

Employer Health Benefits

2015 Summary of Findings

Employer-sponsored insurance covers over half of the non-elderly population, 147 million people in total.¹ To provide current information about employer-sponsored health benefits, the Kaiser Family Foundation (Kaiser) and the Health Research & Educational Trust (HRET) conduct an annual survey of private and nonfederal public employers with three or more workers. This is the seventeenth Kaiser/HRET survey and reflects employer-sponsored health benefits in 2015.

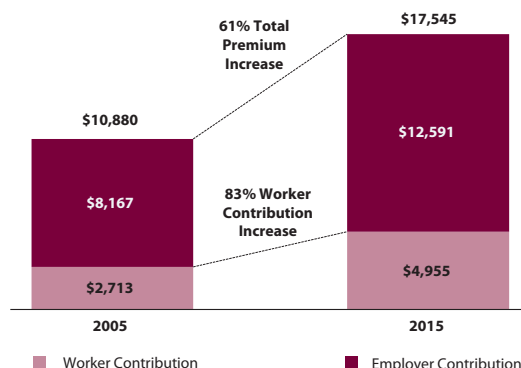
The key findings from the survey, conducted from January through June 2015, include a modest increase (4%) in the average premiums for both single and family coverage in the past year. The average annual single coverage premium is \$6,251 and the average family coverage premium is \$17,545. The percentage of firms that offer health benefits to at least some of their employees (57%) and the percentage of workers covered at those firms (63%) are statistically unchanged from 2014. Relatively small percentages of employers with 50 or more full-time equivalent employees reported switching full-time employees to part time status (4%), changing part-time workers to full-time workers (10%), reducing the number of full-time employees they intended to hire (5%) or increasing waiting periods (2%) in response to the employer shared responsibility provision which took effect for some firms this year. Employers continue to be interested in programs addressing the health and behaviors of their employees, such as health risk assessments, biometric screenings, and health promotion and wellness programs. Meaningful numbers of employers which offer one of these screening programs now offer incentives to employees who complete them; 31% of large firms offering health benefits provide an incentive to complete a health risk assessment and 28% provide an incentive to complete a biometric screening. A majority of large employers (200 or more workers) (53%) have analyzed their health benefits to see if they would be subject to the high-cost plan tax when it takes effect in 2018, with some already making changes to their benefit plans in response to the tax.

HEALTH INSURANCE PREMIUMS AND WORKER CONTRIBUTIONS

In 2015, the average annual premiums for employer-sponsored health insurance are \$6,251 for single coverage and \$17,545

EXHIBIT A

Exhibit A: Average Annual Health Insurance Premiums and Worker Contributions for Family Coverage, 2005–2015



SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2005–2015.

for family coverage (Exhibit A). Each rose 4% over the 2014 average premiums. During the same period, workers' wages increased 1.9% and inflation declined by 0.2%.² Premiums for family coverage increased 27% during the last five years, the same rate they grew between 2005 and 2010 but significantly less than they did between 2000 to 2005 (69%) (Exhibit B).

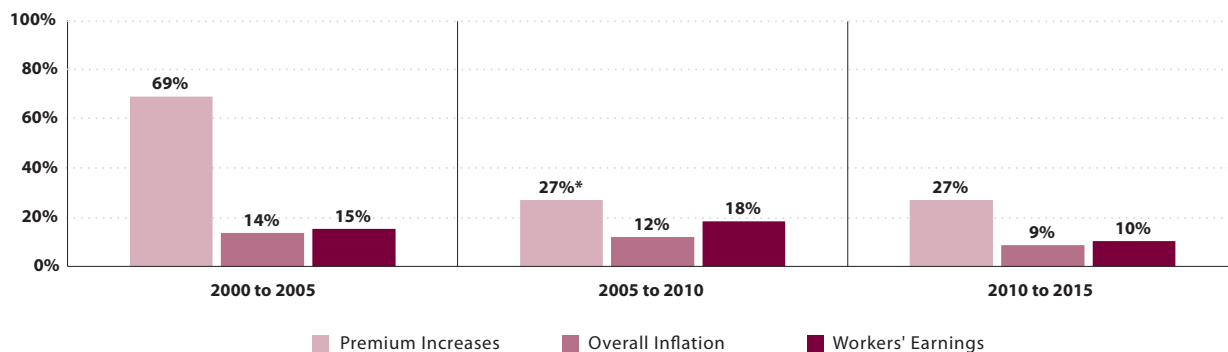
Average premiums for high-deductible health plans with a savings option (HDHP/SOs) are lower than the overall average for all plan types for both single and family coverage (Exhibit C), at \$5,567 and \$15,970, respectively. The average premium for family coverage is lower for covered workers in small firms (3-199 workers) than for workers in large firms (200 or more workers) (\$16,625 vs. \$17,938).

As a result of differences in benefits, cost sharing, covered populations, and geographical location, premiums vary significantly around the averages for both single and family coverage. Eighteen percent of covered workers are in plans with an annual total premium for family coverage of at least \$21,054 (120% or more of the average family premium), and

22% of covered workers are in plans where the family premium is less than \$14,036 (less than 80% of the average family premium). The distribution is similar around the average for single coverage premiums (Exhibit D).

Employers generally require that workers make a contribution towards the cost of the premium. Covered workers contribute on average 18% of the premium for single coverage and 29% of the premium for family coverage, the same percentages as 2014 and statistically similar to those reported in 2010. Workers in small firms contribute a lower average percentage for single coverage compared to workers in large firms (15% vs. 19%), but they contribute a higher average percentage for family coverage (36% vs. 26%). Workers in firms with a higher percentage of lower-wage workers (at least 35% of workers earn \$23,000 a year or less) contribute higher percentages of the premium for family coverage (41% vs. 28%) than workers in firms with a smaller share of lower-wage workers.

As with total premiums, the share of the premium contributed by workers varies considerably. For single coverage, 61% of

EXHIBIT B**Average Premium Increases for Covered Workers with Family Coverage, 2000-2015**

* Premium change is statistically different from previous period shown ($p < .05$).

