encourage workers to complete the assessment, the same as the percentage (50%) in 2019 [Figure 12.2].

Figure 12.1
Among Firms Offering Health Benefits, Percentage of Firms That Provide an Opportunity to Complete a Health Risk Assessment, by Firm Size, 2022



* Estimate is statistically different from estimate for all other firms not in the indicated size category (p < .05).
NOTE: A health risk assessment or appraisal includes questions on medical history, health status, and lifestyle and is designed to identify the health risks of the person being assessed. Small Firms have 3-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2022

Figure 12.2
Among Firms Offering Health Benefits and Providing an Opportunity to Complete a Health Risk Assessment (HRA), Percentage of Firms That Offer Workers Incentives to Complete the HRA, by Firm Size, 2022



* Estimate is statistically different from estimate for all other firms not in the indicated size category (p < .05).
NOTE: A health risk assessment or appraisal includes questions on medical history, health status, and lifestyle and is designed to identify the health risks of the person being assessed. Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2022

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.

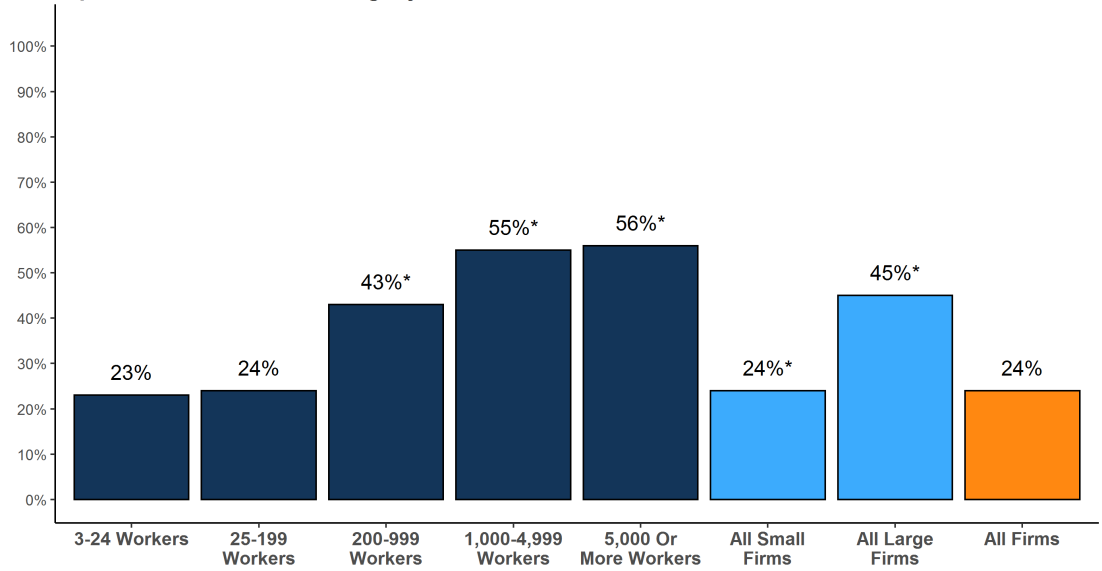
The share of firms with biometric screening fell during 2021, likely due to COVID-19-related disruptions at workplaces, such as employees working remotely and reduced access at on-site health clinics.

- Among firms offering health benefits, 24% of small firms and 45% of large firms provide workers the opportunity to complete a biometric screening [Figure 12.3]. The percentage of large firms with a biometric screening program is higher than the percentage in 2021 (38%). This suggests that some large employers are reinstating or revamping programs that were discontinued or suspended during the pandemic [Figure 12.4].
- Some firms with biometric screening programs offer incentives to encourage workers to complete a biometric screening.

Among large firms with a biometric screening program, 57% use incentives or penalties to encourage workers to complete the assessment, similar to the percentage (58%) in 2019 [Figure 12.5].

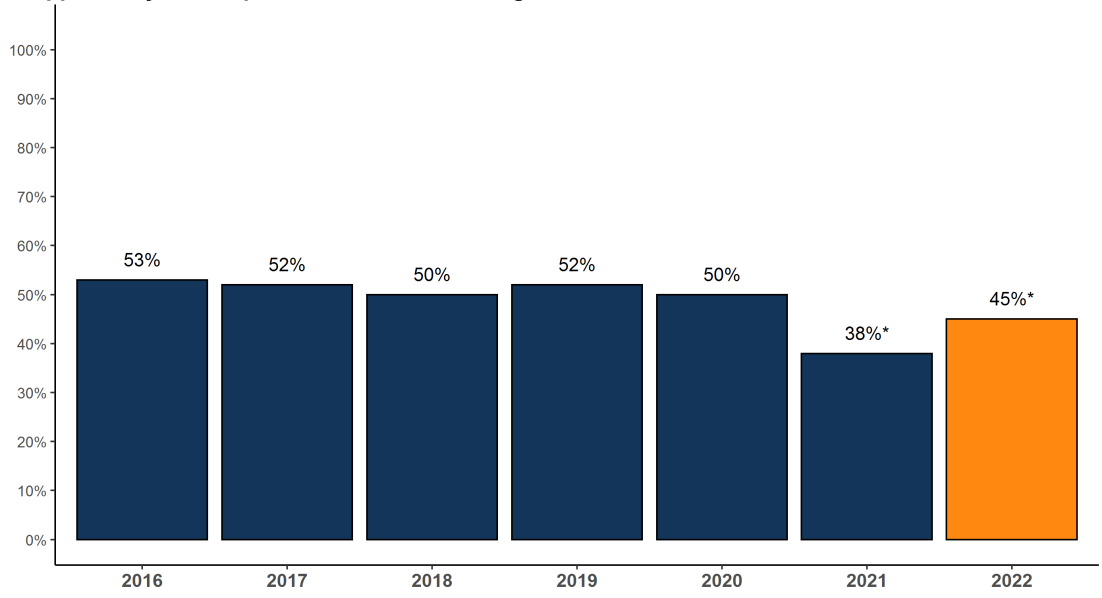
- In addition to incentives for completing a biometric screening, some firms offer workers incentives to meet biometric outcomes, such as maintaining a certain cholesterol level or body weight. Among large firms with a biometric screening program, 18% have incentives or penalties tied to whether workers meet or achieve specified biometric outcomes, similar to the percentage (14%) in 2019 [Figure 12.5].
  - The size of the incentives firms offer for meeting biometric outcomes varies considerably. Among large firms offering a reward or penalty for meeting biometric outcomes, the maximum reward is valued at $150 or less for 16% of firms and more than $1,000 for 21% of firms [Figure 12.6]. Nineteen percent of these firms combine the reward with incentives for other activities. This may include employers who ask employees to complete several health screening, disease management, wellness/health promotion activities in order to qualify for incentives.

Figure 12.3
Among Firms Offering Health Benefits, Percentage of Firms That Provide an Opportunity to Complete a Biometric Screening, by Firm Size, 2022



* 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, 2022

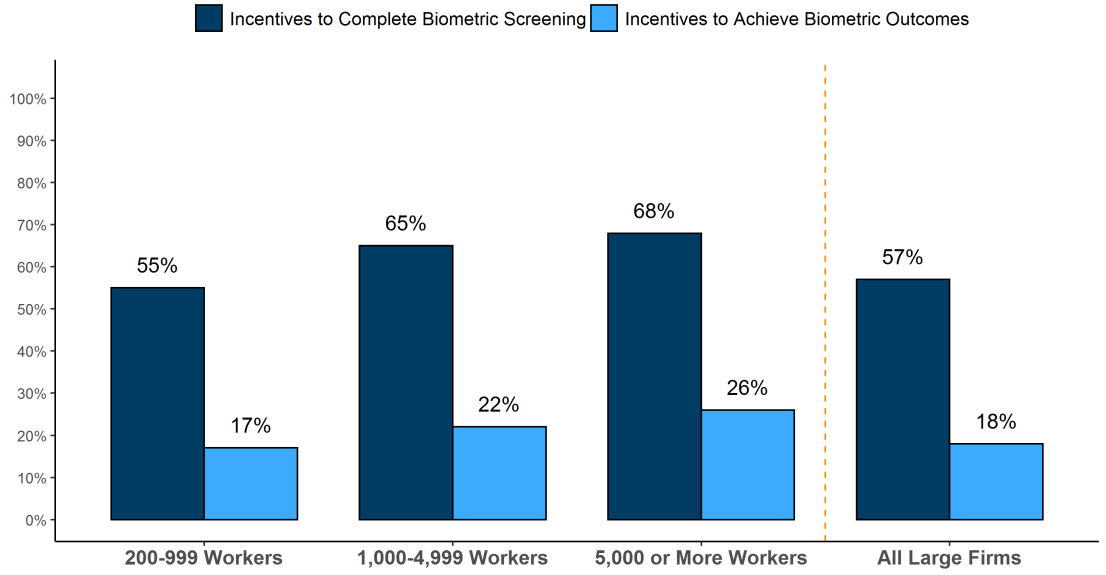
Figure 12.4
Among Large Firms Offering Health Benefits, Percentage of Firms That Provide an Opportunity to Complete Biometric Screening, 2012-2022



* 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. Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2018-2022; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2016-2017

Figure 12.5

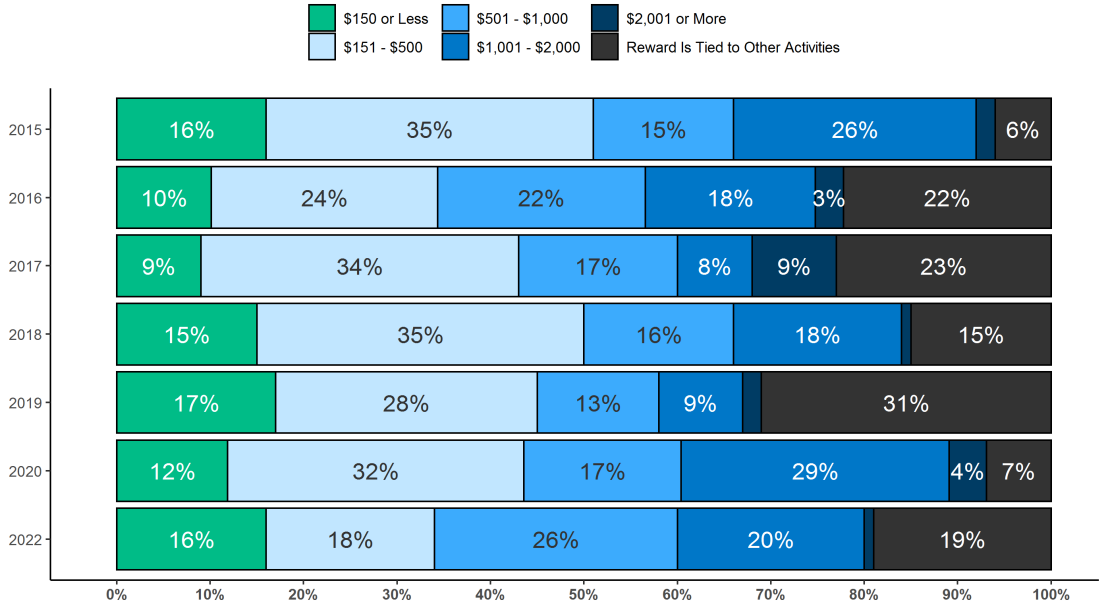
Among Large Firms Offering Health Benefits and Providing an Opportunity to Complete a Biometric Screening, Percentage of Firms with Incentives to Complete the Screening or Achieve Biometric Outcomes, by Firm Size, 2022



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, 2022

Figure 12.6

Among Large Firms Offering Workers an Incentive to Meet Biometric Outcomes, Maximum Value a Worker Can Receive for Achieving Outcomes, 2015-2022



Tests found no statistical difference from distribution for the previous year shown ($p < .05$).
NOTE: Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2018-2022; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2015-2017

Figure 12.7

Among Large Firms Offering Health Benefits, Percentage of Firms That Provide an Opportunity to Complete a Biometric Screening or a Health Risk Assessment, by Region and Industry, 2022

	Health Risk Assessment	Biometric Screening
REGION		
Northeast	59%	41%
Midwest	64*	47
South	51	43
West	48	49
INDUSTRY		
Agriculture/Mining/Construction	49%	42%
Manufacturing	72*	45
Transportation/Communications/Utilities	55	47
Wholesale	59	55
Retail	52	34
Finance	56	54
Service	54	46
State/Local Government	69	59
Health Care	43*	38
All Large Firms (200 or More Workers)	**55%**	**45%**

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

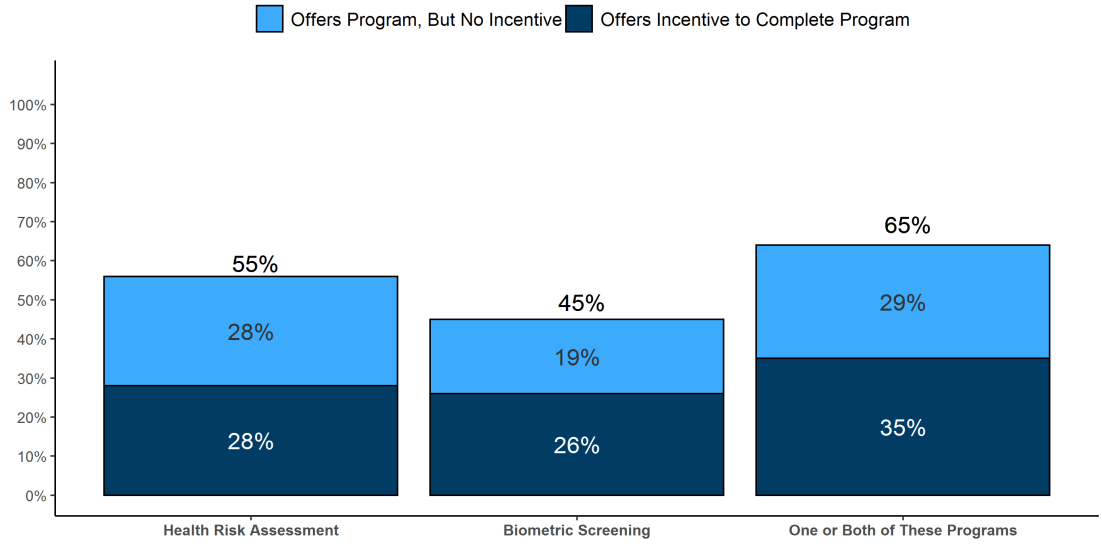
* Estimate is statistically different from estimate for all firms not in the indicated region or industry category ($p < .05$).

SOURCE: KFF Employer Health Benefits Survey, 2022

HEALTH SCREENING PROGRAMS

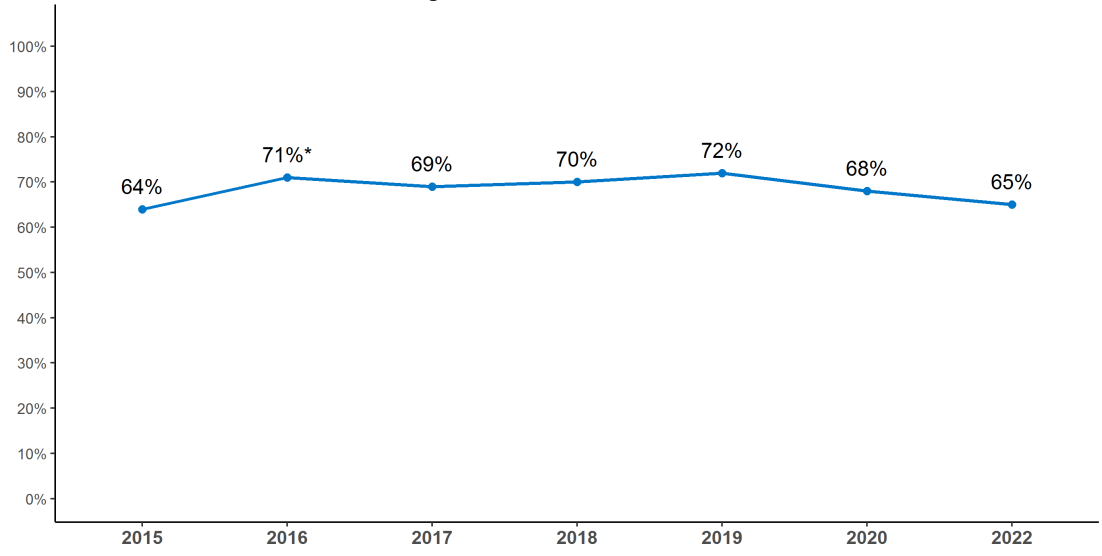
Among firms offering health benefits, 48% of small firms and 65% of large firms offer workers a health risk assessment, biometric screening or both screening programs [Figure 12.8].

