UBA
Health Plan Survey

2020 EXECUTIVE SUMMARY

HEALTH PLAN SURVEY

Health Plan Intelligence for Strategic Business Decisions

UBA

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SHARED WISDOM

POWERFUL RESULTS

As the coronavirus pandemic sweeps the nation in 2020, a crucial pillar supporting the U.S. workforce is employer-sponsored healthcare. Together, the independent Partner Firms that comprise United Benefit Advisors® (UBA) have been closely watching plan design and cost trends in order to advise the tens of thousands of employers across the United States who rely on them for procuring the most competitive health plans in the marketplace. While we wait to see how postponed preventive care and delayed elective surgeries will affect the health of the nation's workforce, and how the total costs of COVID-19 testing, treatment, and vaccinations will be financed, UBA Partners are already leveraging their local knowledge, along with data from the national UBA Health Plan Survey to recommend renewal strategies for 2021.

from the president

Begun in 2005, the UBA Health Plan Survey is the nation's largest independent health plan benchmarking survey, providing unprecedented longitudinal cost trends. You, as employers, have the unique opportunity exclusively through UBA Partners to compare your plans with competitors by region, state, industry, and size. Without this level of detail, you face two major pitfalls when benchmarking only against national averages or data from a single carrier: 1) paying too much for your benefit plan, or 2) losing the best and brightest employees to competitors with better plans. Instead, the UBA Health Plan Survey dives deep into thousands of plans offered by employers of all shapes and sizes to uncover trends that help you more strategically mitigate cost increases while still being an employer of choice.

Over the last 15 years, we've seen that a one-size-fits-all approach to healthcare planning certainly does not fit all, especially during turbulent times. When some sectors increased employees' contribution toward premiums and copays, other employer groups introduced lower cost plan types such as high deductible health plans, while still others found increasing deductibles and prescription drug plan segmentation were better cost containment strategies. Almost always, a company's industry, size, and location dictate the best plan design. UBA Health Plan Survey data can help you identify the best cost levers to adjust on your plan at renewal for your specific situation.

With superior data come optimal rates and value for our Partners' clients. In fact, UBA Partners cut initial proposed rates nearly in half for their clients in 2020. That's the power of the UBA Health Plan Survey. That's the power of UBA Partner Firms.

In health,

COLLEEN KUCERA
President
United Benefit Advisors

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UBA | Shared Wisdom. Powerful Results.®

INTRODUCTION

EACH YEAR, UNITED BENEFIT ADVISORS® (UBA) surveys thousands of employers throughout the United States—of all sizes and industries—to create the largest health plan database that now spans 15 years of data collection. With significant investments in continuous improvement, we also offer digital access to our entire survey database in real time.

By analyzing everything from cost, funding methods, enrollment, plan design, and coverage features, to wellness, prescription drug coverage, and more, the UBA Health Plan Survey has become the nation's definitive independent health plan survey. Featuring plan data from more small, midsize, and large employers than most other surveys combined, employers can more reliably benchmark their plans against their regional, industry and size-based peers instantly. In fact, UBA's new survey data visualization tool enables our Partners to benchmark any plan in minutes from any phone, tablet, or laptop. As a result, the UBA Health Plan Survey provides a national and local perspective that helps employers more strategically contain healthcare costs, while attracting and retaining the best employees.

1. After record high cost increases in 2018, employers were relieved that, for the second year in a row, rate increases hovered around a more manageable 5% in 2020. Quality benchmarking along with savvy negotiation cut initial proposed rates nearly in half.

2. The hardest hit employers facing the biggest cost increases from last year are those in the Western U.S. states, the construction industry, and large employers (1,000+ employees).

3. The smallest groups (fewer than 25 employees) fared the best at the negotiating table for the second year in a row, largely due to plan design choices. They typically set higher deductibles than their larger counterparts, increased employees' share of premium, and added more tiers to prescription drug plans.

4. Approximately 80% of plans are fully insured, and 20% are self-funded or level-funded. Not surprisingly, more than 60% of large employers (500+ employees) and 30% of midsize employers (100-499 employees) choose self-funding or level-funding. What is surprising is the continued increase in the number of small employers opting for self-funding. While only 7% of these employers chose self-funding five years ago, 18% of these groups chose to self-fund in 2020.

5. Across the nation, employers largely prefer preferred provider organization (PPO)/point of service (POS) plans, despite the higher costs. However, health maintenance organization (HMO)/exclusive provider organization (EPO) plans dominate in California and have a strong presence in the Northeastern states. In addition, these plans have attractive markets in select states, including Wisconsin, Colorado, Florida and Hawaii. Health savings account (HSA) plans (often referred to as "high deductible" or "consumer directed" plans) are most common in the Central and North Central U.S. (particularly Minnesota and Indiana), and in Northeastern states such as Maryland, Maine and Vermont.

6. Employees overwhelmingly prefer PPO/POS plans, with nearly 60% enrolled in these plans throughout the U.S. HSAs attract roughly a quarter of employees, and, excluding California, HMO/EPO plans garner fewer than 15% of employees.

7. On average, employees continue to pick up about 32% of the premiums while employers pick up approximately 68%, relieving fears (at least temporarily) that employers would rapidly move further away from the typical 70/30 employer/employee split. Government employees contribute the least toward plan costs (only 23.4%), while the construction/transportation industry passes on the most cost to employees (36.4%).

8. Employers generally kept copays and in-network deductibles for singles flat in 2020, but in-network deductibles for families are inching up by $500 on average. To contain costs, employers also continue to raise copays on specialty drugs, as well as out-of-network deductibles and out-of-pocket maximums.

9. To help manage higher deductibles and out-of-pocket costs, approximately one quarter of all plans offer a health savings account (HSA), and of those, nearly 70% provide an employer contribution. While the average employer contribution for singles remained flat in 2020, employers decreased their contributions to families' accounts. Only 7.3% of plans offer a health reimbursement arrangement (HRA).

