KFF

Employer Health Benefits

2024

Annual Survey

KFF

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Introduction

This is the 26th annual Employer Health Benefits 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, abortion coverage, family building benefits, coverage for GLP-1 agonists as well as programs for lower-wage workers. The 2024 survey includes 2,142 interviews with non-federal public and private firms.

Annual premiums for employer-sponsored family health coverage reached $25,572 this year, 7% higher. On average, workers contributed $6,296 toward the cost of family coverage. The average deductible among covered workers in a plan with a general annual deductible is $1,787 for single coverage. Fifty-three percent of small firms and 98% of large firms offer health benefits to at least some of their workers, with an overall offer rate of 54%.

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 154 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 26th Employer Health Benefits Survey (EHBS) and reflects employer-sponsored health benefits in 2024.

HEALTH INSURANCE PREMIUMS AND WORKER CONTRIBUTIONS

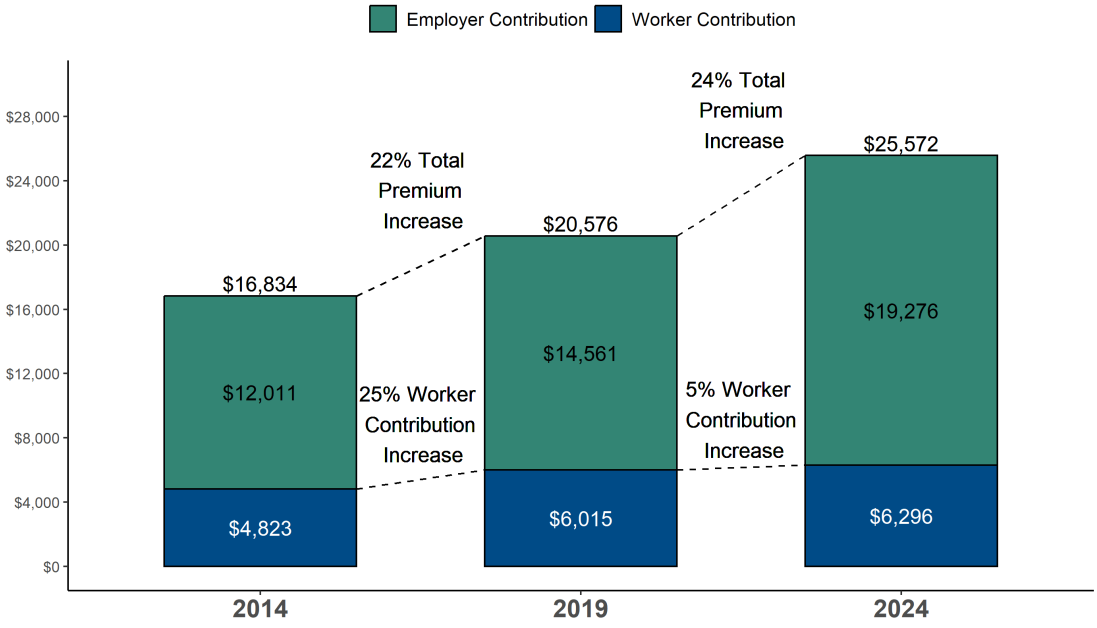
The average annual premiums for employer-sponsored health insurance in 2024 are $8,951 for single coverage and $25,572 for family coverage. Over the last year, the average single premium increased by 6% and the average family premium increased by 7%. Comparatively, there was an increase of 4.5% in workers' wages and inflation of 3.2%[2]. Over the last five years, the average premium for family coverage has increased by 24%, compared to a 28% increase in workers' wages and inflation of 23% [Figure A, Figure B].

The average premiums for small and large firms are comparable for covered workers with single coverage ($9,131 vs. $8,884) and family coverage ($25,167 vs. $25,719). 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 both single coverage ($8,275) and family coverage ($24,196) [Figure C]. On the other hand, average premiums for covered workers enrolled in PPOs are higher than the overall average premiums for both single ($9,383) and family coverage ($26,678). The average premiums for both single and family coverage are lower for covered workers at private for-profit firms and higher for covered workers in private not-for-profit firms. The average premiums for single coverage for covered workers at firms with a larger 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 at firms with smaller shares of older workers ($9,171 vs. $8,738).

[1] KFF. Health Insurance Coverage of the Nonelderly [Internet]. San Francisco (CA): KFF; 2023 [cited 2024 September 9]. Available from: https://www.kff.org/other/state-indicator/nonelderly-0-64/.

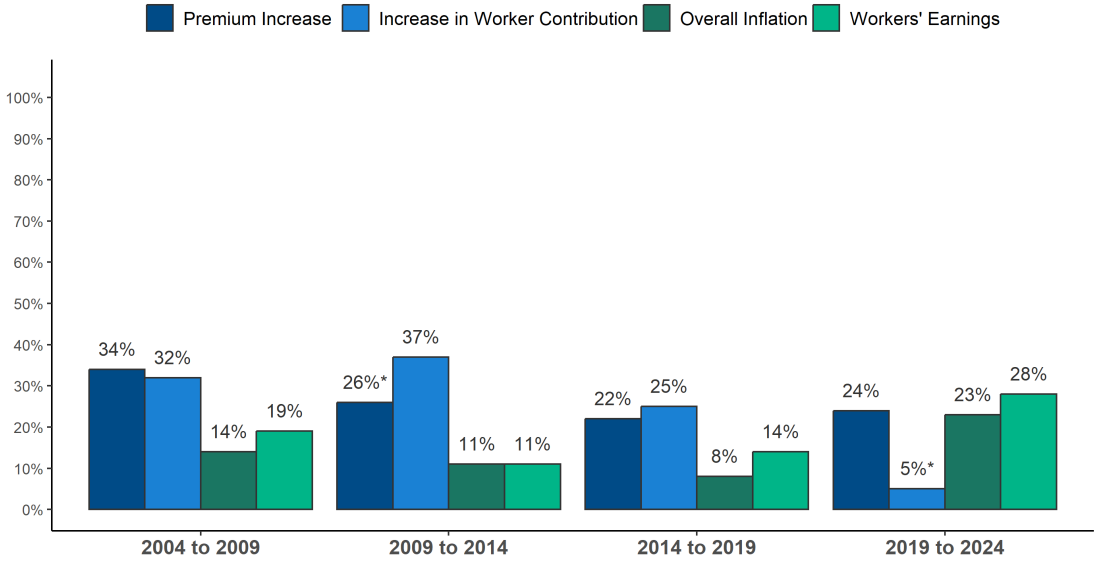
[2] Bureau of Labor Statistics. Consumer Price Index for All Urban Consumers (CPI-U) [Internet]. Washington (DC): BLS; [cited 2024 Jul 17]. Available from: https://www.bls.gov/regions/mid-atlantic/data/consumerpriceindexhistorical1967base_us_table.htm Average hourly earnings of production and nonsupervisory employees (seasonally adjusted) from the Current Employment Statistics Survey. Bureau of Labor Statistics. Current Employment Statistics—CES (National) [Internet]. Washington (DC): BLS; [cited 2024 Jul 17]. Available from: https://www.bls.gov/ces/data/

Figure A
Average Annual Worker and Employer Premium Contributions for Family Coverage, 2014, 2019, and 2024



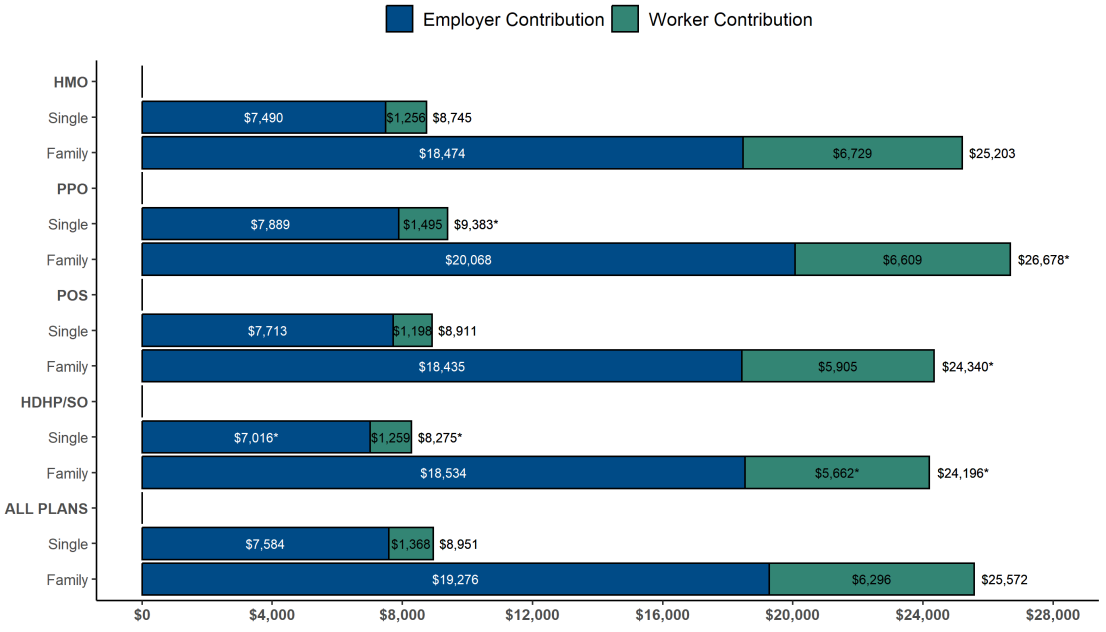
SOURCE: KFF Employer Health Benefits Survey, 2019 and 2024; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2014.

Figure B
Cumulative Premium Increases, Inflation, and Earnings for Covered Workers with Family Coverage, 2004-2024



* Estimate is statistically different from previous five year period shown ($p < .05$). Workers' earnings and inflation are not tested for significance.
SOURCE: KFF Employer Health Benefits Survey, 2018-2024; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2004-2017. Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation, 2004-2024; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 2004-2024.

Figure C
Average Annual Worker and Employer Premium Contributions for Single and Family Coverage, by Plan Type, 2024



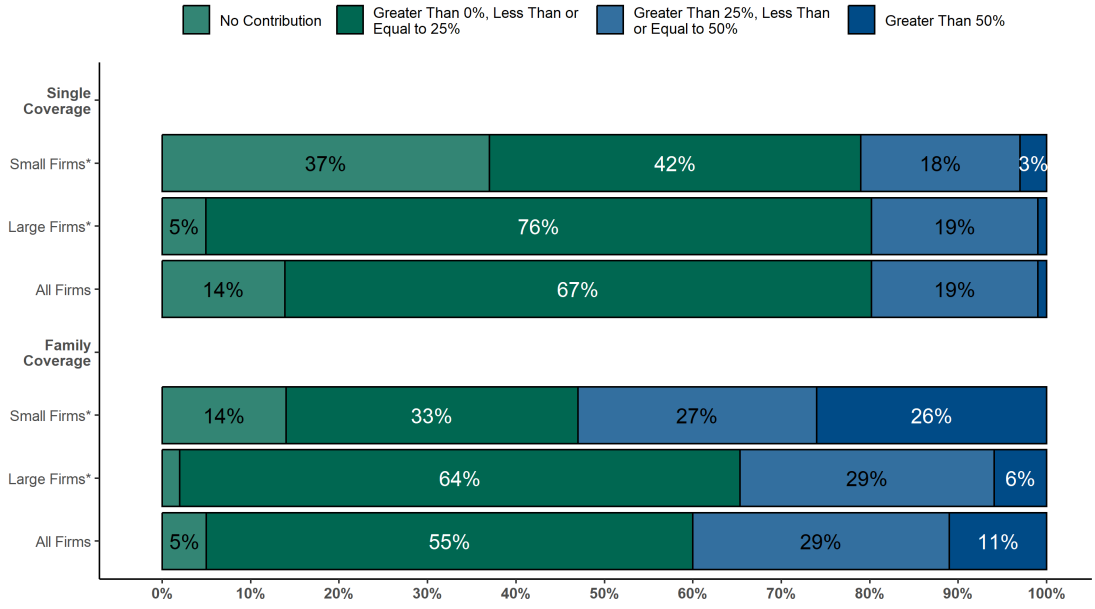
* Estimate is statistically different from All Plans estimate within coverage type (single or family) ($p < .05$).
SOURCE: KFF Employer Health Benefits Survey, 2024

Most covered workers contribute to the cost of the premium. On average, covered workers contribute 16% of the premium for single coverage and 25% of the premium for family coverage, lower than the percentages contributed in 2023. The average contribution rate for covered workers in small firms is lower than the average contribution rate for covered workers in large firms for single coverage (14% vs.16%) but higher than the average contribution rate for covered workers in large firms for family coverage (33% vs. 23%). On average, covered workers at private, for-profit firms have relatively high premium contribution rates for both single coverage and family coverage.

Thirty-seven 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 5% of covered workers at large firms. In contrast, 26% 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 6% of covered workers at large firms [Figure D].

The average annual dollar amounts contributed by covered workers in 2024 are $1,368 for single coverage and $6,296 for family coverage, similar to the amounts last year. The average contribution amount for covered workers at small firms ($1,204) is lower than the average contribution amount for covered workers at large firms ($1,429). However, the opposite is true for family coverage, where the average contribution amount for covered workers at small firms ($7,947) is higher than the amount at large firms ($5,697). Eight 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, 2024

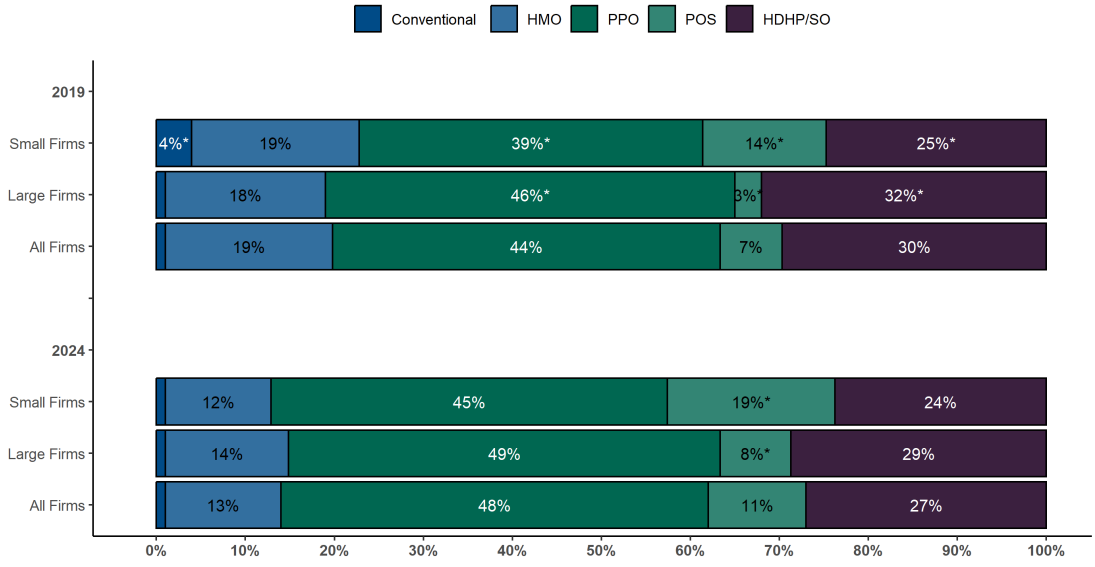


* Distributions are statistically different between Small Firms and Large Firms within coverage type ($p < 0.05$).
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2024

PLAN ENROLLMENT

PPOs remain the most common plan type. In 2024, 48% of covered workers are enrolled in a PPO, 27% in a high-deductible plan with a savings option (HDHP/SO), 13% in an HMO, 11% in a POS plan, and 1% in a conventional (also known as an indemnity) plan [Figure E]. This distribution of covered workers across plan types is similar to the distributions of covered workers by plan type in recent years.

Figure E
Distribution of Health Plan Enrollment for Covered Workers, by Plan Type and Firm Size, 2019 and 2024



* 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, 2019-2024;

SELF FUNDING

Many firms - particularly larger firms - have self-funded health plans, which means that they pay for the health services for their workers directly from their own funds rather than through the purchase of health insurance. Sixty-three percent of covered workers, including 20% of covered workers at small firms and 79% at large firms are enrolled in plans that are self-funded. The percentage of covered workers in self-funded plans in 2024 is similar to last year.

Thirty-six percent of covered workers in small firms offering health benefits are covered by a level-funded plan, similar to the percentage in 2023. 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

Eighty-seven percent of workers with single coverage have a general annual deductible that must be met before most services are paid for by the plan, similar to the percentage last year (90%).

The average deductible amount in 2024 for workers with single coverage and a general annual deductible is $1,787, similar to last year. The average deductible is higher for covered workers at small firms ($2,575) than at large firms ($1,538). Among workers with single coverage and an annual deductible, the average amount is similar to the deductible amount five years ago ($1,655) but is 47% higher than the amount ten years ago.

In 2024, 32% of covered workers are in a plan with a general annual deductible of $2,000 or more for single coverage, similar to the percentage (31%) last year. Covered workers in small firms are more likely than those in large firms to be in such a plan (50% vs. 26%). The percentage of covered workers with a general annual deductible of $2,000 or more for single coverage has grown over the last ten years, from 18% to 32% [Figure F].

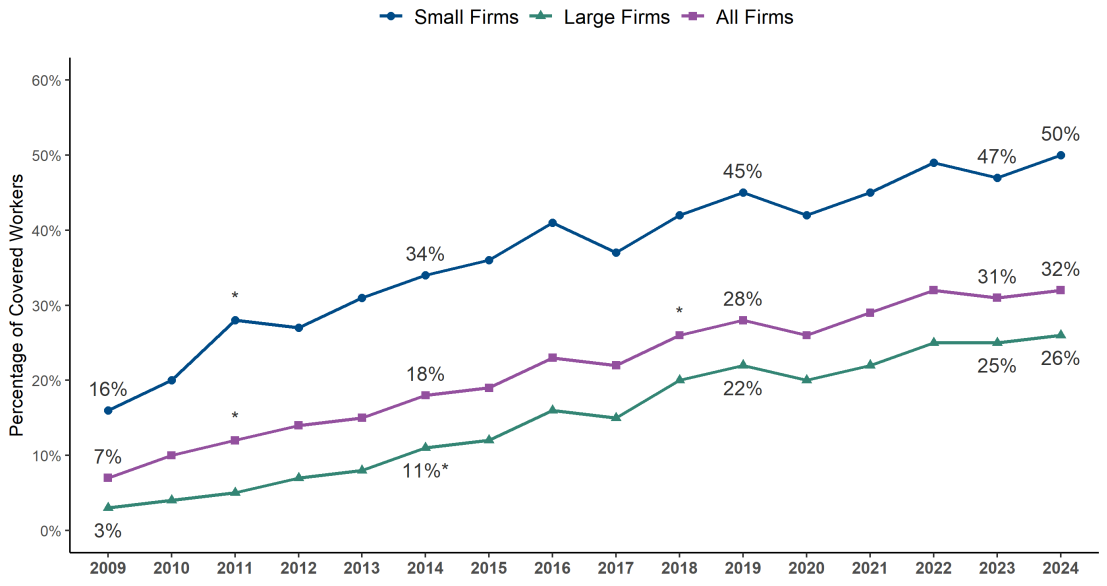
Some workers in health plans with high deductibles also receive contributions to savings accounts from their employers. These contributions can be used to reduce cost sharing amounts. Twenty-five percent of covered workers in an HDHP with a Health Reimbursement Arrangement (HRA), and 2% of covered workers in a Health Savings Account (HSA)-qualified HDHP receive an account contribution for single coverage that is greater than or equal to their deductible amount. Additionally, 24% of covered workers in an HDHP with an HRA and 9% 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.

In addition to any general annual deductible they may have, most covered workers also pay a portion of the cost of care when they use health care services, typically a copayment (a fixed dollar amount) or coinsurance (a percentage of the covered amount). For physician office visits, the average copayments are $26 for a primary care visit and $42 for a visit to a specialist. The average coinsurance rate is 20% for both primary care and specialist visits. All of these amounts are similar to the amounts in 2023.

When admitted to the hospital, 59% of covered workers have coinsurance requirements, 16% have a copayment, and 9% have both a copayment and coinsurance requirement. The average coinsurance rate for a hospital admission is 21% and the average copayment amount is $343. The cost sharing requirements for outpatient surgery follow a similar pattern to those for hospital admissions, although the average copayment amount for outpatient surgery is lower, at $216.

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, 14% are in a plan with an out-of-pocket limit of $2,000 or less, while 24% are in a plan with a limit above $6,000.

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, 2009-2024



* 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, 2018-2024; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2009-2017

AVAILABILITY OF EMPLOYER-SPONSORED COVERAGE

In 2024, 54% of all firms offered some health benefits, similar to the percentage last year (53%). Large firms (200 or more workers) are much more likely than small firms to offer health benefits to at least some of their workers (98% vs. 53%).

Most firms are very small, leading to fluctuations in the overall offer rate, as estimates of the offer rate for small firms can vary widely from year to year. Most workers, however, work for larger firms, where the offer rates are higher and much more stable. Over ninety percent (93%) of firms with 50 or more workers offer health benefits in 2024. 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.

Despite almost nine in ten workers being employed by firms that offer health benefits to at least some workers, many workers are not covered by their employers' plans. Some are not eligible to enroll (due to factors such as waiting periods or part-time or temporary work status), while others who are eligible choose not to enroll (they may feel the coverage is too expensive, or they may be covered through another source). Additionally, some firms provide incentives for workers to not enroll in their plans, or to enroll in a spouses' plan. Overall, at firms that offer coverage, an average of 81% of workers are eligible. Among eligible workers, 75% take up the firm's offer. Ultimately, 61% of workers at firms that offer health benefits are enrolled in coverage. All these percentages are similar to those in 2023.

The average shares of workers covered by jobs vary with workforce characteristics. Among workers at firms offering health benefits, those working for firms with a relatively large share of younger workers are less likely to be covered by their own firm than workers in firms with a smaller share of younger workers (44% vs. 64%). Workers at firms with a relatively large share of lower-wage workers are less likely to be covered by their own firm than workers at firms with a smaller share of lower-wage workers (50% vs. 64%)[3]. The share of workers employed at public organizations covered by their own employer (72%) is higher than the shares of workers employed at private for-profit firms (59%), or private non-for-profit firms (60%) covered at their work.

Across firms that offer health benefits and firms that do not, 54% of all workers are covered by health plans offered by their employer.

Inducements Not to Enroll. Among firms with ten or more employees that offer health benefits, 9% provide additional compensation or benefits to employees if they enroll in a spouse's plan, and 11% provide additional compensation or benefits to employees if they do not participate in the firm's health benefits.

AVAILABILITY OF COVERAGE FOR SPOUSES OF COVERED WORKERS

A very large share of firms that offer health benefits offer to cover dependents of covered workers. Among firms offering health benefits, 95 percent of firms with 10 to 49 employees and virtually all (99%) larger firms offered spouses an opportunity to enroll.

Among firms with 200 or more workers offering coverage to spouses, 10% do not allow the spouse to enroll if they are offered health insurance from another source, 13% place conditions on spouses wishing to enroll, such as limiting plan choice, or requiring a surcharge for enrolling spouses if they are offered coverage from another source. Among firms with 200 or more workers offering coverage to spouses, 8% require a surcharge for spouses who are offered coverage from another source.

[3]This threshold is based on the twenty-fifth percentile of workers' earnings ($35,000 in 2024). Seasonally adjusted data from the Current Employment Statistics Survey. Bureau of Labor Statistics. Current Employment Statistics—CES (national) [Internet]. Washington (DC): BLS. Available from: https://www.bls.gov/ces/publications/highlights/highlights-archive.htm

HEALTH PROMOTION AND WELLNESS PROGRAMS

Many firms sponsor programs to help workers identify health issues and manage chronic conditions. These programs include health risk assessments, biometric screenings, and health promotion programs.

Health Risk Assessments. Among firms offering health benefits, 31% of small firms and 56% of large firms provide workers the opportunity to complete a health risk assessment. Among large firms that offer a health risk assessment, 54% use incentives or penalties to encourage workers to complete the assessment.

Biometric Screenings. Among firms offering health benefits, 9% of small firms and 44% of large firms provide workers the opportunity to complete a biometric screening. Among large firms with a biometric screening program, 65% use incentives or penalties to encourage workers to complete the assessment, similar to the percentage last year.

Health and Wellness Promotion Programs. Many firms offering health benefits offer programs to help workers identify and address health risks and unhealthy behaviors. Fifty-four percent of small firms and 79% 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 both small firms and large firms offering one of these programs are similar to the percentages last year (62% and 80%, respectively).

GLP-1 DRUG COVERAGE FOR WEIGHT LOSS

GLP-1 (Glucagon-like peptide-1) agonists, used to help control blood sugar levels in people with type 2 diabetes, have also been shown to be an effective drug to help people lose weight. However, the high cost of these drugs, combined with the large number of people who could benefit and the potential for long-term usage, has raised questions about the potential costs to plans that cover them.

Eighteen percent of firms with 200 or more employees, including 25% of firms with 1,000 or more employees, cover GLP-1 agonists when used primarily for weight loss. Firms with 200 to 999 employees are more likely than larger firms to respond that they do not to know to this question [Figure G].

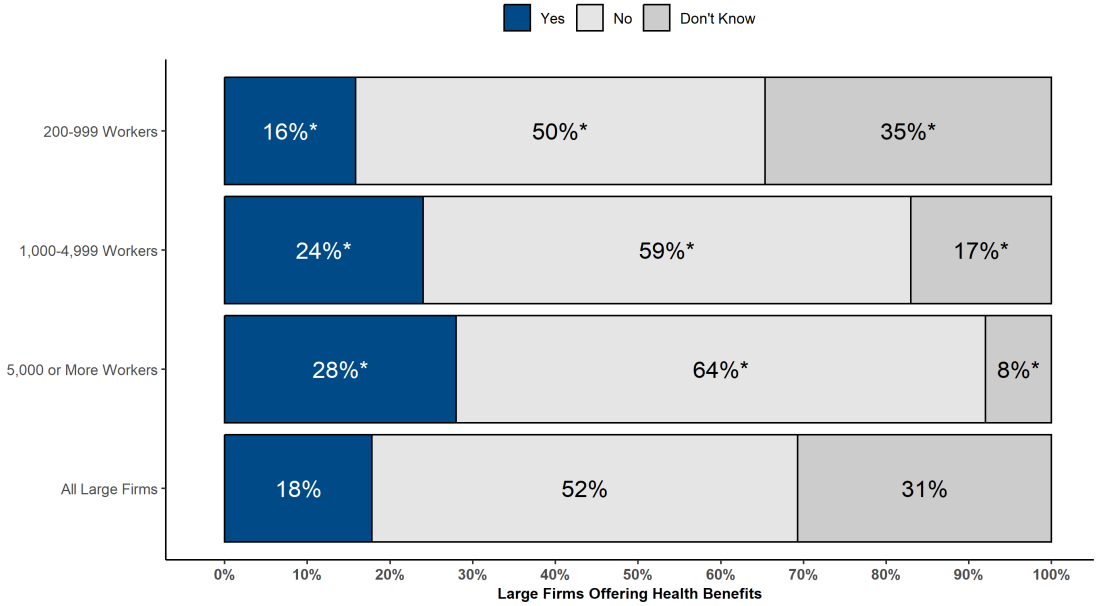
Among firms with 200 or more employees that provide coverage for GLP-1 agonists primarily for weight loss, 53% have some type of condition or requirement associated with covering these medications. These include 24% that require employees to meet with a professional, such as a dietitian, psychologist, case worker, or therapist before approving a GLP-1 drug prescription, 8% that require employees to enroll in a lifestyle or weight loss program for a period of time before approving a GLP-1 drug prescription and 10% that require employees to enroll in lifestyle or weight loss program while taking GLP-1 drugs.

Firms with 200 or more employees covering GLP-1 agonists primarily for weight loss were asked about the potential impacts on costs and employee satisfaction. Thirty-three percent of these firms, including 58% of firms with 5,000 or more employees, say that covering these medications for weight loss will have a "significant impact" on their prescription drug spending. Sixteen percent of firms offering health benefits say that covering these medications for weight loss will be "very important" for employees' satisfaction with their health plan, including 28% which currently cover GLP-1 agonists for weight loss [Figure H].

Among firms with 200 or more employees that do not provide coverage for GLP-1 agonists primarily for weight loss, 62% say that they are "not likely" to begin covering these medications for weight loss within the next twelve months, 23% say that they are "somewhat likely" to do so, 3% say that they are "very likely" to do so, and 11% do not know.

Figure G

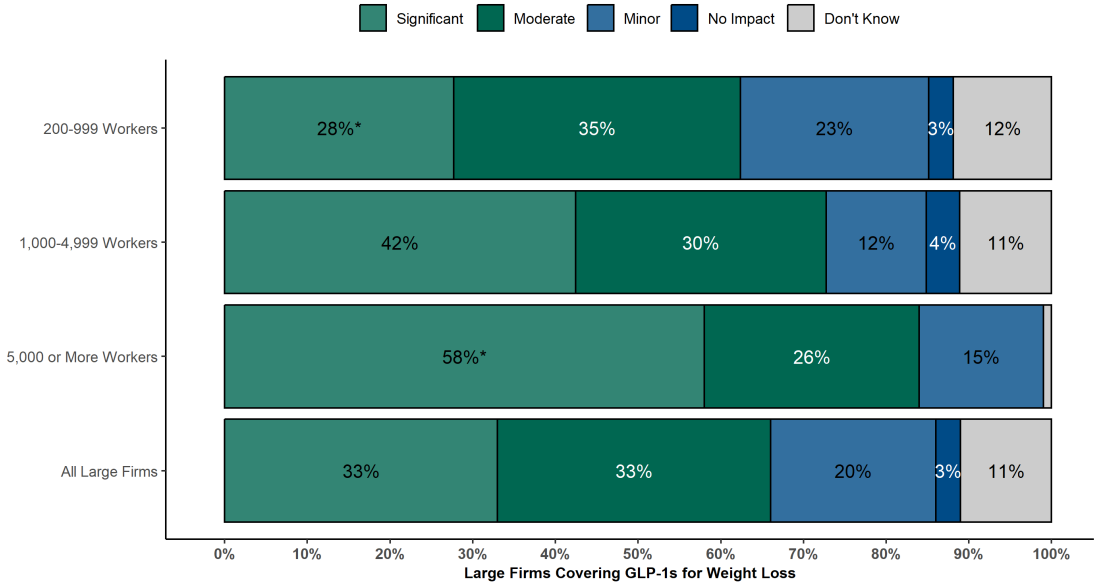
Percentage of Firms Covering GLP-1 Agonists When Used Primarily For Weight Loss, by Firm Size, 2024



* 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. Firms with multiple plans were asked about their plan with the largest enrollment.
SOURCE: KFF Employer Health Benefits Survey, 2024

Figure H

Firms View on How Much Of An Impact GLP-1 Agonists Will Have on Prescription Drug Spending, by Firm Size, 2024



* 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. Among firms with 200 or more workers that offer health benefits, 18% reported that their largest plan included coverage for any GLP-1 antagonists when used primarily for weight loss.
SOURCE: KFF Employer Health Benefits Survey, 2024

HEALTH PLAN PROVIDER NETWORKS

Tiered and Narrow Networks. Health plans structure their networks of providers to provide access to care and to encourage enrollees to use providers that are lower cost, or that provide better care. One option to accomplish these goals are high-performance or tiered network plans, which use cost-sharing or other incentives to encourage enrollees to use in-network providers that have better performance or quality, or have lower costs. Another option are narrow network plans, which significantly restrict the number of participating providers in order to reduce costs.

Among firms with 50 or more employees that offer health benefits, 20% have a high-performance network or tiered network as part of their health plan with the largest enrollment in 2024. Firms with 1,000 or more employees are more likely to include a high-performance or tiered network in their largest health plan than smaller employers (27% vs. 20%). Eight percent of firms with 50 or more employees that offer health benefits offer a health plan that can be considered a narrow network in 2024, similar to the percentage last year (11%). Firms with 5,000 or more employees are more likely to offer a narrow network plan than employers with fewer employees (18% vs. 8%).

Employer Views on the Breadth of Their Provider Networks.

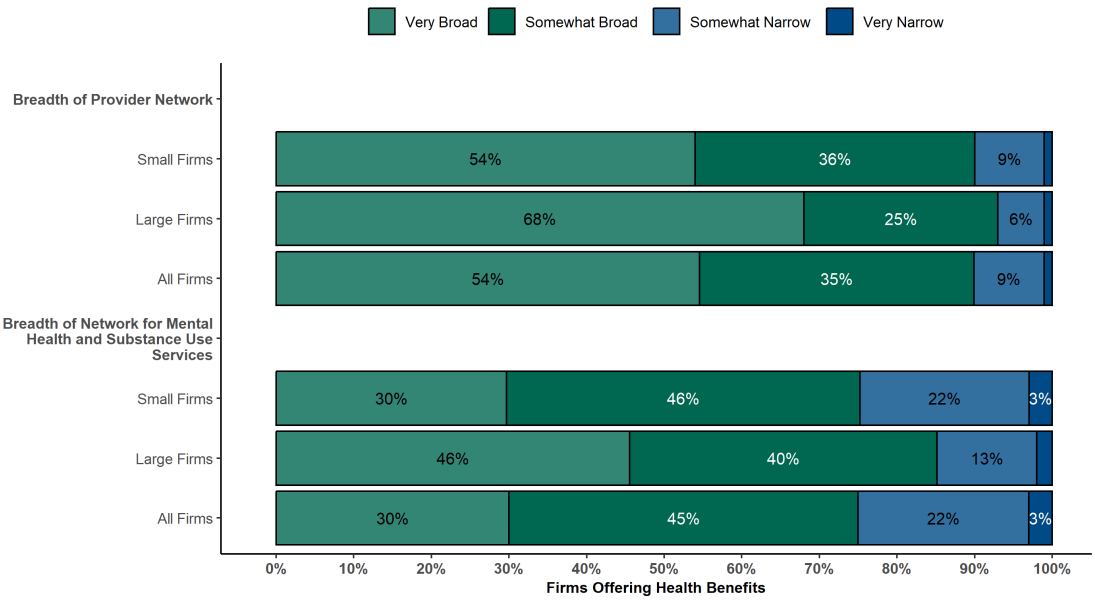
Employers that offer health benefits were asked to characterize the breadth of the provider network in their plan with the largest enrollment overall, and for services for mental health and substance use conditions.

Fifty-four percent of firms characterize the network in their plan with the largest enrollment as 'very broad,' 35% say it is 'somewhat broad', and 10% say it is 'somewhat narrow' or 'very narrow'. Firms with 200 or more employees are more likely than smaller firms to characterize the provider network in their plan with the largest enrollment as "very broad" (68% vs. 54%).

Thirty percent of firms characterize the network in their plan with the largest enrollment as 'very broad' for mental health and substance use condition services, 45% say it is 'somewhat broad' for these services, and 24% say it is 'somewhat narrow' or 'very narrow'. Firms with 200 or more employees are more likely than smaller firms to characterize the provider network in their plan with the largest enrollment as "very broad" for mental health and substance use condition services (46% vs. 30%) [Figure I].

Employers that offer health benefits are less likely to characterize their network with the largest enrollment as 'very broad' for mental health and substance use condition services than for medical services overall. This is true for small firms (3 to 199 employees) (30% vs. 54%) and larger firms (46% vs. 68%). However, 48% of large employers have increased the number of mental health counseling resources available to employees through an employee assistance program or some other third-party vendors, such as Headspace or Lyra Health.

Figure I
How Broad the Firm Considers Their Largest Plan's Provider Network, by Firm Size, 2024



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. Firms with multiple plans were asked about their plan with the largest enrollment.
SOURCE: KFF Employer Health Benefits Survey, 2024

BENEFITS FOR FAMILY BUILDING SERVICES

Some employers have introduced benefits to help employees trying to conceive or adopt a child. Among firms with 200 or more employees that offer health benefits, 37% provide coverage for fertility medications in their plan with the largest enrollment, 26% provide coverage for intrauterine (artificial) insemination, 27% provide coverage for in-vitro fertilization (IVF), 12% provide coverage for cryopreservation, sometimes called egg or sperm freezing, 13% provide coverage for adoption services, and 7% have coverage for other family-building services. Many large employers were uncertain about their coverage of family building benefits and reported don't know, including 29% for fertility medications, 32% for artificial insemination, 30% for IVF, 38% for cryopreservation and 26% for adoption.

PRICE AND COST SHARING INFORMATION FOR ENROLLEES

New federal rules require health plans (including self-funded plans) to make information available to enrollees about the estimated cost of services and cost-sharing on a "real-time" basis. Among firms with 200 or more employees that offer health benefits, 41% say that providing employees with additional information about the cost of services will help their health care decision making "a great deal", 38% of these firms say that it will help their decision making "somewhat", 15% say that it will help their decision making "very little", and 2% say that it will help their decision making "not at all". Thirteen percent of these firms say that the new requirements will reduce health spending "a great deal", 50% say that the new requirements will reduce health spending "somewhat", 24% say that the new requirements will reduce health spending "very little", and 7% say that the new requirements will reduce health spending "not at all".

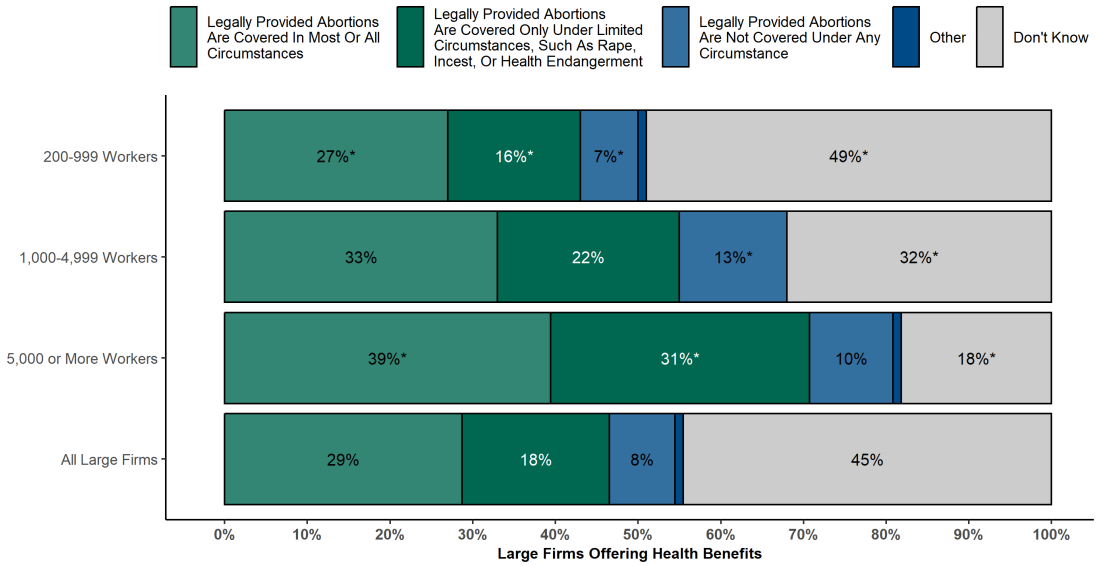
ABORTION SERVICES

The United States Supreme Court decision in Dobbs vs. Jackson, and subsequent state activity to regulate abortion has increased interest in coverage for abortion services in employer plans. Firms with 200 or more employees offering health benefits were asked which of several statements best described the coverage of abortion services in their largest health plan.

- Twenty-nine percent of these firms said that legally provided abortions are covered in most or all circumstances (sometimes referred to as elective or voluntary abortion). Firms with 5,000 or more workers were more likely than smaller firms to give this response (39%) [Figure J].
- Eighteen percent of these firms said that legally provided abortions are covered only under limited circumstances, such as rape, incest, or health or life endangerment of the pregnant enrollee. Firms with 5,000 or more workers were more likely than smaller firms to give this reply (31%).
- Eight percent of these firms said that legally provided abortions are not covered under any circumstance. Firms reporting that legally provided abortions are not covered were asked to confirm that their largest plan would not cover abortion under any circumstance, even in states where abortion was legal. In total, 81% verified this was their policy.
- Forty-five percent of responding firms answered "Don't know" to this question. Respondents with 200 to 999 workers were more likely than other respondents to answer, "Don't know," while respondents with 1,000 to 4,999 workers and 5,000 or more workers were less likely to do so.

Five percent of large firms offering health benefits currently provide or plan to provide financial assistance for travel expenses for enrollees who travel out of state to obtain an abortion if they do not have access near their home. Firms with 5,000 or more workers are more likely than other firms to say they provide or plan to provide travel benefits (21% vs. 5%).

Figure J
Percentage of Firms Whose Largest Plan Covers Legally Provided Abortion, by Firm Size, 2024



* 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. Large Firms have 200 or more workers. Firms reporting that legally provided abortions are not covered were asked to confirm that their largest plan would not cover abortion under any circumstance, even in states where abortion was legal. In total, 81% verified that this was their policy.
SOURCE: KFF Employer Health Benefits Survey, 2024

ASSISTANCE FOR LOWER-WAGE WORKERS

Some firms have programs to make it easier for lower-wage workers to afford to enroll in a health plan. Among firms with 200 or more employees offering health benefits, 6% have a program that reduces cost sharing for lower-wage workers and 14% have a program that reduces their premium contributions. Employers with 5,000 or more workers are relatively more likely to have a program that reduces premium contributions for lower-wage workers while employers with 200 to 999 employees are relatively less likely to have such a program. Fourteen percent of these firms offer a plan with reduced benefits and a low premium contribution to make it affordable for lower-wage workers.

DISCUSSION

The average annual premium increased 6% for single coverage and 7% for family coverage in 2024, similar to the rates in 2023. These increases likely reflect higher prices for health care, which have followed the higher prices in the rest of the economy over the last several years. Changes in premiums can lag other economic measures because insurers lock in prospective prices with providers. Therefore, it may take some time for premium changes to reflect the more modest inflation in 2024. Looking over a longer period, family premiums have grown 24% over the last five years, roughly comparable to the rate of inflation (23%) and the change in wages (28%) over the period.

Unlike the change in premiums, deductible amounts have been stable for several years, though they are still quite high. The average deductible in 2024 for single coverage among those with a deductible ($1,787) is not statistically different than last year ($1,735) nor five years ago ($1,655).

Whether and how to cover GLP-1 agonists when used primarily for weight loss has been a much-discussed issue for employers and other public and private health insurance payers. These drugs, which have recently been shown to be an effective drug to help people lose weight, are quite costly and have the potential to be used for long periods of time. Among employers with 1,000 or more employees, only one-in-four employers cover these drugs when used primarily for weight loss in 2024; 69% of these employers that do not cover them for this purpose say that they are not likely to do so within the next twelve months. Among the one-in-four that do cover them, 46% say that covering these medications for weight loss will have a "significant impact" on their prescription drug spending, while only 31% say that covering these medications for weight loss will be "very important" for employees' satisfaction with their health plan.

Coverage for these drugs is likely to remain a hot future topic as employers and other payers gain insights about the long-term effectiveness and costs associated with these drugs. A key issue for payers and users of these medications is whether those who use them can eventually maintain lower weights without continued reliance on these medications. Many payers that currently cover these drugs for weight loss have accompanying requirements such as counseling or enrollment in lifestyle or weight loss programs with the hope that users can reduce or eliminate their need for these medications over time. The effectiveness of these programs is likely to be an important factor for employers in their future decision making about whether and how to cover these medications.

METHODOLOGY

The KFF 2024 Employer Health Benefits Survey reports findings from a survey of 2,142 randomly selected non-federal public and private employers with three or more workers. Davis Research, LLC conducted the field work between January and July 2024. 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 graphs to improve readability. Some distributions may not sum due to rounding. For more information about 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

2024 Annual Survey

Survey Design and Methods

Survey Design and Methods

KFF has conducted this annual survey of employer-sponsored health benefits since 1999. Since 2020, KFF has employed Davis Research LLC (Davis) to field the survey. From January to July 2024, Davis interviewed business owners as well as human resource and benefits managers at 2,142 firms.

SURVEY TOPICS

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

Firms that offer health benefits are asked about the plan attributes of their largest health maintenance organization (HMO), preferred provider organization (PPO), point-of-service (POS) plan, and high-deductible health plan with a savings option (HDHP/SO).[4] We treat exclusive provider organizations (EPOs) and HMOs as one plan type and conventional (or indemnity) plans as PPOs. The survey defines an HMO as a plan that does not cover nonemergency out-of-network services. POS plans use a primary care gatekeeper to screen for specialist and hospital visits. HDHP/SOs are 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 about premiums, worker contributions and deductibles for their two largest plan types. Within each plan type, respondents are asked about the plan with the most enrollment.

Firms are asked about the attributes of their current plans during the interview. While the survey's fielding period begins in January, many respondents may have a plan whose 2024 plan year lags behind the calendar year. In some cases, plans may report the attributes of their 2023 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' 2020 Statistics of U.S. Businesses (SUSB) for private firms and the 2022 Census of Governments (COG) for non-federal public employers. At the time of the sample design (December 2023), this 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 2021 SUSB). We determine the sample size based on the number of firms needed to ensure a target number of completes in six size categories.

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

We attempted to repeat interviews with prior years' survey respondents (with at least ten employees) who participated in either the 2022 or the 2023 survey, or both. Firms with 3-9 employees are not included in the panel to minimize the potential of panel effects. In total, 278 firms participated in 2022, 464 firms participated in 2023, and 612 firms participated in both 2022 and 2023. 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 businesses 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].[5] The response rate for panel firms is higher than the response rate for non-panel firms. Similar to other employer and household surveys, the Employer Health Benefits Survey has seen a general decrease in response rates over time. Since 2017, we have attempted to increase the number of completes by increasing the number of non-panel firms in the sample. While this generally increases the precision of estimates by ensuring a sufficient number of respondents in various sub-groups, it has the effect of reducing the overall response rate.

The vast majority of questions are asked only of firms that offer health benefits. A total of 1,703 of the 2,142 responding firms indicated they offered health benefits. We asked one question of all firms in the study with which we made phone contact even if the firm declined to participate: "Does your company offer a health insurance program as a benefit to any of your employees?". A total of 4,769 firms responded to this question (including 2,142 who responded to the full survey and 2,627 who responded to this one question). These responses are included in our estimates of the percentage of firms offering health benefits.[6] The response rate for this question is 31% [Figure M.1].

Figure M.1

Response Rates for Various Subsets of the Sample, 2024

Firm Type	Response Rate for Full Survey	Response Rate for Firms Answering A6
Small Firms (3-9 Workers)	12%	30%
Small Firms (3-199 Workers)	21%	36%
Large Firms (200 or More Workers)	10%	28%
Panel Firms (Completed Survey in at Least One of the Past Two Years)	50%	57%
Non Panel Firms	6%	26%
ALL FIRMS	**14%**	**31%**

SOURCE: KFF Employer Health Benefits Survey, 2024

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. Collectively, 3,200,000 of the 71,600,000 workers covered by their own firm's health benefits in the United States were employed by firms

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

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

which completed in the survey. 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, 2024

	Sample Size	Sample Distribution After Weighting	Percentage of Total for Weighted Sample
NA			
3-9 Workers	151	1,967,108	60.4%
10-24 Workers	310	782,944	24
25-49 Workers	242	269,895	8.3
50-199 Workers	356	184,882	5.7
200-999 Workers	528	43,896	1.3
1,000-4,999 Workers	385	8,349	0.3
5,000 or More Workers	170	2,276	0.1
REGION			
Northeast	330	521,510	16%
Midwest	592	787,756	24.2
South	661	1,152,003	35.3%
West	559	798,081	24.5
INDUSTRY			
Agriculture/Mining/Construction	160	388,607	11.9
Manufacturing	191	167,964	5.2
Transportation/Communications/Utilities	120	129,233	4
Wholesale	103	150,436	4.6
Retail	144	364,252	11.2
Finance	104	206,652	6.3
Service	849	1,393,226	42.7
State/Local Government	172	48,865	1.5%
Health Care	299	410,115	12.6
ALL FIRMS	**2,142**	**3,259,350**	**100**

SOURCE: KFF Employer Health Benefits Survey, 2024

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.

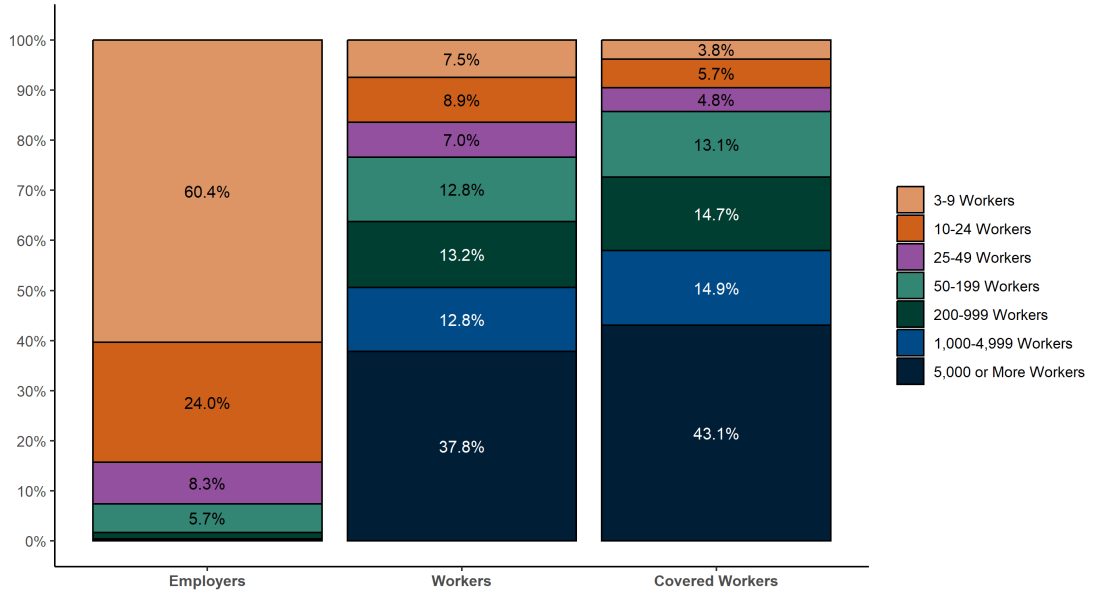
Figure M.4
States by Region, 2024

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, 2024. 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 60.4% employ 3 to 9 workers; such firms employ 7.5% of workers, and 3.8% of workers covered by health insurance. In contrast, less than one percent of firms employ 5,000 or more workers; these firms employ 37.8% of workers and 43.1% 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, 2024



NOTE: Data are based on a data request to the U.S. Census Bureau for their most recent (2021) Statistics of U.S. Businesses data on private sector firms. State and local government data are from the Census Bureau's 2022 Census of Governments.
SOURCE: KFF Employer Health Benefits Survey, 2024

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 $35,000 or less per year for lower-wage workers and $77,000 or more for higher-wage workers. These thresholds are based on the 25th and 75th percentile of workers' earnings as reported by the Bureau of Labor Statistics using data from the Occupational Employment Statistics (OES) (2022).[7] The cutoffs were inflation-adjusted and rounded to the nearest thousand.

Annual inflation estimates are calculated as an average of the first three months of the year. The 12 month percentage change for this period was 3.2%.[8] Data presented is nominal unless indicated specifically otherwise.

ROUNDING AND IMPUTATION

Some figures in the report do not sum to totals due to rounding. Although overall totals and totals for size and industry are statistically valid, some breakdowns may not be available due to limited sample sizes or high relative standard errors. Where the unweighted sample size is fewer than 30 observations, figures include the notation "NSD" (Not Sufficient Data). Estimates with high relative standard errors are reviewed and in some cases not

[7] Seasonally Adjusted Data from the Current Employment Statistics Survey. Bureau of Labor Statistics. Current Employment Statistics—CES (National) [Internet]. Washington (DC): BLS; [cited 2023 Aug 1]. Available from: https://www.bls.gov/ces/publications/highlights/highlights-archive.htm

[8] 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 2023 Aug 1]. 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, 12% of observations are imputed. All variables, with the exception of some single coverage premiums, 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. For a given firm, if both single and family coverage premiums are missing, the single coverage premium is predicted using other known characteristics of the plan and firm through a random forest algorithm. This method reduces bias and improves subsequently hotdecked values (such as family premiums and worker contributions). In 2024, there were sixty-one 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, 2020-2024

	2020	2021	2022	2023	2024
HMO					
Single Premium	5.1%	6.1%	10.7%	7.8%	9.1%
Single Contribution	3.7	2.9	7.4*	4.7	5
Single Deductible	2.7	2	9*	5.1	4.4
Family Premium	5.7	8.3	13.5	13.3	11.4
Family Contribution	6.4	9.1	10.2	10.5	9.5
Family Deductible	4.7	5.4	8.5	5.8	6.9
PPO					
Single Premium	7%	5.6%	8.4%*	8%	7.5%
Single Contribution	3.6	2.5	5.2*	5	3.4
Single Deductible	2.7	1.2*	4.9*	3.1*	2.5
Family Premium	9.1	6.9	10*	10.8	8.2*
Family Contribution	6.4	5	7.9*	7.9	5.7
Family Deductible	5.4	4	5.9	4.9	5
POS					
Single Premium	15.5%	10.3%	16%	17.6%	21.1%
Single Contribution	10	4.9	7.8	12.5	9.6
Single Deductible	8.2	7.6	11.3	12.2	10.4
Family Premium	21.3	16.4	21.7	21.4	26.6
Family Contribution	21.3	13.1*	14.5	18.8	21.4
Family Deductible	15.7	13.1	15.7	12.2	14.4
HDHP/SO					
Single Premium	4.9%	6.5%	7.1%	6.3%	7.4%
Single Contribution	3.3	2	3	3.9	3.6
Single Deductible	1.6	1.1	4.6*	2.5*	2.3
Family Premium	6	6	7.4	6.9	8.1
Family Contribution	4.8	2.9	4.4	5.9	4.4
Family Deductible	3.4	4.5	4.9	5.5	4.4

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

SOURCE: KFF Employer Health Benefits Survey, 2020-2024;

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 2021 Statistics of U.S. Businesses for firms in the private sector, and the 2022 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 4.4.0 (2024-04-24 ucrt) and the library "survey" version 4.4.2 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 some 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 and not others. 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.

DATA COLLECTION AND SURVEY MODE

Starting in 2022, we expanded the use of computer assisted web interview (CAWI), offering most respondents the opportunity to complete the survey using an online questionnaire rather a telephone interview. In 2024, fifty-seven percent of survey responses were completed via telephone interview, and the remainder were completed online.

Survey mode did not impact the survey results in a systematic or obvious manner. The effects of mode and firm size on major firm characteristics such as annual premiums, contributions, and deductibles was tested using standard linear regression. For certain plan types, survey implementation through telephone interview had a negative effect on the reported value. However, the plan types affected were random, so this effect is more likely due to confounding variables. When examining demographic characteristics between the two modes, there were small differences in the distribution of categorical variables such as region and age.

PRICSSA

In their Journal of Survey Statistics and Methodology article, Seidenberg, Moser, and West (2023) propose a checklist for survey administrators and sponsoring organizations to help external researchers quickly understand the methods used to create a complex sample dataset.[9] The Preferred Reporting Items for Complex Sample Survey Analysis (PRICSSA) recommends a standard format to enumerate data collection and analysis techniques across a variety of different surveys. KFF has adopted this checklist to increase transparency for our readership and also to promote reproducibility among external researchers granted access to our public use files.

- 1.1 Data collection dates: January 15, 2024–July 12, 2024.
- 1.2 Data collection mode(s): fifty-seven percent computer-assisted telephone interviewing (CATI), and the remainder completed with computer assisted web interview (CAWI).
- 1.3 Target population: Private firms as well as state and local government employers with three or more employees in 50 US states and Washington DC.
- 1.4 Sample design: A sample stratified by ten industry categories and six size categories drawn from a Dynata list (based on a census assembled by Dun and Bradstreet) of the nation's private employers and the Census of Governments for public employers.
- 1.5 Full Survey response rate: 14 percent (CASRO method).
- 2.1 Missingness rates: On average, 12% of observations are imputed.
- 2.2 Observation deletion: Observations found to be duplicated firms.
- 2.3 Sample sizes: 2,142 firms completed the entire survey, 4,769 completed at least the offer question, out of 26,426 initially sampled firms, generalizing to a total of three million firms.
- 2.4 Confidence intervals / standard errors: All statistical tests are performed at the .05 confidence level.
- 2.5 Weighting: `empwt` (firms), `empwt_a6` (firms, including those answering only the offer question), `wkrwt` (workers), `covwt` (policyholders), `hmowt`, `ppowt`, `poswt`, and `hdpwt` (plan weights)
- 2.6 Variance estimation: Taylor Series Linearization with `newcell` used as the stratum variable but no PSU variable.
- 2.7 Subpopulation analysis: The R `survey` package toolkit such as `svyby` and a complex sample design's `subset` method allowed for most analysis of subdomains.

[9] Seidenberg, Andrew B, Richard P Moser, and Brady T West. 2023. "Preferred Reporting Items for Complex Sample Survey Analysis (PRICSSA)." Journal of Survey Statistics and Methodology 11 (4): 743–57. https://doi.org/10.1093/jssam/smac040.

- 2.8 Suppression rules: Where the unweighted sample size is fewer than 30 observations, figures include the notation "NSD" (Not Sufficient Data). Estimates with high relative standard errors are reviewed and in some cases not published.
- 2.9 Software and code: All design-based analyses were performed using R version 4.4.0 (2024-04-24 ucrt) and `survey` library version 4.4.2.

2024 SURVEY

The 2024 survey features new questions, on prescription drug policy, mental health and substance use, GLP-1 drug coverage, family-building services, transparency, and affordability issues for lower-wage workers.

As in previous years, modification were made to existing survey questions, both to improve clarity or respond to changes in the marketplace. Starting in 2024, the introductory text for web-based interviews was condensed. In an effort to reduce respondent burden, we removed questions on waiting periods, emergency room cost sharing, wellness program incentives, disease management, sites of care, and prior authorization. We also restricted clarification follow-up calls (or callbacks) to only firms with at least one premium or cost sharing-related item: observations for firms with outliers only in the drug tier section of the questionnaire were imputed based on logic rules.

In some cases respondents report they offer coverage, but do not offer a comprehensive major medical plan. This year we added additional questions to clarify whether plans with low premiums were major medical plans. We dropped fewer than five firms where the respondent told us they did not cover most physician services and hospital admissions other than preventative care from the premium average.

9.8 percent of respondents in 2024 were either unable to provide their firm's single coverage premium, or provided a response which was logically inconsistent with other values. In these cases, in order to minimize non-response bias, missing responses were imputed. In prior years, if a firm was missing a single premium value, this value was imputed using a 'hot deck' approach in which a single premium was selected among firms with similar demographic characteristics. This year we revised this method. In cases in which both the single and family premiums were missing, the single premium was estimated based on other known characteristics of the plan and firm. This method is advantageous because it predicts single premiums based on specific firm characteristics related to the premium, such as cost-sharing and deductibles, as well as demographics. Then, the family premium, as well as single and family worker contributions (if missing), were subsequently hot decked based on their relationship to the single premium. In cases in which a firm provides a response to the family premium, the single premium is imputed based on a ratio of the premiums. Therefore, in total, 8% of responses were affected by this change.

The updated imputation process uses a random forest machine learning model. The model was trained on EHBS data from 2021-2023. Features were selected using step wise regression. The hyper-parameters of the model were tuned using the grid search algorithm. Compared to hot-decking, this method is significantly better at explaining the variation in the observed data (R-squared of 0.2071 versus 0.00018540). This methodological change has a relatively minor impact on the overall premium; the 2024 premium would be 0.8% different if we did not implement the new method. However, this change meaningfully impacts the precision of premium estimates for demographic subgroups.

OTHER RESOURCES

Additional information on the 2024 Employer Health Benefit Survey is available at http://ehbs.kff.org/, including an article in the Journal Health Affairs, an interactive graphic and historic reports. Standard errors for some statistics are available in the online technical supplement. Researchers may also request a public use dataset here: https://www.kff.org/contact-us/

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

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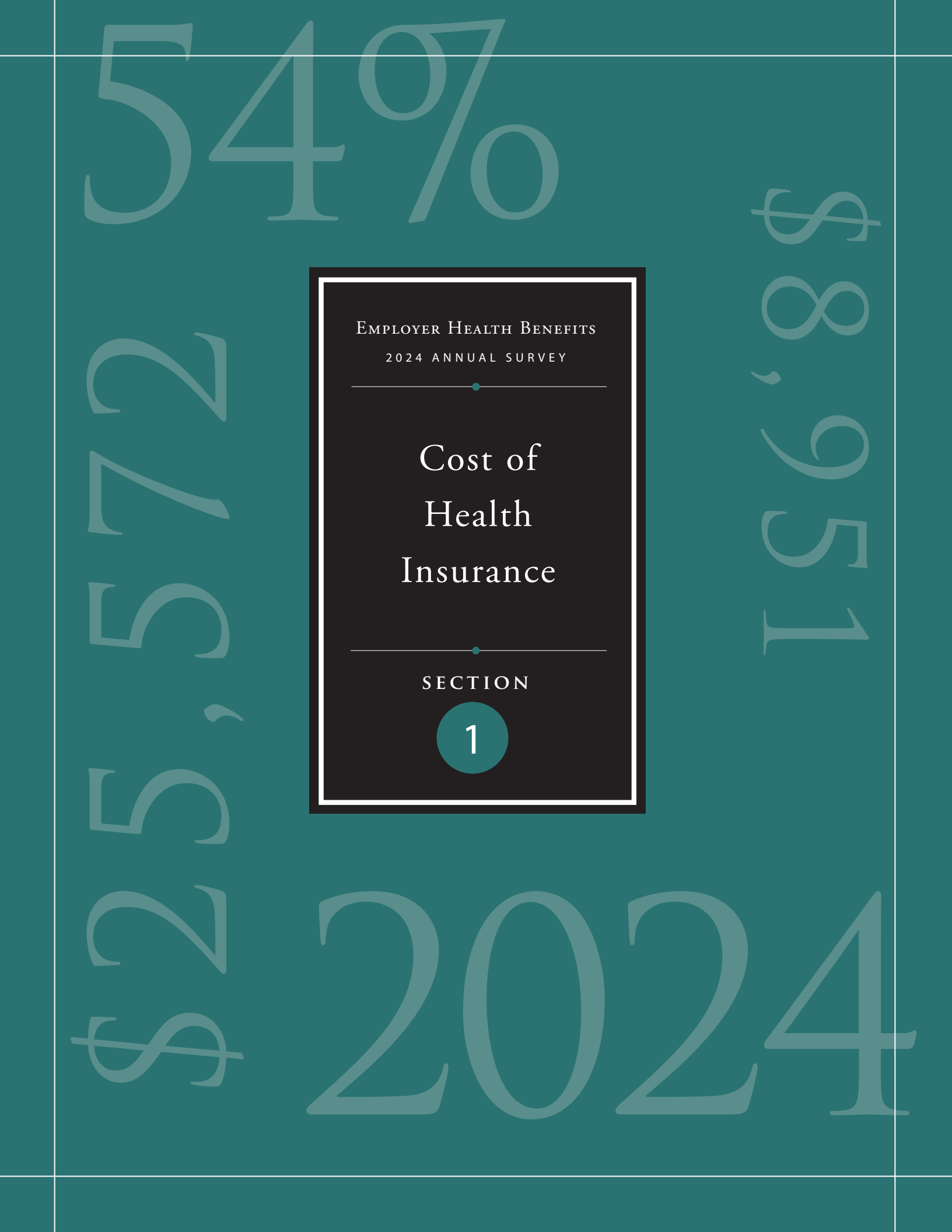


Employer Health Benefits

2024 Annual Survey

Cost of Health Insurance

SECTION

1

Section 1

Cost of Health Insurance

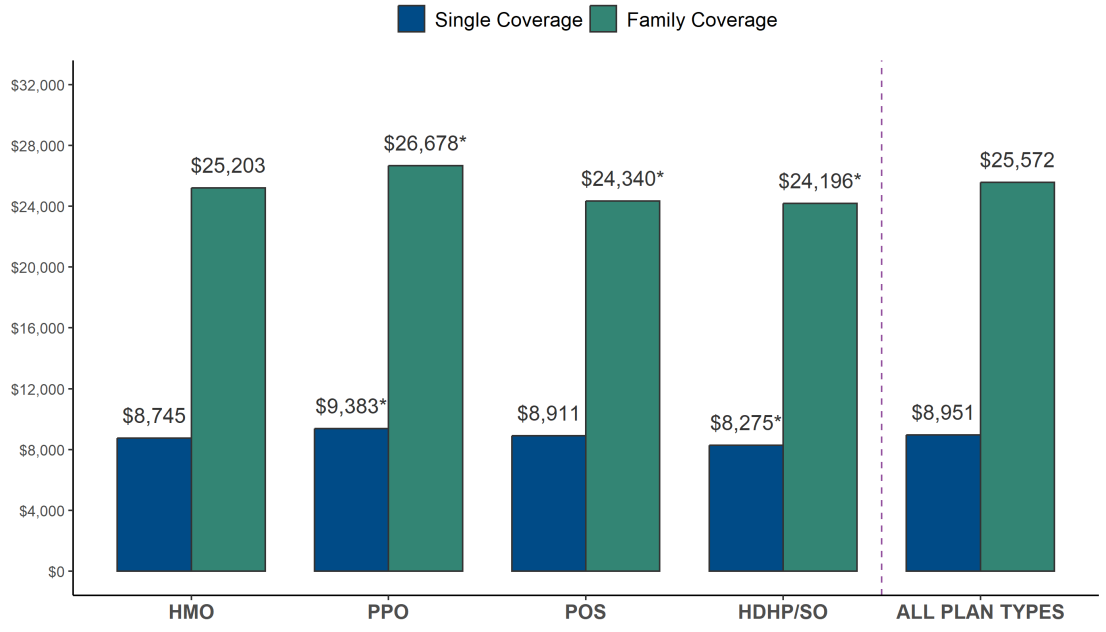
The average annual health insurance premiums in 2024 are $8,951 for single coverage and $25,572 for family coverage. The average single coverage premium increased 6% in 2024 while the average family premium increased 7%. The average family premium has increased 24% since 2019 and 52% since 2014.

As part of this report, KFF publishes an online tool which 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

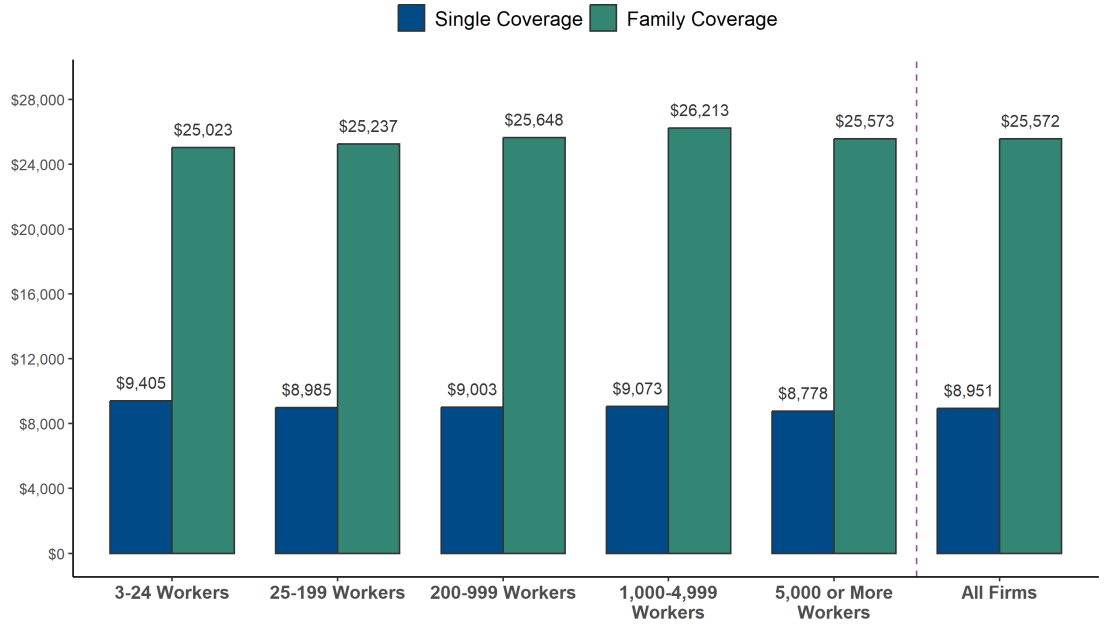
- The average premium for single coverage in 2024 is $8,951 per year. The average premium for family coverage is $25,572 per year [Figure 1.1].
  - The average annual premiums for single coverage are similar for covered workers at small firms ($9,131) and at large firms ($8,884) [Figure 1.3].
  - The average annual premiums for family coverage are similar for covered workers at small firms ($25,167) and at large firms ($25,719) [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 ($8,275 vs. $8,951) and family coverage ($24,196 vs. $25,572). The average premiums for covered workers in PPOs are higher than the overall average premiums for both single coverage ($9,383 vs. $8,951) and family coverage ($26,678 vs. $25,572) [Figure 1.1].
- The average premium for covered workers with both single and family coverage is relatively higher in the Northeast and relatively lower in the South [Figure 1.4].
- The average premiums for covered workers at firms with a relatively large share of older workers (firms where at least 35% of the workers are age 50 or older) are higher than the average premium for covered workers at firms with smaller shares of older workers for single coverage ($9,171 vs. $8,738) [Figure 1.6].
- The average premiums for single coverage and family coverage are lower for covered workers at private for-profit firms and higher for covered workers at private not-for profit firms [Figure 1.6] and [Figure 1.7].

Figure 1.1
Average Annual Premiums for Covered Workers, Single and Family Coverage, by Plan Type, 2024



* Estimate is statistically different from All Plans estimate ($p < .05$).
SOURCE: KFF Employer Health Benefits Survey, 2024

Figure 1.2
Average Annual Premiums for Covered Workers, Single and Family Coverage, by Firm Size, 2024



Tests found no statistical difference from All Plans estimate ($p < .05$).
SOURCE: KFF Employer Health Benefits Survey, 2024

Figure 1.3

Average Monthly and Annual Premiums for Covered Workers, by Plan Type and Firm Size, 2024

	Monthly		Annual	
	Single Coverage	Family Coverage	Single Coverage	Family Coverage
HMO				
All Small Firms	$668*	$1,948	$8,018*	$23,381
All Large Firms	749*	2,148	8,985*	25,780
ALL FIRM SIZES	**$729**	**$2,100**	**$8,745**	**$25,203**
PPO				
All Small Firms	$819*	$2,274	$9,824*	$27,287
All Large Firms	769*	2,206	9,231*	26,467
ALL FIRM SIZES	**$782**	**$2,223**	**$9,383**	**$26,678**
POS				
All Small Firms	$777	$1,974	$9,329	$23,692
All Large Firms	712	2,069	8,539	24,831
ALL FIRM SIZES	**$743**	**$2,028**	**$8,911**	**$24,340**
HDHP/SO				
All Small Firms	$678	$1,900	$8,137	$22,805
All Large Firms	693	2,052	8,317	24,620
ALL FIRM SIZES	**$690**	**$2,016**	**$8,275**	**$24,196**
ALL PLANS				
All Small Firms	$761	$2,097	$9,131	$25,167
All Large Firms	740	2,143	8,884	25,719
ALL FIRM SIZES	**$746**	**$2,131**	**$8,951**	**$25,572**

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

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

SOURCE: KFF Employer Health Benefits Survey, 2024

Figure 1.4

Average Monthly and Annual Premiums for Covered Workers, by Plan Type and Region, 2024

	Monthly		Annual	
	Single Coverage	Family Coverage	Single Coverage	Family Coverage
HMO				
Northeast	$860*	$2,530*	$10,317*	$30,363*
Midwest	801*	2,136	9,607*	25,633
South	680	1,919*	8,155	23,034*
West	682	2,018	8,190	24,212
ALL REGIONS	**$729**	**$2,100**	**$8,745**	**$25,203**
PPO				
Northeast	$820	$2,398*	$9,842	$28,774*
Midwest	785	2,217	9,417	26,609
South	754*	2,178	9,044*	26,136
West	790	2,110	9,481	25,321
ALL REGIONS	**$782**	**$2,223**	**$9,383**	**$26,678**
POS				
Northeast	$874*	$2,291*	$10,483*	$27,492*
Midwest	748	2,111	8,982	25,330
South	662*	1,820*	7,941*	21,836*
West	803	2,212	9,635	26,544
ALL REGIONS	**$743**	**$2,028**	**$8,911**	**$24,340**
HDHP/SO				
Northeast	$753	$2,188	$9,037	$26,255
Midwest	705	2,017	8,458	24,199
South	661	2,003	7,934	24,034
West	640*	1,830*	7,684*	21,957*
ALL REGIONS	**$690**	**$2,016**	**$8,275**	**$24,196**
ALL PLANS				
Northeast	$814*	$2,359*	$9,768*	$28,305*
Midwest	750	2,122	9,005	25,470
South	710*	2,060*	8,524*	24,724*
West	738	2,048	8,859	24,574
ALL REGIONS	**$746**	**$2,131**	**$8,951**	**$25,572**

* 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, 2024

Figure 1.5

Average Monthly and Annual Premiums for Covered Workers, by Plan Type and Industry, 2024

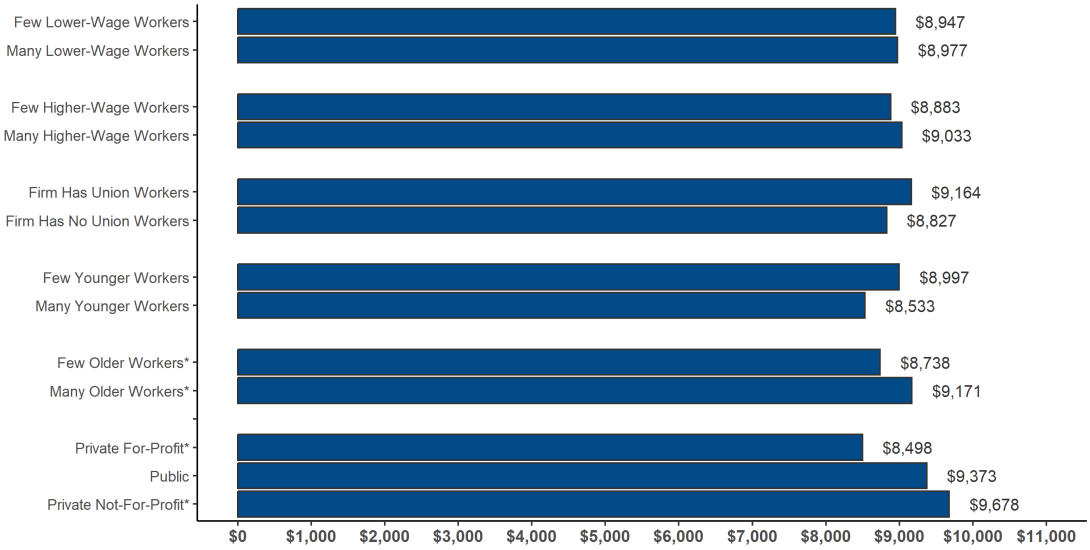
	Monthly		Annual	
	Single Coverage	Family Coverage	Single Coverage	Family Coverage
PPO				
Agriculture/Mining/Construction	$673*	$1,843*	$8,081*	$22,119*
Manufacturing	757	2,208	9,085	26,491
Transportation/Communications/Utilities	753	2,308	9,033	27,696
Wholesale	755	2,184	9,060	26,203
Retail	735	2,144	8,823	25,730
Finance	797	2,327	9,560	27,923
Service	819*	2,268	9,830*	27,221
State/Local Government	749	1,978*	8,983	23,742*
Health Care	818	2,329	9,811	27,951
ALL INDUSTRIES	**$782**	**$2,223**	**$9,383**	**$26,678**
HDHP/SO				
Agriculture/Mining/Construction	$676	$1,987	$8,111	$23,844
Manufacturing	635	1,866	7,625	22,389
Transportation/Communications/Utilities	724	2,321	8,690	27,848
Wholesale	704	2,047	8,442	24,567
Retail	571*	1,685*	6,855*	20,225*
Finance	664	1,944	7,969	23,330
Service	697	2,002	8,359	24,023
State/Local Government	741	1,974	8,889	23,682
Health Care	723	2,101	8,673	25,213
ALL INDUSTRIES	**$690**	**$2,016**	**$8,275**	**$24,196**
ALL PLANS				
Agriculture/Mining/Construction	$666*	$1,888*	$7,987*	$22,654*
Manufacturing	732	2,081	8,789	24,971
Transportation/Communications/Utilities	717	2,217	8,603	26,601
Wholesale	732	2,132	8,779	25,588
Retail	685*	2,004	8,217*	24,043
Finance	743	2,153	8,913	25,834
Service	765	2,133	9,186	25,600
State/Local Government	767	2,058	9,199	24,694
Health Care	777	2,239*	9,322	26,864*
ALL INDUSTRIES	**$746**	**$2,131**	**$8,951**	**$25,572**

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 by industry.

