UBA
Health Plan Survey

HEALTH PLAN SURVEY

HEALTH PLAN ANALYTICS FOR STRATEGIC BUSINESS DECISIONS

UBA

SHARED WISDOM

POWERFUL RESULTS

from the president

As U.S. employers emerge from the coronavirus pandemic, while still managing vaccine policies and virus variants that impact the workplace in countless ways, businesses have many worries related to group health care. Among them: 1) the 2022 claims experience may be vastly different as many employees resume preventive care that was put off during the pandemic, and 2) labor shortages due to federal and state unemployment programs have significantly changed how employers must attract and retain employees. On the one hand, employers must prepare now for the possibility of even higher premiums next year, since the three-year reprieve we've recently experienced with relatively modest and manageable price increases may come to an end. On the other hand, simply manipulating typical cost levers (such as employee premium contributions, deductibles, copays, prescription drug plan segmentation, etc.) to shift these rising costs to employees is no longer a valid retention strategy in the current labor market. The solution? The most effective total compensation and rewards programs will rely more heavily than ever before on competitively structured group health insurance that can only be designed through precise benchmarking.

During these turbulent economic times marked by rapidly changing health care regulation, employers must take a more granular approach to health plan benchmarking in order to be an employer of choice. Since 2005, the independent Partner Firms that comprise United Benefit Advisors® (UBA) have leveraged their shared wisdom to offer the most powerful group health plan benchmarking platform in the industry. Local UBA Partners can help employers anywhere in the country compare their specific plans against competitors by region, state, industry, and size. Such unprecedented analysis enables the employers we serve to obtain the most competitive health care coverage at the best rates. In fact, UBA Partners cut initial proposed rate increases in half for their clients this year.

After careful study of the 2021 UBA Health Plan Survey trends shared in this report, UBA Partner Firms are already preparing for the ramifications in 2022. At such a pivotal time, merely aligning health plans with national benchmarking averages will have detrimental consequences for employers. When businesses use our survey data to uncover new plan options that are taking hold in their region – or discover that their costs per employee are higher than their industry counterparts or learn that other groups their size have unique cost containment strategies – that's the power of UBA Partner Firms. Our Partner Firms have the local depth and the national breadth to ensure that employers make the most informed decisions on what benefits to offer. As we say at UBA, "Shared wisdom. Powerful results."

In health,

COLLEEN KUCERA
President
United Benefit Advisors

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UBA | Shared Wisdom. Powerful Results.®

INTRODUCTION

FOR 16 YEARS, UNITED BENEFIT ADVISORS® (UBA) has surveyed nearly 200,000 employers throughout the United States to create one of the largest health plan databases in the nation, containing detailed information on group health care by industry, group size, geography, and more. Real-time, digital access to our entire survey database offers employers unprecedented benchmarking and trend data to better inform their health plan design and renewal decisions.

The UBA Health Plan Survey assesses cost, funding methods, enrollment, plan types, out-of-pocket costs, employee contributions, coverage features, wellness programs, prescription drug coverage, ancillary benefits, and hundreds of other data points to provide the definitive source of independent data on employer-sponsored health plans. We not only have studied thousands of large employers over the years, but we also have surveyed tens of thousands of small and midsize groups to enable best-practice, peer-based benchmarking. Unlike other health plan surveys that have limited sample sets, or a large-group focus, UBA offers the most wide-ranging data set to enable the most laser-focused comparison modeling unique to each employer.

The data added from the 2021 UBA Health Plan Survey includes 21,533 plans offered by 10,414 employers covering approximately 1.3 million employees. What's more, UBA's survey data visualization tool enables our Partners to benchmark any employer's plan against regional, industry and size-based peers – from any phone, tablet, or laptop – instantly. Simply put, the extraordinary national and local perspective of the UBA Health Plan Survey transforms health care negotiation so employers can recruit and retain the best employees.

1. Rate increases again hovered around a more manageable 5% in 2021, a three-year trend that settled the industry after record high cost increases in 2018. UBA Partners continue to credit highly specialized benchmarking along with informed negotiation to cut initial proposed rates nearly in half.

2. The hardest hit employers facing the biggest cost increases from last year are those in the Southeast U.S., the government/education/utilities sector, and the middle market (200-999 employees).

3. Marking a three-year trend, the smallest employers (fewer than 25 employees) fared the best at the negotiating table, largely due to plan design choices. They typically set higher family deductibles than their larger counterparts, increased specialty/urgent/emergency room copays, raised employees' share of premium (to more than 38% versus the average 34%), and opted for four- and six-tier prescription drug plans that have higher copays for specialty drugs.

4. Employers across the nation are increasing employee contributions, a cost lever they hesitated to use in previous years. Historically, from 2009 to 2018, employers picked up approximately 72% of premiums while employees paid 28% on average. In recent years, the average employee contribution began to increase at a faster rate. In 2021, employee contributions are now approximately 34%.

5. Industry disparities in employee contributions continue to favor government workers over blue-collar workers. Government employers pass on the least cost to employees (while offering the richest plans), who contribute only 23.9%, on average, toward the total costs of their health plans. In contrast, the administrative/waste and construction/transportation industries pass on the most cost to employees, who pick up 39.5% and 38.1% of the tab, respectively.

6. Though they cost more, employers in the United States largely prefer preferred provider organization (PPO)/point of service (POS) plans. 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 Colorado, Florida, Wisconsin, 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.

7. Employees overwhelmingly prefer PPO/POS plans, with more than 60% enrolled in these plans throughout the United States. HSAs attract just over a quarter of employees, and, excluding California and a few Northeastern states, HMO/EPO plans garner fewer than 14% of employees nationwide.

8. In 2021, PPO/POS plans generally did not increase deductibles or out-of-pocket maximums for singles or families (in or out of network). In previous years, in-network deductibles for families and out-of-network benefits in general had experienced routine increases.