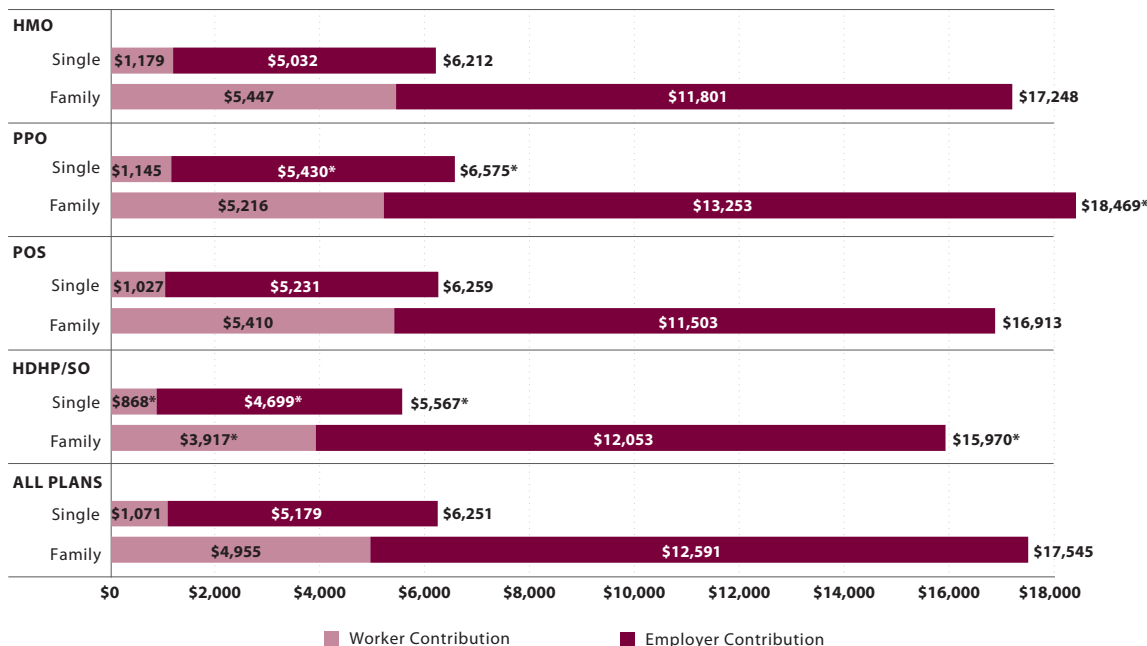
SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2000-2015; Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to April), 2000-2015; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 2000-2015 (April to April).

covered workers are in plans that require them to make a contribution of less than or equal to a quarter of the total premium, 2% are in plans that require more than half of the premium, and 16% are in plans that require no contribution at all. For family coverage, 44% of covered workers are in plans that require them to make a contribution of less than or equal to a quarter of the total premium and 15% are in plans that require more than half of the premium, while only 6% are in plans that require no contribution at all (Exhibit E).

Employers use different strategies to structure their employer contributions; 45% of small employers offering health benefits indicated that they contribute the same dollar amount for family coverage as single coverage, 34% contributed a larger dollar amount for family than single coverage, and 18% used some other approach.

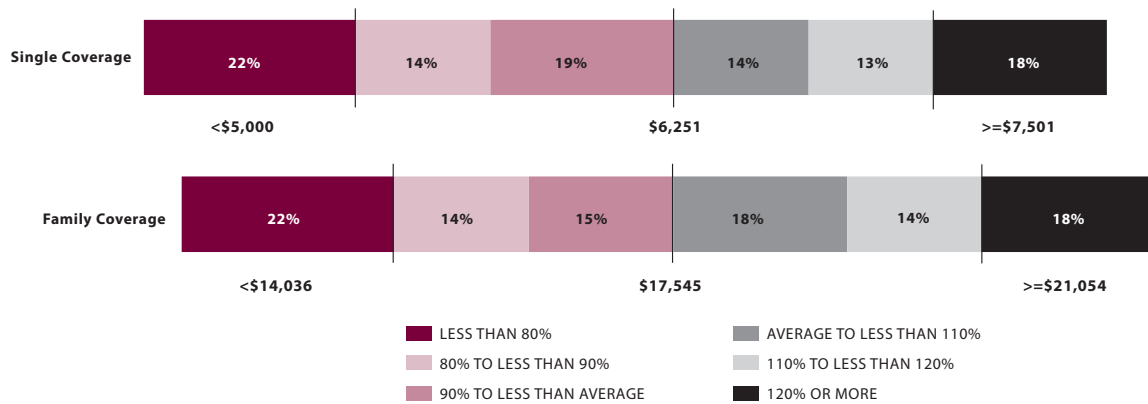
Looking at the dollar amounts that workers contribute, the average annual premium contributions in 2015 are

\$1,071 for single coverage and \$4,955 for family coverage. Covered workers' average dollar contribution to family coverage has increased 83% since 2005 and 24% since 2010 (Exhibit A). Workers in small firms have lower average contributions for single coverage than workers in large firms (\$899 vs. \$1,146), but higher average contributions for family coverage (\$5,904 vs. \$4,549). Workers in firms with a higher percentage of lower-wage workers have higher average contributions for family coverage (\$6,382 vs. \$4,829) than workers

EXHIBIT C**Average Annual Firm and Worker Premium Contributions and Total Premiums for Covered Workers for Single and Family Coverage, by Plan Type, 2015**

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

SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2015.

EXHIBIT D**Distribution of Annual Premiums for Single and Family Coverage Relative to the Average Annual Single or Family Premium, 2015**

NOTE: The average annual premium is \$6,251 for single coverage and \$17,545 for family coverage. The premium distribution is relative to the average single or family premium. For example, \$5,000 is 80% of the average single premium, \$5,625 is 90% of the average single premium, \$6,876 is 110% of the average single premium, and \$7,501 is 120% of the average single premium. The same break points relative to the average are used for the distribution for family coverage.

SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2015.

in firms with lower percentages of lower-wage workers.