10. Employers—particularly small businesses—continue to control drug costs through increased segmentation. With single and two-tier drug plans nearly extinct, three-tier plans are also plummeting in popularity. Nearly half of plans have four tiers, and nearly 30% of prescription drug plans have five or six tiers.

While these national trends tell one story, there are significant differences in some areas of the country, as well as within different industries or group sizes. The balance of this report expands on these national trends but also uncovers more localized findings that are critical when benchmarking more strategically.

TRENDS AT A GLANCE

KEY FINDINGS FOR MORE MEANINGFUL BENCHMARKING AND TREND ANALYSIS

HEALTH PLAN COSTS/PREMIUM INCREASES

Average health plan premiums rose more modestly in 2020. At 5.4%, up slightly from the 4.6% increase in 2019, but still considerably less than the nearly 10% increase seen in 2018 (which marked a ten-year high). These modest increases were a product of good negotiation. UBA Partners reported that the average initial or proposed rate increase was 9.7%, with final rate increases averaging 5.4% after negotiation.

Employees, on average, contribute approximately 32% toward total plan costs, virtually unchanged from last year.

PREFERRED PROVIDER ORGANIZATION (PPO)/POINT OF SERVICE (POS) PLANS

Although PPO/POS plans continue to cost more per employee than the average plan ($11,249 vs. $10,736), they still dominate in both plan prevalence and enrollment. Nearly 57% of plans are PPO/POS plans and enrollment continues to increase, with nearly 60% of employees enrolling in these types of plans.

PLAN TYPE	2020 AVERAGE TOTAL COST PER EMPLOYEE
PPO/POS	$11,249
HSA	$10,089
HMO/EPO	$10,040
ALL PLAN TYPES	**$10,736**

HEALTH SAVINGS ACCOUNT (HSA) PLANS

Health savings account (HSA) plans—sometimes referred to as "consumer-directed" or "high deductible" health plans—cost $10,089 per employee on average. While HSA plans were typically more expensive than HMO/EPO plans prior to 2017, their costs have been about the same as these plans for the last two years. Approximately one quarter of plans are HSAs and about 26% of employees are enrolled in these plans.

HEALTH MAINTENANCE ORGANIZATION (HMO)/EXCLUSIVE PROVIDER ORGANIZATION (EPO) PLANS

Health maintenance organization plans (HMOs)/exclusive provider organization plans (EPOs) cost $10,040 per employee on average, which is less than PPOs, but is about the same as HSA plans. Only 18.7% of plans are HMOs/EPOs and only 14.6% of employees choose to enroll in these plans.

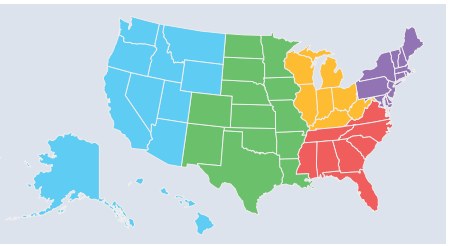
COSTS BY REGION

Nationally, average costs per employee rose 2.8% from 2019 to 2020.

YEAR	2020	2019	2018	2017	2016
TOTAL AVERAGE COST PER EMPLOYEE (NATIONAL)	$10,736	$10,447	$10,313	$9,934	$9,727
PERCENT INCREASE FROM PRIOR YEAR	2.4%	1.3%	3.8%	2.1%	-0.1%

Regional cost averages vary from the national picture, making it essential to benchmark both nationally and regionally. For example, a significant difference exists between the cost to insure an employee in the Northeast versus the Southeast U.S.—plans in the Northeast continue to cost the most since they typically have lower deductibles, contain more state-mandated benefits, and feature higher in-network coinsurance, among other factors. Though historically the lowest cost plans were in the Central U.S., steady increases since 2017 no longer position this region as the low-cost leader. Instead, the Southeast offers the least expensive plans in the nation (with no or low increases in the last two years). Plans in the Southeast and North Central U.S. had the lowest cost increases, while average plan costs in the Central and Northeastern states experienced above average cost increases.

REGION	SOUTHEAST	CENTRAL	WEST	NORTH CENTRAL	NORTHEAST	AVERAGE
TOTAL COST PER EMPLOYEE	$9,679	$9,864	$10,127	$11,162	$12,460	$10,736
PERCENT CHANGE FROM 2019	1.0%	3.0%	2.5%	0.9%	3.0%	2.4%



TOP 10 MOST EXPENSIVE STATES FOR EMPLOYER-SPONSORED HEALTH PLANS

1 • NEW YORK
2 • MASSACHUSETTS
3 • VERMONT
4 • NEW JERSEY
5 • CONNECTICUT
6 • WISCONSIN
7 • NEW HAMPSHIRE
8 • OHIO
9 • INDIANA
10 • CALIFORNIA

TOP 10 LEAST EXPENSIVE STATES FOR EMPLOYER-SPONSORED HEALTH PLANS

1 • MONTANA
2 • COLORADO
3 • MISSOURI
4 • KANSAS
5 • IDAHO
6 • SOUTH CAROLINA
7 • OREGON
8 • ARIZONA
9 • HAWAII
10 • TENNESSEE

EMPLOYEE CONTRIBUTIONS BY INDUSTRY

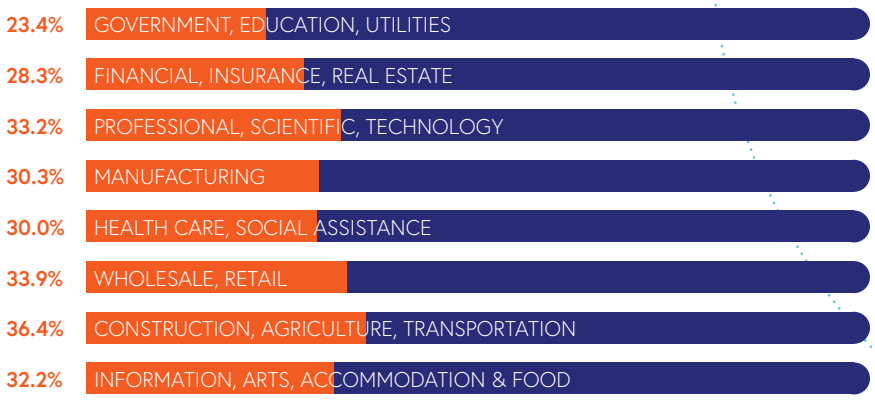
Employees, on average, contribute 32% toward total plan costs in 2020 versus 32.7% in 2019 and 31.2% in 2018. Many experts expected employers to continue to inch further and further away from the typical 70/30 employer/employee cost split, but that trend seems to have slowed. Nevertheless, it is still a metric to watch, especially within different industries. Government employers pass on the least cost to employees (while offering the richest plans), who contribute only 23.4%, on average, toward the total costs. The construction/transportation industry passes on the most cost to employees, who pick up 36.4% of the tab.