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

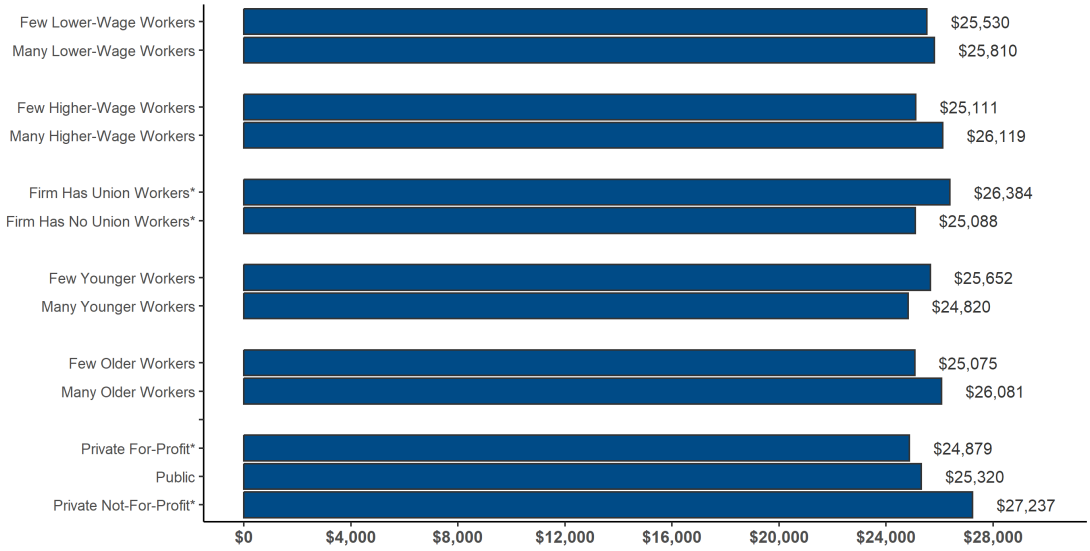
SOURCE: KFF Employer Health Benefits Survey, 2024

Figure 1.6
Average Annual Premiums for Covered Workers with Single Coverage, by Firm Characteristics, 2024



* 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 ($35,000 in 2024). Firms with many higher-wage workers are those where at least 35% earn the 75th percentile or more than of national earnings ($77,000 in 2024). 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, 2024

Figure 1.7
Average Annual Premiums for Covered Workers with Family Coverage, by Firm Characteristics, 2024



* 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 ($35,000 in 2024). Firms with many higher-wage workers are those where at least 35% earn the 75th percentile or more than of national earnings ($77,000 in 2024). 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, 2024

Figure 1.8

Average Annual Premiums for Covered Workers, by Firm Characteristics and Firm Size, 2024

	Single Coverage		Family Coverage	
	All Small Firms	All Large Firms	All Small Firms	All Large Firms
LOWER WAGE LEVEL				
Few Lower-Wage Workers	$9,170	$8,858	$25,281	$25,626
Many Lower-Wage Workers	$8,837	$9,016	$24,293	$26,194
HIGHER WAGE LEVEL				
Few Higher-Wage Workers	$9,085	$8,797	$24,365*	$25,412
Many Higher-Wage Workers	$9,198	$8,981	$26,302*	$26,061
UNIONS				
Firm Has Union Workers	$9,277	$9,158*	$27,313	$26,339
Firm Has No Union Workers	$9,121	$8,626*	$25,016	$25,136
YOUNGER WORKERS				
Few Younger Workers	$9,103	$8,957*	$25,079	$25,863
Many Younger Workers	$9,390	$8,217*	$26,071	$24,408
OLDER WORKERS				
Few Older Workers	$8,721*	$8,745	$23,935*	$25,483
Many Older Workers	$9,554*	$9,027	$26,403*	$25,962
FUNDING ARRANGEMENT				
Fully Insured	$9,106	$8,990	$25,126	$25,948
Self-Funded	$9,227	$8,856	$25,325	$25,659
FIRM OWNERSHIP				
Private For-Profit	$8,853*	$8,324*	$24,659	$24,984*
Public	$9,902	$9,283	$26,697	$25,087
Private Not-For-Profit	$9,687	$9,675*	$26,139	$27,553*
ALL FIRMS	**$9,131**	**$8,884**	**$25,167**	**$25,719**

NOTE: Firms with many lower-wage workers are those where at least 35% earn the 25th percentile or less of national earnings ($35,000 in 2024). Firms with many higher-wage workers are those where at least 35% earn the 75th percentile or more than of national earnings ($77,000 in 2024). 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.

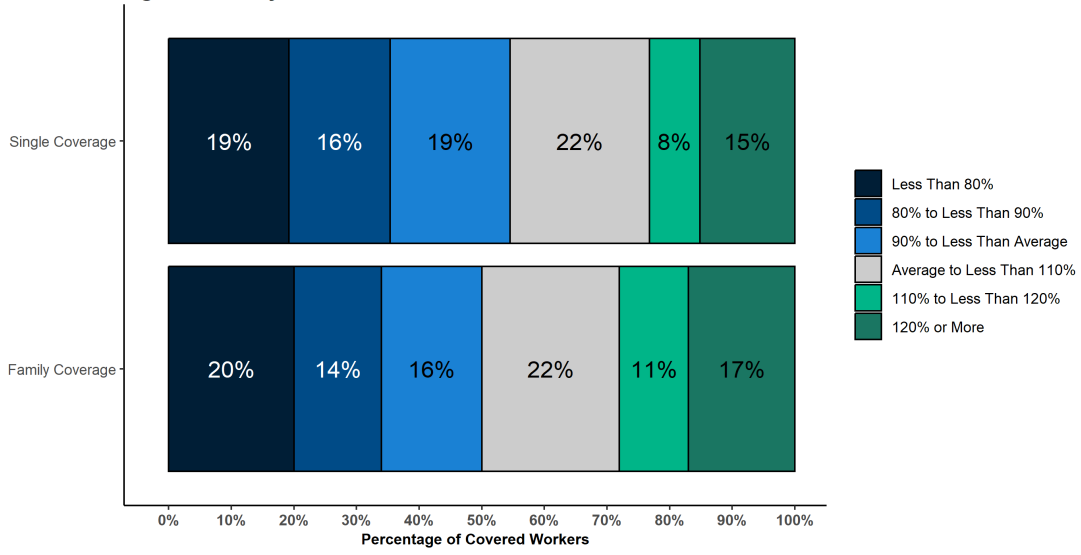
* Estimates are statistically different from estimate for all other firms not in the indicated category within each firm size ($p < .05$).

SOURCE: KFF Employer Health Benefits Survey, 2024

PREMIUM DISTRIBUTION

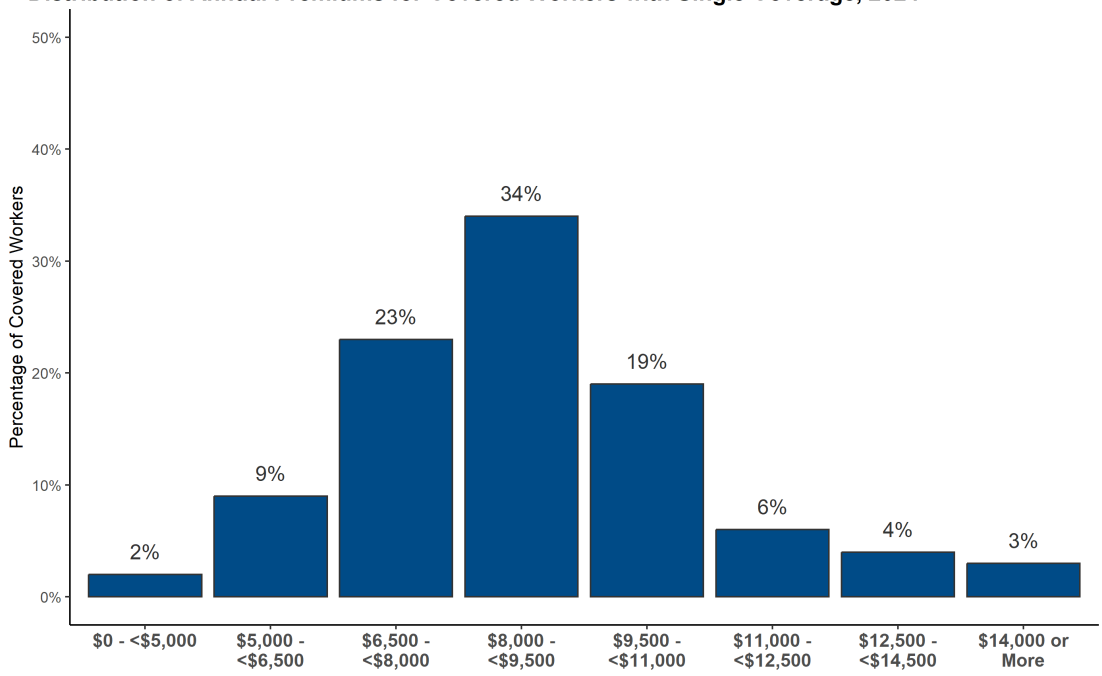
- There is considerable variation in premiums for both single and family coverage.
  - Fifteen percent of covered workers are employed at a firm where the single coverage premium is at least 20% higher than the average single premium, while 19% of covered workers are at firms with a single premium less than 80% of the average single premium [Figure 1.9].
  - For family coverage, 17% of covered workers are employed at a firm with a family premium at least 20% higher than the average family premium, while 20% of covered workers are at firms with a family premium less than 80% of the average family premium [Figure 1.9].
- Seven percent of covered workers are at a firm with an average annual premium of at least $12,500 for single coverage [Figure 1.10]. Ten percent of covered workers are at a firm with an average annual premium of at least $33,000 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, 2024



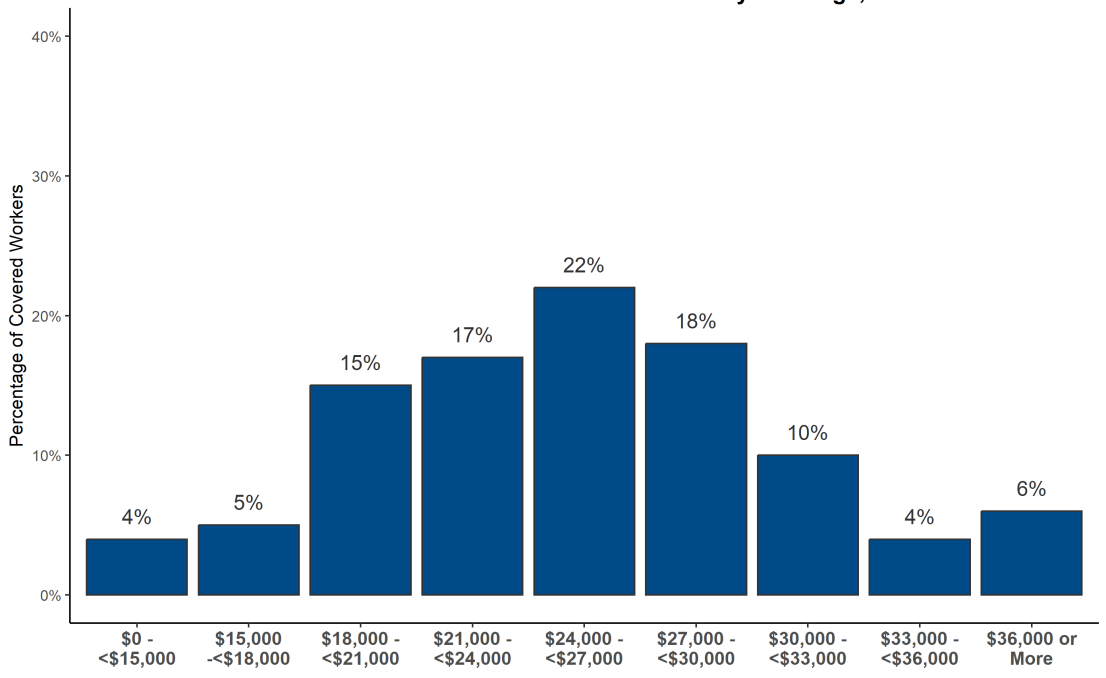
NOTE: The average annual premium is $8,951 for single coverage and $25,572 for family coverage. The premium distribution is relative to the average single or family premium. For example, $7,161 is 80% of the average single premium, $8,056 is 90% of the average single premium, $9,846 is 110% of the average single premium, and $10,742 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, 2024

Figure 1.10
Distribution of Annual Premiums for Covered Workers with Single Coverage, 2024



SOURCE: KFF Employer Health Benefits Survey, 2024

Figure 1.11
Distribution of Annual Premiums for Covered Workers with Family Coverage, 2024



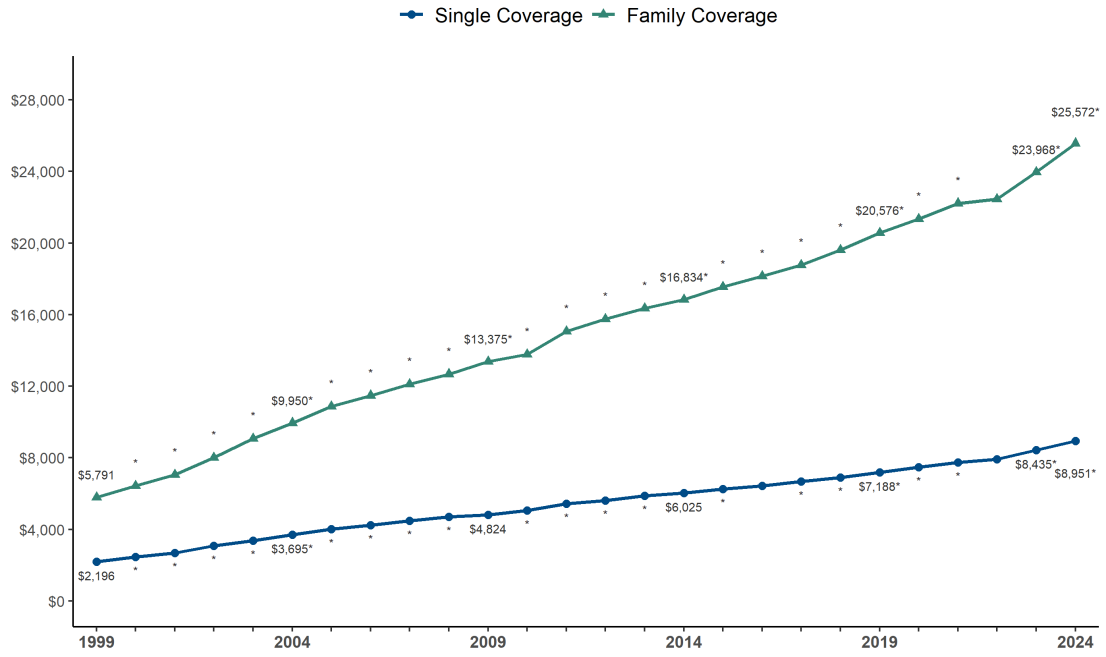
SOURCE: KFF Employer Health Benefits Survey, 2024

PREMIUM CHANGES OVER TIME

- The average premiums for covered workers for single and family coverage increased 6% and 7% respectively from last year [Figure 1.12].
  - The average premium for single coverage has grown 25% in the past five years [Figure 1.12].
  - The $25,572 average family premium in 2024 is 24% higher than the average family premium in 2019 and 52% higher than the average family premium in 2014. The 24% family premium growth in the past five years is similar to the 22% growth between 2014 and 2019 [Figure 1.15].
  - The average family premiums for covered workers at small firms and at large firms have grown at similar rates since 2019 (24% at small firms and 24% at large firms). For small firms, the average family premium rose from $20,236 in 2019 to $25,167 in 2024. For large firms, the average family premium rose from $20,717 in 2019 to $25,719 in 2024 [Figure 1.13].
  - The average family premiums have grown at similar rates since 2014 for covered workers at small firms and at large firms (59% at small firms and 49% at large firms). At small firms, the average family premium rose from $15,849 in 2014 to $25,167 in 2024. In large firms, the average family premium rose from $17,265 in 2014 to $25,719 in 2024 [Figure 1.13].
- Over the past five years, the average family premium for covered workers at large 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 plan (26% for fully insured plans and 24% for self-funded firms) [Figure 1.14].
- The average family premium grew 7% in 2024 while the rate of inflation was (3.2%). Over the last 5 years, family premiums grew 24%, similar to the rate of inflation during this period (23%). Over the last ten years, the growth in the average premium for family coverage far outpaced inflation (52% vs. 32%) [Figure 1.15].

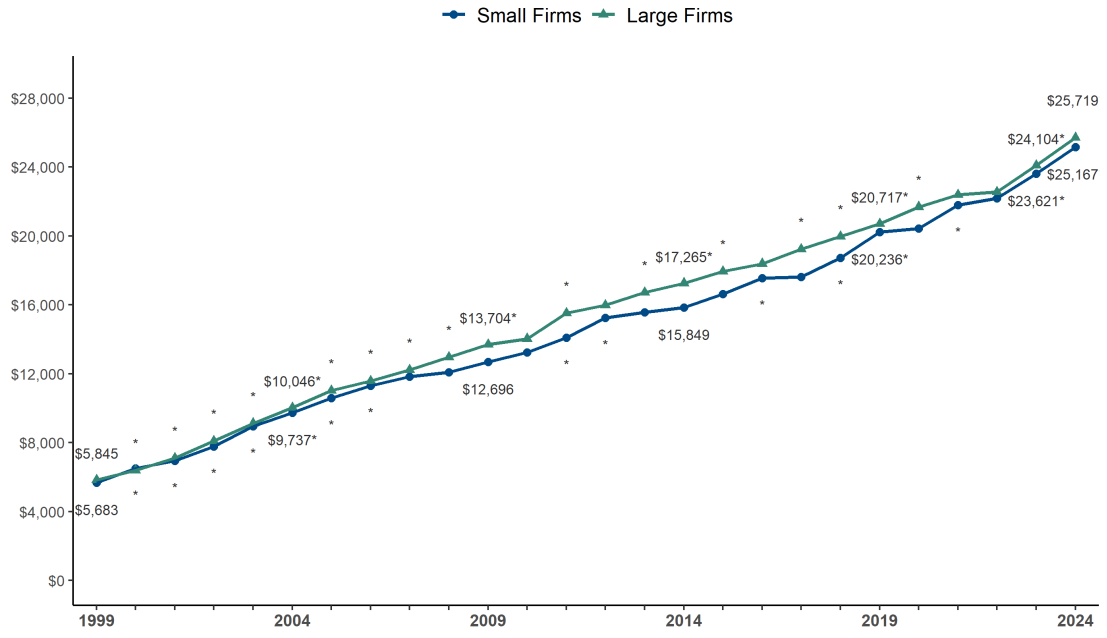
- The average family premium grew 7% in 2024 while wages grew 4.5%. Over the last 5 years, family premiums grew 24%, similar to the 28% growth in wages. Over the last ten years, the average family premium and average wages grew at roughly comparable rates (52% vs. 45%) [Figure 1.15].

Figure 1.12
Average Annual Premiums for Single and Family Coverage, 1999-2024



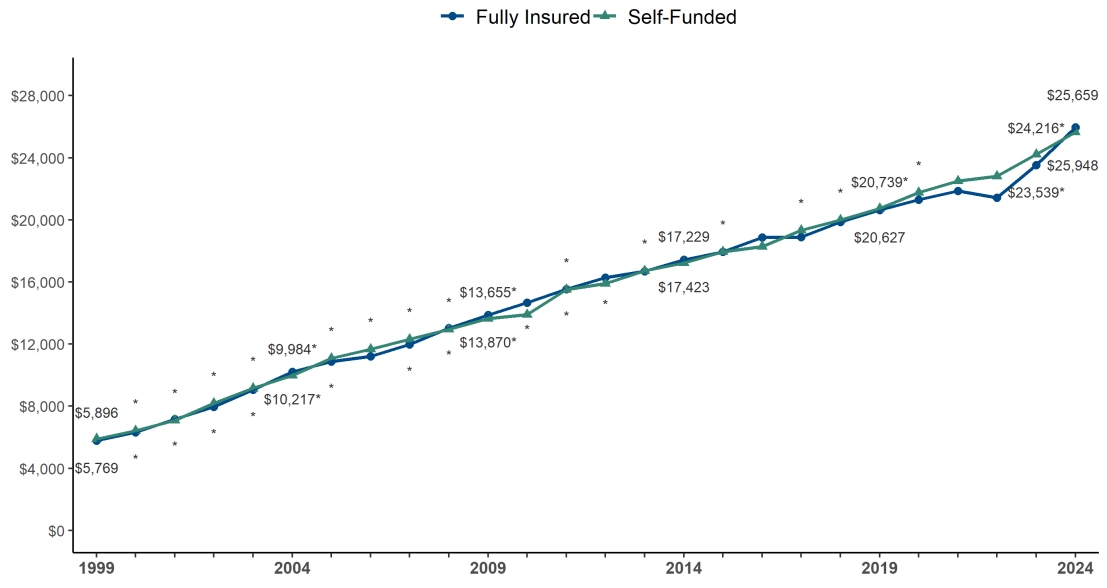
* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
SOURCE: KFF Employer Health Benefits Survey, 2018-2024; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

Figure 1.13
Average Annual Premiums for Covered Workers with Family Coverage, by Firm Size, 1999-2024



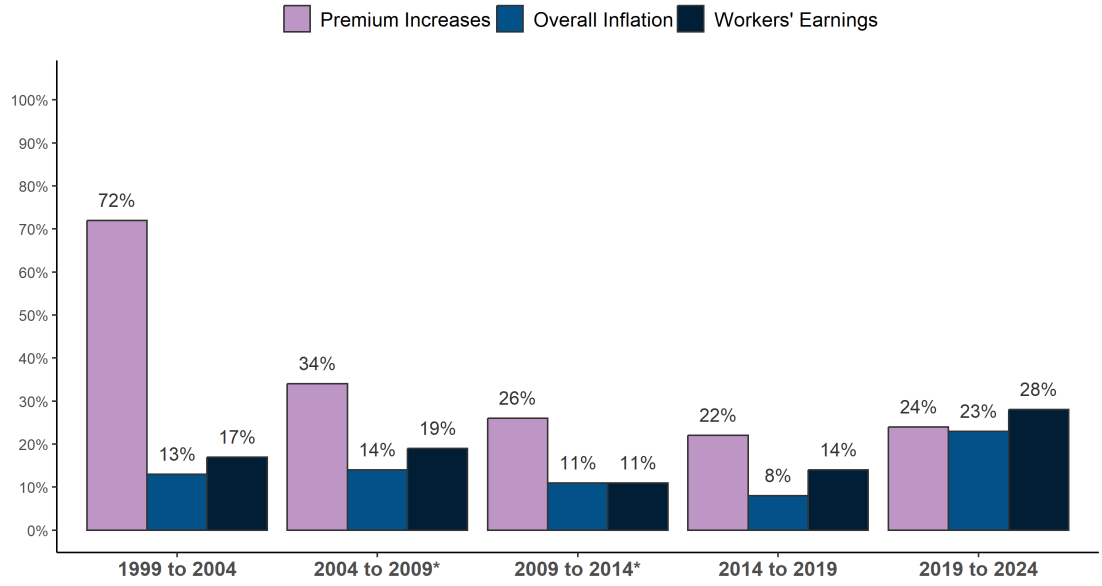
* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2018-2024; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

Figure 1.14
Among Workers in Large Firms, Average Annual Premiums for Family Coverage, by Funding Arrangement, 1999-2024



* 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, 2018-2024; 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, 2004-2024



* Percentage change in family premium is statistically different from previous five year period shown ($p < .05$).
SOURCE: KFF Employer Health Benefits Survey, 2018-2024; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2004-2017. Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation, 2004-2024; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 2004-2024.

Employer Health Benefits
2024 Annual Survey

Health Benefits Offer Rates

SECTION 2

Section 2

Health Benefits Offer Rates

Nearly all (98%) firms with 200 or more workers offer health benefits to at least some workers, while just around one-half (53%) of smaller firms do so. The percentage of all firms offering health benefits in 2024 (54%) is similar to both the percentage of firms offering health benefits last year (53%), and five years ago (57%).

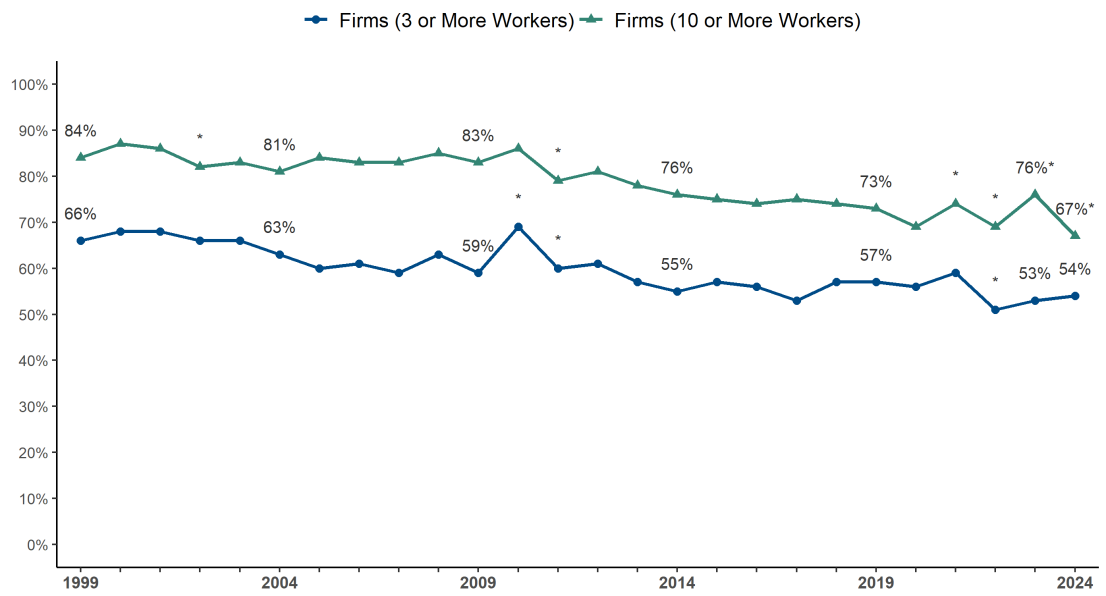
Most firms are very small, so the considerable fluctuation we see across years in the small firm offer rate drives fluctuations in the overall offer rate. However, most workers work for larger firms, where offer rates are high and much more stable. Over ninety percent (93%) of firms with 50 or more workers offer health benefits in 2024; this percentage has remained consistent over the last 10 years. Overall, 89% of workers at firms with 3 or more workers are employed at a firm that offers health benefits to at least some of its workers. Almost all (90%) firms that offer health benefits offer both single and family coverage.

Small firms not offering health benefits say the most important reasons they do not offer coverage are that "the firm is too small" or that "the cost of insurance is too high".

FIRM OFFER RATES

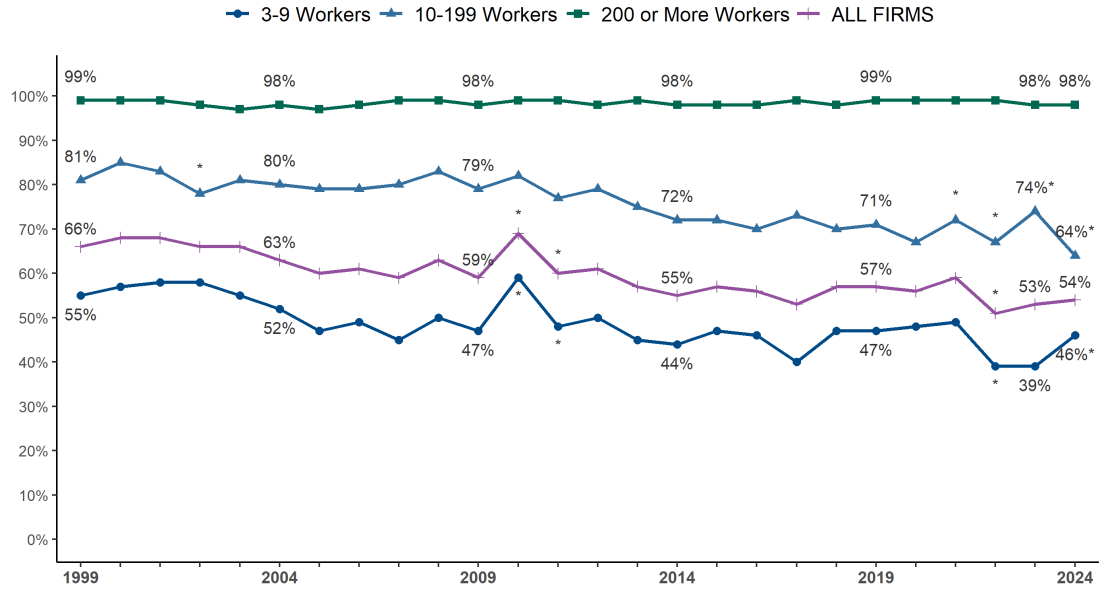
- In 2024, 54% of firms offer health benefits, similar to the percentage last year (53%) [Figure 2.1].
  - The smallest firms are least likely to offer health insurance: 46% of firms with 3-9 workers offer coverage, compared to 56% of firms with 10-24 workers, 68% of firms with 25-49 workers, and 92% of firms with 50-199 workers [Figure 2.3].
  - Since most firms in the country are small, variation in the overall offer rate is driven largely by changes in the offer rates of the smallest firms (3-9 workers) offering health benefits. For more information on the distribution of firms in the country, see the Survey Design and Methods Section and [Figure M.5].
  - Only 51% 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, 1999-2024



* 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). 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, 2018-2024; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

Figure 2.2
Percentage of Firms Offering Health Benefits, by Firm Size, 1999-2024



* 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). 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, 2018-2024; 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, 2024

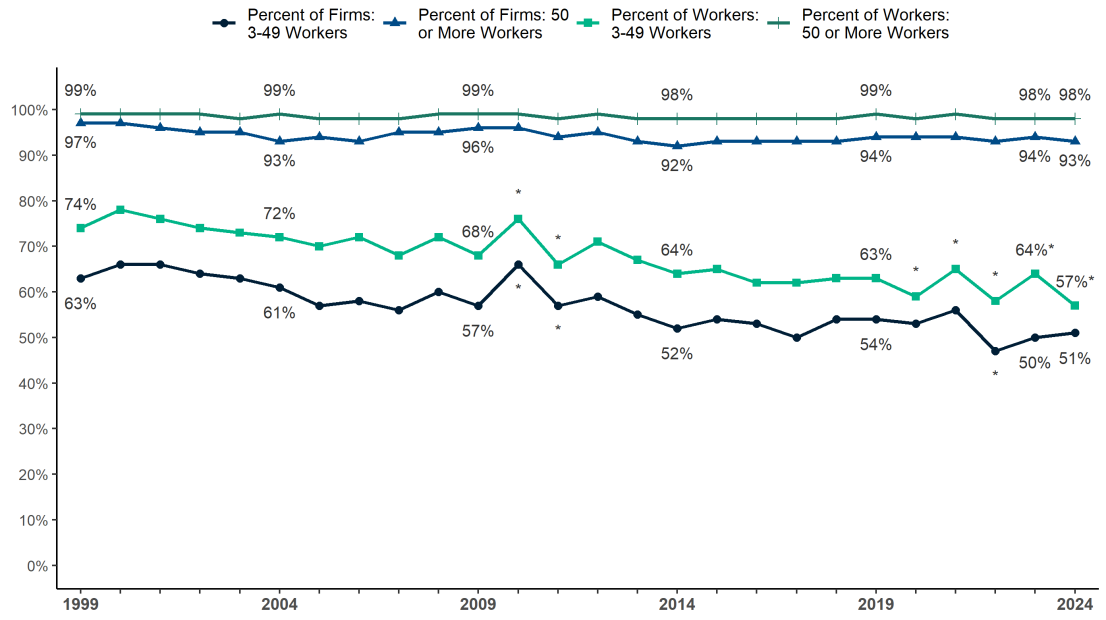
	Percentage of Firms Offering Health Benefits
FIRM SIZE	
3-9 Workers	46%*
10-24 Workers	56
25-49 Workers	68*
50-199 Workers	92*
200-999 Workers	98*
1,000-4,999 Workers	100*
5,000 or More Workers	99*
All Small Firms (3-199 Workers)	**53%***
All Large Firms (200 or More Workers)	**98%***
REGION	
Northeast	55%
Midwest	53
South	52
West	57
INDUSTRY	
Agriculture/Mining/Construction	49%
Manufacturing	65
Transportation/Communications/Utilities	69
Wholesale	62
Retail	40*
Finance	56
Service	52
State/Local Government	83*
Health Care	58
ALL FIRMS	**54%**

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.

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

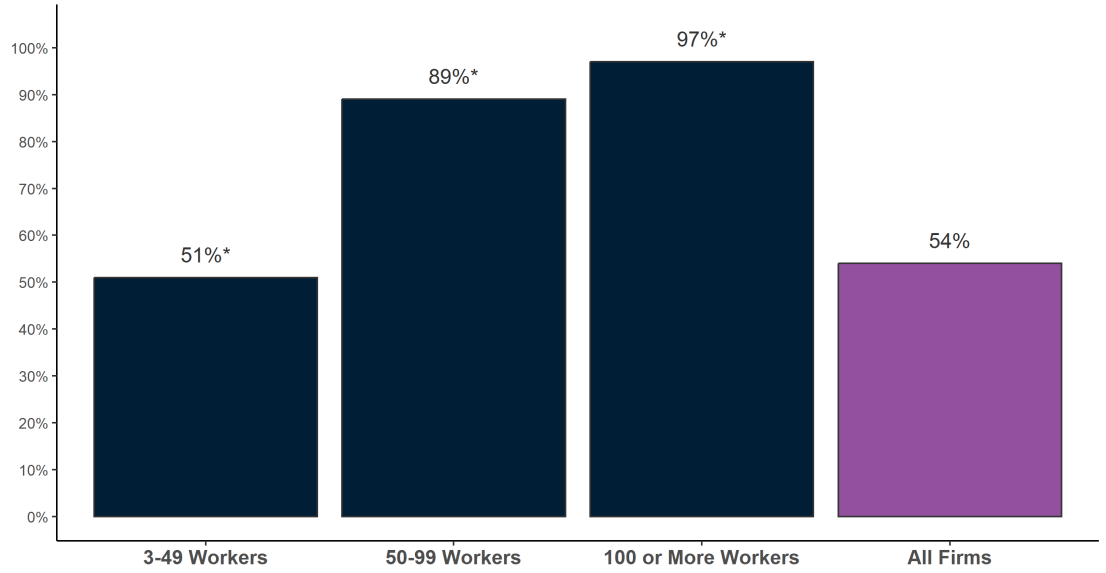
SOURCE: KFF Employer Health Benefits Survey, 2024

Figure 2.4
Percentage of Firms and Workers Offering Health Benefits, by Firm Size, 1999-2024



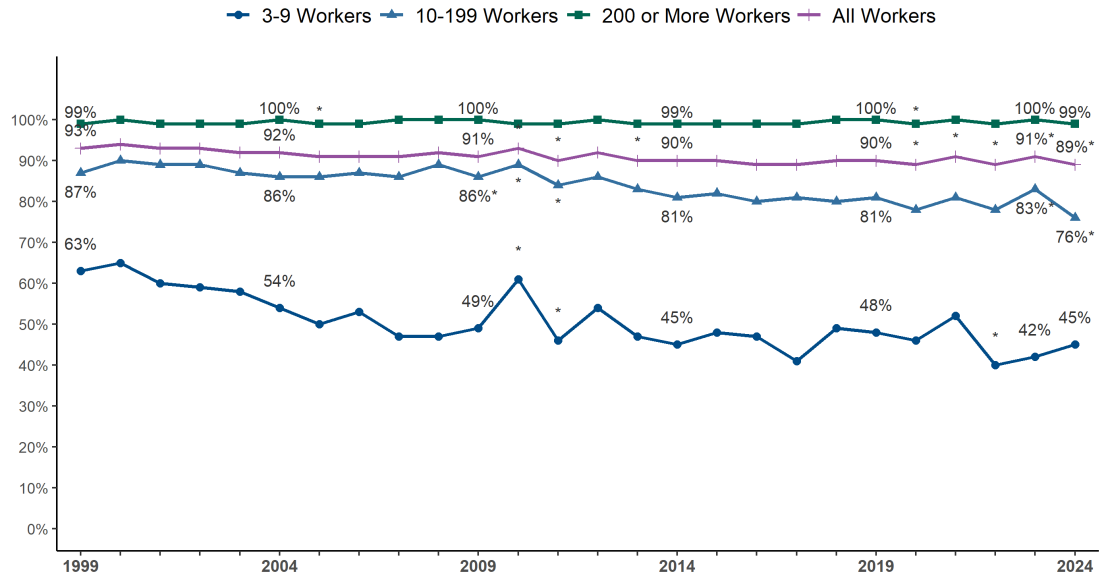
* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
NOTE: Estimates are based on both the sample of firms that completed the entire survey and those that answered just one question about whether they offer health benefits (See Methods). Not all workers at a firm offering benefits are eligible or enrolled in their firm's health benefits.
SOURCE: KFF Employer Health Benefits Survey, 2018-2024; 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, 2024



* 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, 2024

Figure 2.6
Percentage of Workers at Firms That Offer Health Benefits to at Least Some Workers, by Firm Size, 1999-2024

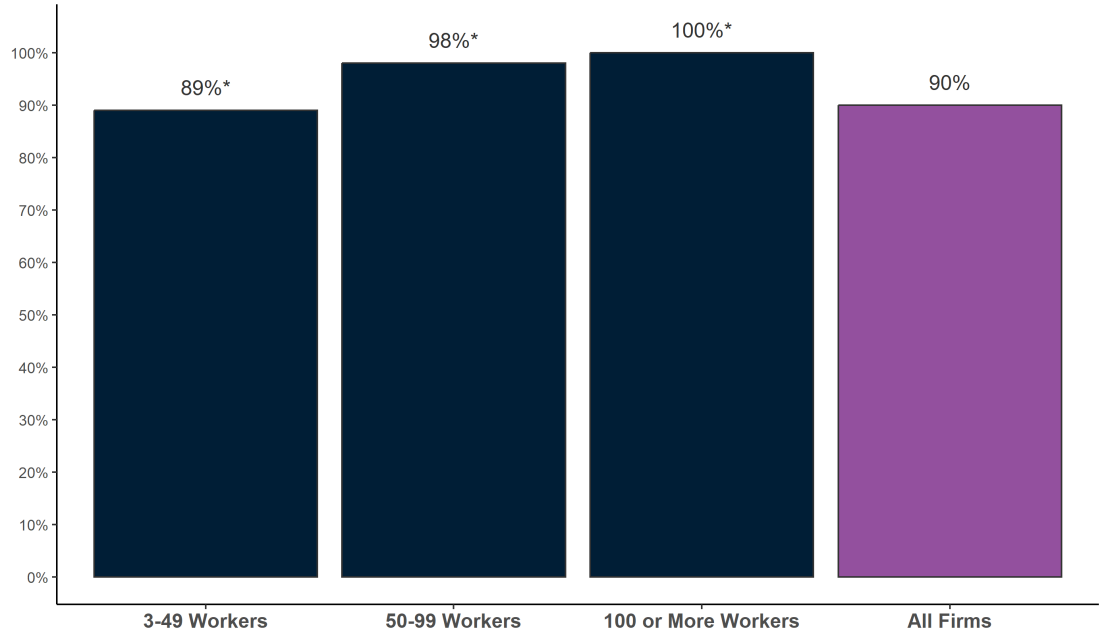


* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
NOTE: Estimates are based on both the sample of firms that completed the entire survey and those that answered just one question about whether they offer health benefits (See Methods). Not all workers at a firm offering benefits are eligible or enrolled in their firm's health benefits.
SOURCE: KFF Employer Health Benefits Survey, 2018-2024; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

OFFERS TO SPOUSES AND DEPENDENTS

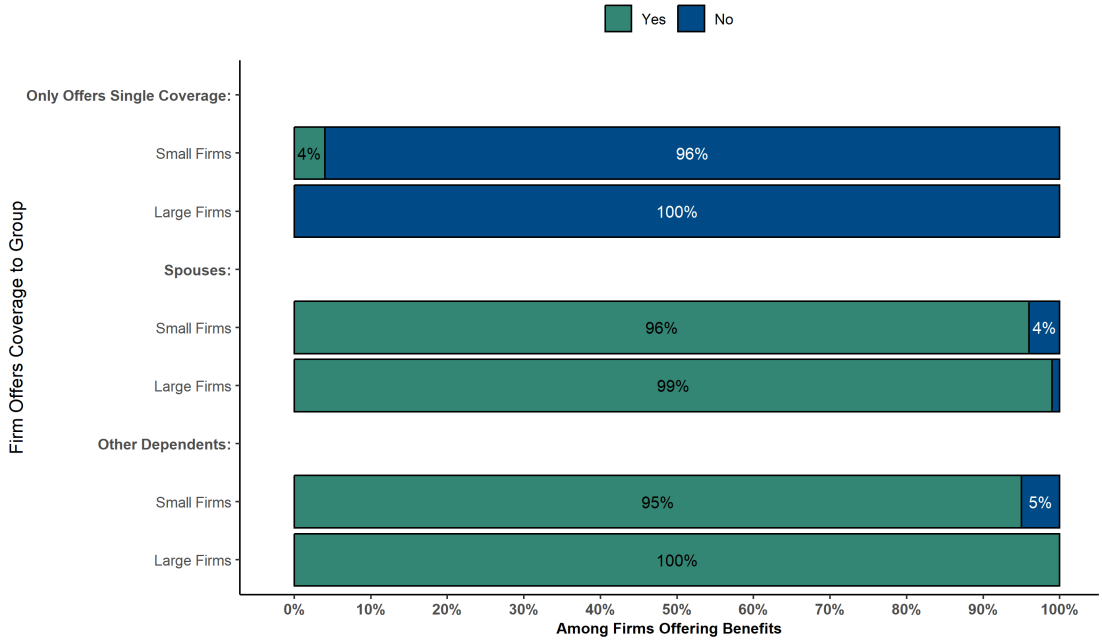
- Almost all firms offering health benefits offer family coverage; in 2024, nearly all large firms and 90% of smaller firms offer family coverage [Figure 2.7].
- The vast majority of firms with 10 or more workers offering health benefits offer to spouses and dependents, such as children. Ninety-six percent of firms with 10 to 199 workers and 99% of larger firms offering health benefits offer coverage to spouses. These percentages are similar to the percentages in 2023 [Figure 2.8].
  - Ninety-five percent of firms with 10 to 199 workers and 100% of larger firms offering health benefits offer coverage to dependents other that spouses, such as children. These percentages are similar to the percentages in 2023 [Figure 2.8].
  - Four percent of firms with 10 to 199 workers offering health benefits offer only single coverage to their workers, similar to the percentage (5%) last year [Figure 2.8].
- Even when family coverage is offered, some workers may elect to enroll in self-only coverage, either because they do not have eligible dependents, or their family members have other coverage options. Among firms with 10 to 199 workers who offer coverage to dependents, 35% of firms report that more than three-quarters of their covered workers enroll in self-only coverage, compared to 23% at larger firms. Among firms offering health benefits to dependents with 5,000 or more workers, 9% of firms report that more than three-quarters of their covered workers enroll in self-only coverage [Figure 2.9].

Figure 2.7
Percentage of Firms Offering Health Benefits Which Offer Family Coverage, by Firm Size, 2024



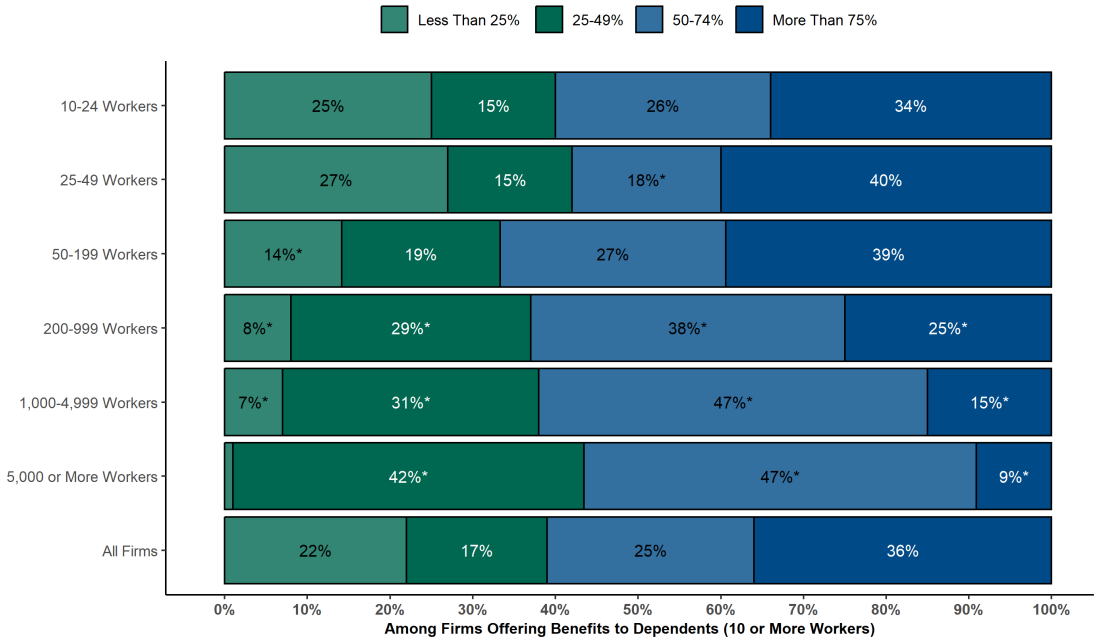
* Estimate is statistically different from estimate for all other firms not in the indicated size category ($p < .05$).
SOURCE: KFF Employer Health Benefits Survey, 2024

Figure 2.8
Percentage That Offer to Spouses and Dependents, by Firm Size, 2024



NOTE: Small Firms have 10-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2024

Figure 2.9
Percentage of Covered Workers Enrolled in Self-Only Coverage, by Firm Size, 2024



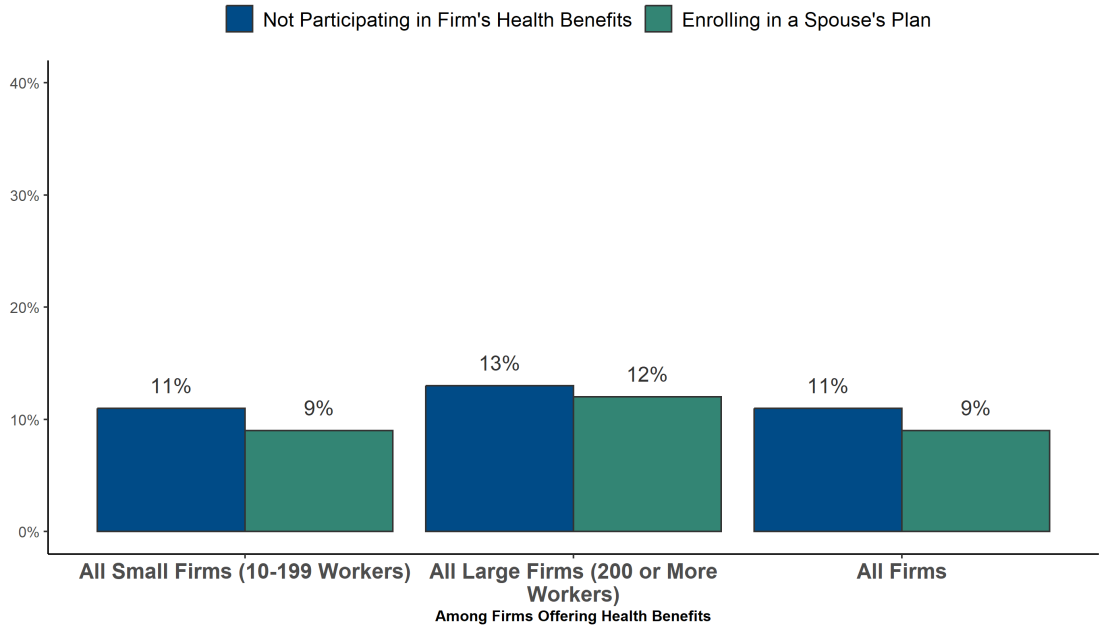
* Estimate is statistically different from estimate for all other firms not in the indicated size category ($p < .05$).
NOTE: Self only coverage is defined as workers who are enrolled in a health plan but do not have dependents on that plan.
SOURCE: KFF Employer Health Benefits Survey, 2024

PROVISIONS TO ENCOURAGE ENROLLMENT IN OTHER COVERAGE

Some firms have provisions to encourage workers or their spouses forgo enrolling in coverage or to choose other coverage when it is available.

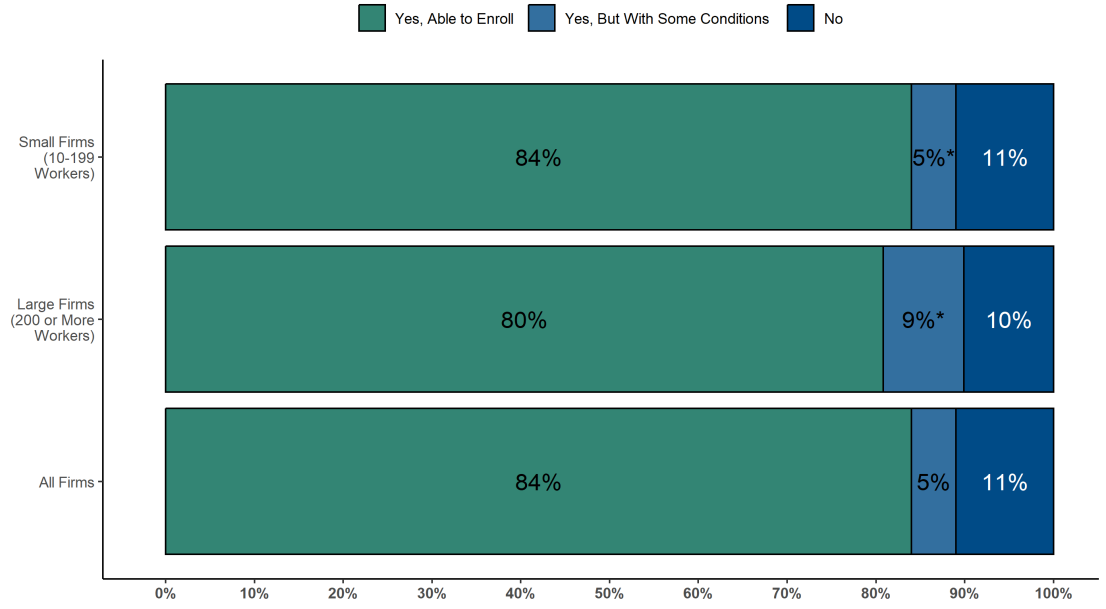
- Among firms with 10 or more workers offering coverage, 11% provide additional compensation or benefits to workers if they choose not to enroll in the firm's health plan and 9% provide additional compensation or benefits to workers who choose to enroll in a spouses health plan [Figure 2.10].
- Among firms with 200 or more workers offering coverage to spouses, 10% do not allow the spouse to enroll if they are offered health insurance from another source, 13% place conditions on spouses wishing to enroll, such as limiting plan choice, or requiring a surcharge for enrolling spouses if they are offered coverage from another source [Figure 2.12]. Among firms with 200 or more workers offering coverage to spouses, 8% require a surcharge for spouses who are offered coverage from another source. In total, 24% of firms with 200 or more workers offering coverage to spouses place a restriction on eligibility or require a surcharge for spouses who have an offer from another source [Figure 2.12].

Figure 2.10
Percentage of Firms That Provide Workers Additional Incentives For Various Enrollment Decisions, by Firm Size, 2024



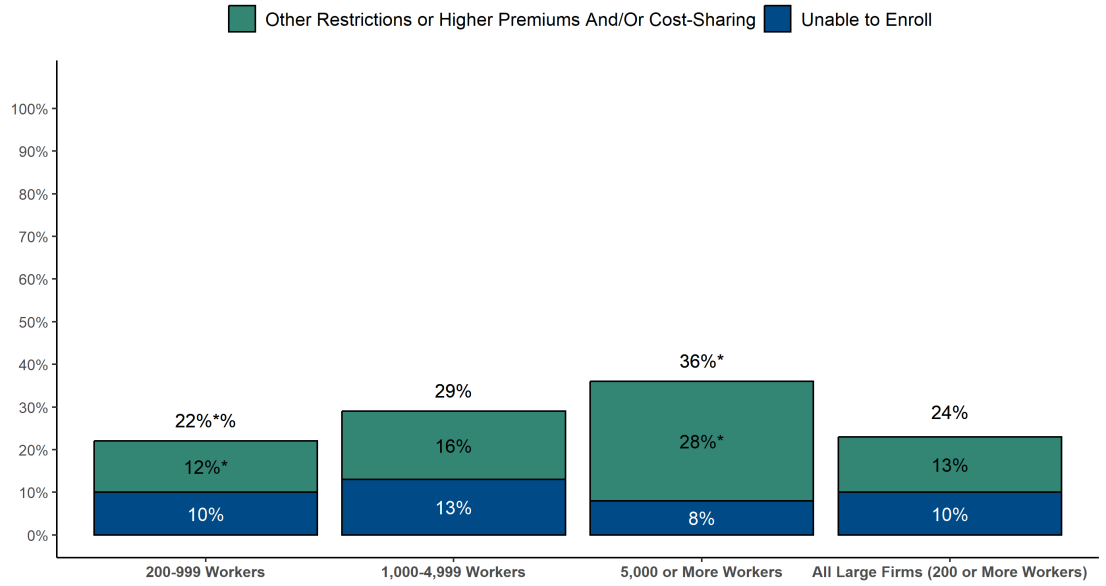
Tests found no statistical difference from estimate for all other firms not in the indicated size category ($p < .05$).
SOURCE: KFF Employer Health Benefits Survey, 2024

Figure 2.11
Percent of Firms Offering Spousal Coverage Which Restrict Spouses' Eligibility if They Have an Offer from Another Source, by Firm Size, 2024



* Estimates are statistically different between Small Firm and Large Firm estimates within category ($p < .05$).
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, 2024

Figure 2.12
Among Large Firms that Offer Spousal Coverage, Spouses' Eligibility if They Have an Offer from Another Source, by Firm Size, 2024



* Estimate is statistically different from estimate for all other firms not in the indicated size category ($p < .05$).
NOTE: Other restrictions may include requirements on the work status of the spouse, or the type of coverage they have access to. Among firms with 200 or more workers offering coverage to spouses, 8% require a surcharge for spouses who are offered coverage from another source.
SOURCE: KFF Employer Health Benefits Survey, 2024

PART-TIME WORKERS

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

The Affordable Care Act (ACA) defines "full-time" workers as those who work an average of at least 30 hours per week, and "part-time" workers as those who work fewer than 30 hours. The employer shared responsibility provision of the ACA requires that firms with at least 50 full-time equivalent employees offer most of their 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 per week. The question did not previously 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 use multiple definitions of "part-time" - one for compliance with legal requirements, and another for internal policies and programs.

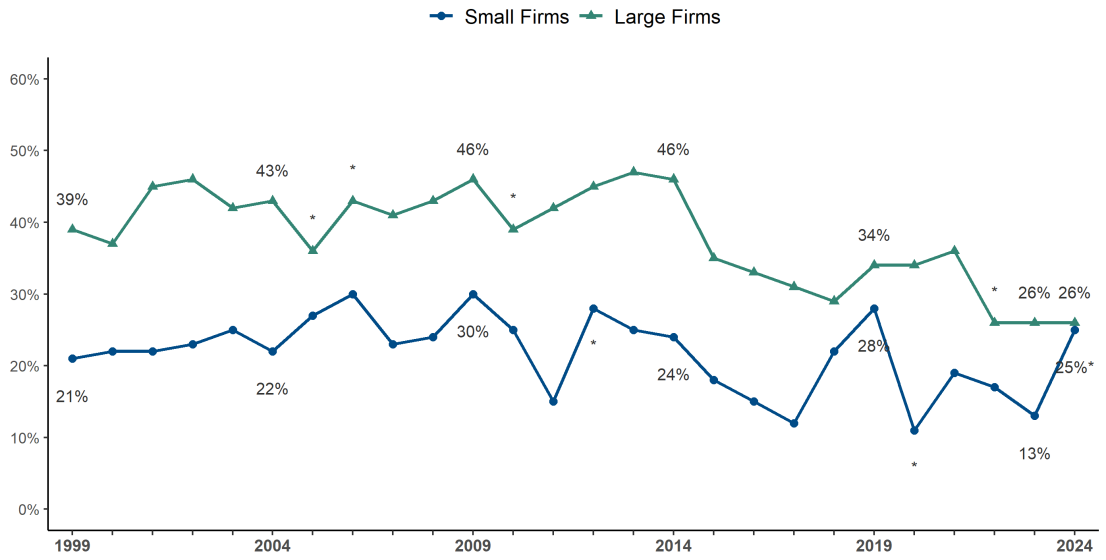
- Twenty-six percent of large firms that offer health benefits in 2024 offer health benefits to part-time workers, the same percentage that did so in 2023 [Figure 2.13]. The share of large firms offering health benefits to part-time workers increases with firm size [Figure 2.14].

Many firms offer voluntary benefits to their workers, separate from coverage provided through their health plans. These plans can help with costs that are not covered by the health plan, or provide additional financial assistance if an enrollee is hospitalized or for specialized services such as telehealth. Employers might contribute toward the cost of these benefits, or employees might pay the entire cost. Some employers extend coverage of voluntary

[1] Employer Responsibility Under the Affordable Care Act. KFF. https://www.kff.org/infographic/employer-responsibility-under-the-affordable-care-act/.

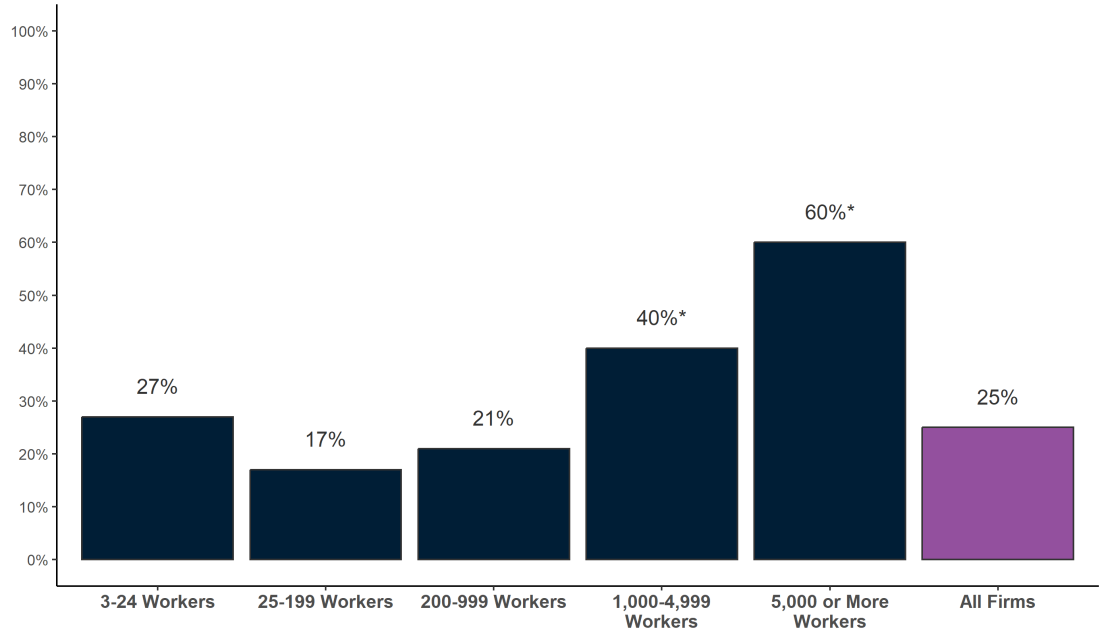
benefits to part-time workers who are not enrolled in the firm's health plans. In 2024, 3% of small firms and 14% of large firms not offering coverage to part-time workers offered them a voluntary benefit [Figure 2.15].

Figure 2.13
Among Firms Offering Health Benefits, Percentage That Offer to Part-Time Workers, by Firm Size, 1999-2024



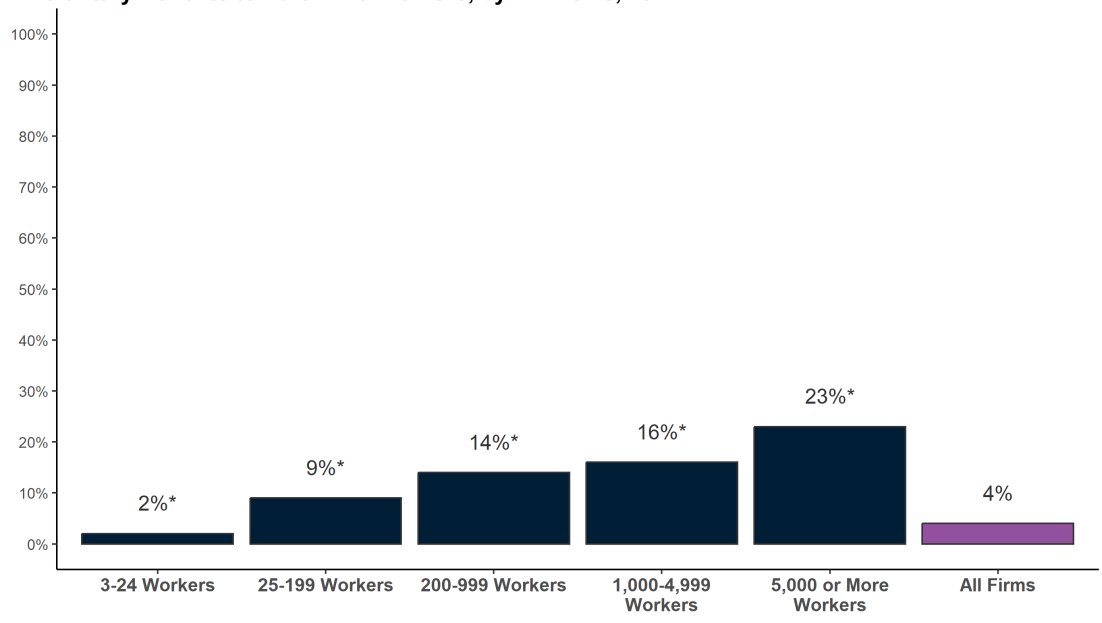
* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers. Prior to 2015, each respondent defined part-time according to their firm's policies; starting in 2015, respondents were asked whether 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, 2018-2024; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

Figure 2.14
Among Firms Offering Health Benefits, Percentage That Offer to Part-Time Workers, by Firm Size, 2024



* Estimate is statistically different from estimate for all other firms not in the indicated size category ($p < .05$).
SOURCE: KFF Employer Health Benefits Survey, 2024

Figure 2.15
Among Firms Not Offering Health Benefits to Part-Time Workers, Percentage That Offer Voluntary Benefits to Part-Time Workers, by Firm Size, 2024



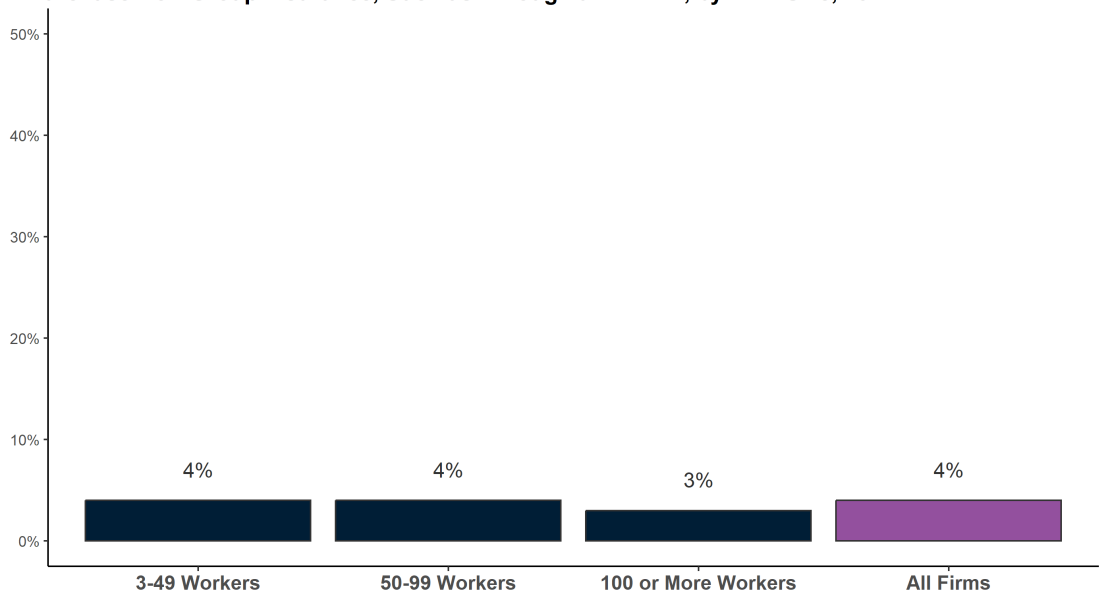
* Estimate is statistically different from estimate for all other firms not in the indicated size category ($p < .05$).
NOTE: Voluntary benefits for part-time workers can include coverage of benefits such as telehealth benefits or hospital indemnity insurance.
SOURCE: KFF Employer Health Benefits Survey, 2024

ICHRA AND ASSISTING EMPLOYEES WITH PURCHASING 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 offer these funds as an alternative to offering a group plan. Additionally, employers that offer a group plan to some employees may use this approach for other types or classes of workers, such as part-time employees. One way an employer can provide tax-preferred assistance for employees to purchase non-group coverage is through an Individual Coverage Health Reimbursement Arrangement, or ICHRA. Both employers that offer and those that do not offer health benefits were asked if they provide funds to any employee to purchase non-group coverage.

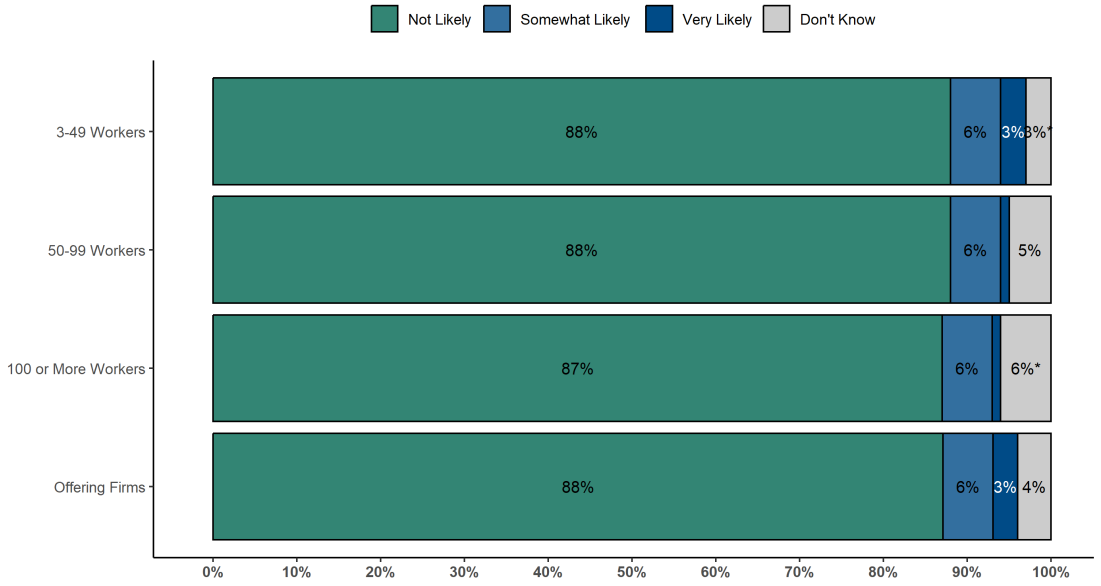
- Four percent of firms offering health benefits, and 7% of firms not offering health benefits, offered funds to one or more of their employees to purchase non-group coverage in 2024 [Figure 2.16].
- Among small firms not offering health benefits, 7% offered funds to one or more of their employees to purchase non-group coverage, a similar percentage (12%) as last year [Figure 2.18].
- Among firms offering health benefits that do not offer funds to any employees to purchase non-group coverage in 2024, 3% say they are "very likely" and an additional 6% are "somewhat likely" to offer an ICHRA to at least some employees in the next two years [Figure 2.17]. Among small firms not offering health benefits that do not offer funds to any employees to purchase non-group coverage in 2024, only 5% say they are "very likely" and an additional 15% say they are "somewhat likely" to offer an ICHRA to at least some employees in the next two years [Figure 2.19].

Figure 2.16
Among Firms Offering Health Benefits, Percentage of Firms That Provide Workers Funds to Purchase Non-Group Insurance, Such as Through an ICHRA, by Firm Size, 2024



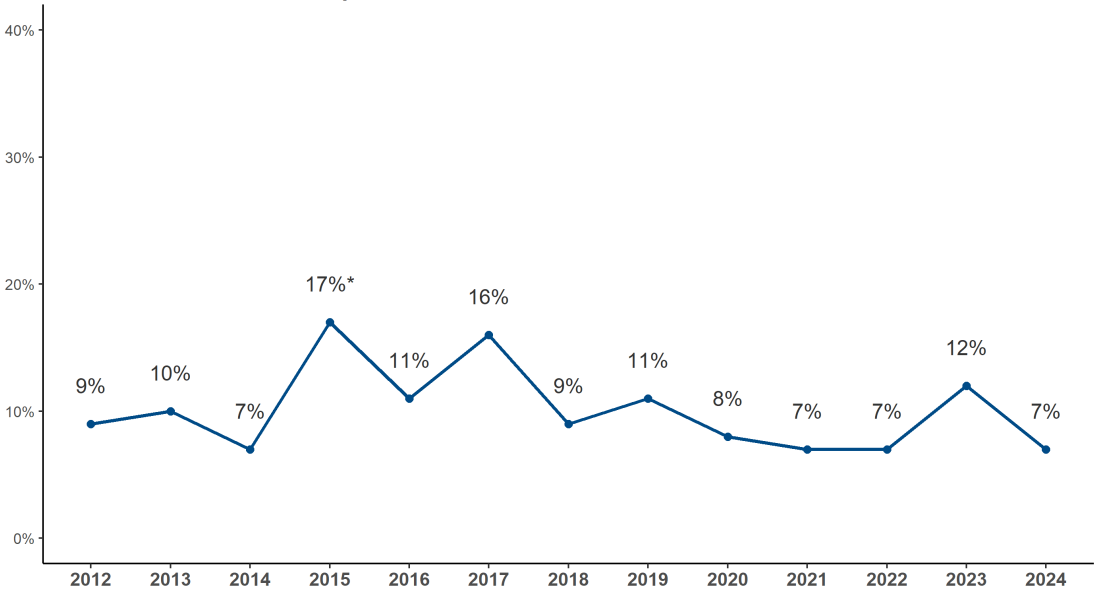
Tests found no statistical difference from estimate for all other firms not in the indicated size category ($p < .05$).
NOTE: Funds may be provided through an ICHRA. An Individual Coverage Health Reimbursement Arrangement (ICHRA) allows employers to reimburse their employees tax-free for premiums, cost-sharing as well as some other health services and equipment
SOURCE: KFF Employer Health Benefits Survey, 2024

Figure 2.17
Among Firms Offering Health Benefits, How Likely is Firm to Offer an ICHRA in the Next Two Years, by Firm Size, 2024



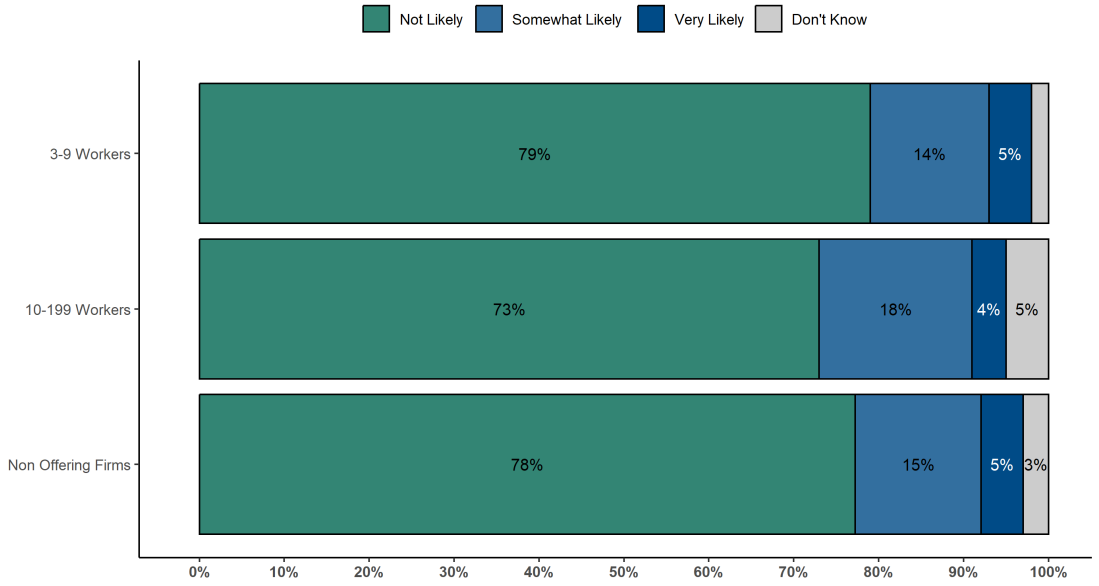
* Estimates are statistically different from each other within category (p < .05).
NOTE: An Individual Coverage Health Reimbursement Arrangement (ICHRA) allows employers to reimburse their employees tax-free for premiums, cost-sharing as well as some other health services and equipment
SOURCE: KFF Employer Health Benefits Survey, 2024

Figure 2.18
Among Small Firms Not Offering Health Benefits, Percentage of Firms That Provide Workers Funds to Purchase Non-Group Insurance, 2012-2024



* 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, 2018-2024; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2012-2017

Figure 2.19
Among Small Firms Not Offering Health Benefits, How Likely is Firm to Offer an ICHRA in the Next Two Years, by Firm Size, 2024



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, 2024

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, what their most important reasons for not offering coverage are, 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, 28% say the "firm is too small," 27% say the cost of insurance is too high, 19% say their "employees are covered under another plan, including coverage on a spouse's plan" and 6% say their "employees are not interested." A small share (3%) of small firms indicate that they do not offer health benefits because they believe employees will get a better deal on the health insurance exchanges [Figure 2.20].
- Some small non-offering firms have either offered health insurance in the past five years or shopped for health insurance in the past year.
  - Ten percent of small non-offering firms have offered health benefits in the past five years, similar to the percentage reported last year [Figure 2.21]. Among these small non-offering firms, 35% stopped offering coverage within the past year.
  - Fourteen percent of small non-offering firms have shopped for coverage in the past year, the same as the percentage last year (13%) [Figure 2.21].