9. Looking at employers of all sizes across the nation, only about 14% offer comprehensive wellness programs. At first glance that might indicate that wellness is not a high priority. However, as is well known, large employers (500+ employees) make greater investments in wellness and, in fact, about half of these groups offer multi-faceted wellness programs that target prevention and wellbeing. But the UBA Health Plan Survey shows another group interested in wellness: smaller employers (fewer than 500 employees) who self- or level-fund their health plans. Among this group, a surprising 23% offer formal wellness initiatives. Regardless of group size, paid time off continues to be the top reward used to incentivize employee participation in wellness programs.

10. Employers continue to control drug costs through increased segmentation. In fact, over three quarters of all prescription drug plans have four to six tiers. Small businesses in particular are leading this trend. Nearly 49% of prescription drug plans offered by employers with fewer than 50 employees are comprised of four tiers and nearly 37% have five or six tiers. Conversely, groups with more than 500 employees largely turn to four-tier (47.6%) and 3-tier (35.7%) prescription drug plans, with only 10% having 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 4.9% in 2021, less than the 5.4% increase seen in 2020, but not as low as the 4.6% increase in 2019. With this three-year trend, premium increases have remained stable, and considerably less than the nearly 10% increase seen in 2018 (which marked a ten-year high). The modest increase in 2021 was a product of good negotiation. UBA Partners reported that the average initial or proposed rate increase was 9.1%, with final rate increases averaging 4.9% after negotiation.

Employees, on average, contribute approximately 33.8% toward total plan costs, up from the 32% employee contribution seen in 2020 and in 2019.

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

Although preferred provider organization (PPO)/point of service (POS) plans continue to cost more per employee than the average plan ($11,521 vs. $10,949), they still dominate in both plan prevalence and enrollment. More than 55% of plans are PPO/POS plans and enrollment continues to increase, with 60.4% of employees enrolling in these types of plans.

PLAN TYPE	2021 AVERAGE TOTAL COST PER EMPLOYEE (COMPOSITE)	2021 AVERAGE TOTAL COST PER SINGLE EMPLOYEE	2021 AVERAGE TOTAL COST PER FAMILY
PPO/POS	$11,521	$7,391	$21,761
HSA	$10,217	$6,383	$18,987
HMO/EPO	$10,272	$6,973	$20,494
ALL PLAN TYPES	**$10,949**	**$7,062**	**$20,804**

HEALTH SAVINGS ACCOUNT (HSA) PLANS

Health savings account (HSA) plans—sometimes referred to as "consumer-directed" or "high deductible" health plans—cost $10,217 per employee on average. HSA plans were typically more expensive than HMO/EPO plans prior to 2017, but since then, they cost about the same. Approximately 23.7% 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 $10,272 per employee on average. Approximately 21% of plans are HMOs/EPOs and only 14% of employees choose to enroll in these plans nationwide. However, prevalence of, and enrollment in, these plans is highly regional. See the corresponding section of this report for more information on where HMO/EPO plans garner high participation.

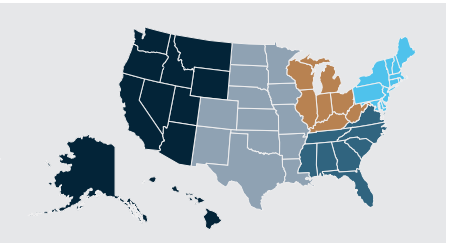
COSTS BY REGION

Nationally, average costs per employee rose 2% from 2020 to 2021.

YEAR	2021	2020	2019	2018	2017	2016
TOTAL AVERAGE COST PER EMPLOYEE (NATIONAL)	$10,949	$10,736	$10,447	$10,313	$9,934	$9,727
PERCENT INCREASE FROM PRIOR YEAR	2.0%	2.8%	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 Central 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. Generally, the Central U.S. has been the low-cost leader and in 2021 again offers some of the least expensive plans in the nation. The Southeast, with its low or no cost increases in the last few years, saw a significant cost increase this year. The Northeast also experienced above-average cost increases. Plans in the Western U.S. had virtually no cost increases in 2021.

REGION	SOUTHEAST	CENTRAL	WEST	NORTH CENTRAL	NORTHEAST	AVERAGE
TOTAL COST PER EMPLOYEE	$10,138	$10,011	$10,141	$11,402	$12,879	$10,949
PERCENT CHANGE FROM 2020	4.7%	1.5%	0.1%	2.2%	3.4%	2.0%



TOP 10 MOST EXPENSIVE STATES

1 • NEW YORK · $17,225
2 • MASSACHUSETTS · $14,934
3 • VERMONT · $13,429
4 • NEW HAMPSHIRE · $12,816
5 • WISCONSIN · $12,751
6 • NEW JERSEY · $12,696
7 • CONNECTICUT · $12,633
8 • OHIO · $12,397
9 • CALIFORNIA · $12,262
10 • MAINE · $12,015

TOP 10 LEAST EXPENSIVE STATES

1 • NEVADA · $6,427
2 • MISSOURI · $8,174
3 • TENNESSEE · $8,807
4 • HAWAII · $9,075
5 • ARKANSAS · $9,089
6 • IDAHO · $9,169
7 • ARIZONA · $9,218
8 • COLORADO · $9,309
9 • OREGON · $9,345
10 • OKLAHOMA · $9,380

EMPLOYERS

thithis year contributed approximately 66% toward health plan costs while employees covered nearly 34%, a departure from the 72/28 employer/employee split seen from 2009 to 2018.

COST BY INDUSTRY

The government/education/utilities sector has the priciest plans, at $12,928 per employee, up nearly 5% from last year. Total costs per employee for the construction/transportation, retail, hospitality, administrative/support, 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 and traditionally less rich plans found in these sectors. After two years of significant increases, the technology sector experienced only slightly above-average increases this year. Similarly, after experiencing the highest cost increases last year, the construction/transportation sector saw price relief in the form of a modest 1.1% increase in 2021. The government/education/utilities sector had the highest cost increases this year (4.9%), followed by the health care/social assistance industry with 3.9% cost increases.