AVERAGE EMPLOYEE CONTRIBUTION

32%

ACROSS ALL INDUSTRIES

AVERAGE PERCENT EMPLOYEE CONTRIBUTION BY INDUSTRY



COST BY INDUSTRY

The government/education/utilities sector has the priciest plans, at $12,324 per employee, up 1.6% from last year. Total costs per employee for the construction/transportation, retail, hospitality, and health care sectors are all lower than average, making employees in these industries among the least expensive to cover. This is typically due to the lower average age among this workforce combined with less rich plans. After a large 6.6% increase last year, the technology sector had the second highest increase of 3.8% this year. The construction sector had the largest cost increases this year (4.6%).

AVERAGE COST ALL INDUSTRIES

2018 **$10,313**

2019 **$10,447**

2020 **$10,736**

COST BY INDUSTRY

INDUSTRY	2017	2018	2019	2020
GOVERNMENT, EDUCATION, UTILITIES	$11,936	$11,943	$12,125	$12,324
FINANCIAL, INSURANCE, REAL ESTATE	$10,735	$11,218	$11,155	$11,554
PROFESSIONAL, SCIENTIFIC, TECHNOLOGY	$10,170	$10,384	$11,074	$11,497
MANUFACTURING	$9,909	$10,462	$10,566	$10,796
HEALTH CARE, SOCIAL ASSISTANCE	$9,643	$10,063	$10,178	$10,401
WHOLESALE, RETAIL	$9,497	$9,714	$9,840	$10,098
CONSTRUCTION, AGRICULTURE, TRANSPORTATION	$9,446	$9,583	$9,681	$10,130
INFORMATION, ARTS, ACCOMMODATION & FOOD	$8,798	$9,110	$9,441	$9,660

EMPLOYEES again this year contributed about 32% of the premiums while employers covered approximately 68%, quelling fears that we were moving rapidly away from the typical 70/30 employer/employee split.

BUILDING ON BENCHMARKING IN THE CONSTRUCTION INDUSTRY

In 2020, the construction industry (which predominantly offers PPO/POS plans) got hit with the highest cost increases. As they face an uncertain 2021 renewal, detailed benchmarking is crucial for smart strategic planning.

For example, based on the UBA Health Plan Survey, construction companies in the Northeast might want to introduce or more heavily promote an HMO plan, while larger construction companies and those in the North Central U.S. might focus on an HSA plan to lower costs. When negotiating premiums, construction companies with 100 to 500 employees should start from a far lower total cost per employee than the national average ($9,385 versus $10,736) while construction companies in the Northeast should be using a much higher starting point ($11,537 versus $10,736).

Most smaller construction companies (fewer than 500 employees) can comfortably set employee contributions at 37%, higher than the typical 32% found among all other employers. Similarly in-network deductibles found among plans serving smaller construction businesses tend to be $500 higher than average for singles and approximately $1,000 higher for families. However, larger construction companies might lose talent with these benchmarks since their peers are typically setting employee contributions at 28% and in-network single/family deductibles for PPO/POS plans are closer to the $2,000/$5,000 average.

For construction employers offering HSAs, their contribution can be about $100 less than average for singles and $200 less than average for families, while still being competitive. Not quite so for Northeastern construction companies who should plan to contribute $100 more than average for singles and $500 more for families.

This ability to mine such granular benchmarking data is not only crucial when designing plans and negotiating rates, but it's a game changer when communicating plan value to employees.

PREVALENCE OF PLAN TYPE BY REGION

When looking at plans by region, PPO/POS plans dominate nationwide, although less so in the Northeast. Interestingly, though the West has historically had a strong prevalence of HMO/EPO plans, they are increasingly offering PPO plans. The Northeast now has the highest prevalence of HMO/EPO plans in the country. It is worth noting that while HMO/EPO prevalence is just 15.6% in the larger Western region, within California alone, 52.4% of employers offer HMO/EPO plans, making these plans as popular as PPO/POS plans in that market. States including Colorado, Florida and Hawaii also have strong HMO markets that may differ from their surrounding region. The Central and North Central regions have the highest prevalence of HSA plans.

PLAN TYPE	WEST	CENTRAL	NORTH CENTRAL	SOUTHEAST	NORTHEAST
PPO/POS	62.8%	60.2%	54.9%	62.2%	44.2%
HSA	15.6%	29.5%	30.1%	21.7%	23.5%
HMO/EPO	21.5%	10.3%	14.9%	15.7%	32.2%

REGIONAL ENROLLMENT BY PLAN TYPE

Understanding what types of plans employers offer to employees and what employees ultimately choose to enroll in can be very informative to any employer's strategic planning efforts. Nationwide, PPO/POS plans have the greatest interest among employees, with nearly 60% enrolled in these plans. Just over a quarter of employees enroll in HSA plans, and nearly 15% enroll in HMO/EPO plans. But there are regional variations and therefore localized benchmarking is crucial.