- Eighty percent of small firms not offering health benefits agreed with the statement that their employees would prefer a two dollar per hour increase in wages rather than health insurance [Figure 2.22].

Figure 2.20

Among Small Firms Not Offering Health Benefits, Most Important Reason for Not Offering, 2024

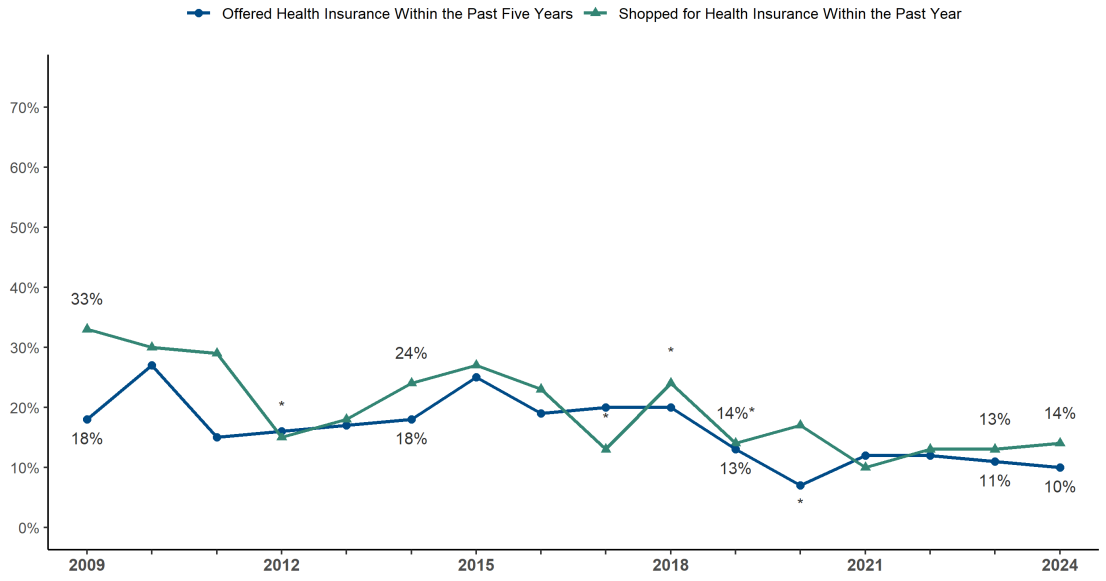
	3-9 Workers	10-199 Workers	All Small Firms
Cost of Health Insurance Too High	23%	37%	**27%**
Firm Is Too Small	32%	19%	**28%**
Employees Are Covered Under Another Plan, Including Spouse's	22%	12%	**19%**
Employees Will Get a Better Deal On Health Insurance Exchanges	2%	7%	**3%**
Employee Turnover Is Too Great	1%	4%	**2%**
No Interest/Employees Do Not Want It	6%	9%	**6%**
Most Employees Are Part-Time or Temporary Workers	11%	11%	**11%**
Other	2%	1%	**2%**
Don't Know	2%	1%	**2%**

NOTE: Small Firms have 3-199 workers.

SOURCE: KFF Employer Health Benefits Survey, 2024

Figure 2.21

Among Small Firms Not Offering Health Benefits, Percentage of Firms That Report the Following Actions, 2009-2024

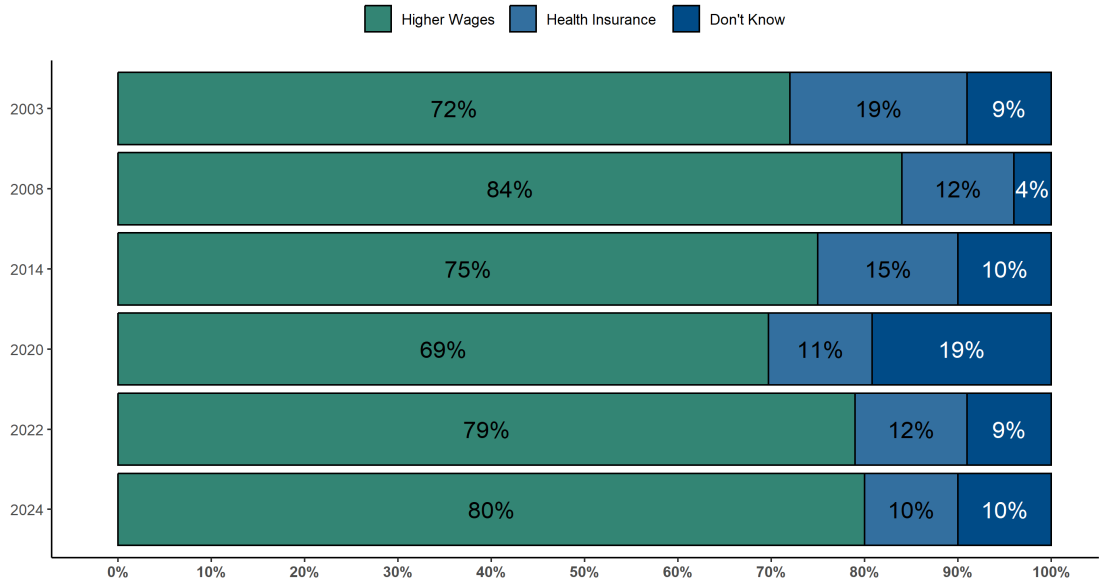


* Estimate is statistically different from estimate for the previous year shown (p < .05).

NOTE: Small Firms have 3-199 workers. 35% 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, 2018-2024; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2009-2017

Figure 2.22
Among Small Firms Not Offering Health Benefits, Firms' View of Employees' Preference for Higher Wages or Health Insurance Benefits, 2008-2024



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, 2020-2024; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2003-2014

Employer Health Benefits
2024 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 154 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 2024, 61% 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

- Some workers employed at firms that offer health benefits may not be eligible to participate. Many firms, for example, do not offer coverage to part-time or temporary workers[2]. Among workers in firms offering health benefits in 2024, 81% are eligible to enroll in the benefits offered by their firm, similar to the percentages last year, five years ago, and ten years ago [Figure 3.1].
  - Eligibility varies considerably with firm wage level. Workers in firms with a relatively large share of lower-wage workers (where at least 35% of workers earn $35,000 a year or less) have a lower average eligibility rate than workers in firms with a smaller share of lower-wage workers (71% vs. 83%) [Figure 3.6].
  - Workers in firms with a relatively large share of higher-wage workers (where at least 35% earn $77,000 or more annually) have a higher average eligibility rate than workers in firms with a smaller share of higher-wage workers (87% vs. 77%) [Figure 3.6].
  - Eligibility also varies by the age of the workforce within firms. Those in firms with a relatively small share of younger workers (where fewer than 35% of the workers are age 26 or younger) have a higher average eligibility rate than those in firms with a larger share of younger workers (84% vs. 61%). 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 (84% vs. 78%) [Figure 3.6].
  - Eligibility rates vary considerably for workers in different industries. The average eligibility rate remains particularly low for workers in retail firms (57%) [Figure 3.3].

[1] KFF. Health Insurance Coverage of the Nonelderly [Internet]. San Francisco (CA): KFF; 2022 [cited 2024 Aug 26. 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, 1999-2024

	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%
2023	82%*	78%	79%	71%	76%	75%	58%	60%	59%
2024	83%	80%	81%	72%	77%	75%	60%	62%	61%

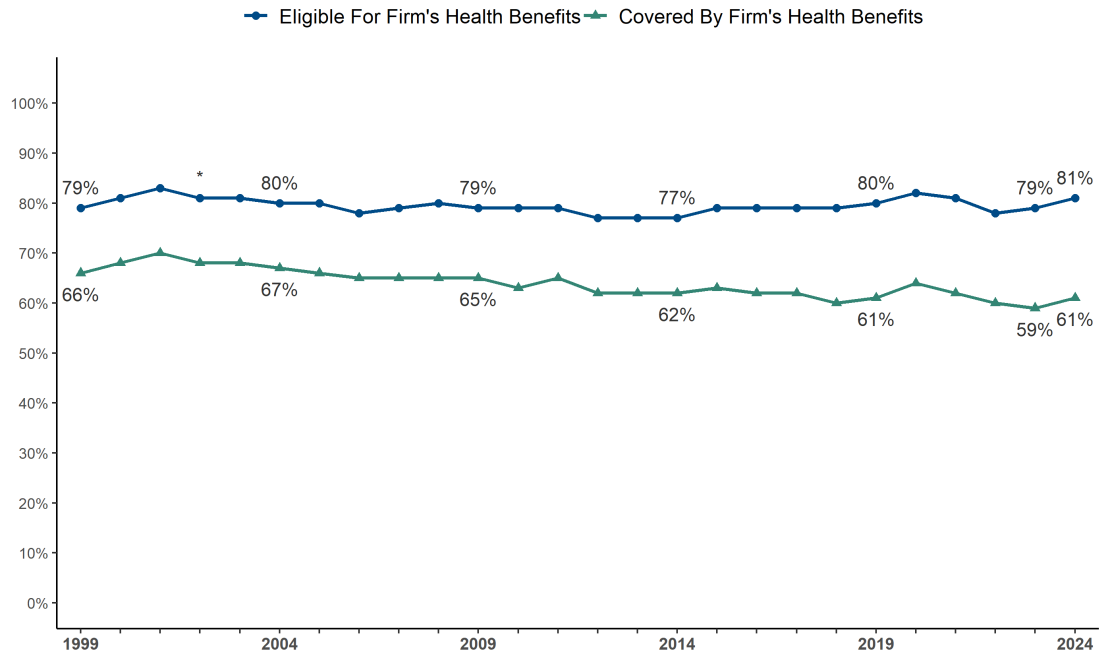
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers.

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

SOURCE: KFF Employer Health Benefits Survey, 2018-2024; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

Figure 3.2

Eligibility and Coverage Rates for Workers in Firms Offering Health Benefits, 1999-2024



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

SOURCE: KFF Employer Health Benefits Survey, 2018-2024; 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, 2024

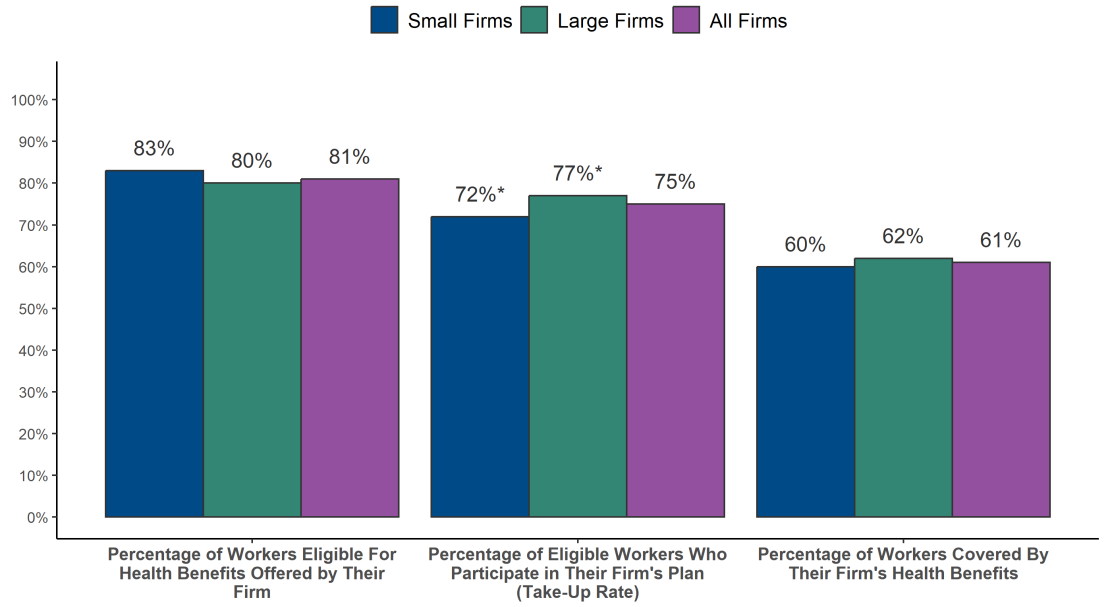
	Percentage of Workers Eligible for Health Benefits Offered by Their Firm	Percentage of Eligible Workers Who Participate in Their Firm's Plan (Take-Up Rate)	Percentage of Workers Covered by Their Firm's Health Benefits
FIRM SIZE			
3-24 Workers	85%	72%	61%
25-49 Workers	84	67*	56
50-199 Workers	81	74	60
200-999 Workers	81	75	61
1,000-4,999 Workers	83	76	63
5,000 or More Workers	79	78*	62
All Small Firms (3-199 Workers)	**83%**	**72%***	**60%**
All Large Firms (200 or More Workers)	**80%**	**77%***	**62%**
REGION			
Northeast	78%	75%	58%
Midwest	83	74	61
South	83	76	63
West	79	78	61
INDUSTRY			
Agriculture/Mining/Construction	82%	60%*	49%*
Manufacturing	93*	78	72*
Transportation/Communications/Utilities	92*	83*	77*
Wholesale	89*	78	69*
Retail	57*	64*	37*
Finance	95*	78	74*
Service	79	74	58*
State/Local Government	88*	90*	79*
Health Care	80	76	61
ALL FIRMS	**81%**	**75%**	**61%**

* 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, 2024

Figure 3.4

Eligibility, Take-Up, and Coverage Rates in Firms Offering Health Benefits, by Firm Size, 2024

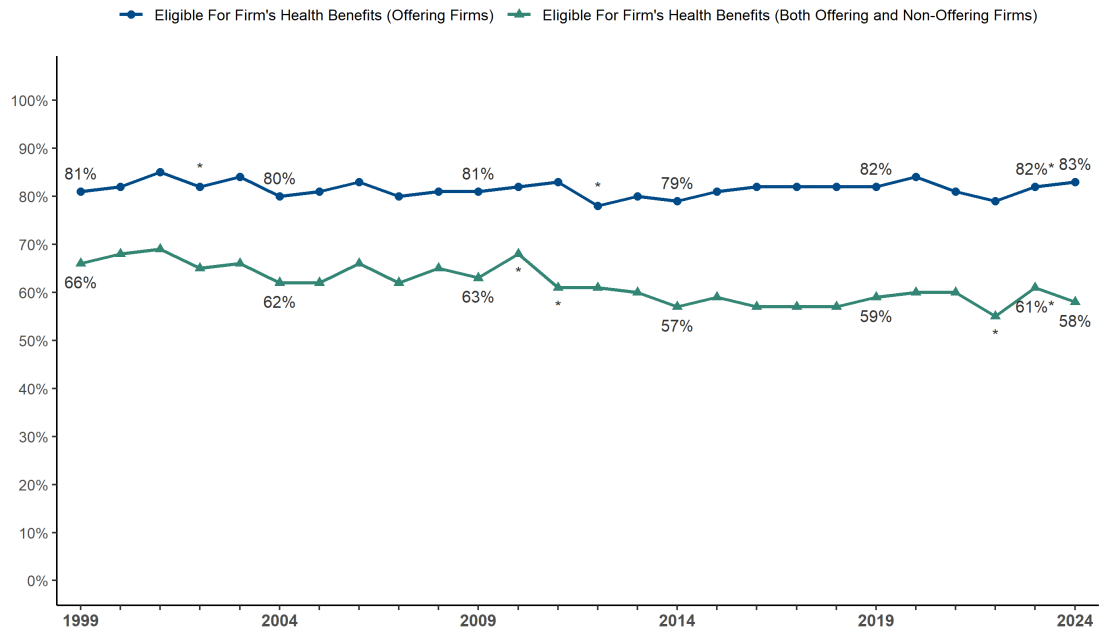


* Estimate for eligibility, take-up, or coverage rate is statistically different between large and small firms ($p < .05$).

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

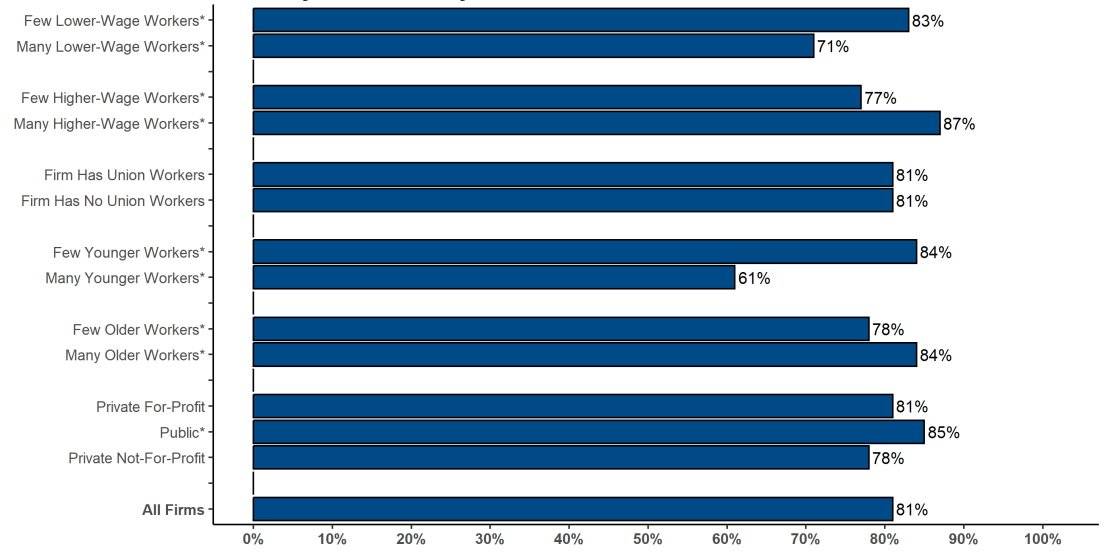
SOURCE: KFF Employer Health Benefits Survey, 2024

Figure 3.5
Among Workers at Small Firms, Eligibility for Workers At Their Own Firms, 1999-2024



* 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. Small Firms have 3-199 workers.
SOURCE: KFF Employer Health Benefits Survey, 2018-2024; 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, 2024

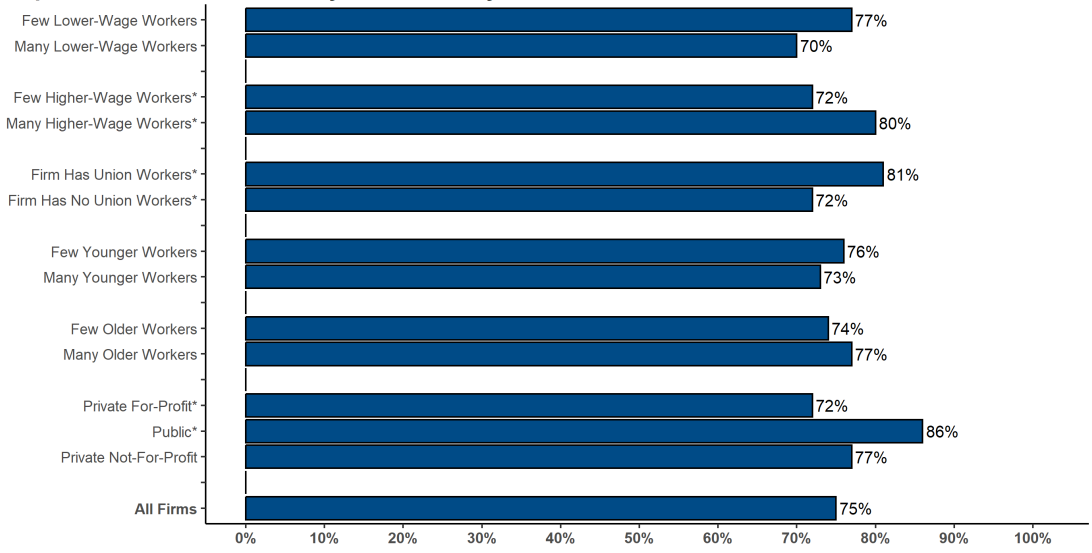


* Estimates are statistically different from each other within category ($p < .05$).
NOTE: Firms with many lower-wage workers are those where at least 35% earn the 25th percentile or less of national earnings ($35,000 in 2024). Firms with many higher-wage workers are those where at least 35% earn the 75th percentile or more than of national earnings ($77,000 in 2024). 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, 2024

TAKE-UP RATE

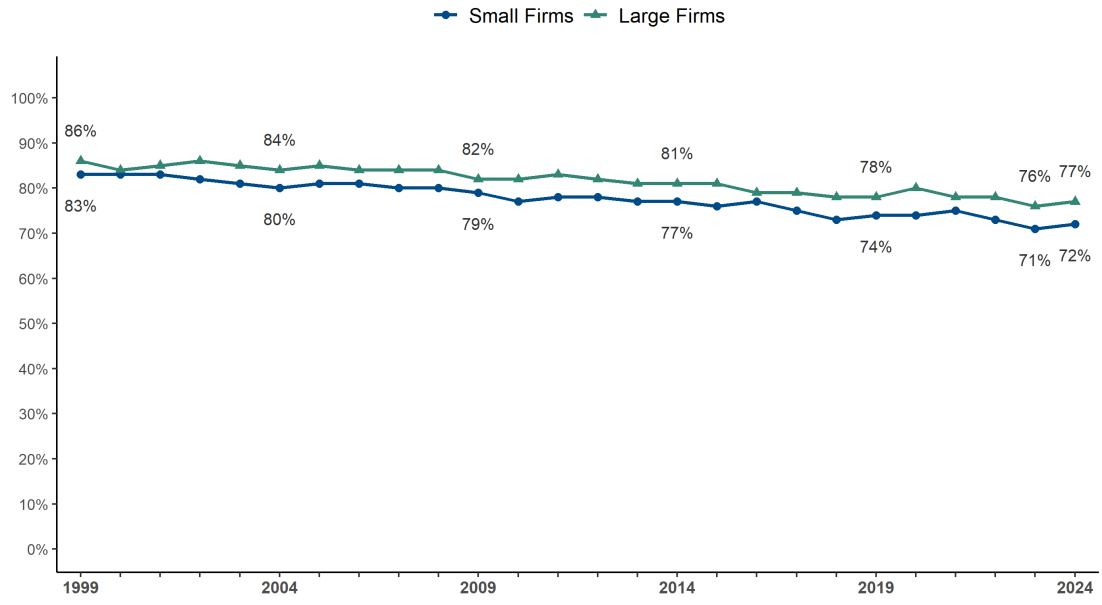
- On average, 75% of eligible workers take up coverage when it is offered to them, similar to the percentage last year [Figure 3.7].
  - Eligible workers in small firms have a lower average take up rate than those in larger firms (72% vs. 77%) [Figure 3.8].
  - Eligible workers in firms with a relatively 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 (80% vs. 72%) [Figure 3.7].
  - Eligible workers in private, for-profit firms have a lower average take up rate (72%) 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 (72%) [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 (75%) is similar to the share in 2019 (76%) but lower than the share in 2014 (80%) [Figure 3.1].

Figure 3.7
Among Workers in Firms Offering Health Benefits, Percentage of Eligible Workers Who Take Up Health Benefits Offered by Their Firm, by Firm Characteristics, 2024



* 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 ($35,000 in 2024). Firms with many higher-wage workers are those where at least 35% earn the 75th percentile or more than of national earnings ($77,000 in 2024). 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, 2024

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, 1999-2024



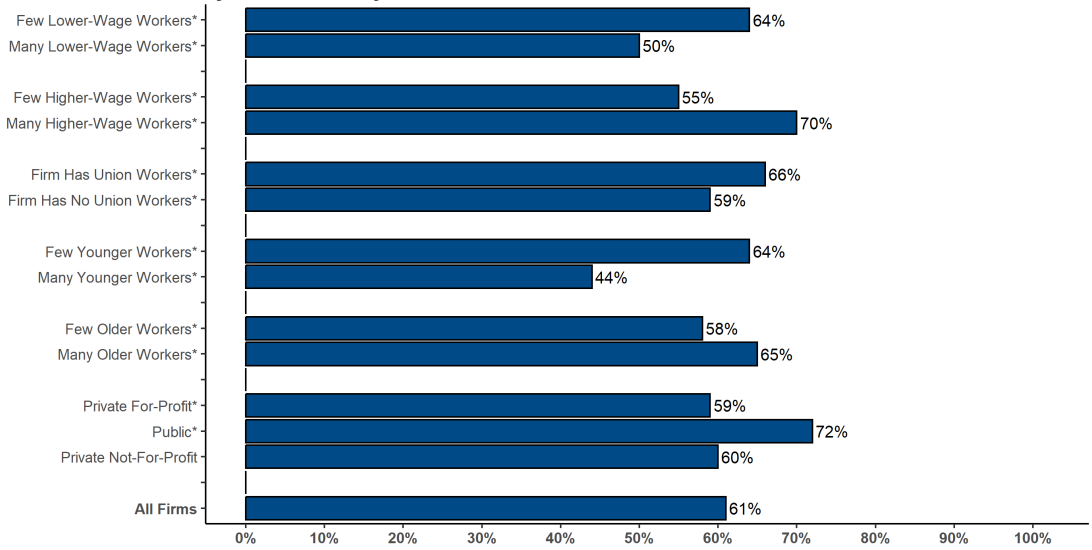
Tests found no statistical difference from estimate for the previous year shown ($p < .05$).
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2018-2024; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

COVERAGE

- In 2024, the percentage of workers at firms offering health benefits covered by their firm's health plan is 61%, similar to the percentage last year [Figure 3.10].
  - The coverage rate at firms offering health benefits is similar for small firms and large firms in 2024. These rates are similar to the rates last year for both small firms and large firms [Figure 3.1].
- 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 (37%) [Figure 3.3].
- The coverage rate also varies with 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 (50% vs. 64%). A similar pattern exists in firms with a relatively large share of higher-wage workers, with workers in these firms being more likely to be covered by their employer's health benefits than those in firms with a smaller share of higher-wage workers (70% vs. 55%) [Figure 3.9].
- The age distribution of workers is also related to variation in coverage rates. Among workers in firms offering health benefits, those in firms with a relatively small share of younger workers are more likely to be covered by their own firm than those in firms with a larger share of younger workers (64% vs. 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 (65% vs. 58%) [Figure 3.9].
- Among workers in firms offering health benefits, those employed at a firm with some union workers are more likely than workers in firms without union workers to be covered by their own firm [Figure 3.9].

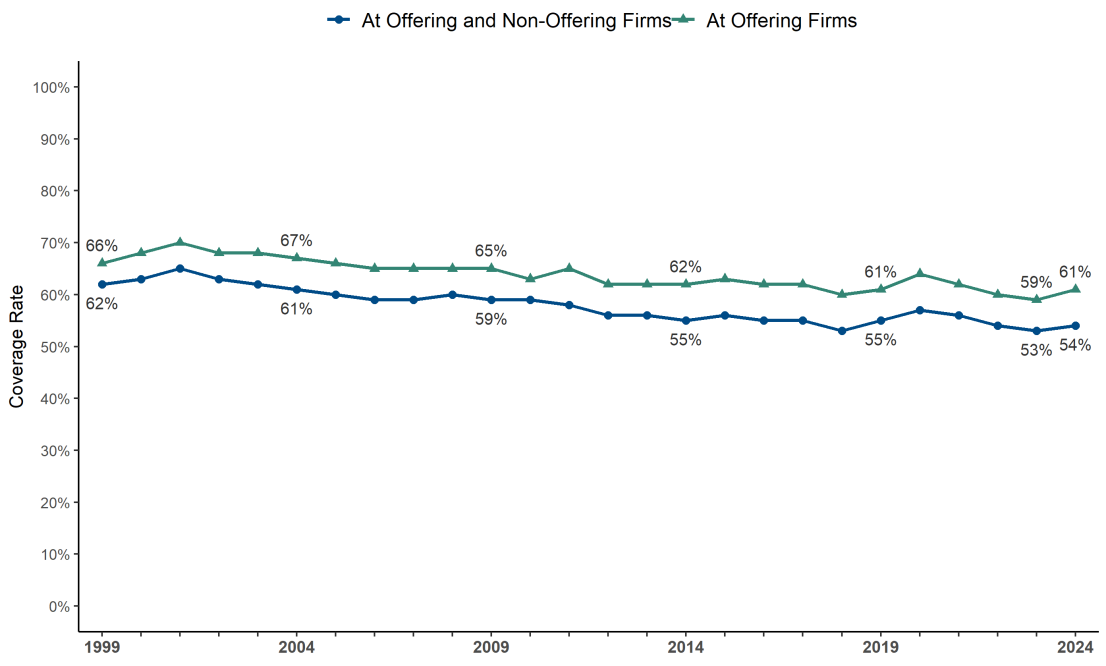
- Among workers in firms offering health benefits, those working in public firms are more likely than workers in other firm types to be covered by their own firm [Figure 3.9].
- Among workers in all firms, including those that offer and those that do not offer health benefits, 54% are covered by health benefits offered by their employer, similar to the percentages last year (53%), five years ago (55%), and ten 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, 2024



* 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 ($35,000 in 2024). Firms with many higher-wage workers are those where at least 35% earn the 75th percentile or more than of national earnings ($77,000 in 2024). 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, 2024

Figure 3.10
Percentage of Workers Covered by Their Firm's Health Benefits, 1999-2024



Tests found no statistical difference from estimate for the previous year shown ($p < .05$).
SOURCE: KFF Employer Health Benefits Survey, 2018-2024; 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, 1999-2024

	3-24 Workers	25-199 Workers	200-999 Workers	1,000-4,999 Workers	5,000 or More Workers	All Small Firms	All Large Firms	**All Firms**
1999	50%	59%	69%	68%	64%	55%	66%	**62%**
2000	50%	62%	69%	68%	66%	57%	67%	**63%**
2001	49%	65%	71%	69%	69%	58%	69%	**65%**
2002	45%	61%	69%	70%	68%	54%	69%	**63%**
2003	44%	60%	68%	69%	68%	53%	68%	**62%**
2004	43%	56%	69%	68%	67%	50%	68%	**61%**
2005	41%	58%	65%	69%	66%	50%	66%	**60%**
2006	45%	60%	66%	68%	60%	53%	63%	**59%**
2007	42%	56%	65%	69%	63%	50%	65%	**59%**
2008	43%	59%	67%	69%	64%	52%	66%	**60%**
2009	39%	58%	63%	67%	65%	49%	65%	**59%**
2010	44%	60%	61%	66%	63%	52%	63%	**59%**
2011	38%	55%	63%	66%	64%	48%*	64%	**58%**
2012	36%	57%	61%	66%	61%	47%	62%	**56%**
2013	36%	55%	63%	67%	58%	46%	61%	**56%**
2014	33%	54%	60%	66%	61%	44%	62%	**55%**
2015	35%	52%	61%	66%	63%	45%	63%	**56%**
2016	32%	53%	62%	63%	60%	44%	61%	**55%**
2017	32%	51%	60%	64%	61%	43%	62%	**55%**
2018	30%	50%	62%	62%	59%	41%	60%	**53%**
2019	32%	53%	65%	66%	58%	44%	61%	**55%**
2020	34%	52%	65%	68%	63%	44%	65%	**57%**
2021	35%	53%	63%	65%	62%	45%	63%	**56%**
2022	31%	48%*	61%	63%	60%	40%*	61%	**54%**
2023	34%	50%	60%	64%	58%	43%	59%	**53%**
2024	31%	50%	59%	62%	62%	42%	62%	**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, 2018-2024; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

Types of Plans Offered

SECTION 4

Section 4

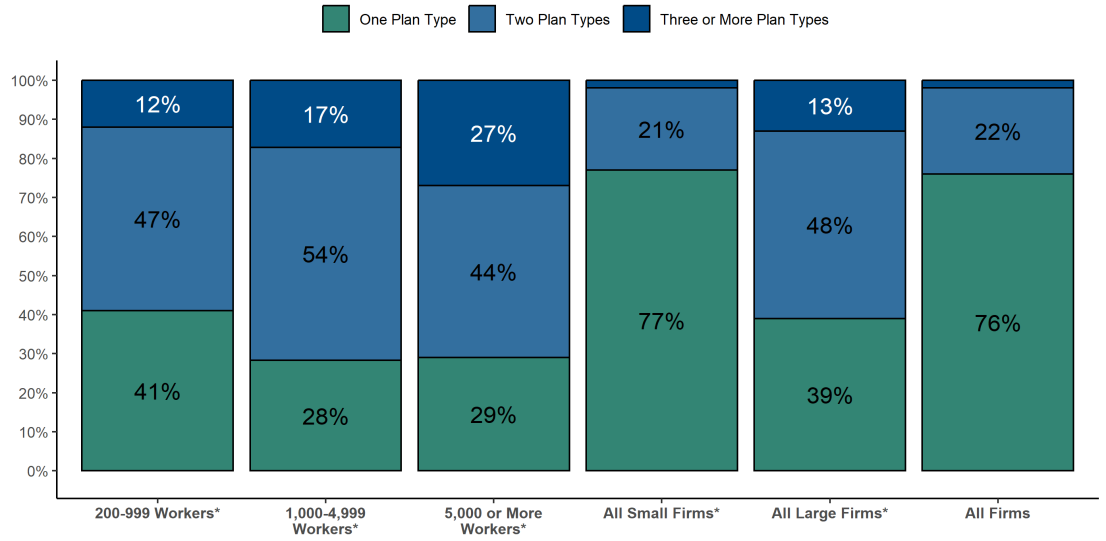
Types of Plans Offered

Most firms (76%) that offer health benefits offer only one type of health plan. 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

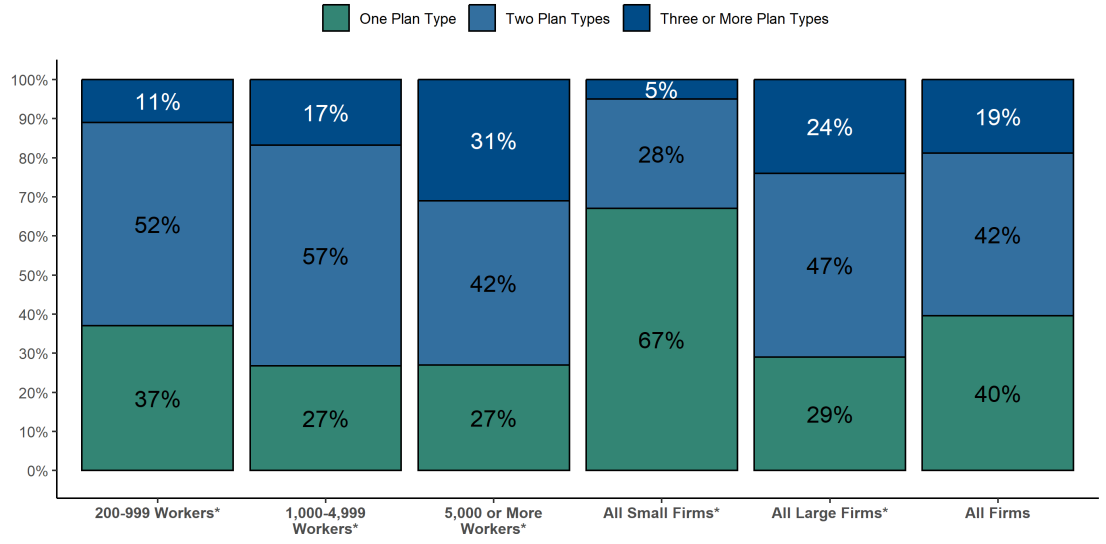
- Seventy-six percent of firms offering health benefits offer only one type of health plan in 2024. Large firms are more likely than small firms to offer more than one plan type (61% vs. 23%) [Figure 4.1].
- Sixty percent of covered workers in 2024 are employed in a firm that offers more than one type of health plan. Seventy-one percent of covered workers in large firms are employed by a firm that offers more than one plan type, compared to 33% of covered workers in small firms [Figure 4.2].
- Sixty-five percent of covered workers in firms offering health benefits work in firms that offer one or more PPOs; 60% work in firms that offer one or more HDHP/SOs; 20% work in firms that offer one or more HMOs; 14% work in firms that offer one or more POS plans; and 3% work in firms that offer one or more conventional plans [Figure 4.4].
- Among covered workers in firms offering only one type of health plan, 54% are in firms that offer only PPOs and 24% are in firms that offer only 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, 2024



* 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, 2024

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, 2024



* 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, 2024

Figure 4.3

Among Firms Offering Health Benefits, Percentage of Firms That Offer the Following Plan Types, by Firm Size, 2024

	Conventional	HMO	PPO	POS	HDHP/SO
FIRM SIZE					
3-24 Workers	0%*	5%*	22%*	11%	20%*
25-199 Workers	1*	14*	32*	16	39*
200-999 Workers	2*	18*	61*	18*	56*
1,000-4,999 Workers	2*	20*	72*	13	66*
5,000 or More Workers	4*	25*	76*	8	69*
All Small Firms (3-199 Workers)	**<1%***	**6%***	**24%***	**12%**	**24%***
All Large Firms (200 or More Workers)	**2%***	**19%***	**63%***	**17%**	**58%***
ALL FIRMS	**<1%**	**6%**	**24%**	**12%**	**25%**

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, 2024

Figure 4.4

Among Firms Offering Health Benefits, Percentage of Covered Workers in Firms That Offer the Following Plan Types, by Firm Size, 2024

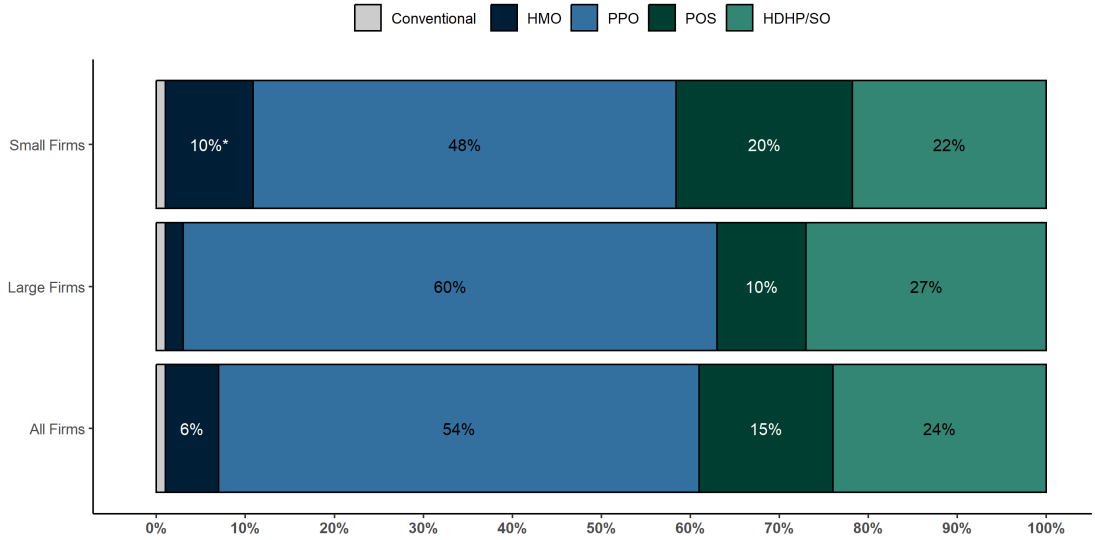
	Conventional	HMO	PPO	POS	HDHP/SO
FIRM SIZE					
200-999 Workers	2%	18%	71%	14%	59%
1,000-4,999 Workers	2	17	77*	10	68*
5,000 or More Workers	6	27*	70	11	74*
All Small Firms (3-199 Workers)	**1%***	**13%***	**49%***	**20%***	**36%***
All Large Firms (200 or More Workers)	**4%***	**23%***	**72%***	**11%***	**70%***
ALL FIRMS	**3%**	**20%**	**65%**	**14%**	**60%**

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, 2024

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, 2024



* 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, 2024

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

2024 Annual Survey

Market Shares of Health Plans

SECTION

5

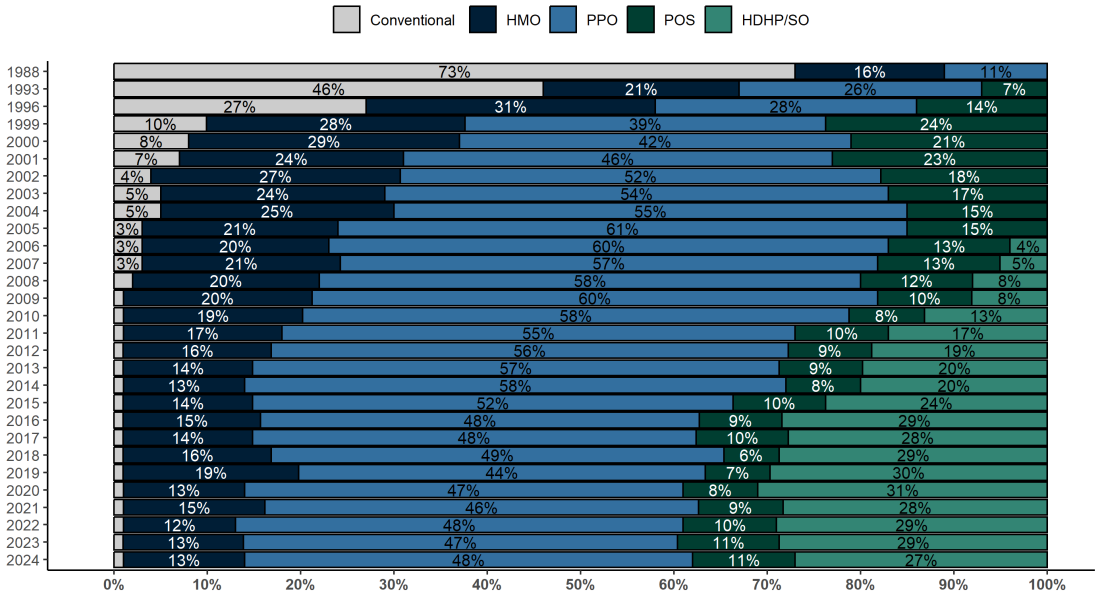
Section 5

Market Shares of Health Plans

Health plans are often characterized into plan types based on their coverage for out-of-network services and their use of primary care gate keeping. In 2024, PPOs remain the most common plan type.

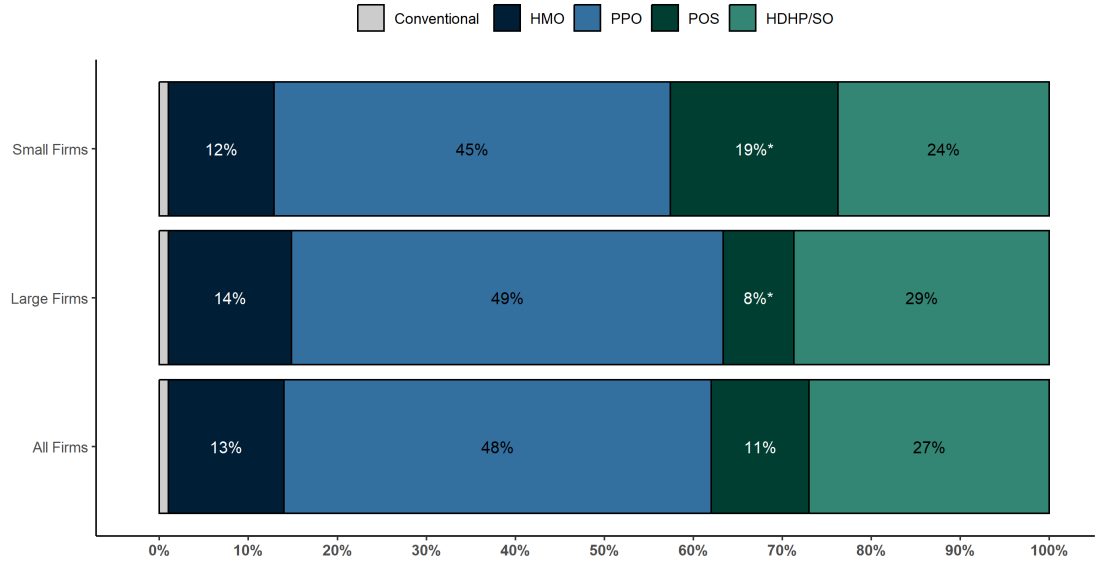
- Forty-eight percent of covered workers are enrolled in PPOs in 2024, followed by HDHP/SOs (27%), HMOs (13%), POS plans (11%), and conventional plans (1%). All of these percentages are similar to the enrollment percentages in 2023 [Figure 5.1].
- The percentage of covered workers enrolled in HDHP/SOs is similar to last year (29%) and five years ago (30%), but higher than the percentage 10 years ago (20%). The percentage of covered workers enrolled in PPOs has decreased 10% over the past decade [Figure 5.1].
- The percentage of covered workers enrolled in HMOs (13%) is similar to the percentages last year (13%) but lower than the percentage five years ago (19%) [Figure 5.1].
- A larger share of covered workers are enrolled in HDHP/SOs than in HMOs in both 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 (29% and 24%). Covered workers in small firms are more likely than covered workers in large firms to be enrolled in POS plans (19% vs. 8%) [Figure 5.2].
- Plan enrollment patterns also differ across regions.
  - HMO enrollment is significantly higher in the West (25%), and significantly lower in the Midwest (6%) [Figure 5.3].
  - Covered workers in the Midwest (40%) are more likely to be enrolled in HDHP/SOs than workers in other regions, while covered workers in the West (19%) are less likely to be enrolled in HDHP/SOs [Figure 5.3].

Figure 5.1
Distribution of Health Plan Enrollment for Covered Workers, by Plan Type, 1988-2024



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, 2018-2024; 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, 2024



* 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, 2024

Figure 5.3

Distribution of Health Plan Enrollment for Covered Workers, by Firm Size, Region, and Industry, 2024

	Conventional	HMO	PPO	POS	HDHP/SO
FIRM SIZE					
3-24 Workers	0%	13%	47%	24%*	16%*
25-49 Workers	1	22*	42	14	22
50-199 Workers	1	7*	45	17*	30
200-999 Workers	1	10	50	10	29
1,000-4,999 Workers	1	10	52	6*	31
5,000 or More Workers	1	16	47	8	28
All Small Firms (3-199 Workers)	**1%**	**12%**	**45%**	**19%***	**24%**
All Large Firms (200 or More Workers)	**1%**	**14%**	**49%**	**8%***	**29%**
REGION					
Northeast	3%	13%	52%	8%	23%
Midwest	1	6*	43	10	40*
South	1	12	50	12	26
West	<1	25*	44	12	19*
INDUSTRY					
Agriculture/Mining/Construction	2%	10%	53%	13%	22%
Manufacturing	0	12	49	11	27
Transportation/Communications/Utilities	<1	26	42	3*	29
Wholesale	<1	7*	52	13	28
Retail	8	8	55	10	18*
Finance	1	7*	47	6*	39*
Service	1	14	47	12	27
State/Local Government	1	18	49	12	20
Health Care	<1	11	45	15	28
ALL FIRMS	**1%**	**13%**	**48%**	**11%**	**27%**

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, 2024

Employer Health Benefits

2024 Annual Survey

Worker and Employer Contributions for Premiums

SECTION

6

Section 6

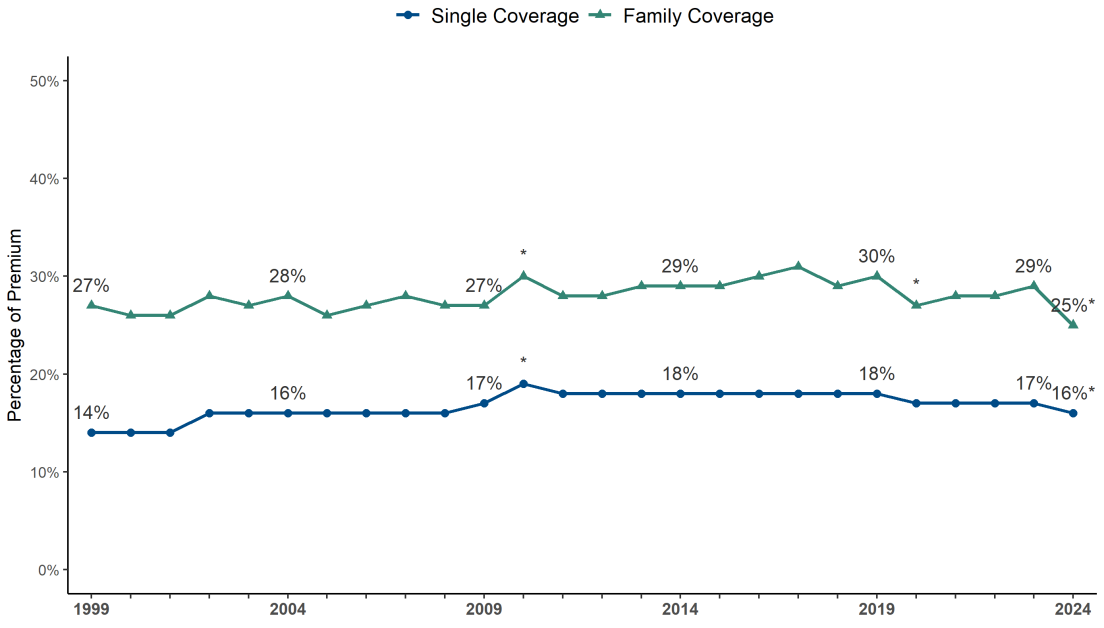
Worker and Employer Contributions for Premiums

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

- In 2024, covered workers contribute, on average, 16% of the premium for single coverage and 25% of the premium for family coverage.
  - The average percentages contributed for single and family coverage are each lower than the average contribution levels last year [Figure 6.1].[1]
  - Covered workers in small firms, on average, contribute a lower percentage of the premium for single coverage than covered workers in large firms (14% vs. 16%) [Figure 6.2].
  - Covered workers in small firms contribute, on average, a much higher percentage of the premium for family coverage than covered workers in large firms (33% vs. 23%) [Figure 6.2].
- The average contribution amount for covered workers for single coverage is $114 per month ($1,368 annually), similar to the amount last year [Figure 6.4].
- The average contribution amount for covered workers for family coverage is $525 per month ($6,296 annually), similar to the amount last year [Figure 6.5].
  - The average contributions for workers enrolled in HDHP/SOs is lower than the overall average worker contributions for family coverage ($5,662 vs. $6,296) [Figure 6.6].
- Covered workers in small firms, on average, contribute a lower amount annually for single coverage than covered workers in large firms ($1,204 vs. $1,429) [Figure 6.7].
- Covered workers in small firms, on average, contribute a significantly higher amount annually for family coverage than covered workers in large firms ($7,947 vs. $5,697) [Figure 6.7].

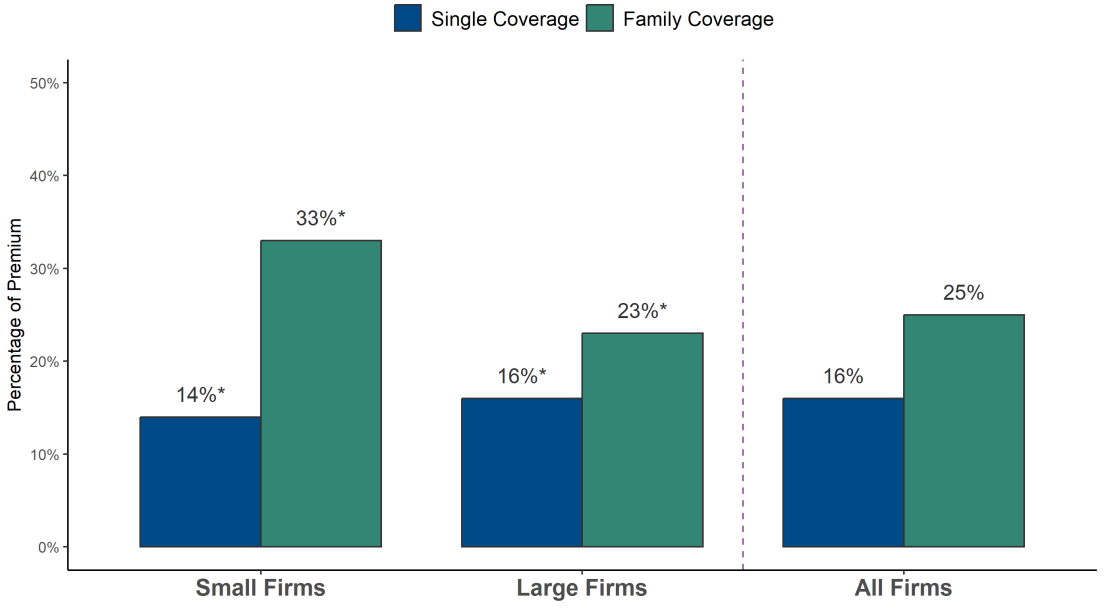
[1] The average percentage contribution is calculated as a weighted average of all a firm's plan types and may not necessarily equal the average worker contribution divided by the average premium.

Figure 6.1
Average Percentage of Premium Paid by Covered Workers for Single and Family Coverage, 1999-2024



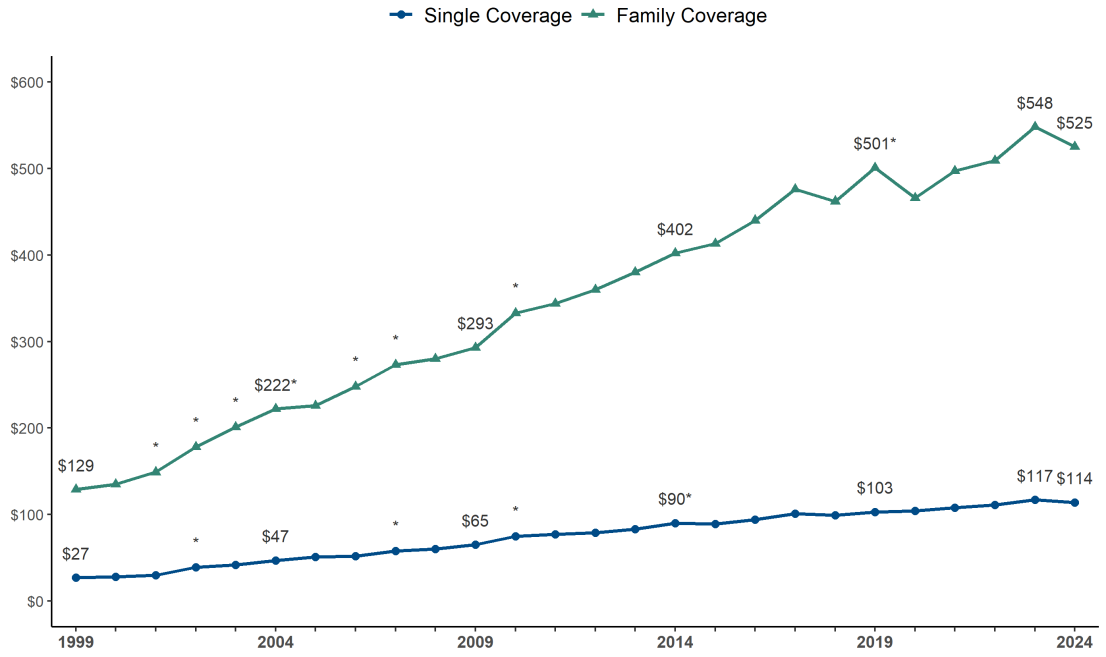
* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
SOURCE: KFF Employer Health Benefits Survey, 2018-2024; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

Figure 6.2
Average Percentage of Premium Paid by Covered Workers for Single and Family Coverage, by Firm Size, 2024



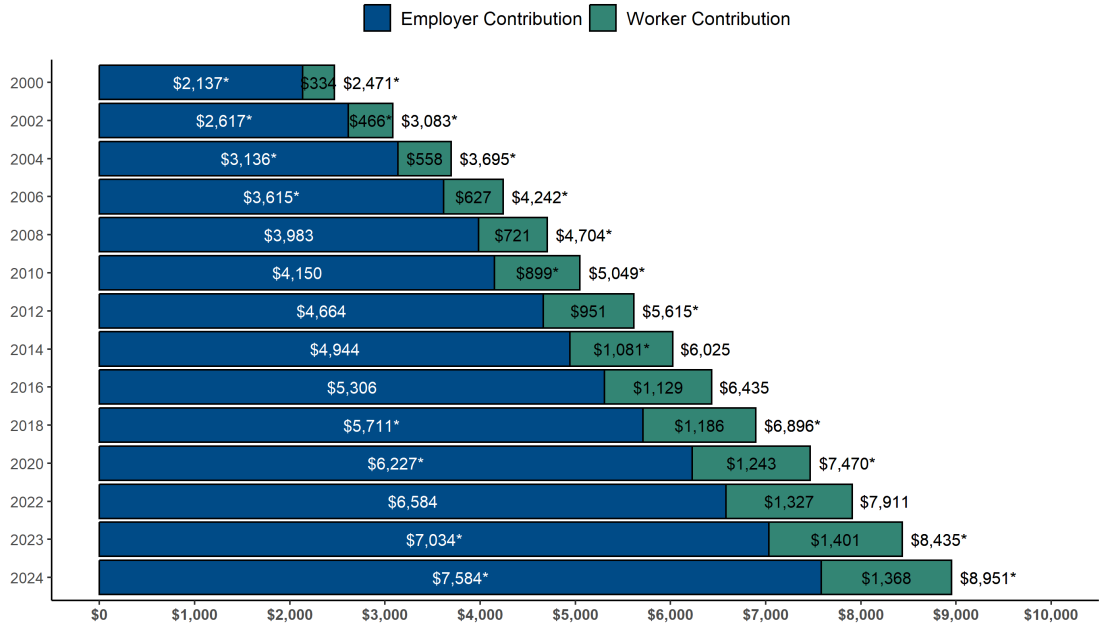
* Estimate is statistically different between All Small Firms and All Large Firms within coverage type ($p < .05$).
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2024

Figure 6.3
Average Monthly Worker Premium Contributions for Single and Family Coverage, 1999-2024



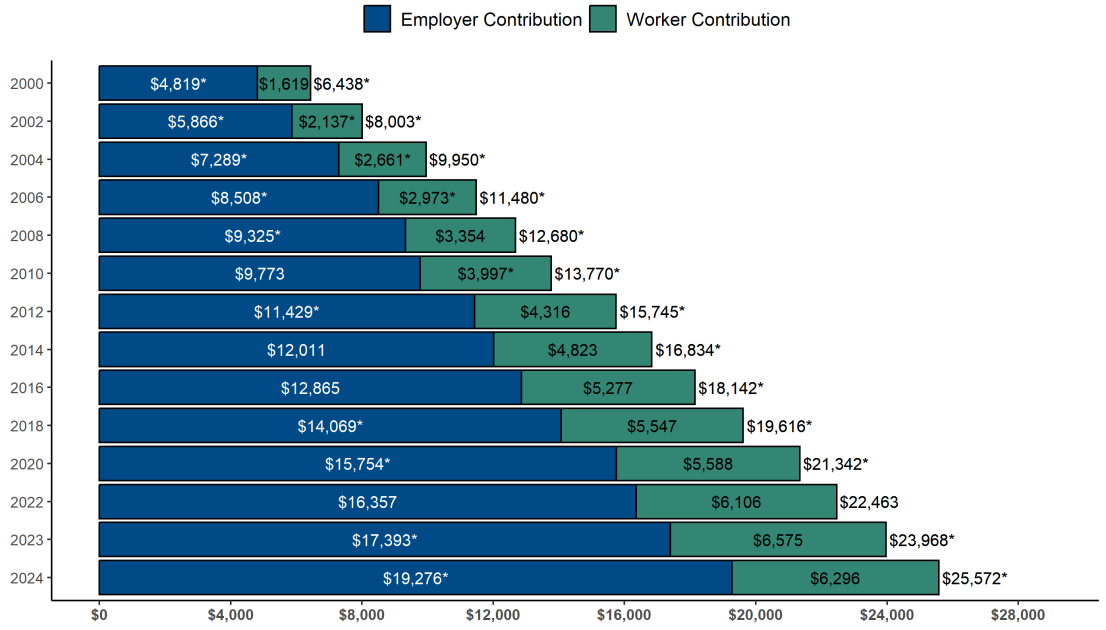
* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
SOURCE: KFF Employer Health Benefits Survey, 2018-2024; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

Figure 6.4
Average Annual Worker and Employer Contributions to Premiums and Total Premiums for Single Coverage, 1999-2024



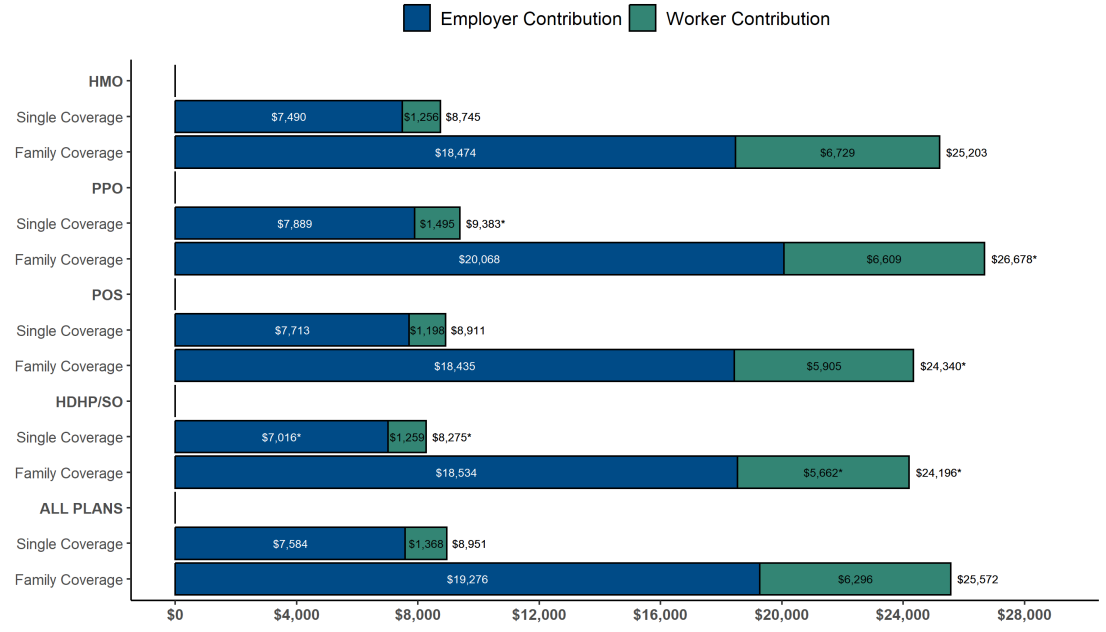
* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
SOURCE: KFF Employer Health Benefits Survey, 2018-2024; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

Figure 6.5
Average Annual Worker and Employer Contributions to Premiums and Total Premiums for Family Coverage, 1999-2024



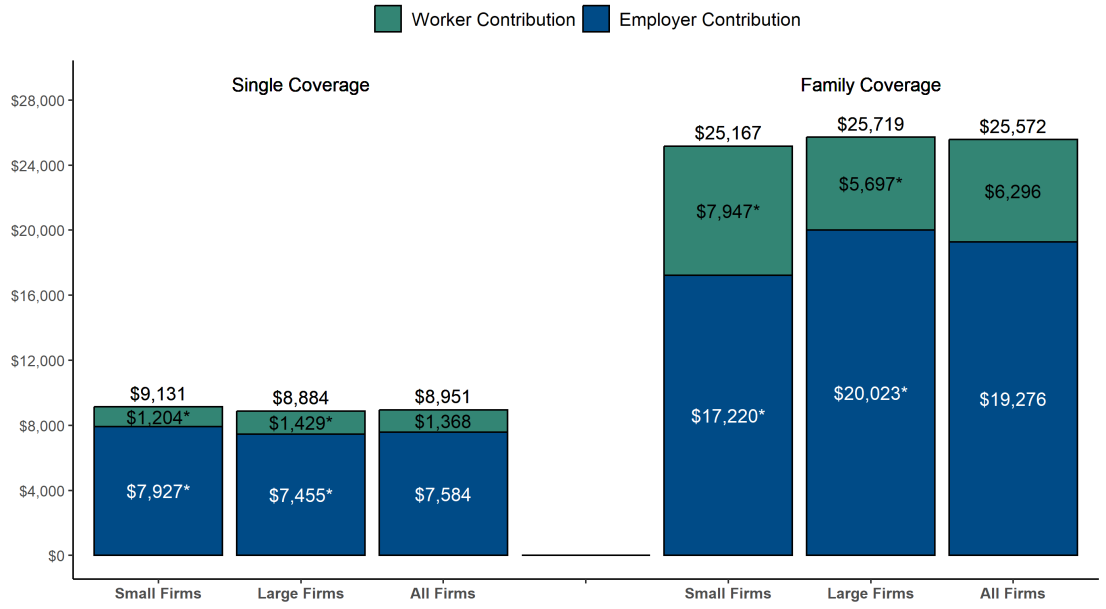
* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
SOURCE: KFF Employer Health Benefits Survey, 2018-2024; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

Figure 6.6
Average Annual Worker and Employer Premium Contributions and Total Premiums for Single and Family Coverage, by Plan Type, 2024



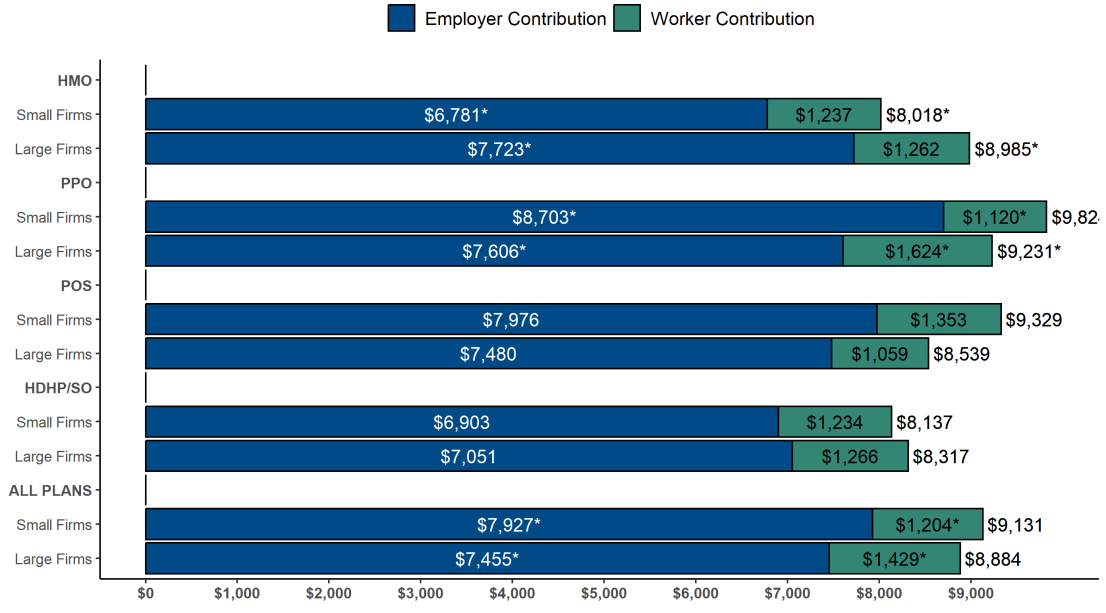
* Estimate is statistically different from All Plans estimate within coverage type ($p < .05$).
SOURCE: KFF Employer Health Benefits Survey, 2024

Figure 6.7
Average Annual Worker and Employer Premium Contributions and Total Premiums for Single and Family Coverage, by Firm Size, 2024



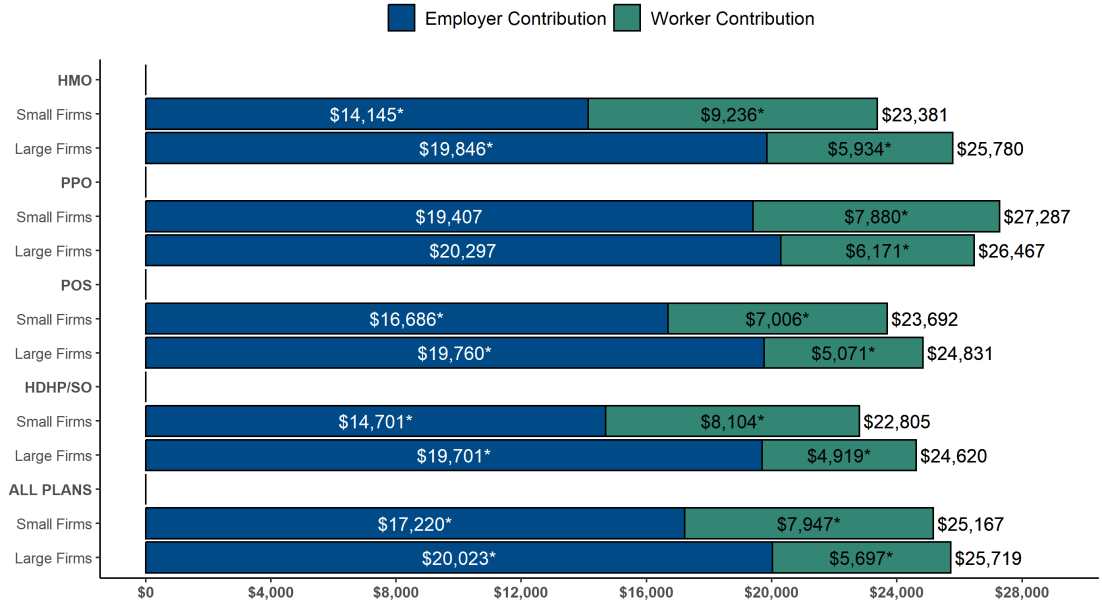
* Estimate is statistically different between All Small Firms and All Large Firms estimate ($p < .05$).
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2024

Figure 6.8
Average Annual Worker and Employer Premium Contributions and Total Premiums for Single Coverage, by Plan Type and Firm Size, 2024



* 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, 2024

Figure 6.9
Average Annual Employer and Worker Premium Contributions and Total Premiums for Family Coverage, by Plan Type and Firm Size, 2024



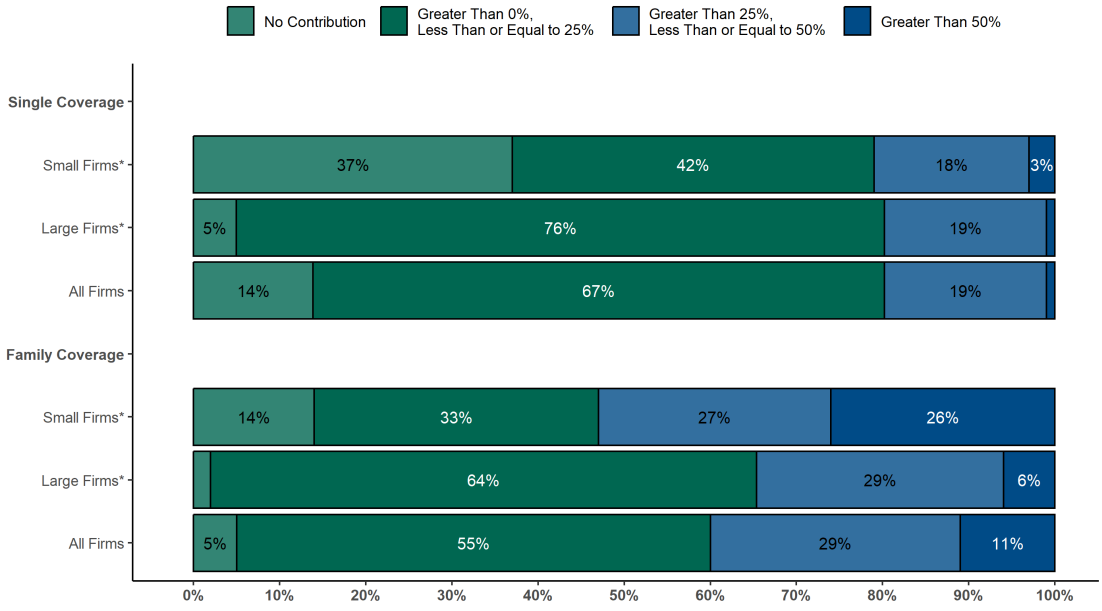
* Estimates are statistically different within plan type between All Small Firms and All Large Firms ($p < .05$).
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2024

DISTRIBUTIONS OF WORKER CONTRIBUTIONS TO THE PREMIUM

- Almost nine in ten (89%) of covered workers are in a plan where the employer contributes at least half of the premium for both single and family coverage.
  - Fourteen 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 for single coverage.
  - Thirty-seven percent of covered workers in small firms have an employer that pays the full premium for single coverage, compared to 5% of covered workers in large firms [Figure 6.10].
  - For family coverage, 14% 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].
- Eleven 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. Twenty-six percent of covered workers in small firms work in a firm where the worker contribution for family coverage is more than half of the premium, a much higher percentage than the 6% of covered workers in large firms [Figure 6.10].
- Small shares of covered workers in small firms (3%) and large firms (less than one percent) must pay more than 50% of the premium for single coverage [Figure 6.10].