PLAN ENROLLMENT

PPO plans remain the most common plan type, enrolling 52% of covered workers in 2015, although a smaller percentage than 2014. Twenty-four percent of covered workers are enrolled in a high-deductible plan with a savings options (HDHP/SO), 14% in an HMO, 10% in a POS plan, and 1% in a conventional (also known as an indemnity) plan (Exhibit F). Enrollment distribution varies by firm size; for example, PPOs are relatively more

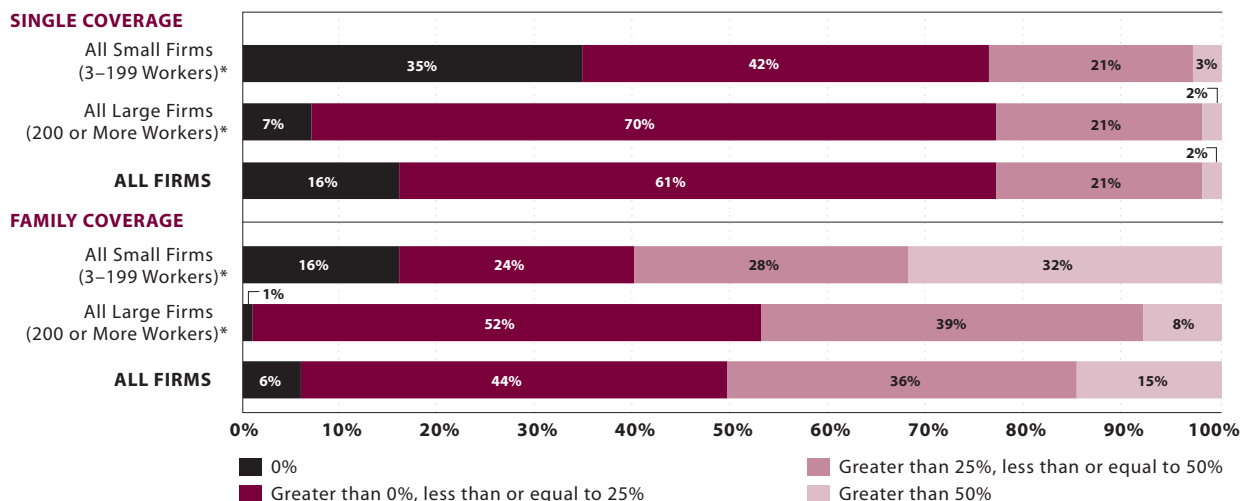
popular for covered workers at large firms than small firms (56% vs. 41%) and POS plans are relatively more popular among small firms than large firms (19% vs. 6%).

Almost a quarter (24%) of covered workers are enrolled in HDHP/SOs in 2015; enrollment in these plans has increased over time from 13% of covered workers in 2010. In 2015, 7% of firms offering health benefits offered a high-deductible health plan with a health reimbursement arrangement (HDHP/HRA), and 20% offered a health savings (HSA) qualified HDHP.

EMPLOYEE COST SHARING

Most covered workers face additional out-of-pocket costs when they use health care services. Eighty-one percent of covered workers have a general annual deductible for single coverage that must be met before most services are paid for by the plan. Even workers without a general annual deductible often face other types of cost sharing when they use services, such as copayments or coinsurance for office visits and hospitalizations.

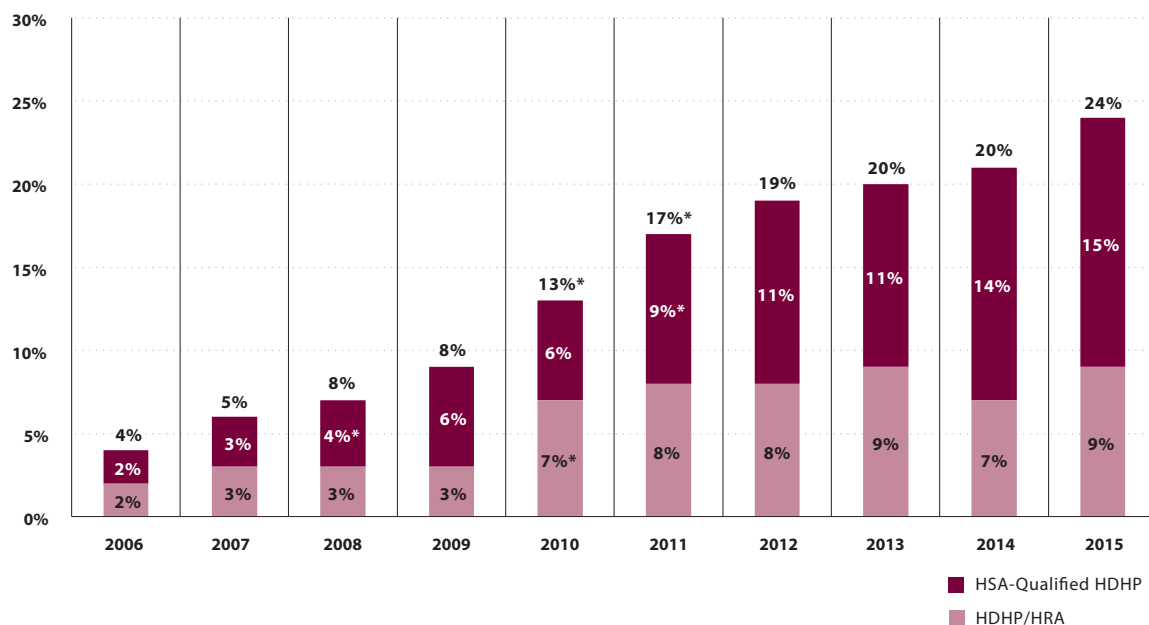
Among covered workers with a general annual deductible, the average deductible

EXHIBIT E**Distribution of Percentage of Premium Paid by Covered Workers for Single and Family Coverage, by Firm Size, 2015**

SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2015.

EXHIBIT F

Percentage of Covered Workers Enrolled in an HDHP/HRA or HSA-Qualified HDHP, 2006-2015



*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. For more information see the Survey Methodology Section. The percentages of covered workers enrolled in an HDHP/SO may not equal the sum of HDHP/HRA and HSA-Qualified HDHP enrollment estimates due to rounding.

SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006-2015.

amount for single coverage is \$1,318. The average annual deductible is similar to last year (\$1,217), but has increased from \$917 in 2010. Deductibles differ by firm size; for workers in plans with a deductible, the average deductible for single coverage is \$1,836 in small firms, compared to \$1,105 for workers in large firms. Sixty-three percent of covered workers in small firms are in a plan with a deductible of at least \$1,000 for single coverage compared to 39% in large firms; a similar pattern exists for those in plans with a deductible of at least \$2,000 (36% for small firms vs. 12% for large firms) (Exhibit G).