Figure 12.8
Among Large Firms Offering Health Benefits, Percentage With Health Screening Programs, 2022



NOTE: A health risk assessment or appraisal includes questions on medical history, health status, and lifestyle and is designed to identify the health risks of the person being assessed. Biometric screening is a health examination that measures a person's risk factors for certain medical issues. Biometric outcomes could include meeting a target body mass index (BMI) or cholesterol level, but not goals related to smoking. Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2022

Figure 12.9
Among Large Firms Offering Health Benefits, Percentage With Either a Health Risk Assessment or a Biometric Screening, 2013-2022



* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
NOTE: A health risk assessment or appraisal includes questions on medical history, health status, and lifestyle and is designed to identify the health risks of the person being assessed. Biometric screening is a health examination that measures a person's risk factors for certain medical issues. Biometric outcomes could include meeting a target body mass index (BMI) or cholesterol level, but not goals related to smoking. Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2018-2022; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2015-2017

Figure 12.10

Among Firms Offering Health Benefits, Percentage of Firms Offering Specific Wellness Programs to Their Workers, by Firm Size and Region, 2022

	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	42%*	39%*	36%*	52%*
50-199 Workers	55*	46	54*	66*
200-999 Workers	72*	64*	75*	84*
1,000-4,999 Workers	78*	71*	79*	88*
5,000 or More Workers	82*	78*	83*	92*
All Small Firms (3-199 Workers)	**43%***	**39%***	**38%***	**54%***
All Large Firms (200 or More Workers)	**74%***	**65%***	**76%***	**85%***
REGION				
Northeast	72%*	44%	63%*	79%*
Midwest	43	40	33	50
South	23*	33	24*	38*
West	51	46	49	62
ALL FIRMS	**44%**	**40%**	**39%**	**55%**

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

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

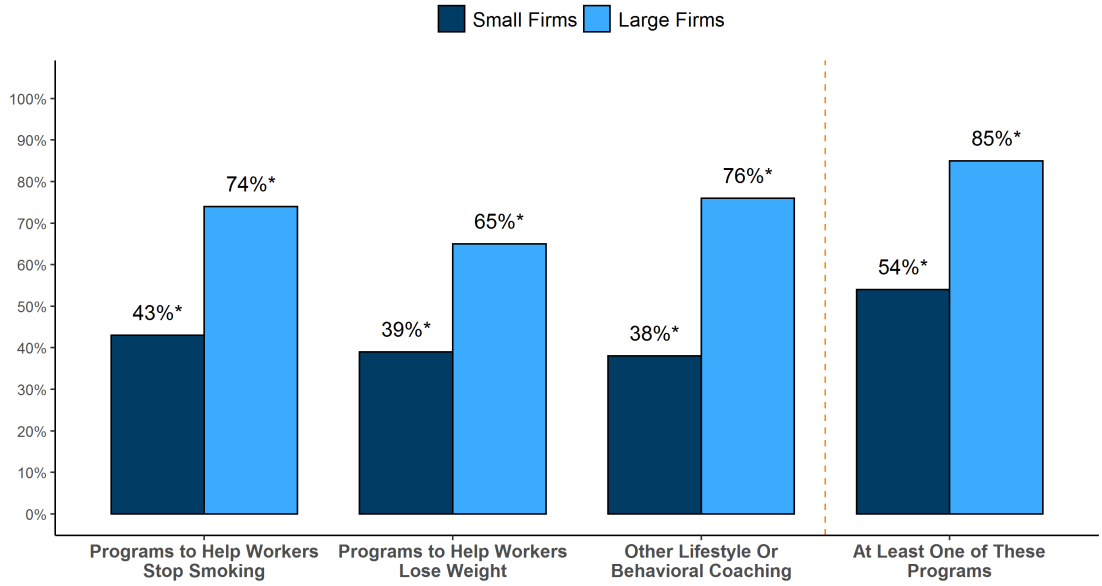
SOURCE: KFF Employer Health Benefits Survey, 2022

WELLNESS AND HEALTH PROMOTION PROGRAMS

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

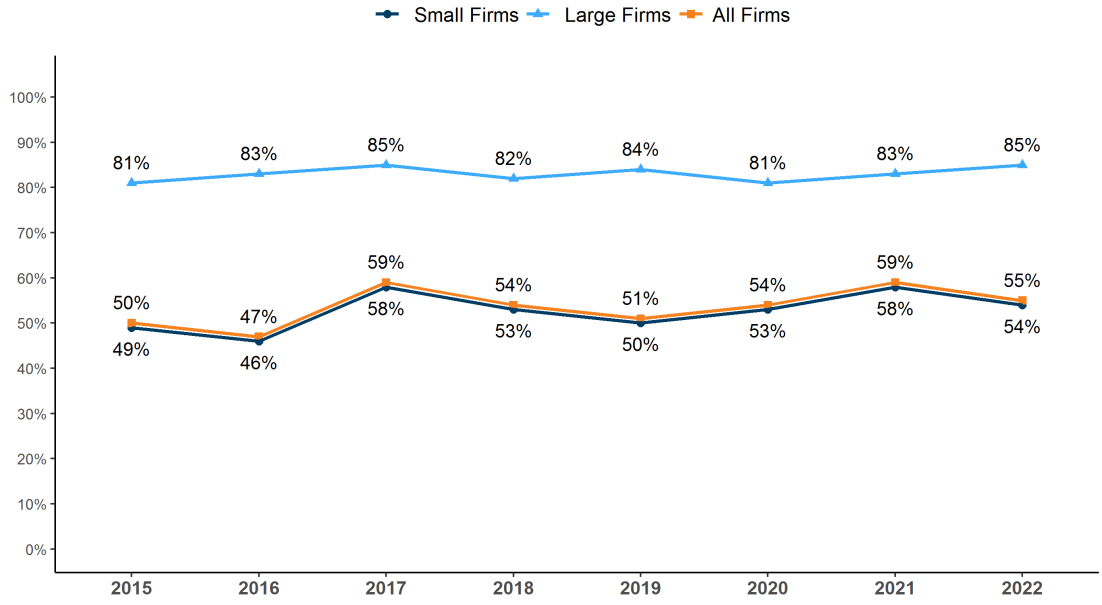
- Among firms offering health benefits, 43% of small firms and 74% of large firms offer programs to help workers stop smoking or using tobacco, 39% of small firms and 65% of large firms offer programs to help workers lose weight, and 38% of small firms and 76% of large firms offer some other lifestyle or behavioral coaching program. Overall, 54% of small firms and 85% of large firms offering health benefits offer at least one of these three programs [Figure 12.11] and [Figure 12.12].
- Forty percent of large firms offering one of these wellness or health promotion programs offer an incentive to encourage workers to participate in or complete the programs [Figure 12.13]

Figure 12.11
Among Firms Offering Health Benefits, Percentage of Firms Offering Specific Wellness Programs to Their Workers, by Firm Size, 2022



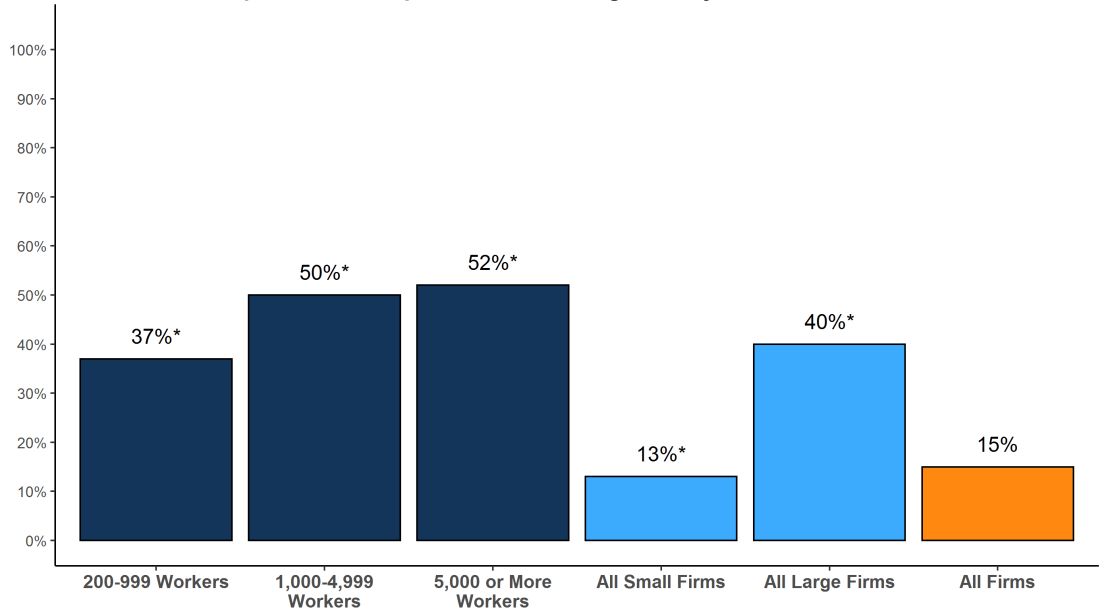
* Estimate is statistically different between All Small Firms and All Large Firms estimate ($p < .05$).
NOTE: 'Other Lifestyle or Behavioral Coaching' can include health education classes, stress management, or substance use counseling. Small Firms have 3-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2022

Figure 12.12
Among Firms Offering Health Benefits, Percentage of Firms Offering Wellness Programs, by Firm Size, 2015-2022



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, 2018-2022; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2015-2017

Figure 12.13
Among Firms Offering Specific Wellness Programs, Percentage of Firms That Offer Incentives to Participate In or Complete Wellness Programs, by Firm Size, 2022



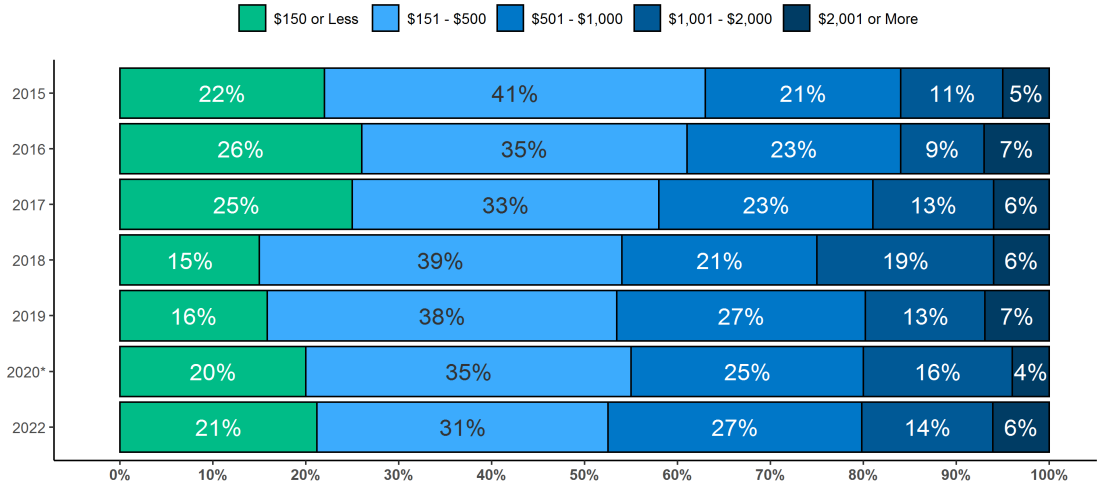
* Estimate is statistically different from estimate for all other firms not in the indicated size category ($p < .05$).
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2022

INCENTIVES FOR WELLNESS AND HEALTH SCREENING PROGRAMS

Firms with incentives for health risk assessments, biometric screenings, or wellness or health promotion programs were asked to report the maximum reward or penalty a worker could earn for all of the firm's health promotion activities combined. Some firms do not offer incentives for individual activities, but offer rewards to workers who complete a variety of activities.[1] Among large firms offering incentives for any of these programs, the maximum value for all wellness-related incentives is $150 or less in 21% of firms and more than $1,000 in 20% of firms [Figure 12.15].

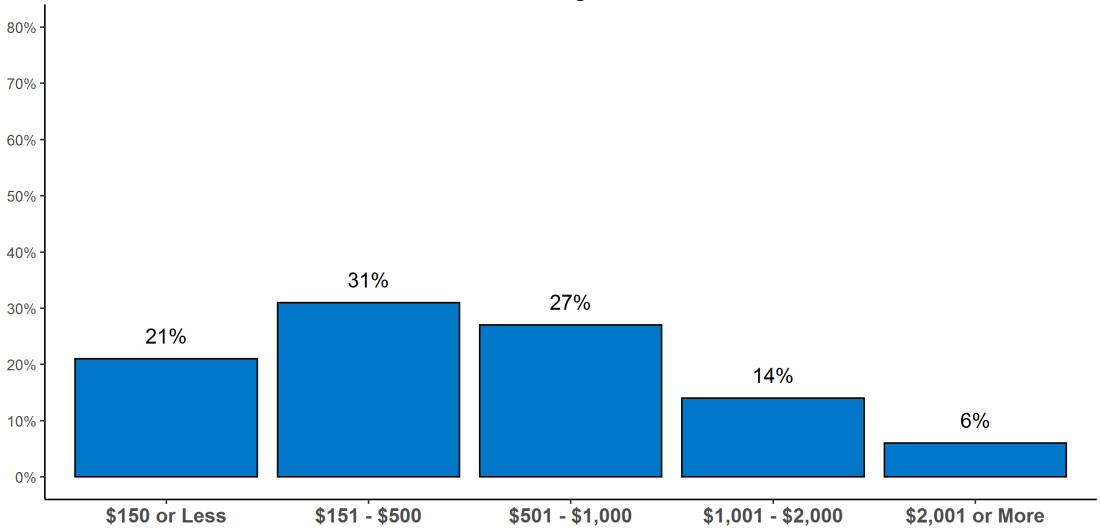
[1] In 2022, less than one percent of firms indicated that they had an incentive for completing health risk assessments, biometric screenings, or wellness or health promotion programs, but had a maximum incentive of zero dollars. These firms may have non-monetary incentives such as preferred parking spots or employee recognition programs.