While historically PPO/POS plans had the greatest enrollment in the Central U.S., the West region now leads in enrollment for these plans. (California differs significantly from the larger Western region trend, however. There, 52.9% of employees enrolled in HMO/EPO plans. This enrollment trend also varies within the state; for example, HMO enrollment is often higher in southern California and EPO enrollment is rare in the northern part of the state. UBA publishes state-level reports that further assist with even more localized benchmarking.) With less interest in PPO/POS plans, a growing number of employees in the Central region are enrolling in HSA plans. Though employers in the North Central U.S. have seen some of the highest employee enrollment in HSA plans, those employees are actually moving away from HSA plans in favor of PPO/POS plans this year. Employees in the Southeast also favor PPO plans but enrollment in HMO/EPO plans is on the rise. The Northeast continues to see employees rapidly move away from HSA plans. In 2020, employees in the Northeastern U.S. increasingly enroll in HMO/EPO plans.

PLAN TYPE	WEST	CENTRAL	NORTH CENTRAL	SOUTHEAST	NORTHEAST
PPO/POS	73.5%	63.6%	54.0%	62.5%	47.0%
HSA	12.2%	28.3%	38.8%	26.2%	19.8%
HMO/EPO	14.1%	8.1%	7.2%	11.2%	33.1%

COSTS BY ORGANIZATION SIZE

Generally, larger groups (those with 200+ employees) pay more than average per employee due to more generous benefit levels. However, the largest groups (1,000+ employees) have seen considerable cost turbulence in the last three years. In 2018 these employers experienced a stunning 9.6% increase, followed by a surprising 4.9% decrease in costs in 2019. In 2020, costs for these employers increased 6.1%, making them the hardest hit group this year (well above the average 2.4% cost increase over all group sizes combined).

AVERAGE COST PER EMPLOYEE BY ORGANIZATION SIZE

AVERAGE COST PER EMPLOYEE	ORGANIZATION SIZE	PERCENT INCREASE FROM 2019
$11,445	1,000+ EMPLOYEES	6.1%
$11,707	500-999 EMPLOYEES	3.8%
$11,260	200-499 EMPLOYEES	2.8%
$10,866	100-199 EMPLOYEES	2.6%
$10,242	50-99 EMPLOYEES	3.3%
$10,347	25-49 EMPLOYEES	3.3%
$10,880	FEWER THAN 25 EMPLOYEES	1.7%
$10,736	**OVERALL AVERAGE**	**2.4%**

Middle market employers (500 to 999 employees), who had the highest increases last year (6.4% increase in 2019), had the second highest increase this year (3.8%) and therefore for the second year in a row these employers have the most expensive plans across all organization sizes. The smallest groups (fewer than 25 employees) fared the best at the negotiating table for the second year in a row, with 1.7% cost increases in 2020 on average. Since small groups have to comply with age and community rating (which drives costs higher), they obtained their competitive rates largely due to plan design choices, most notably applying higher deductibles than their larger counterparts, increasing employees' share of premium (to nearly 40% versus the average 32%), and adding more tiers to prescription drug plans (over a third of these employers with prescription drug plans have five or six tiers instead of the more common four-tier plan, enabling higher out-of-pocket costs for pricier drugs).

MOST EXPENSIVE PLANS

- **PPO/POS PLANS**
- **PLANS IN THE NORTHEAST**
- **PLANS IN THE GOVERNMENT/EDUCATION INDUSTRY**
- **PLANS AMONG MIDDLE MARKET EMPLOYERS (500-999 EMPLOYEES)**

LEAST EXPENSIVE PLANS

- **HMO/EPO PLANS**
- **PLANS IN THE SOUTHEAST**
- **PLANS IN THE HOSPITALITY INDUSTRY (HOTEL, FOOD)**
- **PLANS AMONG SMALL EMPLOYERS (50-99 EMPLOYEES)**

DEDUCTIBLE COSTS

While employers have largely kept in-network deductibles for singles unchanged in 2020, in-network family deductibles increased by $500 on average for those on PPO/POS and HMO/EPO plans. But all plans continue to discourage use of non-participating physicians by singles and families by increasing out-of-network deductibles. For example, singles on a PPO/POS plan who go out of network for care face a $5,000 deductible—up from $4,000 in 2019 and $3,000 in 2018.

Out-of-pocket maximums (both in-network and out-of-network) continue to rise for PPO/POS plans (though they remained flat for other plan types). For example, families in PPO/POS plans face a $12,000 in-network out-of-pocket maximum, up from $11,300 in 2019 and $10,000 in 2018. Similarly, families who go out of network on a PPO/POS plan face an out-of-pocket maximum of $24,000, up from $22,000 in 2019.

BENCHMARKING YOUR DEDUCTIBLES AND OUT-OF-POCKET MAXIMUMS

PPO/POS PLANS	IN-NETWORK BENEFITS	OUT-OF-NETWORK BENEFITS
SINGLE DEDUCTIBLE	$2,000	$5,000
FAMILY DEDUCTIBLE	$4,500	$10,000
SINGLE OUT-OF-POCKET MAXIMUM	$5,900	$12,000
FAMILY OUT-OF POCKET MAXIMUM	$12,000	$24,000

HSA PLANS	IN-NETWORK BENEFITS	OUT-OF-NETWORK BENEFITS
SINGLE DEDUCTIBLE	$3,000	$7,000
FAMILY DEDUCTIBLE	$6,000	$14,000
SINGLE OUT-OF-POCKET MAXIMUM	$5,000	$12,000
FAMILY OUT-OF POCKET MAXIMUM	$10,000	$24,000

HMO/EPO PLANS	IN-NETWORK BENEFITS	OUT-OF-NETWORK BENEFITS*
SINGLE DEDUCTIBLE	$2,000	$4,000
FAMILY DEDUCTIBLE	$4,500	$8,000
SINGLE OUT-OF-POCKET MAXIMUM	$6,000	$7,800
FAMILY OUT-OF POCKET MAXIMUM	$12,000	$15,800

*EPO PLANS

HAWAII AND NEVADA HAVE THE LOWEST IN-NETWORK DEDUCTIBLES FOR SINGLES AND FAMILIES, WHILE MONTANA AND CONNECTICUT HAVE THE HIGHEST IN-NETWORK DEDUCTIBLES FOR SINGLES AND FAMILIES. TEXAS AND NEW HAMPSHIRE HAVE KEPT THEIR DEDUCTIBLES FOR SINGLES IN CHECK, BUT HAVE SOME OF THE HIGHEST DEDUCTIBLES FOR FAMILIES IN THE U.S.