Looking at the increase in deductible amounts over time does not capture the full impact for workers because the share of covered workers in plans with a general annual deductible also has increased significantly, from 55% in 2006 to 70% in 2010 to 81% in 2015. If we look at the change in deductible amounts for all covered workers (assigning a zero value to workers in plans with no deductible), we can look at the impact of both trends together. Using this approach, the average deductible for all covered workers in 2015 is \$1,077, up 67% from \$646 in 2010 and 255% from \$303 in 2006.

A large majority of workers also have to pay a portion of the cost of physician office visits. Almost 68% of covered workers pay a copayment (a fixed dollar amount) for office visits with a primary care or specialist physician, in addition to any general annual deductible their plan may have. Smaller shares of workers pay coinsurance (a percentage of the covered amount) for primary care office visits (23%) or specialty care visits (24%). For in-network office visits, covered workers with a copayment pay an average of \$24 for primary care and \$37 for specialty care. For covered workers with coinsurance, the average coinsurance for office visits is 18% for primary and 19% for specialty care. While the survey collects information only on in-network cost sharing, it is generally understood that out-of-network cost sharing is higher.

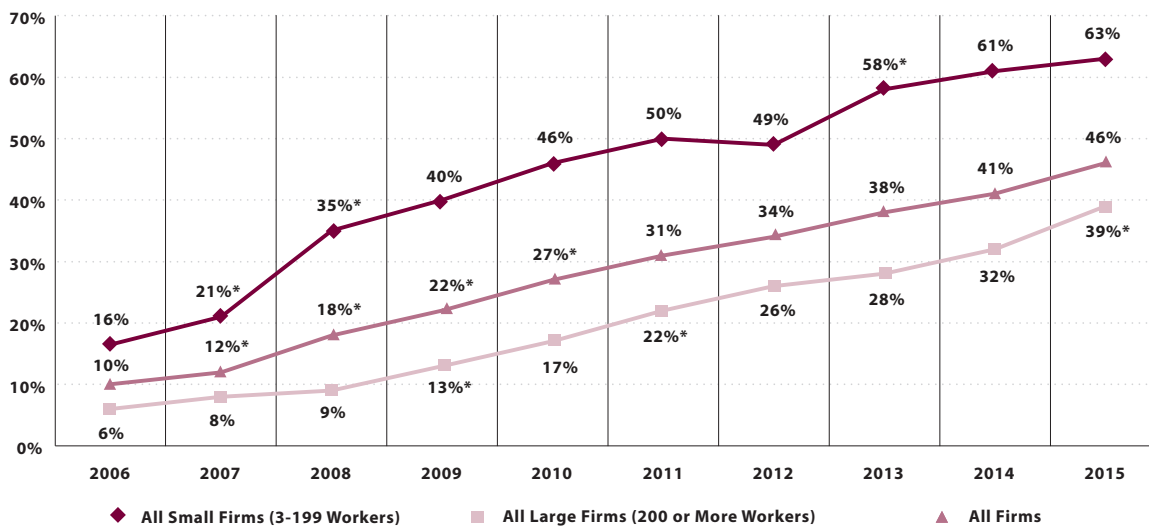
Virtually all (99%) of covered workers are enrolled in a plan that covers some prescription drugs. Cost sharing for filling a prescription usually varies with the type of drug – for example, whether it is a generic, brand-name, or specialty drug – and whether the drug is considered preferred or not on the plan's formulary. These factors result in each drug being assigned to a tier that represents a

different level, or type, of cost sharing. Eighty-one percent of covered workers are in plans with three or more tiers of cost sharing. Twenty-three percent of covered workers are enrolled in a plan with four or more cost sharing tiers compared to 13% in 2010. Copayments are the most common form of cost sharing for tiers one through three. Among workers with plans with three or more tiers, the average copayments in these plans are \$11 for first tier drugs, \$31 for second tier drugs, \$54 for third tier drugs, and \$93 for fourth tier drugs. HDHP/SOs have a somewhat different cost sharing pattern for prescription drugs than other plan types; just 61% of covered workers are enrolled in a plan with three or more tiers of cost sharing, 12% are in plans that pay the full cost of prescriptions once the plan deductible is met, and 22% are in a plan with the same cost sharing for all prescription drugs.

Most covered workers with drug coverage are enrolled in a plan which covers specialty drugs such as biologics (94%). Large employers have used a variety of strategies for containing the cost of specialty drugs including utilization management programs (31%), step therapies where enrollees must first try

EXHIBIT G

Percentage of Covered Workers Enrolled in a Plan with a General Annual Deductible of \$1,000 or More for Single Coverage, By Firm Size, 2006-2015



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

NOTE: These estimates include workers enrolled in HDHP/SO and other plan types. Average general annual health plan deductibles for PPOs, POS plans, and HDHP/SOs are for in-network services.

SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006-2015.

alternatives (30%) and tight limits on the number of units administered at a single time (25%).

Twelve percent of covered workers enrolled in a plan with prescription drug coverage are enrolled in a plan with a separate annual drug deductible that applies only to prescription drugs. Among these workers, the average separate annual deductible for prescription drug coverage is \$231. Five percent of covered workers are enrolled in a plan with an annual deductible for prescription drug coverage of \$500 or more.

Most workers also face additional cost sharing for a hospital admission or an outpatient surgery episode. After any general annual deductible is met, 65% of covered workers have a coinsurance and 14% have a copayment for hospital admissions. Lower percentages have per day (per diem) payments (4%), a separate hospital deductible (2%), or both copayments and coinsurance (11%). The average coinsurance rate for hospital admissions is 19%. The average copayment is \$308 per hospital admission, the average per diem charge is \$281, and the average separate annual hospital deductible is \$1,006. The cost sharing provisions for outpatient surgery are similar to those for hospital

admissions, as most covered workers have either coinsurance (67%) or copayments (15%). For covered workers with cost sharing, for each outpatient surgery episode, the average coinsurance is 19% and the average copayment is \$181.