Figure 12.14
Among Large Firms That Offer Workers an Incentive to Participate In or Complete Any Health Promotion Programs, Maximum Annual Value of the Incentive for All Programs Combined, 2015-2022



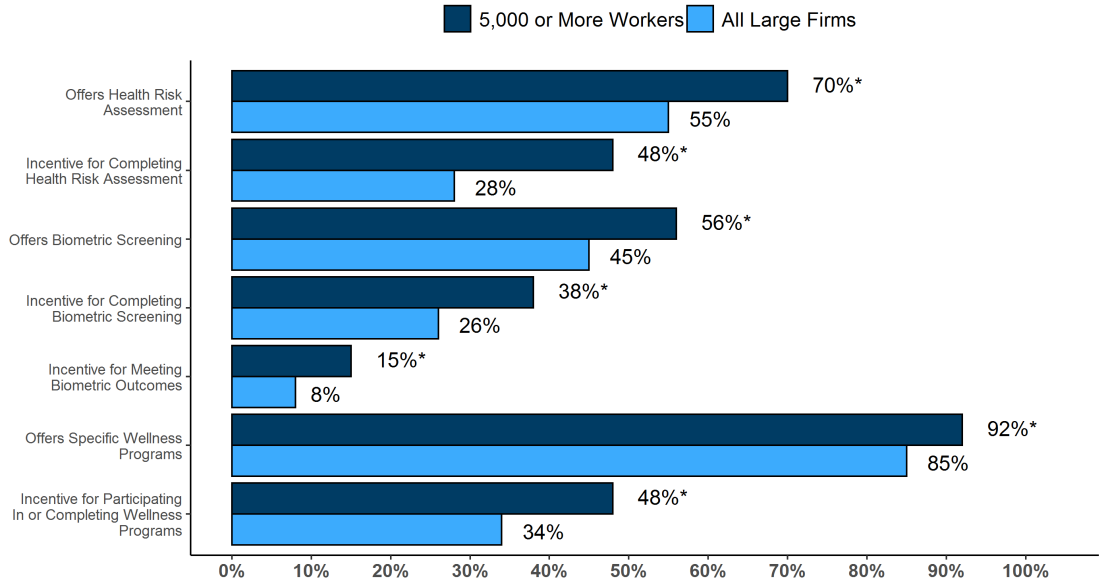
* Distribution is statistically different from distribution for the previous year shown ($p < .05$).
NOTE: Includes incentives for health risk assessments, biometric screenings, and wellness programs. Firms with at least one of the listed health promotion programs were asked to report the maximum incentive a worker and his/her dependents could receive for all the firm's health promotion programs combined. Forty-five percent of large offering firms offer an incentive to complete any of their health promotion programs. In 2022, less than one percent of firms indicated they had a reward of zero dollars. In most cases, this indicates a non-monetary incentive such as a preferred parking spot. Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2018-2022; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2015-2017

Figure 12.15
Among Large Firms Offering Workers an Incentive for Any Health Promotion Programs, Maximum Annual Value of the Incentive for All Programs Combined, 2022



NOTE: Includes incentives for health risk assessments, biometric screenings, and wellness programs. Firms with at least one of the listed health promotion programs were asked to report the maximum incentive a worker and his/her dependents could receive for all the firm's health promotion programs combined. Forty-five percent of large offering firms offer an incentive to complete any of their health promotion programs. In 2022, less than one percent of firms indicated they had a reward of zero dollars. In most cases, this indicates a non-monetary incentive such as a preferred parking spot. Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2022

Figure 12.16
Among Large Firms Offering Health Benefits, Percentage of Firms Offering Various Wellness and Health Promotion Activities and Incentives, by Firm Size, 2022



* Estimates are statistically different between firm size estimates within category ($p < .05$).
NOTE: 'Specific Wellness Programs' include 'Programs to Help Workers Stop Smoking', 'Programs to Help Workers Lose Weight', or 'Other Lifestyle or Behavioral Coaching'. Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2022

EFFECTIVENESS OF WELLNESS AND HEALTH SCREENING PROGRAMS

Large firms (200 or more workers) offering one or more health promotion or health screening programs were asked whether they believed the programs were effective in meeting certain objectives often offered as reasons to have these programs. Firms offering these programs may have different objectives for different programs, so we offered respondents the opportunity to say that a specific objective was not a goal of their programs.

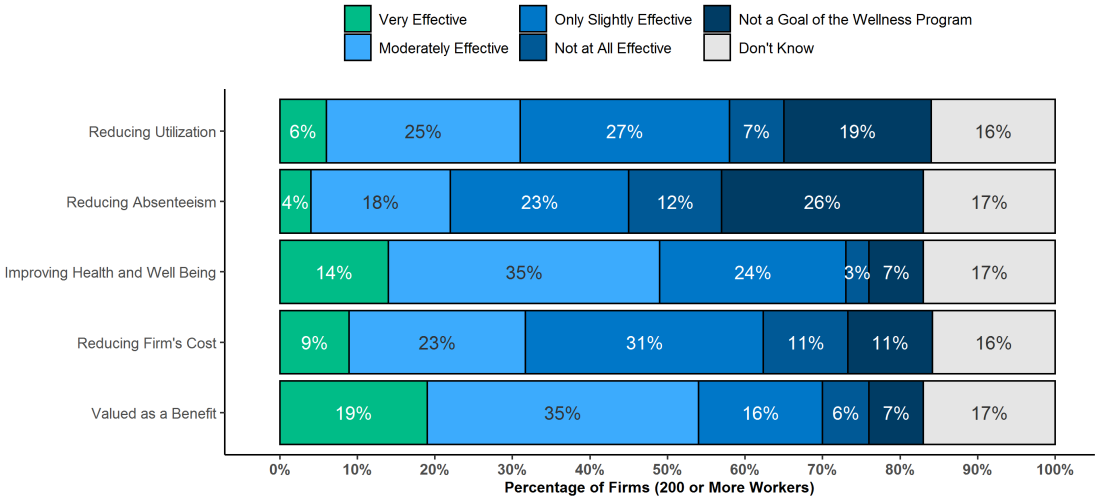
Among large firms offering one or more of these programs:

- Reducing the firm's health care costs - Only 9% said that their programs were "very effective" at reducing health care costs, 23% said that they were "moderately effective", 42% said that they were "only slightly effective" or "not at all effective", 11% said that reducing health care costs is not an objective of their programs, and 16% did not know [Figure 12.17].
- Reducing health care utilization - Only 6% said that their programs were "very effective" at reducing the use of health care, 25% said that they were "moderately effective", 34% said that they were "only slightly effective" or "not at all effective", 19% said that reducing health care use is not an objective of their programs, and 16% did not know [Figure 12.17].
- Reducing employee absenteeism - Only 4% said that their programs were "very effective" at reducing absenteeism by employees, 18% said that they were "moderately effective", 36% said that they were "only slightly effective" or "not at all effective", 26% said that reducing employee absenteeism is not an objective of their programs, and 17% did not know [Figure 12.17].
- Improving the health and well being of enrollees - Fourteen percent said that their programs were "very effective" at improving the health and well being of enrollees, 35% said that they were "moderately

effective", 27% said that they were "only slightly effective" or "not at all effective", 7% said that improving the health and well being is not an objective of their programs, and 17% did not know [Figure 12.17].

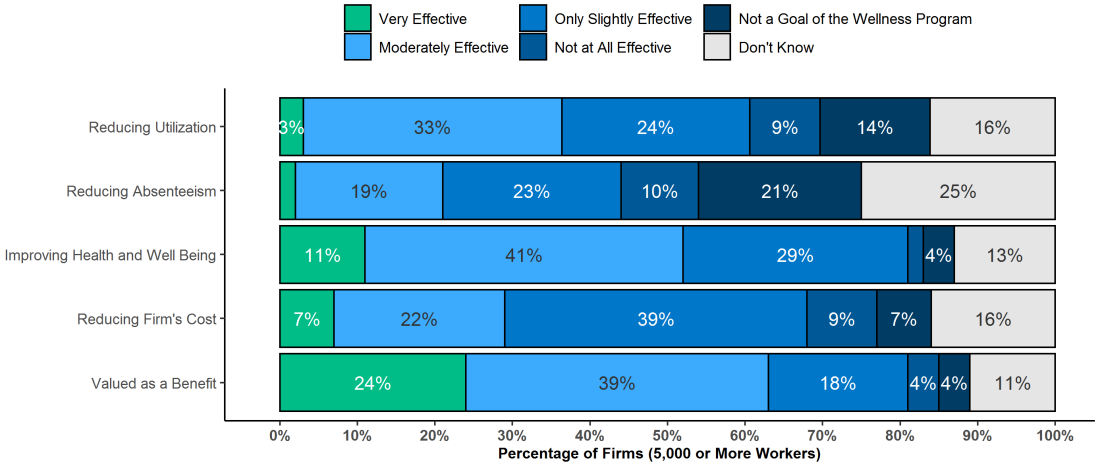
- Being valued as a benefit by employees - Nineteen percent said that their programs were "very effective" at being valued as a benefit by their employees, 35% said that they were "moderately effective", 22% said that they were "only slightly effective" or "not at all effective", 7% said that being valued as a benefit is not an objective of their programs, and 17% did not know [Figure 12.17].

Figure 12.17
Among Large Firms Offering Health Benefits and a Wellness or Health Screening Programs, Firms Opinion of How Effective Programs are at Meeting Various Goals, 2022



NOTE: A health risk assessment or appraisal includes questions on medical history, health status, and lifestyle and is designed to identify the health risks of the person being assessed. Biometric screening is a health examination that measures a person's risk factors for certain medical issues. Biometric outcomes could include meeting a target body mass index (BMI) or cholesterol level, but not goals related to smoking. Wellness programs include programs to help employees lose weight, lifestyle or behavioral coaching or tobacco cessation programs. Among large firms offering health benefits, 90% have a health screening or wellness and/or health promotion program and 45% have an incentive to participate in at least one program. Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2022

Figure 12.18
Among Large Firms (5,000 or More Workers) Offering Health Benefits and a Wellness or Health Screening Programs, Firms Opinion of How Effective Programs are at Meeting Various Goals, 2022



NOTE: A health risk assessment or appraisal includes questions on medical history, health status, and lifestyle and is designed to identify the health risks of the person being assessed. Biometric screening is a health examination that measures a person's risk factors for certain medical issues. Biometric outcomes could include meeting a target body mass index (BMI) or cholesterol level, but not goals related to smoking. Wellness programs include programs to help employees lose weight, lifestyle or behavioral coaching or tobacco cessation programs. Among large firms offering health benefits, 90% have a health screening or wellness and/or health promotion program and 45% have an incentive to participate in at least one program. Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2022

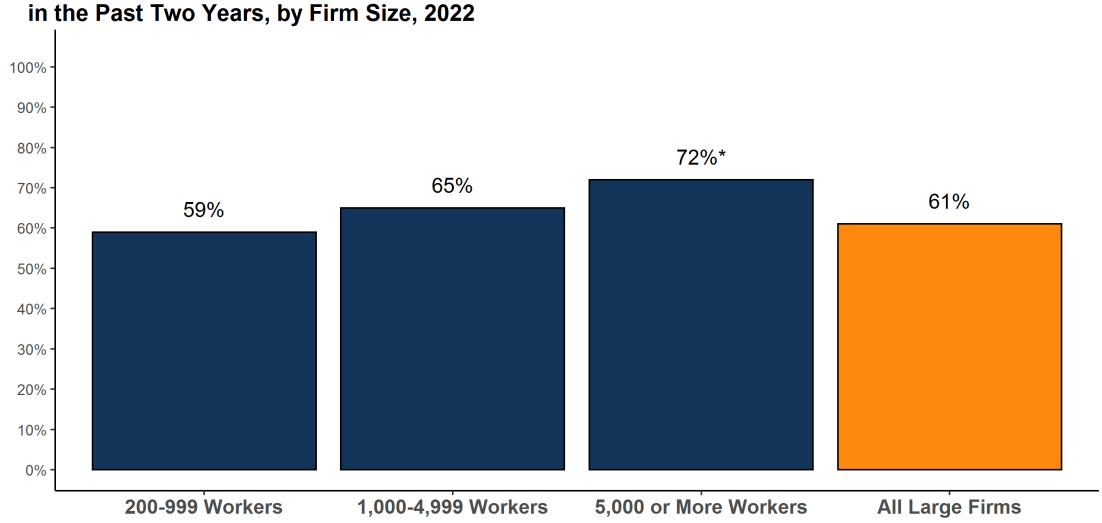
DIGITAL CONTENT FOR WELLNESS PROGRAMS

Sixty-one percent of large firms with a wellness program, including 72% of those with 5,000 or more employees, have added digital content to one or more of their wellness programs in the last two years [Figure 12.19].

- Among large firms that added digital content to a wellness program, 8% say that employees have engaged "a great deal" with the digital content, 39% say that employees have engaged "somewhat," 22% say that employees have engaged "very little" or "not at all," and 31% do not know [Figure 12.20].

Figure 12.19

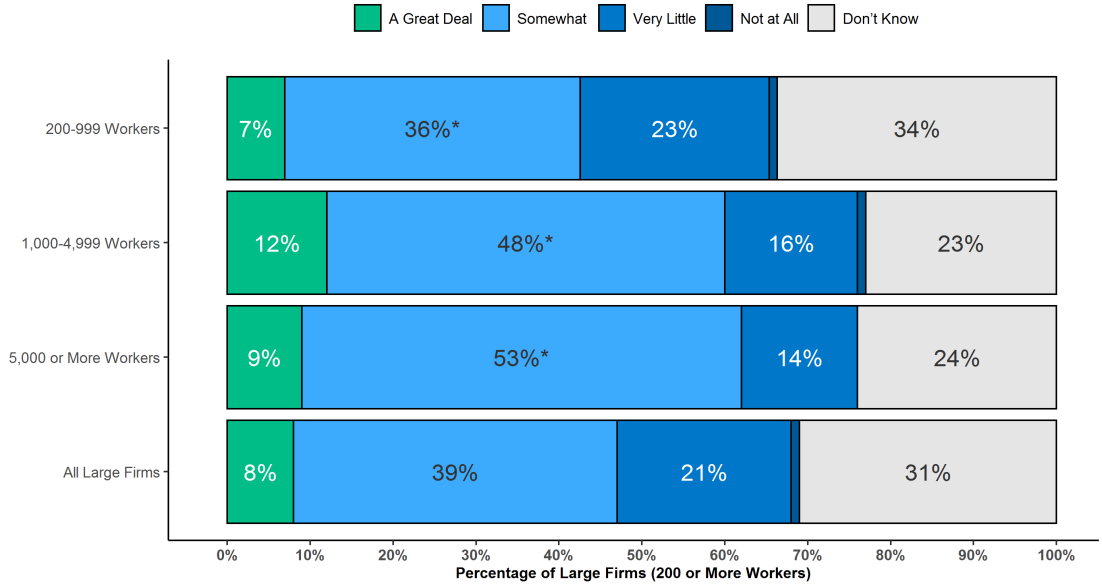
Among Large Firms Offering Health Benefits and a Wellness or Health Screening Programs, Percentage of Firms That Added New Vendors or Digital Content to Their Wellness Programs in the Past Two Years, by Firm Size, 2022



* Estimate is statistically different from estimate for all other firms not in the indicated size category ($p < .05$).
NOTE: A health risk assessment or appraisal includes questions on medical history, health status, and lifestyle and is designed to identify the health risks of the person being assessed. Biometric screening is a health examination that measures a person's risk factors for certain medical issues. Biometric outcomes could include meeting a target body mass index (BMI) or cholesterol level, but not goals related to smoking. Wellness programs include programs to help employees lose weight, lifestyle or behavioral coaching or tobacco cessation programs. Among large firms offering health benefits, 90% have a health screening or wellness and/or health promotion program. Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2022

Figure 12.20

Among Large Firms Which Added Digital Content To Their Wellness Program, How Much Engagement Does Digital Content Get from Employees, by Firm Size, 2022



* Estimates are statistically different from estimate for all other firms not in the indicated category within each firm size ($p < .05$).
NOTE: Among large firms offering a health screening or wellness and/or health promotion program, 61% added new vendors or digital content to their wellness programs in the past two years. Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2022

Employer Health Benefits
2022 Annual Survey

Employer Practices, Telehealth, Provider Networks and the Accessibility of Mental Health Services

SECTION 13

Section 13

Employer Practices, Telehealth, Provider Networks and Coverage for Mental Health Services

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

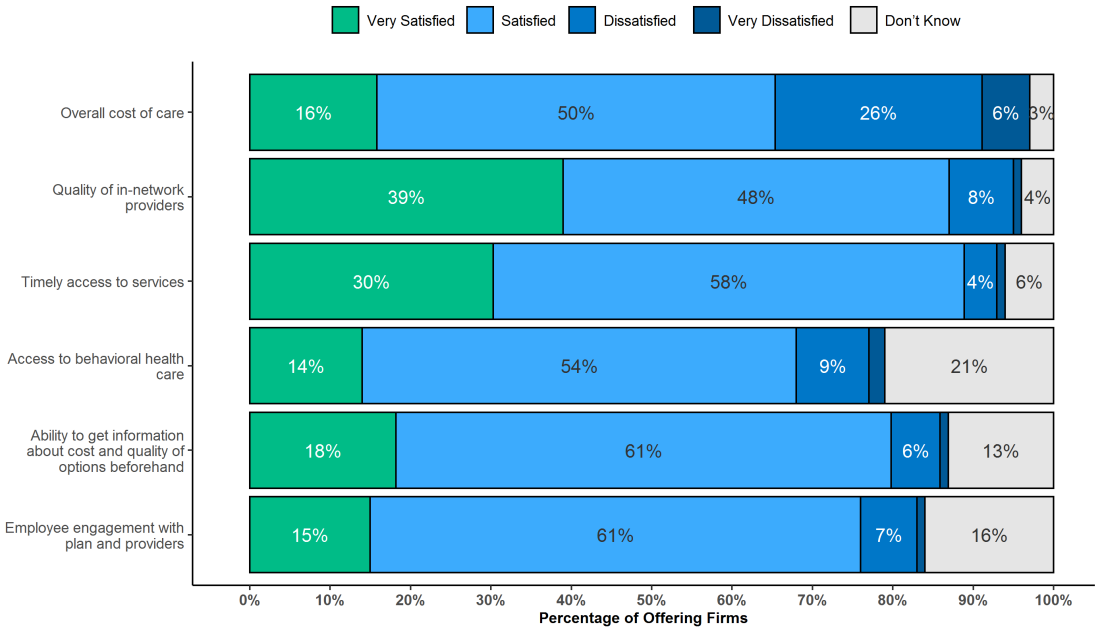
In 2021, with employers focused on COVID-19, we modified the survey to focus on how employers were adjusting their benefits and policies in response to the pandemic. Changes in telemedicine and access to mental health services received particular attention. For 2022 we continued our focus on telemedicine and mental health, although not necessarily through a COVID-19 lens. We also asked employers about their satisfaction with different aspects of their health benefits and health plan options, as well as about health benefit options targeted to lower-wage employees.