COST BY INDUSTRY

INDUSTRY	2017	2018	2019	2020	2021
GOVERNMENT, EDUCATION, UTILITIES	$11,936	$11,943	$12,125	$12,324	$12,928
FINANCIAL, INSURANCE, REAL ESTATE	$10,735	$11,218	$11,155	$11,554	$11,771
PROFESSIONAL, SCIENTIFIC, TECHNOLOGY	$10,170	$10,384	$11,074	$11,497	$11,759
MANUFACTURING	$9,909	$10,462	$10,566	$10,796	$11,045
HEALTH CARE, SOCIAL ASSISTANCE	$9,643	$10,063	$10,178	$10,401	$10,811
WHOLESALE, RETAIL	$9,497	$9,714	$9,840	$10,098	$10,192
CONSTRUCTION, AGRICULTURE, TRANSPORTATION	$9,446	$9,583	$9,681	$10,130	$10,242
INFORMATION, ARTS, ACCOMMODATION & FOOD	$8,798	$9,110	$9,441	$9,660	$9,791
ADMINISTRATIVE & SUPPORT, WASTE MANAGEMENT & REMEDIATION SERVICES	$9,257	$9,670	$9,698	$9,780	$9,908

AVERAGE COST
ALL INDUSTRIES

2018 **$10,313**
2019 **$10,447**
2020 **$10,736**
2021 **$10,949**

EMPLOYEE CONTRIBUTIONS BY INDUSTRY

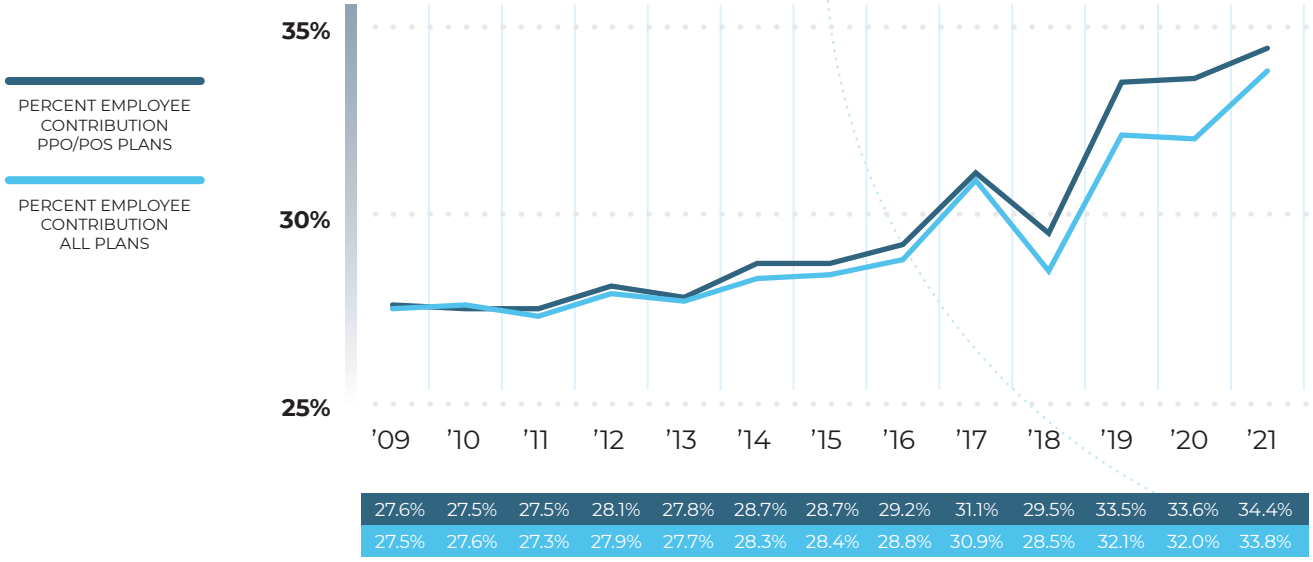
Employees on average contribute 33.8% toward the cost of health plans in 2021, which marks a continued departure from the average employee contribution from 2009 to 2018, which was approximately 28.3% across all plans. When this decade-long average rose to 32% in 2019 and 2020, many experts picked up on the rapidly increasing trend, which further materialized this year.

AVERAGE PERCENT EMPLOYEE CONTRIBUTION BY INDUSTRY

	2020	2021
GOVERNMENT, EDUCATION, UTILITIES	23.4%	23.9%
FINANCIAL, INSURANCE, REAL ESTATE	28.3%	30.6%
PROFESSIONAL, SCIENTIFIC, TECHNOLOGY	33.2%	33.0%
MANUFACTURING	30.3%	30.8%
HEALTH CARE, SOCIAL ASSISTANCE	30.0%	33.2%
WHOLESALE, RETAIL	33.9%	36.8%
CONSTRUCTION, AGRICULTURE, TRANSPORTATION	36.4%	38.1%
INFORMATION, ARTS, ACCOMMODATION & FOOD	32.2%	35.1%
ADMINISTRATION & SUPPORT, WASTE MANAGEMENT & REMEDIATION SERVICES	37.6%	39.5%

Average employee contributions vary significantly by industry. Government employers pass on the least cost to employees (while offering the richest plans), who contribute only 23.9%, on average, toward the total costs. The administrative/waste and construction/transportation industries pass on the most cost to employees, who pick up 39.5% and 38.1% of the tab, respectively. The financial, health care, retail, and hospitality sectors are among those experimenting the most with shifting costs to employees, increasing employee contributions more than 9% on average from 2020 to 2021. Health care employers in particular raised employee contributions nearly 11%, likely due to their high cost increases this year. Keep in mind that their employee contributions this year are still slightly below average, so it may have been the most effective lever to mitigate costs.