COPAYS

Generally, copays are similar across plan types, with the majority of primary care physician copays at $30. Copays for specialty care physicians and urgent care are approximately $50. Emergency room copays are approximately $250. Though in previous years employers occasionally chose modest increases in primary, specialty and urgent care copays ($5 on average), employers largely left these fees alone this year. Even average emergency room copays were unchanged this year after increasing significantly from $150 to $200 in 2018 to $250 in 2019.

MOST COMMON **COPAY** STRUCTURE

- **$30** PRIMARY CARE PHYSICIAN COPAY
- **$50** SPECIALTY CARE PHYSICIAN COPAY
- **$50** URGENT CARE COPAY
- **$250** EMERGENCY ROOM COPAY

DEPENDENT COVERAGE

Historically, in 2010 51.1% of employees opted for dependent coverage, followed by a steady decline reaching a 10-year low in 2017 where only 39.6% of employees obtained dependent coverage. In 2018, 42.2% of employees opted for dependent coverage and that number rose to 44.4% in 2019 but has remained flat in 2020 at 44.8%.

SPOUSE AND PARTNER COVERAGE

Currently, 58.8% of all employers provide no domestic partner benefits. This is likely due to the Supreme Court's decision in *Obergefell v. Hodges*, which legalized same-sex marriage, giving employers a less complicated method to provide coverage for same-sex partners. As a result, many employers are covering just legal spouses rather than legal spouses and domestic partners. Approximately 32.8% of employers cover both same-sex and opposite-sex domestic partners.

INFERTILITY SERVICES

Though the number of plans offering full infertility evaluation and treatment benefits had been declining (22.4% in 2017, 21.5% in 2018, and 20.9% in 2019), more than 25% of plans in 2020 offer these benefits. Still, the vast majority of plans offer evaluation only or no infertility coverage at all. The top five states for full fertility benefits (as mandated by state law) are Hawaii (100% of plans), Illinois (93.5%), Massachusetts (90.3%), Maryland (85.6%), and Delaware (83.3%).

ANCILLARY BENEFITS

In 2020, more than 80% of employers offered dental insurance, while approximately 65% of-fered vision coverage. Sixty-three percent of employers offered basic life insurance and 56% and 42% offered accidental death and dismemberment coverage and voluntary life insurance, respectively. Short-term disability coverage is offered by 41.3% of employers, and 44.4% of employers offered long-term disability coverage.

HSA AND HRA CONTRIBUTIONS

Approximately one quarter of all plans offer a health savings account (HSA), and of those, nearly 70% provide an employer contribution. While the average employer contribution to HSAs for singles had been sharply increasing (from $477 in 2017, to $763 in 2018, to $989 in 2019), contributions remained flat in 2020 at $981. Families experienced a decrease in employer contributions to their HSAs—going from $1,632 in 2019 to $1,515 in 2020 on average.

Only 7.3% of plans offer a health reimbursement arrangement (HRA). Average HRA reimbursements for singles increased from $2,099 in 2019 to $2,532 in 2020. The average employer contribution for families went from $4,037 in 2019 to $4,681 in 2020.

HSA EMPLOYER CONTRIBUTION TREND

YEAR	AVERAGE CONTRIBUTION FOR SINGLES	AVERAGE CONTRIBUTION FOR FAMILIES
2020	$981	$1,515
2019	$989	$1,632
2018	$763	$3,813
2017	$477	$2,189
2016	$474	$801
2015	$491	$882

HRA EMPLOYER CONTRIBUTION TREND

YEAR	AVERAGE CONTRIBUTION FOR SINGLES	AVERAGE CONTRIBUTION FOR FAMILIES
2020	$2,532	$4,681
2019	$2,099	$4,037
2018	$1,547	$5,497
2017	$1,983	$3,743
2016	$1,810	$3,545
2015	$1,767	$3,472

SELF-FUNDING

Across all plans, approximately 80% are fully insured and 20% are self-funded or level-funded. Historically, self-funding has been most attractive to the large group market, with approximately 60% of these groups choosing to self-fund. In 2020, 66% of large employers are self-funded or level-funded, illustrating even greater interest in this funding method among these groups. Among midsize employers (100-499 employees), approximately 30% of employers choose self-funding, which has been fairly consistent over the last five years. The small employer market (25-99 employees) tells a different story. While only 7% of these employers chose self-funding five years ago, 18% of these groups chose to self-fund or level-fund in 2020. This surprising year-over-year growth is a metric to watch and small groups should evaluate this option based on their industry, size, region, plan type, population risk, regulatory environment and other factors. UBA finds that, on a regional basis, there are areas of the country where self-funding is also on the rise, particularly for small and midsize groups, so it is critical to benchmark your plan regionally as well as nationally when evaluating this option.

PERCENTAGE SMALL EMPLOYERS (25-99 EMPLOYEES) FULLY INSURED
2015: 93%
2020: 82%

PERCENTAGE MIDSIZE EMPLOYERS (100-499 EMPLOYEES) FULLY INSURED
2015: 75%
2020: 69%

Along with benefits for employers, self-funding models have an advantage for employees as well, namely lower deductibles. Among self-funded plans in the 2020 survey, the average in-network single deductible is $2,000 and the average in-network family deductible is $4,000, compared to $2,500 for singles and $5,000 for families in fully insured plans.

WELLNESS PROGRAMS

PERCENTAGE LARGE EMPLOYERS (500+ EMPLOYEES) FULLY INSURED
2015: 37%
2020: 34%

Comprehensive wellness programs are offered by 15.2% of all employers. Wellness programs are most prevalent among Northeast employers (24.2%), HSA plans (27%), plans sponsored by government/education employers (28.3%), and most especially among larger groups (40.9% for groups with 500 to 999 employees, and 58.3% for groups with 1,000+ employees). Historically, approximately 60% of the largest employers (1,000+ employees) offered wellness. In 2018, the number dropped significantly to about 50%. In 2019 and 2020, adoption of wellness programs among this cohort was again on the rise. UBA Partners report that wellness programs are of high interest to employers who self-fund or are planning to self-fund their health plans.