EMPLOYER SATISFACTION WITH HEALTH BENEFIT OFFERINGS

We asked employers about their level of satisfaction with their several aspects of their health plan offerings, including the overall costs for employees, access to care, including access to mental health services, quality of care, and adequacy of plan networks.

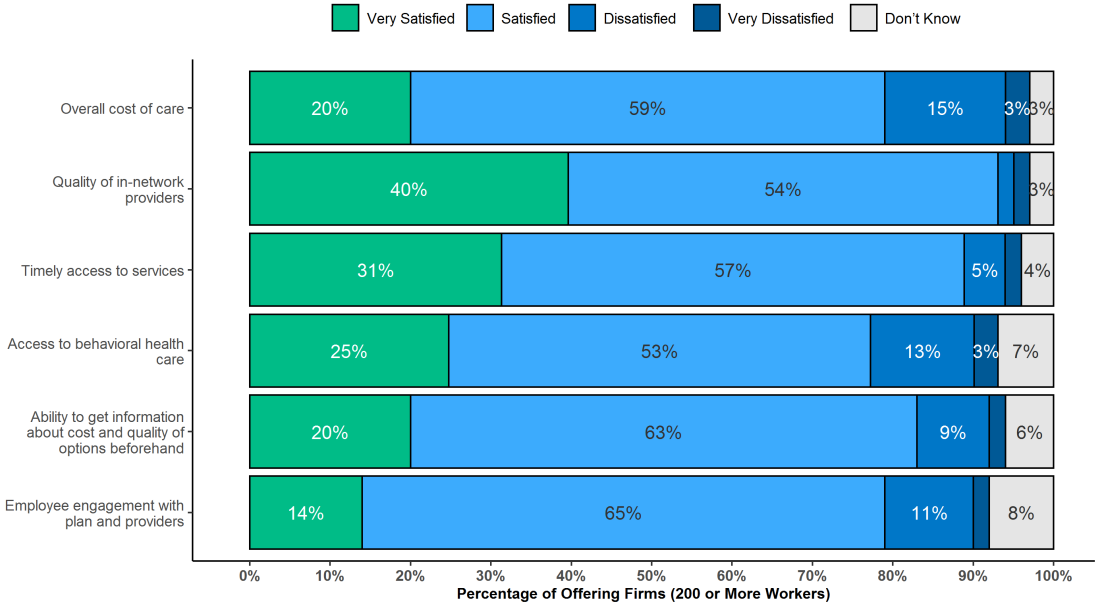
- A large share (66%) of firms offering health benefits said they were "very satisfied" or "satisfied" with the overall cost of care for their employees. Large firms are more likely to be at least "satisfied" with the overall cost of care than small firms (79% vs. 65%)[Figure 13.1] and [Figure 13.2].
- Among firms offering health benefits, 39% are "very satisfied" and another 48% are "satisfied" with the quality of the health care providers participating in their health plan networks. These percentages are similar for large and small firms [Figure 13.1].
- Among firms offering health benefits, 30% are "very satisfied" and another 58% are "satisfied" with the timely access to services for plan enrollees. These percentages are similar for large and small firms.
- Among firms offering health benefits, 14% are "very satisfied" and another 54% are "satisfied" with access to behavioral health care in their health plans for enrollees who need it. Large firms are more likely than small firms to be "very satisfied" with access to behavioral health care in their health plans (25% vs. 13%), while small firms are more likely to say that they do not know (22% vs. 7%) [Figure 13.1].
- Among firms offering health benefits, 15% are "very satisfied" and another 61% are "satisfied" with the level of employee engagement with the plan and providers. These percentages are similar for large and small firms.

Figure 13.1
Among Firms Offering Health Benefits, Firm's Satisfaction With Aspects of Firm's Health Plans, 2022



SOURCE: KFF Employer Health Benefits Survey, 2022

Figure 13.2
Among Large Firms Offering Health Benefits, Firm's Satisfaction With Aspects of Firm's Health Plans, 2022



NOTE: Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2022

TELEMEDICINE

Access to telemedicine benefits, which had been growing steadily before the COVID-19 pandemic, skyrocketed during the lockdown period 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 asked employers about their telemedicine benefit offerings as well as whether they view these benefits as an important source of access to health care in the future.

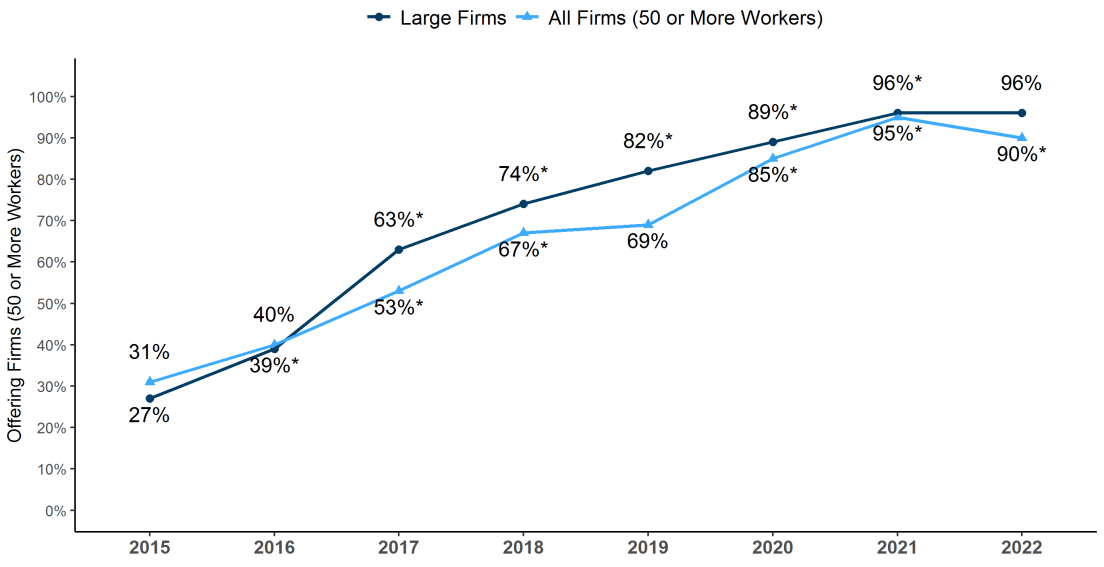
We define telemedicine as the delivery of health care services through telecommunications to a patient from a provider who is at a remote location, including video chat and remote monitoring. This generally does not include the mere exchange of information via email, exclusively web-based resources, 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.

- Among firms with 50 or more workers offering health benefits, 87% of small firms and 96% of large firms cover the provision of some health care services through telemedicine in their largest health plan [Figure 13.3].
  - The percentage of small firms (50-199 workers) offering telemedicine benefits in 2022 is lower than the percentage last year (87% vs. 94%). As a result of this change for small firms, the percentage of all firms offering telemedicine benefits also is lower this year [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 (87% vs. 65% for small firms and 96% vs. 82% for large firms) [Figure 13.3].
- Among firms with 50 or more employees offering telemedicine services, 24% use a specialized telemedicine service provider, such as Teledoc, Doctor on Demand, OR MDLIVE, 59% offer services through their health plan, 14% offer services through both a specialized telemedicine provider and their health plan, and 3% provide services through some other arrangement [Figure 13.4].
  - Small firms are more likely than larger firms to provide telemedicine services only through their health plan (63% vs. 46%) [Figure 13.4].
  - Large firms are more likely than smaller firms to provide telemedicine services through a specialized telemedicine provider (32% vs. 21%) or through both a specialized telemedicine provider and their health plan (20% vs. 13%) [Figure 13.4].
- Among firms with 50 or more employees offering health benefits, only 4% have contracted with a new telemedicine service provider within the last 12 months [Figure 13.6].
- Among firms with 50 or more employees offering telemedicine benefits, 37% say that telemedicine is "very important" in providing access to mental health services for enrollees, and another 38% say that it is "important" to providing access to these services. Large firms are more likely than small firms to say that telemedicine is "very important" to providing access to mental health services. (47% vs. 34%) while small firms are more likely than large firms to say that they do not know [Figure 13.16].
- We asked firms offering health benefits how important they felt telemedicine would be in providing access for their employees to certain types of services in the coming years. Among these firms:
  - Behavioral Health Services - Thirty-six percent say that telemedicine will be "very important" in providing access to behavioral health services in the future, and another 31% say that it will be "important" to providing access to these services. Large firms are more likely than small firms to say that telemedicine will be "very important" to providing access to these services. (55% vs. 36%) [Figure 13.7].

- Primary Care - Thirty-three percent say that telemedicine will be "very important" in providing access to primary care in the future, and another 33% say that it will be "important" to providing access primary care].
- Specialty Care - Twenty-seven percent say that telemedicine will be "very important" in providing access to specialty care in the future, and another 31% say that it will be "important" to providing access to specialty care.
- Enrollees in Remote Areas - Forty percent say that telemedicine will be "very important" in providing future access to care for enrollees in remote areas, and another 27% say that it will be "important" to providing future access for remote enrollees. Large firms are more likely than small firms to say that telemedicine will be "very important" to providing access for enrollees in remote areas (54% vs. 39%) while small firms are more likely than large firms to say that telemedicine will be "not important" in providing access for remote enrollees (12% vs. 5%) or to say that they do not know [Figure 13.7].

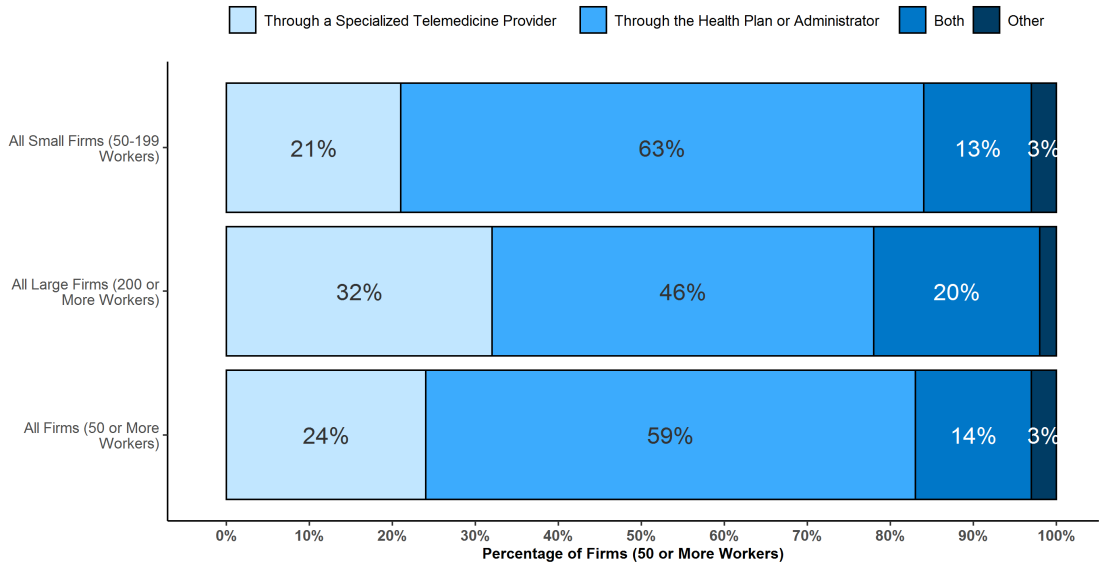
- We asked firms with 50 or more employees offering telemedicine benefits about their expectations and experience with telemedicine use and cost. Among these employers:
  - Thirty-four percent expect the use of telemedicine to increase in 2022 as compared to last year, 14% expect it to decrease, and 42% expect it to stay about the same [Figure 13.8].
  - Four percent say that their costs have increased as a result of telemedicine, 6% say that costs have decreased, 63% say that costs have stayed about the same, and 27% say that they do not know [Figure 13.9].
  - Virtually no firms reported introducing any restrictions on telemedicine benefits due to concerns about use or cost in 2022. Eighty-five percent say that they have not introduced restrictions and 15% say that they do not know.

Figure 13.3
Among Firms Offering Health Benefits, Percentage of Firms Whose Plan with the Largest Enrollment Covers Telemedicine, by Firm Size, 2015-2022



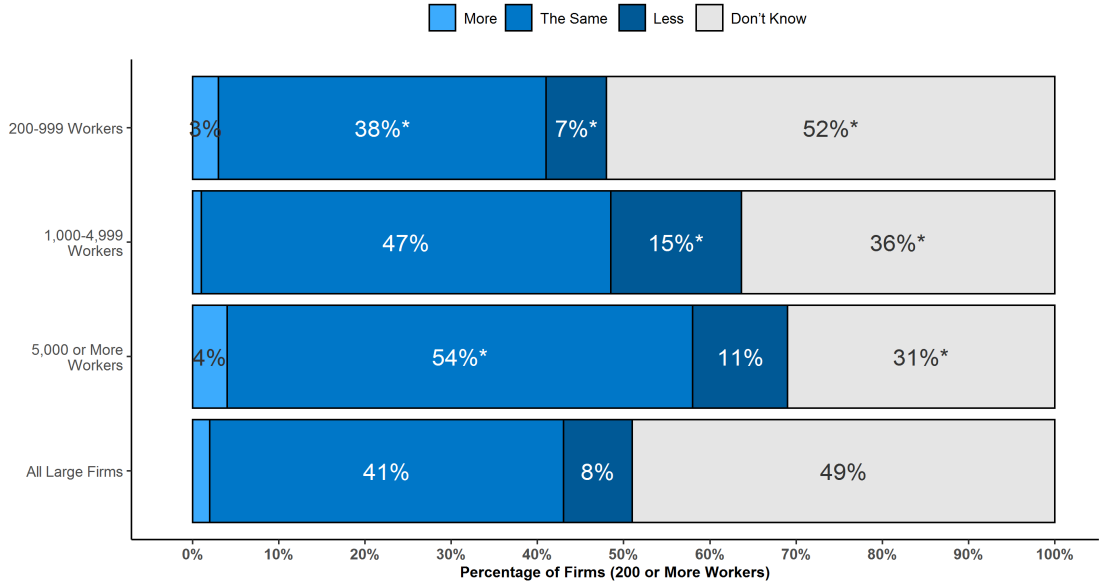
* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
NOTE: Telemedicine is health care services provided to a patient from a provider who is at a different location, including video chat and remote monitoring. We do not include email, exclusively web-based non-interactive resources, or online information a plan may make available unless a health professional provides information specific to the enrollee's condition. Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2018-2022; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2015-2017

Figure 13.4
Among Firms Offering Telemedicine Health Benefits, Structure of the Firm's Telemedicine Coverage, by Firm Size, 2022



NOTE: A specialized telemedicine service provider, may include organizations such as Teledoc, Doctor on Demand, or MDLIVE. Among firms offering health benefits, the plan with the largest enrollment at 87% of small firms (50-199 workers) and 96% of large firms (200 or more workers) cover telemedicine
SOURCE: KFF Employer Health Benefits Survey, 2022