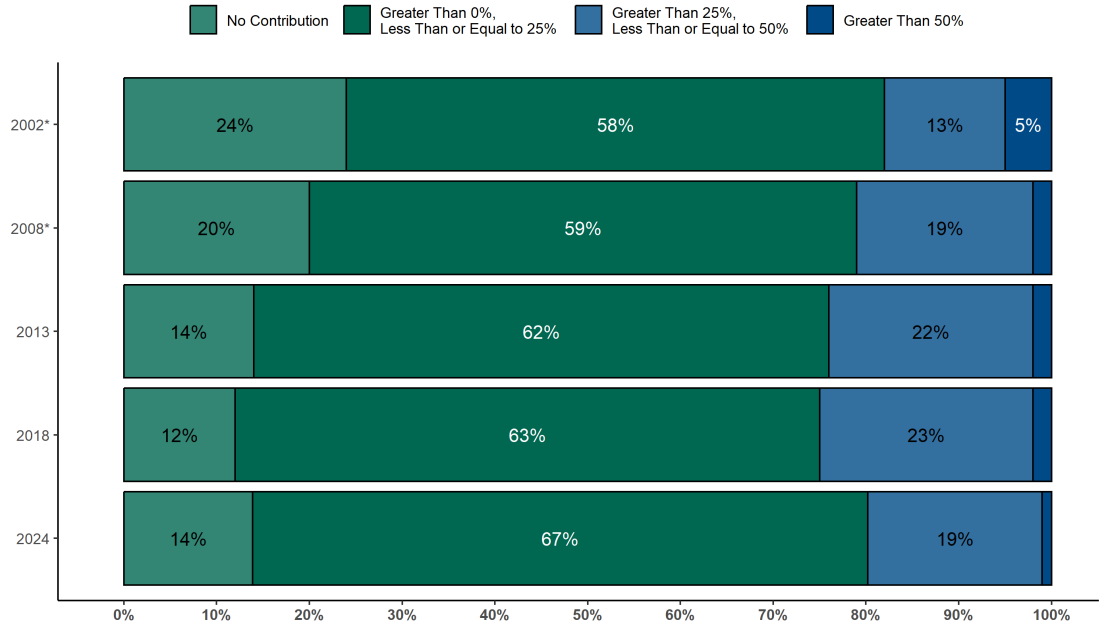
- There is substantial variation between small and large firms in the dollar amounts that covered workers must contribute towards health coverage.
  - Among covered workers in small firms, 43% have a contribution for single coverage of less than $500 a year, while 24% have a contribution of $2,000 or more [Figure 6.13]. For family coverage, 17% have a contribution of less than $1,500, while 28% have a contribution of $10,500 or more [Figure 6.14].
  - Among covered workers in large firms, 13% contribute less than $500 a year for single coverage, while 21% have a contribution of $2,000 or more [Figure 6.13]. For family coverage, only 4% contribute less than $1,500 a year, 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, 2024



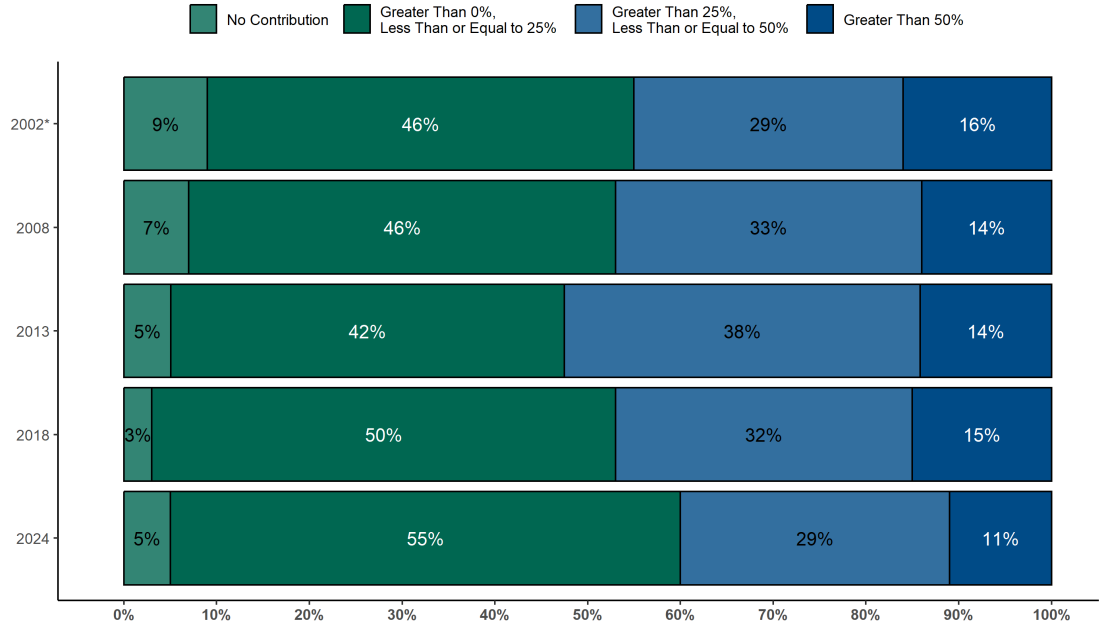
* Distributions are statistically different between All Small Firms and All Large Firms within coverage type ($p < 0.05$).
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2024

Figure 6.11
Distribution of Percentage of Premium Paid by Covered Workers for Single Coverage, 2002-2024



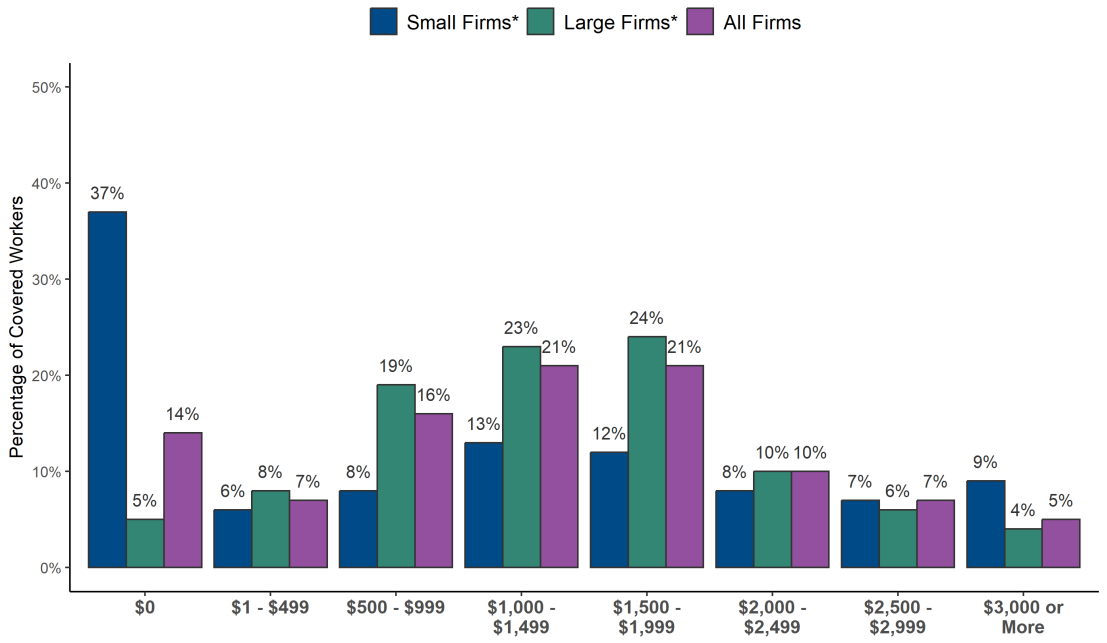
* Distribution is statistically different from distribution for the previous year shown (p < .05).
SOURCE: KFF Employer Health Benefits Survey, 2018-2024; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2002-2017

Figure 6.12
Distribution of Percentage of Premium Paid by Covered Workers for Family Coverage, 2002-2024



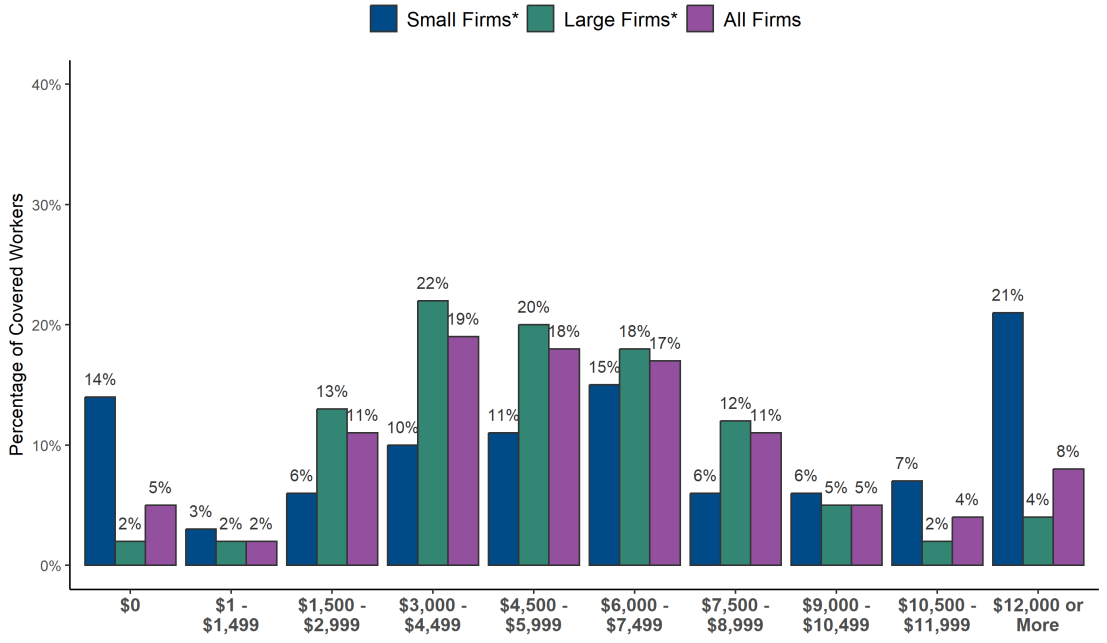
* Distribution is statistically different from distribution for the previous year shown (p < .05).
SOURCE: KFF Employer Health Benefits Survey, 2018-2024; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2002-2017

Figure 6.13
Distribution of Worker Contributions for Single Coverage, by Firm Size, 2024



* 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, 2024

Figure 6.14
Distribution of Worker Contributions for Family Coverage, by Firm Size, 2024

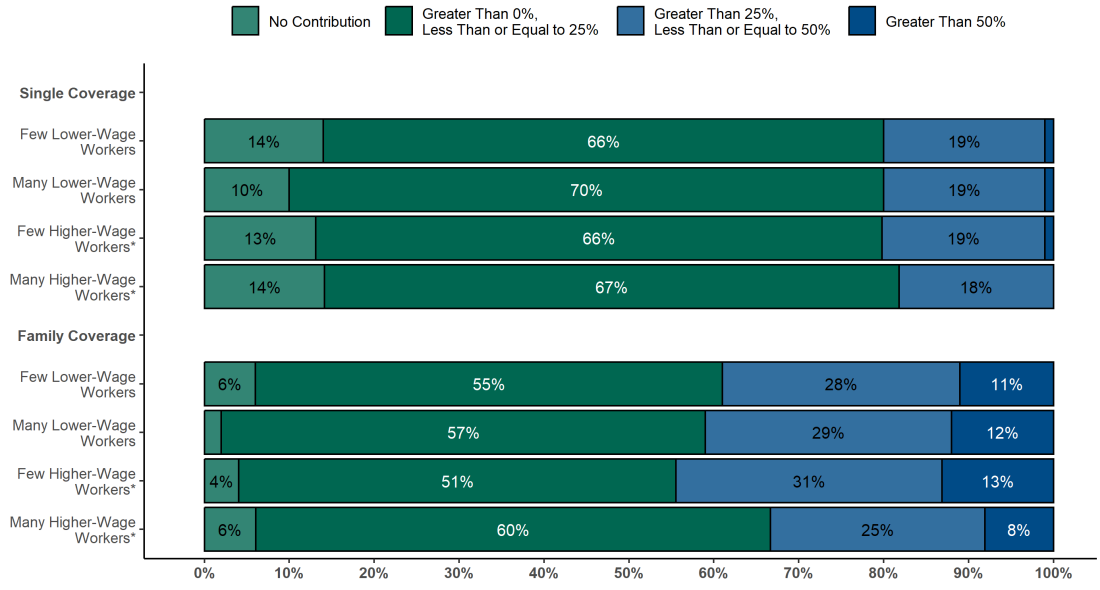


* Distribution is statistically different from distribution for all other firms not in the indicated size category ($p < .05$).
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2024

DIFFERENCES BY FIRM CHARACTERISTICS

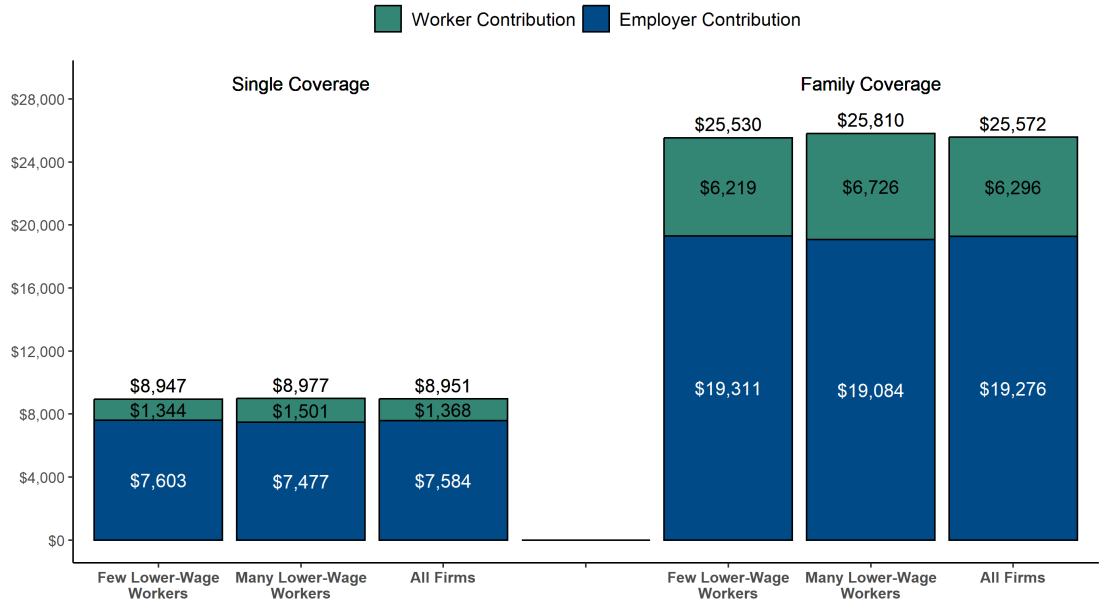
- The percentage of the premium paid by covered workers varies with firm characteristics.
  - Covered workers in private, for-profit firms have a relatively high premium contribution rates for single coverage (18%) and family (27%) coverage. [Figure 6.17].
- Covered workers in firms with a relatively large share of older workers (where at least 35% are age 50 or higher) have a lower average percent contribution for family coverage than those in firms with a smaller share of older workers (24% vs. 27%) [Figure 6.17].
- Covered workers in firms with a relatively large share of higher-wage workers (where at least 35% earn $77,000 or more annually) have a lower average contribution for family coverage than those in firms with a smaller share of higher-wage workers (23% vs. 27%) [Figure 6.17].
- Covered workers in firms that have at least some union workers have a lower average contribution rate for family coverage than those in firms without any union workers (20% vs. 29%) [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, 2024



*Distributions for higher-wage and lower-wage firms are statistically different within 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 ($35,000 in 2024). Firms with many higher-wage workers are those where at least 35% earn the 75th percentile or more than of national earnings ($77,000 in 2024).
SOURCE: KFF Employer Health Benefits Survey, 2024

Figure 6.16
Average Annual Worker and Employer Contributions to Premiums and Total Premiums for Single and Family Coverage, By Firm Wage Level, 2024



Tests found no statistical difference 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 ($35,000 in 2024).
SOURCE: KFF Employer Health Benefits Survey, 2024

Figure 6.17

Average Annual Premium Contributions Paid by Covered Workers for Single and Family Coverage, by Firm Characteristics, 2024

	Single Coverage		Family Coverage	
	Worker Contribution	Percent Contribution	Worker Contribution	Percent Contribution
LOWER WAGE LEVEL				
Few Lower-Wage Workers	$1,344	15%	$6,219	25%
Many Lower-Wage Workers	$1,501	17%	$6,726	26%
HIGHER WAGE LEVEL				
Few Higher-Wage Workers	$1,351	16%	$6,610	27%*
Many Higher-Wage Workers	$1,387	16%	$5,925	23%*
UNIONS				
Firm Has Union Workers	$1,363	15%	$5,186*	20%*
Firm Has No Union Workers	$1,370	16%	$6,958*	29%*
YOUNGER WORKERS				
Few Younger Workers	$1,373	16%	$6,312	25%
Many Younger Workers	$1,321	17%	$6,149	26%
OLDER WORKERS				
Few Older Workers	$1,299	16%	$6,487	27%*
Many Older Workers	$1,439	16%	$6,101	24%*
FUNDING ARRANGEMENT				
Fully Insured	$1,254*	14%*	$7,294*	30%*
Self-Funded	$1,434*	16%*	$5,722*	23%*
FIRM OWNERSHIP				
Private For-Profit	$1,507*	18%*	$6,581	27%*
Public	$1,070*	12%*	$5,635	22%*
Private Not-For-Profit	$1,248	13%*	$6,088	23%
ALL FIRMS	**$1,368**	**16%**	**$6,296**	**25%**

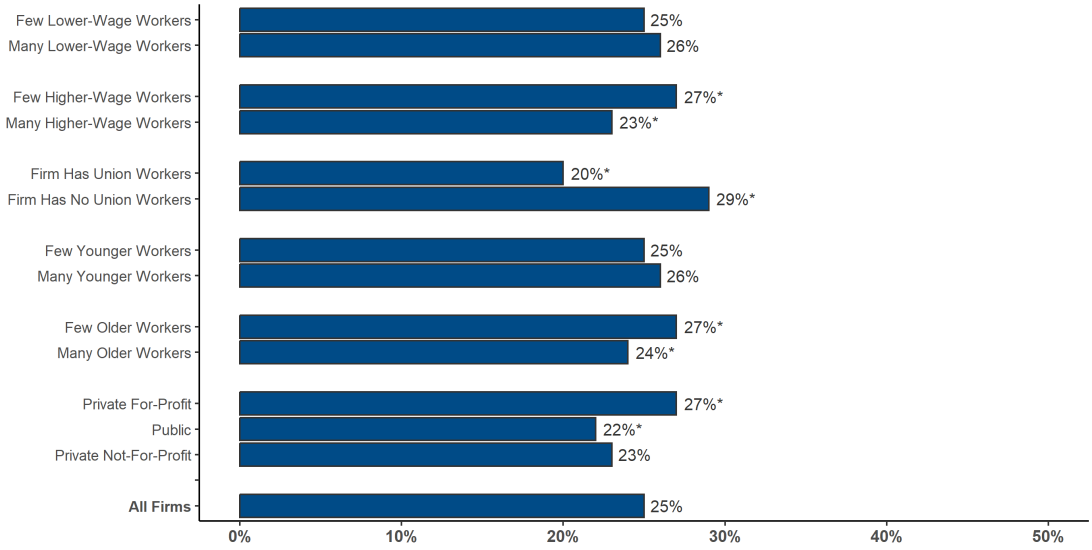
NOTE: Firms with many lower-wage workers are those where at least 35% earn the 25th percentile or less of national earnings ($35,000 in 2024). Firms with many higher-wage workers are those where at least 35% earn the 75th percentile or more than of national earnings ($77,000 in 2024). Firms with many 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, 2024

Figure 6.18

Average Percentage of Family Premium Paid by Covered Workers, by Firm Characteristics, 2024



* 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 ($35,000 in 2024). Firms with many higher-wage workers are those where at least 35% earn the 75th percentile or more than of national earnings ($77,000 in 2024). 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, 2024

Figure 6.19

Average Percentage of Premium Paid by Covered Workers, by Firm Characteristics and Size, 2024

	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	14%	16%	15%	33%	22%	25%
Many Lower-Wage Workers	11%	18%	17%	35%	24%	26%
HIGHER WAGE LEVEL						
Few Higher-Wage Workers	14%	16%	16%	36%*	23%	27%*
Many Higher-Wage Workers	14%	16%	16%	28%*	22%	23%*
UNIONS						
Firm Has Union Workers	14%	15%*	15%	21%*	20%*	20%*
Firm Has No Union Workers	14%	18%*	16%	34%*	25%*	29%*
YOUNGER WORKERS						
Few Younger Workers	14%	16%	16%	33%	22%	25%
Many Younger Workers	13%	18%	17%	29%	25%	26%
OLDER WORKERS						
Few Older Workers	14%	16%	16%	38%*	23%	27%*
Many Older Workers	14%	17%	16%	28%*	22%	24%*
FUNDING ARRANGEMENT						
Fully Insured	14%	16%	14%*	34%*	24%	30%*
Self-Funded	15%	17%	16%*	29%*	22%	23%*
FIRM OWNERSHIP						
Private For-Profit	16%*	19%*	18%*	33%	24%*	27%*
Public	8%*	12%*	12%*	30%	21%	22%*
Private Not-For-Profit	11%*	14%*	13%*	32%	21%	23%
ALL FIRMS	**14%**	**16%**	**16%**	**33%**	**23%**	**25%**

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 ($35,000 in 2024). Firms with many higher-wage workers are those where at least 35% earn the 75th percentile or more than of national earnings ($77,000 in 2024). 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, 2024

DIFFERENCES BY REGION AND INDUSTRY

- The average worker contribution for single coverage is relatively high in the Northeast and relatively low in the West (12%) [Figure 6.20].
- The average worker contribution for family coverage is relatively low in the Northeast (22%) and the Midwest (23%) and relatively high in the South (28%) [Figure 6.20].
- Average worker contributions vary across industries for single and family coverage [Figure 6.21].

Figure 6.20

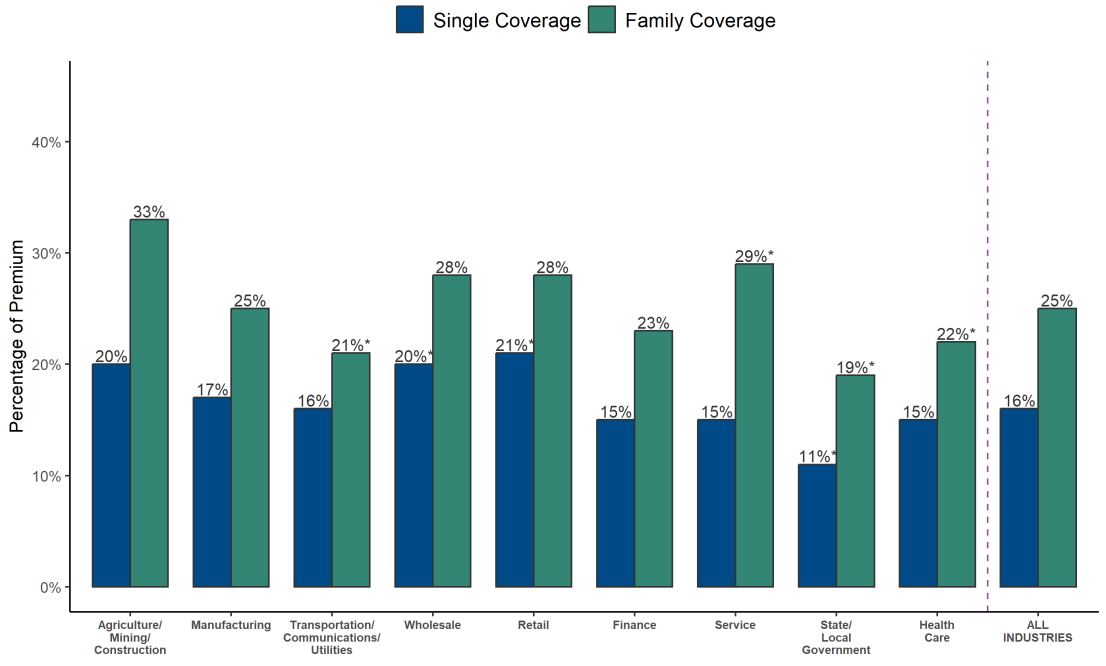
Average Premium Paid by Covered Workers for Single and Family Coverage, by Plan Type and Region, 2024

	Single Coverage		Family Coverage	
	Percent Contribution	Worker Contribution	Percent Contribution	Worker Contribution
HMO				
Northeast	21%*	$2,195*	22%*	$6,761
Midwest	14	1,310	18*	4,370*
South	12	996	29	6,530
West	13	973	34*	7,552
ALL REGIONS	**14%**	**$1,256**	**28%**	**$6,729**
PPO				
Northeast	18%	$1,689	21%*	$6,044
Midwest	18	1,586	24	6,316
South	17	1,507	29*	7,315*
West	13*	1,125*	24	6,202
ALL REGIONS	**17%**	**$1,495**	**25%**	**$6,609**
POS				
Northeast	16%	$1,491	31%	$8,013*
Midwest	12	1,100	22	5,183
South	16	1,286	27	5,562
West	10*	932	25	6,239
ALL REGIONS	**14%**	**$1,198**	**26%**	**$5,905**
HDHP/SO				
Northeast	17%	$1,468	22%	$5,568
Midwest	15	1,244	21*	5,073
South	16	1,288	26	6,266
West	12	951*	28	5,798
ALL REGIONS	**15%**	**$1,259**	**24%**	**$5,662**
ALL PLANS				
Northeast	18%*	$1,687*	22%*	$6,146
Midwest	16	1,387	23*	5,602*
South	16	1,365	28*	6,746
West	12*	1,033*	27	6,468
ALL REGIONS	**16%**	**$1,368**	**25%**	**$6,296**

* 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, 2024

Figure 6.21
Average Percentage of Premium Paid by Covered Workers, by Industry, 2024

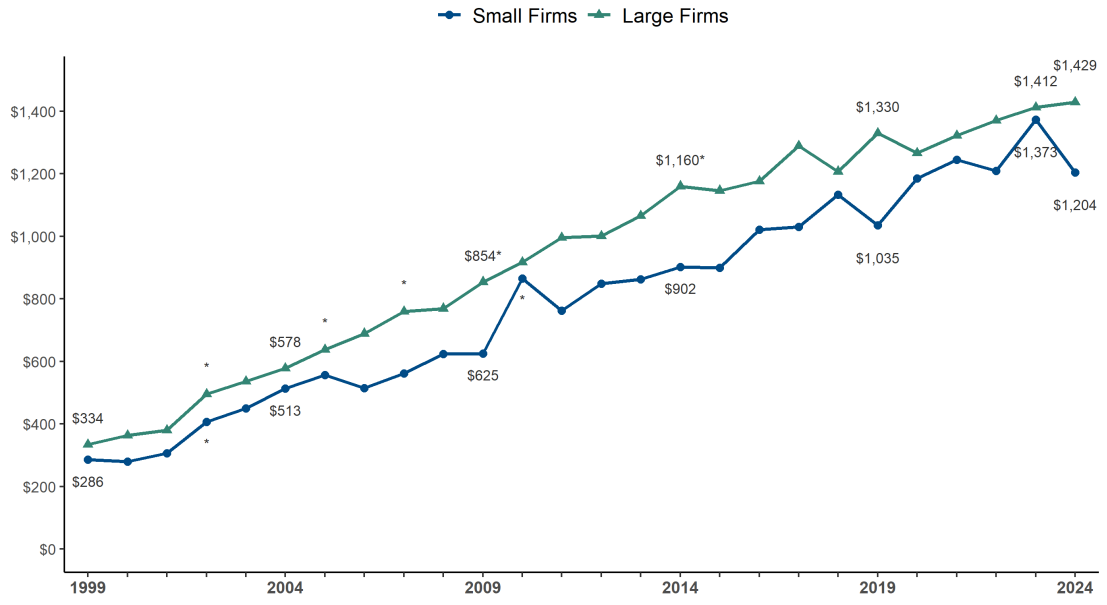


* Estimate is statistically different within coverage type from estimate for all other firms not in the indicated industry category (p < .05).
SOURCE: KFF Employer Health Benefits Survey, 2024

CHANGES OVER TIME

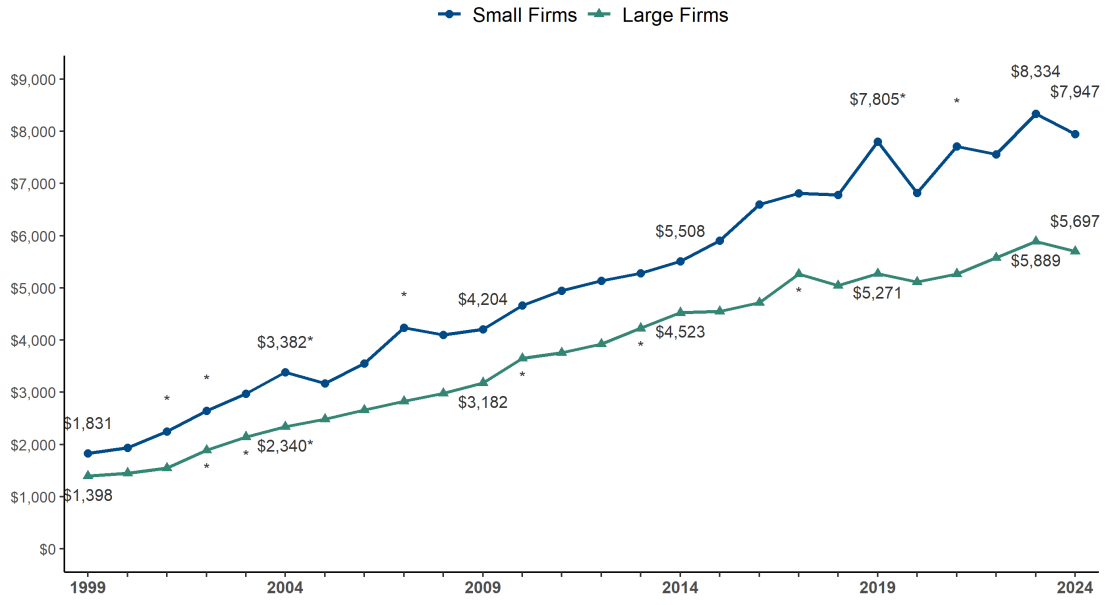
- The average worker contributions in 2024 for single coverage ($1,368) and for family coverage ($6,296) are similar to the average contribution levels last year [Figure 6.4] and [Figure 6.5].
- Over the last five years, the average worker contributions for single coverage has increased 10% and the average worker contribution for family coverage increased 5%.
- Over the last 10 years, the average worker contributions for single coverage has increased 27% and the average worker contribution for family coverage increased 31% [Figure 6.4] and [Figure 6.5].

Figure 6.22
Average Annual Worker Contributions for Covered Workers with Single Coverage, by Firm Size, 1999-2024



* 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, 2018-2024; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

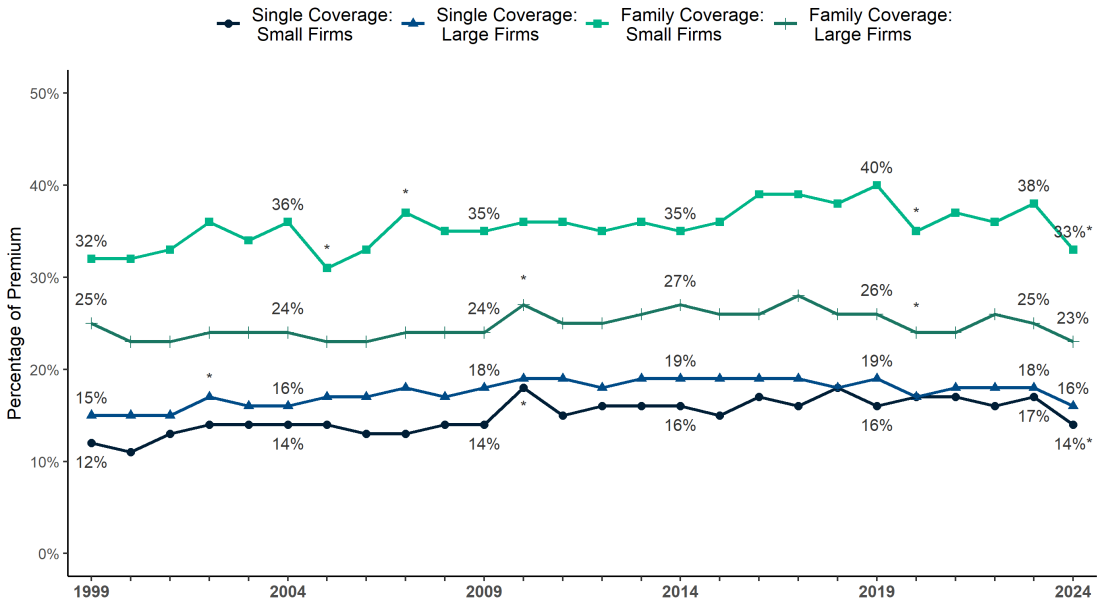
Figure 6.23
Average Annual Worker Contributions for Covered Workers with Family Coverage, by Firm Size, 1999-2024



* 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, 2018-2024; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

Figure 6.24

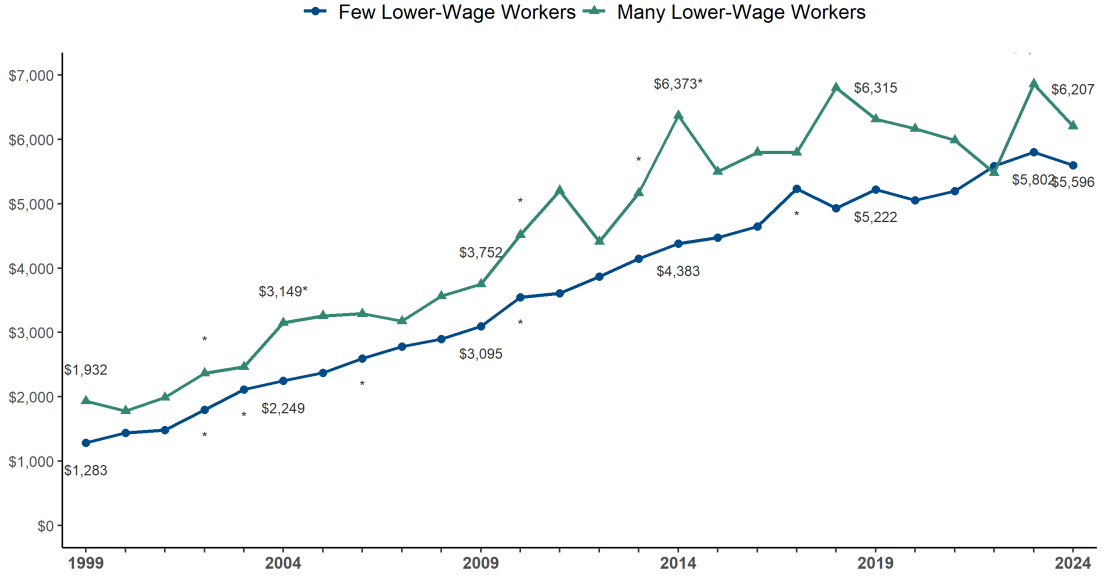
Average Percentage of Premium Paid by Covered Workers for Single and Family Coverage, by Firm Size, 1999-2024



* 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, 2018-2024; 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, 1999-2024



* 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 ($35,000 in 2024).
SOURCE: KFF Employer Health Benefits Survey, 2018-2024; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

Employer Health Benefits
2024 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.

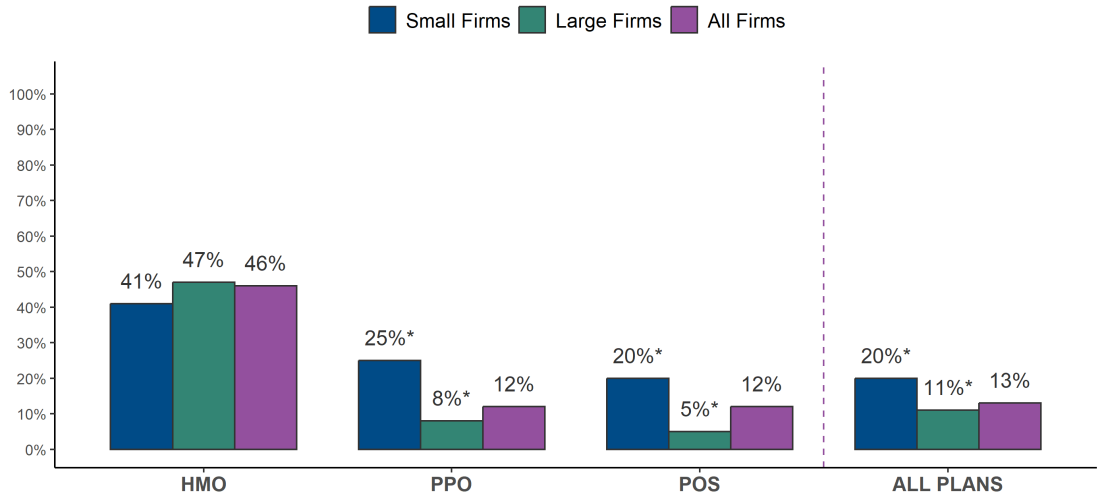
The cost-sharing amounts reported here are for covered workers using in-network services. Plan enrollees receiving services from providers that do not participate in plan networks often face higher cost-sharing and may be responsible for charges that exceed the plan's allowable amounts. The framework 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-seven percent of covered workers in 2024 are enrolled in a plan with a general annual deductible for single coverage, similar to the percentage last year (90%) but higher than the percentages five years ago (82%) and ten years ago (80%) [Figure 7.2].
  - The percent of covered workers enrolled in a plan with a general annual deductible for single coverage is lower for covered workers in small firms (3-199 workers) (80%) than for those in large firms (200 or more workers) (89%) [Figure 7.2].
  - The likelihood of a plan having a general annual deductible varies by plan type. Forty-six percent of covered workers in HMOs do not have a general annual deductible for single coverage, compared to 12% 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 $1,787, similar to the average deductible last year ($1,735) [Figure 7.3] and [Figure 7.8].

- For covered workers in plans with a general annual deductible, the average deductibles for single coverage are $1,484 in HMOs, $1,252 in PPOs, $2,094 in POS plans, and $2,666 in HDHP/SOs [Figure 7.6].
- The average deductibles for single coverage are higher for covered workers at small firms than at large firms in most plan types. For covered workers in PPOs, the most common plan type, the average deductible for single coverage is considerably higher for covered workers in small firms as compared to those in large firms ($1,973 vs. $1,048) [Figure 7.6]. Overall, for covered workers in plans with a general annual deductible, the average deductible for single coverage at small firms ($2,575) is higher than the average deductible at large firms ($1,538) [Figure 7.3].
- The average general annual deductible for single coverage for workers in plans with a deductible is similar to the amount five years ago ($1,787 v. $1,655) but is higher than the amount ten years ago ($1,787) v. $1,217) [Figure 7.8].

Figure 7.1
Percentage of Covered Workers with No General Annual Deductible for Single Coverage, by Plan Type and Firm Size, 2024



* 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. 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 2024 is $1,600 for single coverage and $3,200 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, 2024

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, 2006-2024

	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%
2023	70%	67%	67%	84%	92%	90%	88%	83%	86%	88%	90%	90%
2024	59%	53%	54%	75%	92%	88%	80%	95%	88%	80%*	89%	87%

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, 2018-2024; 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, 2024

	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	73%*	$2,693*
50-199 Workers	88	2,470*
200-999 Workers	86	1,998*
1,000-4,999 Workers	86	1,705
5,000 or More Workers	92*	1,337*
All Small Firms (3-199 Workers)	**80%***	**$2,575***
All Large Firms (200 or More Workers)	**89%***	**$1,538***
REGION		
Northeast	90%	$1,434*
Midwest	94*	1,907
South	85	1,949
West	79*	1,682
ALL FIRMS	**87%**	**$1,787**

* 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, 2024

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, 2024

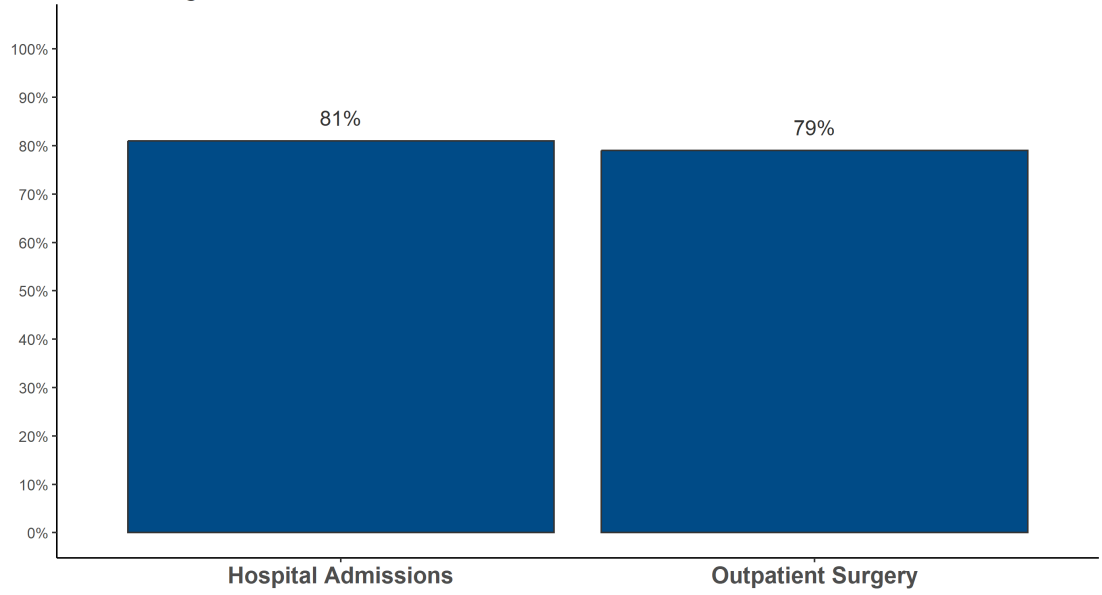
	Percentage of Covered Workers in a Plan With a General Annual Deductible	Among Covered Workers With a General Annual Deductible for Single Coverage, Average Deductible
LOWER WAGE LEVEL		
Few Lower-Wage Workers	86%	$1,778
Many Lower-Wage Workers	90%	$1,835
HIGHER WAGE LEVEL		
Few Higher-Wage Workers	86%	$1,874
Many Higher-Wage Workers	88%	$1,683
UNIONS		
Firm Has Union Workers	87%	$1,316*
Firm Has No Union Workers	87%	$2,087*
YOUNGER WORKERS		
Few Younger Workers	86%	$1,793
Many Younger Workers	92%	$1,738
OLDER WORKERS		
Few Older Workers	89%	$1,794
Many Older Workers	84%	$1,780
FIRM OWNERSHIP		
Private For-Profit	88%	$2,021*
Public	84%	$1,246*
Private Not-For-Profit	86%	$1,607
ALL FIRMS	**87%**	**$1,787**

NOTE: Firms with many lower-wage workers are those where at least 35% earn the 25th percentile or less of national earnings ($35,000 in 2024). Firms with many higher-wage workers are those where at least 35% earn the 75th percentile or more than of national earnings ($77,000 in 2024). 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 ($p < .05$).

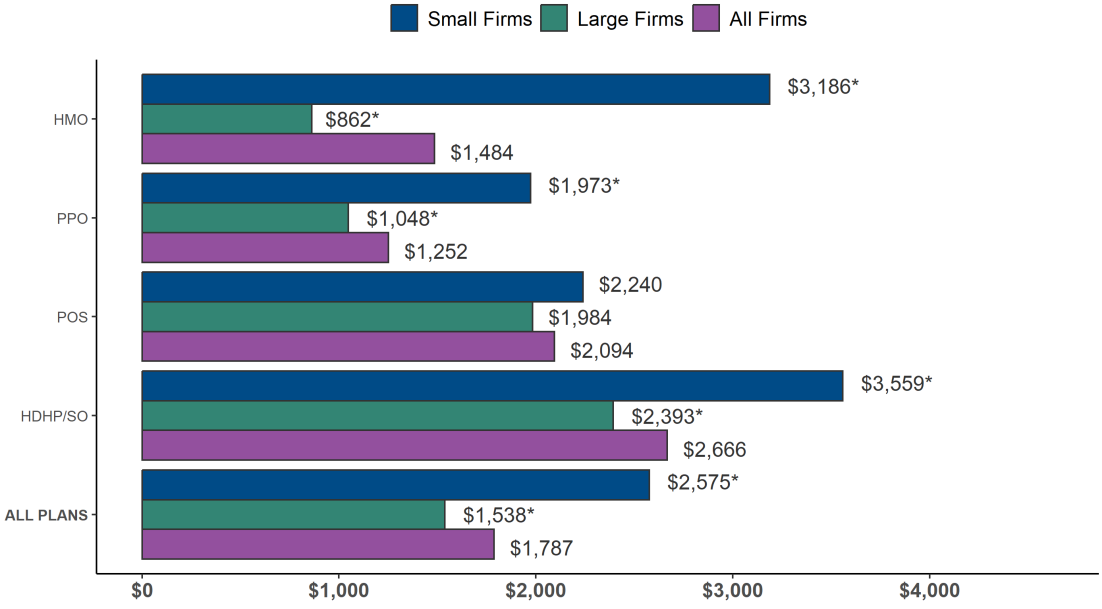
SOURCE: KFF Employer Health Benefits Survey, 2024

Figure 7.5
Among Covered Workers with No General Annual Deductible, Percentage Who Face Other Types of Cost Sharing, 2024



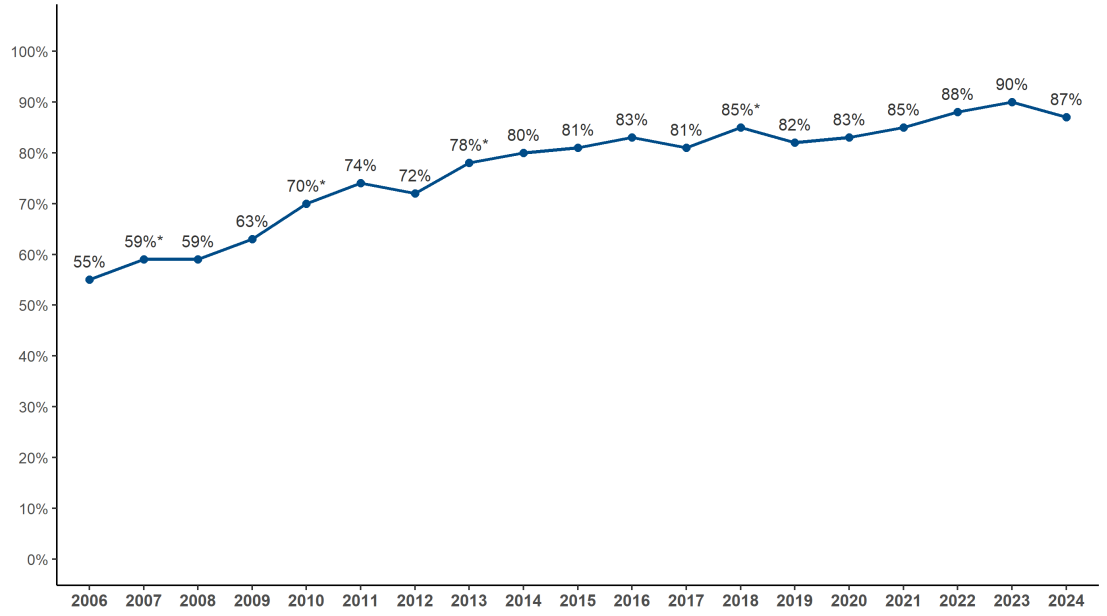
NOTE: Other cost sharing include a separate annual deductible, copayment, coinsurance or charge per day. Percentages are similar between single and family coverage.
SOURCE: KFF Employer Health Benefits Survey, 2024

Figure 7.6
Among Covered Workers with a General Annual Deductible for Single Coverage, Average Deductible, by Plan Type and Firm Size, 2024



* 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, 2024

Figure 7.7
Percentage of Covered Workers with a General Annual Deductible for Single Coverage, 2006-2024



* 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, 2018-2024; 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, 2006-2024

	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
2023	$2,949	$2,979	$3,855	$4,909	$1,835	$1,435	$3,337	$3,637	$1,200	$1,281	$1,783	$2,611	$1,735
2024	$3,777	$2,770	$4,217	$4,991	$1,548	$1,635	$3,651	$4,055	$1,484	$1,252	$2,094	$2,666	$1,787

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, 2018-2024; 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 over time, from 80% in 2014 to 87% in 2024 [Figure 7.7]. The average deductible amount for covered workers in plans with a deductible has also increased over this period, from $1,217 in 2014 to $1,787 in 2024 [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 than the averages for only people in plans with deductibles, but the changes over time reflect both workers facing higher monetary deductible amounts and a greater number of workers facing deductibles.
  - Using this approach, the average general annual deductible for single coverage for all covered workers (with or without a deductible) in 2024 is $1,562, similar to the amount last year ($1,568) [Figure 7.10].
  - The 2024 value is 12% higher than the average general annual deductible in 2019 ($1,396) and 58% higher than in 2014 ($989) [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. Thirty-two percent of covered workers are in plans with a general annual deductible of $2,000 or more for single coverage, similar to the percentages last year (31%) and five years ago (28%) [Figure 7.14].
  - Workers at small firms are considerably more likely to have a general annual deductible of $2,000 or more for single coverage than workers at large firms (50% vs. 26%) [Figure 7.12].

Figure 7.9

Prevalence and Value of General Annual Deductibles for Single Coverage, by Firm Size, 2006-2024

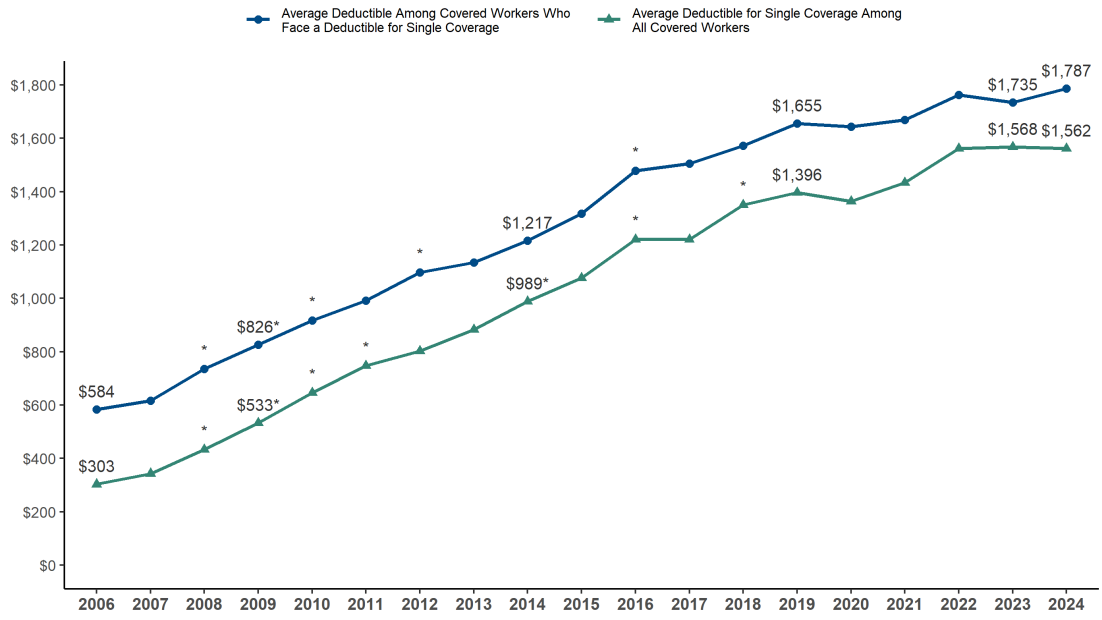
	Average General Annual Deductible Among Covered Workers Who Face A Deductible For Single Coverage			Percentage Of Covered Workers With A General Annual Deductible For Single Coverage			Average General Annual Deductible For Single Coverage Among All Covered Workers		
	All Small Firms	All Large Firms	All 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
2023	$2,434	$1,478	$1,735	88%	90%	90%	$2,138	$1,341	$1,568
2024	$2,575	$1,538	$1,787	80%*	89%	87%	$2,061	$1,374	$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 ($p < .05$).

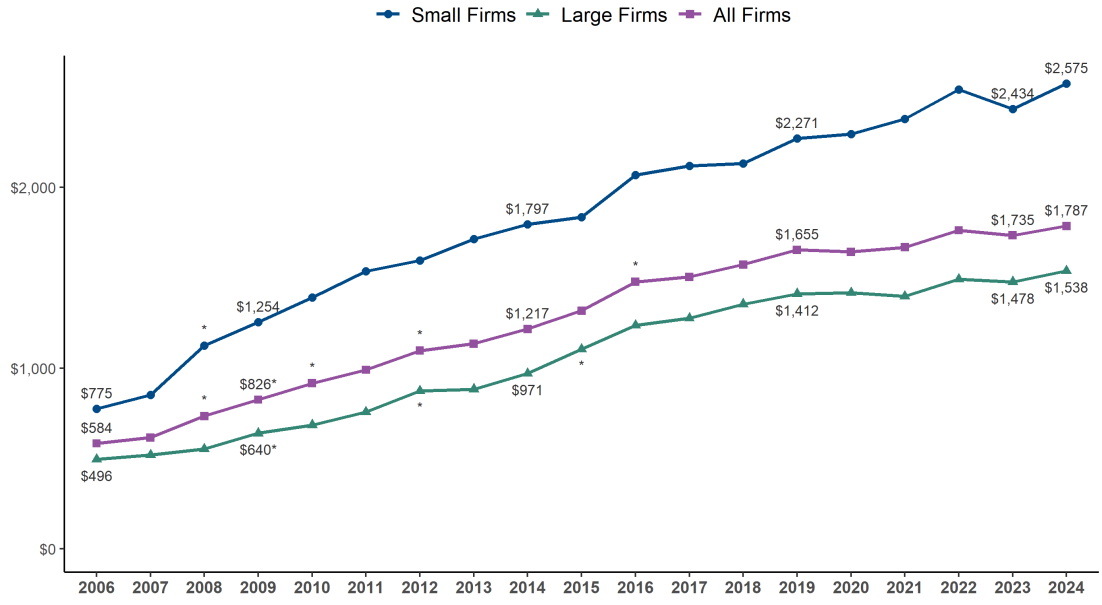
SOURCE: KFF Employer Health Benefits Survey, 2018-2024; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006-2017

Figure 7.10
Average General Annual Deductibles for Single Coverage, 2006-2024



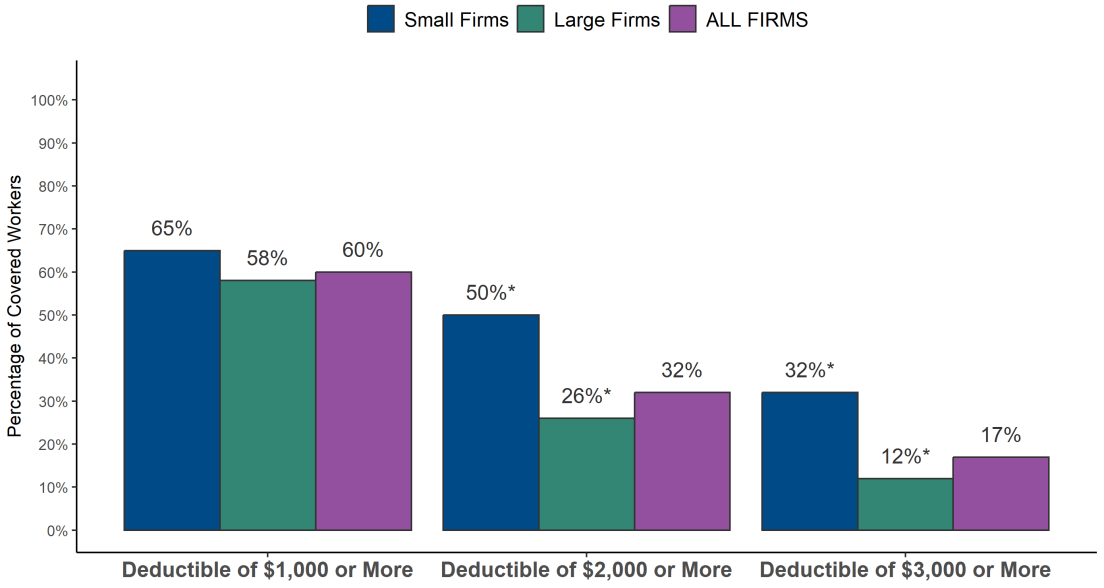
* Estimate is statistically different from estimate for the previous year shown (p < .05).
NOTE: Average general annual deductibles are among all covered workers. Workers in plans without a general annual deductible for in-network services are assigned a value of zero.
SOURCE: KFF Employer Health Benefits Survey, 2018-2024; 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, 2006-2024



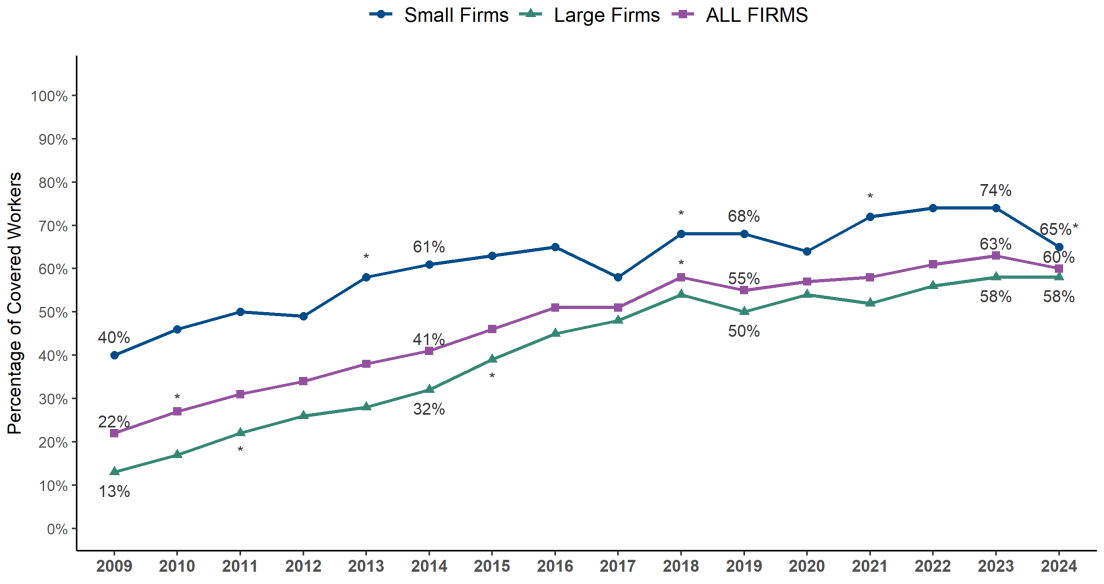
* Estimate is statistically different from estimate for the previous year shown (p < .05).
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers. Average general annual deductibles are for in-network providers.
SOURCE: KFF Employer Health Benefits Survey, 2018-2024; Kaiser/HRET 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, 2024



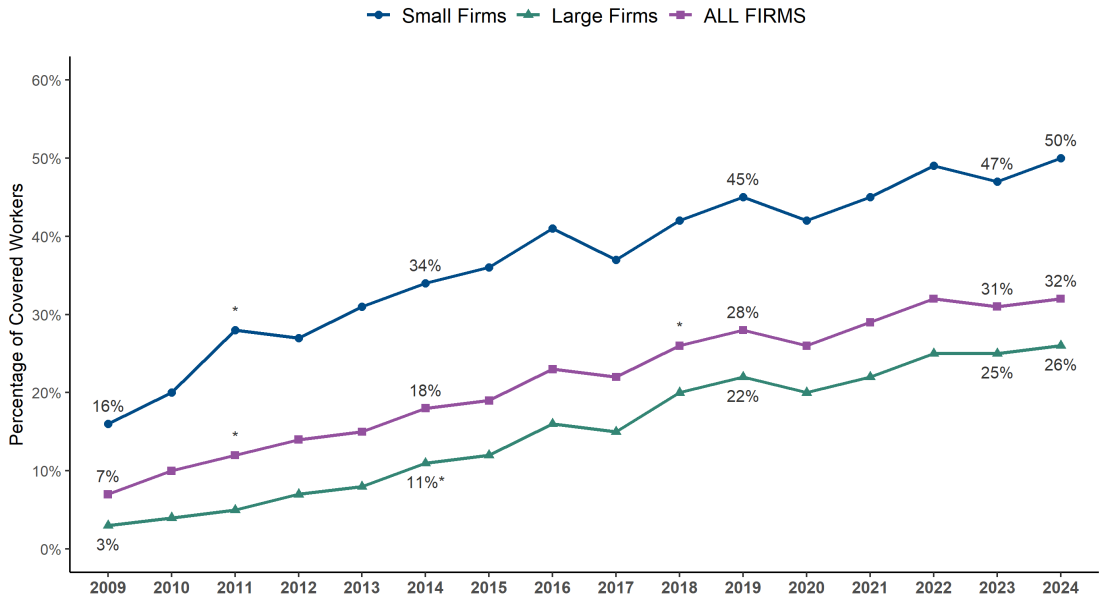
* Estimate is statistically different between All Small Firms and All Large Firms estimate ($p < .05$).
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers. These estimates include workers enrolled in HDHP/SOs and other plan types. Average general annual health plan deductibles for PPOs, POS plans, and HDHP/SOs are for in-network services.
SOURCE: KFF Employer Health Benefits Survey, 2024

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, 2009-2024



* 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, 2018-2024; 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, 2009-2024

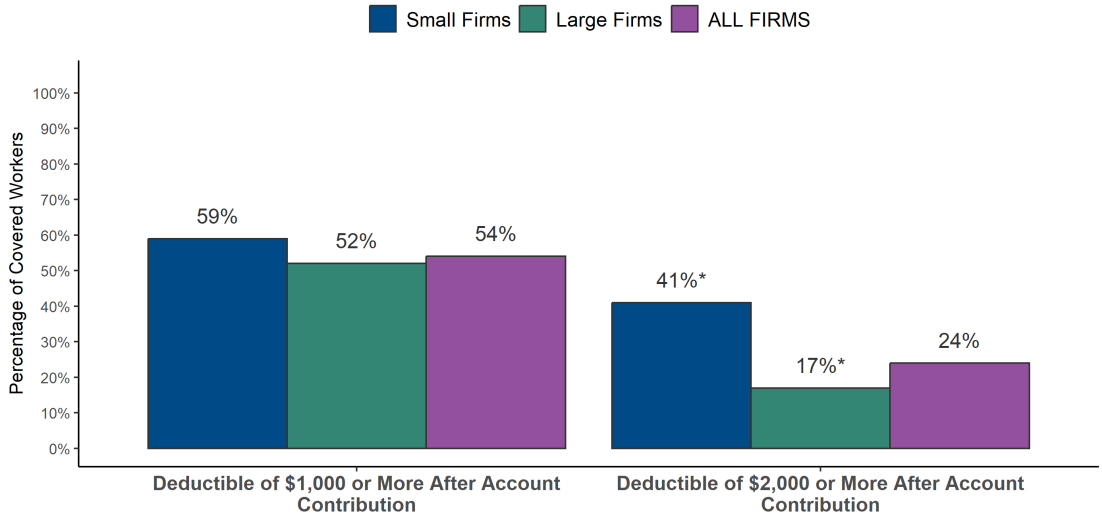


* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
NOTE: These estimates include workers enrolled in HDHP/SOs and other plan types. Average general annual deductibles are for in-network providers.
SOURCE: KFF Employer Health Benefits Survey, 2018-2024; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2009-2017

GENERAL ANNUAL DEDUCTIBLES AND ACCOUNT CONTRIBUTIONS

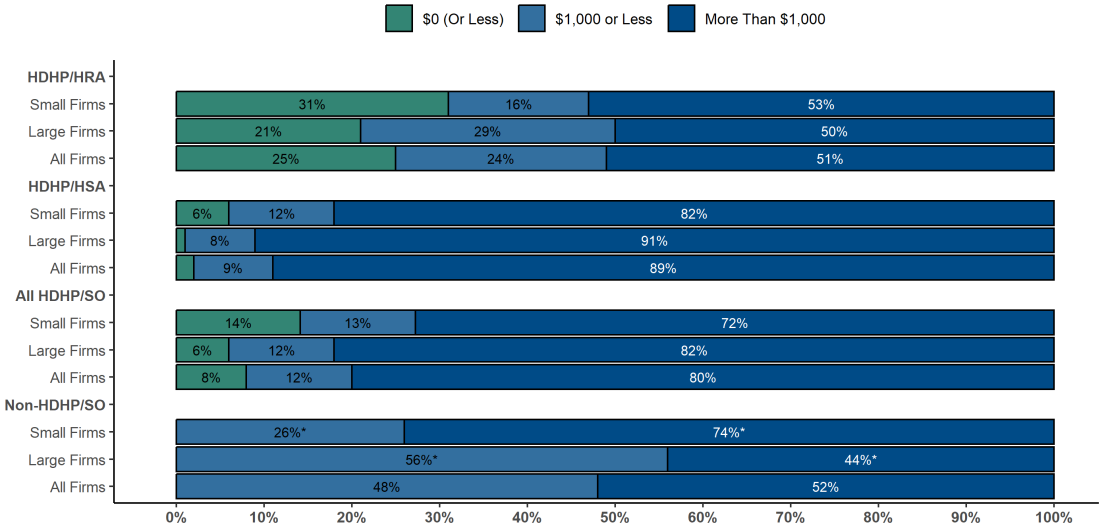
- One of the reasons for the growth in general annual deductibles is the growth in enrollment in HDHP/SOs, which have higher deductibles than other plans. While having a higher deductible in other plan types generally increases enrollee out-of-pocket liability, the shift in enrollment to HDHP/SOs does not necessarily do so, because many HDHP/SO enrollees receive an account contribution from their employers, reducing the higher cost-sharing in these plans.
  - Twenty-five percent of covered workers in an HDHP with an HRA and 2% of covered workers in an HSA-qualified HDHP receive an account contribution from their employer for single coverage that is at least equal to their deductible. Another 24% of covered workers in an HDHP with an HRA and 9% 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 60% 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, 2024



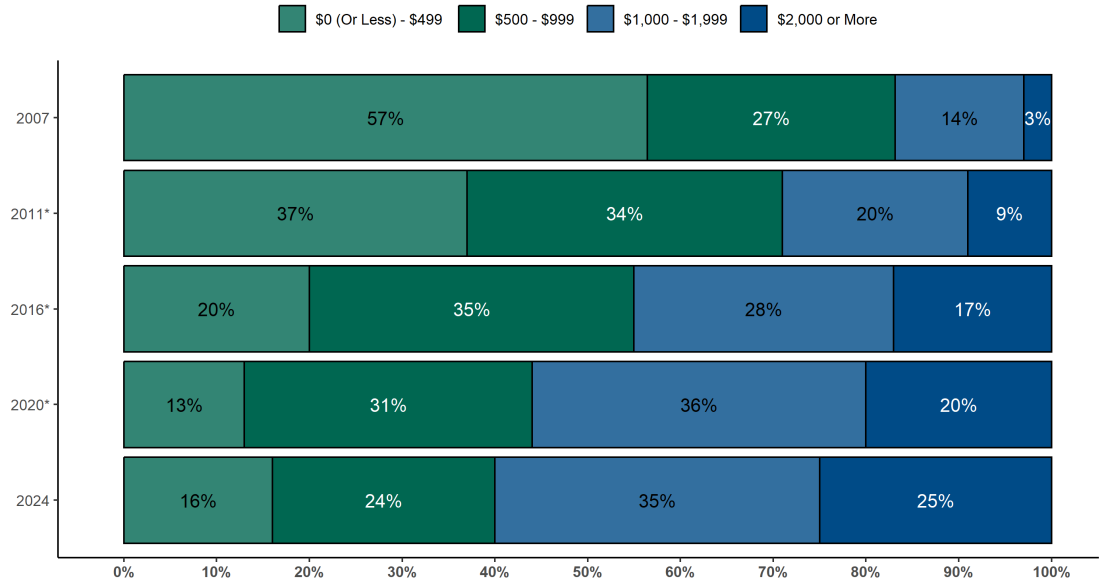
* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
NOTE: These estimates include workers enrolled in HDHP/SOs and other plan types. Average general annual health plan deductibles for PPOs, POS plans, and HDHP/SOs are for in-network services. The net liability 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, 2018-2024; 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, 2024



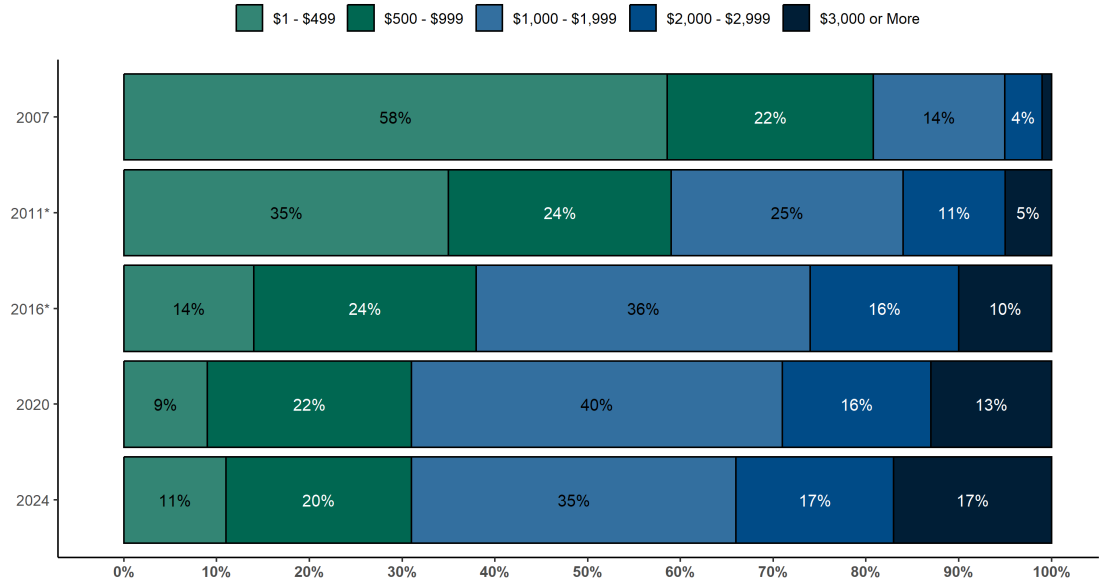
* Estimate is statistically different between All Small Firms and All Large Firms estimate ($p < .05$).
NOTE: The net liability for covered workers enrolled in a plan with an HSA or HRA is calculated by subtracting the account contribution from the single coverage deductible. HRAs are notional accounts, 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, 2024

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, 2007-2024



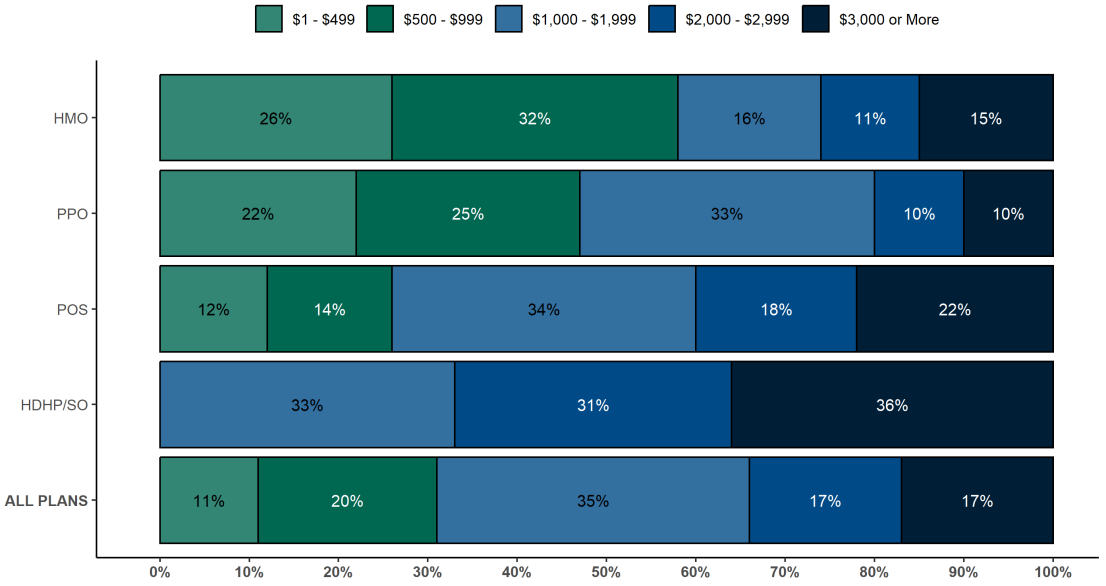
* Distribution is statistically different from distribution for the previous year shown (p < .05).
NOTE: Account contributions include an employer's contribution to an HSA or HRA. These estimates include workers enrolled in HDHP/SOs and other plan types. Average general annual deductibles are for in-network providers.
SOURCE: KFF Employer Health Benefits Survey, 2018-2024; 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, 2007-2024



* Distribution is statistically different from distribution for the previous year shown (p < .05).
NOTE: Average general annual deductibles are for in-network providers. In 2024, 87% of covered workers are enrolled in a plan with a general annual deductible.
SOURCE: KFF Employer Health Benefits Survey, 2018-2024; 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, 2024



NOTE: Average general annual deductibles are for in-network providers. In 2024, 87% of covered workers are enrolled in a plan with a general annual deductible.
SOURCE: KFF Employer Health Benefits Survey, 2024

GENERAL ANNUAL DEDUCTIBLES FOR WORKERS ENROLLED IN FAMILY COVERAGE

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 where 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]

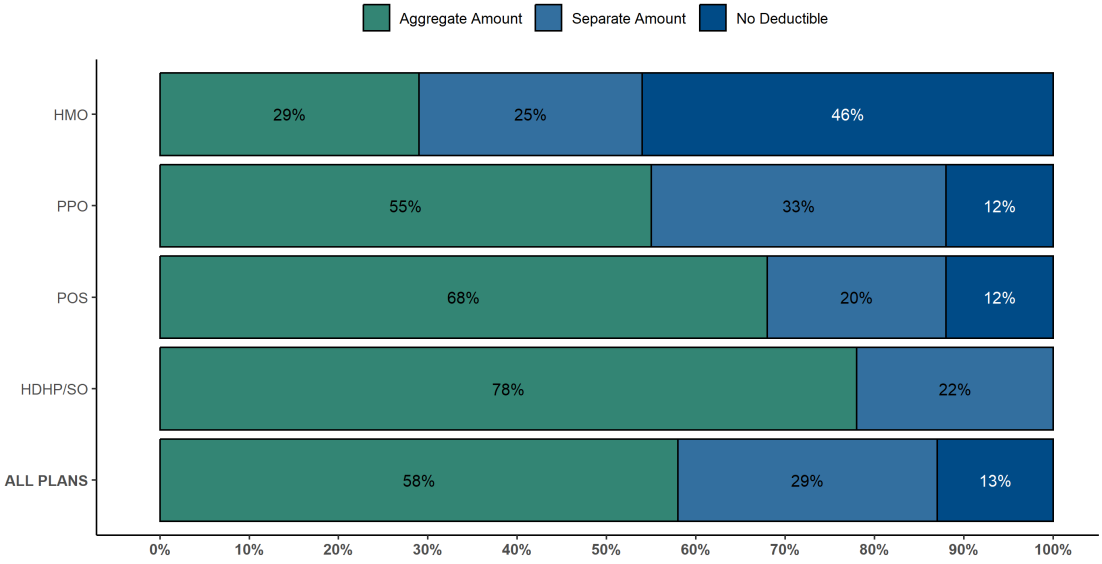
- Forty-six percent of covered workers in HMOs are in plans without a general annual deductible for family coverage. The percent of workers in plans without family deductibles is lower for workers in PPOs (12%) and POS plans (12%). As defined, all covered workers in HDHP/SOs have a general annual deductible 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 29% for workers in HMOs, 55% for workers in PPOs, 68% for workers in POS plans, and 78% 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 $3,777 for HMOs, $2,770 for PPOs, $4,217 for POS plans, and $4,991 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 at small firms are higher than at large firms for covered workers in PPOs, HMO plans, 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 25% for workers in HMOs, 33% for workers in PPOs, 20% for workers in POS plans, and 22% 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 $1,635 for PPOs, and $4,055 for HDHP/SOs [Figure 7.21].
- Forty 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, 2024