AVERAGE EMPLOYEE CONTRIBUTION NEARLY **34%** ACROSS ALL INDUSTRIES AND PLAN TYPES



	'09	'10	'11	'12	'13	'14	'15	'16	'17	'18	'19	'20	'21
PPO/POS	27.6%	27.5%	27.5%	28.1%	27.8%	28.7%	28.7%	29.2%	31.1%	29.5%	33.5%	33.6%	34.4%
ALL PLANS	27.5%	27.6%	27.3%	27.9%	27.7%	28.3%	28.4%	28.8%	30.9%	28.5%	32.1%	32.0%	33.8%

CAREFUL BENCHMARKING IN THE HEALTH CARE INDUSTRY

As "thank you" signs dot the nation's lawns and windows hailing health care workers for their heroic work during the coronavirus pandemic, perhaps no other industry more than the health care industry knows the importance of employer-sponsored benefits as a crucial recruitment, retention, and workplace safety tool. While the costs to insure their own employees in 2021 jumped nearly 11%, their plan costs ($10,811 per employee per year on average) are now in line with national averages. To offset those costs, health care employers around the U.S. are asking their employees to pick up 33% of the costs, versus the historical 72/28 employer/employee split. More than half of health plans in this sector are PPO/POS plans, while HMO/EPO and HSA plans each represent a quarter of all plans offered. Approximately two thirds of health care employees enroll in PPO/POS plans, making it the most prevalent plan covering this workforce.

There are some important variations by region and group size that should inform health care employers as they design and negotiate their health plans going forward. For example, health care companies in the Northeast, as well as small health care companies in general, have experienced success with more affordable HMO/EPO plans, garnering nearly 40% of employee enrollment. Health care employers in the Central U.S. have experienced similar success with HSA plans—35% of plans in this region are now HSA plans, and over a quarter of employees choose this option. In many cases, these plans lower the total average per employee cost, and often enable employers to set below-average employee contributions for these plans.

Regional differences are also pivotal when it comes to total cost per employee per year and employee contribution. For example, PPO/POS plans for health care workers in the Southeast typically cost $10,550 per employee per year, however employees pick up nearly 40% of the cost. Conversely, these plans in the Northeast cost $12,975 per employee per year on average, while health care workers pick up less than 28% of the cost. Group size has a similar effect on costs and contributions. Small health care businesses (fewer than 100 employees) in the U.S. can expect to pay $10,749 per employee per year on average for a PPO/POS plan, and their workers pick up more than 37% of the cost. Meanwhile, large health care employers (500+ employees) pay approximately $11,747 per employee per year, while employees only contribute about 28% of the cost.

Out-of-pocket costs for employees are always important plan design factors for all stakeholders. In the health care industry, PPO/POS plan copays for primary, specialty, urgent, and emergency room care are usually $30/$50/$60/$250, respectively, which is in line with national averages for all other industries. However, the health care sector sets PPO/POS plan in-network deductibles for singles and families below average at $2,000 and $4,500, respectively. Furthermore, large health care companies as well as health care companies located in the West are setting their deductibles well below both industry and national averages.

As U.S. health care employers emerge from the pandemic, they are particularly concerned about workplace safety, employee health and wellbeing, and the ramifications of the surge in formerly postponed preventive care. Optimal health care plans for their own population will continue to require granular benchmarking not only to ensure the best clinical and financial outcomes, but to see how plans stack up against industry competitors – and, equally importantly, to communicate plan value to employees.

PREVALENCE OF PLAN TYPE BY REGION

For the last four years, PPO/POS plans have comprised approximately 55% of the group health plans offered nationwide, while about a quarter of plans offered are HSA plans and approximately 20% are HMO/EPO plans. When looking at plans by region, PPO/POS plans especially dominate in the Southeast, but less so in the Northeast. Interestingly, though the West has historically had a strong prevalence of HMO/EPO plans, the Northeast actually had the highest prevalence of these plans for the past two years. (It is worth noting that while HMO/ EPO prevalence is just 26.8% in the larger Western region, within California alone, 55.4% of employers offer HMO/EPO plans, making these plans more popular than PPO/POS plans in that market.) States including Colorado, Florida, Wisconsin, and Hawaii also have strong HMO markets that differ from their surrounding regions. The Central and North Central regions have the highest prevalence of HSA plans.

PLAN TYPE	WEST	CENTRAL	NORTH CENTRAL	SOUTHEAST	NORTHEAST
PPO/POS	58.8%	54.7%	53.6%	63.3%	45.9%
HSA	14.4%	30.1%	29.6%	20.4%	21.9%
HMO/EPO	26.8%	15.2%	16.7%	16.3%	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 more than 60% enrolled in these plans. Just over a quarter of employees enroll in HSA plans, and approximately 14% enroll in HMO/EPO plans. But like other health care metrics, there are regional variations which make localized benchmarking crucial.

PPO/POS plans have the greatest enrollment in the Southeast and West regions of the country. California differs significantly from the larger Western region trend, however. There, 54% of employees are 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, employers in the North Central U.S. have seen some of the highest employee enrollment in HSA plans. Likewise, the Northeast has some of the highest enrollment in HMO/EPO plans (as does California, per the previous note). It is interesting to note that the Northeast and the Southeast continue to see employees rapidly move away from HSA plans.

PLAN TYPE	WEST	CENTRAL	NORTH CENTRAL	SOUTHEAST	NORTHEAST
PPO/POS	69.2%	66.0%	48.5%	75.5%	57.9%
HSA	15.1%	25.9%	41.9%	15.8%	15.2%
HMO/EPO	15.7%	8.2%	9.6%	8.6%	26.9%

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 four 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%, but this year, they had nearly a 2% decrease in costs. Experts are watching these large groups to see if the course corrections start to stabilize in the years ahead.