Almost all (98%) of covered workers are in plans with an out-of-pocket maximum for single coverage, significantly more than the 88% in 2013. While almost all workers have an out-of-pocket limit, the actual dollar limits differ considerably. For example, among covered workers in plans that have an out-of-pocket maximum for single coverage, 13% are in plans with an annual out-of-pocket maximum of \$6,000 or more, and 9% are in plans with an out-of-pocket maximum of less than \$1,500.

AVAILABILITY OF EMPLOYER-SPONSORED COVERAGE

Fifty-seven percent of firms offer health benefits to their workers, statistically unchanged from 55% last year and 60% in 2005 (Exhibit H). The likelihood of offering health benefits differs significantly by size of firm, with only 47% of employers with 3 to 9 workers offering coverage, but virtually all employers with 1,000 or more workers offering coverage to at least some of their employees. Ninety percent of workers are in a firm that offers health benefits to at least some of its

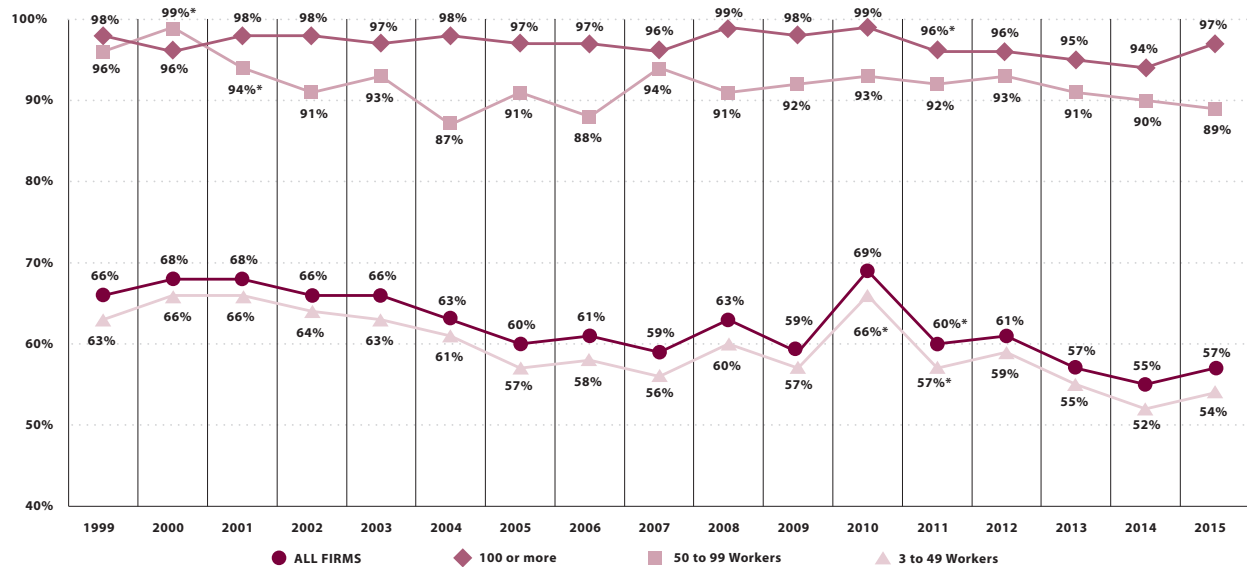
employees, similar to 2014 (90%).

Even in firms that offer health benefits, not all workers are covered. Some workers are not eligible to enroll as a result of waiting periods or minimum work-hour rules. Other workers do not enroll in coverage offered to them because of the cost of coverage or because they are covered through a spouse. Among firms that offer coverage, an average of 79% of workers are eligible for the health benefits offered by their employer. Of those eligible, 79% take up their employer's coverage, resulting in 63% of workers in offering firms having coverage through their employer. Among both firms that offer and those that do not offer health benefits, 56% of workers are covered by health plans offered by their employer, similar to 2014 (55%).

Beginning in 2015, employers with at least 100 full-time equivalent employees (FTEs) must offer health benefits to their full-time workers that meet minimum standards for value and affordability or pay a penalty. The requirement applies to employers with 50 or more FTEs beginning in 2016. Of firms reporting at least 100 FTEs (or, if they did not know FTEs, of firms with at least 100 employees), 96% report that they offer one health plan that would meet these

EXHIBIT H

Percentage of Firms Offering Health Benefits, by Firm Size, 1999-2015



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

NOTE: Estimates presented in this exhibit are based on the sample of both firms that completed the entire survey and those that answered just one question. For more information see the Survey Methods Section.

SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2015.

requirements, two percent did not and three percent reported “don’t know.” Five percent of these firms reported that this year they offered more comprehensive benefits to some workers who previously were only offered a limited benefit plan. Twenty-one percent reported that they extended eligibility to groups of workers not previously eligible because of the employer shared responsibility provision.

We asked firms reporting 50 or more FTEs (or, if they did not know how many FTEs, firms with at least 50 employees) about changes to their workforce in response to the employer requirement. Four percent reported that they changed some job classifications from full-time to part-time so employees would not be eligible for health benefits while 10% reported changing some job classifications from part-time to full-time so that they would become eligible. Four percent also reported reducing the number of full-time employees that they intended to hire because of the cost of health benefits.

RETIREE COVERAGE

Twenty-three percent of large firms that offer health benefits in 2015 also offer retiree health benefits, similar to the percentage in 2014 (25%). Among large firms that offer retiree health benefits,

92% offer health benefits to early retirees (workers retiring before age 65), 73% offer health benefits to Medicare-age retirees, and 2% offer a plan that covers only prescription drugs. Employers offering retiree benefits report interest in new ways of delivering them. Among large firms offering retiree benefits, seven percent offer them through a private exchange and 26% are considering changing the way they offer retiree coverage because of the new health insurance exchanges established by the ACA.