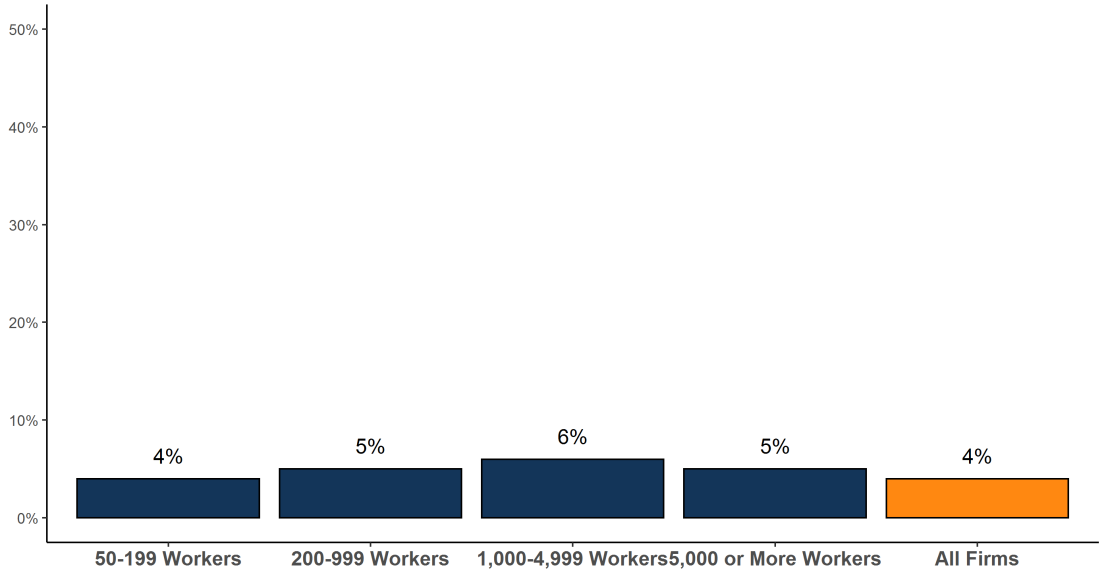
Figure 13.5
Among Large Firms Offering Telemedicine Health Benefits Through the Health Plan, How Reimbursment for Primary Care Compares Between Telehealth and In-Person Rates, 2022



* Estimates are statistically different from estimate for all other firms not in the indicated category within each firm size ($p < .05$).
NOTE: Large Firms have 200 or more workers. 65% of large firms offering telehealth benefits offer coverage through the health plan or plan adminstrator.
SOURCE: KFF Employer Health Benefits Survey, 2022

Figure 13.6

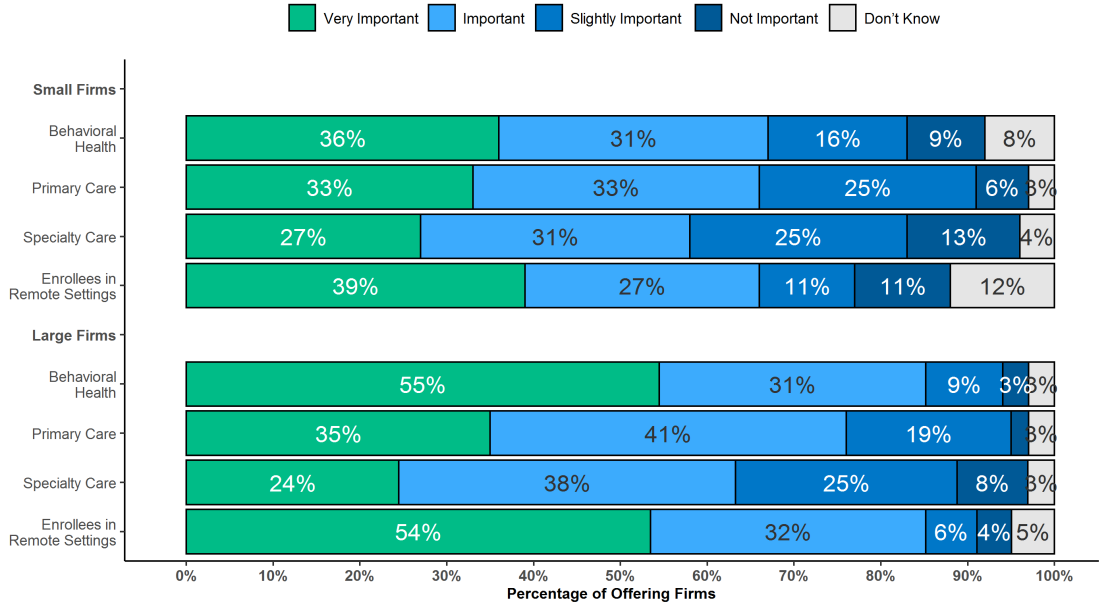
Among Firms Offering Telemedicine Health Benefits, Percentage of Firms Which Have Contracted With a New Telemedicine Service Provider in The Last 12 Months, 2022



Tests found no statistical difference from estimate for all other firms not in the indicated size category ($p < .05$).
NOTE: A specialized telemedicine service provider, may include organizations such as Teledoc, Doctor on Demand, or MDLIVE. Among firms offering health benefits, the plan with the largest enrollment at 87% of small firms (50-199 workers) and 96% of large firms (200 or more workers) cover telemedicine
SOURCE: KFF Employer Health Benefits Survey, 2022

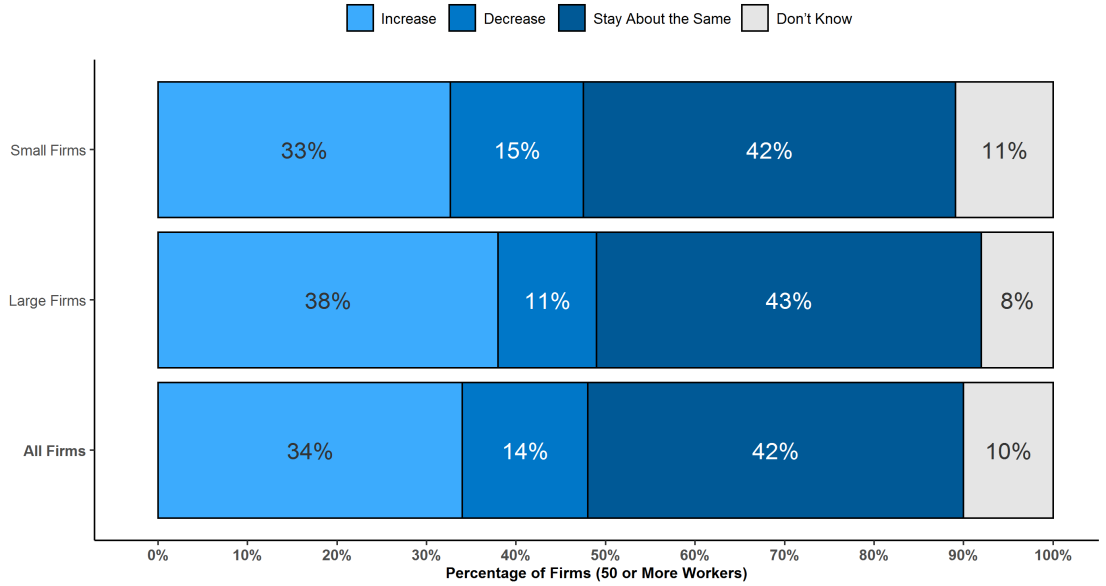
Figure 13.7

Among Firms Offering Health Benefits, How Important Will Telemedicine Be in Providing Access to Various Groups Going Forward, 2022



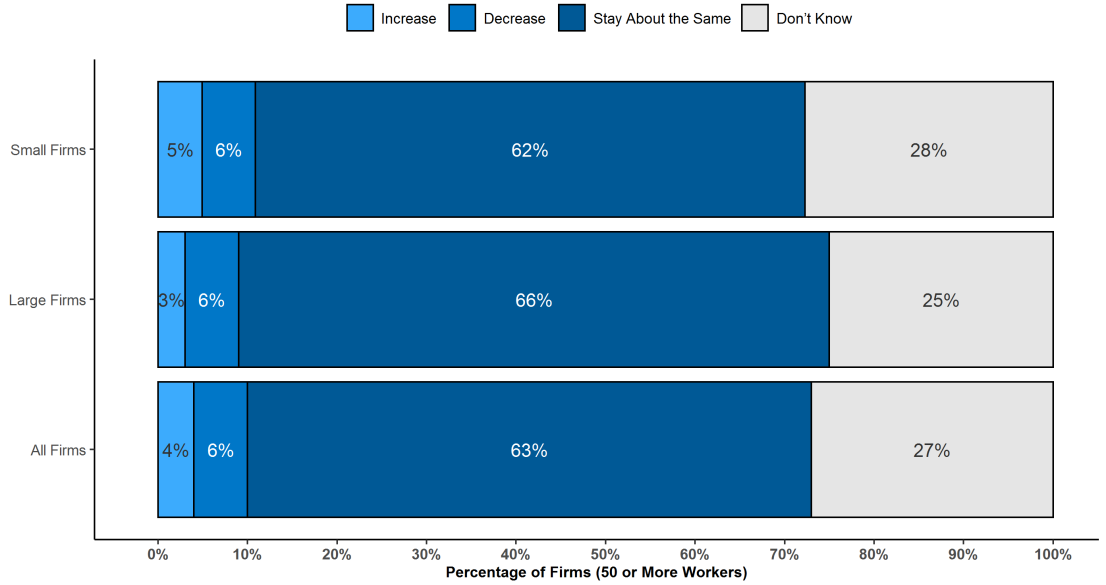
NOTE: Small Firms have 50-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2022

Figure 13.8
Among Firms Offering Telemedicine Health Benefits, How the Firm Expects Telehealth Use Will Compare to Last Year, 2022



Tests found no statistical difference from estimate for all other firms not in the indicated category within each firm size ($p < .05$).
NOTE: Among firms offering health benefits, the plan with the largest enrollment at 87% of small firms (50-199 workers) and 96% of large firms (200 or more workers) cover telemedicine Small Firms have 50-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2022

Figure 13.9
Among Firms Offering Telemedicine Health Benefits, As a Result of Telemedicine How Have the Firm's Costs Changed, 2022



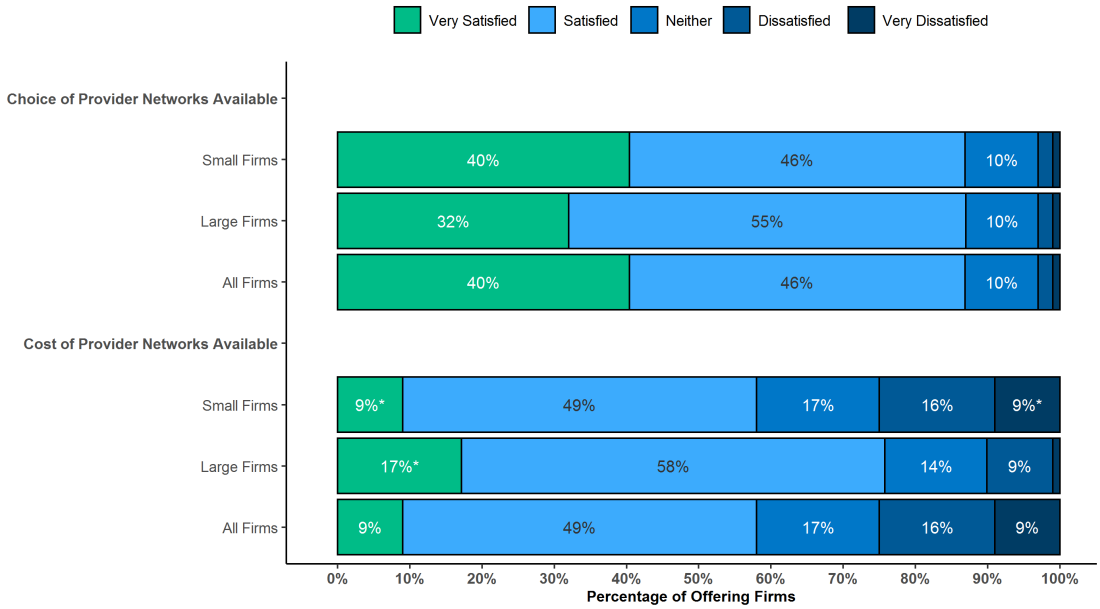
NOTE: Among firms offering health benefits, the plan with the largest enrollment at 87% of small firms (50-199 workers) and 96% of large firms (200 or more workers) cover telemedicine Small Firms have 50-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2022

FIRM APPROACHES TO PLAN NETWORKS

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

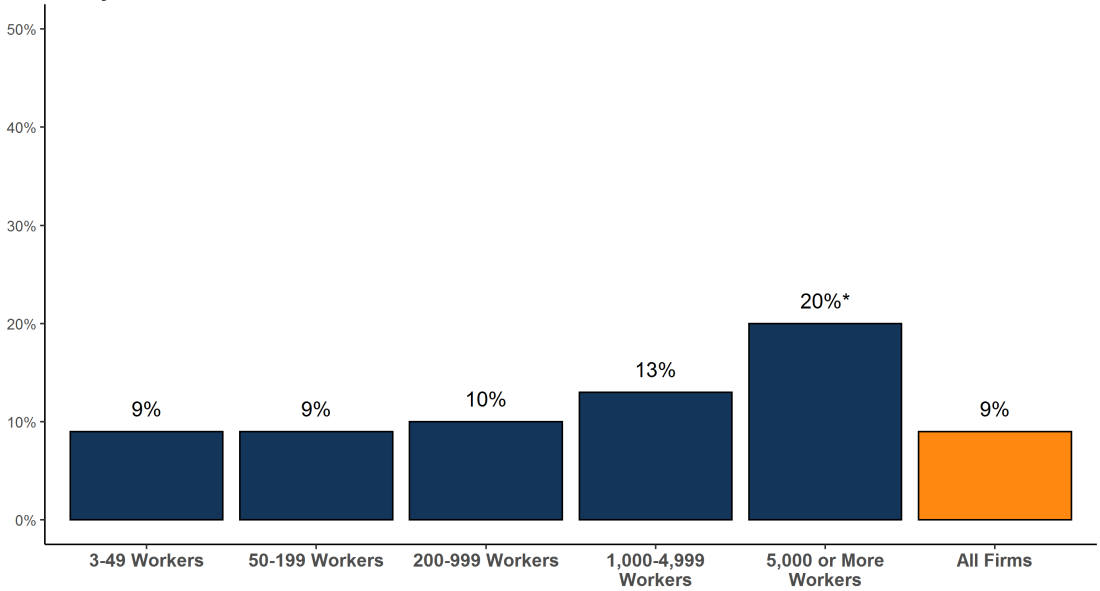
- Overall, employers report being satisfied with the choice of provider networks made available to them by their insurer or plan administrator.
  - Among firms offering health benefits, 40% report being "very satisfied" and 46% report being "satisfied" by the choice of provider networks available to them [Figure 13.10].
  - Employers are somewhat less satisfied with the cost of the provider networks available to them from their insurer or administrator. Among employers offering health benefits, only 9% of firms report being "very satisfied" while 49% report being "satisfied" with the cost of provider networks available to them. Large firms are more likely than small firms to be "very satisfied" with the cost of the provider networks available to them. Small firms are more likely than large firms to be "very dissatisfied" [Figure 13.10].
- Some employers offer a health plan with a relatively small, or narrow, network of providers to their employees. Narrow network plans limit the number of providers that can participate in order to reduce costs, and generally are more restrictive than standard HMO networks.
  - Nine percent of firms offering health benefits report that they offer at least one plan that they considered to be a narrow network plan, similar to the percentage reported in 2020 [Figure 13.12].
  - Firms with 5,000 or more workers offering health benefits are more likely than firms of other sizes to offer at least one plan with a narrow network (20%) [Figure 13.11].
- We asked employers offering health benefits to characterize the breadth of the provider network in their plan with the largest enrollment. Fifty percent of firms say that the network in the plan with the largest enrollment is "very broad," 37% say it is "somewhat broad," and 12% say it is 'somewhat narrow' [Figure 13.13].
  - Large firms are more likely than small firms to characterize the network in their largest health plan to be "very broad" (63% vs. 50%) [Figure 13.13].
- We also asked employers offering health benefits to characterize the breadth of the network for mental health and substance use services in their plan with the largest enrollment. Twenty percent of firms say that the network for mental health and substance use in the plan with the largest enrollment is "very broad," 51% say it is "somewhat broad," 21% say it is "somewhat narrow," and 8% say it is "very narrow" [Figure 13.13].
  - Large firms are more likely than small firms to characterize the network for mental health and substance use services in their largest health plan as "very broad" (30% vs. 19%) [Figure 13.13].
- We asked firms offering health benefits about whether they believed that the provider network for their health plan with the largest enrollment provided timely access to certain services.
  - Over four in five (82%) firms offering health benefits believe that there are a sufficient number primary care providers in the plan's networks to provide timely access to services for workers and their family members [Figure 13.15].
  - In contrast, only 44% of firms offering health benefits believe that there is a sufficient number of behavioral health providers in the plan's network to provide timely access to services for workers and their family members. Thirty-three percent of small firms and 18% of large firms do not know the answer to this question [Figure 13.15].