NOTE: HDHP/SOs are defined as having a minimum deductible of $2,000 for aggregate 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.
SOURCE: KFF Employer Health Benefits Survey, 2024

Figure 7.21

Among Covered Workers With a General Annual Deductible, Average Deductibles for Family Coverage, by Deductible Type, Plan Type, and Firm Size, 2024

	Aggregate Amount	Separate Per-Person Amount
HMO		
All Small Firms	$6,468*	NSD
All Large Firms	$2,216*	NSD
ALL FIRM SIZES	**$3,777**	**$1,548**
PPO		
All Small Firms	$4,188*	$2,223
All Large Firms	$2,269*	$1,528
ALL FIRM SIZES	**$2,770**	**$1,635**
POS		
All Small Firms	$4,965	NSD
All Large Firms	$3,659	$3,959
ALL FIRM SIZES	**$4,217**	**$3,651**
HDHP/SO		
All Small Firms	$6,697*	$5,500
All Large Firms	$4,422*	$3,750
ALL FIRM SIZES	**$4,991**	**$4,055**

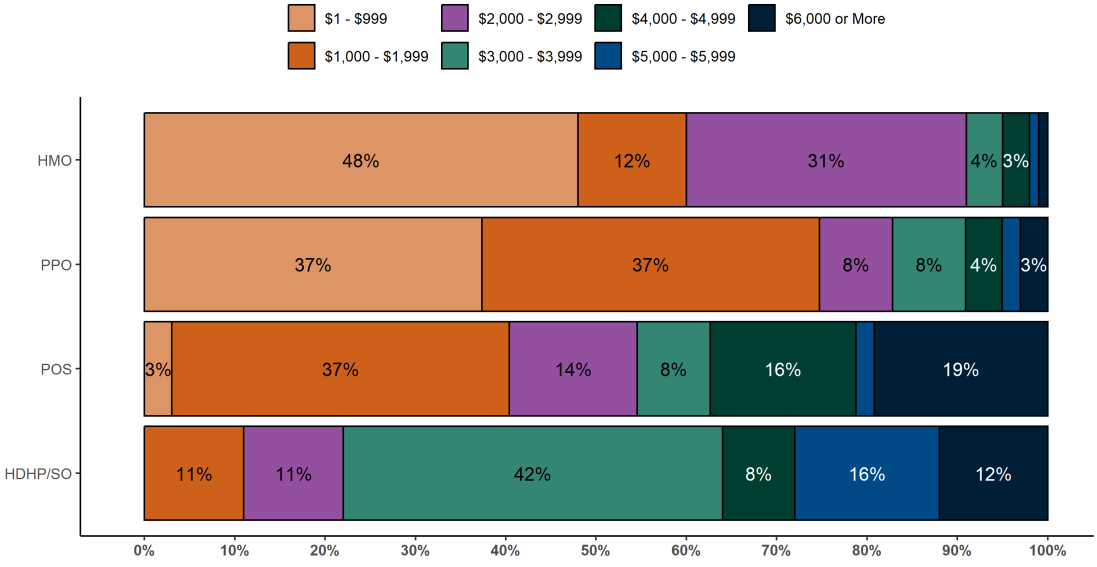
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers. Average general annual deductibles are for in-network providers. The survey distinguishes between plans that have an aggregate family deductible and plans that have a separate per-person deductible, typically with a limit 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, 2024

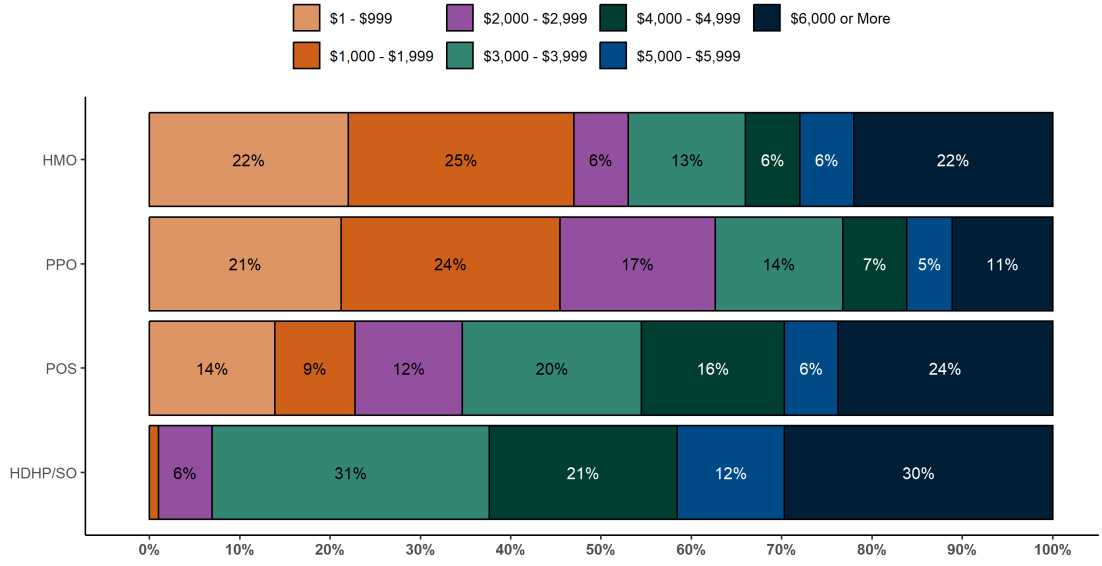
Figure 7.22

Among Covered Workers with a Separate Per-Person General Annual Deductible for Family Coverage, Distribution of Deductibles, by Plan Type, 2024



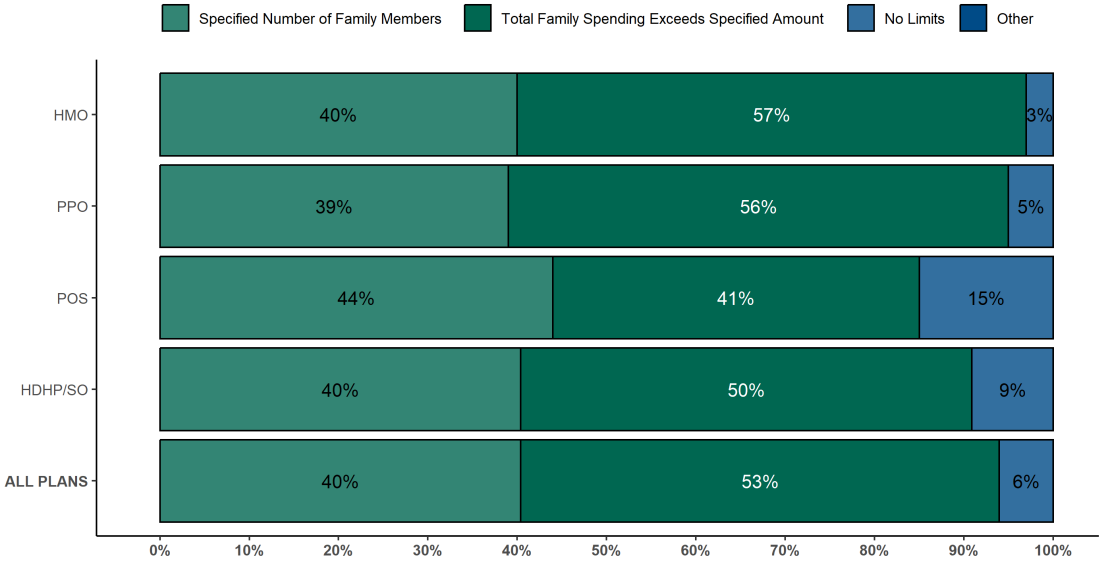
NOTE: Average general annual deductibles are for in-network providers. The survey distinguishes between plans that have an aggregate family deductible and plans that have a separate per-person deductible, typically with a limit on the number of family members required to reach that amount.
SOURCE: KFF Employer Health Benefits Survey, 2024

Figure 7.23
Among Covered Workers with an Aggregate General Annual Deductible for Family Coverage, Distribution of Deductibles, by Plan Type, 2024



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, 2024

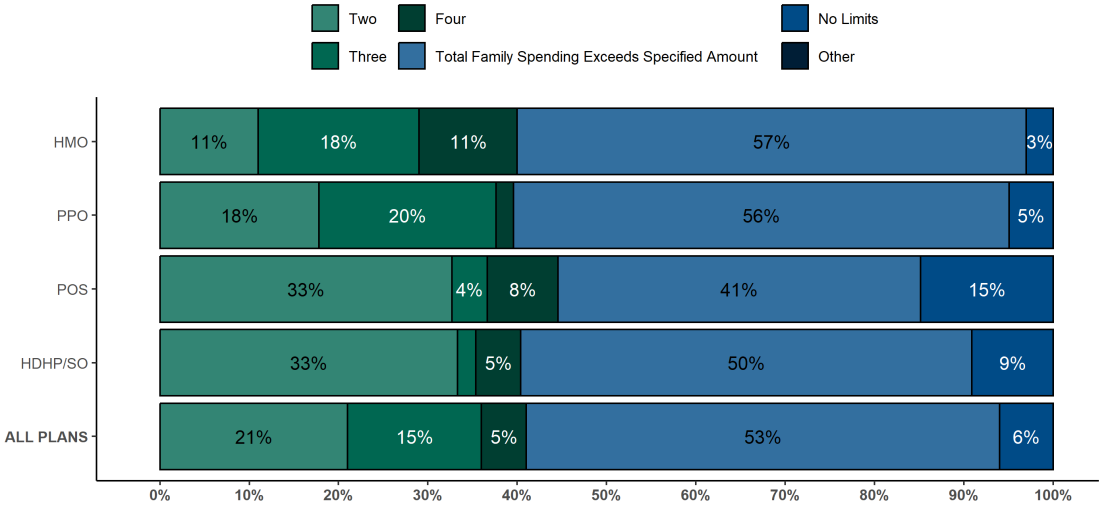
Figure 7.24
Among Covered Workers With a Separate Per-Person General Annual Deductible for Family Coverage, Structure of Deductible Limits, by Plan Type, 2024



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, 2024

Figure 7.25

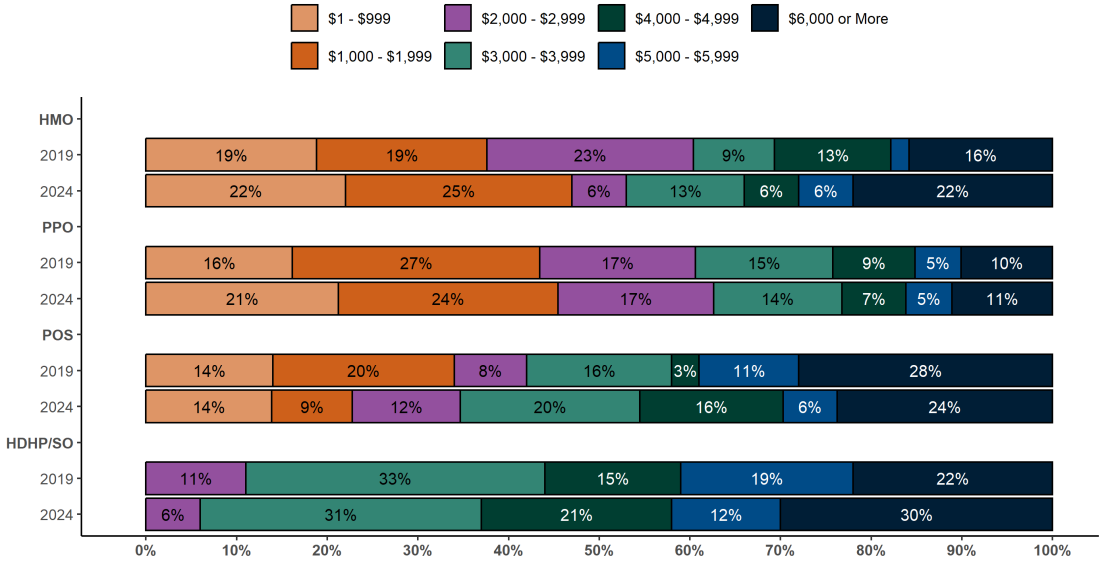
Among Covered Workers With a Separate Per-Person General Annual Deductible for Family Coverage and a Per-Person Limit, Distribution of Maximum Number of Family Members Required to Meet the Deductible, by Plan Type, 2024



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, 2024

Figure 7.26

Among Covered Workers With an Aggregate General Annual Deductible for Family Coverage, Distribution of Aggregate Deductibles, by Plan Type, 2019 and 2024

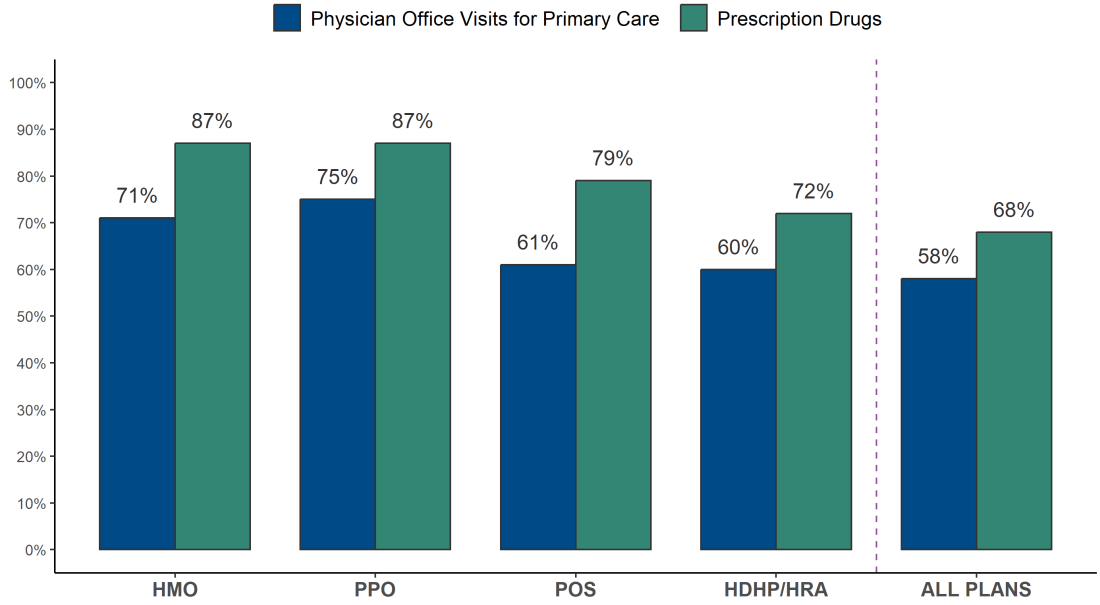


Tests found no statistical difference from distribution for the previous year shown ($p < .05$).
NOTE: By definition, 100% of covered workers in an HDHP/SO with an aggregate deductible have a family deductible of $2,000 or more. Average general annual deductibles are for in-network providers. The survey 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, 2019-2024;

COVERAGE OF SERVICES AND PRODUCTS BEFORE MEETING THE GENERAL ANNUAL DEDUCTIBLES

- The majority of covered workers with a general annual deductible are enrolled 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.
  - Among covered workers enrolled in a plan with a general annual deductible, large shares (71% in HMOs, 75% in PPOs, 61% in POS plans, and 60% in HDHP/HRAs) are enrolled 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 covered workers enrolled in a plan with a general annual deductible, large shares (87% in HMOs, 87% in PPOs, 79% in POS plans, and 72% in HPHD/HRAs) do not have to meet the general annual deductible before prescription drugs are covered [Figure 7.27].

Figure 7.27
Among Covered Workers with a General Annual Deductible, Percentage with Coverage for the Following Services Without Having to First Meet the Deductible, by Plan Type, 2024



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, 2024

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 cost-sharing methods. Coinsurance, in particular, may include minimums or maximums which affect an enrollee's liability. We report the distribution of cost-sharing for covered workers enrolled in a plan which covers hospital admissions and outpatient surgery, respectively. A small share of respondents indicate that they have an "other" type of cost-sharing arrangement.

- In addition to any general annual deductible that may apply, 59% of covered workers have coinsurance and 16% have a copayment that applies to inpatient hospital admissions. A lower percentage of covered workers have per-day (per diem) payments (5%), a separate hospital deductible (2%), or both a copayment and coinsurance (9%). Fifteen percent of covered workers have no additional cost-sharing for hospital admissions after any general annual deductible has been met [Figure 7.28]. Covered workers with both a copay and coinsurance may be required to pay both or whichever is greater.
  - On average, covered workers in HMO 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 7.28].
  - The average coinsurance rate for a hospital admission is 21%, the average copayment is $343 per hospital admission, and the average per diem charge is $369 [Figure 7.31]. Seventy-two 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 7.32].
- The cost-sharing provisions for outpatient surgery are similar to those for hospital admissions, as most workers have coinsurance or copayments. In 2024, 13% of covered workers have a copayment and 64% have a coinsurance rate for outpatient surgery. In addition, 7% have both a copayment and a coinsurance rate, while 15% have no additional cost-sharing after any general annual deductible has been met [Figure 7.29] and [Figure 7.30].
  - For covered workers with cost-sharing for outpatient surgery, the average coinsurance rate is 20% and the average copayment is $216 [Figure 7.31].

Figure 7.28

Distribution of Covered Workers' Cost Sharing for Hospital Admissions, by Plan Type, 2024

Plan Type	Separate Annual Deductible for Hospital Admissions	Copayment	Coinsurance	Both Copayment and Coinsurance	Charge Per Day	None After Any General Annual Deductible Is Met
HMO	1%	36%*	41%	4%	11%*	16%
PPO	1	13	64	10	4	11
POS	7	29	45	15	13	9
HDHP/SO	<1*	5*	64	6	2*	24*
ALL PLANS	**2%**	**16%**	**59%**	**9%**	**5%**	**15%**

NOTE: Based on the cost-sharing in addition to any general annual plan deductible. The distribution may 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. For HDHP/SOs plans, information on separate deductibles was collected only for HDHP/HRAs because regulations for HSA-qualified plans make it unlikely they would have a services specfic deductible. 'Both Copayment and Coinsurance' includes the requirements to pay the higher amount of a copayment or coinsurance under the plan. Less than one percent of covered workers are enrolled in a plan that does not cover hospital admissions. These workers are excluded from the distribution.

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

SOURCE: KFF Employer Health Benefits Survey, 2024

Figure 7.29

Distribution of Covered Workers' Cost Sharing for Outpatient Surgery, by Plan Type, 2024

Plan Type	Separate Annual Deductible for Outpatient Surgery	Copayment	Coinsurance	Both Copayment and Coinsurance	None After Any General Annual Deductible Is Met
HMO	2%	32%*	48%	4%	16%
PPO	1	9*	70	10	10
POS	3	32*	46*	7	14
HDHP/SO	<1*	2*	68	4	26*
ALL PLANS	**1%**	**13%**	**64%**	**7%**	**15%**

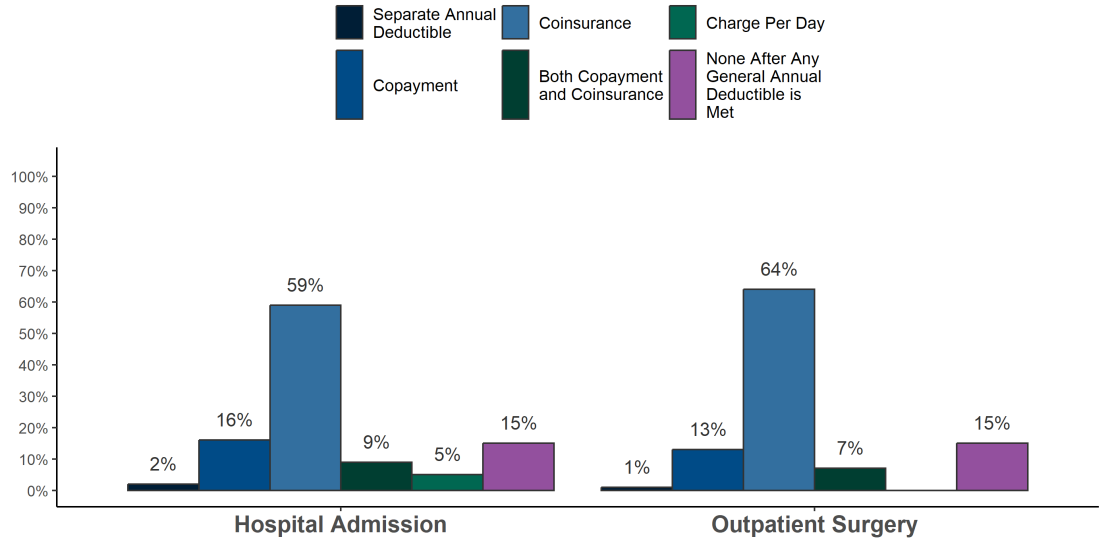
NOTE: Based on the cost-sharing in addition to any general annual plan deductible. The distribution may not equal 100% because workers may face a combination of types of cost sharing. Less than one percent of covered workers have an 'Other' type of cost sharing. For HDHP/SOs plans, information on separate deductibles was collected only for HDHP/HRAs because regulations for HSA-qualified plans make it unlikely they would have a services specfic deductible. 'Both Copayment and Coinsurance' includes the requirements to pay the higher amount of a copayment or coinsurance under the plan. Less than one percent of covered workers are enrolled in a plan that does not cover outpatient surgery. These workers are excluded from the distribution.

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

SOURCE: KFF Employer Health Benefits Survey, 2024

Figure 7.30

Percentage of Covered Workers with the Following Types of Cost Sharing for Hospital Admissions and Outpatient Surgery, in Addition to Any General Annual Deductible, 2024



NOTE: Based on the cost-sharing in addition to any general annual plan deductible. The distribution may 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.For HDHP/SOs plans, information on separate deductibles was collected only for HDHP/HRAs because regulations for HSA-qualified plans make it unlikely they would have a services specfic deductible. 'Both Copayment and Coinsurance' includes the requirements to pay the higher amount of a copayment or coinsurance under the plan.

SOURCE: KFF Employer Health Benefits Survey, 2024

Figure 7.31

Among Covered Workers With Separate Cost Sharing for Hospital Admissions or Outpatient Surgery, Average Cost Sharing, by Type, 2024

	Charge Per Day	Coinsurance	Copayment
Outpatient Surgery	N/A	20%	$216
Hospital Admission	$369	21%	$343

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, 2024

Figure 7.32

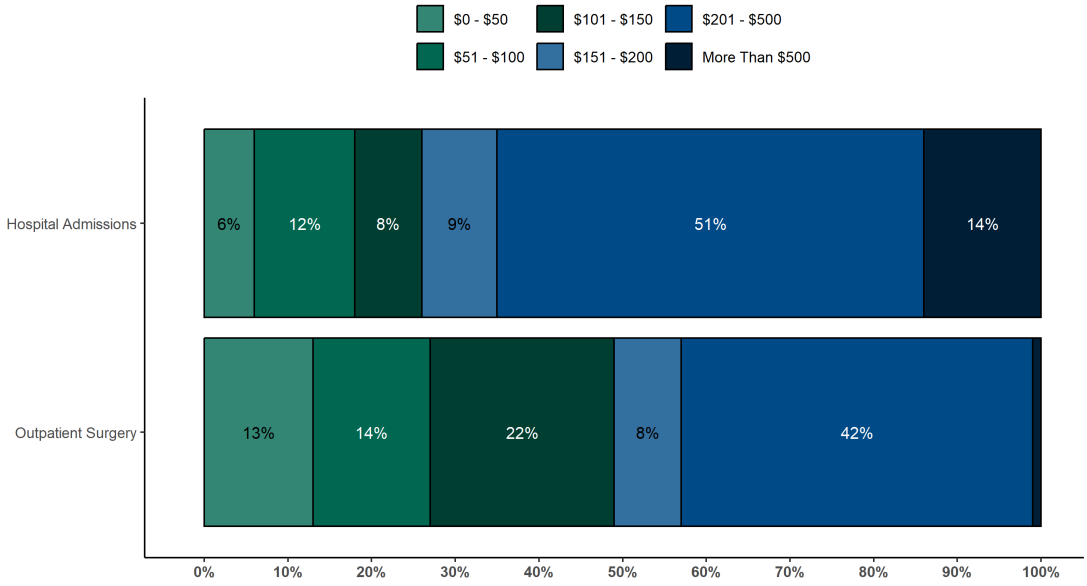
Among Covered Workers With a Charge Per Day for Hospital Admissions, Average Cost Sharing Features, 2024

	Among Covered Workers With a Charge Per Day for Hospital Admissions
Average Charge Per Day	$369
Percentage of Covered Workers With a Limit On the Number of Days a Worker Must Pay Per-Day Amount	72%

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.

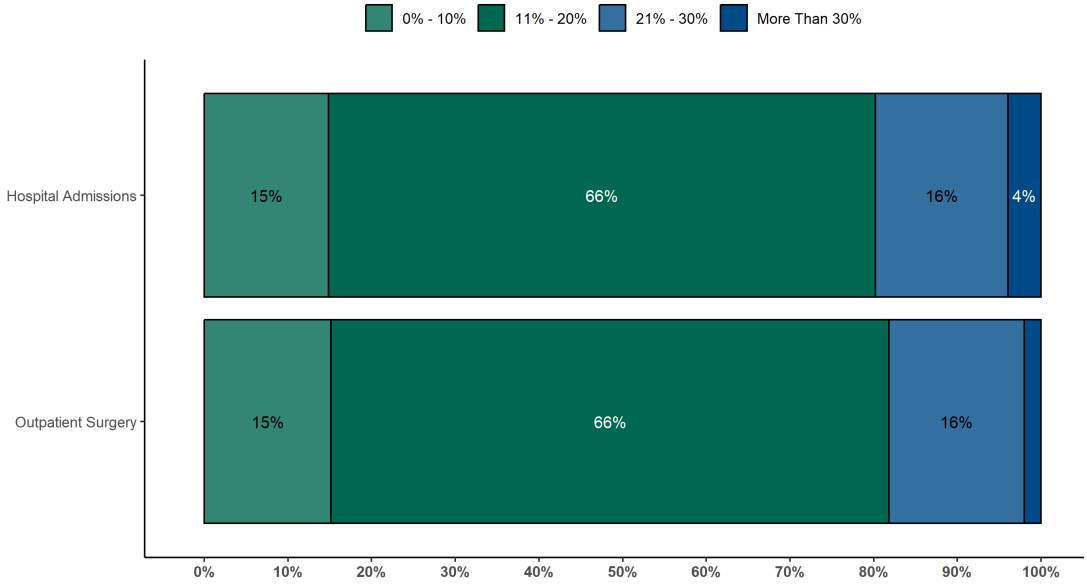
SOURCE: KFF Employer Health Benefits Survey, 2024

Figure 7.33
Among Covered Workers with a Copayment for Hospital Admissions or Outpatient Surgery, Distribution of Copayments, 2024



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, 2024

Figure 7.34
Among Covered Workers with Coinsurance for Hospital Admissions or Outpatient Surgery, Distribution of Coinsurance Rates, 2024



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, 2024

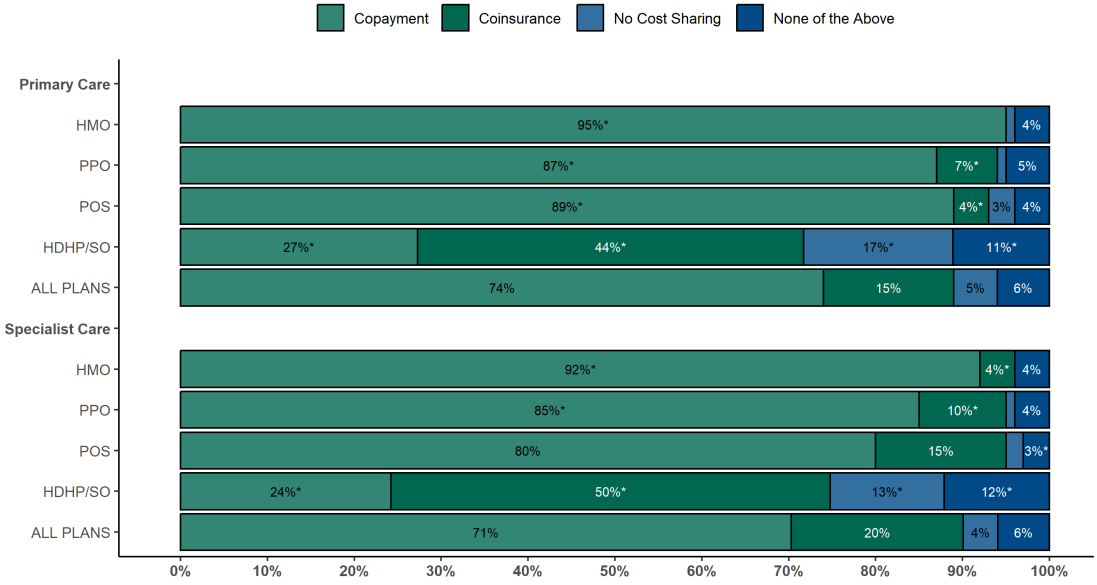
COST-SHARING FOR PHYSICIAN OFFICE VISITS

- 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 visit is a copayment. Seventy-four percent of covered workers have a copayment for a primary care physician office visit and 15% have coinsurance. For office visits with a specialty physician, 71% of covered workers have a copayment and 20% have coinsurance [Figure 7.35].
  - The share of covered workers with coinsurance for office visits with a specialty physician in 2024 is lower than the percentage five years ago (20% vs. 26%).
  - The form of cost-sharing for physician office visits varies by firm size. Covered workers at small firms are less likely to have coinsurance than workers at large firms for in-network primary care office visits (8% vs. 18%), and for in-network office visits with specialists (9% vs. 24%) [Figure 7.37].
  - 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, 27% of covered workers in HDHP/SOs have a copayment, 44% have coinsurance, and 17% have no cost-sharing after the general annual plan deductible is met [Figure 7.35].
  - Among covered workers with a copayment for in-network physician office visits, the average copayment for primary care physician office visits is $26, the same as average copayment last year ($26) [Figure 7.36].
  - Among covered workers with a copayment for in-network physician office visits, the average copayment for specialty physician office visits is $42, similar to the amount last year ($44) [Figure 7.36].
  - For covered workers with a copayment for physician office visits, average copayment amounts are higher for workers at small firms than those at large firms for both primary care physician office visits ($28 vs. $25) and specialty physician office visits ($48 vs. $40).
  - Among covered workers with coinsurance for in-network physician office visits, the average coinsurance rates are 20% for a visit with a primary care physician and 20% for a visit with a specialist, similar to the rates last year [Figure 7.36].

[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 7.35

Percentage of Covered Workers with the Following Types of Cost Sharing for Physician Office Visits, by Plan Type, 2024



* 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, 2024

Figure 7.36

Among Covered Workers With Copayments And/Or Coinsurance for Physician Office Visits, Average Copayments and Coinsurance, by Plan Type, 2024

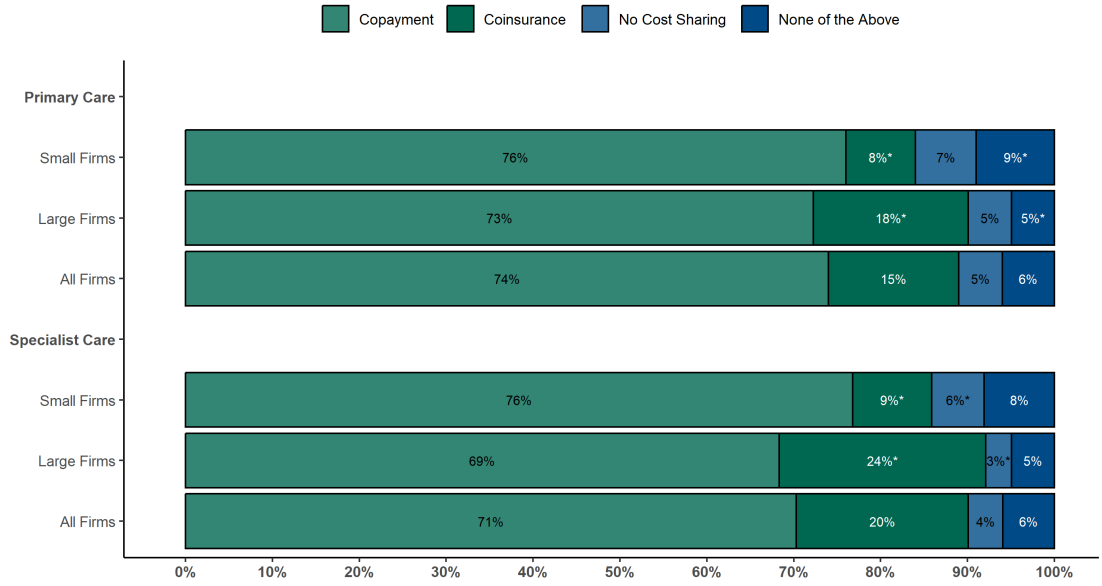
	HMO	PPO	POS	HDHP/SO	All Plans
Primary Care Office Visit					
Average Copayment ($)	$24	$26	$30*	$27	**$26**
Average Coinsurance (%)	NSD	20%	NSD	20%	**20%**
Specialty Care Office Visit					
Average Copayment ($)	$37	$42	$47*	$47	**$42**
Average Coinsurance (%)	NSD	22%	NSD	19%	**20%**

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

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

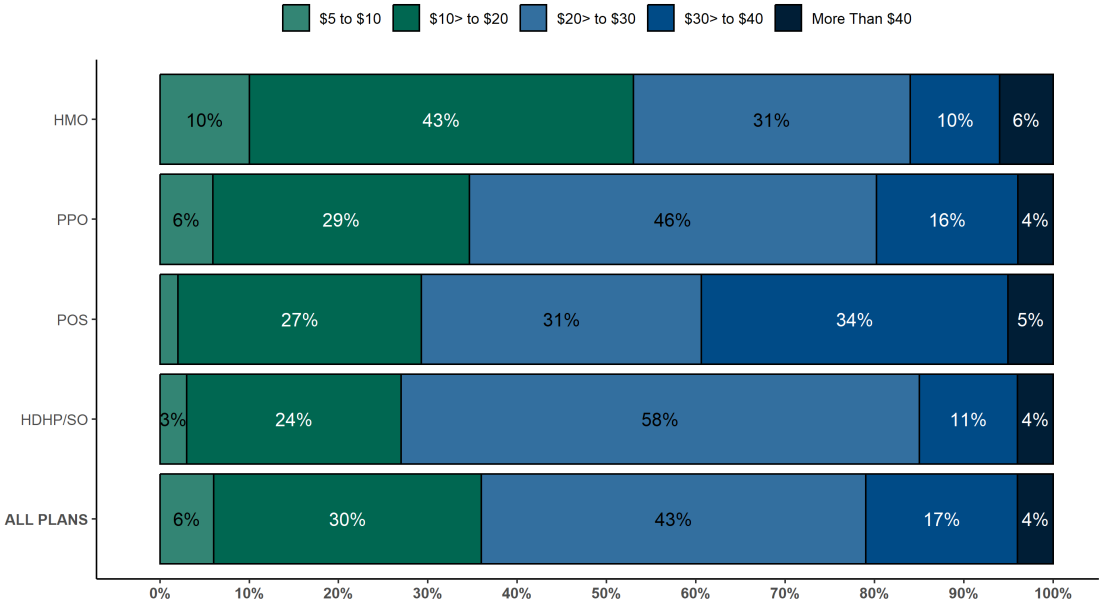
SOURCE: KFF Employer Health Benefits Survey, 2024

Figure 7.37
Percentage of Covered Workers with the Following Types of Cost Sharing for Physician Office Visits, by Firm Size, 2024



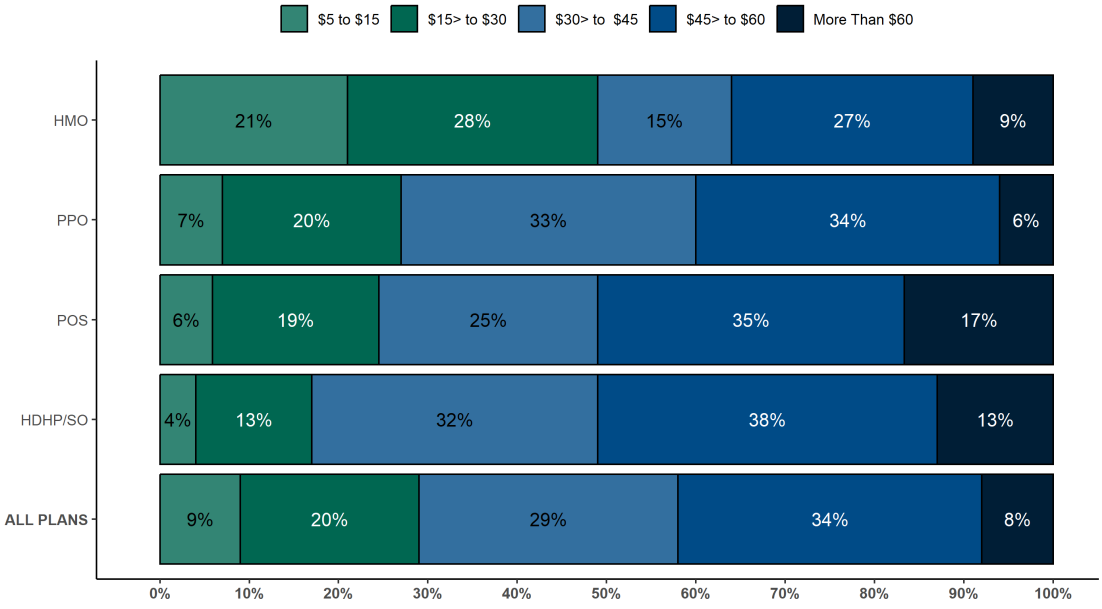
* Estimate is statistically different from estimate for all other firms not in the indicated size category ($p < .05$).
NOTE: Figure represents cost sharing in addition to any general annual deductible. The survey includes questions on cost sharing for in-network services only.
SOURCE: KFF Employer Health Benefits Survey, 2024

Figure 7.38
Among Covered Workers with a Copayment for a Primary Care Physician Office Visit, Distribution of Copayments, by Plan Type, 2024



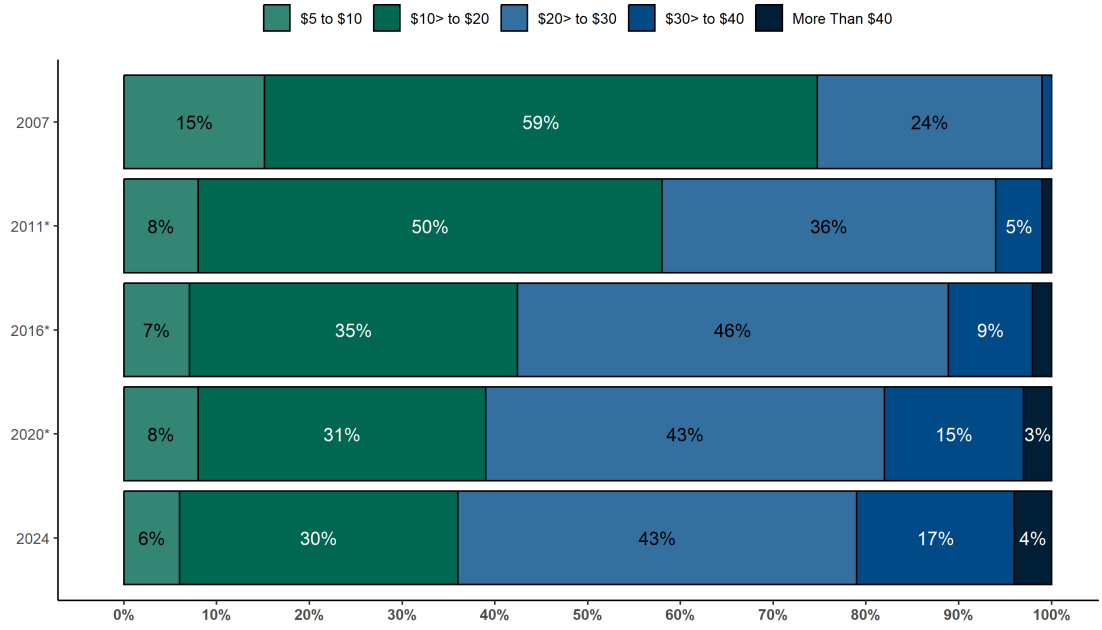
NOTE: Copayments are for in-network providers.
SOURCE: KFF Employer Health Benefits Survey, 2024

Figure 7.39
Among Covered Workers with a Copayment for a Specialist Physician Office Visit, Distribution of Copayments, by Plan Type, 2024



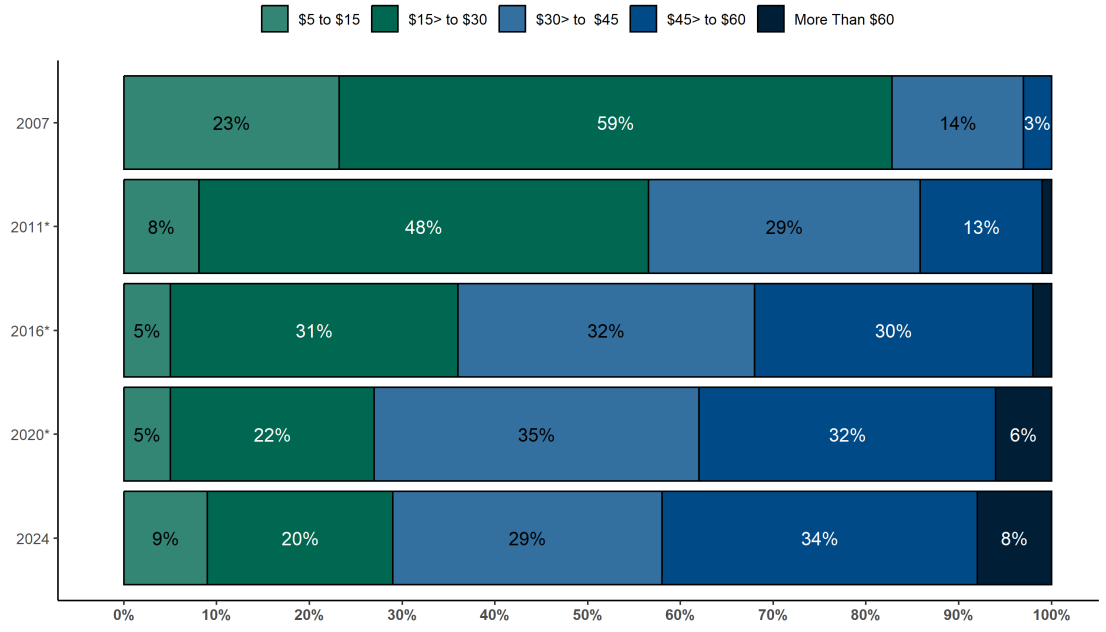
NOTE: Copayments are for in-network providers.
SOURCE: KFF Employer Health Benefits Survey, 2024

Figure 7.40
Among Covered Workers with a Copayment for a Primary Care Physician Office Visit, Distribution of Copayments, 2006-2024



* Distribution is statistically different from distribution for the previous year shown ($p < .05$).
SOURCE: KFF Employer Health Benefits Survey, 2018-2024; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2007-2017

Figure 7.41
Among Covered Workers with a Copayment for a Specialist Physician Office Visit, Distribution of Copayments, 2007-2024



* Distribution is statistically different from distribution for the previous year shown (p < .05).
SOURCE: KFF Employer Health Benefits Survey, 2018-2024; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2007-2017

Figure 7.42

Among Covered Workers With a Copayment And/Or Coinsurance for Physician Office Visits, Average Copayment and Coinsurance, 2006-2024

	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%
2023	$26	19%	$44	20%
2024	$26	20%	$42	20%

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

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

SOURCE: KFF Employer Health Benefits Survey, 2018-2024; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006-2017

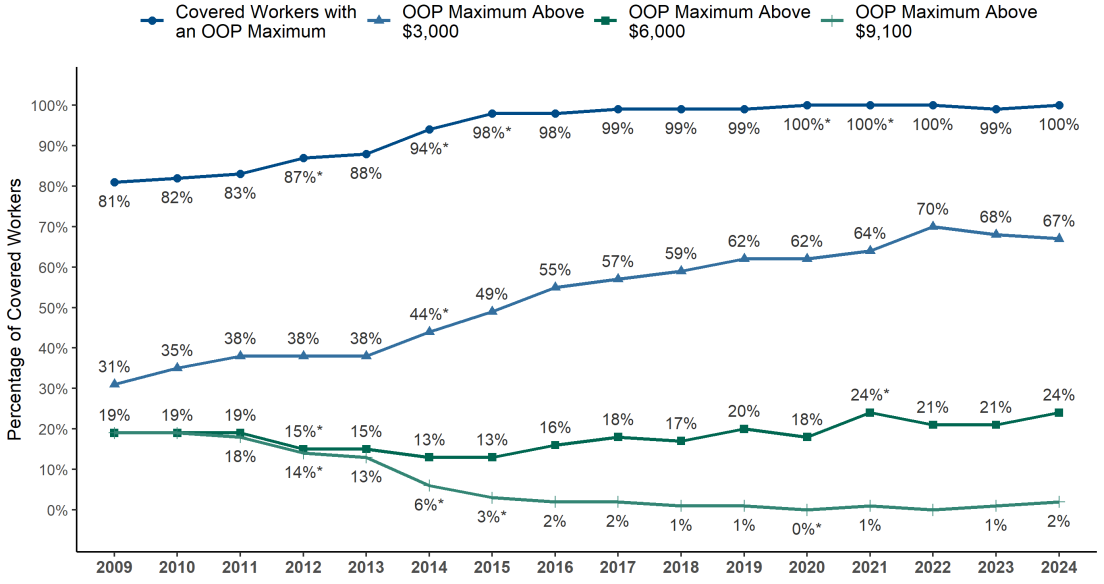
OUT-OF-POCKET MAXIMUMS

- Virtually all covered workers are in a plan that either 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 annual out-of-pocket maximum of no more than $9,450 for single coverage and $18,900 for family coverage in 2024. Out-of-pocket limits in HSA qualified HDHP/SOs are required to be somewhat lower.[3] Many plans have complex out-of-pocket structures, which makes it difficult to accurately collect information on this element of plan design.

[3] For those enrolled in an HDHP/HSA, the out-of-pocket maximum may be no more than $8,050 for an individual plan and $16,100 for a family plan in 2024.

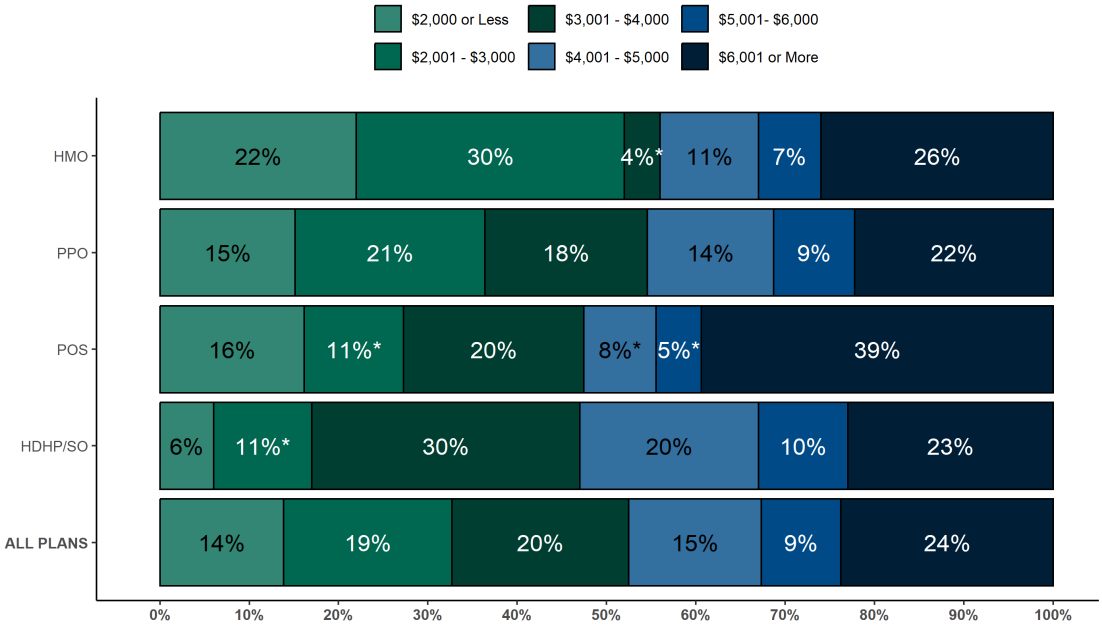
- In 2024, more than 99% of covered workers are in a plan that has an out-of-pocket maximum for single coverage [Figure 7.43].
- For covered workers in plans with an out-of-pocket maximum for single coverage, there is wide variation in spending limits [Figure 7.44].
  - Fourteen percent of covered workers in plans with an out-of-pocket maximum have an out-of-pocket maximum of $2,000 or less for single coverage, while 24% of these workers have an out-of-pocket maximum above $6,000 [Figure 7.44].

Figure 7.43
Percentage of Covered Workers in a Plan with an Out-of-Pocket Maximum Above Certain Thresholds for Single Coverage, 2009-2024



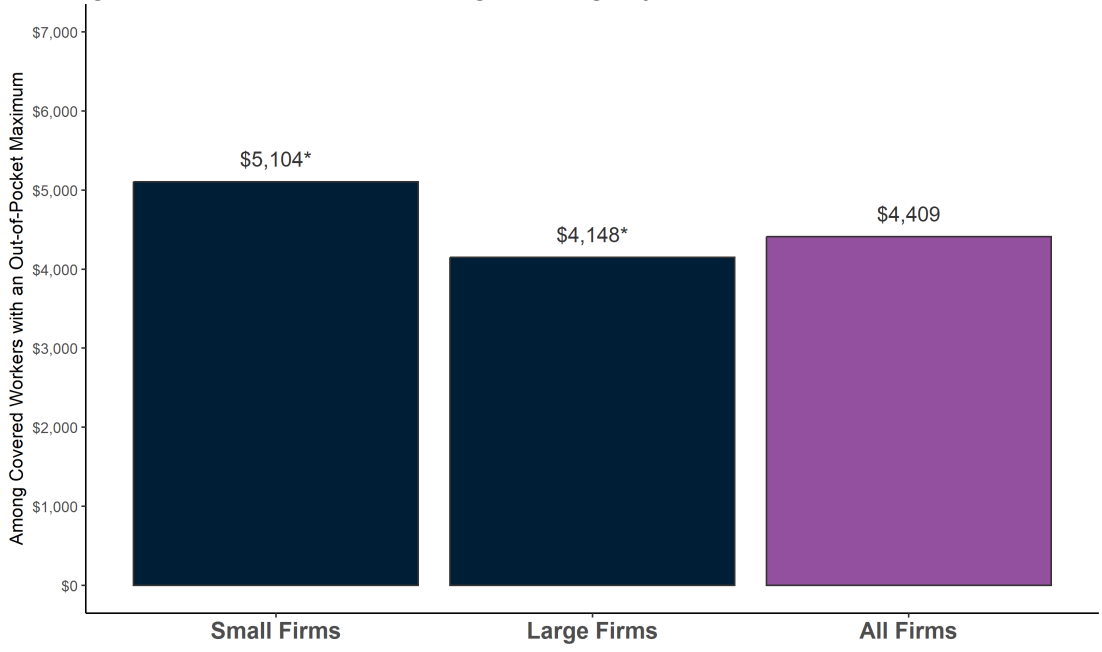
* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
NOTE: OOP is 'out-of-pocket'. OOP maximums are for in-network services. Covered workers without an OOP maximum are considered to be exposed to at least the specified threshold. Some of these workers may be enrolled in plans whose cost-sharing structure has other limits.
SOURCE: KFF Employer Health Benefits Survey, 2018-2024; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2009-2017

Figure 7.44
Among Covered Workers with an Out-of-Pocket Maximum for Single Coverage, Distribution of Out-of-Pocket Maximums, by Plan Type, 2024



* Estimate is statistically different from All Plans estimate within plan type (p < .05).
SOURCE: KFF Employer Health Benefits Survey, 2024

Figure 7.45
Average Out-of-Pocket Maximum For Single Coverage, by Firm Size, 2024



* 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, 2024

Employer Health Benefits
2024 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 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]

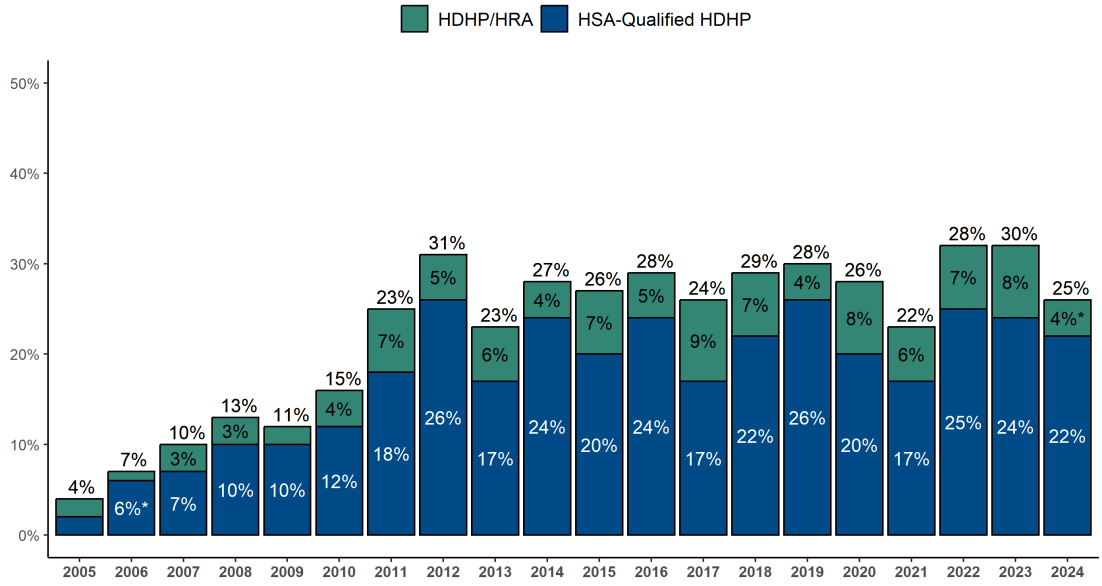
PERCENTAGE OF FIRMS OFFERING HDHP/HRAS AND HSA-QUALIFIED HDHPS

- Twenty-five percent of firms offering health benefits offer an HDHP/HRA, an HSA-qualified HDHP, or both. Among firms offering health benefits, 4% offer an HDHP/HRA and 22% 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 to at least some workers than small firms (3-199 workers) (58% vs. 24%) [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 $1,500 for single coverage and $3,000 for family coverage for HSA-qualified HDHPs in 2024 (or $1,400 and $2,800, respectively, for plans in their 2023 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.

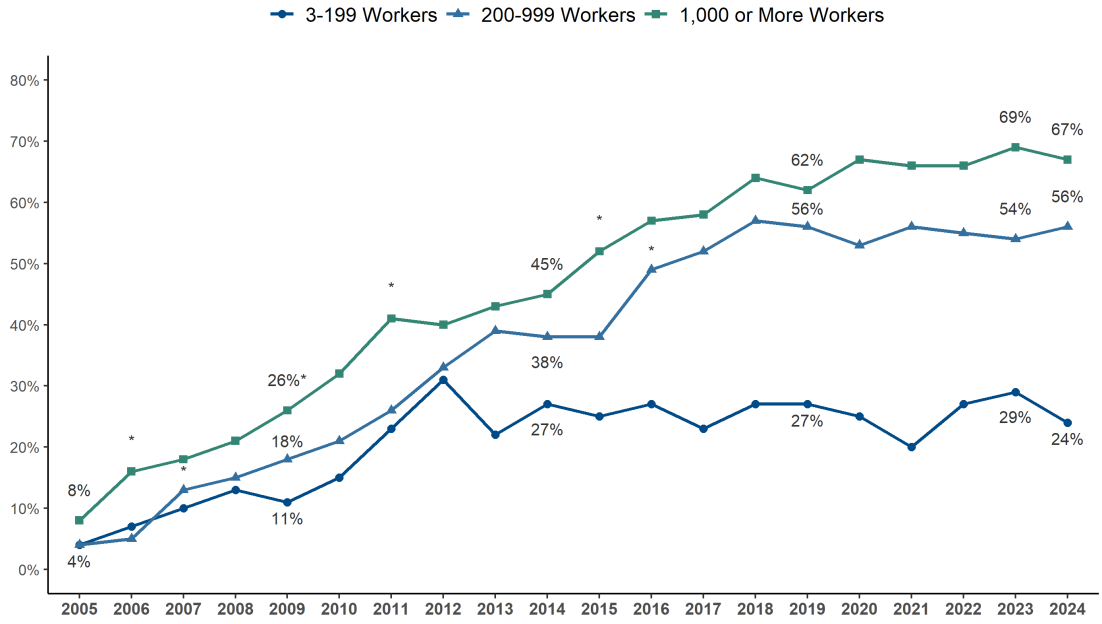
[2] The definitions of HDHP/SOs do not include other consumer-driven plan options, such as arrangements that combine an HRA with a lower-deductible health plan or arrangements in which an insurer (rather than the employer as in the case of HRAs or the enrollee as in the case of HSAs) establishes an account 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, 2005-2024



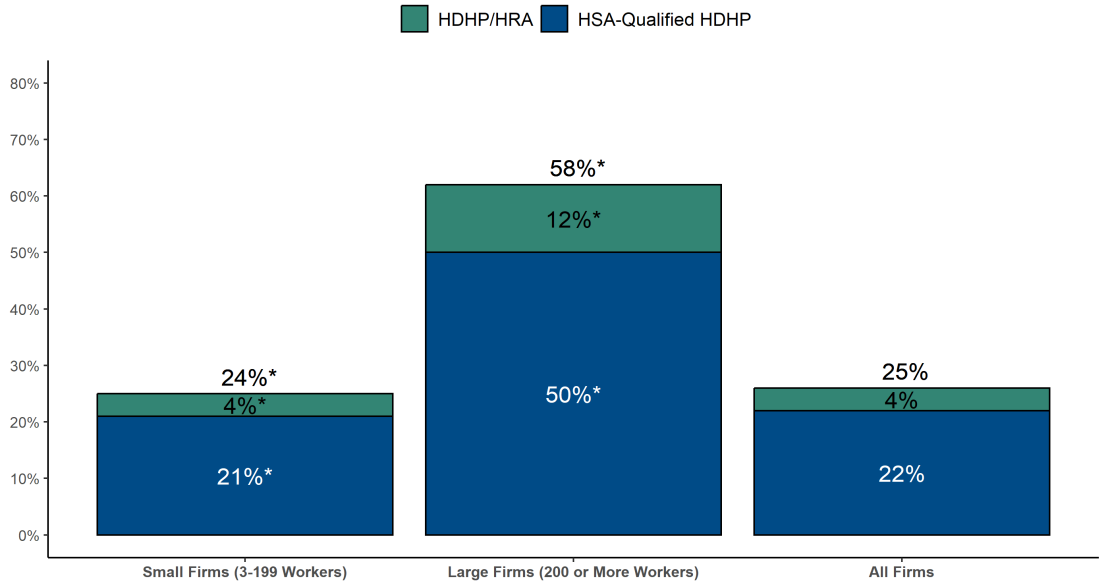
* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
NOTE: Among all firms that offer health benefits, 0.7% offer both an HDHP/HRA and an HSA-Qualified HDHP. Adding the percentage of firms offering HDHP/HRA and HSA-Qualified HDHPs may not sum to the percentage of firms offering HDHP/SOs because some firms offer both.
SOURCE: KFF Employer Health Benefits Survey, 2018-2024; 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, 2005-2024



* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
SOURCE: KFF Employer Health Benefits Survey, 2018-2024; 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, 2024

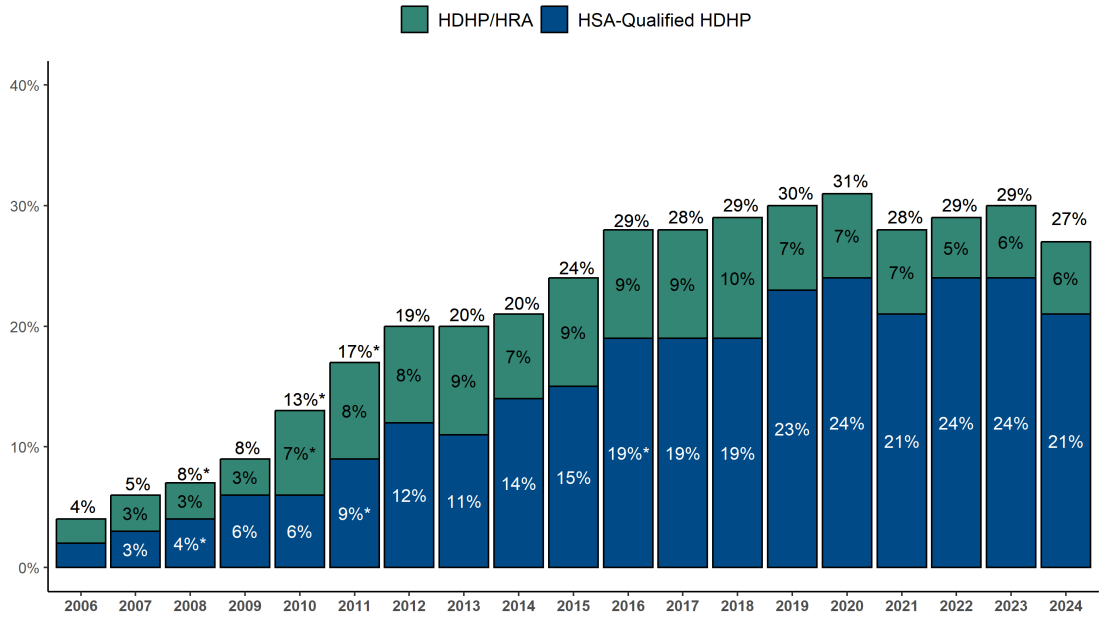


* Estimate is statistically different between All Small Firms and All Large Firms estimate ($p < .05$).
NOTE: Among all firms that offer health benefits, 0.7% offer both an HDHP/HRA and an HSA-Qualified HDHP. Adding the percentage of firms offering HDHP/HRA and HSA-Qualified HDHPs may not sum to the percentage of firms offering HDHP/SOs because some firms offer both.
SOURCE: KFF Employer Health Benefits Survey, 2024

ENROLLMENT IN HDHP/HRAS AND HSA-QUALIFIED HDHPS

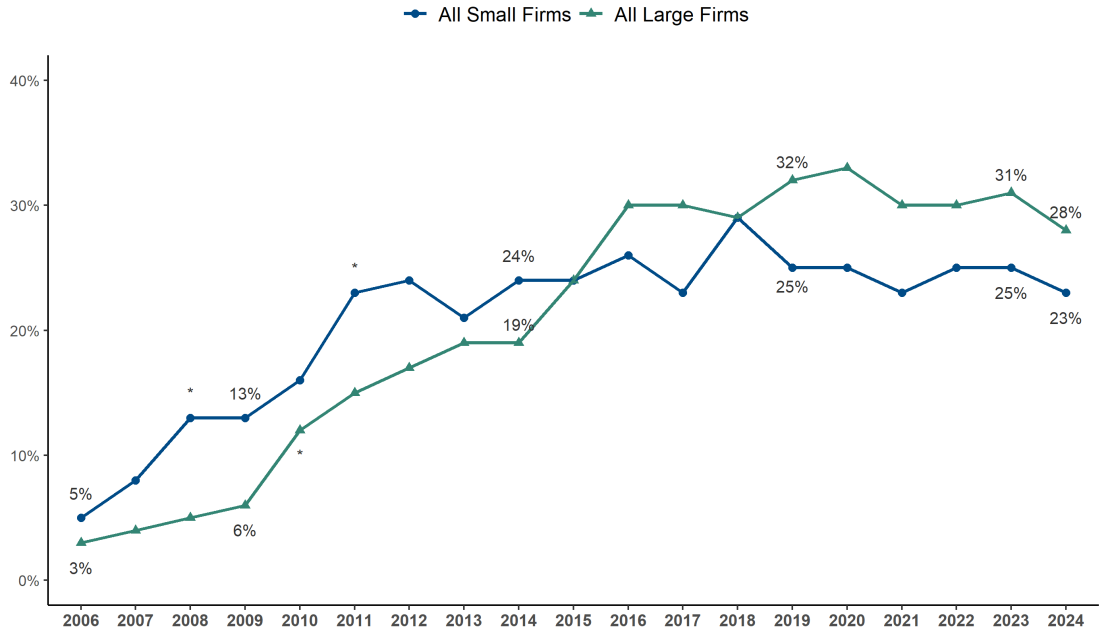
- Twenty-seven percent of covered workers are enrolled in an HDHP/SO in 2024, similar to the percentage last year (29%) [Figure 8.4].
- The share of covered workers enrolled in HDHP/SOs is similar to the share five years ago (27% v. 30%) but is higher than the share ten years ago (27% v. 20%) [Figure 8.4].
  - Six percent of covered workers are enrolled in HDHP/HRAs and 21% of covered workers are enrolled in HSA-qualified HDHPs in 2024. These percentages are similar to those 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, 2006-2024



* 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, 2018-2024; 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, 2006-2024



* 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, 2018-2024; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006-2017

PREMIUMS AND WORKER CONTRIBUTIONS

- In 2024, average annual premiums for covered workers in HDHP/HRAs are $9,291 for single coverage and $26,813 for family coverage [Figure 8.6].
- The average annual premiums for workers in HSA-qualified HDHPs are $7,982 for single coverage and $23,436 for family coverage [Figure 8.7]. These amounts are significantly less than the average single and family premium for covered workers in plans that are not HDHP/SOs.
- The average annual worker premium contribution amounts for workers enrolled in HDHP/HRAs are $1,412 for single coverage and $5,824 for family coverage [Figure 8.6]. These amounts are similar to the average premium contribution amounts for covered workers in plans that are not HDHP/SOs [Figure 8.7].
- The average annual worker premium contribution amounts for workers in HSA-qualified HDHPs are $1,206 for single coverage and $5,631 for family coverage. These amounts are lower than the average premium contribution amounts for covered workers in plans that are not HDHP/SOs [Figure 8.7].

Figure 8.6

HDHP/HRA and HSA-Qualified HDHP Features for Covered Workers, 2024

	HDHP/HRA		HSA-Qualified HDHP	
Annual Plan Averages For:	Single Coverage	Family Coverage	Single Coverage	Family Coverage
Premium	$9,291	$26,813	$7,982	$23,436
Worker Contribution to Premium	$1,412	$5,824	$1,206	$5,631
General Annual Deductible	$2,700	$5,343	$2,658	$4,952
Out-Of-Pocket Maximum	$5,279	Not Available	$4,444	Not Available
Firm Contribution to the HRA or HSA	$1,724	$3,274	$705	$1,297

NOTE: Firms were not asked about out-of-pocket maximums for family coverage in 2024. Deductibles for family coverage are for covered workers with an aggregate amount. 21% of covered workers enrolled in an HDHP/HRA and 22% 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 (32% for single coverage and 23% for family coverage) are excluded, the average firm HSA contribution for covered workers is $857 for single coverage and $1,571 for family coverage. One 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. (One percent for single coverage and one percent for family coverage.)

SOURCE: KFF Employer Health Benefits Survey, 2024

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, 2024

	Single Coverage			Family Coverage		
	HDHP/HRA	HSA-Qualified HDHP	Non-HDHP/SO Plans	HDHP/HRA	HSA-Qualified HDHP	Non-HDHP/SO Plans
Annual Premium	$9,291	$7,982*	$9,199	$26,813	$23,436*	$26,084
Worker Contribution to Premium	$1,412	$1,206*	$1,407	$5,824	$5,631*	$6,531
Firm Contribution to Premium	$7,879	$6,777*	$7,791	$20,990	$17,804*	$19,553
Annual Firm Contribution to HRA or HSA	$1,724	$705	Not Applicable	$3,274	$1,297	Not Applicable
Total Annual Firm Contribution (Firm Share of Premium Plus Firm Contribution to HRA or HSA)	$9,603*	$7,488	$7,791	$24,264*	$19,126	$19,553
Total Annual Cost (Total Premium Plus Firm Contribution to HRA or HSA)	**$11,015***	**$8,690***	**$9,199**	**$30,087***	**$24,751**	**$26,084**

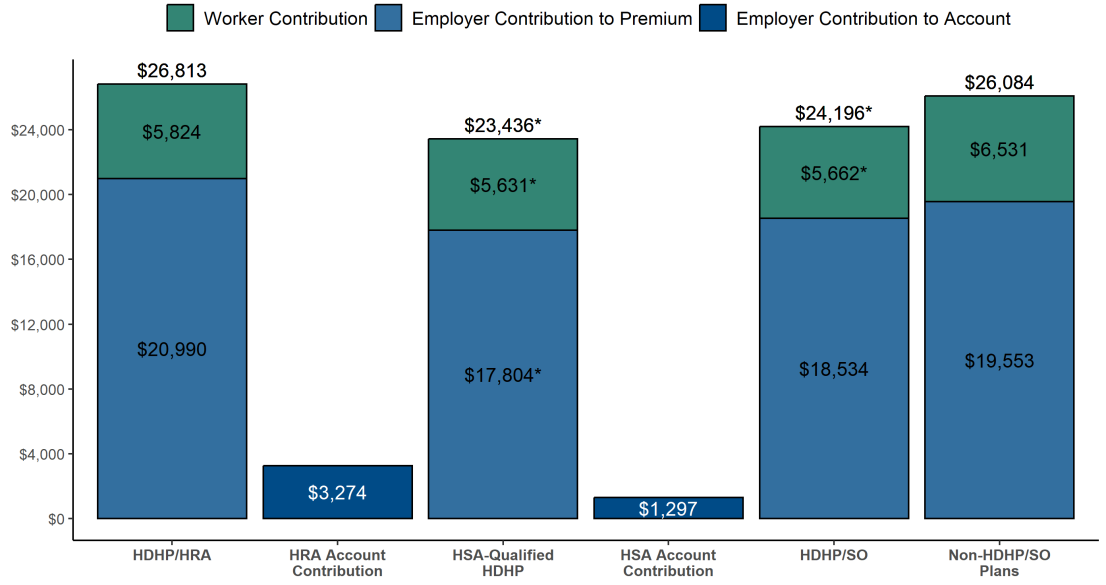
NOTE: Values shown in the table may not equal the sum of their component parts. The averages presented in the table are aggregated at the firm level and then averaged, which is methodologically more appropriate than adding the averages. See the note in Figure 8.6 for additional information on HSA and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

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

SOURCE: KFF Employer Health Benefits Survey, 2024

Figure 8.8

Average Annual Premiums and Contributions for Covered Workers in HDHP/SOs and Non-HDHP/SOs, for Family Coverage, 2024

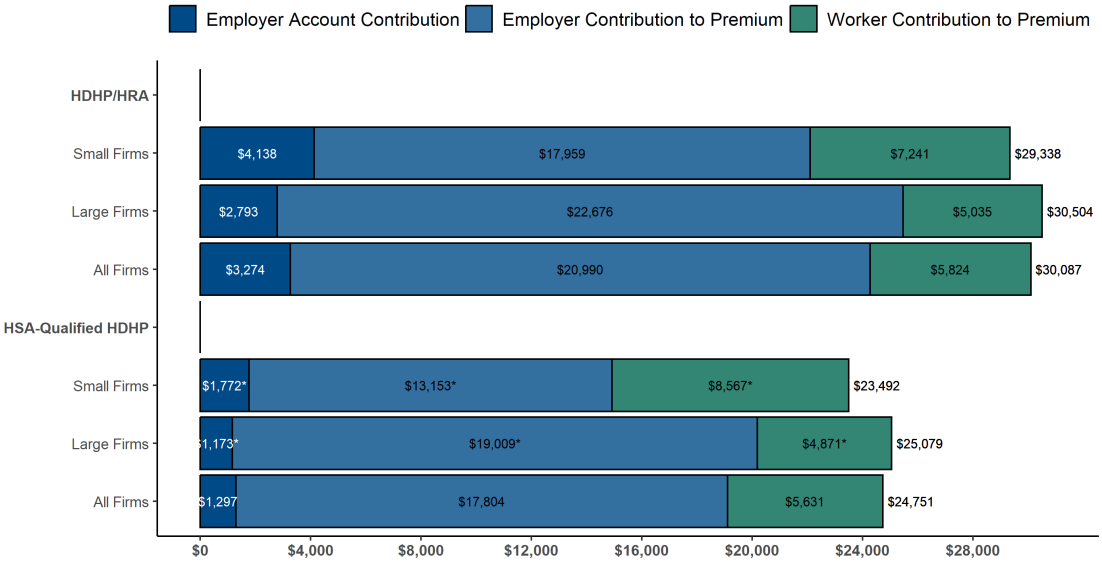


* Estimate is statistically different from estimate from Non-HDHP/SO plans ($p < .05$).

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, rather than adding the averages. See the note in Figure 8.6 for additional information on HSA and HRA contributions.