WELLNESS, HEALTH RISK ASSESSMENTS AND BIOMETRIC SCREENINGS

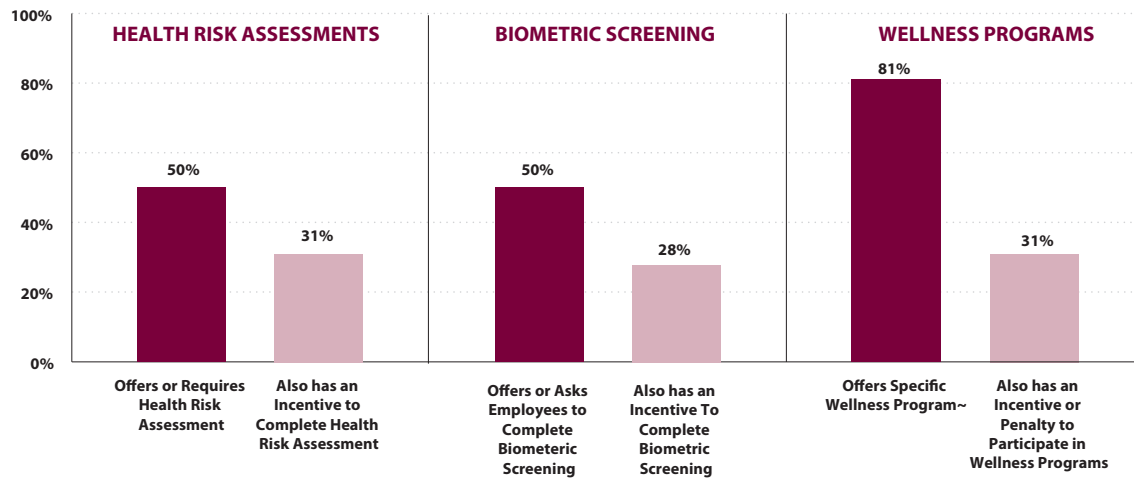
Health Risk Assessment. Employers continue to offer programs that encourage employees to identify health issues and to manage chronic conditions. A majority of larger employers now offer health screening programs including health risk assessments, which are questionnaires asking employees about lifestyle, stress or physical health, and in-person examinations such as biometric screenings. Some employers have incentive programs that reward or penalize employees for a range of activities including participating in wellness programs or meeting biometric outcomes.

Fifty percent of large employers offering health benefits provide employees with an opportunity or require employees to complete a health risk assessment. A health risk assessment includes questions about medical history, health status, and lifestyle, and is designed to identify the health risks of the person being assessed. Large firms are more likely than small firms to offer an opportunity or require employees to complete a health risk assessment (50% vs. 18%). Among firms with a health risk assessment, 62% of large firms report that they provide incentives to employees that complete the assessment. There is significant variation in the percentage of employees that complete a health risk assessment among firms; 27% of large firms with a health risk assessment report that more than three-quarters of employees complete the screening while 41% report that a quarter or less complete it.

Biometric Screening. Fifty percent of large firms and 13% of small firms offering health benefits ask or offer employee the opportunity to complete a biometric screening. Biometric screening is a health examination that measures an employee’s risk factors such as body weight, cholesterol, blood pressure, stress, and nutrition. Among large firms

EXHIBIT I

Among Large Firms (200 or more workers) Offering Health Benefits, Percentage of Firms Offering Incentives for Various Wellness and Health Promotion Activities, 2015



~ Firms which offer either "Programs to Help Employees Stop Smoking", "Programs to Help Employees Lose Weight", or "Other Lifestyle or Behavioral Coaching"

SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2015.

with biometric screening programs, 56% offer employees incentives to complete a biometric screening. Among firms with a biometric screening program and an incentive to complete it, 20% have a reward or penalty for meeting specified biometric outcomes such as achieving a target body mass index (BMI) or cholesterol level. The maximum financial value for meeting biometric outcomes ranges considerably across these firms: 16% have a maximum annual incentive of \$150 or less and 28% have a maximum annual incentive of more than \$1,000.

Wellness Programs. Many employers offer wellness or health promotion programs to improve their employees' health. Eighty-

one percent of large employers and 49% of small employers offer employees programs to help them stop smoking, lose weight, or make other lifestyle or behavioral changes. Of firms offering health benefits and a wellness program, 38% of large firms and 15% of small firms offer employees a financial incentive to participate in or complete a wellness program. Among large firms with an incentive to participate in or complete a wellness program, 27% believe that incentives are "very effective" at encouraging employees to participate (Exhibit I).

Disease management programs. Disease management programs try to improve the health and reduce the costs for enrollees

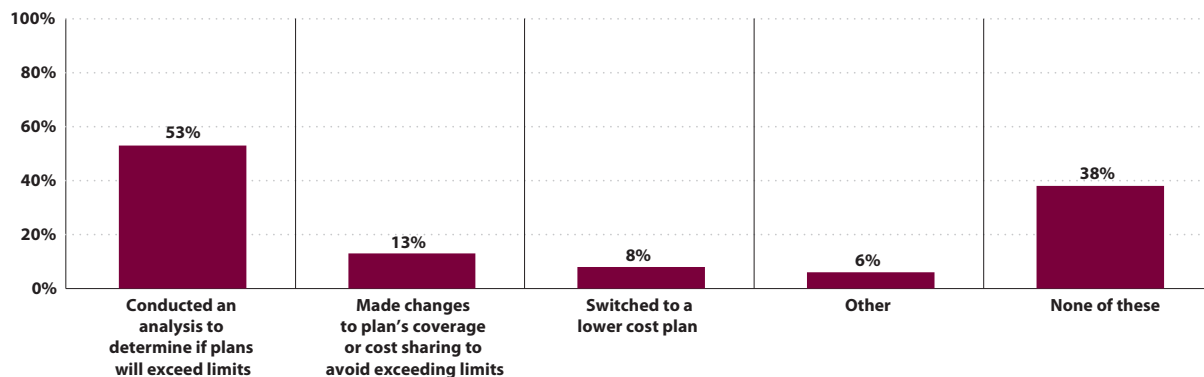
with chronic conditions. Thirty-two percent of small employers and 68% of large employers offer disease management programs. Among firms with disease management programs, eight percent of large firms and 24% of firms with 5,000 or more workers offer a financial incentive to employees who participate.

PROVIDER NETWORKS**High Performance or Tiered Networks.**

Seventeen percent of employers offering health benefits have high performance or tiered networks in their largest health plan. These programs identify providers that are more efficient or have higher quality care, and may provide financial or other

EXHIBIT J

Among Large Firms (200 or more Workers) Offering Health Benefits, Percentage of Firms Who Have Taken Various Actions in Anticipation of the Excise Tax on High Cost Plans, by Firm Size, 2015



SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2015.

incentives for enrollees to use the selected providers. Firms with 1,000–4,999 workers employees are more likely to have a largest plan that includes a high performance or tiered network (33%) than firms in other size categories.