Figure 13.10
Among Firms Offering Health Benefits, Satisfaction with Provider Networks Available from Insurer or Third Party Administrator, by Firm Size, 2022



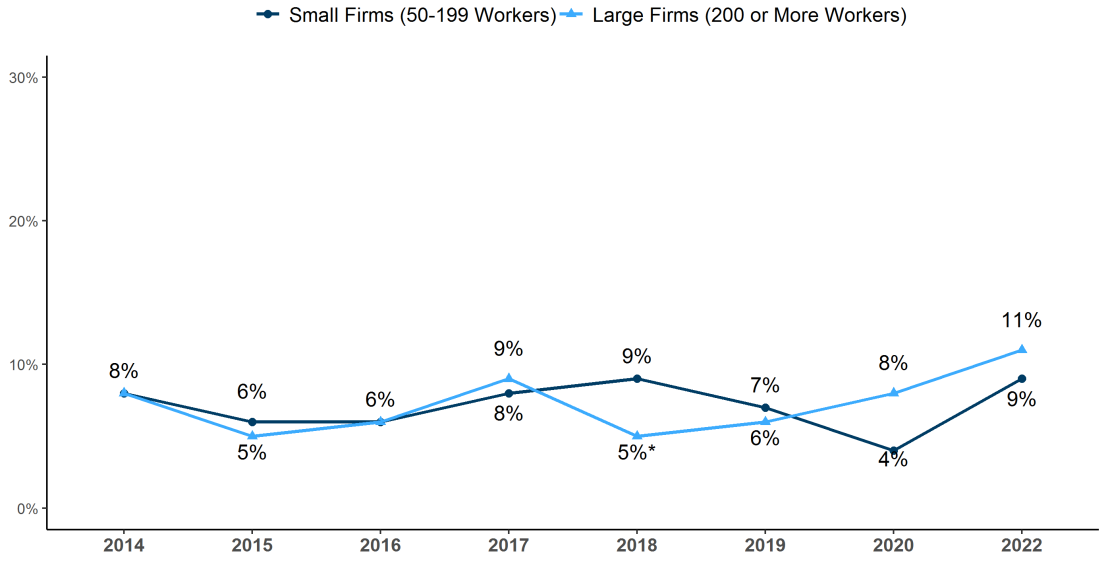
* Estimates are statistically different from estimate for all other firms not in the indicated category within each firm size ($p < .05$).
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2022

Figure 13.11
Among Firms Offering Health Benefits, Percentage of Firms That Offer a Narrow Network Plan, by Firm Size, 2022



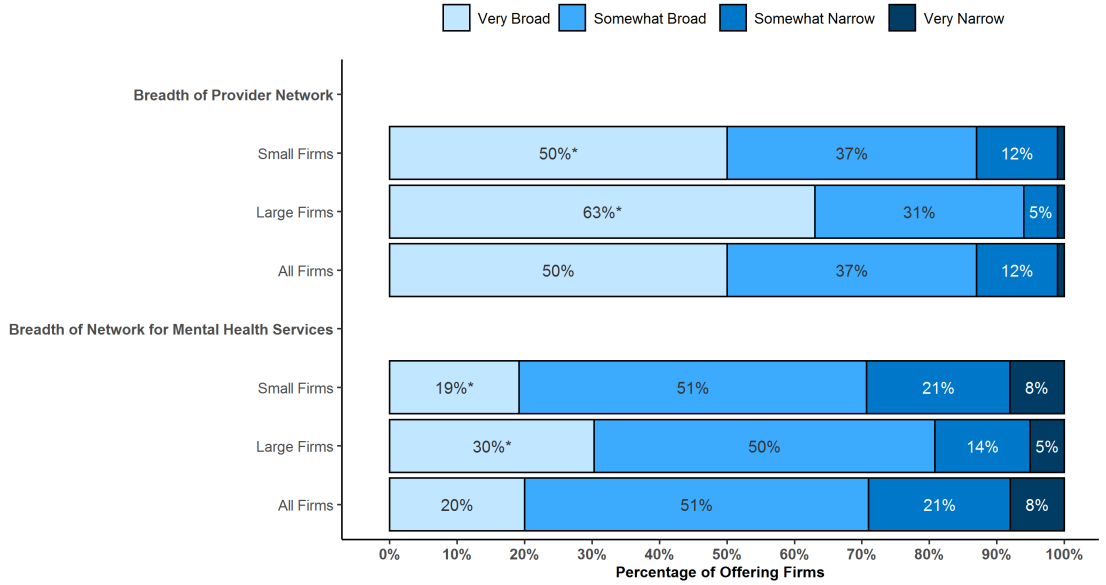
* Estimate is statistically different from estimate for all other firms not in the indicated size category ($p < .05$).
NOTE: Narrow network plans limit the number of providers that can participate in order to reduce costs and generally are more restrictive than standard HMO networks.
SOURCE: KFF Employer Health Benefits Survey, 2022

Figure 13.12
Among Firms with 50 or More Workers Offering Health Benefits, Percentage of Firms That Offer a Narrow Network Plan, by Firm Size, 2014-2022



* Estimate is statistically different from estimate for the previous year shown (p < .05).
NOTE: This question was asked of offering firms with 50 or more workers in 2014, but has since been asked of all offering firms regardless of firm size. In 2022, 9% of all offering firms offer a plan that could be considered a narrow network plan.Narrow network plans limit the number of providers that can participate in order to reduce costs and generally are more restrictive than standard HMO networks.
SOURCE: KFF Employer Health Benefits Survey, 2018-2022; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2014-2017

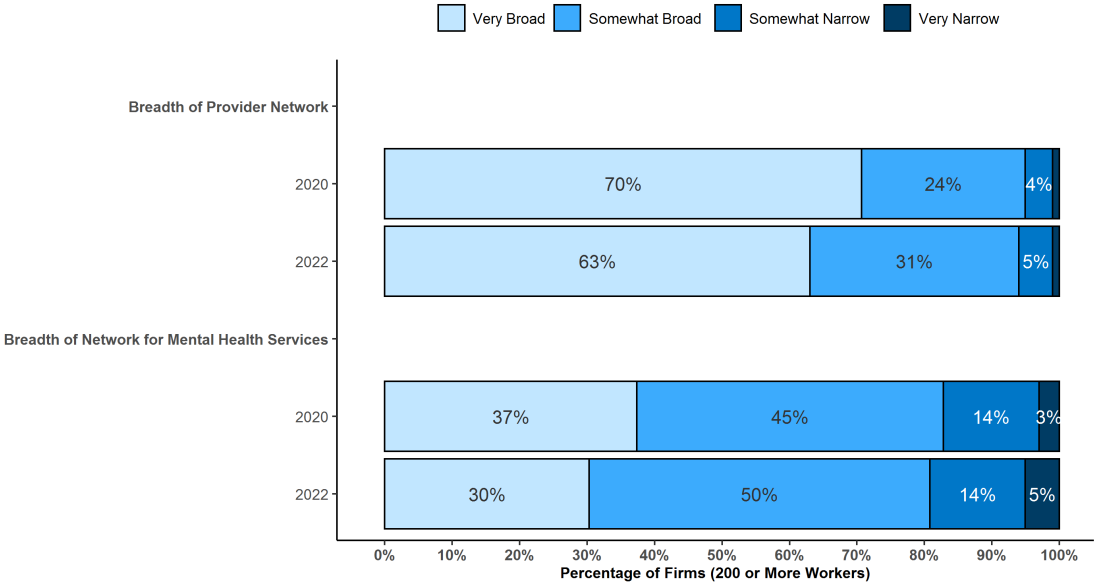
Figure 13.13
Among Firms Offering Health Benefits, How Broad the Firm Considers Their Largest Plan's Provider Network, by Firm Size, 2022



* Estimates are statistically different from estimate for all other firms not in the indicated category within each firm size (p < .05).
NOTE: A broad network includes most doctors and hospitals in the area, a narrow network is one which is limited to a small number of providers. Small Firms have 3-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2022

Figure 13.14

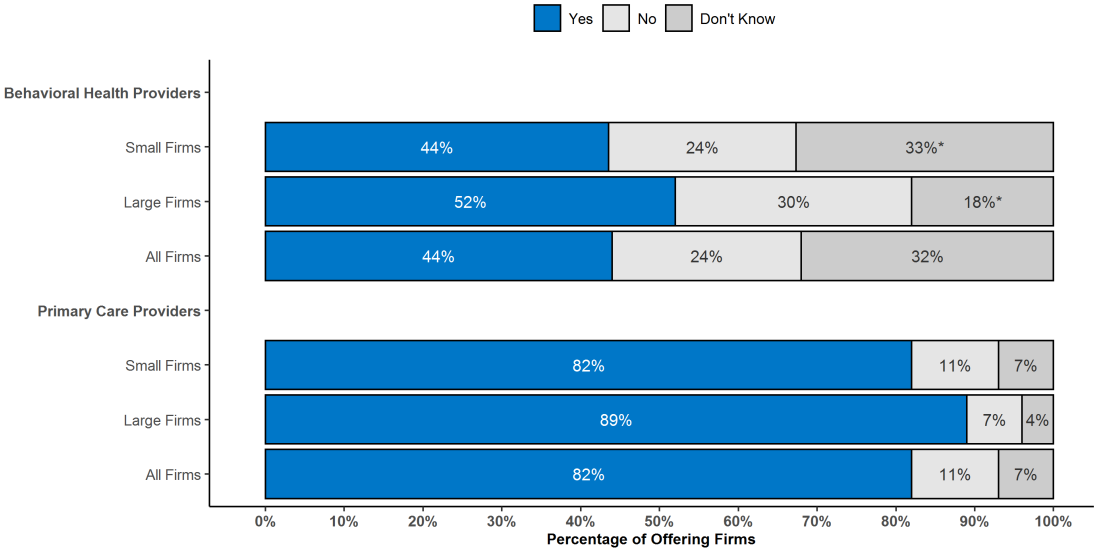
Among Large Firms Offering Health Benefits, How Broad the Firm Considers Their Largest Plan's Provider Network, by Firm Size, 2020-2022



NOTE: A broad network includes most doctors and hospitals in the area, a narrow network is one which is limited to a small number of providers. Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2022

Figure 13.15

Among Firms Offering Health Benefits, Percentage of Firms Which Believe That There Are a Sufficient Number of Providers in Their Plan's Networks To Provide Timely Access to Services, by Firm Size, 2022



* Estimates are statistically different from estimate for all other firms not in the indicated category within each firm size ($p < .05$).
NOTE: Firms with multiple plans were asked about their plan with the largest enrollment Small Firms have 3-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2022

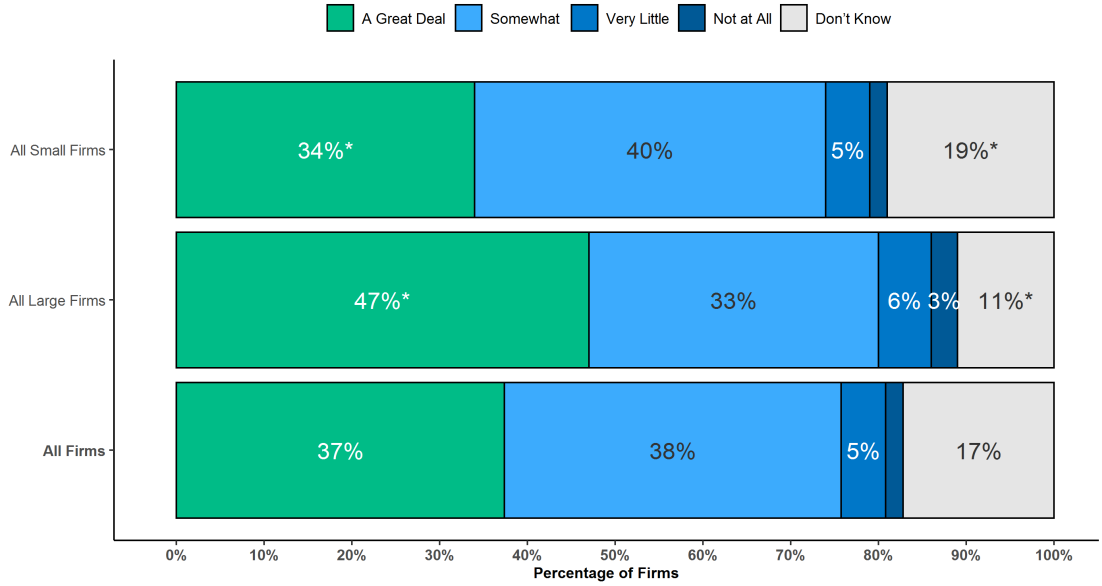
MENTAL AND BEHAVIORAL HEALTH

Access to mental and behavioral health services has been an issue for employers and policymakers for a number of years. The COVID-19 pandemic, with the accompanying social and economic disruptions, focused even more attention this topic. In the 2021 survey, we documented steps that employers and health plans were taking to improve access and meet the increased demand for these services. This year we asked employers about the demand for and use of these services, and whether they took further steps to expand access in 2022. The issue of network adequacy for mental and behavioral health services is addressed in the next section.

- Among firms with 50 or more workers offering health benefits, 22% of small firms and 48% of large firms say that the percentage of employees receiving mental health services increased in the last year. Large shares of small firms (48%) and large firms (38%) responded "Don't Know" to this question [Figure 13.17].
- Among firms with 50 or more workers offering health benefits, 6% of small firms and 14% of large firms say that the percentage of employees receiving services for substance use conditions increased in the last year. As with the question about mental health services, large shares of small firms (49%) and large firms (52%) responded "Don't Know" to this question [Figure 13.17].
- Among firms with 50 or more workers offering health benefits, 13% of small firms and 29% of large firms say that the percentage of employees requesting FMLA leave for mental health conditions increased in the last year [Figure 13.18].
- We asked all firms offering health benefits whether they were concerned with the growth of substance use conditions among their employees since the beginning of the COVID-19 pandemic. A relatively small share of firms say that they are concerned "a great deal" about the growth of substance conditions (2%), 14% say that they are "somewhat" concerned, 35% say that they are concerned "a very little," and 40% say that they are "not at all" concerned [Figure 13.19].
  - Large firms are more likely than small firms to say that they are concerned "a great deal" (7% vs. 2%) or "somewhat" concerned (36% vs. 13%) [Figure 13.19].
  - Small firms are more likely than large firms to say that they are "not at all" concerned (41% vs. 16%) [Figure 13.19].
- We asked firms with 50 or more workers offering health benefits if they had taken steps to expand the availability of mental health services.
  - Ten percent of small firms and 22% of large firms, including 33% of firms with 1,000 or more workers, say they expanded the availability of mental health services by adding new virtual providers [Figure 13.20].
  - Seven percent of small firms and 14% of large firms say they expanded the availability of mental health services by adding new providers or facilities for in-person care [Figure 13.20].
- Among large firms (200 or more workers) offering health benefits, 4% say that they have taken actions to reduce coverage for out-of-network mental health or substance use services, due to concerns about cost or quality of these services [Figure 13.21].
- Among large firms (200 or more workers) offering health benefits, 15% say that their health plan with the highest enrollment has a center of excellence or high-performance network for substance use or mental health services. Thirty-eight percent of these firms did not know the answer to this question [Figure 13.22].
- Among large firms (200 or more workers) offering health benefits, 44% offer employees mental health self-care applications, such as resources to guide meditation or manage stress, separate from those available through the health plan [Figure 13.23].
- Among large firms (200 or more workers) offering health benefits, a large share (81%) offer employee assistance programs, separate from those available through the health plan, for mental health [Figure 13.24].