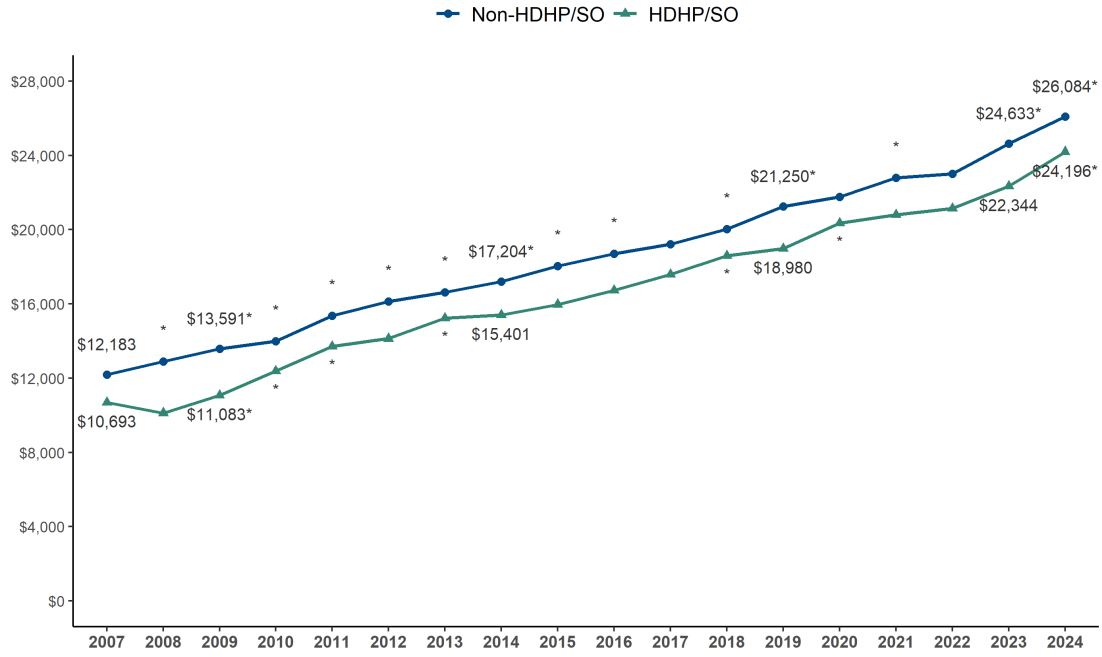
SOURCE: KFF Employer Health Benefits Survey, 2024

Figure 8.9
Total Annual Costs (Premiums and Account Contributions) for Covered Workers in HDHP/SOs, for Family Coverage, by Firm Size, 2024



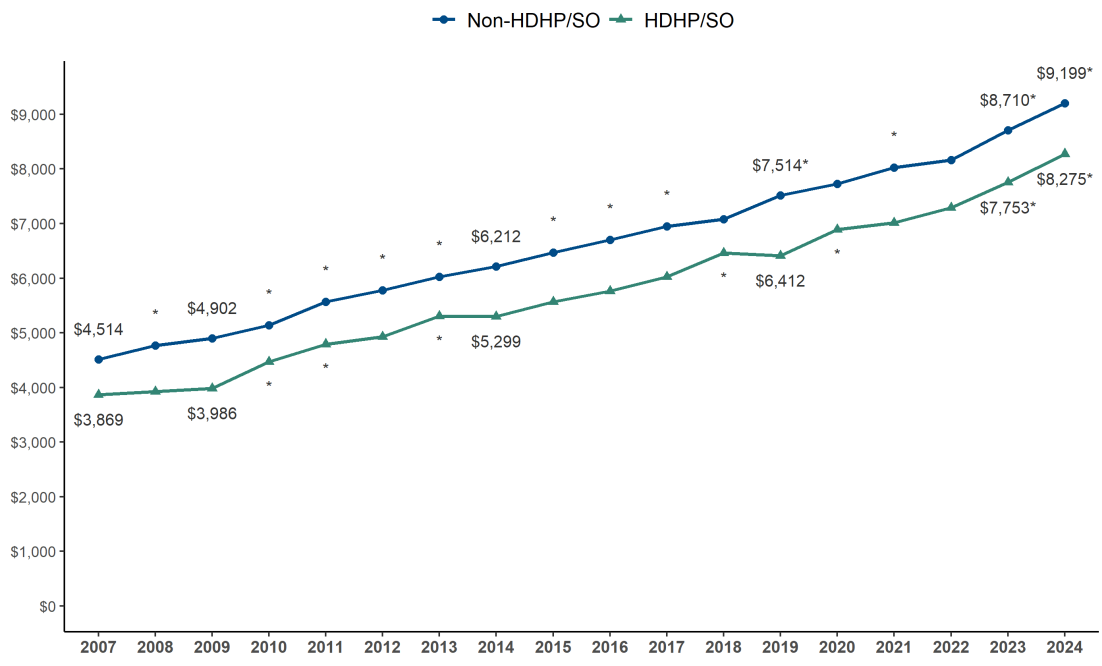
* Estimate is statistically different between All Small Firms and All Large Firms estimate ($p < .05$).
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers. Values shown in the table may not equal the sum of their component parts. The averages presented in the table are aggregated 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, 2024

Figure 8.10
Average Annual Premiums for Covered Workers with Family Coverage, by Plan Type, 2007-2024



* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
SOURCE: KFF Employer Health Benefits Survey, 2018-2024; 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, 2007-2024



* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
SOURCE: KFF Employer Health Benefits Survey, 2018-2024; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2007-2017

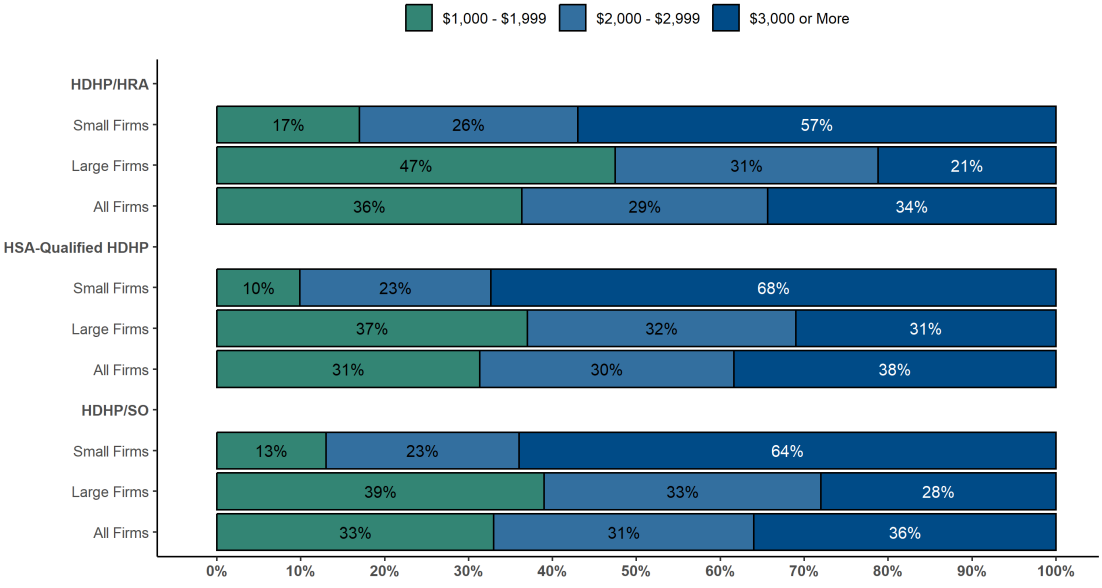
OUT-OF-POCKET MAXIMUMS AND PLAN DEDUCTIBLES

- HSA-qualified HDHPs are legally required to have an annual out-of-pocket maximum of no more than $8,050 for single coverage and $16,100 for family coverage in 2024. Non-grandfathered HDHP/HRA plans are required to have out-of-pocket maximums of no more than $9,450 for single coverage and $18,900 for family coverage. Virtually all HDHP/HRA plans have an out-of-pocket maximum for single coverage in 2024.
  - The average annual out-of-pocket maximum for single coverage is $5,279 for HDHP/HRAs and $4,444 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 $2,700 for HDHP/HRAs and $2,658 for HSA-qualified HDHPs [Figure 8.6]. There is wide variation around these averages: 33% 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 36% 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 $5,343 for HDHP/HRAs and $4,952 for HSA-qualified HDHPs [Figure 8.6]. As with single coverage, there is wide variation around these averages for family coverage: 6% of covered workers enrolled in HDHP/SOs with an aggregate

family deductible have a deductible between $2,000 and $2,999 while 30% 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, 2024



NOTE: For HSA-qualified HDHPs, the legal minimum deductible for 2024 is $1,600 for single coverage and $3,200 for family coverage. Small Firms have 3-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2024

Figure 8.13

General Annual Deductible for Workers in HDHP/SOs After Any Employer Account Contributions for Single Coverage, by Firm Size, 2024

	HDHP/HRA	HSA-Qualified HDHP	HDHP/SO
General Annual Deductible			
All Small Firms	$3,353*	$3,579*	$3,559*
All Large Firms	2,334*	2,419*	2,393*
All Firms	**$2,700**	**$2,658**	**$2,666**
General Annual Deductible After Any HRA or HSA Contributions			
All Small Firms	$1,288	$2,579*	$2,211*
All Large Firms	1,023	1,801*	1,632*
All Firms	**$1,118**	**$1,961**	**$1,768**

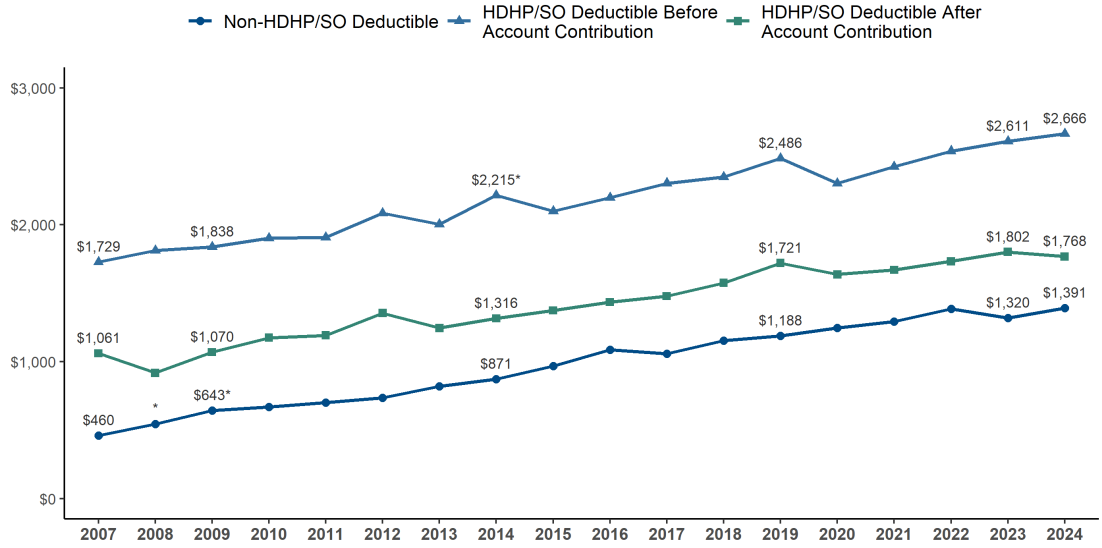
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers. The net liability for covered workers enrolled in a plan with an HSA or HRA is calculated by subtracting the account contribution from the single coverage deductible. HRAs are notional accounts, and employers are not required 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, 2024

Figure 8.14

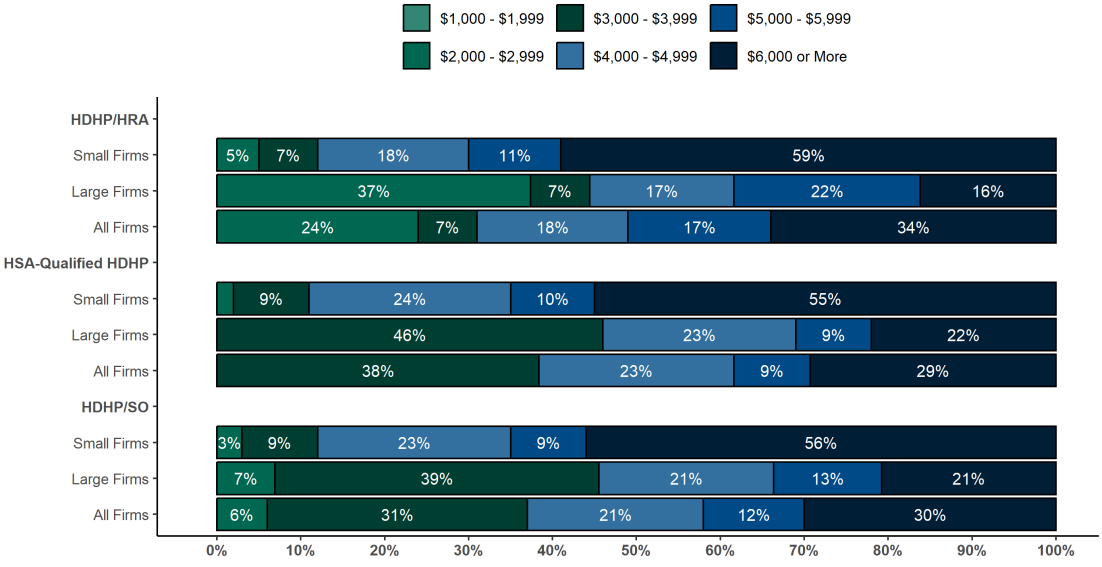
Among Covered Workers with a General Annual Deductible, Average Deductibles for Workers in Non-HDHP/SOs Compared to HDHP/SOs Before and After Any Employer Account Contributions, for Single Coverage, 2007-2024



* 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, 2018-2024; 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, 2024



NOTE: Deductibles for family coverage are for covered workers with an aggregate amount. 21% of covered workers enrolled in an HDHP/HRA and 22% 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 2024 is $1,600 for single coverage and $3,200 for family coverage. Small Firms have 3-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2024

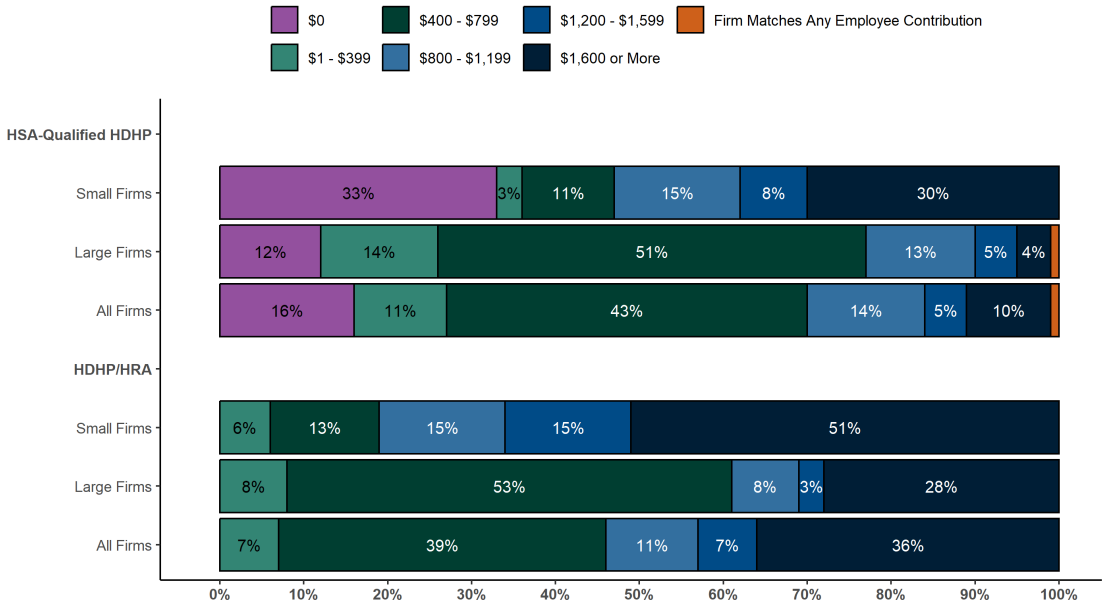
EMPLOYER CONTRIBUTIONS

- 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).
  - The average annual employer contribution to premiums for workers in HDHP/HRAs is $7,879 for single coverage and $20,990 for family coverage. The average contribution for family coverage is higher than the amount last year ($20,990 vs. $16,547) [Figure 8.7].
  - The average annual employer contribution to premiums for workers in HSA-qualified HDHPs is $6,777 for single coverage and $17,804 for family coverage. The average employer contributions for single coverage and family coverage for workers in HSA-qualified HDHPs are lower than those 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 $1,724 for single coverage and $3,274 for family coverage [Figure 8.7].
  - HRAs are generally structured in such a way that employers may not actually spend the whole amount that they make available to their employees' HRAs.[3] Amounts committed to an employee's HRA that are not used by the employee generally roll over and can be used in future years, but any balance may revert back to the employer if the employee leaves his or her job. Thus, the employer contribution amounts to HRAs that we capture in the survey may exceed the amount that employers will actually spend.
- Covered workers enrolled in HSA-qualified HDHPs receive an average annual employer HSA contribution of $705 for single coverage and $1,297 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-two percent of employers offering single coverage and 23% 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, 16% enrolled in single coverage and 16% 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 $842 for single coverage and $1,539 for family coverage.
  - The percentages of covered workers enrolled in a plan where the employer makes no HSA contribution, (16% for single coverage and 16% 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-six percent of covered workers in an HDHP/HRA receive an annual HRA contribution of less than $800 for single coverage, while 36% receive an annual HRA contribution of $1,600 or more [Figure 8.16].
  - Twenty-eight percent of covered workers in an HSA-qualified HDHP receive an annual HSA contribution of less than $400 for single coverage, including 16% who receive no HSA contribution from their employer [Figure 8.16]. In contrast, 15% of covered workers in an HSA-qualified HDHP receive an annual HSA contribution of $1,200 or more. One percent of covered workers have an employer that matches any HSA contribution for single coverage.

[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.

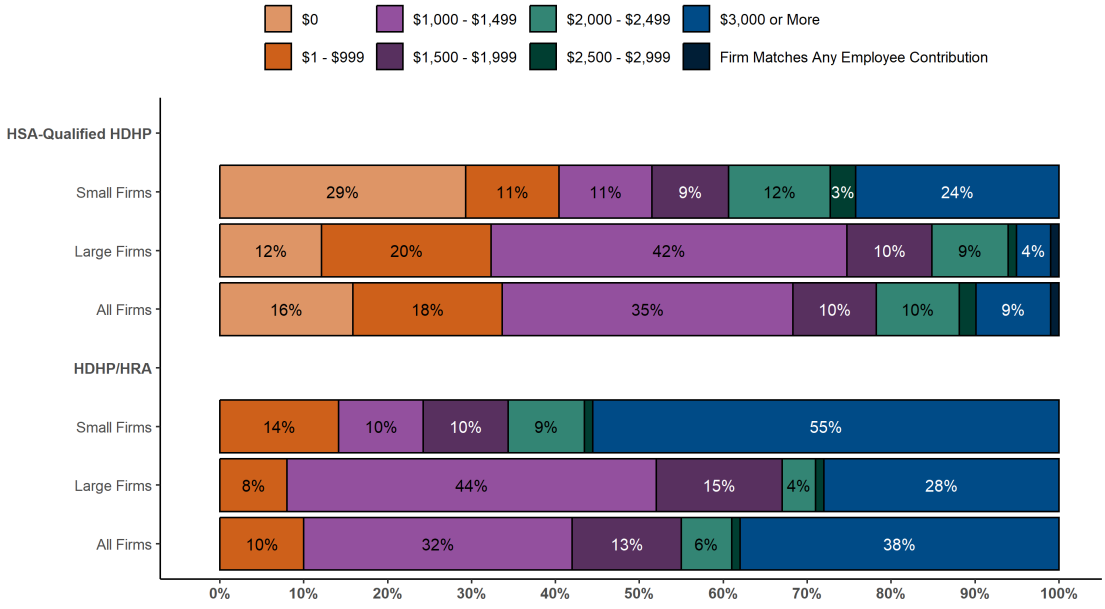
- Employer contributions to savings account options (i.e., the HRAs and HSAs themselves) for their workers can be added to their health plan premium contributions to calculate total employer contributions toward HDHP/SOs. We note that HRAs are a promise by an employer to pay up to a specified amount 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 $9,603 for single coverage and $24,264 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 $7,488 for single coverage and $19,126 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, 2024



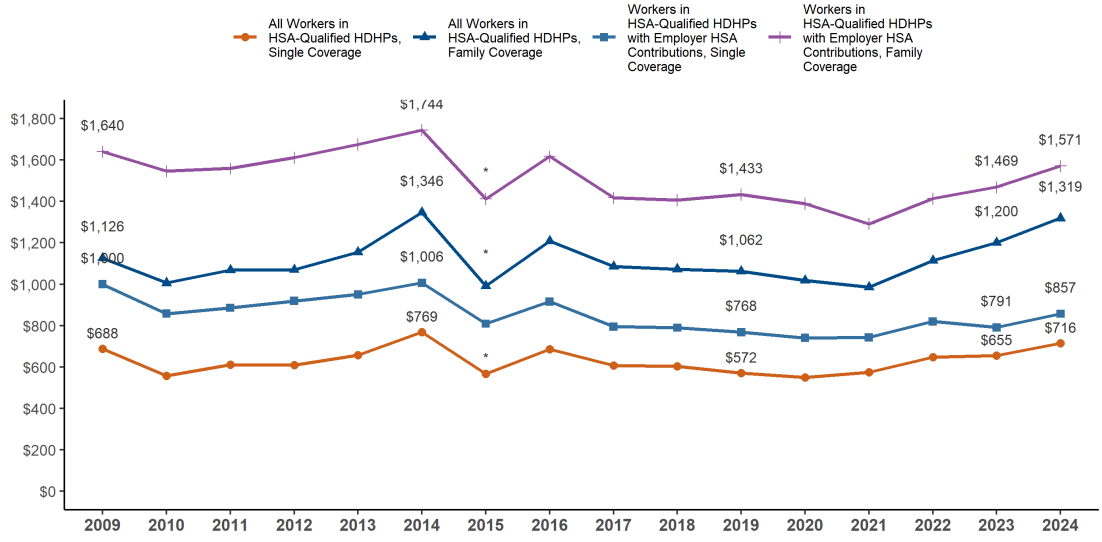
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2024

Figure 8.17
Distribution of Covered Workers with the Following Annual Employer Contributions to Their HRA or HSA, for Family Coverage, 2024



NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2024

Figure 8.18
Average Annual Employer Contributions to HSA Accounts for Covered Workers Enrolled in an HSA-Qualified HDHP, 2009-2024



* 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. In 2024, 16% of workers in an HSA-Qualified single coverage plan and 16% 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. (One percent for single coverage and one percent for family coverage.)
SOURCE: KFF Employer Health Benefits Survey, 2018-2024; 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, 2024

	Average Employer Account Contribution
HSA: Single Coverage	
All Small Firms	$1,003*
All Large Firms	628*
ALL FIRMS	**$705**
HSA: Family Coverage	
All Small Firms	$1,772*
All Large Firms	1,173*
ALL FIRMS	**$1,297**
HRA: Single Coverage	
All Small Firms	$2,212
All Large Firms	1,450
ALL FIRMS	**$1,724**
HRA: Family Coverage	
All Small Firms	$4,138
All Large Firms	2,793
ALL FIRMS	**$3,274**

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, 2024

COST SHARING FOR OFFICE VISITS

- The cost-sharing pattern for primary care office visits varies for workers enrolled in HDHP/SOs. Seventy-one percent of covered workers in HDHP/HRAs have a copayment for primary care physician office visits, compared to 9% enrolled in HSA-qualified HDHPs [Figure 8.20]. Workers in other plan types are much more likely to face copayments than coinsurance for physician office visits (see Section 7 for more information).

Figure 8.20

Distribution of Covered Workers in HDHP/HRAs and HSA-Qualified HDHPs With the Following Types of Cost Sharing in Addition to the General Annual Deductible, 2024

	HDHP/HRA	HSA-Qualified HDHP	HDHP/SO	Non-HDHP/SO
Separate Cost Sharing for Primary Care Physician Office Visits				
Copayment	71%	9%*	27%	85%*
Coinsurance	18%	55%*	44%	8%*
None	9%	21%*	17%	2%*
Other	2%	15%*	11%	5%*
Separate Cost Sharing for Specialty Care Physician Office Visits				
Copayment	65%	8%*	24%	82%*
Coinsurance	29%	58%*	50%	12%*
None	4%	18%*	13%	1%*
Other	3%	17%*	12%	4%*

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, 2024

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 $1,500 for single coverage and $3,000 for family coverage in 2024 or $1,400 and $2,800, respectively, in 2023) 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 $4,150 for single coverage and $8,300 for family coverage in 2024. 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

Section 9

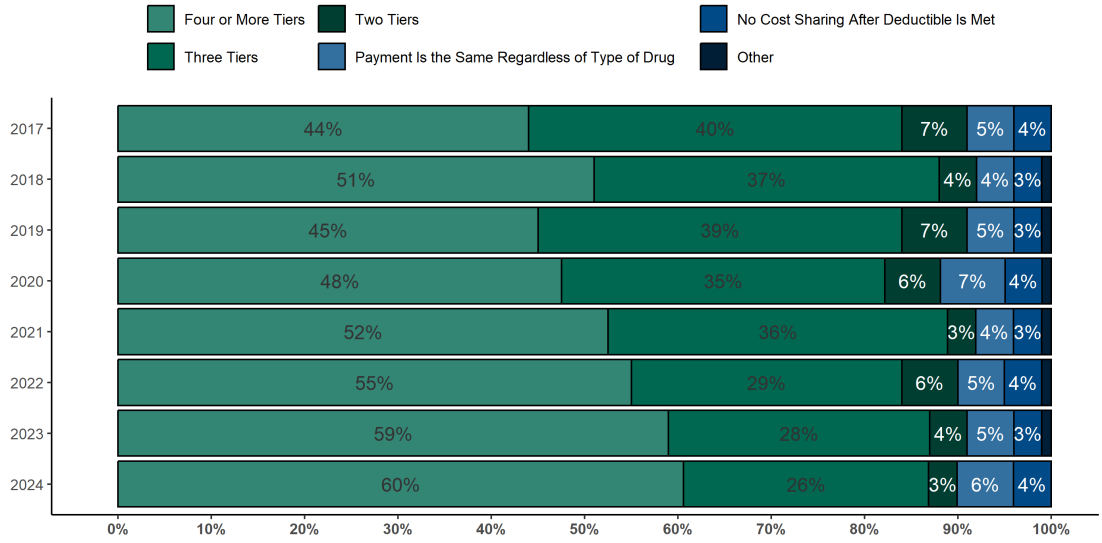
Prescription Drug Benefits

Nearly all (99%) covered workers are at a firm which provides prescription drug coverage to enrollees in its largest health plan. Over time, employer plans have incorporated more complex benefit designs for prescription drugs as employers and insurers expand the use of formularies with multiple cost-sharing tiers, as well as other management approaches. To reduce the burden on respondents, we ask offering firms about the attributes of prescription drug coverage only for their largest health plan. This survey asks employers about the cost-sharing in up to four tiers, plus, if applicable, a tier exclusively for specialty drugs. Some plans may have more than one tier for specialty drugs or other variations that are not captured in the survey. There also may be other areas of variation in how plans structure their formularies that are not captured.

DISTRIBUTION OF COST SHARING

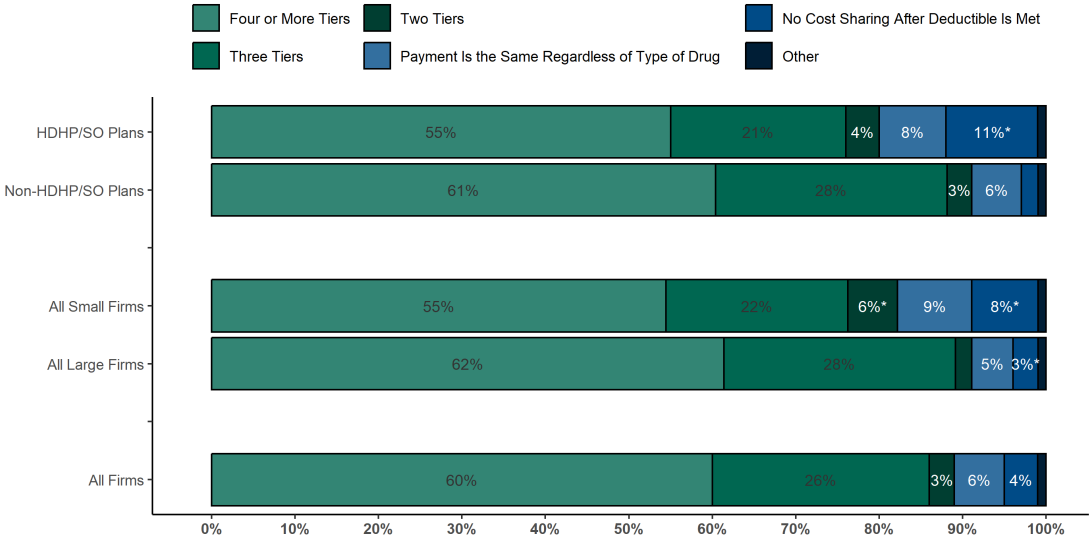
- The large majority of covered workers (89%) are in a plan with tiered cost sharing for prescription drugs [Figure 9.1]. Cost-sharing tiers generally refer to a health plan placing a drug on a formulary or preferred drug list that classifies drugs into categories that are subject to different cost sharing or management. Commonly, there are different tiers for generic, preferred and non-preferred drugs. In recent years, plans have created additional tiers that may be used for specialty drugs or more expensive drugs such as biologics. Some plans may have multiple tiers for different categories.
- Eighty-six 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, although the cost-sharing information for the specialty tier is reported separately below.
- Compared to covered workers in other plan types, those in HDHP/SOs are more likely to be in a plan that has no cost sharing for prescriptions once the plan deductible is met (11% vs. 2%) [Figure 9.2].
- Small firms are more likely to have no cost sharing after the deductible is met compared to large firms (8% vs. 3%) [Figure 9.2].

Figure 9.1
Distribution of Covered Workers Facing Different Cost-Sharing Formulas for Prescription Drug Benefits, 2017-2024



Tests found no statistical difference from distribution for the previous year shown ($p < .05$).
NOTE: Number of tiers include any tiers specifically for specialty drugs. Excluding tiers specifically for specialty drugs, 23% of covered workers with prescription drug coverage are enrolled in a plan with four or more tiers, 60% have three tiers, 5% have two tiers, 4% have the same cost sharing regardless of the drug, and 7% 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, 2018-2024; 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, 2024

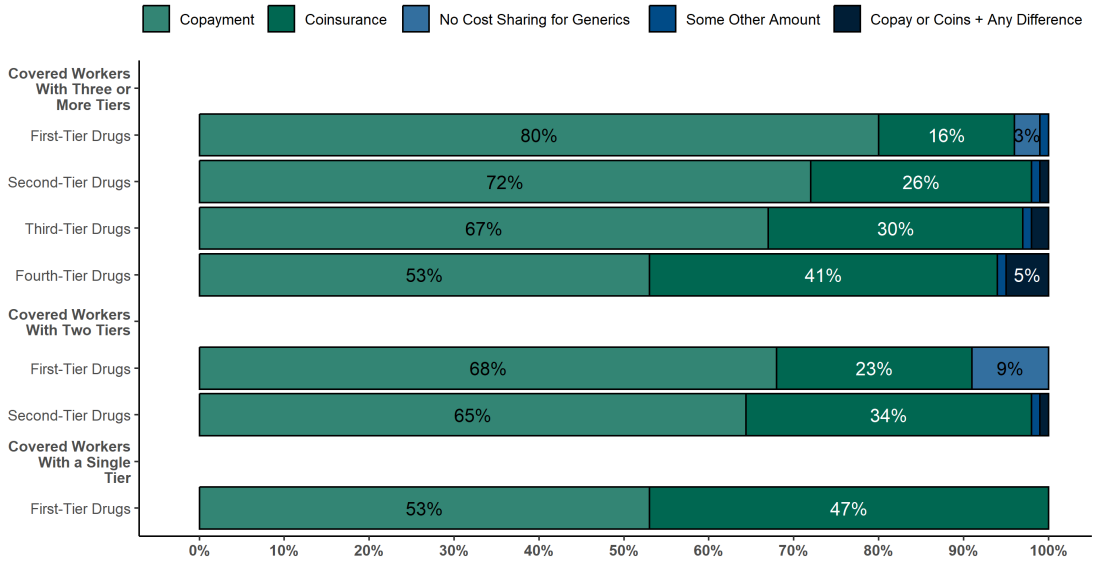


* Distribution is statistically different between HDHP/SO Plan and Non-HDHP/SO distributions or between Large and Small Firms ($p < .05$).
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers. Number of tiers include any tiers specifically for specialty drugs. Excluding tiers specifically for specialty drugs, 23% of covered workers with prescription drug coverage are enrolled in a plan with four or more tiers, 60% have three tiers, 5% have two tiers, 4% have the same cost sharing regardless of the drug, and 7% 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, 2024

TIERS NOT EXCLUSIVELY FOR SPECIALTY DRUGS

- Even when formulary tiers covering only specialty drugs are not counted, a large share (83%) of covered workers are in a plan with three or more tiers of cost sharing for prescription drugs. The cost-sharing statistics presented in this section do not include information about tiers that cover only specialty drugs. In cases in which a plan covers specialty drugs on a tier with other drugs, they will be included in these averages. Cost-sharing statistics for tiers covering only specialty drugs are presented separately below.
- 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 $12 for first-tier drugs, $36 second-tier drugs, $65 for third-tier drugs, and $128 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 22% for first-tier drugs, 27% for second-tier drugs, 35% for third-tier drugs, and 33% for fourth-tier drugs [Figure 9.6].
- Five 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 both tiers [Figure 9.3]. The average copayment is $11 for the first tier and $39 for the second tier. [Figure 9.6].
- Four percent of covered workers are in a plan with the same cost sharing for prescriptions regardless of the type of drug (excluding tiers covering only specialty drugs) [Figure 9.2].
  - Among these workers, 53% have copayments and 47% 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, 2024



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, 2024

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, 2024

	Copayment	Coinsurance	No Cost Sharing for Generics	Some Other Amount
First-Tier Drugs, Often Called Generics				
All Small Firms	87%*	7%*	5%	<1%
All Large Firms	78*	19*	3	<1
ALL FIRMS	**80%**	**16%**	**3%**	**<1%**
Second-Tier Drugs, Often Called Preferred Drugs			**Copayment or Coinsurance Plus Any Difference**	
All Small Firms	91%*	7%*	1%	1%
All Large Firms	65*	33*	2	<1
ALL FIRMS	**72%**	**26%**	**1%**	**1%**
Third-Tier Drugs, Often Called Non-Preferred Drugs				
All Small Firms	88%*	10%*	1%	1%
All Large Firms	61*	37*	2	1
ALL FIRMS	**67%**	**30%**	**2%**	**1%**
Fourth-Tier Drugs				
All Small Firms	67%*	27%*	6%	1%
All Large Firms	44*	52*	4	<1
ALL FIRMS	**53%**	**41%**	**5%**	**<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, 2024

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, 2024

	Copayment	Coinsurance	No Cost Sharing for Generics	Some Other Amount
First-Tier Drugs, Often Called Generics				
HDHP/SO Plans	56%*	38%*	5%	2%
Non-HDHP/SO Plans	86*	11*	3	<1
ALL PLANS	**80%**	**16%**	**3%**	**<1%**
Second-Tier Drugs, Often Called Preferred Drugs			**Copayment or Coinsurance Plus Any Difference**	
HDHP/SO Plans	45%*	49%*	4%	2%
Non-HDHP/SO Plans	79*	20*	1	<1
ALL PLANS	**72%**	**26%**	**1%**	**1%**
Third-Tier Drugs, Often Called Non-Preferred Drugs				
HDHP/SO Plans	43%*	51%*	4%	2%
Non-HDHP/SO Plans	74*	25*	1	<1
ALL PLANS	**67%**	**30%**	**2%**	**1%**
Fourth-Tier Drugs				
HDHP/SO Plans	24%*	69%*	6%	1%
Non-HDHP/SO Plans	61*	34*	5	<1
ALL PLANS	**53%**	**41%**	**5%**	**<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, 2024

Figure 9.6

Among Covered Workers With Prescription Drug Coverage, Average Copayments and Coinsurance, 2024

	Average Copayment	Average Coinsurance
Plans With Three or More Tiers		
First Tier	$12	22%
Second Tier	$36	27%
Third Tier	$65	35%
Fourth Tier	$128	33%
Plans With Two Tiers		
First Tier	$11	NSD
Second Tier	$39	NSD
Plans With the Same Cost Sharing For All Covered Drugs		
First Tier	$16	19%

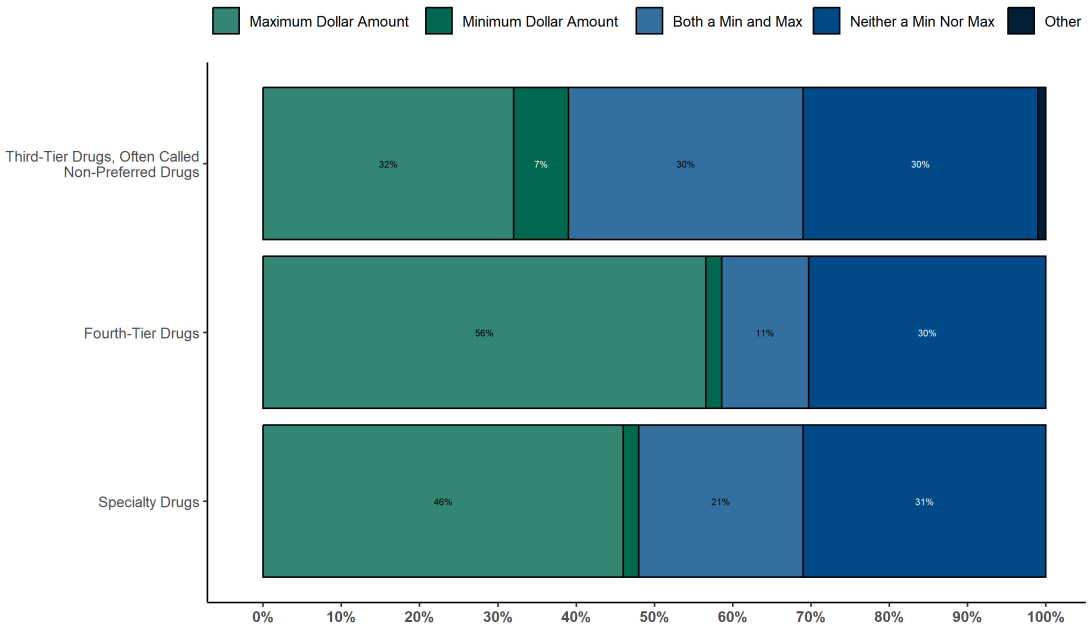
NOTE: Number of tiers refers to the number of tiers excluding those specifically for specialty drugs.
NSD: Not Sufficient Data

SOURCE: KFF Employer Health Benefits Survey, 2024

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, 32% have only a maximum dollar amount attached to the coinsurance rate, 7% have only a minimum dollar amount, 30% have both a minimum and maximum dollar amount, and 30% have neither. For those in a plan with coinsurance for the fourth cost-sharing tier, 56% have only a maximum dollar amount attached to the coinsurance rate, 2% have only a minimum dollar amount, 11% have both a minimum and maximum dollar amount, and 30% have neither [Figure 9.7].

Figure 9.7
Distribution of Coinsurance Structures for Covered Workers Facing a Coinsurance for Prescription Drugs, 2024



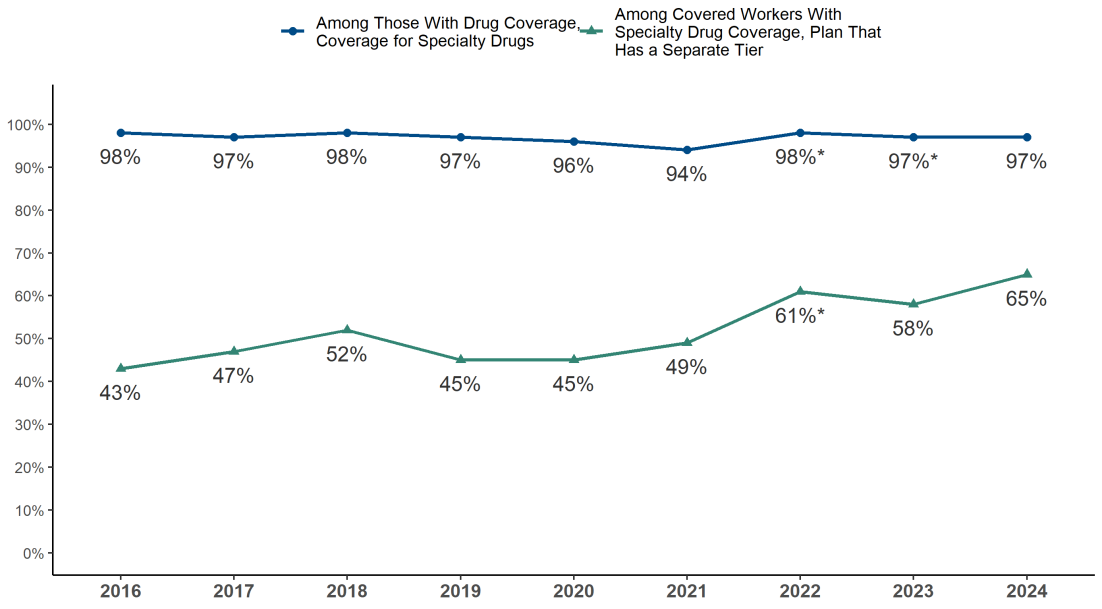
SOURCE: KFF Employer Health Benefits Survey, 2024

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. In 2016, we revised our survey questions to obtain more information about formulary tiers that are exclusively for specialty drugs. We are reporting results only among large firms because small firm respondents had large shares of "don't know" responses to some of these questions.

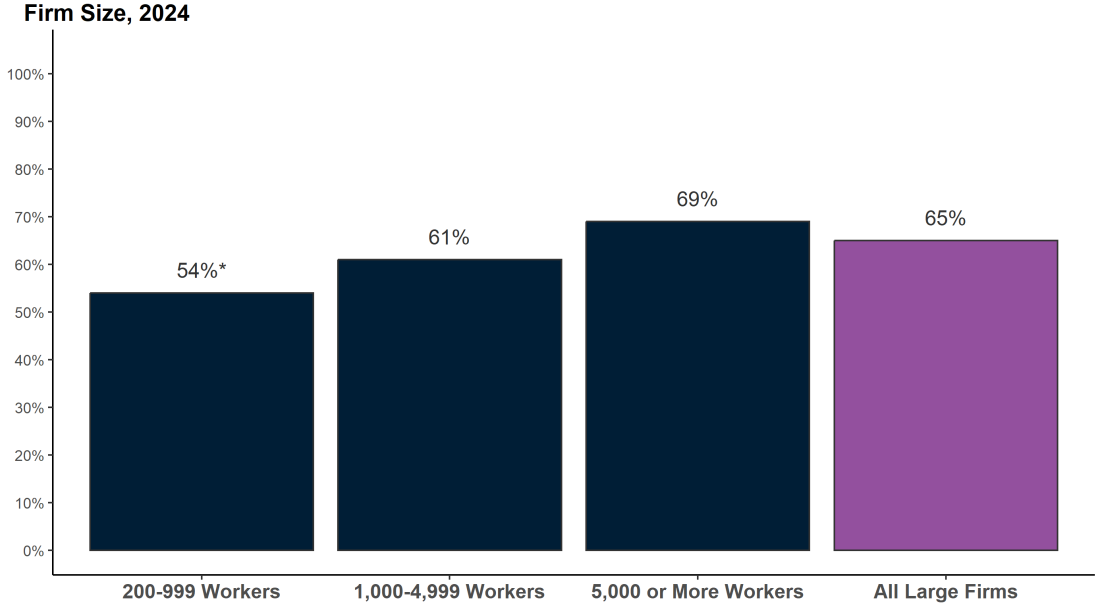
- Ninety-seven percent of covered workers at large firms have coverage for specialty drugs, the same percentage as last year. Among these workers, 65% are in a plan with at least one cost-sharing tier just for specialty drugs [Figure 9.8].
- Among covered workers at large firms in a plan with at least one separate tier for specialty drugs, 41% have a copayment for specialty drugs and 55% have coinsurance [Figure 9.10]. The average copayment is $118 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 Workers With Coverage for Specialty Drugs, 2024



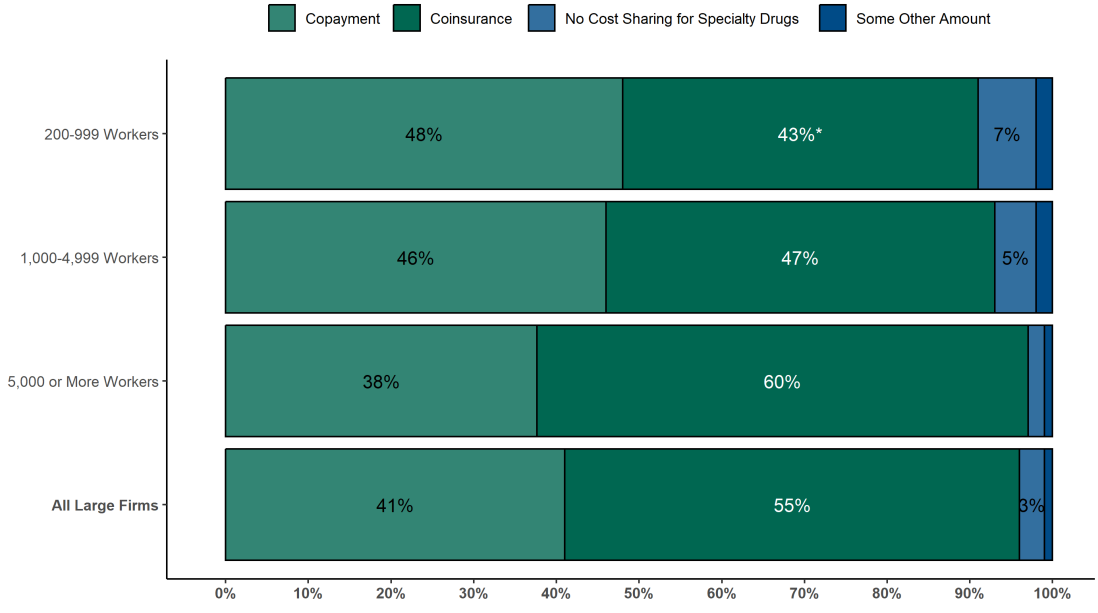
* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
NOTE: Large Firms have 200 or more workers. Ninety-nine percent of firms offering health benefits offer prescription drug coverage.
SOURCE: KFF Employer Health Benefits Survey, 2024

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, 2024



* 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, 2024

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, 2024



* 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, 2024

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 & 2024

	2017		2024	
	Average Copayment ($)	Average Coinsurance (%)	Average Copayment ($)	Average Coinsurance (%)
FIRM SIZE				
200-999 Workers	$90	24%	$109	25%
1,000-4,999 Workers	89	27	102	26
5,000 or More Workers	111*	28	127	24
All Large Firms (200 or More Workers)	**$101**	**27%**	**$118**	**25%**

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

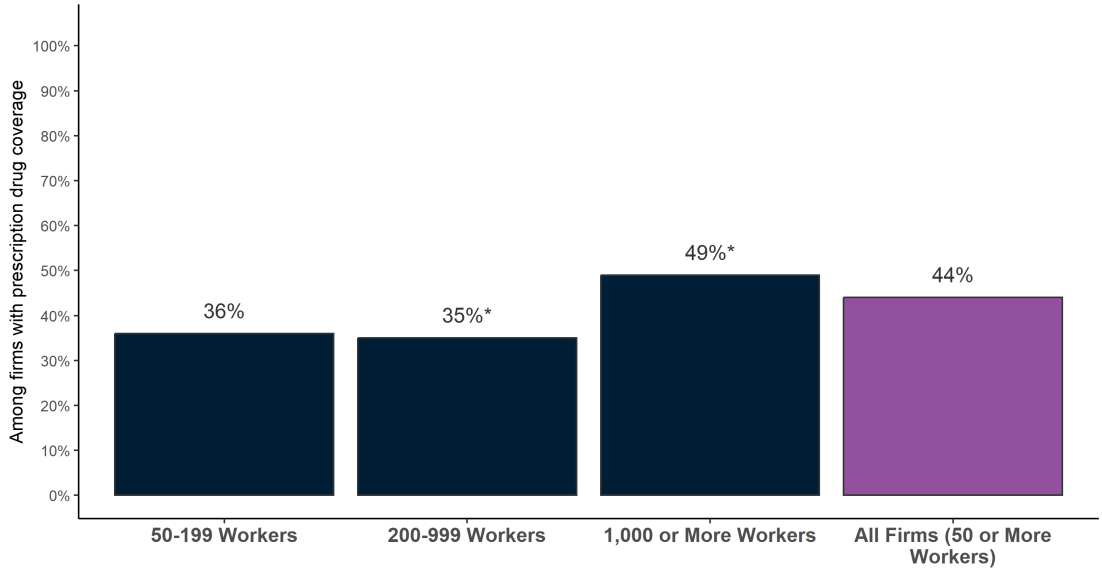
SOURCE: KFF Employer Health Benefits Survey, 2024; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2017

PRESCRIPTION DRUG ADMINISTRATION

Firms with 50 or more workers that offer coverage for prescriptions were asked about several attributes of their prescription drug coverage. Among the covered workers in these firms:

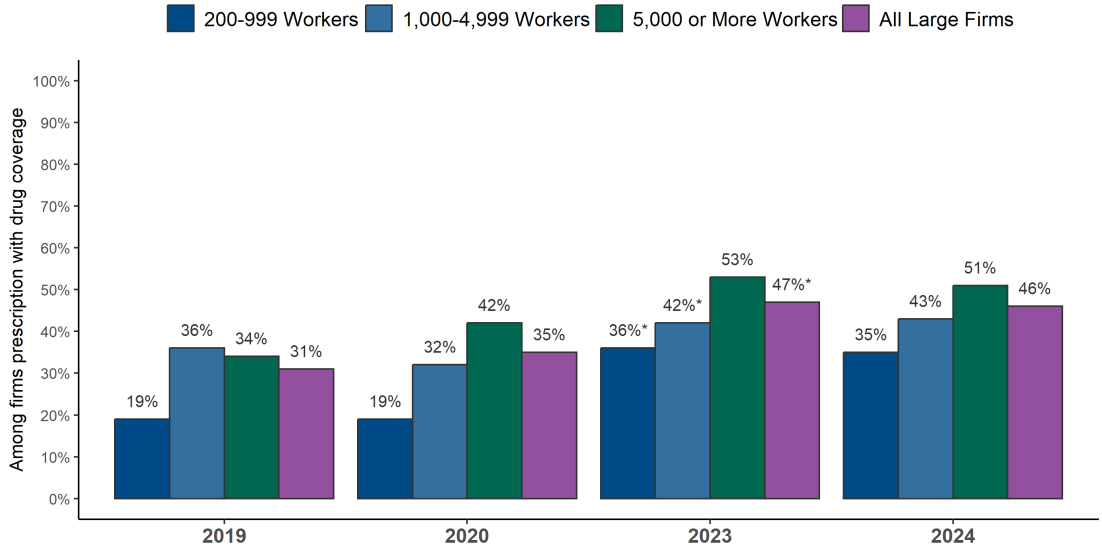
- Forty-four percent are enrolled in a plan that reduces or waives cost sharing for prescription drugs needed to maintain health for one or more chronic illnesses, such as insulin products for diabetics [Figure 9.12]. Firms with 5,000 or more workers are more likely to have this policy (51%) [Figure 9.13].
- Fifty-eight percent are enrolled in a plan that has incentives such as lower cost sharing to encourage enrollees to fill prescriptions through a mail-order pharmacy. Firms with 5,000 or more workers are more likely to have this policy (65%) while firms with 50 to 199 workers are less likely to have this policy (44%) [Figure 9.15].
- Eighteen percent are enrolled in a plan that limits coverage for some medications only to those received through a mail-order pharmacy [Figure 9.14].
- Thirty-one percent are enrolled in a plan that offers coverage for lower cost, mail-order generics, either as part of the plan or through a third- party vendor, such as “Mark Cuban Cost Plus” or “GoodRx” [Figure 9.16].

Figure 9.12
Percentage of Covered Workers with Reduced or No Cost-Sharing for Maintenance Drugs, by Firm Size, 2024



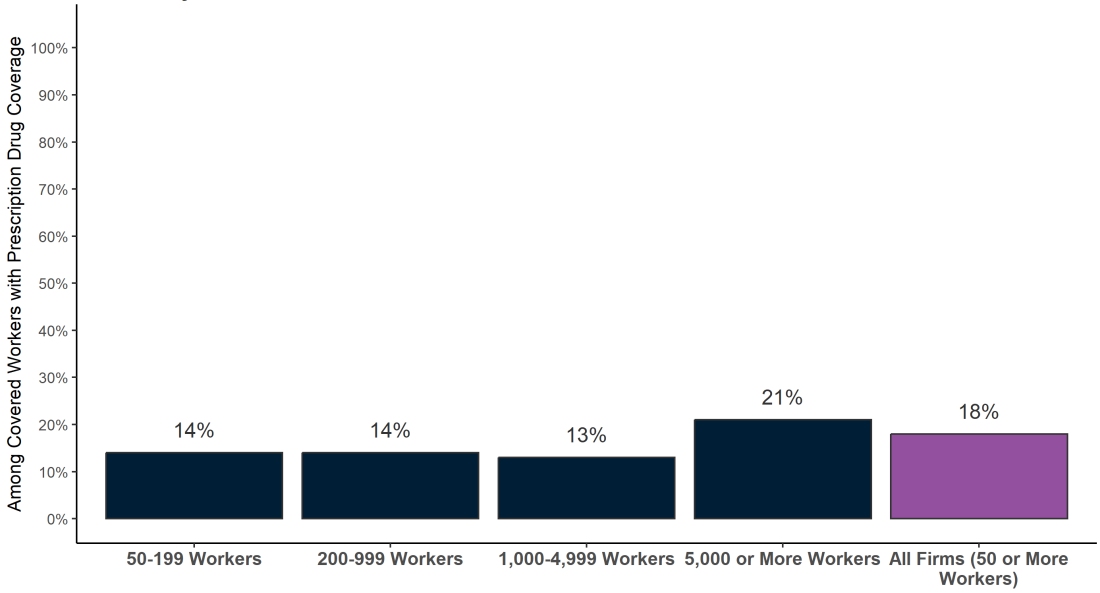
* Estimate is statistically different from estimate for all other firms not in the indicated size category (p < .05).
NOTE: Among firms with 50 or more workers and prescription drug coverage. Cost-sharing includes deductibles, copays and coinsurance. Maintenance drugs for chronic conditions may include insulin for diabetes. Firms were asked about their plans with largest enrollment, within their plan type with the most enrollment.
SOURCE: KFF Employer Health Benefits Survey, 2024

Figure 9.13
Among Covered Workers with Prescription Drug Coverage at Large Firms, Percentage of Covered Workers with Reduced or No Cost-Sharing for Maintenance Drugs, Within Firm Size, 2019-2024



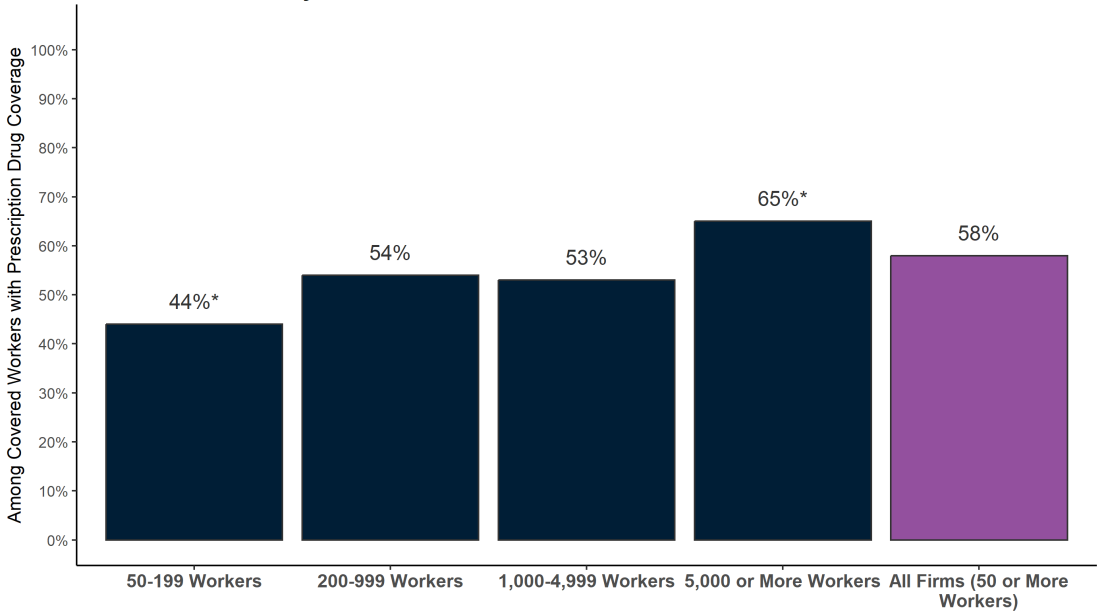
* Estimate is statistically different from estimate for the previous year shown (p < .05).
NOTE: Large Firms have 200 or more workers. Cost-sharing includes deductibles, copays and coinsurance. Maintenance drugs for chronic conditions may include insulin for diabetes. Firms were asked about their plan with the largest enrollment, within their plan type with the most enrollment.
SOURCE: KFF Employer Health Benefits Survey, 2019-2024;

Figure 9.14
Percentage of Covered Workers Whose Plan Only Covers Some Drugs Through Mail Order Pharmacies, by Firm Size, 2024



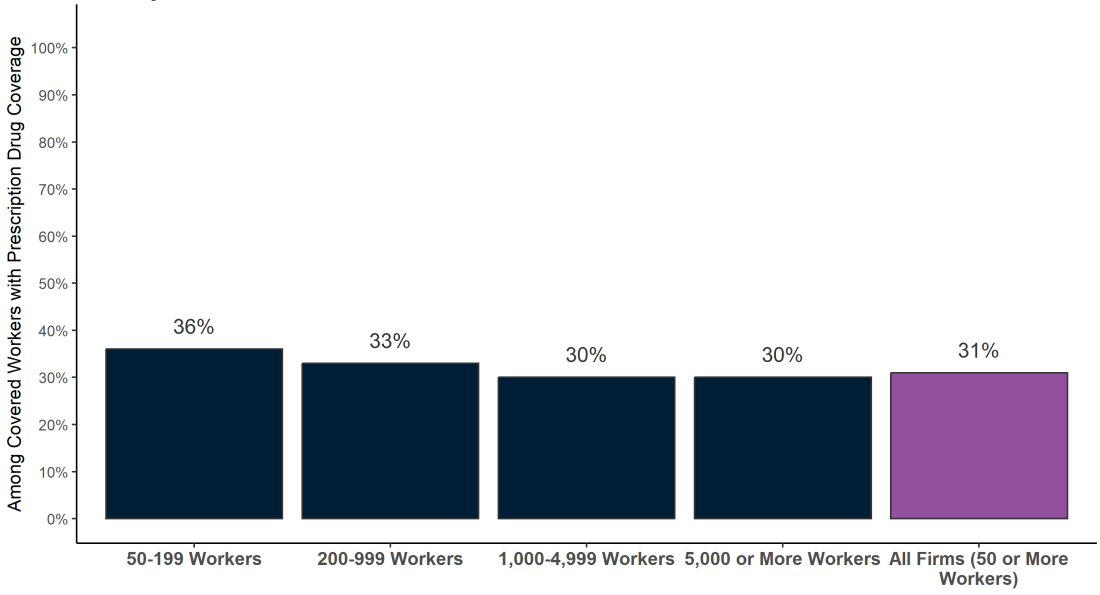
Tests found no statistical difference from estimate for all other firms not in the indicated size category ($p < .05$).
NOTE: Plans with mail only coverage would generally not pay anything for some prescriptions if the enrollee visited an in-person pharmacy. Firms were asked about their plan with the largest enrollment, within their plan type with the most enrollment.
SOURCE: KFF Employer Health Benefits Survey, 2024

Figure 9.15
Percentage of Covered Workers With Financial Incentives to Fill Prescriptions at Mail-Order Pharmacies, by Firm Size, 2024



* Estimate is statistically different from estimate for all other firms not in the indicated size category ($p < .05$).
NOTE: Firms were asked about their plan with the largest enrollment, within their plan type with the most enrollment.
SOURCE: KFF Employer Health Benefits Survey, 2024

Figure 9.16
Percentage of Covered Workers Whose Plan Offers Coverage for Lower Cost Mail Order Generics, by Firm Size, 2024



Tests found no statistical difference from estimate for all other firms not in the indicated size category ($p < .05$).
NOTE: Lower cost-mail order generics may include coverage from either the plan or through a third-party vendor of products from companies such as 'Mark Cuban Cost Plus' or 'GoodRx'. Firms were asked about their plan with the largest enrollment, within their plan type with the most enrollment.
SOURCE: KFF Employer Health Benefits Survey, 2024

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

2024 Annual Survey

Plan Funding

SECTION

10

Section 10

Plan Funding

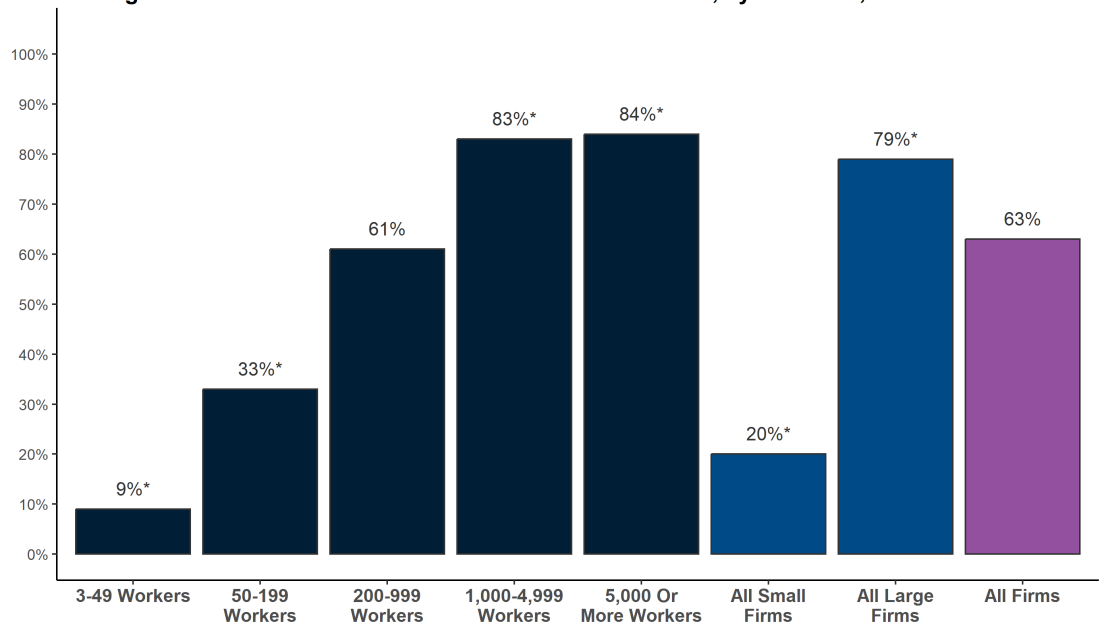
Many firms, particularly larger firms, choose to pay for some or all of the health services of their workers directly from their own funds rather than by purchasing health insurance to cover them. This is called self-funding. Both public and private employers can use self-funding to provide health benefits. 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 some consumer protection regulations. In 2024, 63% of covered workers are in a self-funded health plan. 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-six percent of covered workers in small firms (3-199 workers) are in a level-funded plan in 2024.

SELF-FUNDED PLANS

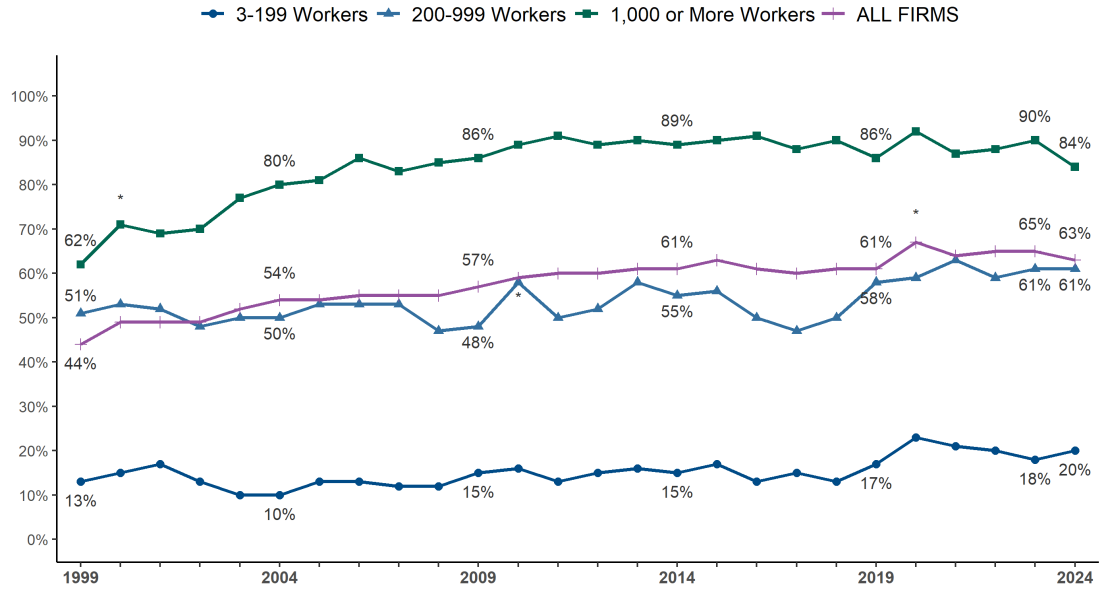
- Sixty-three percent of covered workers are in a plan that is self-funded, similar to the percentage (65%) last year [Figure 10.2].
  - The percentage of covered workers enrolled in self-funded plans is similar to the percentages five years ago (61%) and ten years ago (61%) [Figure 10.2].
  - As expected, covered workers in large firms are significantly more likely to be in a self-funded plan than covered workers in small firms (79% 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, 2024



* 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, 2024

Figure 10.2
Percentage of Covered Workers Enrolled in a Self-Funded Plan, by Firm Size, 1999-2024



* 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, 63% of covered workers are in a self-funded plan in 2024. 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.
SOURCE: KFF Employer Health Benefits Survey, 2018-2024; 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, 2024

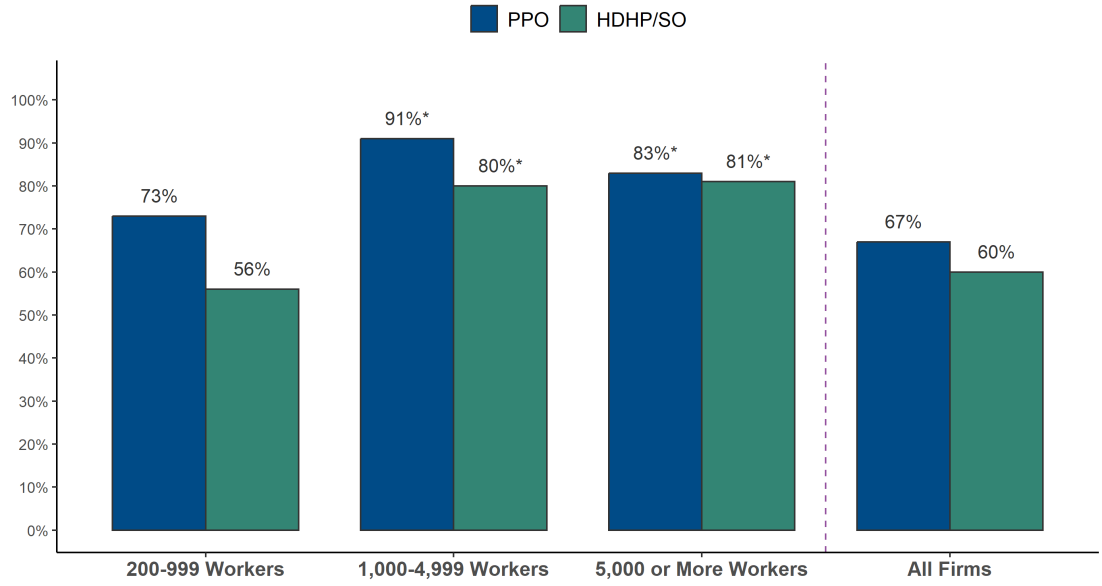
	Covered Workers in a Self-Funded Plan
FIRM SIZE	
200-999 Workers	61%
1,000-4,999 Workers	83*
5,000 or More Workers	84*
All Small Firms (3-199 Workers)	**20%***
All Large Firms (200 or More Workers)	**79%***
REGION	
Northeast	64%
Midwest	68
South	68
West	45*
INDUSTRY	
Agriculture/Mining/Construction	37%*
Manufacturing	51*
Transportation/Communications/Utilities	80*
Wholesale	59
Retail	70
Finance	66
Service	48*
State/Local Government	73
Health Care	87*
ALL FIRMS	**63%**

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 ($p < .05$).

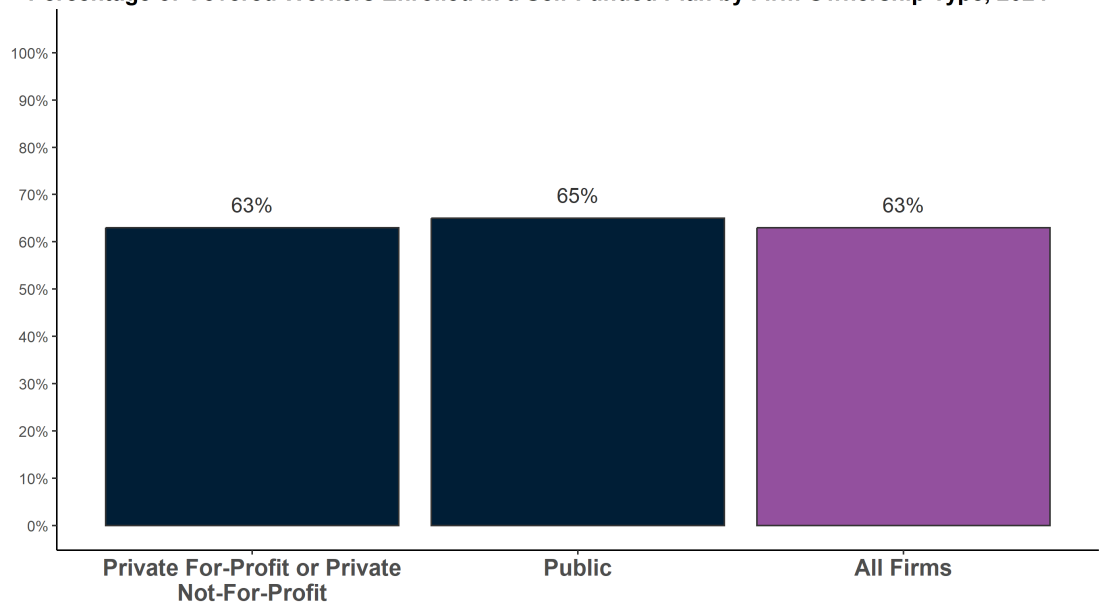
SOURCE: KFF Employer Health Benefits Survey, 2024

Figure 10.4
Percentage of Covered Workers Enrolled in a Self-Funded Plan, by Plan Type and Firm Size, 2024



* 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, 2024

Figure 10.5
Percentage of Covered Workers Enrolled in a Self-Funded Plan by Firm Ownership Type, 2024



Tests found no statistical difference between firm ownership type ($p < .05$).
NOTE: Includes covered workers enrolled in self-funded plans in which the firm's liability is limited through stoploss coverage. Private firms include both private for-profit and private not-for-profit. Sixty-four percent of covered workers in private for-profits and 60% of workers enrolled at private not-for-profits are self-funded
SOURCE: KFF Employer Health Benefits Survey, 2024

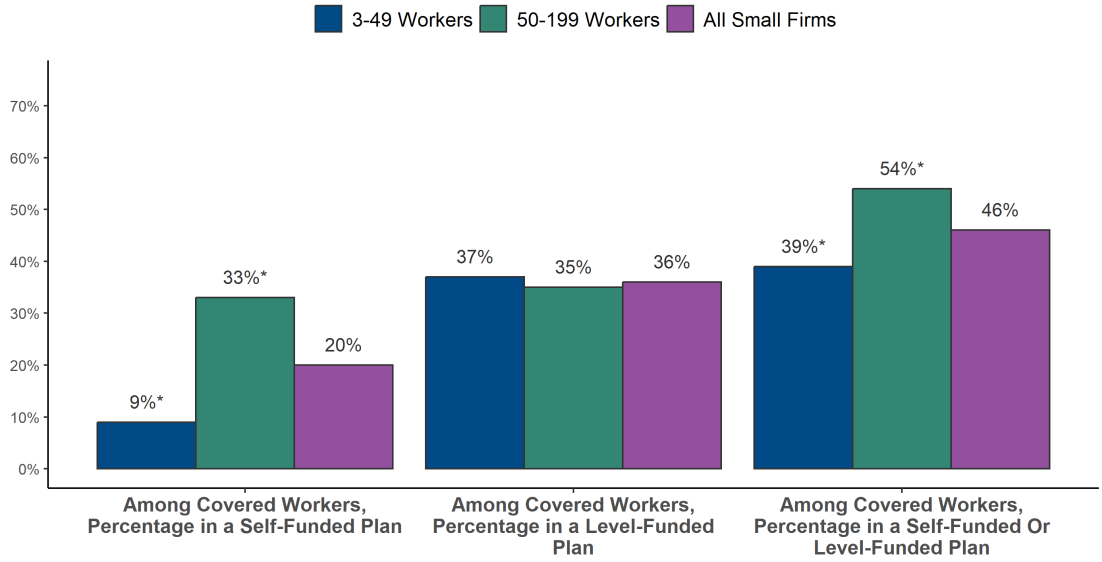
LEVEL-FUNDED PLANS

In recent years, insurers have been offering health plans that provide a nominally self-funded option for small and mid-sized employers that incorporates stoploss insurance with relatively low attachment points. In these arrangements, the insurer calculates an expected monthly expense for the employer, which includes a share of the estimated annual cost for benefits, premiums 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, although small employers are often protected from any meaningful additional liability. 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. There also may be confusion because different plan administrators (generally insurers) use different labels to refer to these arrangements. We asked employers with fewer than 200 workers whether they have a level-funded plan.

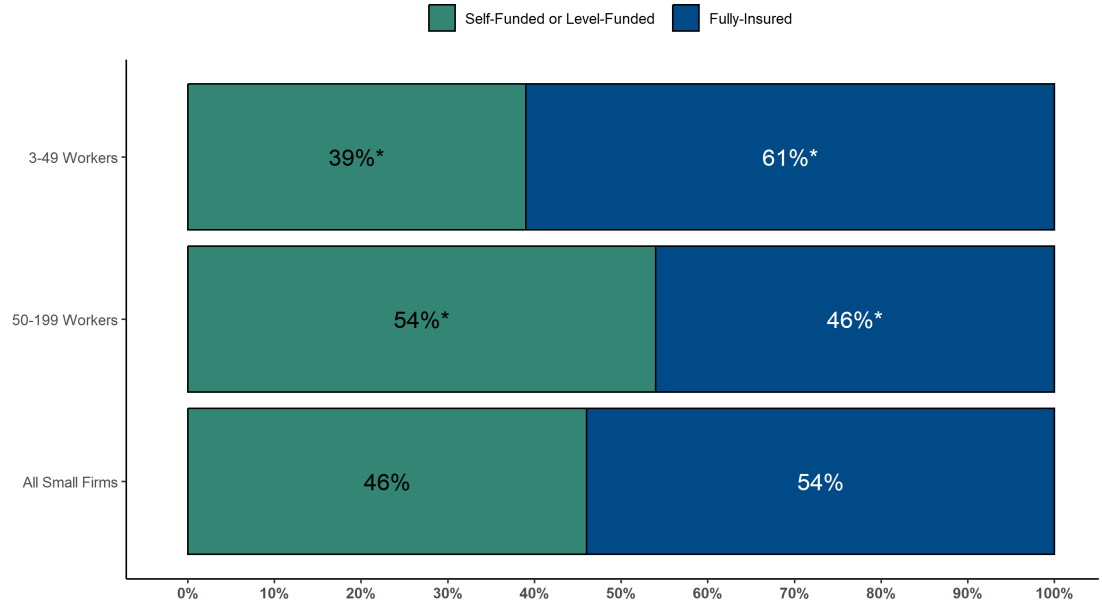
- Forty-two percent of small firms that report offering health benefits offer a level-funded plan in 2024. This amount is not statistically different from the percentage (34%) last year.
  - The apparent instability in the small firm estimate results from responses of the relatively few firms with 3 to 9 workers that offer health coverage. Among firms with 10 to 199 workers that offer health benefits, 37% offer a level-funded plan in 2024, similar to the percentage 39% last year.
- Thirty-six percent of covered workers in small firms are enrolled in a level-funded plan in 2024, similar to the percentage last year [Figure 10.6] and [Figure 10.8]. Forty-six percent of covered workers in small firms are enrolled in either a level-funded plan or a self-insured plan, the same as the percentage last year [Figure 10.7] and [Figure 10.8].