Narrow Networks. Some employers limit their provider networks to reduce the cost of the plan. Nine percent of employers reported that their plan eliminated hospitals or a health system to reduce cost and seven percent offer a plan considered a narrow network plan. These plans typically have a provider network more limited than the standard HMO network.

Telemedicine. Telemedicine includes exchanging health information electronically, including through smart phones or webcasts in order to improve a patient's health. The largest health plan at 27% of large firms (200 or more workers) offering health benefits covers telemedicine.

OTHER TOPICS

Pre-Tax Premium Contributions. Thirty-seven percent of small firms and 90% of large firms have a plan under section 125 of the Internal Revenue Service Code (sometimes called a premium-only plan) to allow employees to use pre-tax dollars to pay for a share of health insurance premiums.

Flexible Spending Accounts. Seventeen percent of small firms and 74% of large firms offer employees the option of contributing to a flexible spending account (FSA). FSAs permit employees to make pre-tax contributions that may be used during the year to pay for eligible medical expenses. The Affordable Care Act put some additional limits on FSAs, including capping the amount that could be contributed in a year (\$2,550 in 2015) and limits on the use of FSA dollars for non-prescribed over the counter medications and premiums.³ Three percent of firms not offering health benefits offered an FSA in 2015.

Waiting Periods and Enrollment. With exceptions for orientation periods and variable hour employees, the ACA limits waiting periods to no more than 90 days for all group health plans.⁴ The average waiting period for covered workers who face a waiting period decreased from 2.1 months in 2014 to 2 months in 2015. The provision of the Affordable Care Act

requiring employers with 200 or more full-time employees to automatically enroll eligible new full-time employees in one of the firm's health plans after any waiting period has not yet taken effect. In 2015, 13% of large employers (200 or more workers) and 42% of small employers automatically enroll eligible employees.

Self-Funding. Seventeen percent of covered workers at small firms and 83% of covered workers at large firms are enrolled in plans that are either partially or completely self-funded. Overall, 63% of covered workers are enrolled in a plan that is either partially or completely self-funded, 60 percent of whom are covered by additional insurance against high claims, sometimes known as stop loss coverage. The percentage of covered workers at both small and large firms in self-funded plans is similar to the percentage reported in 2010.

Private Exchanges. Private exchanges are arrangements created by consultants, brokers or insurers that allow employers to offer their employees a choice of different benefit options, often from different insurers. While these arrangements are fairly new, 17% of firms with more than 50 employees offering health benefits say they are considering offering benefits through a private exchange. Twenty-two percent of employers with 5,000 or more employees are considering this option. Enrollment to this point has been modest: 2% of covered workers in firms with more than 50 employees are enrolled in a private exchange.

Professional Employment Organization. Some firms provide for health and other benefits by entering into a co-employment relationship with a Professional Employer Organization (PEO). Under this arrangement, the firm manages the day-to-day responsibilities of employees but the PEO hires the employees and acts as the employer for insurance, benefits, and other administrative purposes. Five percent of employers offering health benefits with between three and 499 workers offer coverage through a PEO.

Grandfathered Health Plans. The ACA exempts "grandfathered" health plans from a number of its provisions, such as the requirements to cover preventive benefits without cost sharing or the new rules for small employers' premiums ratings and benefits. An employer-sponsored health

plan can be grandfathered if it covered a worker when the ACA became law (March 23, 2010) and if the plan has not made significant changes that reduce benefits or increase employee costs.⁵ Thirty-five percent of firms offering health benefits offer at least one grandfathered health plan in 2015. Twenty-five percent of covered workers are enrolled in a grandfathered health plan in 2015.

EXCISE TAX ON HIGH-COST HEALTH PLANS

Beginning in 2018, employer health plans will be subject to an excise tax of 40% on the amount by which their cost exceeds specified thresholds (\$10,200 for single coverage and \$27,000 for family coverage in 2018).⁶ The tax is calculated with respect to each employee based on the combinations of health benefits received by that employee, including the employer and employee share of health plan premiums (or premium equivalents for self-funded plans), FSA contributions, and employer contributions to health savings accounts and health reimbursement arrangement contributions. Fifty-three percent of large firms (200 or more workers) offering health benefits have conducted an analysis to determine if they will exceed the 2018 thresholds, with 19% of these firms saying that their largest health plan would exceed the 2018 threshold. A small percentage of large employers offering health benefits report that they already have made changes to their plans' coverage or cost-sharing requirements (13%) or switched to a lower cost plan (8%) in response to the anticipated tax (Exhibit J).

CONCLUSION

The continuing implementation of the ACA has brought about a number of changes for employer-based coverage, ranging from benefits changes (such as the requirement to cover certain preventive care without cost sharing or have an out-of-pocket limit) to the requirement for larger employers to offer coverage to their full-time workers or face financial penalties. Even with these new requirements, most market fundamentals have stayed consistent with prior trends, suggesting that the implementation has not caused significant disruption for most market participants. Premiums for single and family coverage increased by 4% in 2015, continuing a fairly long period (2005 to 2015) where annual premium

growth has averaged about 5%. The percentage of employers offering coverage (57%) is similar to recent years,⁷ as is the percentage of workers in offering firms covered by their own employer (63%). The offer and coverage rates have been declining very gradually since we have been doing the survey, with the current values generally below those we saw prior to 2005.

The stability we have seen over the last several years does not mean that no changes are occurring. Employers continue to focus on wellness and health promotion and extend their programs to assess health risk; here programs that collect personal health information and provide financial incentives for employees to undertake health programs or meet biometric targets have the potential to significantly alter how people with employer-based coverage interact with their health plan. Employers, particularly large employers, continue to show interest in private exchanges, although enrollment to date is not very large. If these exchanges succeed, they have the potential to move some of the decision-making about benefits away from employers, which could transform how employees and employers interact over benefits.