AVERAGE COST PER EMPLOYEE BY ORGANIZATION SIZE

ORGANIZATION SIZE	AVERAGE COST PER EMPLOYEE	PERCENT INCREASE FROM 2020
1,000+ EMPLOYEES	$11,242	-1.8%
500-999 EMPLOYEES3	$12,273	4.8%
200-499 EMPLOYEES	$11,773	4.6%
100-199 EMPLOYEES	$11,211	3.2%
50-99 EMPLOYEES	$10,622	3.7%
25-49 EMPLOYEES	$10,312	-0.3%
FEWER THAN 25 EMPLOYEES	$11,019	1.3%
OVERALL AVERAGE	**$10,949**	**2.0%**

Middle market employers (200 to 999 employees), who have had some of the highest increases in recent years, not only have the most expensive plans in 2021, but also the highest cost increases this year. Costs for employers with 500 to 999 employees rose 4.8% and costs for employers with 200 to 499 employees rose 4.6% from 2020 to 2021, making them the hardest hit group this year (well above the average 2% cost increase over all group sizes combined).

MOST EXPENSIVE PLANS

- PPO/POS PLANS
- PLANS IN THE NORTHEAST
- PLANS IN THE GOVERNMENT/ EDUCATION/UTILITIES INDUSTRY
- PLANS AMONG MIDDLE MARKET EMPLOYERS (200-999 EMPLOYEES)

LEAST EXPENSIVE PLANS

- HSA PLANS
- PLANS IN THE CENTRAL U.S.
- PLANS IN THE HOSPITALITY INDUSTRY (HOTEL, FOOD)
- PLANS AMONG SMALL EMPLOYERS (1-99 EMPLOYEES)

The smallest groups (1 to 49 employees) fared the best at the negotiating table for the third year in a row, with 0.5% cost increases in 2021 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 family deductibles than their larger counterparts, increasing specialty/urgent/emergency room copays, raising employees' share of premium (to more than 38% versus the average 34%), and choosing four- and six-tier prescription drug plans with higher co-pays for specialty drugs.

DEDUCTIBLES AND MAXIMUMS

Employers are not generally increasing in-network deductibles and out-of-pocket maximum costs as part of their cost mitigation strategies in 2021. In fact, employers have kept the in-network costs for singles and families on PPO/POS and HSA plans virtually the same as last year. But employers offering HMO/EPO plans (which represent approximately 20% of all plans offered) have raised in-network deductibles for singles approximately 12%, and out-of-pocket maximums (in-network) for singles and families on these plans rose nearly 6%.

When it comes to out-of-network benefits, employers offering PPO/POS plans had been raising deductibles and out-of-pocket maximums steadily prior to this year (for example singles paid $3,000 in 2018, $4,000 in 2019 and $5,000 in 2020). However, in 2021, PPO/POS plan out-of-network costs have largely remained the same, indicating employer reluctance to continue using this cost lever to manage costs. On the other hand, HSA and EPO plans continue to discourage use of non-participating physicians by singles and families by raising out-of-network costs; in 2021 HSA and EPO plan out-of-network deductibles increased 7% and 12.5%, respectively. Similarly, out-of-network maximums for HSA and EPO plans rose on average 7% and 20%, respectively, with families hardest hit.

BENCHMARKING DEDUCTIBLES AND OUT-OF-POCKET COSTS

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	$6,000	$12,000
FAMILY OUT-OF POCKET MAXIMUM	$12,000	$25,000

HSA PLANS	IN-NETWORK BENEFITS	OUT-OF-NETWORK BENEFITS
SINGLE DEDUCTIBLE	$3,000	$7,500
FAMILY DEDUCTIBLE	$6,000	$15,000
SINGLE OUT-OF-POCKET MAXIMUM	$5,000	$12,700
FAMILY OUT-OF POCKET MAXIMUM	$10,000	$25,800

HMO/EPO PLANS	IN-NETWORK BENEFITS	OUT-OF-NETWORK BENEFITS*
SINGLE DEDUCTIBLE	$2,250	$4,500
FAMILY DEDUCTIBLE	$4,500	$9,000
SINGLE OUT-OF-POCKET MAXIMUM	$6,350	$8,900
FAMILY OUT-OF POCKET MAXIMUM	$12,700	$20,000

*EPO PLANS

HAWAII AND ALABAMA HAVE THE LOWEST IN-NETWORK DEDUCTIBLES FOR SINGLES AND FAMILIES, WHILE CONNECTICUT AND NEW HAMPSHIRE HAVE THE HIGHEST IN-NETWORK DEDUCTIBLES FOR SINGLES AND FAMILIES. TEXAS HAS KEPT ITS DEDUCTIBLES FOR SINGLES IN CHECK, BUT IT HAS THE HIGHEST DEDUCTIBLES FOR FAMILIES IN THE NATION.

COPAYS

Generally, copays are similar across plan types, with the majority of primary care physician copays at $30, which has remained unchanged for two years in a row. However, plans offered by larger employers (more than 100 employees) as well as groups in the Northeast, tend to lower primary care copays to $25. Copays for specialty care physicians are approximately $50, though again, larger groups often set this copay lower, around $40. Copays for urgent care range from $50 to $60, however, HSA plans often set these copays higher, at $75. Emergency room copays are approximately $250, a metric which has remained the same since 2019 following some significant increases in prior years (from $150 in 2017, to $200 in 2018, to $250 in 2019). Employers in the Central and Southeast U.S., as well as small businesses, often choose to increase emergency room copays to $300.

DEPENDENT COVERAGE

Historically, in 2010, 51.1% of employees opted for dependent coverage, followed by a steady decline reaching a ten-year low in 2017 where only 39.6% of employees obtained dependent coverage. From 2018 to 2021, approximately 43.7% of employees on average opted for dependent coverage.

SPOUSE AND PARTNER COVERAGE

Currently, nearly 60% 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 40% of health plans 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), those benefits are becoming more common. In 2020, more than 25% of plans offered these benefits and in 2021, that number increased to nearly 28%. Still, the vast majority of plans offer evaluation only or no infertility coverage at all.