Among all wellness programs, 72% include health risk assessments, 70.2% offer employee incentives for participation, 62.4% offer biometric screenings or physical exams, 51.9% include on-site or telephone coaching for high-risk employees,

and 44.3% include seminars or workshops. Health risk assessments have decreased by more than 10% since 2014 when 80.3% of plans had a health risk assessment. The use of health risk assessments is worth watching closely due to the government's increased scrutiny and regulation regarding their use.

The primary form of wellness incentives are in the form of extra paid time off. Over 52% of wellness programs that incentivize participation reward employees with paid time off, up 12% from 2019 and an astronomical 952% from five years ago (when only 5% of wellness plans offered this type of incentive). In fact, from 2014 to 2018, the most popular incentive was offering cash toward premiums. In 2018, employers largely incentivized with gift certificates. The surprising shift in 2019 to paid time off as the incentive of choice—and its continued increase in 2020—will be an interesting statistic to watch going forward. UBA Partners report that gift certificates to particular retailers are often limiting to employers and employees alike. Offering paid time off instead avoids this issue. Plus, there are no tax implications for this type of incentive, and it is often easier to administer than cash rewards.

WELLNESS PROGRAMS COMPONENTS

HEALTH RISK ASSESSMENTS	72.0%
INCENTIVES/REWARDS	70.2%
PHYSICAL EXAM/BLOOD DRAW	62.4%
WEB PORTAL	59.6%
COACHING	51.9%
SEMINARS/WORKSHOPS	44.3%
OTHER	4.1%

PERCENTAGE OF EMPLOYERS OFFERING WELLNESS PROGRAMS

LESS THAN 25 EMPLOYEES	10.5%
25-49 EMPLOYEES	11.3%
50-99 EMPLOYEES	13.5%
100-199 EMPLOYEES	20.7%
200-499 EMPLOYEES	32.3%
500-999 EMPLOYEES	40.9%
1,000+ EMPLOYEES	58.3%

PRESCRIPTION DRUG PLANS

Always mindful of the exponential increases in prescription drug costs, particularly for chronic conditions and specialty care, employers and carriers alike continue to seek ways to mitigate these costs in order to hold premiums in line. As a result, plans continue to become more complicated, with ever-expanding medication tiers and benefit structures that can include copays, coinsurance, a combination of copays and coinsurance, deductibles, as well as stipulations on the types of medications in each tier.

With single-tier and two-tier drug plans nearly extinct, three-tier plans are also plummeting in popularity. Survey data show only 19.9% of prescription drug plans now have three tiers, down nearly 18% from 2019. Nearly 47% of plans have four tiers, up 6% from 2019, making it the most common prescription drug plan configuration. Like last year, approximately 14% of plans have five tiers. However, plans with six tiers grew 42% from last year to 14.5% in 2020. As a result, nearly 30% of prescription drug plans have five or six tiers.

Employers with 100 or more employees still primarily offer three- and four-tier plans. However, smaller employers are leading the expansion of five- and six-tier plans, while rapidly divesting of three-tier plans. In fact, nearly 49% of prescription drug plans offered by employers with fewer than 50 employees are comprised of four tiers and more than 36% have five or six tiers. Conversely, only 11.2% of prescription drug plans offered by these small businesses have three tiers.

Benefit levels for generic prescriptions were flat this year, preserving the median $10 copay across all tier structures. While employers are keeping copays for generics low, copays for specialty drugs are costly. For those plans with three or more tiers, the median out-of-pocket costs for specialty drugs in 2020 are $150 for preferred specialty drugs and $250 for non-preferred specialty drugs.

TRENDS OUTLOOK

WHAT WE SEE TODAY,

MAY BE PREDICTORS OF

WHAT IS COMING IN

THE FUTURE

LEGISLATIVE INSIGHTS

Legislation enacted and proposed this year has almost exclusively been focused on relaxing the Internal Revenue Code's (IRC) reporting, disclosure and benefits administration rules in recognition of the business interruption caused by the coronavirus pandemic. Throughout the United States and beyond, each state has been subject to stay-at-home orders that made it difficult for employers to perform even the most mundane benefits tasks. The poor economic conditions have also forced many employers to furlough or terminate employees, creating a host of health coverage issues that the country's benefits regulatory scheme was ill equipped to handle. Until a vaccine is discovered, which would lead to the end of the pandemic, Congress has committed to a continued rapid response by the proposal of relief related legislation.

On March 13, 2020, President Trump issued the Proclamation on Declaring a National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak, which was followed by the enactment of the Families First Coronavirus Response Act (FFCRA) and the Coronavirus, Aid, Relief and Economic Security Act (CARES Act). The FFCRA implemented the Emergency Family Medical Leave Expansion Act (EFMLEA) and the Emergency Paid Sick Leave Act (EPSLA), which required covered employers to provide paid leave due to COVID-19 related absences.

The FFCRA also requires health plans to fully pay for COVID-19 testing deemed medically necessary. The CARES Act established the Paycheck Protection Program, which provides small employers with an incentive to keep workers on their payroll during the COVID-19 crisis by allowing employers to borrow up to $10 million. Loans may be forgiven if employers maintain their workforce. The CARES Act also authorized payment of stimulus

checks and enhanced state employment benefits. On July 27, 2020, Senate Republicans proposed the Additional Emergency Appropriations For Coronavirus Health Response and Agency Operations ("Appropriations Bill"), which allocates more than $3 billion in support to federal agencies during the pandemic. The Appropriations Bill, in part, extends some of the relief provided under the CARES Act and provides support for the Department of Health and Human Services and the Department of Labor.