While the ACA has not transformed the market, changes are occurring and more are likely to come. Some employers report that they have modified job classifications in reaction to the employer requirement to offer benefits, with more reporting that they increased the number of jobs with full-time status than decreasing it. Additionally, five percent of large firms (200 or more workers) employers reported that they intend to reduce the number of full-time employees that they intend to hire because of the cost of providing health care benefits. Employers also are considering the potential impacts that the high-cost plan tax may have on their health benefits, with small percentages already taking action to lower plan costs. Over a longer period, the high-cost plan tax has the potential to cause significant changes in employer-sponsored coverage

as employers and workers look for ways to keep cost increases to inflation far below the even moderate premium increases we have seen in recent years.

Whether the period of moderate premium growth will continue as the economy improves is one the biggest questions facing the employer market. Higher costs tend to follow improvements in economic growth,⁸ and recent increases in spending for health services will put upward pressure on premiums.⁹ At the same time, concerns about the high-cost plan tax will have employers and insurers looking for savings. These competing pressures may well lead to plan changes such as tighter networks, stricter management and higher cost sharing as employers and insurers struggle to contain these higher costs.

METHODOLOGY

The Kaiser Family Foundation/Health Research & Educational Trust 2015 Annual Employer Health Benefits Survey (Kaiser/HRET) reports findings from a telephone survey of 1,997 randomly selected public and private employers with three or more workers. Researchers at the Health Research & Educational Trust, NORC at the University of Chicago, and the Kaiser Family Foundation designed and analyzed the survey. National Research, LLC conducted the fieldwork between January and June 2015. In 2015, the overall response rate is 42%, which includes firms that offer and do not offer health benefits. Among firms that offer health benefits, the survey's response rate is also 41%.

We asked all firms with which we made phone contact, even if the firm declined to participate in the survey: "Does your company offer a health insurance program as a benefit to any of your employees?" A total of 3,191 firms responded to this question (including the 1,997 who responded to the full survey and 1,194 who responded to this one question). Their responses are included in our estimates of the percentage of firms offering health coverage. The response rate

for this question is 67%.

Since firms are selected randomly, it is possible to extrapolate from the sample to national, regional, industry, and firm size estimates using statistical weights. In calculating weights, we first determine the basic weight, then apply a nonresponse adjustment, and finally apply a post-stratification adjustment. We use the U.S. Census Bureau's Statistics of U.S. Businesses as the basis for the stratification and the post-stratification adjustment for firms in the private sector, and we use the Census of Governments as the basis for post-stratification for firms in the public sector. Some numbers in the report's exhibits do not sum up to totals because of rounding effects, and, in a few cases, numbers from distribution exhibits referenced in the text may not add due to rounding effects. Unless otherwise noted, differences referred to in the text and exhibits use the 0.05 confidence level as the threshold for significance.

For more information on the survey methodology, please visit the Methodology section at <http://ehbs.kff.org/>.

The Kaiser Family Foundation, a leader in health policy analysis, health journalism and communication, is dedicated to filling the need for trusted, independent information on the major health issues facing our nation and its people. The Foundation is a non-profit private operating foundation based in Menlo Park, California.

The Health Research & Educational Trust (HRET) is a private, not-for-profit organization involved in research, education, and demonstration programs addressing health management and policy issues. Founded in 1944, HRET, an affiliate of the American Hospital Association, collaborates with health care, government, academic, business, and community organizations across the United States to conduct research and disseminate findings that help shape the future of health care.

- ¹ Majerol, Melissa, Newkirk, Vann and Garfield, Rachel. "The uninsured: A primer—key facts about health insurance on the eve of coverage expansions." Kaiser Commission on Medicaid and the Uninsured. Dec 2014. <http://kff.org/uninsured/report/the-uninsured-a-primer/> See supplemental tables - Table 1: 268.9 million non-elderly people, 54.6% of whom are covered by ESI.
- ² Kaiser/HRET surveys use the April-to-April time period, as do the sources in this and the following note. The inflation numbers are not seasonally adjusted. Bureau of Labor Statistics. Consumer Price Index - All Urban Consumers: Department of Labor; 2015. [cited 2015 September 2] http://data.bls.gov/timeseries/CUUR0000SA0?output_view=pct_1mth. Wage data are from the Bureau of Labor Statistics and based on the change in total average hourly earnings of production and nonsupervisory employees. Employment, hours, and earnings from the Current Employment Statistics survey: Department of Labor; 2015 [cited 2015 September 2]. <http://data.bls.gov/timeseries/CES0500000008>
- ³ "Application of Market Reform and other Provisions of the Affordable Care Act to HRAs, Health FSAs, and Certain other Employer Healthcare Arrangements." Notice 2013-54. Internal Revenue Service. <http://www.irs.gov/pub/irs-drop/n-13-54.pdf>
- ⁴ Federal Register. Volume 79, No 36, February 24, 2014. <http://webapps.dol.gov/FederalRegister/HtmlDisplay.aspx?DocId=27369&Month=2&Year=2014>
- ⁵ Federal Register. Vol. 75, No 221, November 17, 2010, <http://www.gpo.gov/fdsys/pkg/FR-2010-11-17/pdf/2010-28861.pdf>.
- ⁶ Claxton, Gary & Levitt, Larry. "How Many Employers Could be Affected by the Cadillac Plan Tax?" Kaiser Family Foundation. Apr 2015. <http://kff.org/health-reform/issue-brief/how-many-employers-could-be-affected-by-the-cadillac-plan-tax/>
- ⁷ The 2015 offer rate is significantly lower than the 69% of firms which indicated that they offered benefits in 2010. The increase in the 2010 estimate was primarily driven by a 12 percentage point increase in firms with between 3 and 9 employees offering coverage. Given the number of small firms in the country, statistics weighted by the number of employers tend to be volatile - for more information see the survey design section.
- ⁸ "Assessing the Effects of the Economy on the Recent Slowdown in Health Spending." Kaiser Family Foundation. Apr 2013. <http://kff.org/health-costs/issue-brief/assessing-the-effects-of-the-economy-on-the-recent-slowdown-in-health-spending-2/>
- ⁹ "How has health spending changed over time?" Peterson-Kaiser Health System Tracker. June 2015. <http://www.healthsystemtracker.org/chart-collection/how-has-health-spending-changed-over-time/?slide=1>



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

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*The full report of survey findings (#8775) is available on the Kaiser Family Foundation's website at www.kff.org.
This summary (#8776) is also available at www.kff.org.*