Figure 10.6
Among Covered Workers at Small Firms, Percentage Enrolled in a Level-Funded or Self-Funded Plan, by Firm Size, 2024



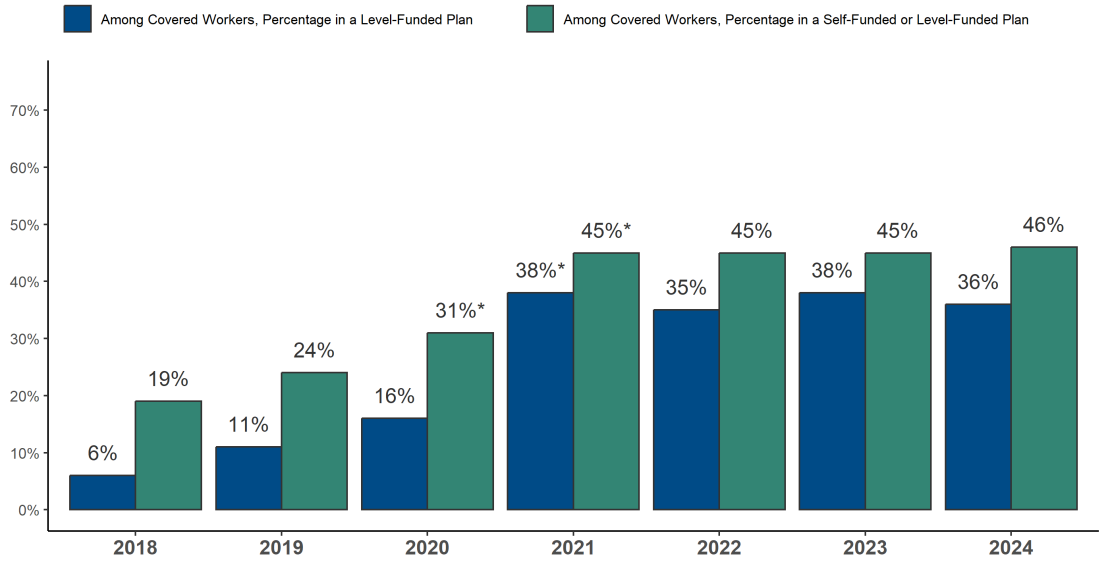
* Estimates are statistically different from estimate for all other firms not in the indicated category within each firm size ($p < .05$).
NOTE: See end of Section 10 for definitions of self-funded, fully-insured, and level-funded premium plans. Small Firms have 3-199 workers. This figure shows the percentage of covered workers; In 2024, 42% of small firms reported that they had a level-funded plan. This includes respondents who indicated both that their plan was level-funded and fully insured.
SOURCE: KFF Employer Health Benefits Survey, 2024

Figure 10.7
Among Covered Workers at Small Firms, Percentage Enrolled in a Level-Funded or Self-Insured Plan, by Firm Size, 2024



* Estimate is statistically different 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. Small Firms have 3-199 workers.
SOURCE: KFF Employer Health Benefits Survey, 2024

Figure 10.8
Among Covered Workers at Small Firms, Percentage Enrolled in a Level-Funded or Self-Funded Plan, 2018-2024



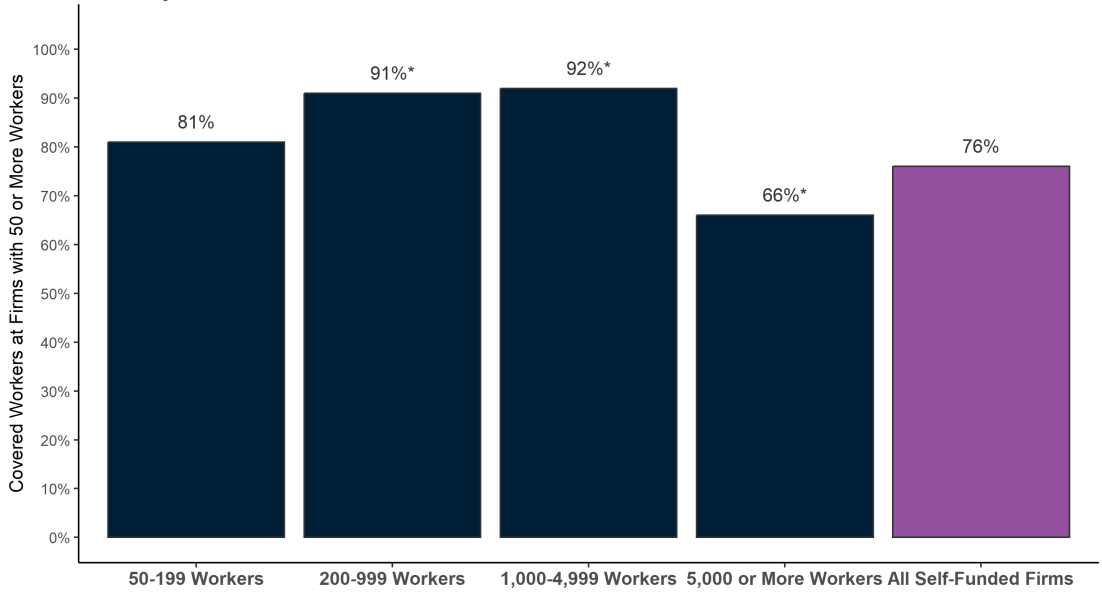
* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
NOTE: See end of Section 10 for definitions of self-funded, fully-insured, and level-funded premium plans. Small Firms have 3-199 workers. This figure shows the percentage of covered workers; In 2024, 42% of small firms reported that they had a level-funded plan. This includes respondents who indicated both that their plan was level-funded and fully insured.
SOURCE: KFF Employer Health Benefits Survey, 2018-2024;

STOPLOSS COVERAGE

Employers purchase insurance, often referred to as "stoploss" coverage, to protect themselves from unexpected losses for claims incurred by 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 may be focused on particular types of claims (e.g., transplants). A firm may have more than one type of stoploss coverage.

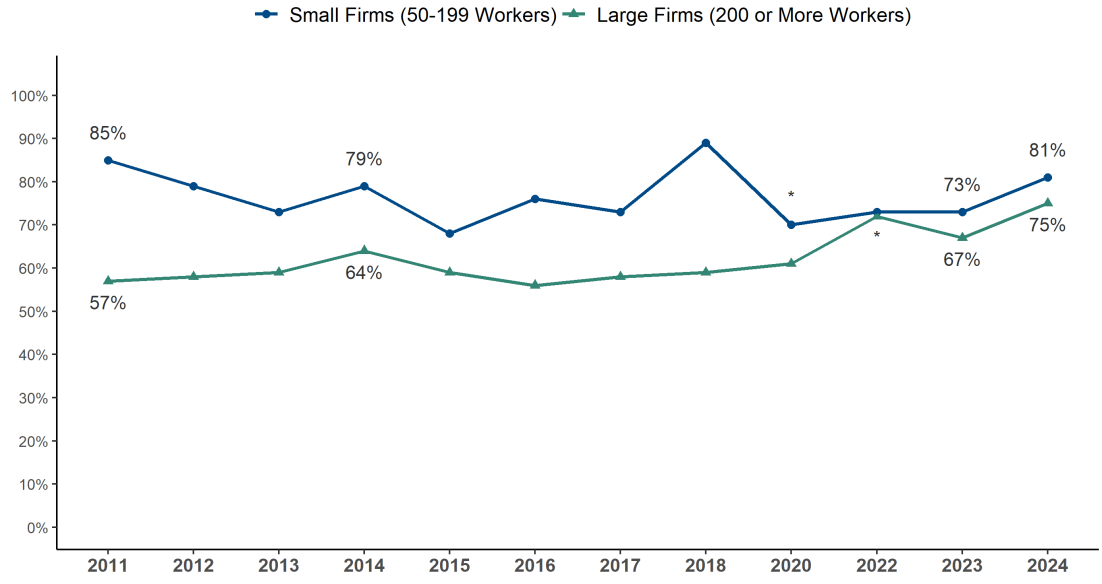
- At large firms (200 or more workers), 75% of covered workers in self-funded health plans are in plans that have stoploss insurance, similar to the percentage last year (67%) [Figure 10.10]. Covered workers in firms with 5,000 or more workers are less likely than covered workers in smaller firms to be in a plan with stopless insurance [Figure 10.9].

Figure 10.9
Among Covered Workers Enrolled in a Self-Funded Plan, Percentage Covered by Stoploss Insurance, by Firm Size, 2024



* 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, 2024

Figure 10.10
Among Covered Workers Enrolled in a Self-Funded Plan, Percentage Covered by Stoploss Insurance (At Firms with 50 or More Workers), by Firm Size, 2011-2024



* 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, 2018-2024; 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
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Retiree Health Benefits

SECTION

11

Section 11

Retiree Health Benefits

Retiree health benefits are an important consideration for older workers making decisions about retirement, and 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.

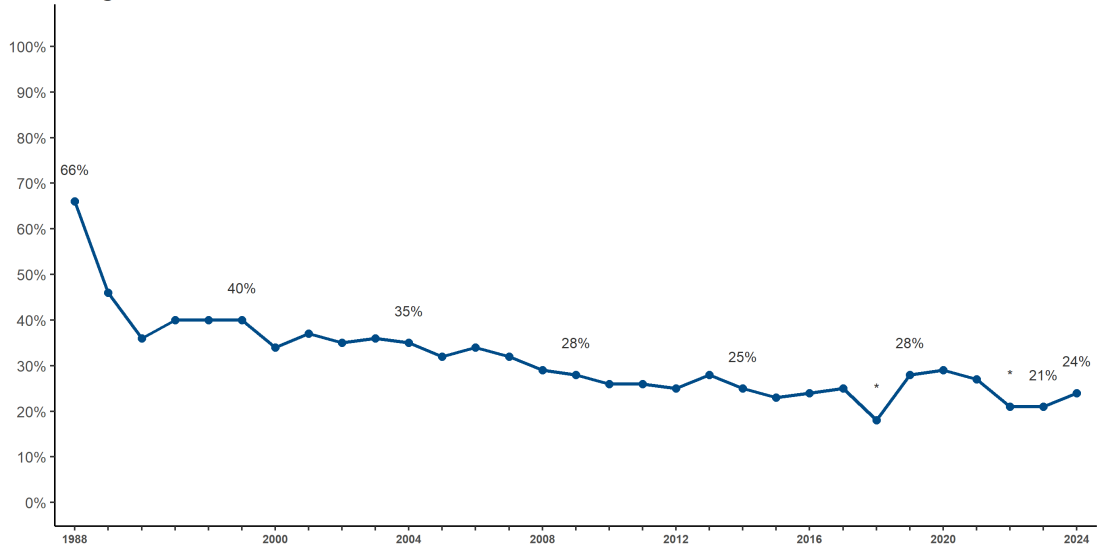
Twenty-four percent of large firms offering health benefits offer retiree health benefits in 2024, similar to the percentage in 2023 (21%).

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

EMPLOYER RETIREE BENEFITS

- In 2024, 24% of large firms that offer health benefits offer retiree health benefits for at least some current workers or retirees [Figure 11.1]. In 2019, we modified the question about retiree health benefits to instruct firms to respond "yes" if they were providing coverage for retirees but weren't offering current employees these benefits, or if they were planning to give current employees 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, firms with 1,000 or more workers are more likely to offer retiree health benefits than those with 200 to 999 workers (36% v. 21%) [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 (65%) and private for-profit employers are less likely (10%) to offer retiree health benefits than other firm types [Figure 11.3].
  - Large firms offering health benefits with at least some union workers are more likely to offer retiree health benefits than large firms without any union workers (47% vs. 17%) [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 (29% vs. 20%) [Figure 11.3].

Figure 11.1
Among Large Firms Offering Health Benefits to Active Workers, Percentage of Firms Offering Retiree Health Benefits, 1988-2024



* 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 in 2019. See the 2019 Methods section for details.
SOURCE: KFF Employer Health Benefits Survey, 2018-2024; 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

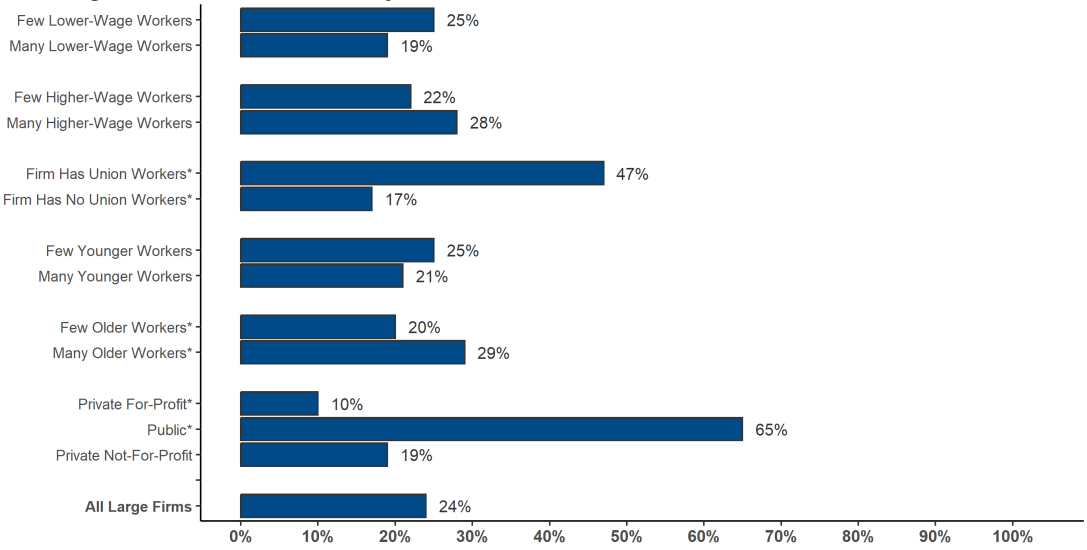
Among Large Firms Offering Health Benefits to Active Workers, Percentage of Firms Offering Retiree Health Benefits, by Firm Size, Region, and Industry, 2024

	Large Firms Offering Retiree Health Benefits
FIRM SIZE	
200-999 Workers	21%*
1,000-4,999 Workers	36*
5,000 or More Workers	38*
REGION	
Northeast	19%
Midwest	26
South	22
West	31*
INDUSTRY	
Agriculture/Mining/Construction	4%*
Manufacturing	10*
Transportation/Communications/Utilities	38*
Wholesale	3*
Retail	13*
Finance	35
Service	29*
State/Local Government	68*
Health Care	12*
All Large Firms (200 or More Workers)	**24%**

* 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, 2024

Figure 11.3
Among Large Firms Offering Health Benefits to Active Workers, Percentage of Firms Offering Retiree Health Benefits, by Firm Characteristics, 2024

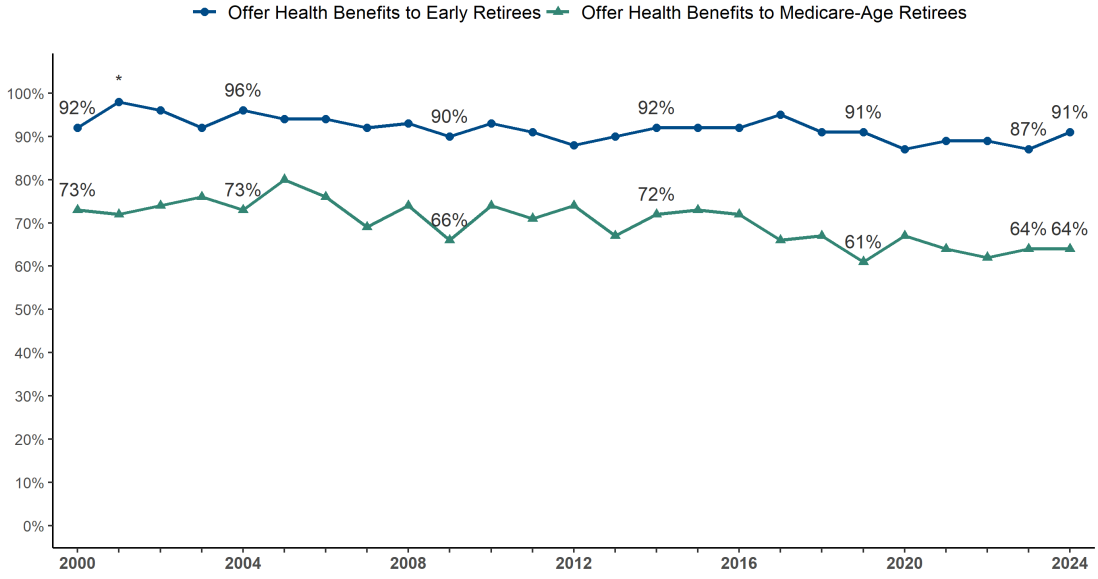


* Estimates are statistically different from each other within category ($p < .05$).
NOTE: Large Firms have 200 or more workers. Firms with many lower-wage workers are those where at least 35% earn the 25th percentile or less of national earnings ($35,000 in 2024). Firms with many higher-wage workers are those where at least 35% earn the 75th percentile or more than of national earnings ($77,000 in 2024). 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, 2024

COVERAGE FOR EARLY RETIREES AND MEDICARE-AGE RETIREES

- Among large firms offering retiree health benefits to active workers and retirees, 91% offer benefits to early retirees under the age of 65 and 64% offer them to Medicare-age retirees [Figure 11.4].
- Among large firms offering retiree health benefits, 59% offer benefits to both early and Medicare-age retirees.
- Among all large firms offering health benefits, 15% offer retiree health benefits to 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, 2000-2024

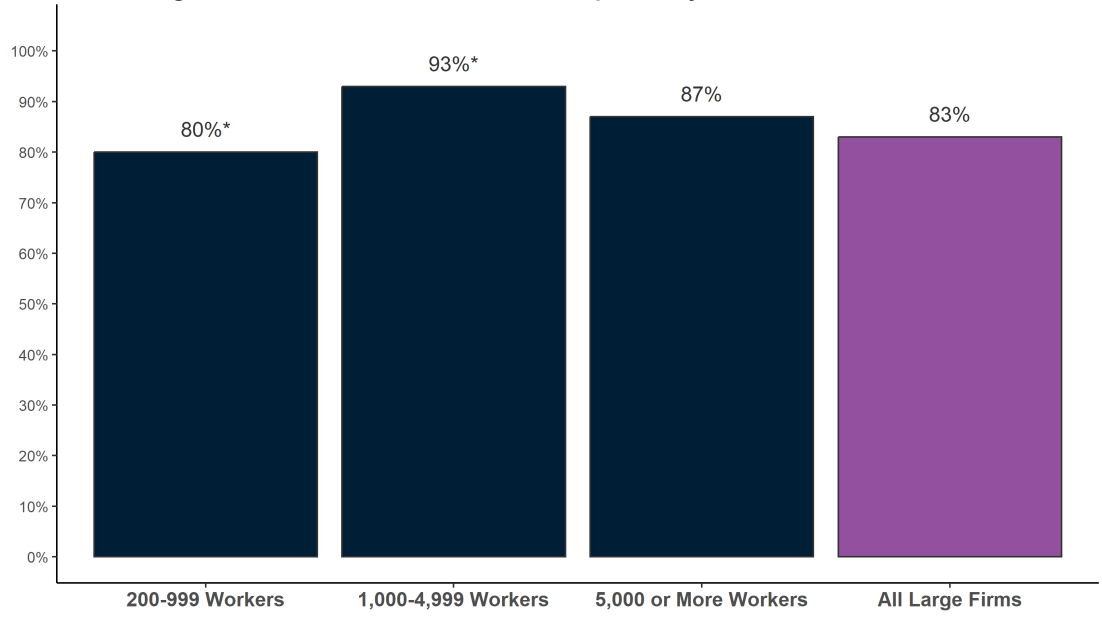


* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
NOTE: Among Large Firms offering health benefits to active workers and offering retiree coverage, 59% offer health benefits to both early and Medicare-age retirees. Large Firms have 200 or more workers. Early retirees are those who retire before the age of 65.
SOURCE: KFF Employer Health Benefits Survey, 2018-2024; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2000-2017

BENEFIT ELIGIBILITY

- Among large firms offering retiree benefits, a large share (83%) 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, 2024

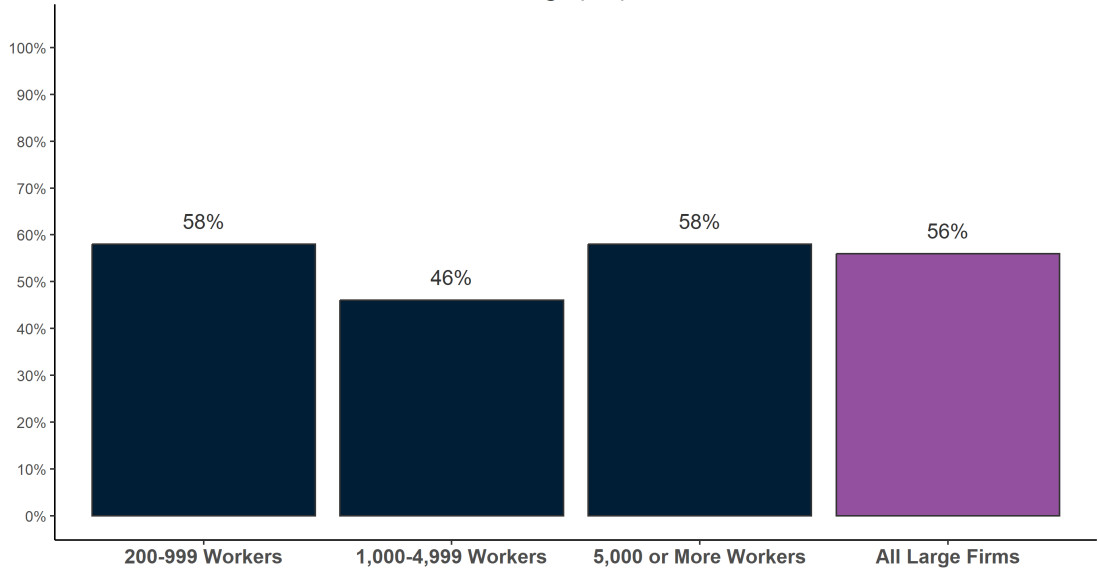


* Estimate is statistically different from estimate for all other firms not in the indicated size category ($p < .05$).
NOTE: Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2024

MEDICARE ADVANTAGE

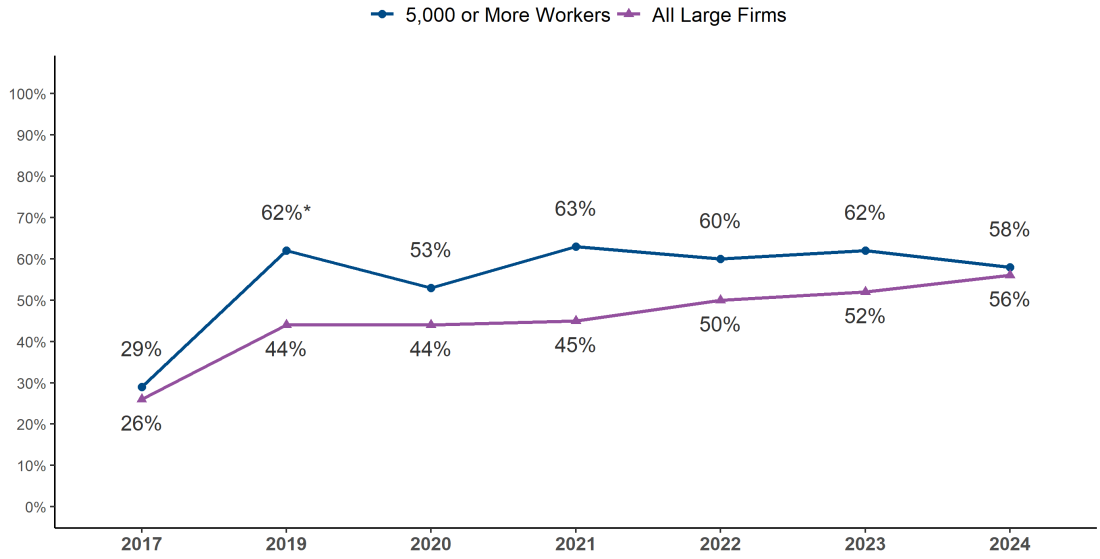
- Fifty-six percent of large employers offering retiree health benefits to Medicare-age retirees offer coverage to at least some Medicare-age retirees through a contract with a Medicare Advantage plan, similar to last year (52%) [Figure 11.7]. This share has more than doubled since 2017 (26%).
- Among large firms offering retiree health benefits through a Medicare Advantage plan, 53% offer retiree health benefits only through Medicare Advantage plans while 47% offer a choice of other types of plans for retiree for retiree health benefits [Figure 11.9]. Both of these shares are similar to last year.
- Among large firms offering retiree health benefits through a Medicare Advantage plan, 56% said to the best of their knowledge that the shift to offering Medicare Advantage plans lowered their per retiree costs, 11% said the shift to Medicare Advantage plans did not lower their per retiree costs, while 33% did not know the answer [Figure 11.10].
- Among large firms offering retiree health benefits that do not offer benefits through a Medicare Advantage plan in 2024, 6% are “Very Likely” or “Somewhat Likely” to do so in the next two years [Figure 11.8].

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, 2024



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-four percent of large firms offering retiree health benefits offer retiree health benefits to Medicare-age retirees. Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2024

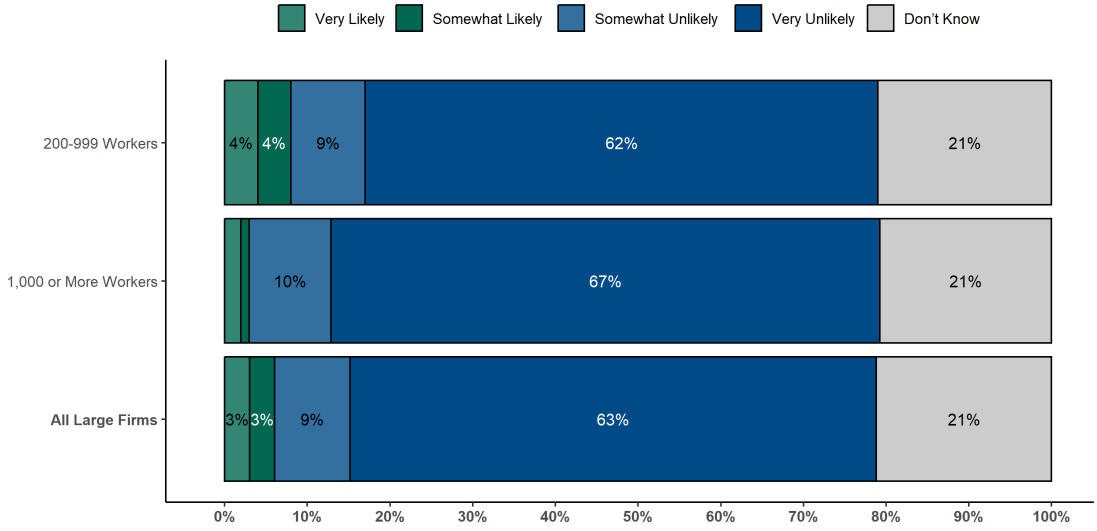
Figure 11.7
Among Large Firms That Offer Retiree Health Benefits to Medicare-Age Retirees, Percentage of Firms That Contract with a Medicare Advantage (MA) Plan, 2017-2024



* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
NOTE: Large Firms have 200 or more workers. MA refers to Medicare Advantage, an arrangement where private health plans receive capitated payments to provide all Medicare-covered services to enrollees. In 2024 sixty-four percent of large firms offering retiree health benefits offer retiree health benefits to Medicare-age retirees.
SOURCE: KFF Employer Health Benefits Survey, 2019-2024; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2017

Figure 11.8

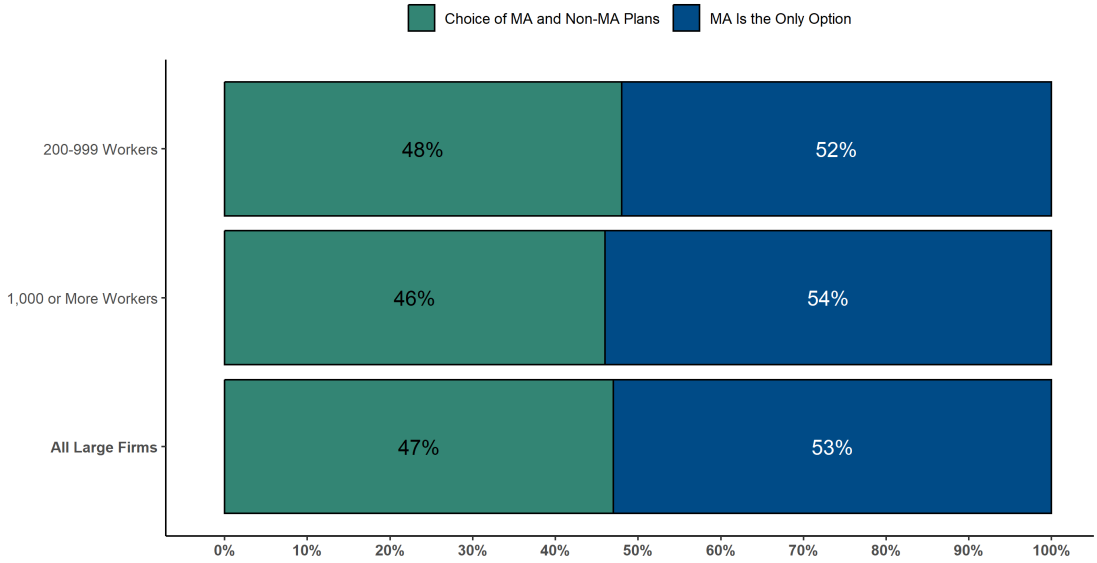
Among Large Firms Offering Retiree Benefits But Not Currently Contracting with a Medicare Advantage (MA) plan, Percentage of Firms Which Plan to Start Offering Medicare-Age Retirees Health Benefits Through a Medicare Advantage Plan in the Next Two Years, 2024



NOTE: Large Firms have 200 or more workers. MA refers to Medicare Advantage, an arrangement where private health plans receive capitated payments to provide all Medicare-covered services to enrollees. Thirty-one percent of large firms offering retiree health benefits contract with a Medicare Advantage (MA) plan.
SOURCE: KFF Employer Health Benefits Survey, 2024

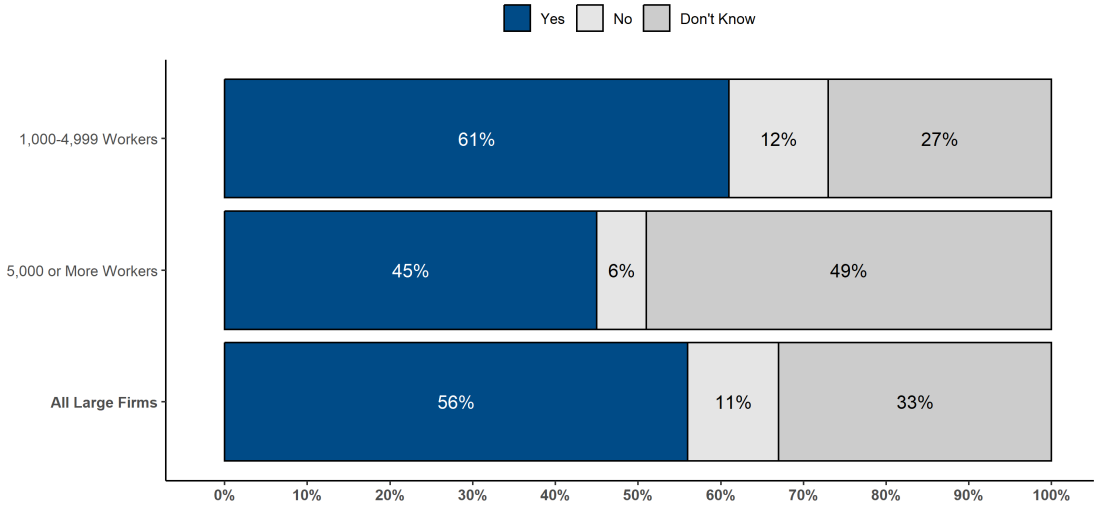
Figure 11.9

Among Large Firms Offering Retiree Benefits Through A Contract with a Medicare Advantage Plan, Percentage of Firms Which Offer Workers a Choice, 2024



NOTE: MA refers to Medicare Advantage, an arrangement where private health plans receive capitated payments to provide all Medicare-covered services to enrollees. Thirty-five percent of large firms offering retiree health benefits contract with a Medicare Advantage (MA) plan. Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2024

Figure 11.10
Among Large Firms Offering Retiree Benefits Through A Contract with a Medicare Advantage Plan, Percentage of Firms Which Believe The Shift to Medicare Advantage Lowered The Cost Per Retiree, 2024



NOTE: MA refers to Medicare Advantage, an arrangement where private health plans receive capitated payments to provide all Medicare-covered services to enrollees. Thirty-five percent of large firms offering retiree health benefits contract with a Medicare Advantage (MA) plan. Large Firms have 200 or more workers. There were insufficent responses to report firms with 200-999 workers seperately, but they are included in the 'all large firm' total.
SOURCE: KFF Employer Health Benefits Survey, 2024

Employer Health Benefits
2024 Annual Survey

Health Screening and Health Promotion and Wellness Programs

SECTION 12

Section 12

Health Screening and Health Promotion and Wellness Programs

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

In addition to offering wellness programs, many large firms offer health screening programs. These include health risk assessments, which are questionnaires asking workers about lifestyle, stress, or physical health, and biometric screenings, 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 (more than 200 workers) offering health benefits in 2024, 56% offer workers the opportunity to complete a health risk assessment, 44% offer workers the opportunity to complete a biometric screening, and 79% offer workers one or more wellness programs, such as programs to help them stop smoking or lose weight, or lifestyle and behavioral coaching. Substantial shares of these firms provide incentives for workers to participate in or complete the programs.

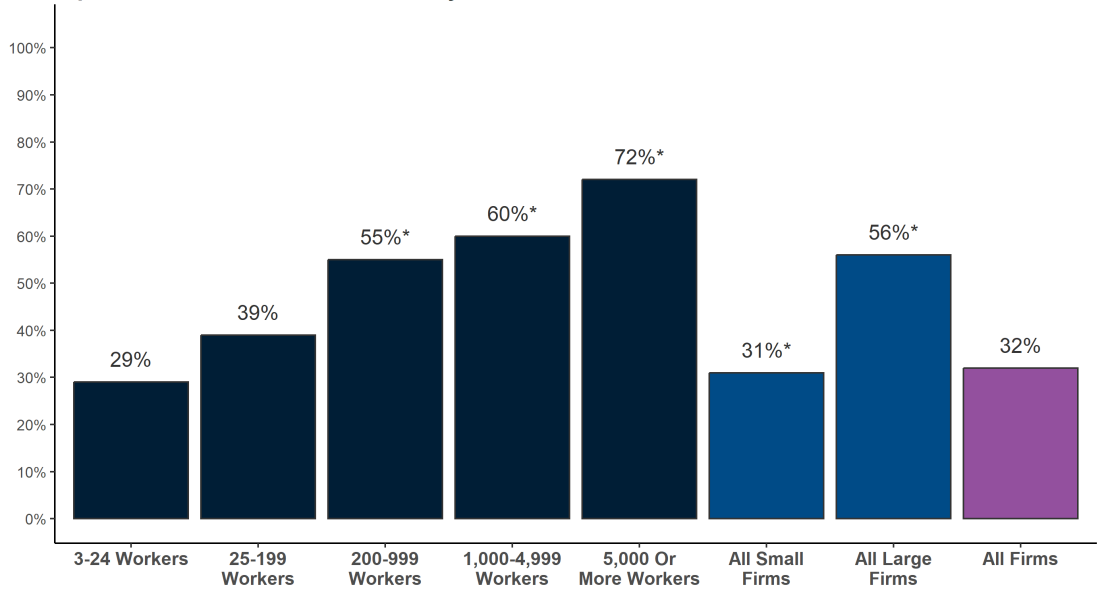
Only firms offering health benefits were asked about their wellness and health promotion programs.

HEALTH RISK ASSESSMENTS

Many firms give their workers the option 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.

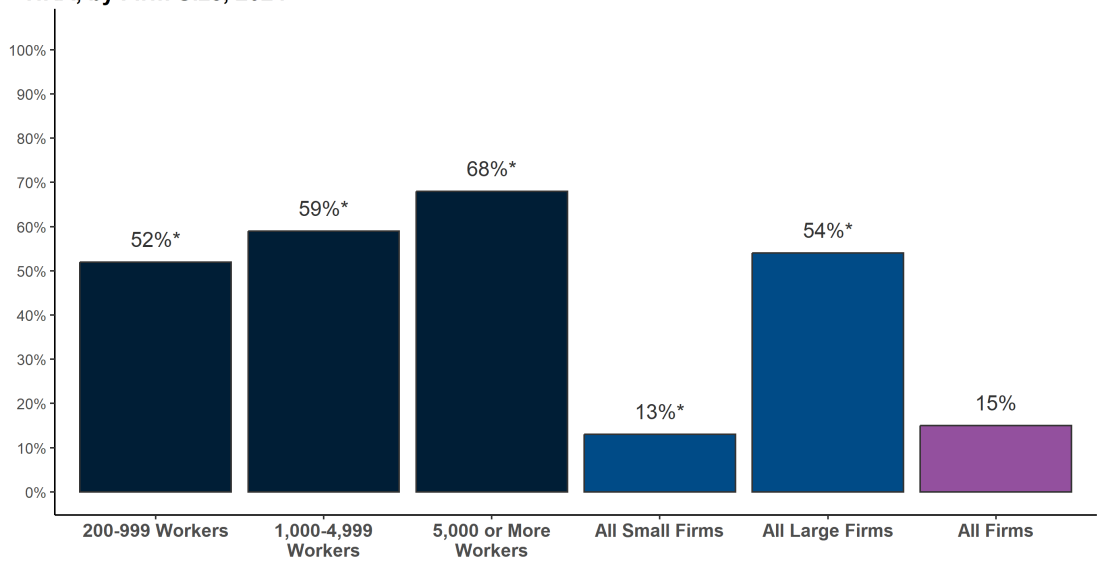
- Among firms offering health benefits, 31% of small firms and 56% of large firms provide workers with the option to complete a health risk assessment, similar to the percentages last year. The percentage of large firms giving workers this opportunity remains lower than the pre-pandemic level for large firms in 2019 (56% vs. 65%) [Figure 12.1].
  - Among large firms giving workers the opportunity to complete a health risk assessment, firms with 5,000 or more workers are more likely to do so (72%) and firms with 200 to 999 workers are less likely to do so (55%) [Figure 12.1].
- Some firms offer incentives to encourage workers to complete a health risk assessment.
  - Among large firms that offer a health risk assessment, 54% use incentives or penalties to encourage workers to complete the assessment, similar to the percentage (59%) last year [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, 2024



* 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, 2024

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, 2024



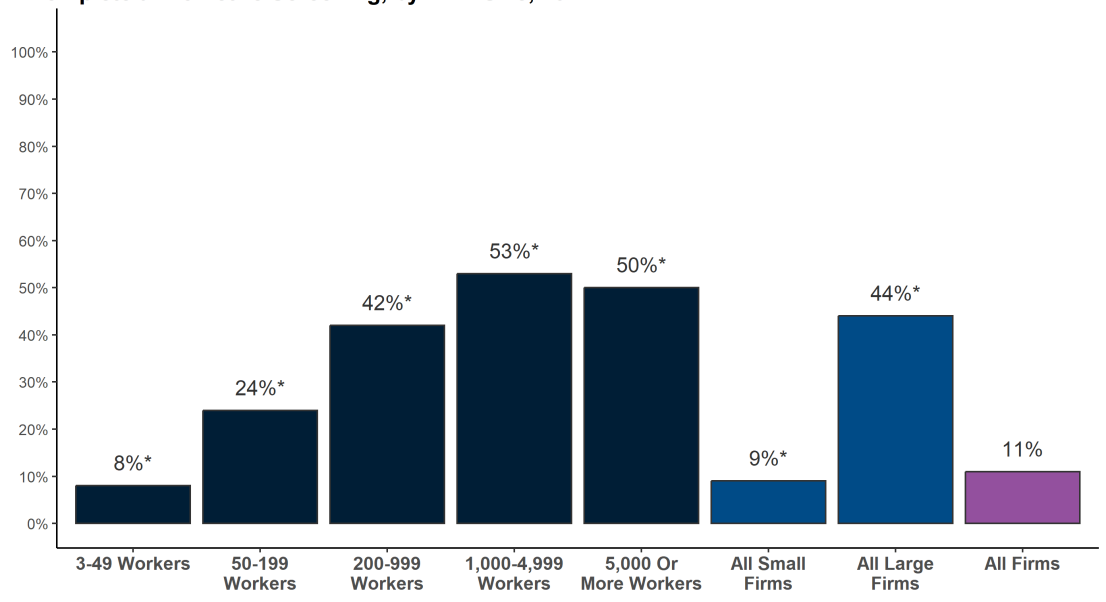
* Estimate is statistically different from estimate for all other firms not in the indicated size category ($p < .05$).
NOTE: A health risk assessment or appraisal includes questions on medical history, health status, and lifestyle and is designed to identify the health risks of the person being assessed. Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2024

BIOMETRIC SCREENING

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

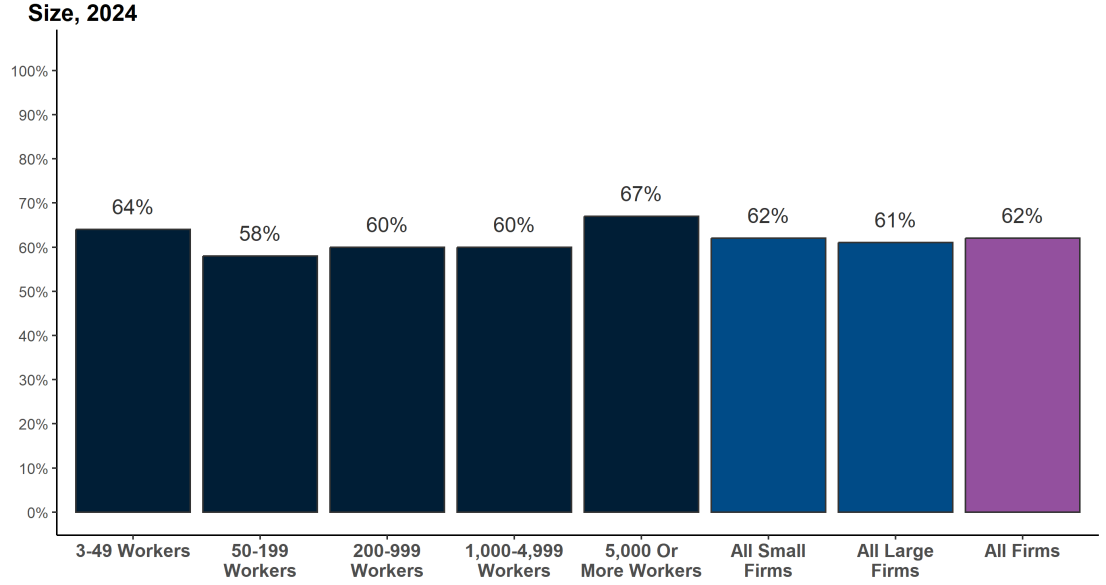
- Among firms offering health benefits, 9% of small firms and 44% of large firms provide workers the opportunity to complete a biometric screening [Figure 12.3]. These percentages are similar to those last year, but the percentage of large employers with a biometric screening program remains lower than the pre-pandemic level in 2019 (52%) [Figure 12.5].
- With increases in remote work, some firms developed options for workers to complete biometric screening remotely. Among firms providing workers the opportunity to complete a biometric screening, 62% allow employees to complete the screening remotely [Figure 12.4]
- Some firms with biometric screening programs offer incentives to encourage workers to complete the screening.
  - Among large firms with a biometric screening program, 65% use incentives or penalties to encourage workers to complete the assessment, similar to the percentage year (67%) [Figure 12.6].
- 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, 14% have incentives or penalties tied to whether workers meet specified biometric outcomes [Figure 12.6].

Figure 12.3
Among Firms Offering Health Benefits, Percentage of Firms That Provide an Opportunity to Complete a Biometric Screening, by Firm Size, 2024



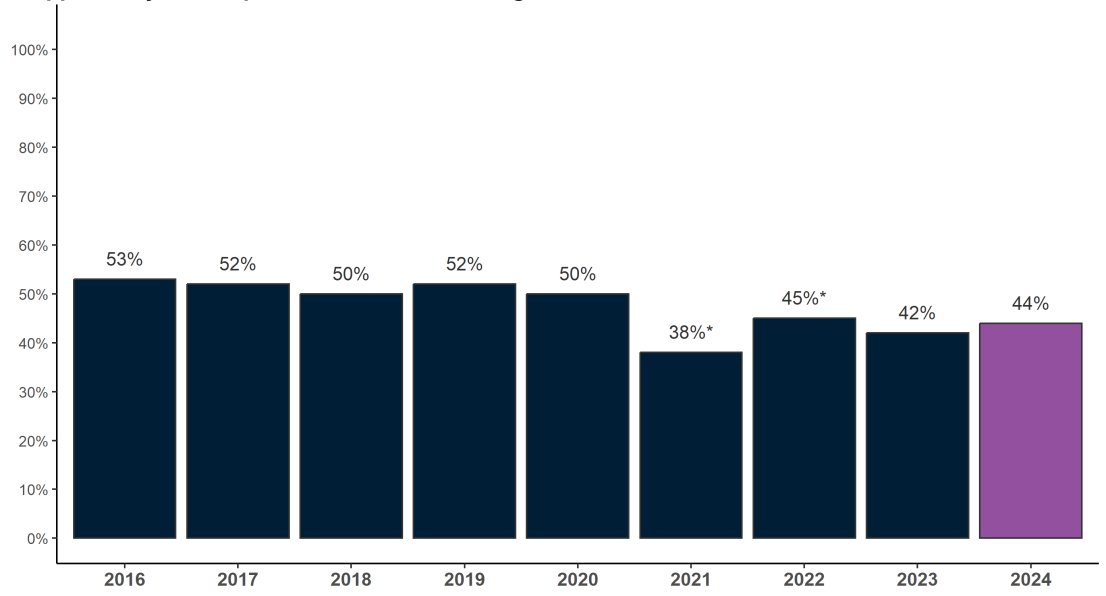
* Estimate is statistically different from estimate for all other firms not in the indicated size category ($p < .05$).
NOTE: Biometric screening is a health examination that measures a person's risk factors for certain medical issues. Biometric outcomes could include meeting a target body mass index (BMI) or cholesterol level, but not goals related to smoking. Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2024

Figure 12.4
Among Firms Offering Health Benefits and Providing an Opportunity to Complete a Biometric Screening, Percentage of Firms That Allow The Screening to Be Completed Remotely, by Firm Size, 2024



Tests found no statistical difference 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.
SOURCE: KFF Employer Health Benefits Survey, 2024

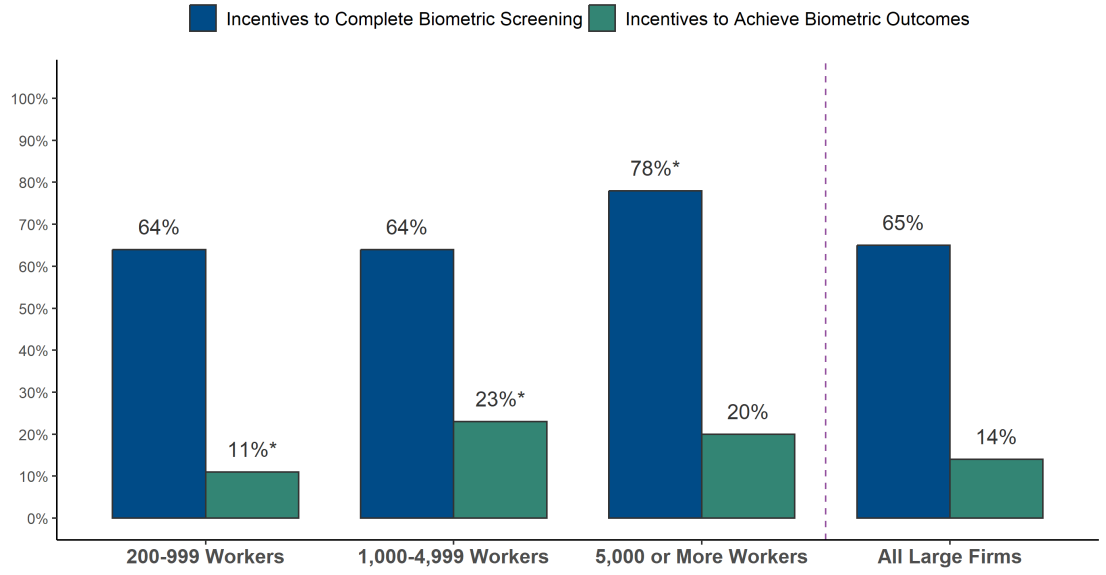
Figure 12.5
Among Large Firms Offering Health Benefits, Percentage of Firms That Provide an Opportunity to Complete Biometric Screening, 2012-2024



* 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, 2018-2024; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2016-2017

Figure 12.6

Among Large Firms Offering Health Benefits and Providing an Opportunity to Complete a Biometric Screening, Percentage of Firms with Incentives to Complete the Screening or Achieve Biometric Outcomes, by Firm Size, 2024



* 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, 2024

HEALTH SCREENING PROGRAMS

Among firms offering health benefits, 64% of large firms offer workers a health risk assessment, biometric screening, or both, similar to the percentage last year (63%) [Figure 12.9].

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, 2024

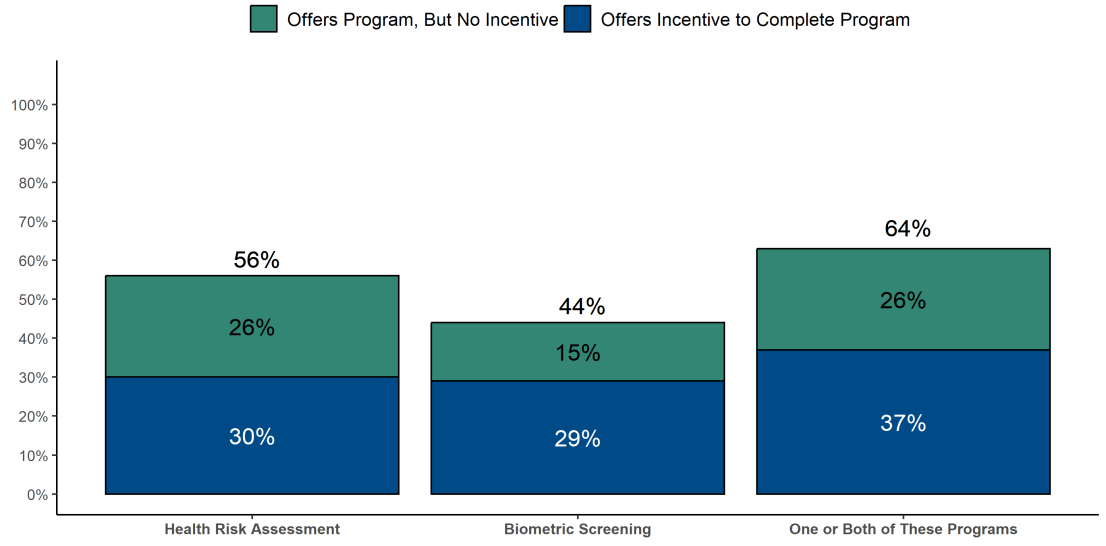
	Health Risk Assessment	Biometric Screening
REGION		
Northeast	54%	37%
Midwest	59	49
South	58	45
West	53	46
INDUSTRY		
Agriculture/Mining/Construction	32%*	27%*
Manufacturing	60	39
Transportation/Communications/Utilities	62	60*
Wholesale	62	50
Retail	47	27*
Finance	73*	52
Service	55	47
State/Local Government	63	51
Health Care	52	34*
All Large Firms (200 or More Workers)	**56%**	**44%**

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 ($p < .05$).

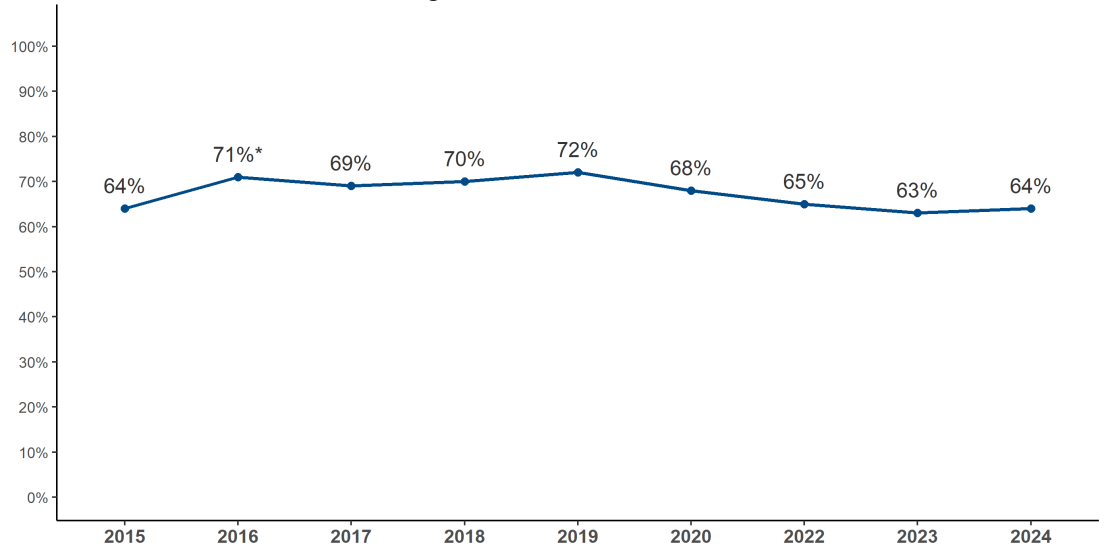
SOURCE: KFF Employer Health Benefits Survey, 2024

Figure 12.8
Among Large Firms Offering Health Benefits, Percentage With Health Screening Programs, 2024



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, 2024

Figure 12.9
Among Large Firms Offering Health Benefits, Percentage With Either a Health Risk Assessment or a Biometric Screening, 2013-2024



* 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, 2018-2024; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2015-2017

WELLNESS AND HEALTH PROMOTION PROGRAMS

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

- Among firms offering health benefits, 40% of small firms and 69% of large firms offer programs to help workers stop smoking or using tobacco, 34% of small firms and 62% of large firms offer programs to help workers lose weight, and 33% of small firms and 70% of large firms offer some other lifestyle or behavioral coaching program. Overall, 54% of small firms and 79% of large firms offering health benefits offer at least one of these three programs [Figure 12.10] and [Figure 12.11].
- Forty-six percent of large firms offering one of these wellness or health promotion programs offer an incentive for workers to participate in or complete the program, similar to the percentage 46% last year [Figure 12.13].

Figure 12.10

Among Firms Offering Health Benefits, Percentage of Firms Offering Specific Wellness Programs to Their Workers, by Firm Size and Region, 2024

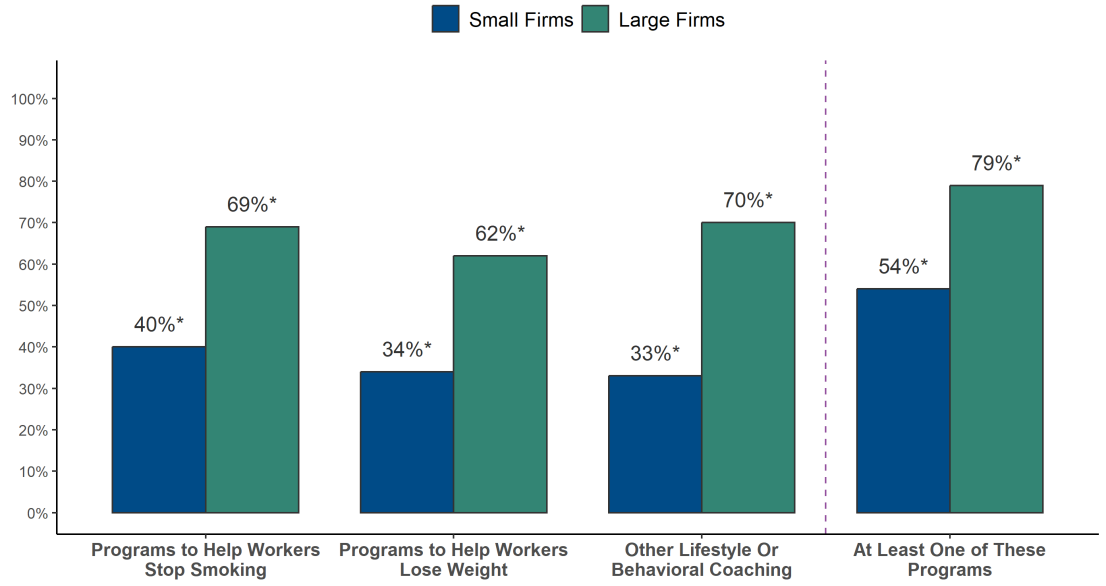
	Programs to Help Workers Stop Smoking	Programs to Help Workers Lose Weight	Other Lifestyle or Behavioral Coaching	At Least One of These Programs
FIRM SIZE				
3-49 Workers	39%*	33%*	31%*	53%*
50-199 Workers	51	46*	50*	65
200-999 Workers	67*	59*	68*	77*
1,000-4,999 Workers	75*	71*	75*	87*
5,000 or More Workers	85*	78*	87*	95*
All Small Firms (3-199 Workers)	**40%***	**34%***	**33%***	**54%***
All Large Firms (200 or More Workers)	**69%***	**62%***	**70%***	**79%***
REGION				
Northeast	42%	27%	51%	69%
Midwest	29	40	26	48
South	48	31	31	54
West	44	39	38	55
ALL FIRMS	**41%**	**35%**	**34%**	**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 ($p < .05$).

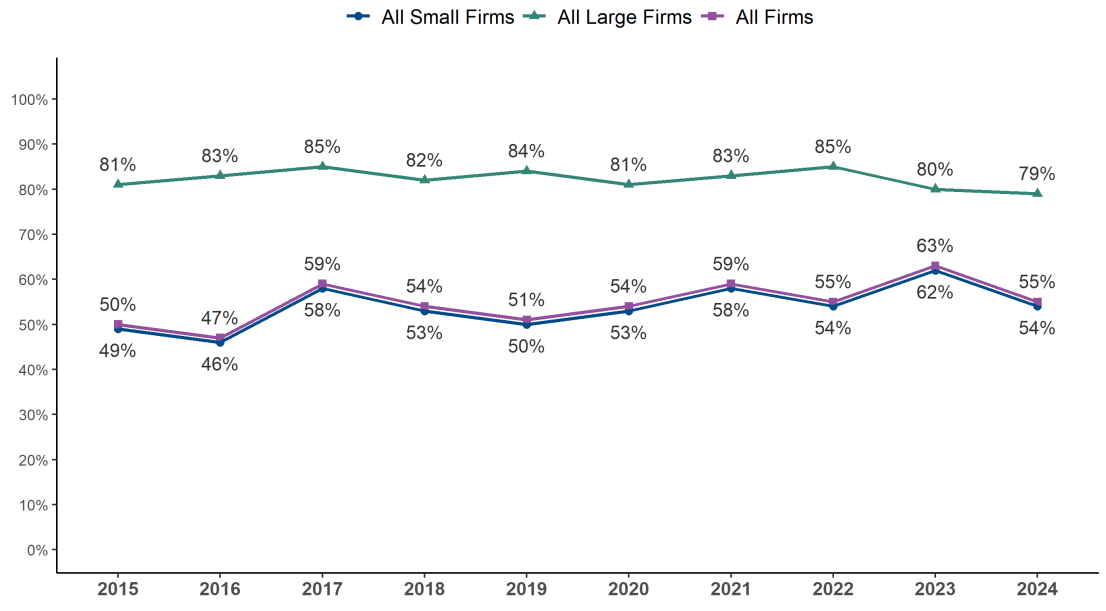
SOURCE: KFF Employer Health Benefits Survey, 2024

Figure 12.11
Among Firms Offering Health Benefits, Percentage of Firms Offering Specific Wellness Programs to Their Workers, by Firm Size, 2024



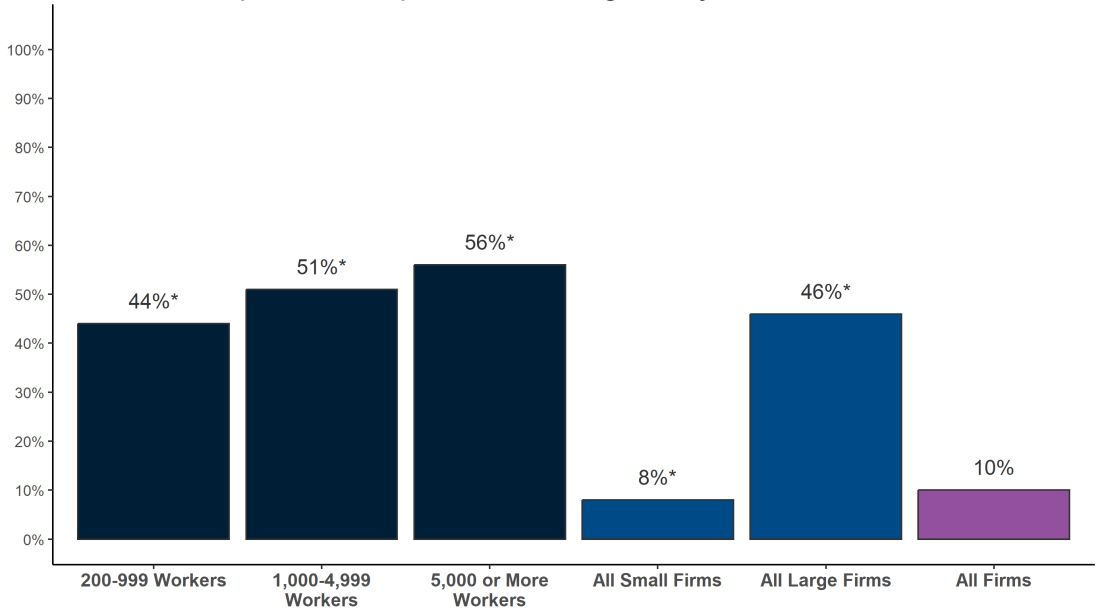
* Estimate is statistically different between All Small Firms and All Large Firms estimate ($p < .05$).
NOTE: 'Other Lifestyle or Behavioral Coaching' can include health education classes, stress management, or substance use counseling. Small Firms have 3-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2024

Figure 12.12
Among Firms Offering Health Benefits, Percentage of Firms Offering Wellness Programs, by Firm Size, 2015-2024



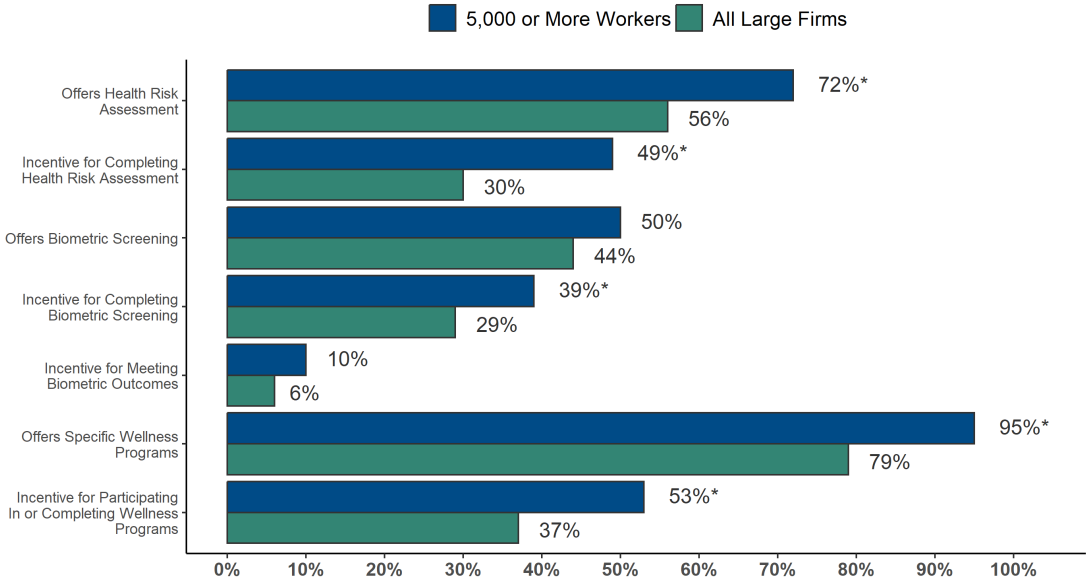
Tests found no statistical difference from estimate for the previous year shown ($p < .05$).
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2018-2024; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2015-2017

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, 2024



* 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, 2024

Figure 12.14
Among Large Firms Offering Health Benefits, Percentage of Firms Offering Various Wellness and Health Promotion Activities and Incentives, by Firm Size, 2024



* 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, 2024

54%

$25,572

$8,951

2024

Employer Health Benefits

2024 Annual Survey

Employer Practices, Provider Networks, Coverage for GLP-1s, Abortion and Family Building Benefits

SECTION

13

Section 13

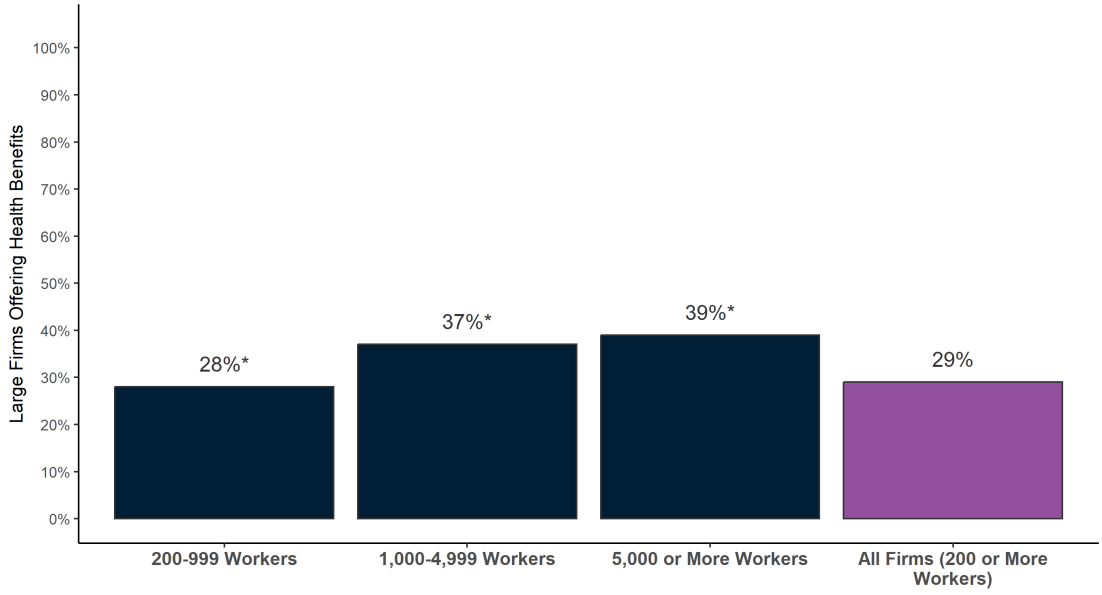
Employer Practices, Provider Networks, Coverage for GLP-1s, Abortion and Family Building Benefits

Employers frequently review and modify their health plans to incorporate new options or adapt to new circumstances. The topics this year include: questions about concierge services; centers of excellence; telemedicine; plan network adequacy; access to mental health services; prescription drug practices, including GLP-1 agonists; price information for plan enrollees; gender-affirming hormonal therapy; access to abortion and related services; benefits for family-building services; and programs to increase affordability for lower-wage workers.

CONCIERGE SERVICES

Some firms contract with a third-party vendors outside of their health plans to offer concierge services to their employees. These services can include helping enrollees navigate plan services, advocating for enrollees as patients and providing medical opinions or options. Twenty-nine percent of firms with 200 or more workers that offer health benefits contract with a vendor offering concierge services to their covered workers in 2024 [Figure 13.1]. Firms with 1,000 or more workers were more likely to contract with a concierge service vendor than smaller firms (37% v. 28%).

Figure 13.1
Percentage of Large Firms Which Contract with a Patient Advocacy Vendor, by Firm Size, 2024



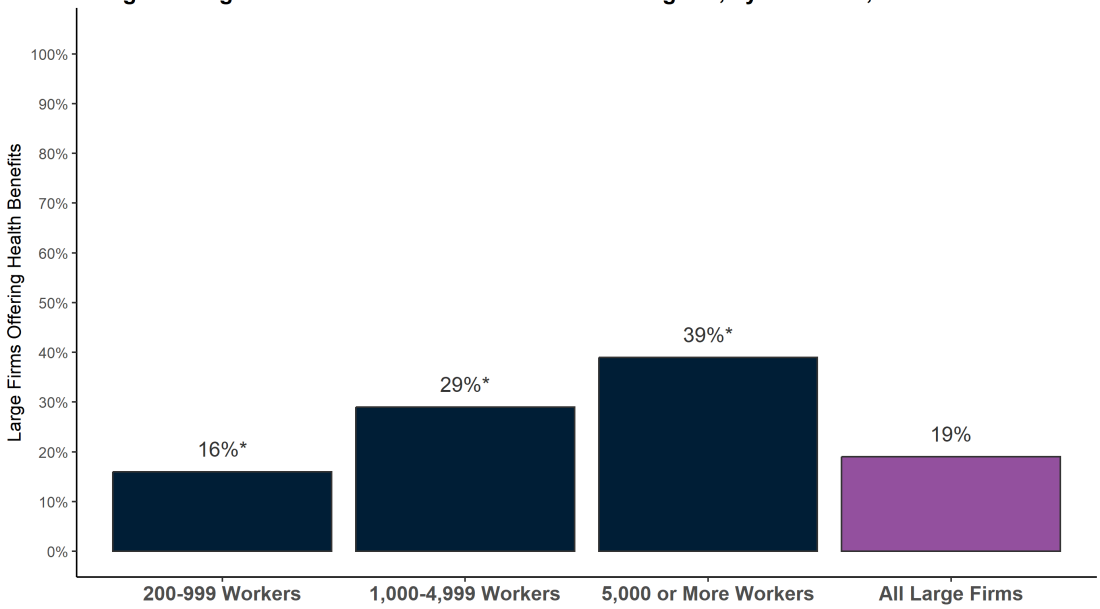
* Estimate is statistically different from estimate for all other firms not in the indicated size category (p < .05).
NOTE: Large Firms have 200 or more workers. Sometimes referred to as 'concierge navigation', or 'expert medical opinion' programs, health advocates help employees find providers, answer questions about insurance, address medical billing errors or assist with appeals.
SOURCE: KFF Employer Health Benefits Survey, 2024

CENTERS OF EXCELLENCE

"Centers of Excellence" are facilities or providers which health plans and employers identify as providers of exceptionally high-value specialty care for specific conditions. Plans and employers may encourage or require enrollees to use these designated providers to receive coverage for certain types of care. Centers of excellence may provide care that is particularly complex or specialized, such as organ transplants, or care that employers and health plans believe may be subject to abuse or poor care delivery, such as care for musculoskeletal injuries.

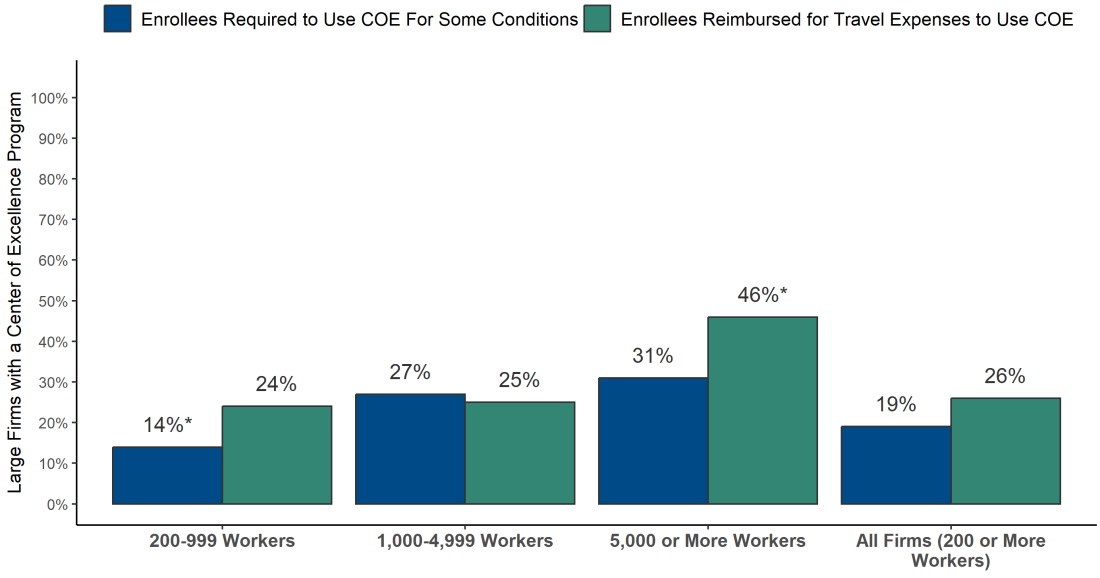
- Among firms with 200 or more workers that offer health benefits, 19% said that they offered a center of excellence program in 2024 [Figure 13.2]. Firms with fewer than 1,000 workers are less likely to offer a centers of excellence program (16%) and firms with 1,000-4,999 and 5,000 or more workers are more likely to offer such a program (29% and 39%, respectively) [Figure 13.2].
- Some firms with centers of excellence programs require enrollees to use a centers of excellence to receive benefits for defined services. Among firms with 200 or more workers with a centers of excellence program, 19% require enrollees to use to use a center of excellence to be covered for one or more specified services [Figure 13.3].
- Among firms with 200 or more workers with a centers of excellence program, 26% reimburse travel costs for employees using services at a center of excellence. Firms with 5,000 or more workers are more likely to reimburse travel for enrollees using these services than all smaller firms (46% v. 24%) [Figure 13.3].