MOST COMMON **COPAY** STRUCTURE

$30 PRIMARY CARE PHYSICIAN COPAY

$50 SPECIALTY CARE PHYSICIAN COPAY

$50 URGENT CARE COPAY

$250 EMERGENCY ROOM COPAY

ANCILLARY BENEFITS

In 2021, more than 81% of employers offered dental insurance, while approximately 67% offered vision coverage. Sixty-one percent of employers offered basic life insurance, 54% offered accidental death and dismemberment (AD&D) coverage, and 42% offered voluntary life insurance. Short-term disability coverage was provided by 40.7% of employers, and 43.1% of employers offered long-term disability coverage. Approximately 15% of employers offer critical illness insurance while nearly 16% provide access to accident insurance. When you consider all U.S. employers of all sizes as a whole, legal, pet, long term care, and college loan benefits are very rarely offered (less than 3%). However, prevalence rates of all ancillary benefits increase significantly among the nation's largest employers with more than 500 employees (dental: 96%, vision: 91%, basic/voluntary life: 87%, AD&D: 86%, short- and long-term disability: 81%)—and even less common benefits such as legal and pet insurance are more common among these large groups (13%).

HSA AND HRA CONTRIBUTIONS

Approximately 24% of all plans offer a health savings account (HSA), and of those, only 30.4% 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 have remained flat for the last two years at around $980. Families experienced a slight increase in employer contributions to their health savings accounts—going from $1,515 in 2020 to $1,543 in 2021 on average.

Only 6.5% of plans offer a health reimbursement arrangement (HRA). Average HRA reimbursements for singles increased from $2,532 in 2020 to $2,723 in 2021. The average employer contribution for families went from $4,681 in 2020 to $4,916 in 2021.

HSA EMPLOYER CONTRIBUTION TREND

YEAR	AVERAGE CONTRIBUTION FOR SINGLES	AVERAGE CONTRIBUTION FOR FAMILIES
2021	$980	$1,543
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
2021	$2,723	$4,916
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 79.2% are fully insured and 21.8% 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, the number of large group, self- or level-funded plans increased to 66% and in 2021, that number rose again to 69.1%, illustrating even greater interest in this funding method among these employers. Among midsize employers (100 to 499 employees), 32% of employers choose self-funding, up slightly from the historical average of 30% for these groups. The small employer market (25 to 99 employees) tells a similar story. In 2021, 15% of these groups chose to self-fund or level-fund, which is fairly consistent with last year. However, since only 7% of these employers chose self-funding in 2015, small group adoption rates of self- or level-funded plans continues to be a metric to watch. 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%
2021: 84.8%

PERCENTAGE MIDSIZE EMPLOYERS (100-499 EMPLOYEES) FULLY INSURED
2015: 75%
2021: 68%

Along with benefits for employers, self-funding models have an advantage for employees as well, namely lower contributions toward premiums. For example, in 2021 employees at midsize companies (100 to 499 employees) contributed approximately 25% toward self- and level-funded plans, while their counterparts on fully insured plans had to contribute nearly 30% toward premiums.

PERCENTAGE LARGE EMPLOYERS (500+ EMPLOYEES) FULLY INSURED
2015: 37%
2021: 30.9%

WELLNESS PROGRAMS

Comprehensive wellness programs are offered by 14.1% of all employers. Wellness programs are most prevalent among HSA plans (16.9%), Northeast employers (20.5%), plans sponsored by government/education employers (28.5%), and most especially among larger groups (42.1% for groups with 500 to 999 employees, and 52.3% for groups with 1,000+ employees). UBA Partners report that wellness programs are also of interest to smaller employers who self- or level-fund or are planning to self-fund their health plans. Approximately 23% of small groups (fewer than 500 employees) with self- or level-funded plans offer wellness.

Among all wellness programs, 77.6% include health risk assessments, 72.1% offer employee incentives for participation, 55.7% offer biometric screenings or physical exams, 55.5% include on-site or telephone coaching for high-risk employees, and 47.1% include seminars or workshops. Due to the government's increased scrutiny, the use of health risk assessments had been declining since 2014 when 80.3% of plans featured these tools. However, in 2021, employers were once again more interested in using health risk assessments. In contrast, the use of physical exams/biometric screenings decreased 11%.

WELLNESS PROGRAMS COMPONENTS

HEALTH RISK ASSESSMENTS	77.6%
INCENTIVES/REWARDS	72.1%
PHYSICAL EXAM/BLOOD DRAW	55.7%
WEB PORTAL	61.3%
COACHING	55.5%
SEMINARS/WORKSHOPS	47.1%
OTHER	4.0%

PERCENTAGE OF EMPLOYERS OFFERING WELLNESS PROGRAMS

FEWER THAN 25 EMPLOYEES	12.3%
25-49 EMPLOYEES	9.1%
50-99 EMPLOYEES	13.5%
100-199 EMPLOYEES	21.2%
200-499 EMPLOYEES	29.4%
500-999 EMPLOYEES	42.1%
1,000+ EMPLOYEES	52.3%

For the past three years, the primary wellness incentives are in the form of extra paid time off. In 2021, nearly 57% of wellness programs that incentivize participation reward employees with paid time off, drastically different from 2015 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. 2019 marked a surprising shift to paid time off as the incentive of choice—which has steadily increased ever since. 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.

IN 2021, 56.7% of employers offering wellness programs incentivize participation with extra paid time off. Nearly 30% offer cash toward premiums and 21% incentivize with gift certificates.

Approximately 68% of wellness programs are provided by the employee's insurance carrier, while 14.4% of wellness programs are provided by an independent supplier.