The Small Business Expense Protection Act of 2020 is pending in the Senate Finance Committee. This bill also amends the CARES Act, and if passed will protect business' tax deductions for ordinary business expenses and other tax incidents for businesses that receive COVID-19 relief under the Paycheck Protection Program and otherwise. The Preparing for the Next Pandemic Act legislation has been proposed to maintain sufficient onshore manufacturing for tests, treatments and vaccines, and enhance state and federal supplies such as personal protective equipment and ventilators.

Additional pending legislation may also soon become law. The Crisis Care Improvement and Suicide Prevention Act is intended to enhance mental health crisis services, particularly during the pandemic, which could impact health insurance arrangements. Legislation has been introduced to enhance the availability of telehealth services in Medicare on a permanent basis and generally, with proposals made by both Republicans and Democrats, in addition to the KEEP Telehealth Options Act, which would require the federal government to study the expansion of telehealth services during crisis along with other proposed bipartisan legislation to expand the availability of telehealth. Legislation is also pending to support American innovation in U.S. medicines and COVID-19 cures.

In recognition that access to healthcare has been strained during the pandemic due to increasing unemployment rates and economic instability, legislation has been introduced to reduce the current 7.5% income threshold for the medical expense deduction to 5% for 2020 and 2021, and make the 7.5% income threshold permanent for all other years. Further, the Ensuring Parity in MA for Audio-Only Telehealth Act bipartisan legislation has been proposed to ensure that Medicare Advantage enrollees are able to access care through audio visits during the pandemic if telehealth video access in not available.

A monumental change in the law could occur this year if the U.S. Supreme Court overturns the Affordable Care Act (ACA). The court is expected to hear oral arguments later this year but is unlikely to rule before the 2020 elections.

To address the multitude of benefits administration issues during the pandemic, the Department of Labor (DOL) and the Department of the Treasury (Treasury) issued a final rule that extends certain timeframes under the Employee Retirement Income Security Act (ERISA) and the IRC for group health plans, disability, and other welfare plans, and participants and beneficiaries of these plans during the COVID-19 national emergency. The HIPAA special enrollment timeframe, COBRA notice requirements and the ERISA claims procedure deadlines have all been extended.

The Internal Revenue Service (IRS) issued guidance that provides increased flexibility for making mid-year elections or changes under a Section 125 cafeteria plan during calendar year 2020 related to employer-sponsored health coverage, health flexible spending arrangements (health FSAs), and dependent care assistance programs (DCAPs). This guidance also provides increased flexibility with respect to grace periods to apply unused amounts in health FSAs to medical care expenses incurred through December 31, 2020, and unused amounts in DCAPs to dependent care expenses incurred through December 31, 2020.

In response the President's Executive Order 13765 "Minimizing the Economic Burden of the Patient Protection and Affordable Care Act Pending Repeal" issued on January 20, 2017, the Department of Health and Human Services, DOL, and Treasury issued proposed rules for grandfathered health plans that would make changes to certain types of cost-sharing requirements without causing a loss of grandfathered status. Due to the pandemic, Treasury postponed taxpayer filing and payment deadlines. As the pandemic continues, and thereafter, additional guidance from regulatory agencies will be published.

UNITED STATES

ALABAMA
Valent Group - Birmingham

ALASKA
Fejes & Associates, Inc. - Anchorage

ARIZONA
Benefit Intelligence, Inc. - Mesa
Fendley Benefits - Flagstaff
JP Griffin Group - Scottsdale
Matsock and Associates - Phoenix
Reseco Insurance Advisors, LLC - Phoenix

ARKANSAS
Alexander & Company - Fayetteville
Stephens Insurance, LLC - Little Rock

CALIFORNIA
AEIS - San Mateo
Benefit Pro Insurance Services, Inc. - San Diego
BJA Partners - San Diego
Fredericks Benefits - Redlands
The Henehan Company - San Bernardino
Horstmann Financial and Insurance Services - Fresno
JHC Benefits - Ventura
Johnson & Dugan Insurance Services Corp. - Burlingame
KBI Benefits, Inc. - Los Altos
Vita - Moutain View

COLORADO
Sage Benefit Advisors - Fort Collins

CONNECTICUT
Blueprint Benefit Advisors - Hamden

FLORIDA
The Clemons Company - Panama City
Earl Bacon Agency, Inc. - Tallahassee
The Enterprise Team, Inc. - Altamonte Springs
GCD Insurance Consultants, Inc. - Tampa
K&P Benefits Consulting Group - Sarasota
Keystone Benefit Group, LLC - Jacksonville
Leading Edge Benefit Advisors, LLC - Ft. Myers
Selden Beattie - Coral Gables
The Stoner Organization, Inc. - St. Petersburg

GEORGIA
Arista Consulting Group - Alpharetta
The Benefit Company - Atlanta
BIS Benefits, Inc. - Roswell
Snellings Walters Insurance - Atlanta

HAWAII
Atlas Insurance Agency, Inc. - Honolulu

IDAHO
Fredriksen Health Insurance, LLC - Boise

ILLINOIS
Byrne, Byrne and Company - Chicago
Coordinated Benefits Company - Schaumburg
Lang Financial Group - Skokie
R.W. Garrett Agency, Inc. - Lincoln
Terrill Insurance Solutions - Lake Bluff
TrueNorth Companies, LLC - Rosemont
VistaNational Insurance Group, Inc. - Oak Brook

INDIANA
Benefits 7, Inc. - Vincennes
The DeHayes Group - Fort Wayne
LHD Benefit Advisors, LLC - Indianapolis

IOWA
TrueNorth Companies, LLC - Cedar Rapids, West Des Moines

KANSAS
Creative Planning Benefits, LLC - Overland Park

KENTUCKY
Bim Group - Lexington
Schwartz Insurance Group - Louisville
Sterling Thompson Company, LLC - Louisville

LOUISIANA
Becker Suffern McLanahan, Ltd. - Mandeville
Dwight Andrus Insurance - Lafayette

MAINE
Acadia Benefits, Inc. - Portland

MARYLAND
Insurance Solutions - Annapolis
PSA Insurance & Financial Services, Inc. - Hunt Valley
TriBridge Partners, LLC - Baltimore