Figure 13.2
Percentage of Large Firms with a Center of Excellence Program, by Firm Size, 2024



* 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. Plans with Center of Excellence have significantly lower cost-sharing for services if the enrollees seeks treatment at a designated hospital even though other hospitals may also be part of the plan's network.
SOURCE: KFF Employer Health Benefits Survey, 2024

Figure 13.3
Coverage and Policies for Firm's Center of Excellence (COE) Program, by Firm Size, 2024



* 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. Firms with multiple plans were asked about their plan with the largest enrollment. Among firms with 200 or more employees that offer health benefits, 19% offered a center of excellence program. Plans with Center of Excellence have significantly lower cost-sharing for services if the enrollees seeks treatment at a designated hospital even though other hospitals may also be part of the plan's network.
SOURCE: KFF Employer Health Benefits Survey, 2024

TELEMEDICINE

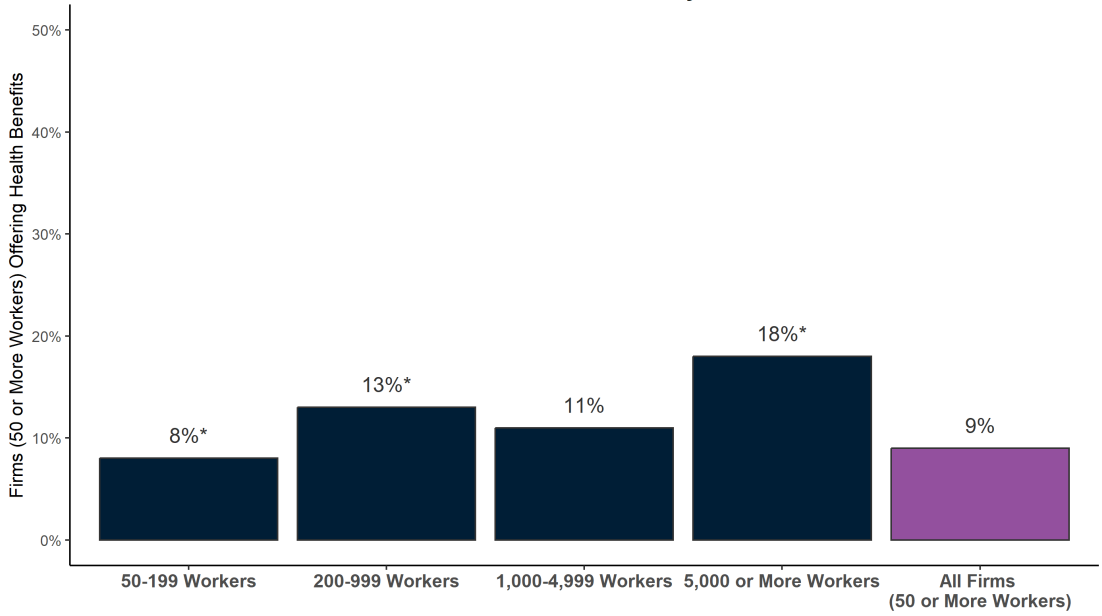
We define telemedicine as the delivery of health care services through telecommunications from a provider to a patient who is at a remote location, including video chat and remote monitoring. This generally does not include the mere exchange of information via email, exclusively web-based resources, or online information that a plan may make available, unless a health professional provides information specific to the enrollee's condition.

- Among firms with 50 or more workers offering health benefits, 8% of smaller firms (50-199 workers) and 13% of larger firms (200 or more workers) contracted with a new telemedicine service provider within the last 12 months. Firms with 5,000 or more workers are more likely to have contracted with a new telemedicine service provider than smaller employers (18%) [Figure 13.4].

With the effects of the pandemic waning, medical services are generally available on an in-person basis. With this context, we asked employers how important they felt telemedicine would be in providing care to employees going forward.

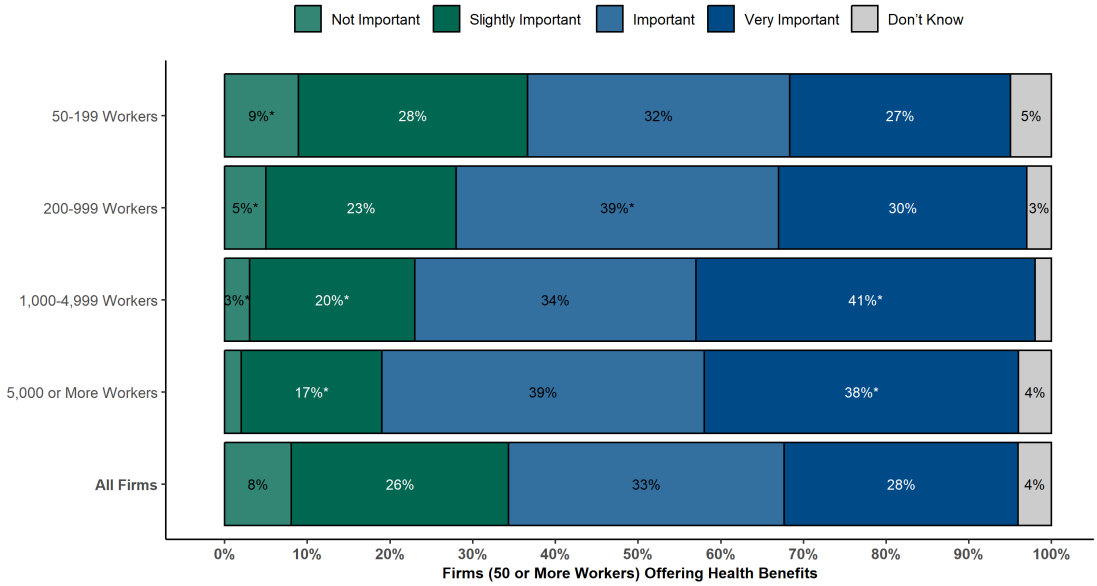
- Among firms with 50 or more workers offering health benefits, 28% believe that telemedicine services will be 'very important', 33% believe that they will be 'important', 26% believe that they will 'somewhat important', 8% believe that they will be 'not important', with 4% responding 'don't know' [Figure 13.5].
- Firms with 1,000 or more workers are more likely to believe that telemedicine will be 'very important" providing care to employees going forward (40% v. 27%) [Figure 13.5].

Figure 13.4
Among Firms Offering Health Benefits, Percentage of Firms Which Have Contracted With a New Telemedicine Service Provider in The Last 12 Months, by Firm Size, 2024



* Estimate is statistically different 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.
SOURCE: KFF Employer Health Benefits Survey, 2024

Figure 13.5
Among Firms Offering Health Benefits, How Important The Firm Believes Telehealth Will Be In Delivering Care Going Forward, by Firm Size, 2024



* Estimates are statistically different from estimate for all other firms not in the indicated category within each firm size ($p < .05$).
NOTE: Firms were asked to consider the importance of telehealth for enrollees going forward in the context of many services returning to in-person care
SOURCE: KFF Employer Health Benefits Survey, 2024

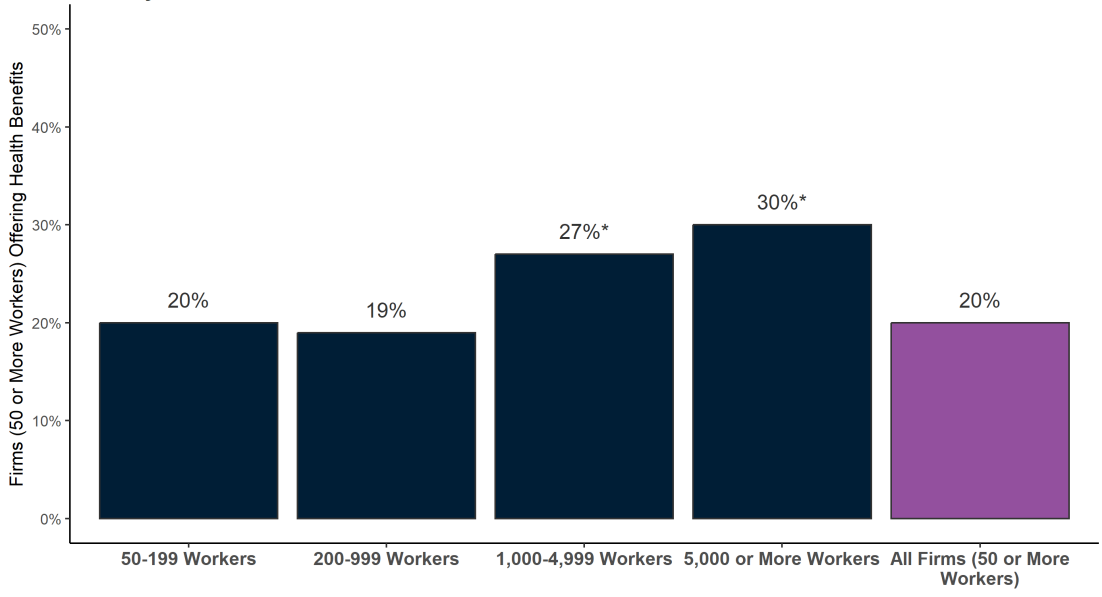
PROVIDER NETWORKS

Firms and health plans structure their networks of providers to ensure access to care, and to encourage enrollees to use providers who are lower cost, or who provide better care.

- Some employers offer high-performance networks or tiered networks. These types of networks use cost-sharing or other incentives to encourage enrollees to use in-network providers that have better performance or quality or have lower costs.
  - Among firms with 50 or more workers that offer health benefits, 20% have a high-performance network or tiered network as part of their health plan with the largest enrollment in 2024 [Figure 13.6]. This is higher than the percentage five years ago (14%) [Figure 13.7].
  - Firms with 1,000 or more workers are more likely to include a high-performance or tiered network in their largest health plan than are smaller firms (27% v. 20%).
- 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 are generally more restrictive than standard HMO networks.
  - Among firms that offer health benefits, 6% offer a health plan that can be considered a narrow network in 2024, similar to the percentage (9%) last year.
  - Firms with 1,000 or more workers are more likely to offer a narrow network plan than are smaller firms (13% v. 6%).

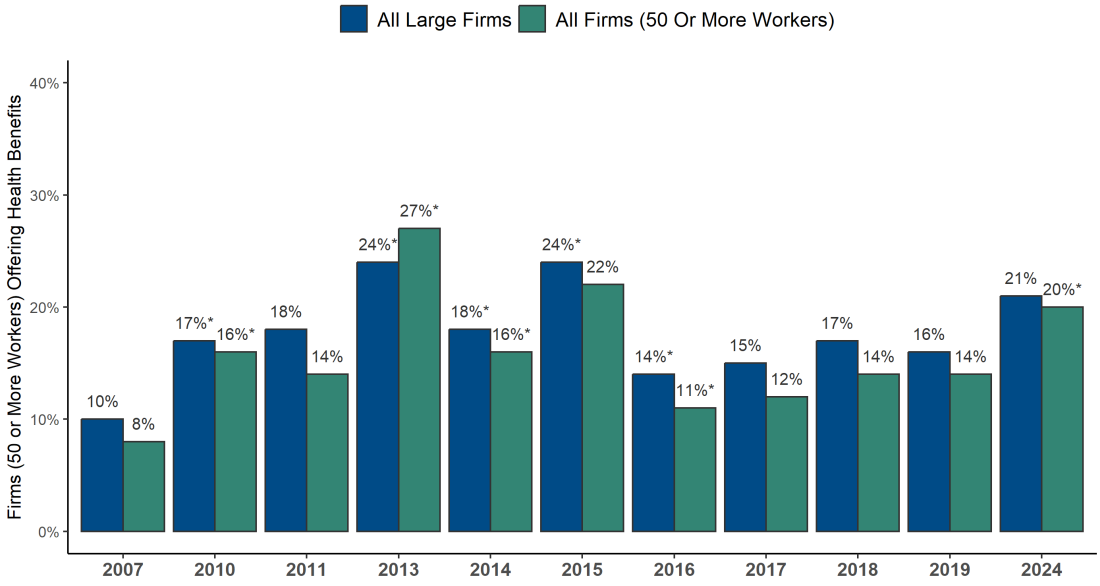
- Employers that offer health benefits were asked to characterize the breadth of the provider network in their plan with the largest enrollment. Employers were also asked to characterize the network's breadth for services for mental health and substance use conditions.
  - Fifty-four percent of firms characterize the network in their plan with the largest enrollment as 'very broad', 35% say it is 'somewhat broad', and 10% say it is 'somewhat narrow' or 'very narrow' [Figure 13.10].
  - Firms with 200 or more workers are more likely than smaller firms to characterize the provider network in their plan with the largest enrollment as "very broad" (68% v. 54%). The share of large firms characterizing the provider network in their plan with the largest enrollment as "very broad" is similar to percentage in 2022.
- Employers that offer health benefits are less likely to characterize their network with the largest enrollment as 'very broad' for mental health and substance use condition services than for medical services overall.
  - Thirty percent of firms characterize the network in their plan with the largest enrollment as 'very broad' for mental health and substance use condition services, 45% say it is 'somewhat broad' for these services, and 24% say it is 'somewhat narrow' or 'very narrow' [Figure 13.10].
  - Firms with 200 or more workers are more likely than smaller firms to characterize the provider network in their plan with the largest enrollment as "very broad" for mental health and substance use condition services (46% v. 30%). The share of large firms characterizing the provider network in their plan with the largest enrollment as "very broad" is higher than the percentage in 2022 (46% v. 30%).

Figure 13.6
Percentage of Firms Whose Largest Plan Includes a High-Performance or Tiered Provider Network, by Firm Size, 2024



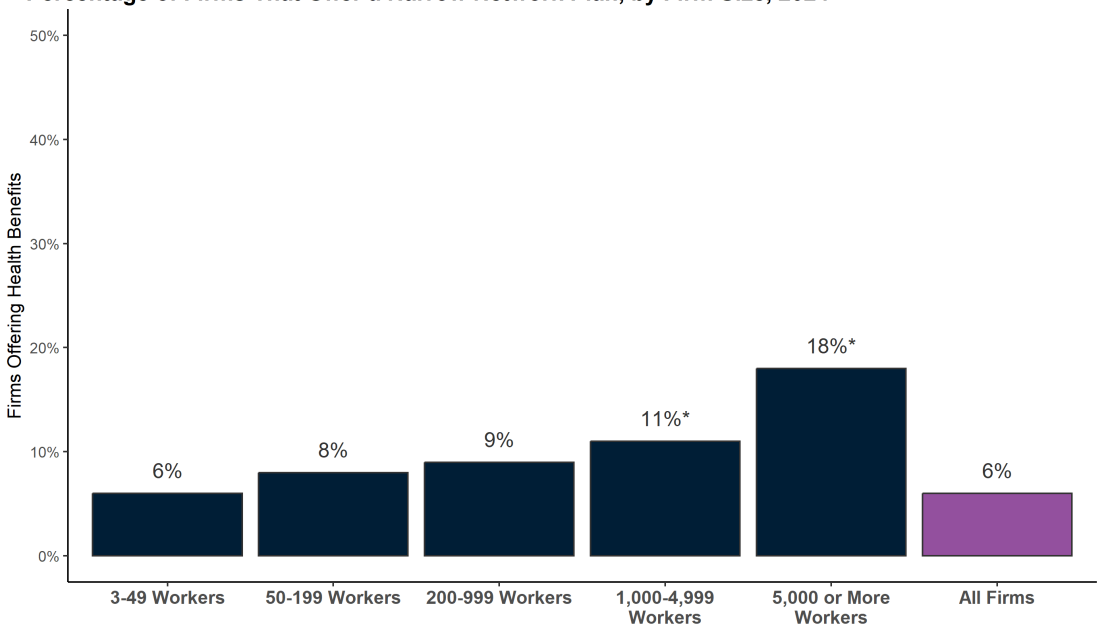
* Estimate is statistically different from estimate for all other firms not in the indicated size category ($p < .05$).
NOTE: Firms with multiple plans were asked about their plan with the largest enrollment. A high-performance network groups providers within the network based on quality, cost, and/or the efficiency of care they deliver.
SOURCE: KFF Employer Health Benefits Survey, 2024

Figure 13.7
Percentage of Firms Whose Largest Plan Includes a High-Performance or Tiered Provider Network, by Firm Size, 2007-2024



* Estimate is statistically different from estimate for the previous year shown (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, 2018-2024; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2007-2017

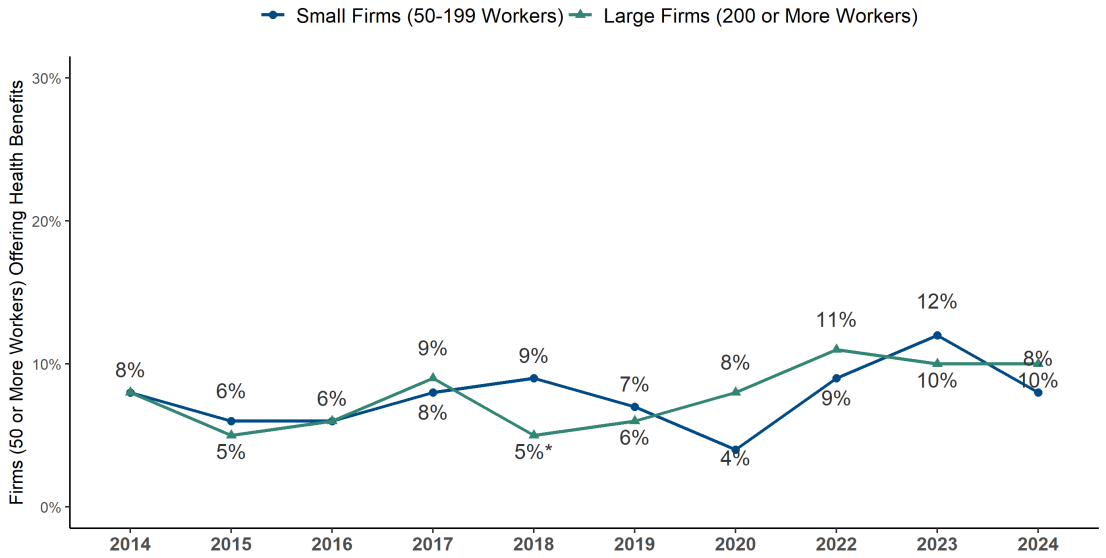
Figure 13.8
Percentage of Firms That Offer a Narrow Network Plan, by Firm Size, 2024



* 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, 2024

Figure 13.9

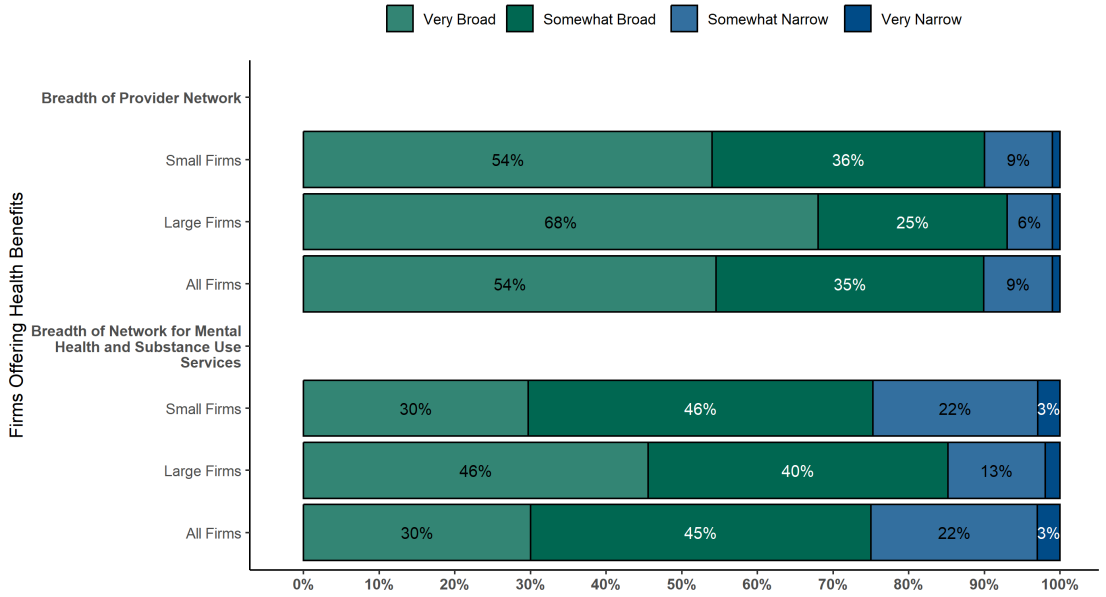
Among Firms Offering Health Benefits, Percentage of Firms That Offer a Narrow Network Plan, by Firm Size, 2014-2024



* 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 2024, 6% 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, 2018-2024; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2014-2017

Figure 13.10

How Broad the Firm Considers Their Largest Plan's Provider Network, by Firm Size, 2024

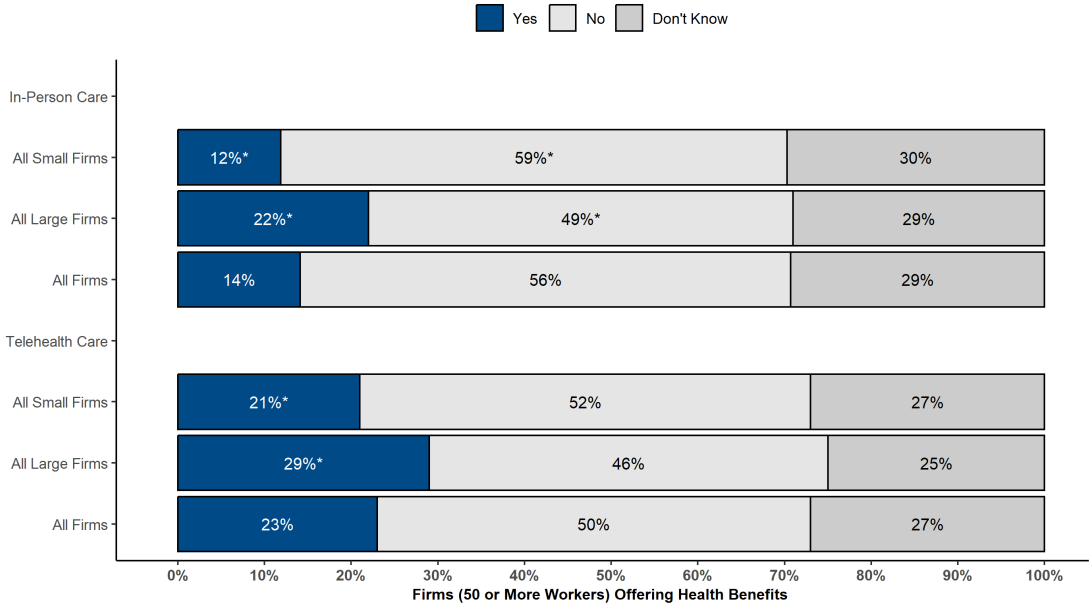


NOTE: A broad network includes most doctors and hospitals in the area, a narrow network is one which is limited to a small number of providers. Small Firms have 3-199 workers and Large Firms have 200 or more workers. Firms with multiple plans were asked about their plan with the largest enrollment.
SOURCE: KFF Employer Health Benefits Survey, 2024

ACCESS TO SERVICES FOR MENTAL HEALTH AND SUBSTANCE USE CONDITIONS

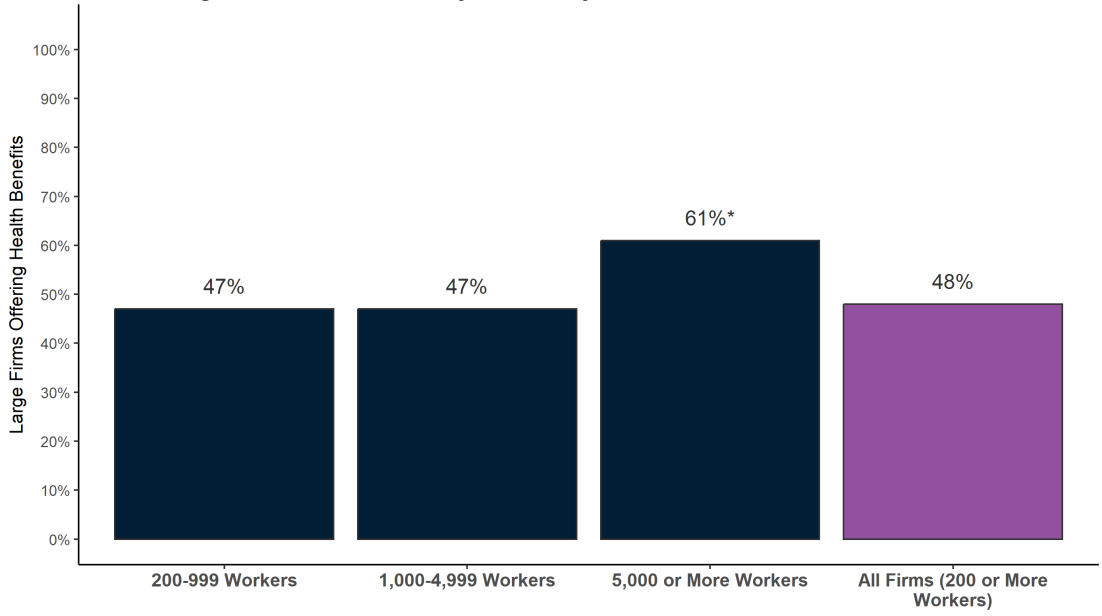
- Firms with 50 or more workers that offer health benefits were asked whether they had taken steps within the last 12 months to add in-network providers to treating mental health and substance use conditions.
  - Fourteen percent of firms with 50 or more workers that offer health benefits took steps to add in-person care for these services. Small firms (50-199 workers) are less likely to have taken steps to add in-network, in-person care and large firms (200 or more workers) are more likely to have done so. A consistent share of respondents across firm sizes did not know the answer to this question [Figure 13.11].
  - Twenty-three percent of firms with 50 or more workers that offer health benefits took steps to add telehealth care for these services. Firms with 50 to 199 workers are less likely to have taken steps to add in-network telehealth care and larger firms (200 or more workers) are more likely to have done so. A consistent share of respondents did not know the answer to this question [Figure 13.11].
- In addition to a health plan many employers sponsor Employee Assistance Programs (EAP). These programs help employees with personal or work-related problems, including mental health support, counseling, and stress management. Among firms with 200 or more workers that offer health benefits, 48% increased the number of mental health counseling resources available to employees through an employee assistance program or some other third-party vendor. Firms with 5,000 or more workers were more likely than smaller firms to have increased the number of mental health counseling resources (61%) [Figure 13.12].

Figure 13.11
Percentage of Firms Which Have Taken Any Steps to Increase The Number of Mental Health or Substance Use Providers, by Firm Size, 2024



* Estimate is statistically different from estimate for all other firms not in the indicated size category ($p < .05$).
NOTE: Small Firms have 50-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2024

Figure 13.12
Percentage of Firms Which Expanded the Number of Mental Health Counseling Resources Available Through an EAP or Third-Party Vendor, by Firm Size, 2024



* 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, 2024

PRESCRIPTION DRUGS

The cost of prescription drugs is a significant challenge for employers and families. Recent policy options have focused on the complexity involving the delivery and pricing of prescription drugs and the lack of transparency about the true price for individual prescriptions. We asked employers about two issues related to price transparency, prescription drug rebates and programs operated by drug manufacturers to assist patients with the cost of prescriptions.

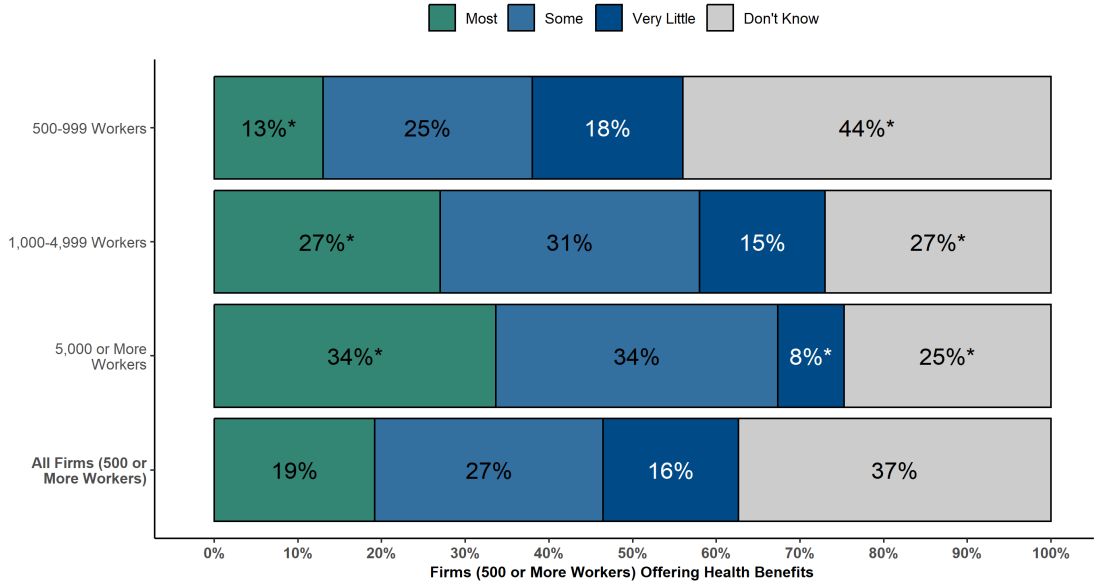
Rebates are payments made by drug manufacturers to insurers, pharmacy benefit managers (PBMs), and employers that reduce the actual price of the drugs, usually in exchange for favorable placement on health plan formularies. Some payers are concerned that insurers and PBMs may not be passing all of the rebates they collect onto the ultimate payers. Some drug manufacturers operate or fund programs to reduce the costs of prescriptions for patients. Some of these programs are aimed at lower income or uninsured patients, while others assist people with coverage who still may face high out-of-pocket costs. Some drug manufacturers provide coupons to patients who are prescribed their drugs. Coupons are discounts that prescription users can present at the pharmacy that reduce their cost sharing liability. Some payers are concerned that coupons and other patient assistance programs affect the financial incentives employees otherwise may have to use lower cost drugs.

- Among firms with 500 or more workers that offer health benefits in 2024, 19% say that they receive 'most' of the prescription drug rebate negotiated by their PBM or health plan, 27% say that they receive 'some' of the negotiated rebate, 16% say that they receive 'very little' of the negotiated rebate, and 37% do not know [Figure 13.13].
  - Only one-in-three of firms with 5,000 or more workers say that they receive 'most' of the prescription drug rebates negotiated by their PBM or health plan [Figure 13.13].

- Firms with 1,000 or more workers are relatively more likely to say that they receive 'most' of the drug rebates negotiated by their PBM or health plan. Firms with less than 1,000 workers are less likely to say this.

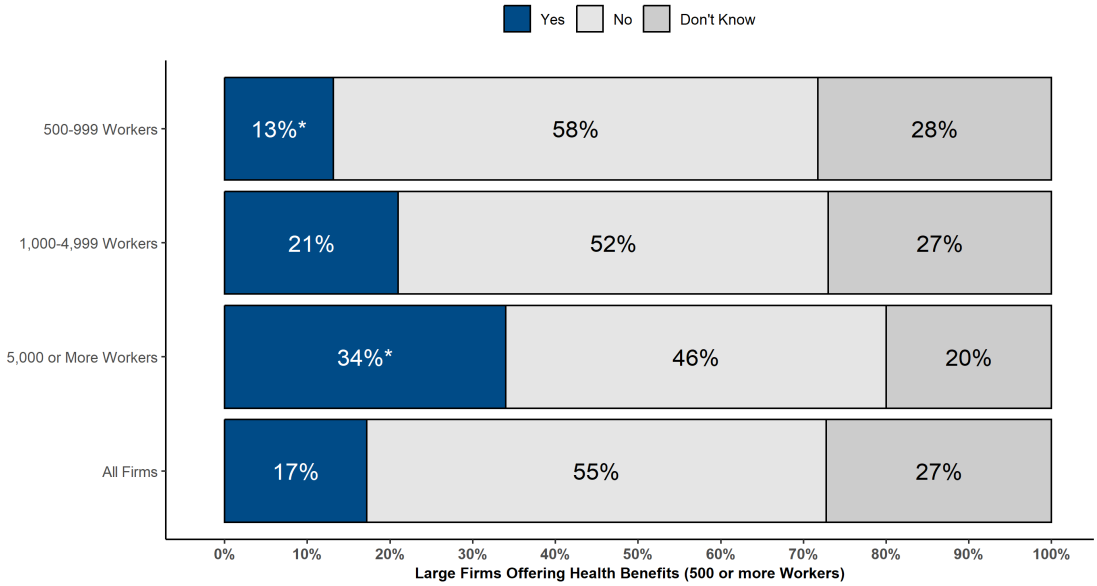
- Some firms have programs, sometimes referred to as "copay accumulator programs", which do not count amounts paid by an enrollee with a manufacturer coupon when calculating whether the enrollee has met their deductible or out-of-pocket limit.
  - Among firms with 500 or more workers offering health benefits in 2024, 17% have copay accumulator or similar programs for their health plan with the largest enrollment, 55% reported that they did not and 27% did not know [Figure 13.14].
  - Firms with 5,000 or more workers are relatively more likely to have a copay accumulator or similar program while firms with 500 to 999 workers are relatively less likely to have such a program.

Figure 13.13
Firms View Over How Much of Prescription Drug Rebates Negotiated by PBMs Does The Firm Receive As Savings, by Firm Size, 2024



* 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 500 or more workers. Pharmacy benefit managers (PBMs), are companies that manage prescription drug benefits on behalf of health insurers.
SOURCE: KFF Employer Health Benefits Survey, 2024

Figure 13.14
Percentage Large Firms With A Copay Accumlator Program for Prescription Drugs, by Firm Size, 2024



* Estimate is statistically different from estimate for all other firms not in the indicated size category ($p < .05$).
NOTE: Large Firms have 500 or more workers. A copay accumulator programs requires that enrollee's spending from copay cards or drug manufacturers coupons do not count towards either the deductible or the out-of-pocket maximum
SOURCE: KFF Employer Health Benefits Survey, 2024

GLP-1 DRUG COVERAGE FOR WEIGHT LOSS

GLP-1 agonists, used to help control blood sugar levels in people with type 2 diabetes, have also been shown to be an effective drug to help people lose weight. Common brand names include Ozempic, Wegovy, Mounjaro, Saxenda, and Victoza. Health plans generally have covered these medications when prescribed for people with diabetes, but there has been a growing interest in the extent to which employer plans and other payers cover them for people who have a clinical need to lose weight. The high cost of these drugs, combined with potential for long-term usage, has raised questions about the potential costs to plans that cover them.

Firms with 200 or more workers that offer health benefits were asked about their coverage of GLP-1 agonists when used primarily for weight loss.

- Among these firms, 18% cover GLP-1 agonists when used primarily for weight loss [Figure 13.15].
  - Firms with 200 to 999 workers are more likely not to know whether their firm provided this coverage compared to larger firms (35% v. 15%) [Figure 13.5].
- Firms with 200 or more workers that provide coverage for GLP-1 agonists primarily for weight loss were asked if they had certain conditions or requirements associated with covering these medications.
  - Twenty-four percent of these firms require employees to meet with a professional, such as a dietitian, psychologist, case worker, or therapist (otherwise known as case management) before approving a GLP-1 drug prescription [Figure 13.16].
  - Eight percent of these firms require employees to enroll in a lifestyle or weight loss program for a period of time before approving a GLP-1 drug prescription [Figure 13.16].

  - Ten percent of these firms require employees to enroll in lifestyle or weight loss program while taking GLP-1 drugs [Figure 13.16].
  - Twenty-six percent of these firms have some other type of condition or requirement [Figure 13.16]. When asked to provide examples of other conditions on covering GLP-1 for weight-loss, many respondents indicated that they had prior authorization programs and may have more restrictive eligibility requirements such as a higher BMI threshold.
  - Twenty-eight percent of these firms did not know if there were any conditions or requirements [Figure 13.16].

- Among these firms with 200 or more workers that provide coverage for GLP-1 agonists primarily for weight loss, 53% have some type of condition or requirement associated with covering these medications [Figure 13.16].

- Among firms with 200 or more workers that cover GLP-1 agonists primarily for weight loss, 33% say that covering these medications for weight loss will have a "significant impact" on their prescription drug spending, 33% say that it will have a "moderate impact", 20% say that it will have a "minor impact", 3% say that it will have "no impact", and 11% do not know what the impact will be [Figure 13.18].

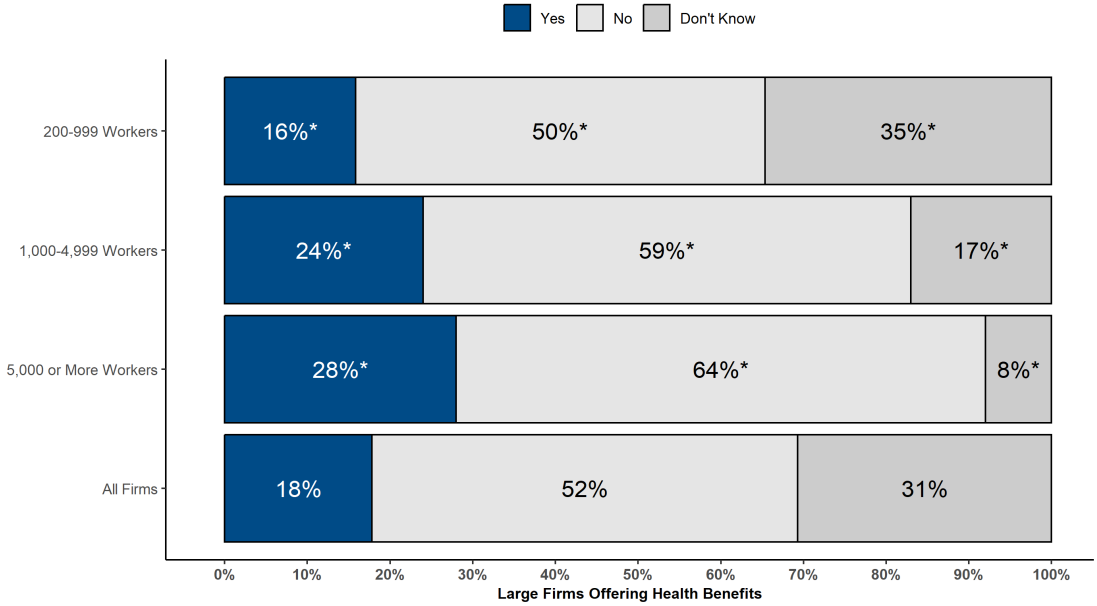
  - Firms with 5,000 or more workers are more likely than smaller firms to say that covering these medications for weight loss will have a "significant" impact on their prescription drug spending (58% v. 31%). Firms with 200 to 999 workers were less likely to say that covering these medications for weight loss will have a "significant" impact on prescription drug spending [Figure 13.18].

- Among firms with 200 or more workers offering health benefits, 16% say that covering these medications for weight loss will be "very important" for employees' satisfaction with their health plan, 28% say that it will be "important", 32% say that it will be "slightly important", 10% say that it will be "not important", and 13% say that they do not know how important it will be [Figure 13.19].

- Among firms with 200 or more workers that do not provide coverage for GLP-1 agonists primarily for weight loss, 62% say that they are "not likely" to begin covering these medications for weight loss within the next twelve months, 23% say that they are "somewhat likely" to do so, 3% say that they are "very likely" to do so, and 11% do not know [Figure 13.20].

Figure 13.15

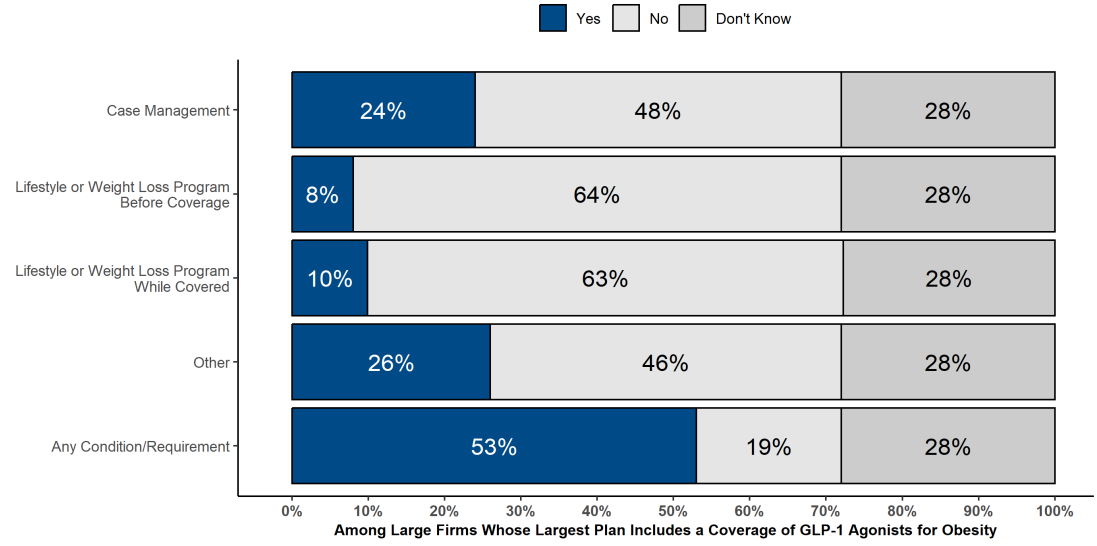
Percentage of Firms Whose Largest Plan Includes Coverage For GLP-1 Agonists When Used Primarily For Weight Loss, by Firm Size, 2024



* 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. Firms with multiple plans were asked about their plan with the largest enrollment.
SOURCE: KFF Employer Health Benefits Survey, 2024

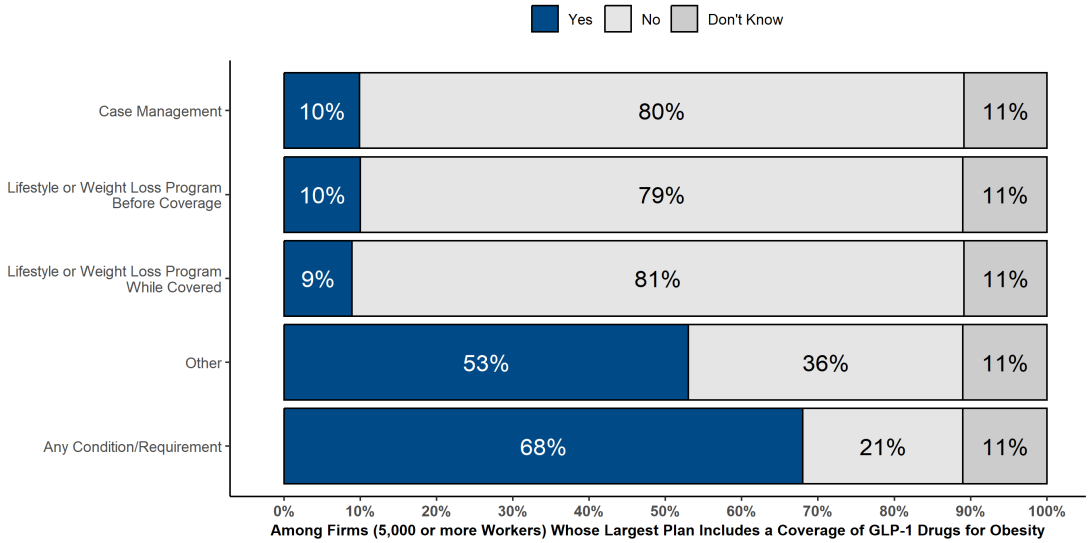
Figure 13.16

Percentage of Firms Who Require Steps to Be Taken Before GLP-1 Agonist Coverage for Weight Loss is Approved, 2024



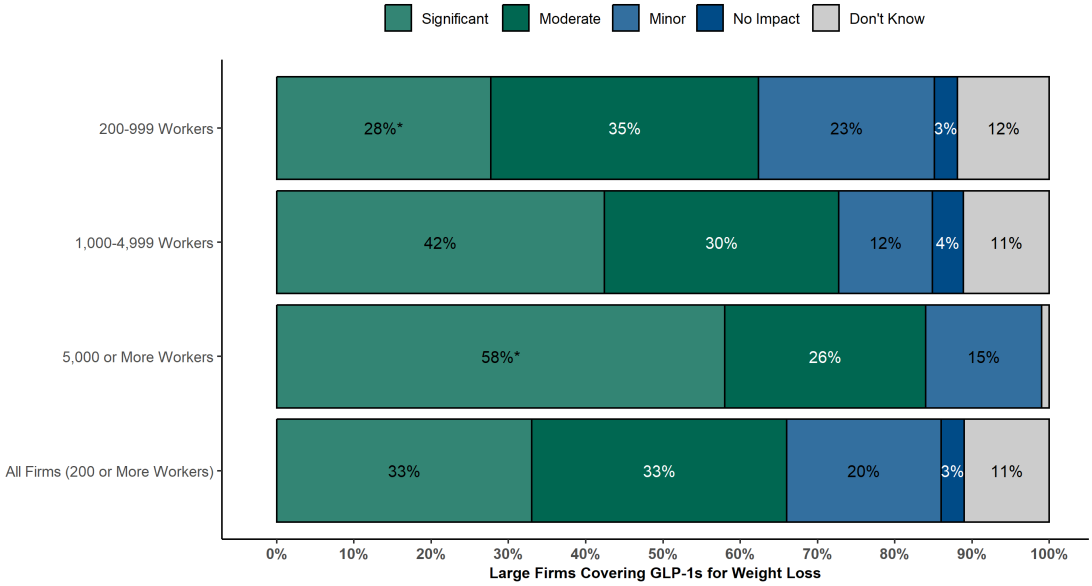
NOTE: Large Firms have 200 or more workers. Firms with multiple plans were asked about their plan with the largest enrollment. Among firms with 200 or more workers that offer health benefits, 18% reported that their largest plan included coverage for any GLP-1 inhibitor drugs when used primarily for weight loss. Case management is defined as requiring employees to meet with a professional such as a dietitian, psychologist, case worker, or therapist before approving a GLP-1 drug prescription.
SOURCE: KFF Employer Health Benefits Survey, 2024

Figure 13.17
Percentage of Larger Firms Who Require Steps to Be Taken Before GLP-1 Agonist Coverage for Weight Loss is Approved, 2024



Tests found no statistical difference from estimate for all other firms not in the indicated category within each firm size ($p < .05$).
NOTE: Large Firms have 5,000 or more workers. Firms with multiple plans were asked about their plan with the largest enrollment. Among firms with 5,000 or more workers that offer health benefits, 28% reported that their largest plan included coverage for any GLP-1 inhibitor drugs when used primarily for weight loss. Case management is defined as requiring employees to meet with a professional such as a dietitian, psychologist, case worker, or therapist before approving a GLP-1 drug prescription.
SOURCE: KFF Employer Health Benefits Survey, 2024

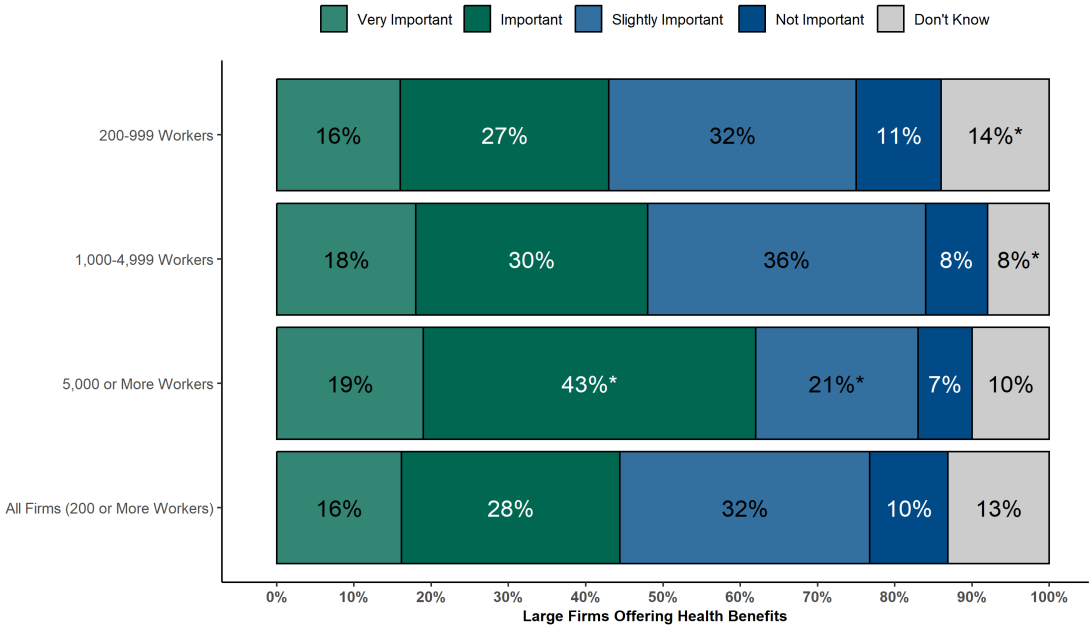
Figure 13.18
Firms View on How Much Of An Impact GLP-1 Agonists Will Have on Prescription Drug Spending, by Firm Size, 2024



* 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. Among firms with 200 or more workers that offer health benefits, 18% reported that their largest plan included coverage for any GLP-1 inhibitor drugs when used primarily for weight loss.
SOURCE: KFF Employer Health Benefits Survey, 2024

Figure 13.19

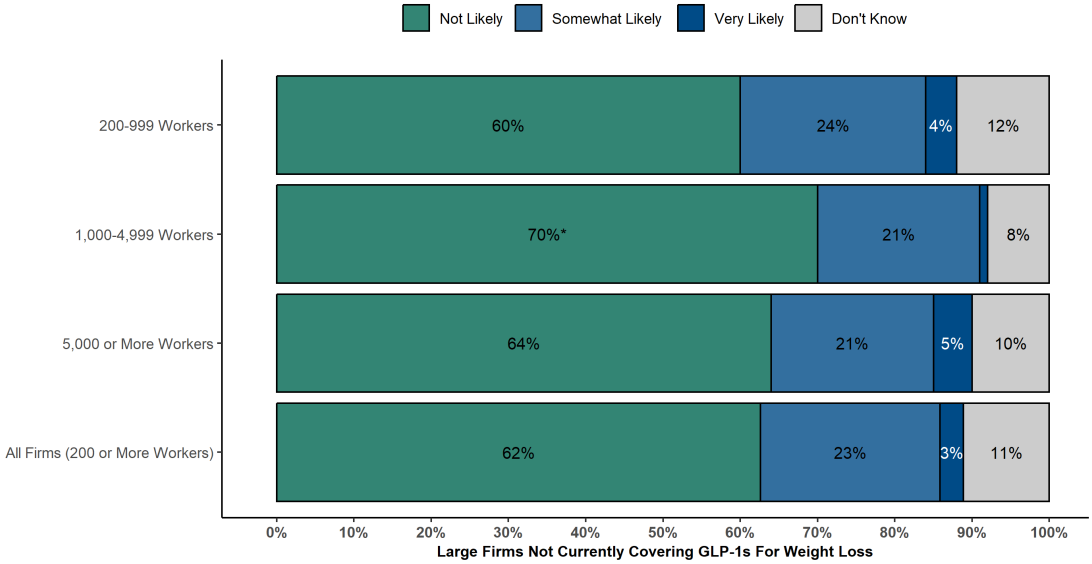
Firms View on the Importance of GLP-1 Agonist Coverage For Weight Loss on Enrollee Satisfaction With Plans, by Firm Size, 2024



* 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, 2024

Figure 13.20

Among Firms Not Covering GLP-1 Angonists For Weight Loss, Firm Views on How Likely It Is Add Coverage In The Next 12 Months, by Firm Size, 2024

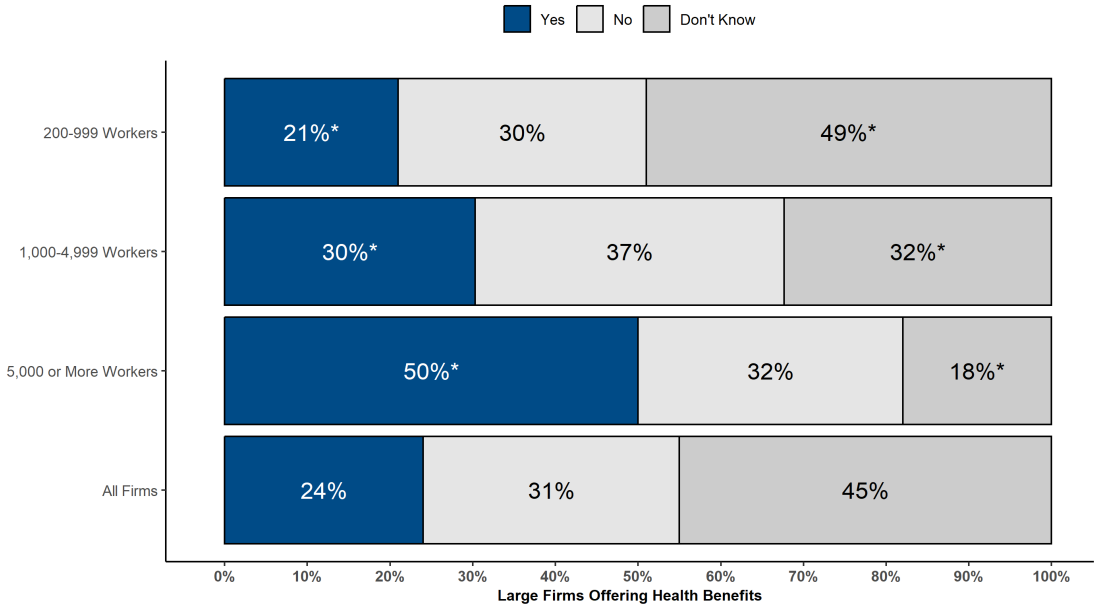


* Estimates are statistically different from estimate for all other firms not in the indicated category within each firm size ($p < .05$).
NOTE: Firms with multiple plans were asked about their plan with the largest enrollment. Among firms with 200 or more workers that offer health benefits, 52% reported that their largest plan did not include coverage for any GLP-1 agonists when used primarily for weight loss. Firms which did not know, were not asked whether there were likely to add coverage.
SOURCE: KFF Employer Health Benefits Survey, 2024

COVERAGE FOR GENDER-AFFIRMING HORMONE THERAPY

- Among firms with 200 or more workers that offer health benefits, 24% cover gender affirming hormone therapy in their health plan with the largest enrollment in 2024 [Figure 13.21].
  - Employers with 1,000 or more workers are more likely than smaller firms to cover gender affirming hormone therapy (35% v. 21%).
  - Substantial shares of firms did not know whether or not these services covered (45%) [Figure 13.21].

Figure 13.21
Percentage of Firms Whose Largest Plan Covers Gender Affirming Hormone Therapy, by Firm Size, 2024



* 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. Firms with multiple plans were asked about their plan with the largest enrollment.
SOURCE: KFF Employer Health Benefits Survey, 2024

ABORTION SERVICES

In June 2022, the Supreme Court of the United States issued the *Dobbs v. Jackson* decision, overturning Roe v. Wade, eliminating the federal constitutional right to abortion in the United States, and allowing states to set their own policies protecting or banning abortion [1]. This ruling and subsequent state activity to limit access to abortion services has increased public interest in coverage for abortion services in employer plans.

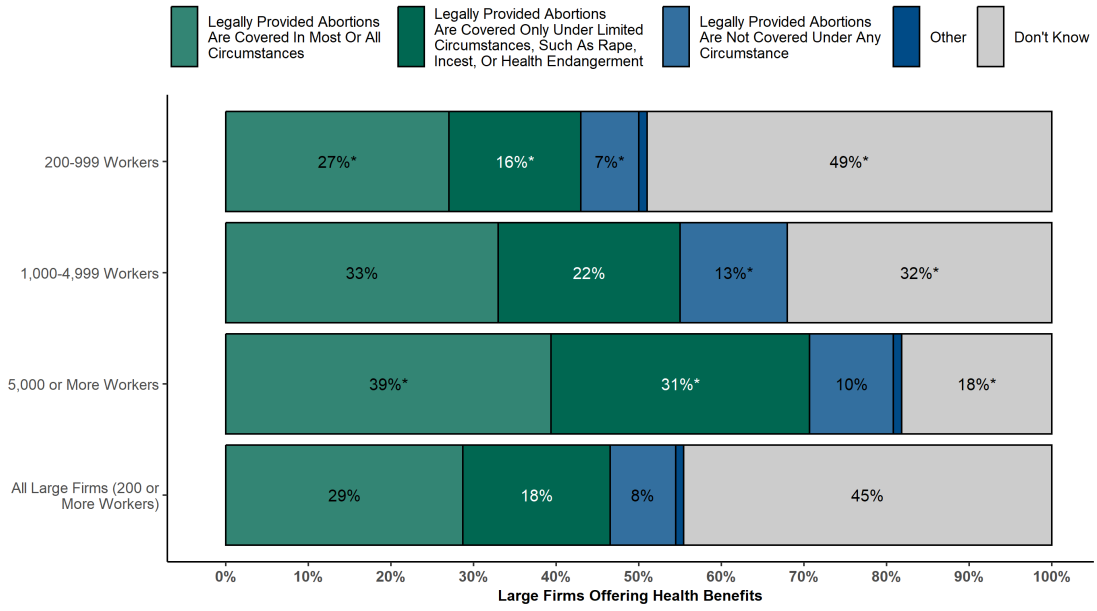
- Firms with 200 or more workers that offer health benefits were asked which of several statements best describes coverage of abortion in their health plan with the largest enrollment.
  - Twenty-nine percent of these firms said that legally provided abortions are covered in most or all circumstances (sometimes referred to as elective or voluntary abortion). Firms with 5,000 or more workers were more likely than smaller firms to give this reply while firms with 200 to 999 workers were less likely to do so [Figure 13.22].

[1] KFF. 10 Things to Know About Abortion Access Since the Dobbs Decision [Internet]. San Francisco (CA): KFF; 2024 [cited 2024 September 20]. Available from: https://www.kff.org/policy-watch/10-things-to-know-about-abortion-access-since-the-dobbs-decision/.

- Eighteen percent of these firms said that legally provided abortions are covered only under limited circumstances, such as rape, incest, or danger to the health or life of the pregnant enrollee. Firms with 5,000 or more workers were more likely than smaller firms to give this reply while firms with 200 to 999 workers were less likely to do so [Figure 13.22].
- Eight percent of these firms said that legally provided abortions are not covered under any circumstance [Figure 13.22]. Firms reporting that legally provided abortions are not covered were asked to confirm that their largest plan would not cover abortion under any circumstance, even in states where abortion was legal. In total, 81% verified this was their policy.
- Forty-five percent of these responding firms answered "don't know" to this question. Firms with 200 to 999 workers were more likely than other firms to answer "don't know" to this question and firms with 5,000 or more workers were less likely to do so [Figure 13.22].

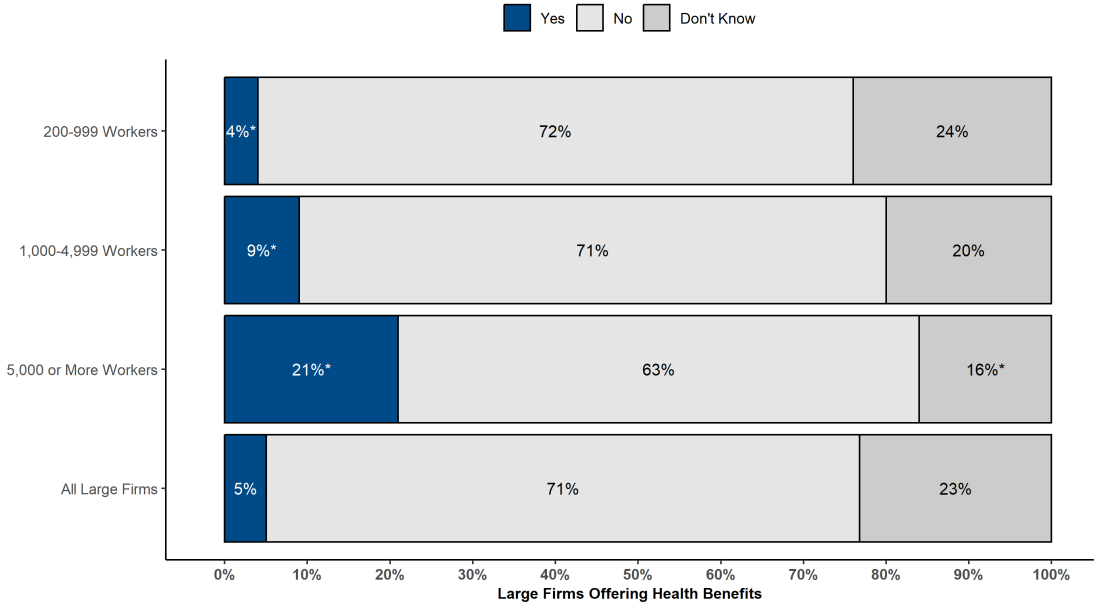
- Among firms with 200 or more workers that offer health benefits, 5% provide, or plan to provide, financial assistance for travel expenses for enrollees who travel out of state to obtain abortion care if they do not have access near their home. This share is similar to last year. Firms with 5,000 or more workers are more likely than smaller firms to say they provide or plan to provide travel benefits for enrollees who travel out of state to obtain an abortion (21% vs. 5%) [Figure 13.23].

Figure 13.22
Percentage of Firms Whose Largest Plan Covers Legally Provided Abortion, by Firm Size, 2024



* 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. Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2024

Figure 13.23
Percentage of Firms That Provide, or Plan to Provide, Financial Assistance for Travel Expenses for Enrollees Who Travel Out of State to Obtain an Abortion, by Firm Size, 2024



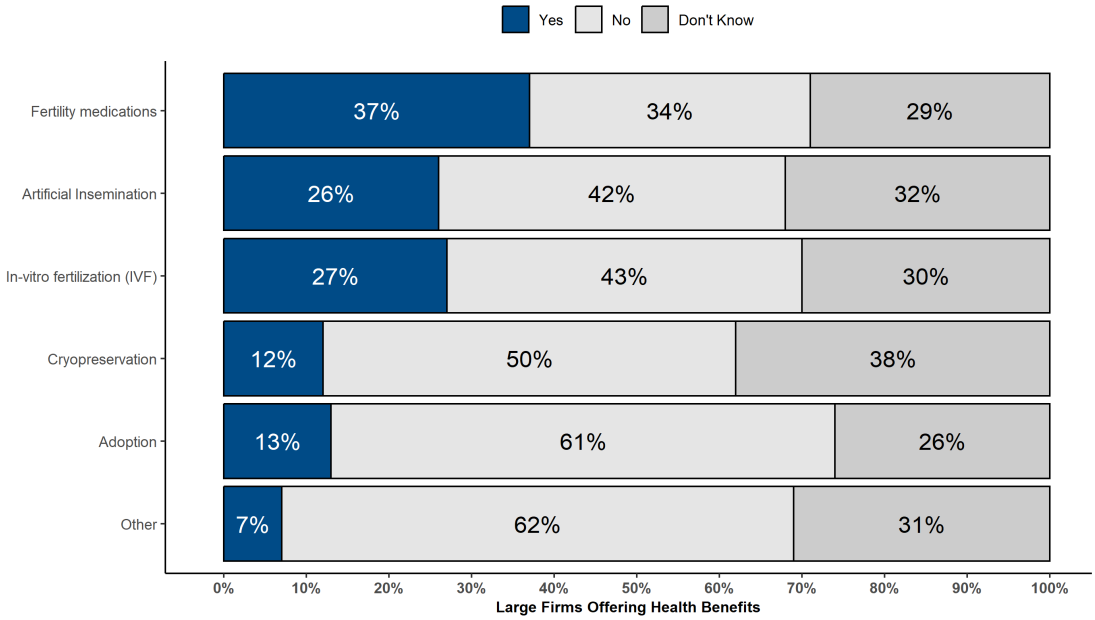
* Estimates are statistically different from estimate for all other firms not in the indicated category within each firm size ($p < .05$).
NOTE: Firms with multiple plans were asked about their plan with the largest enrollment. Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2024

COVERAGE FOR FAMILY BUILDING SERVICES

Employers were asked if they provide any coverage for certain family-building services in their plan with the largest enrollment or through a third-party vendor. Even if employers responded yes to these questions, we don't know what percentage of these services they cover. Out-of-pocket costs for family building services, even with some amount of coverage, can still be very expensive.

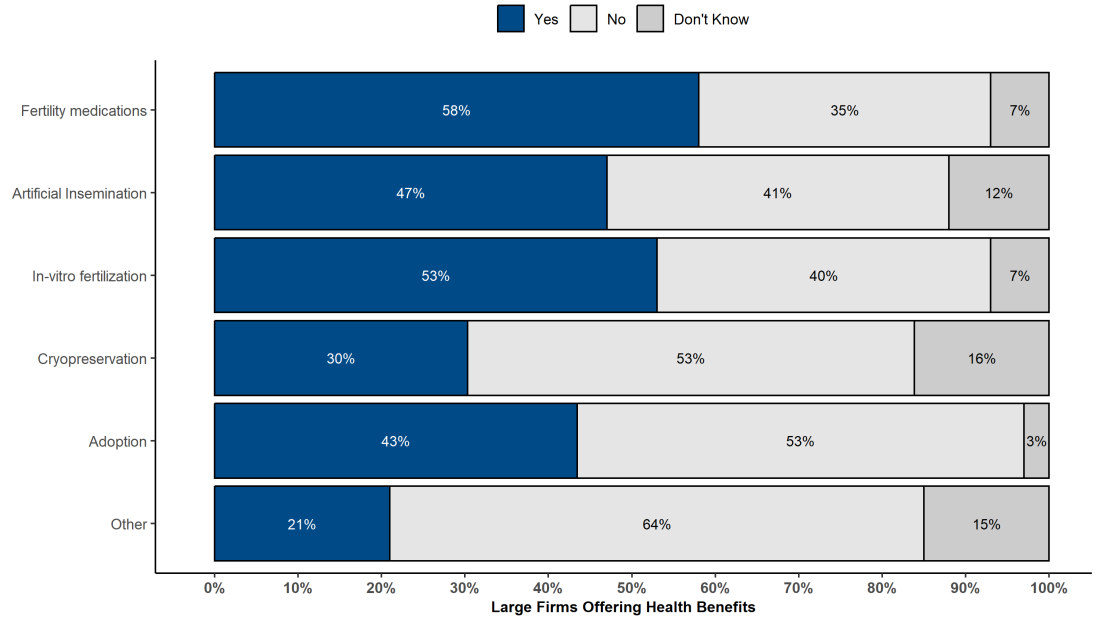
- Among firms with 200 or more workers that offer health benefits,
  - 37% have coverage for fertility medications [Figure 13.24].
  - 26% have coverage for intrauterine insemination [Figure 13.24].
  - 27% have coverage for in-vitro fertilization [Figure 13.24].
  - 12% have coverage for cryopreservation, sometimes called egg or sperm freezing [Figure 13.24].
  - 13% have coverage for adoption services [Figure 13.24].
  - 7% have coverage for other family-building services [Figure 13.24].
- For each of these services, the share that did not know whether the service is covered decreased with firm size category, with firms with 200 to 999 workers having fairly high rates of "do not know".

Figure 13.24
Percentage of Firms Which Cover Family Building Benefits, 2024



NOTE: Firms with multiple plans were asked about their plan with the largest enrollment. Large Firms have 200 or more workers. We asked about coverage offered either through the plan or through a third-party vendor.
SOURCE: KFF Employer Health Benefits Survey, 2024

Figure 13.25
Percentage of Larger Firms Which Cover Family Building Benefits, 2024



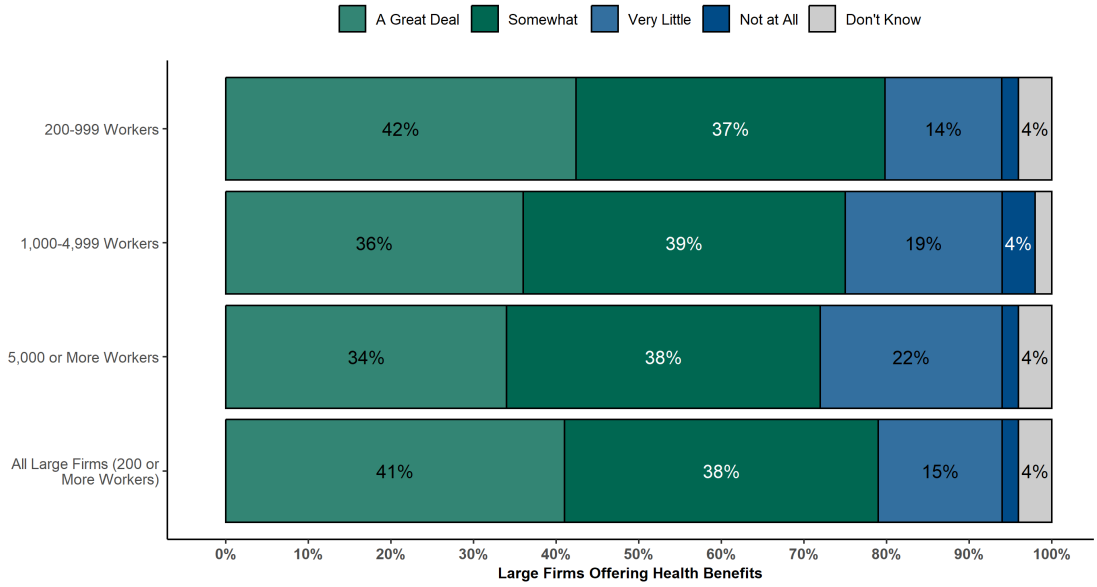
NOTE: Firms with multiple plans were asked about their plan with the largest enrollment. Larger Firms have 5,000 or more workers. We asked about coverage offered either through the plan or through a third-party vendor. IVF refers to In-vitro fertilization.
SOURCE: KFF Employer Health Benefits Survey, 2024

PRICE AND COST SHARING INFORMATION FOR ENROLLEES

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

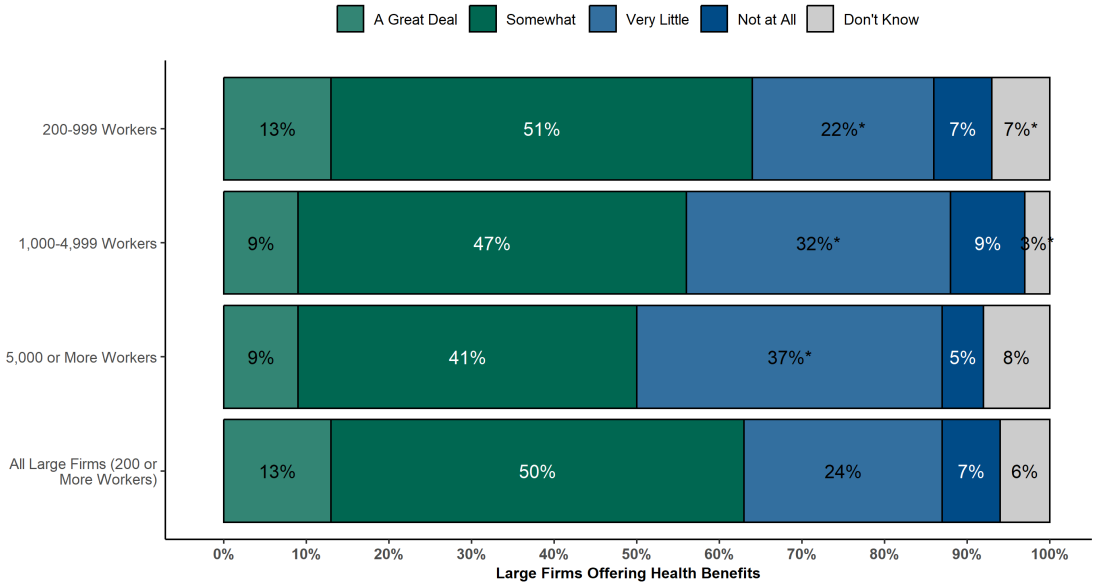
- Among firms with 200 or more workers that offer health benefits, 41% say that providing employees with additional information about the cost of services will help their health care decision making "a great deal", 38% say that it will help their decision making "somewhat", 15% say that it will help their decision making "very little", and 2% say that it will help their decision making "not at all" [Figure 13.26].
- Among firms with 200 or more workers that offer health benefits, 13% say that the new requirements will reduce health spending "a great deal", 50% say that the new requirements will reduce health spending "somewhat", 24% say that the new requirements will reduce health spending "very little", 7% say that the new requirements will reduce health spending "not at all". [Figure 13.27].

Figure 13.26
Firms View on The Impact of Providing Employees With Additional Information About The Cost of Services Will Have on Health Care Decision Making, by Firm Size, 2024



* Estimates are statistically different from estimate for all other firms not in the indicated category within each firm size ($p < .05$).
NOTE: Federal policy now requires that health plans make available the price of services at different providers as well as cost-sharing estimates for enrollees, in real-time. Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2024

Figure 13.27
Firms' View of How Much Transparency Rules Will Reduce Healthcare Spending, by Firm Size, 2024



* Estimates are statistically different from estimate for all other firms not in the indicated category within each firm size ($p < .05$).
NOTE: Federal policy now requires that health plans make available the price of services at different providers as well as cost-sharing estimates for enrollees, in real-time. Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2024

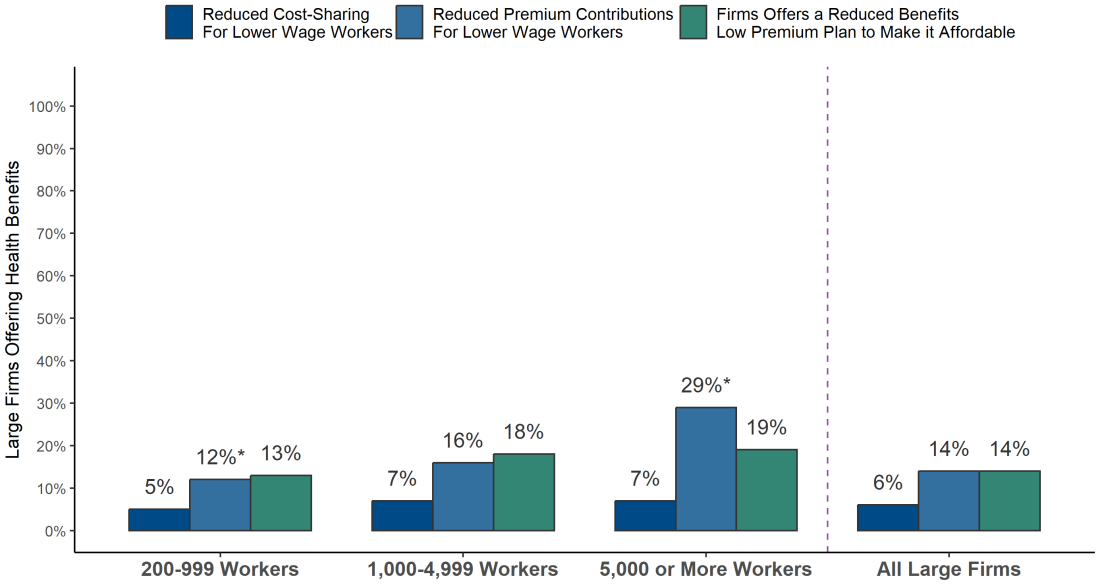
ASSISTANCE FOR LOWER-WAGE WORKERS

Some firms have programs to improve the affordability of premium contributions and cost-sharing for their lower-wage workers.

- Among firms with 200 or more workers offering health benefits, 6% have a program that reduces cost sharing for lower-wage workers [Figure 13.28].
- Among firms with 200 or more workers offering health benefits, 14% have a program that reduces premium contributions for lower-wage workers [Figure 13.28].
  - Employers with 5,000 or more workers are relatively more likely to have a program that reduces premium contributions for lower-wage workers while employers with 200 to 999 employees are relatively less likely to have such a program [Figure 13.28].
- Among firms with 200 or more workers offering health benefits, 14% offer a plan with reduced benefits and a low premium contribution to make it affordable for lower-wage workers [Figure 13.28].

Figure 13.28

Percentage of Firms Which Have Programs to Help Lower Wage Workers Pay for Health Expenses, by Firm Size, 2024



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

NOTE: Programs to lower cost sharing may include lower deductibles or copayments for eligible workers/ Program to lower premium contributions may include basing contributions on an employee's income.Large Firms have 200 or more workers.

SOURCE: KFF Employer Health Benefits Survey, 2024

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