Figure 13.16

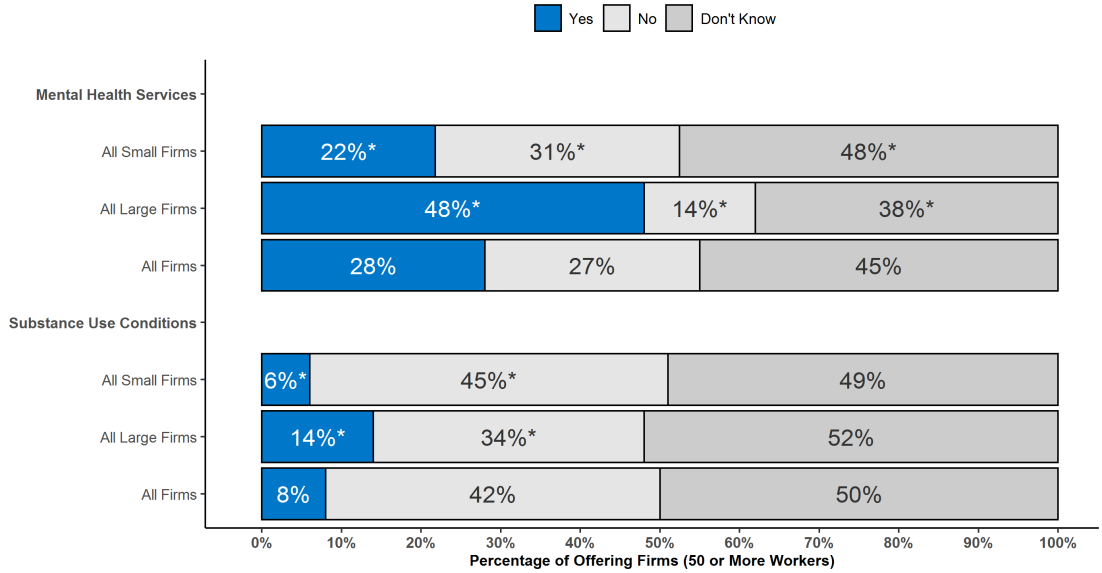
Among Firms Offering Health Benefits, How Important Firm Believe Telemedicine is in Providing Access to Mental Health Services, by Firm Size, 2022



* Estimates are statistically different from estimate for all other firms not in the indicated category within each firm size (p < .05).
NOTE: A broad network includes most doctors and hospitals in the area, a narrow network is one which is limited to a small number of providers. Small Firms have 50-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2022

Figure 13.17

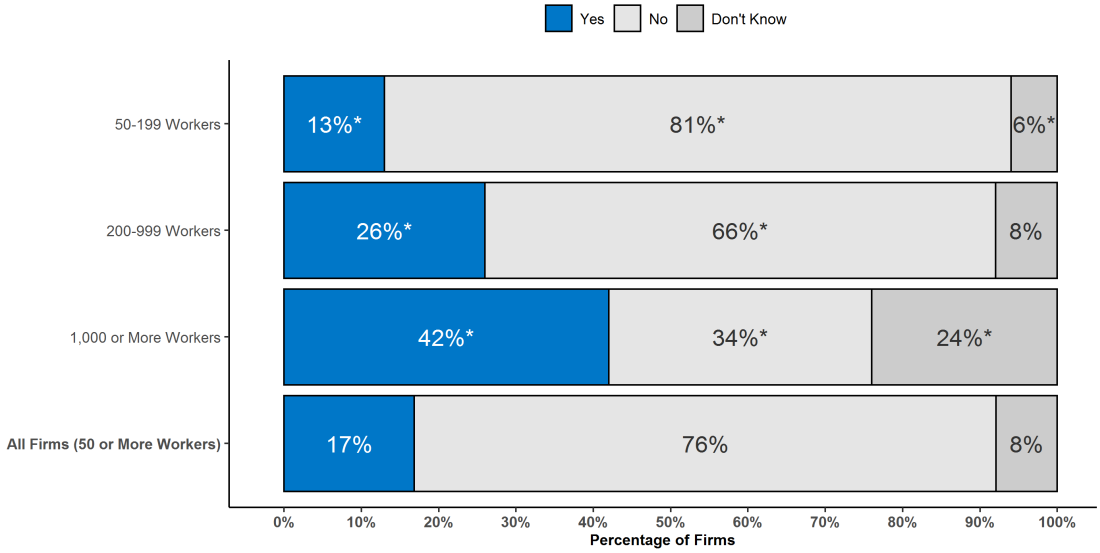
Among Firms Offering Health Benefits, Percentage of Firms Which Have Seen an Increase in Employees Seeking Mental Health and Substance Use Services in the Past Year, by Firm Size, 2022



* Estimates are statistically different from estimate for all other firms not in the indicated category within each firm size (p < .05).
NOTE: Small Firms have 50-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2022

Figure 13.18

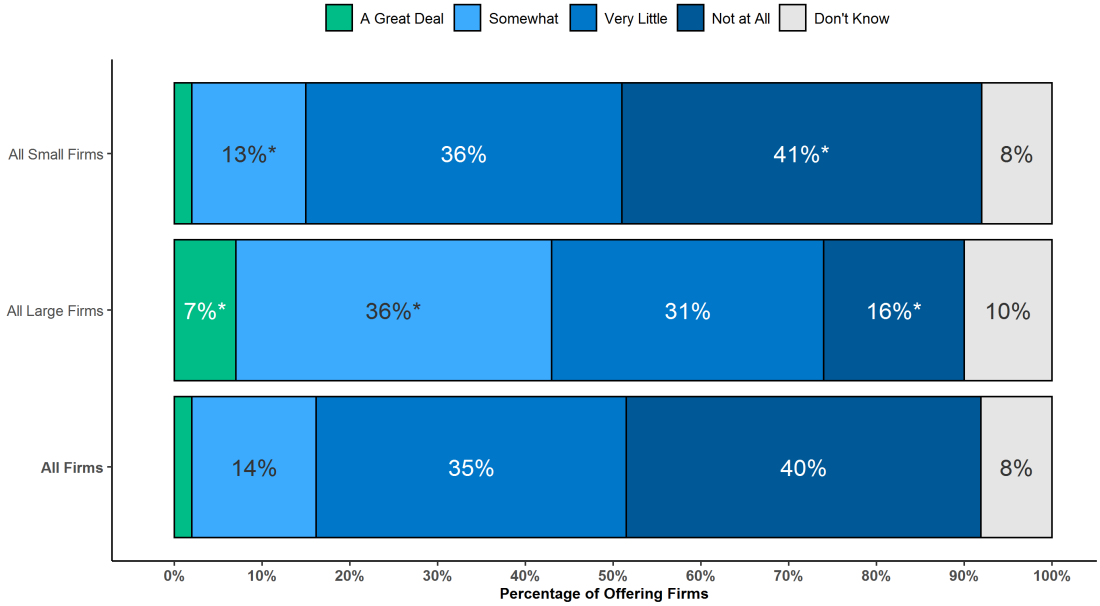
Among Firms Offering Health Benefits, Percentage of Firms Which Have Seen an Increase in the Percentage of Employees Requesting FMLA leave for Mental Health Conditions, by Firm Size, 2022



* 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 FMLA leave mental health (eight percent) in the past year.
SOURCE: KFF Employer Health Benefits Survey, 2022

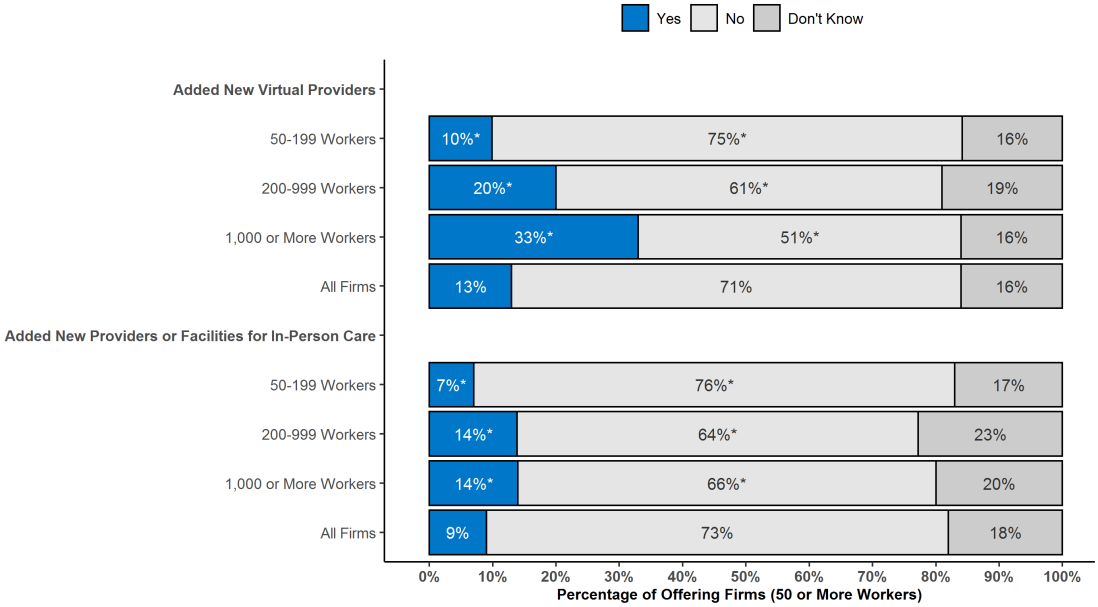
Figure 13.19

Among Firms Offering Health Benefits, How Concerned is Firm with the Growth of Substance Use Conditions Among Employees, by Firm Size, 2022



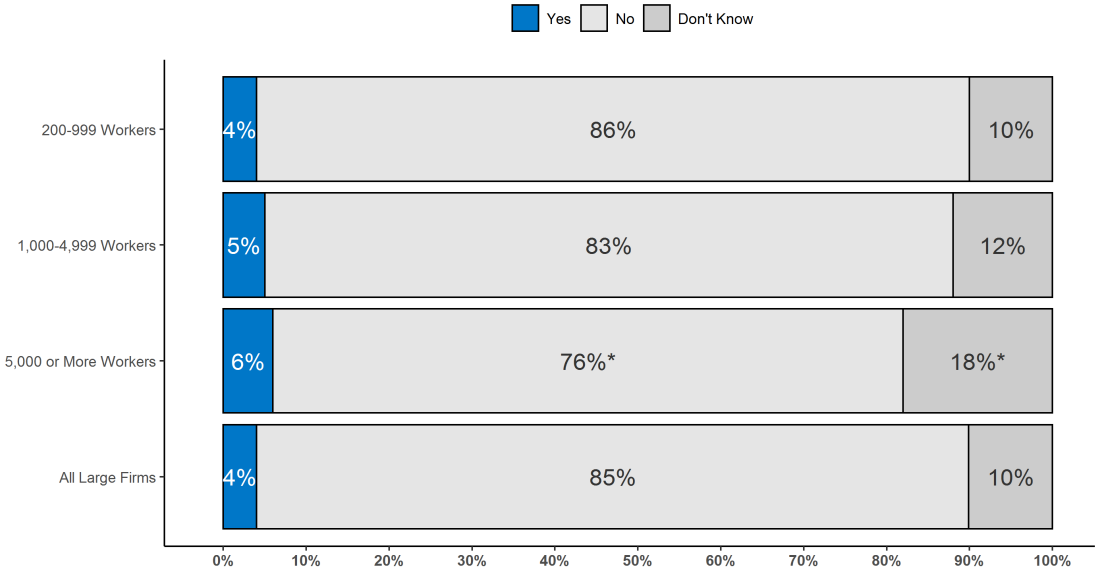
* Estimates are statistically different from estimate for all other firms not in the indicated category within each firm size ($p < .05$).
NOTE: Respondents were asked to consider changes since January 2020.
SOURCE: KFF Employer Health Benefits Survey, 2022

Figure 13.20
Among Firms Offering Health Benefits, Percentage of Firms Which Expanded the Availability of Mental Health Services, by Firm Size, 2022



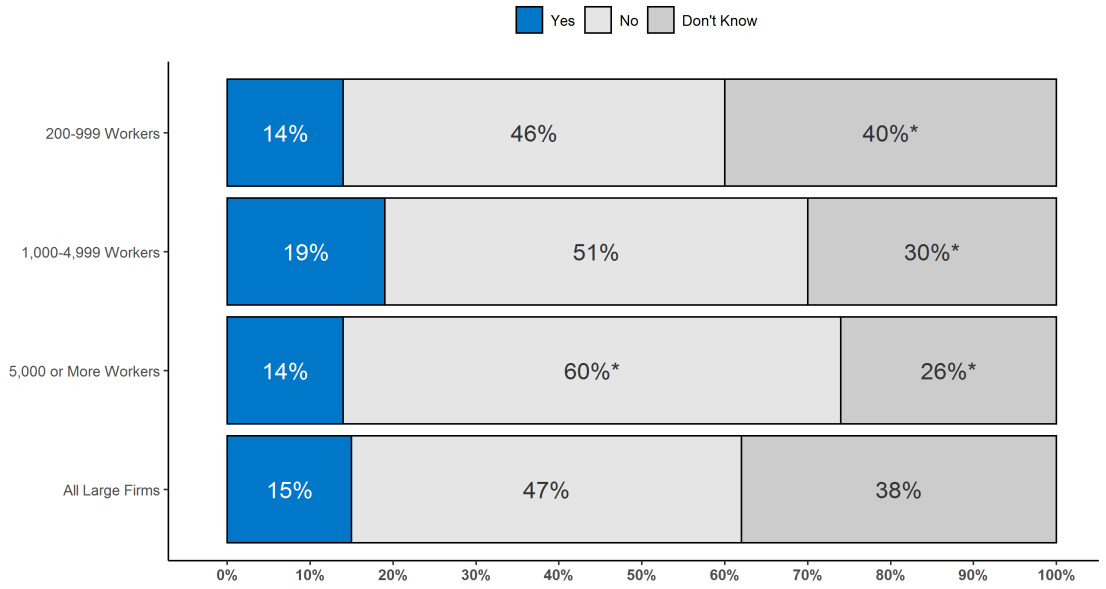
* Estimates are statistically different from estimate for all other firms not in the indicated category within each firm size ($p < .05$).
NOTE: Small Firms have 50-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2022

Figure 13.21
Among Large Firms Offering Health Benefits, Percentage of Firms Which Have Taken Actions to Reduce Coverage for Out-of-Network Mental Health or Substance Use Services Due to Concerns About Cost or Quality of These Services, 2022



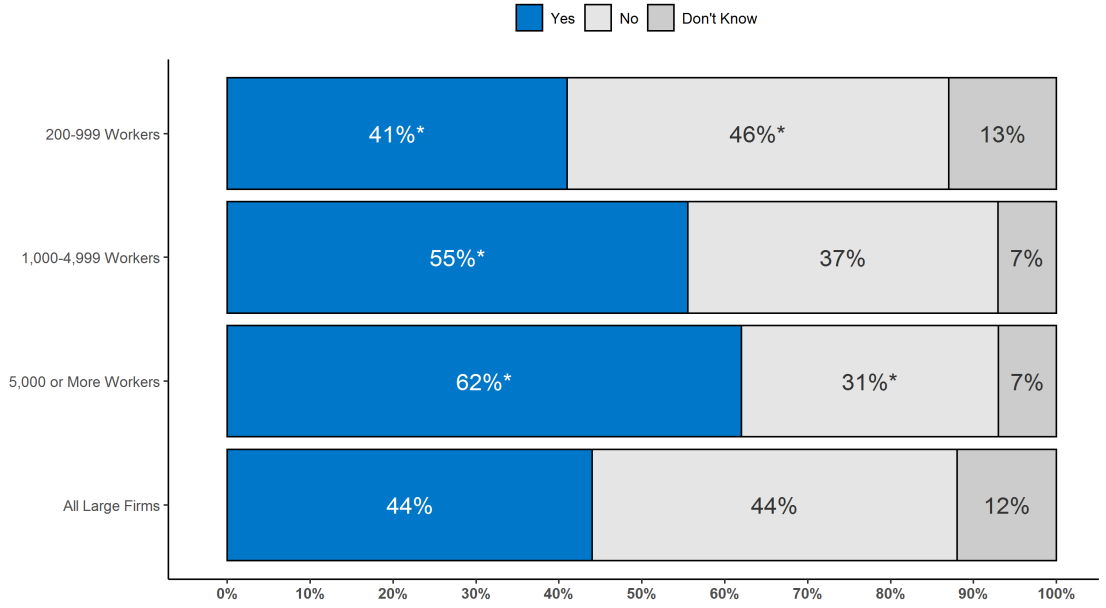
* Estimate is statistically different from estimate for all other firms not in the indicated size category ($p < .05$).
NOTE: Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2022