PRESCRIPTION DRUG PLANS

Prescription drugs, particularly for chronic conditions and specialty care, continue to be a significant cost driver in group health care. Employers and carriers alike continue to seek ways to mitigate these costs in order to hold health care premiums in line. As a result, prescription drug plans continue to become more complicated, with more 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 (only 4.3% of plans), the use of three-tier plans also remains less common. Survey data show only 20.3% of prescription drug plans have three tiers in 2021, unchanged from last year. Approximately 46.3% of plans have four tiers, making it the most prevalent prescription drug plan configuration. For the third year in a row, approximately 14% of plans have five tiers. The survey also shows that 15.2% of plans have six tiers. As a result, nearly 30% of prescription drug plans have five or six tiers, superseding three-tier plan usage overall.

Employers with 100 or more employees still primarily offer three- and four-tier plans. However, smaller employers more commonly offer plans with four or more tiers. In fact, nearly 49% of prescription drug plans offered by employers with fewer than 50 employees are comprised of four tiers and nearly 37% have five or six tiers. Conversely, only 10.9% of prescription drug plans offered by these small businesses have three tiers.

Benefit levels for generic prescriptions remained flat in 2021, preserving the median $10 copay across all tier structures. While employers are keeping copays for generics low, copays for specialty drugs continue to be costly. The median out-of-pocket costs for specialty drugs in 2021 are $150 for preferred specialty drugs and $250 for non-preferred specialty drugs. Plans offered to larger groups (100+ employees) can typically provide lower specialty drug copays: $75 to $100 for preferred specialty drugs and $150 for non-preferred specialty drugs.

TRENDS OUTLOOK

WHAT WE SEE TODAY,

MAY BE PREDICTORS

OF WHAT IS COMING

IN THE FUTURE

In 2021, the government has been focused on health care pricing and compensation transparency, as well as subsidies to continue individual coverage when group coverage is lost. Understanding the related legislation will be important as employers prepare for 2022 plan renewals.

LEGISLATIVE INSIGHTS

COVID-19-focused legislation has dominated 2021, which includes sweeping transparency requirements in connection with the cost of health coverage and other provisions in order to protect consumers. The pandemic renewed Congress' interest in the lack of health care pricing transparency from providers, which often results in participants receiving unexpected balance bills. The U.S. Congress has passed the Consolidated Appropriations Act, 2021 (CAA), generally effective December 27, 2021, which included the No Surprises Act. The CAA included roughly $900 billion in COVID-19 relief, including provisions beneficial to hospitals and health systems. The CAA also established a new rule which requires that brokers and consultants disclose direct and indirect compensation received in connection with ERISA covered group health plans. Additionally, Congress enacted the American Rescue Plan Act (ARPA) on March 11, 2021, which provided eligible individuals with temporary COBRA subsidies in response to involuntary employment terminations which may have been caused by the COVID-19 pandemic.

NO SURPRISES ACT

Under the No Surprises Act, group health plans, or health insurance issuers offering group or individual health insurance coverage, that provide or cover any benefits for services in an emergency department of a hospital (including a hospital outpatient department that provides emergency services) or an independent freestanding emergency department (in-network or out-of-network, also referred to as participating and nonparticipating), must cover the emergency services with no pre-authorization and without regard to any other term or condition of such coverage (other than exclusion or coordination of benefits, or an affiliation or waiting period, permitted under the Patient Protection and Affordable Care Act (ACA), and incorporated pursuant to ERISA and the Internal Revenue Code, and other applicable cost-sharing).

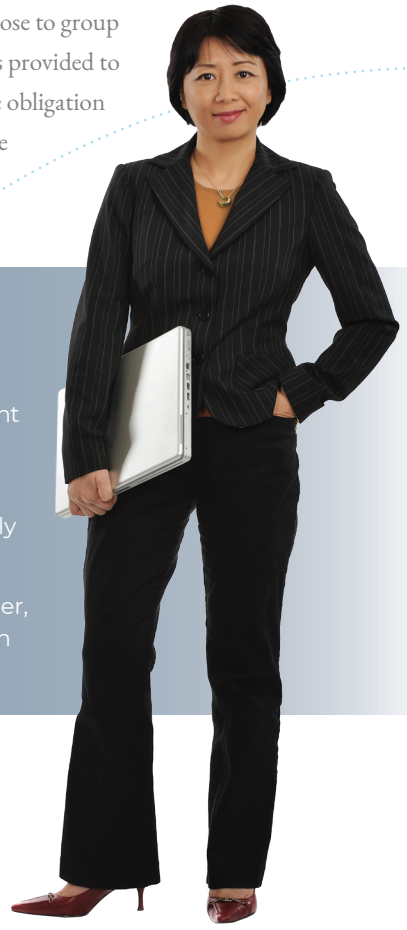
On July 1, 2021, the U.S. Departments of Health and Human Services, Labor, and Treasury, along with the Office of Personnel Management (collectively, the Departments), issued an interim final rule (IFR) to explain provisions of the No Surprises Act, which are likely to be finalized in September 2021.

If the emergency services are provided by a non-participating provider or non-participating emergency facility, the plan or issuer must cover the emergency services without imposing requirements for prior authorization or any limitation on coverage that is more restrictive than the requirements or limitations that apply to emergency services received from participating providers and participating emergency facilities. Also, a plan may not apply higher cost-sharing than would apply if emergency services were provided by a participating provider or a participating emergency facility. The cost-sharing requirement is calculated as if the total amount that would have been charged for emergency services by the participating provider or participating emergency facility were equal to the recognized amount (the amount specified by state law, or a qualifying payment amount, or an amount determined under an All-Payer Model Agreement entered into by the state) for the services, plan or coverage, and year.

If a nonparticipating provider (such as an anesthesiologist or physician) renders services at a participating facility or at a nonparticipating emergency facility, the provider may not bill beyond an allowed cost-sharing amount (based on the "recognized amount" set forth in the IFR). Further, within 30 days from when the provider transmits a bill to the plan, it must determine an initial payment amount and directly pay the provider or issue a notice of denial. If the provider disagrees with the plan's payment, the parties may begin a 30-day open negotiation period. If the parties fail to reach an agreement, the plan or provider has four days to notify the other party and the Secretary of the Department of Health and Human Services (HHS) that they are initiating the Independent Dispute Resolution (IDR) process provided for under the Act.