MASSACHUSETTS
Axial Benefits Group, LLC - Burlington
Borislow Insurance - Methuen
EBS - Newton
Sullivan Benefits - Marlborough

MICHIGAN
BenePro - Royal Oak
Comprehensive Benefits, Inc. - Southfield
Great Lakes Benefit Group - Southfield
Olivier-VanDyk Insurance Agency, Inc. - Wyoming
Saginaw Bay Underwriters - Saginaw
Strategic Services Group, Inc. - Rochester Hills

MINNESOTA
Horizon Agency, Inc. - Eden Prairie
Johnson Insurance Consultants - Duluth
Mahowald - Saint Cloud
SevenHills Cleveland Benefit Partners - Bloomington

MISSOURI
Cammon Company - St. Louis
Employee Benefit Design, LLC - Springfield

NEBRASKA
Swartzbaugh-Farber & Associates, Inc. - Omaha

NEVADA
Dillon Insurance Services - Reno

NEW HAMPSHIRE
Granite Group Benefits, LLC - Manchester
Melcher & Prescott Insurance - Laconia

NEW JERSEY
Innovative Benefit Planning, LLC - Moorestown
Katz/Pierz, Inc. - Cherry Hill
Meeker Sharkey & Hurley - Cranford

NEW YORK
Benetech, Inc. - Wynantskill
Brio Benefit Consulting, Inc. - New York
Meridian Risk Management - Pelham
RGA Wealth Management - Brooklyn

NORTH CAROLINA
Dennis Insurance Group - Greensboro
ECM Solutions - Charlotte
GriffinEstep Benefit Group, Inc. - Wilmington
JRW Associates, Inc. - Raleigh

OHIO
Andres, O'Neil & Lowe Agency - Archbold
ClearPath Benefit Advisors LLC - Columbus
DCW Group - Boardman
HORAN - Cincinnati
Kaminsky & Associates, Inc. - Maumee
Ohio Health Benefits - Tallmadge
Schwendeman Agency, Inc. - Marietta
Todd Associates, Inc. - Beachwood

OKLAHOMA
Dillingham Benefits, LLC - Oklahoma City

OREGON
Hagan Hamilton Insurance Solutions - McMinnville
KPD Insurance, Inc. - Springfield

PENNSYLVANIA
Commonwealth Benefits Group - Dillsburg
EHD - Lancaster
Fairmount Benefits, Inc. - Radnor
Lehigh Valley Benefits Group, Inc. - Allentown
Lillis, McKibben, Bongiovanni & Co. - Erie
Power Kunkle Benefits Consulting - Wyomissing

SOUTH CAROLINA
ECM Solutions - Greenville
Fulcrum Risk Solutions - Columbia
Longleaf Advisors - West Columbia

TENNESSEE
Athens Insurance Agency - Athens
Bernard Health - Nashville
CanopyNation - Memphis
Insurance Consulting Group, Inc. - Memphis
PMG Benefit Consulting, LLC - Nashville

TEXAS
Brinson Benefits, Inc. - Dallas
CBS Insurance LLP - Abilene
GSM Insurors - Rockport
J.S. Edwards & Sherlock Insurance Agency - Beaumont
K&S Insurance - Rockwall
Kainos Partners, Inc. - Jersey Village
Shepard & Walton Employee Benefits - Austin
Stephens Insurance, LLC - Houston
Upshaw Insurance Agency - Amarillo

UTAH
DPW Benefits - Salt Lake City
Fringe Benefit Analysts, LLC - Layton

VERMONT
The Richards Group - Brattleboro

VIRGINIA
AHT Insurance - Leesburg
D & S Agency - Roanoke
Managed Benefits, Inc. - Glen Allen
Tower Benefit Consultants, Inc. - Virginia Beach

WASHINGTON
AHT Insurance - Seattle
PSG Washington, Inc. - Everett

WISCONSIN
Hemb Insurance Group, LLC - Madison

CANADA

ALBERTA
Belay Advisory - Edmonton

BRITISH COLUMBIA
Montridge Advisory Group, Ltd. - Vancouver

MANITOBA
ONYX Financial Group - Winnipeg

NEW BRUNSWICK
OMG Benefits Consulting Inc. - Saint John

EUROPE

ENGLAND
Churchills International Consulting Ltd - Edingley, Notts.

IRELAND
Glennon Employee Benefits & Financial Planning - Dublin

UBA
Health Plan Survey

ABOUT THIS SURVEY

Data in the 2020 UBA Health Plan Survey are based on responses from 11,788 employers sponsoring 21,980 health plans covering 1,366,186 employees nationwide. Altogether, UBA's survey is nearly three times larger than the next two of the nation's largest health plan benchmarking surveys combined. The resulting volume of data provides employers of all sizes more detailed—and therefore more meaningful—benchmarks and trends than any other source.

The scope of the survey allows regional, industry-specific, and employee size differentials to emerge from the data. In addition, the large number of plans represented allows for both a broader range of categories by plan type than traditionally reported and a larger number of respondents in each category. Historically, these types of benchmark data were unavailable to small and mid-size employers. For larger employers, the survey provides benchmarking data on a more detailed level than ever before.

By using these data, the independent benefit advisory firms that comprise UBA can help employers more accurately evaluate costs, contrast the current benefit plan's effectiveness against competitors' plans, and adjust accordingly. This gives employers a distinct competitive edge in negotiating rates—and recruiting and retaining a superior workforce.

ABOUT UBA

United Benefit Advisors is the nation's leading independent employee benefits advisory organization with more than 200 offices throughout the United States, Canada, England and Ireland. As trusted and knowledgeable advisors, UBA Partners collaborate with more than 2,000 fellow professionals to deliver expertise, thought leadership, and best-in-class solutions that positively impact employers and make a real difference in the lives of their employees and families. Employers, advisors, and industry-related organizations interested in obtaining powerful results from the shared wisdom of our Partners should visit UBA online at www.ubabenefits.com.

UBA
Partner Firm