Figure 13.22
Among Large Firms Offering Health Benefits, Percentage of Firms Which Have a Center of Excellence or High-Performance Network for Substance Use or Mental Health Services, 2022



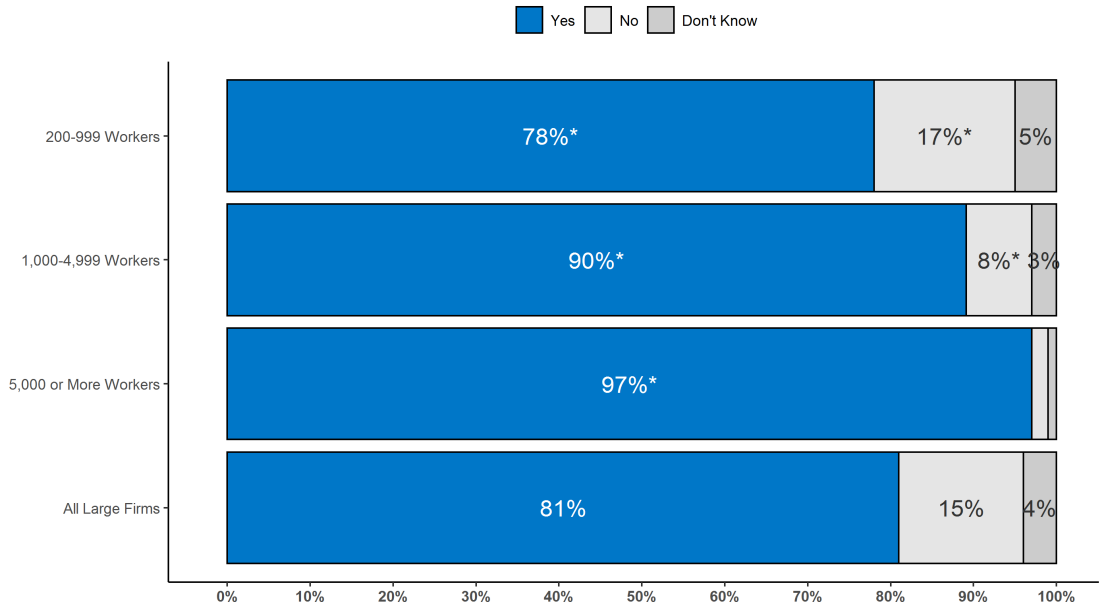
* Estimate is statistically different from estimate for all other firms not in the indicated size category ($p < .05$).
NOTE: Large Firms have 200 or more workers. Firms with multiple plans were asked about their plan with the largest enrollment A high-performance network groups providers within the network based on quality, cost, and/or the efficiency of care they deliver.
SOURCE: KFF Employer Health Benefits Survey, 2022

Figure 13.23
Among Large Firms Offering Health Benefits, Percentage of Firms Which Offer Mental Health Self-Care Apps, 2022



* 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. Apps may include resources to guide meditation or manage stress
SOURCE: KFF Employer Health Benefits Survey, 2022

Figure 13.24
Among Large Firms Offering Health Benefits, Percentage of Firms Which Offer An EAP for Mental Health Services, 2022



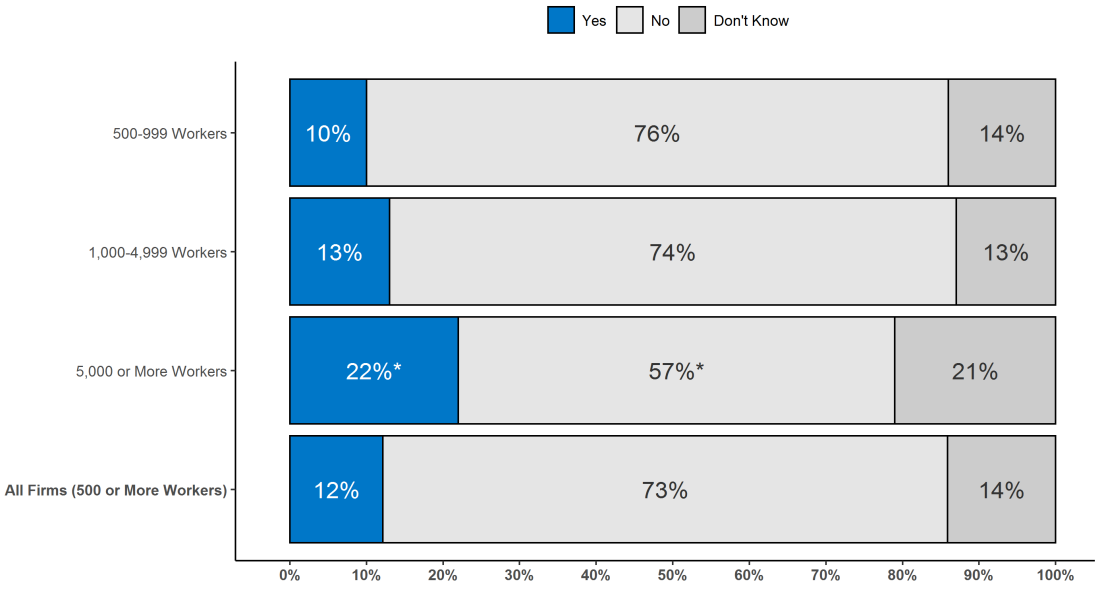
* Estimate is statistically different from estimate for all other firms not in the indicated size category ($p < .05$).
NOTE: Large Firms have 200 or more workers. EAP refers to Employee Assistance Programs.
SOURCE: KFF Employer Health Benefits Survey, 2022

STATE ALL-PAYER CLAIMS DATABASES

Some states have databases that collect medical claims and eligibility information from public and private health plans. The information in these databases can be used to study state and local health care markets and to compare the cost and performance of providers and payers. We asked firms with 500 or more workers about their awareness of these efforts and their participation.

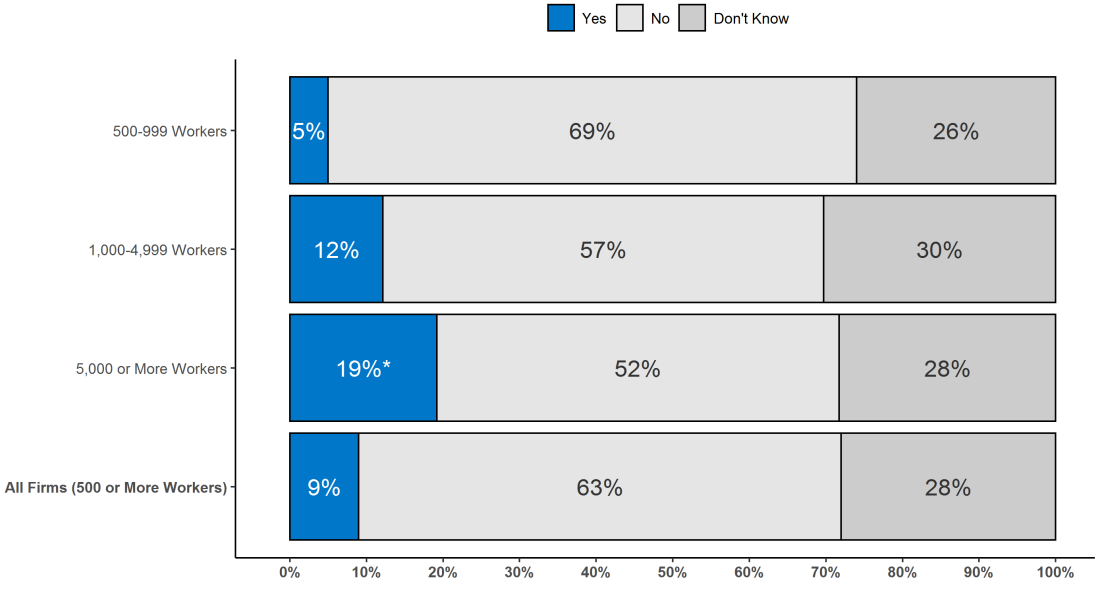
- Among firms with 500 or more workers that currently offer health benefits, 12% say that they are aware of state all-payer claims databases. Firms with 5,000 or more workers are more likely to be aware of them [Figure 13.25].
- Among firms with 500 or more workers that currently offer health benefits, 9% contribute information to at least one state all-payer claims databases. Firms with 5,000 or more workers are more likely than other large firms to contribute information to a state all-payer claims database and firms with 500 to 999 workers are less likely to do so [Figure 13.26].
- We asked firms with 500 or more workers that currently offer health benefits how valuable they consider these databases for employers, the public, and policymakers. Among these employers, 14% say they have "a great deal" of value, 37% say that they are "somewhat" valuable, 10% say they have "very little" value, 3% say that they are "not at all" valuable, and 35% responded "don't know" [Figure 13.27].

Figure 13.25
Among Large Firms (500 or More Workers) Offering Health Benefits, Percentage of Firms Which Are Aware of Any All-Payer Claims Databases, 2022



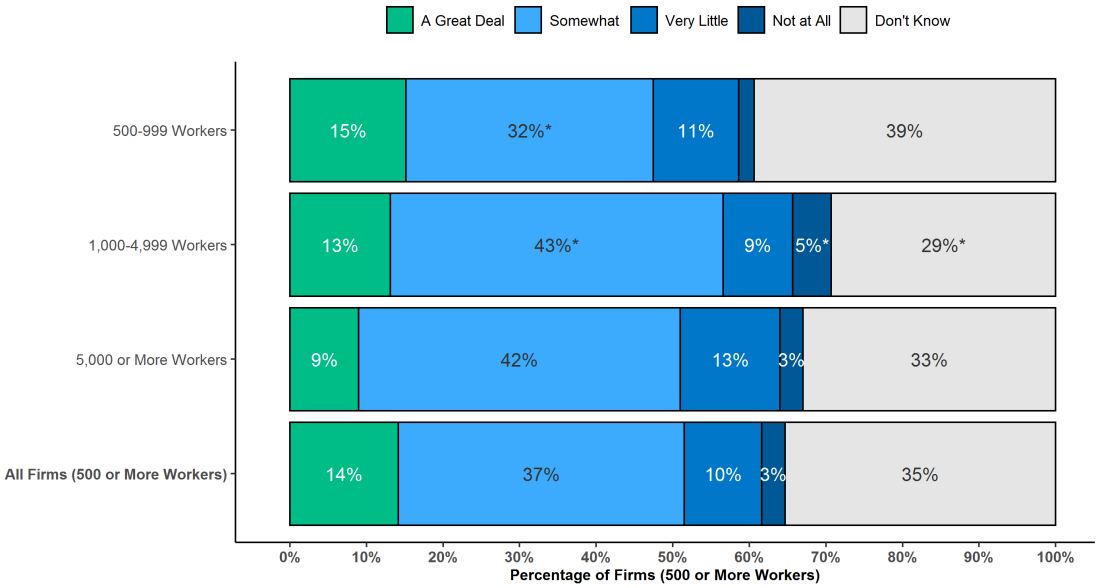
* Estimates are statistically different from estimate for all other firms not in the indicated category within each firm size (p < .05).
NOTE: All-payer claims databases combine information on medical claims, and eligibility from private and public payers. These datasets are run by state governments, with data submitted from insurers and third party administrators.
SOURCE: KFF Employer Health Benefits Survey, 2022

Figure 13.26
Among Large Firms (500 or More Workers) Aware of An APCD, Percentage of Firms Which Contribute Information to a State All-Payer Claims Databases, 2022



* Estimates are statistically different from estimate for all other firms not in the indicated category within each firm size (p < .05).
NOTE: All-payer claims databases combine information on medical claims, and eligibility from private and public payers. These datasets are run by state governments, with data submitted from insurers and third party administrators.
SOURCE: KFF Employer Health Benefits Survey, 2022

Figure 13.27
Among Large Firms (500 or More Workers), How Valuable Do Firms Consider All-Payer Claims Databases for Employers, The Public and Policymaker, 2022



* Estimates are statistically different from estimate for all other firms not in the indicated category within each firm size ($p < .05$).
NOTE: All-payer claims databases combine information on medical claims, and eligibility from private and public payers. These datasets are run by state governments, with data submitted from insurers and third party administrators.
SOURCE: KFF Employer Health Benefits Survey, 2022

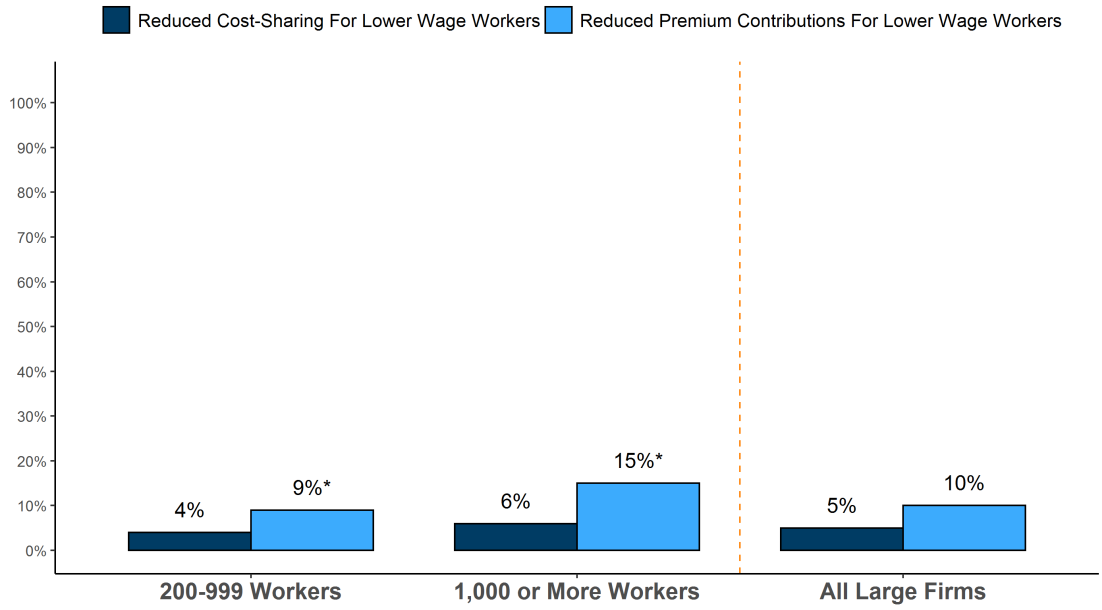
ASSISTANCE FOR LOWER-WAGE WORKERS

Some employers provide assistance to their lower-wage employees to help them with the costs of participating in their health plans. We asked large firms whether they provided assistance to help lower-wage workers with contributions or cost sharing.

- Ten percent of large firms offering health benefits have a program to lower the premium contributions of lower-wage workers, similar to the percentage (11%) in 2018 [Figure 13.28].
  - Firms with 1,000 or more workers are more likely to have a program to lower premium contributions for lower-wage workers than other large firms, while firms with 200 to 999 workers are less likely to do so [Figure 13.28].
- Five percent of large firms offering health benefits have a program to lower the cost sharing of lower-wage workers, similar to the percentage (6%) in 2020 [Figure 13.28].

Figure 13.28

Among Large Firms Offering Health Benefits, Percentage of Firms Which Have Programs to Help Lower Wage Workers Pay for Health Expenses, 2022



* Estimate is statistically different from estimate for all other firms not in the indicated size category ($p < .05$).
NOTE: This could include help paying deductibles or copayments for eligible workers.
SOURCE: KFF Employer Health Benefits Survey, 2022

KFF

Headquarters and Conference Center
185 Berry Street, Suite 2000
San Francisco, CA 94107
650-854-9400

Washington Offices and Conference Center
1330 G Street, NW
Washington, DC 20005
202-347-5270

This publication is available at kff.org.

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

October 2022