BROKER COMPENSATION DISCLOSURE REQUIREMENT

The CAA also amended ERISA to require that brokers and consultants ("service providers") disclose to group health plan sponsors the direct and indirect compensation received in connection with the services provided to those plans. Prior to the enactment of the CAA, ERISA also contained a compensation disclosure obligation that only applied to retirement plans. The new rules, effective December 27, 2021, require a service provider to provide a written disclosure to the responsible plan fiduciary regarding compensation in excess of $1,000 received in connection with the services, including, but not limited to:



- A description of the services to be provided to the plan pursuant to the contract or arrangement.
- If applicable, a statement that the service provider, an affiliate, or a subcontractor will provide, or reasonably expects to provide, services pursuant to the contract or arrangement directly to the plan as a fiduciary.
- A description of all direct compensation, either in the aggregate or by service, that the service provider, an affiliate, or a subcontractor reasonably expects to receive in connection with the services.
- A description of all indirect compensation that the covered service provider, an affiliate, or a subcontractor reasonably expects to receive in connection with the services described.

Failure of the service provider to provide the written description may result in a prohibited transaction and a possible Department of Labor (DOL) enforcement action. These new rules will have a direct impact on service providers' administrative processes.

COBRA SUBSIDY

On March 11, 2021, President Biden signed the ARPA, which is a $1.9 trillion legislative package that includes pandemic relief for individuals and families. The Act implemented a mandatory 100% COBRA premium subsidy and state-mandated continuation coverage subsidy for individuals who lost group health plan coverage due to the involuntary termination of employment or reduction in hours. Spouses and dependents who are qualified beneficiaries at the time of the loss of health coverage were also eligible for the subsidy. Employers are entitled to a tax credit under the ARPA to fund the costs. Plan sponsors were required to permit a 60-day election period to allow subsidy eligible individuals to enroll and are also required to issue several notices in connection with the COBRA subsidy. The individuals eligible for COBRA assistance ("AEIs") included those who were or became COBRA-qualified beneficiaries as a result of an involuntary termination or reduction in hours, subject to certain rules. The COBRA subsidy began on April 1, 2021, and generally ended on September 30, 2021. Around the effective date of the mandated COBRA subsidy rules, plan sponsors struggled with implementation, in part, due to the absence of guidance. Subsequently, both the IRS and DOL issued much needed guidance.

During 2021, not only were employers dealing with economic instability resulting from the COVID-19 pandemic, they were also required to understand how to navigate these new rules. As we look forward to the 2022 calendar year, we are hopeful that the COVID-19 pandemic will not have a lasting adverse effect on plan sponsors and service providers attempting to remain compliant amid financial uncertainty and a rapidly changing regulatory scheme.

UNITED STATES

ALABAMA
Valent Group - Vestavia

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

ARKANSAS
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. - Redwood City
KBI Benefits, Inc. - Los Altos
Morris & Garritano Insurance Agency, Inc. - San Luis Obispo
Relational Advisors, LLC - Irvine
Vita - Moutain View

COLORADO
TrueNorth Companies, LLC - Longmont

CONNECTICUT
Blueprint Benefit Advisors - Hamden

FLORIDA
The Clemons Company - Panama City
Earl Bacon Agency, Inc. - Tallahassee
The Enterprise Team, Inc. - Altamonte Springs
JDI Group - Palm Beach Gardens
K&P Benefits Consulting Group - Lakewood Ranch
Keystone Benefit Group, LLC - Jacksonville
The Stoner Organization, Inc. - St. Petersburg

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

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

LOUISIANA
Alford & Associates - Houma
Becker Suffern McLanahan, Ltd. - Mandeville
Dwight Andrus Insurance - Lafayette

MAINE
Acadia Benefits, Inc. - Portland

MARYLAND
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
Nulty Insurance - Kalamazoo
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
Lovell Sagebrush Insurance Group - Lee's Summit

MONTANA
Rocky Mountain Insurance Group - Bozeman

NEBRASKA
Swartzbaugh-Farber & Associates, Inc. - Omaha

NEVADA
Dillon Insurance Services - Reno

NEW HAMPSHIRE
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
Ohio Health Benefits - Tallmadge
Schwendeman Agency, Inc. - Marietta

OKLAHOMA
Dillingham Benefits, LLC - Oklahoma City

OREGON
Hagan Hamilton Insurance Solutions - McMinnville
PBC Insurance - Eugene

PENNSYLVANIA
Ally Partners - Allentown
Commonwealth Benefits Group - Dillsburg
EHD - Lancaster
Fairmount Benefits, Inc. - Radnor
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 - Knoxville

TEXAS
Brinson Benefits, Inc. - Dallas
CBS Insurance LLP - Abilene
GSM Insurors - Rockport
InSource Insurance Group - Midland
Insurors of Texas General Agency - Waco
J.S. Edwards & Sherlock Insurance Agency - Beaumont
K&S Insurance - Rockwall
Shepard & Walton Employee Benefits - Austin
Stephens Insurance, LLC - Houston
Upshaw Insurance Agency - Amarillo

UTAH
DPW Benefits - Salt Lake City

VERMONT
The Richards Group - Brattleboro

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

WASHINGTON
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

ENGLAND
Churchills International Consulting Ltd - Edingley, Notts.

IRELAND
Glennon Employee Benefits & Financial Planning - Dublin

UBA
Health Plan Survey

ABOUT THIS SURVEY

Data in the 2021 UBA Health Plan Survey are based on responses from 10,414 employers sponsoring 21,533 health plans covering approximately 1.3 million employees nationwide. UBA's survey is one of the nation's largest health plan benchmarking surveys. The resulting volume of data provides employers of all sizes more detailed—and therefore more meaningful—benchmarks and trends than most other sources.

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 midsize 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