ADVANCED ANALYTICAL
CONSULTING GROUP

SELF-INSURED HEALTH BENEFIT PLANS 2025
APPENDIX B
Based on Filings through 2022

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SUMMARY

This document analyzes the funding mechanisms of employer-sponsored health benefit plans that filed a *Form 5500 Annual Return/Report of Employee Benefit Plans* ("Form 5500") for the reporting period (plan year) that ended in 2022. It compares fully insured, self-insured, and mixed-funded (funded through a mixture of insurance and self-insurance) health plans and presents selected historical series for the plan years 2013 through 2022. This document also uses publicly available corporate financial data for a subset of health plan sponsors, based on the financial data that is available from Bloomberg.

The analysis separates plans with at least 100 participants at the start of the reporting period ("large plans") from plans with fewer than 100 participants at the start of the reporting period ("small plans"). As discussed further below, this is because small plans generally are only required to file a Form 5500 if they operate a trust, which is associated with self-insurance. As a result, small plans in the analysis are a non-random subset of small plans nationwide.

For small plans that filed a Form 5500, the primary findings are as follows:

- The number of small plans that filed a Form 5500 rose by 7.7% from 24,693 in 2021 to 26,606 in 2022, with the number of participants in small plans nearly unchanged between 2021 and 2022, at about 260,000 participants. This relatively modest increase in the number of small plans is a notable change from the nearly 50% or more increases over the preceding four years (2018 to 2019, 2019 to 2020, and 2020 to 2021). The inflow of small plans in previous years appears to have been driven by a growing number of small plans with a trust that participate in a non-plan Multiple Employer Welfare Arrangement (MEWA).
- A large majority (98.7%) of small plans that filed a Form 5500 were self-insured. The share of participants in small plans that were self-insured increased from 85.5% in 2021 to 92.9% in 2022. External sources of information about health insurance of small employers, such as the Insurance Component of the Medical Expenditure Panel Survey (MEPS-IC), document far less self-insurance among small employers nationwide, underscoring the non-representative nature of small plans in our analysis due to exemptions from the Form 5500 filing requirements.
- Small self-insured plans were more than twice as likely to have stop-loss coverage as large self-insured plans. Among small self-insured plans that filed a Form 5500, stop-loss coverage has shown a consistent rise over time, reaching 54.2% in 2022.
- Most small self-insured plans that filed a Form 5500 are concentrated in the services and construction sectors.

The primary findings for large plans are as follows:

- In 2022, 58,290 large health plans covered 86.6 million participants. The number of plans increased by 2.2% from 2021. The number of plan participants increased by 4.6%.
- In 2022, almost one-half (46.3%) of large plans were self-insured or mixed-funded, and those plans covered 78.9% of large plan participants.

- At the plan level, the share of large plans that are self-insured (38.5%), mixed-funded (7.8%), and fully insured (53.7%) show a slight shift toward self-insured and mixed-funded from 2021 (38.1% and 7.6%, respectively).
- In 2022, 44.2% of large plan participants were covered by self-insured plans while mixed-funded plans covered 34.7%, and fully insured plans covered 21.1%. These participant-level shares correspond to a shift of about 3.2 percentage points of participants moving from plans with some self-insured component into fully insured plans, compared to 2021. However, this change in participants' coverage results from the shifts of two large plans out of mixed-funded into fully insured under the algorithm used to classify each plan's funding. One was due to about a one-third decline in premiums per participant paid to insurers. In the other case, it was due to a slow increase in premiums paid relative to the faster increase of premiums in the general market. We discuss shifts in the funding status of these two plans in more detail below.
- The prevalence of self-insurance (mixed-funded or self-insured) among large plans generally increased with plan size. For example, 29.1% of health plans with 100–199 participants were mixed-funded or self-insured in 2022, compared with 90.1% of health plans with 5,000 or more participants. This pattern is similar to prior years.
- Mixed-funding is found primarily among very large plans. For example, 2.0% of plans with 100–199 participants were mixed-funded in 2022, compared with 43.8% of plans with 5,000 or more participants.
- As reported in Form 5500 filings, stop-loss coverage among large, self-insured plans declined 0.5 percentage points, from 21.2% in 2021 to 20.7% in 2022. Similarly, mixed-funded, large plans experienced a decline in reported stop-loss coverage from 16.4% in 2021 to 14.8% in 2022. These figures likely understate the true prevalence of stop-loss insurance for large plans because the Form 5500 does not require stop-loss insurance for the benefit of the sponsor to be reported (as opposed to the plan).
- The rate of some form of self-insurance (self-insured or mixed-funded) varied by industry for large plans, with the highest rates occurring in the utilities (91.8%) and mining (84.8%) industries. 71% of large plans in each industry had some form of self-insurance in 2022.
- Funding for large plans sponsored by for-profit and not-for-profit organizations mainly differed in rates of mixed-funded and self-insured. Weighted by participants, mixed-funded was far more prevalent at for-profit entities, where 39.5% of for-profit entities' sponsored plans were mixed-funded, compared to 12.0% at not-for-profits. Conversely, self-insurance was less prevalent at for-profit entities than at not-for-profit entities, with 38.6% of for-profit entities' sponsored plans being self-insured, compared to 70.8% at not-for-profits. Large for-profit and not-for-profit entities diverged slightly in their prevalence of fully insured plans between 2021 and 2022, with 17.3% of not-for-profit entities' sponsored plans and 21.9% of for-profit entities' sponsored plans fully insured.
- We found no consistent evidence that the financial health of sponsors of fully insured large plans differed from that of sponsors of large plans that were mixed-funded or self-insured.

In addition to group health plans discussed above, this report briefly characterizes Group Insurance Arrangements (GIAs), which by definition are fully insured.[1] For 2022, 50 GIAs filed a Form 5500. They covered about 343,000 participants, were generally larger than group health plans, and were disproportionately in the finance, insurance, and real estate industries.

[1] A GIA is an arrangement that provides benefits to the employees of two or more unaffiliated employers (not in connection with a multiemployer plan or a collectively-bargained multiple-employer plan). A GIA fully insures one or more welfare plans of each participating employer through insurance contracts purchased solely by the employers or purchased partly by the employers and partly by their participating employees, with all benefit payments made by the insurance company. The GIA uses a trust or other entity as the holder of the insurance contracts and uses a trust as the conduit for payment of premiums to the insurance company. A GIA may file a single Form 5500 on behalf of all participating employers. 29 CFR § 2520.104-21, -43.

CONTENTS

1. INTRODUCTION

The 2010 Patient Protection and Affordable Care Act (ACA) (§1253) mandates that the Secretary of Labor "prepare an aggregate annual report on self-insured group health plans and self-insured employers," with general information on self-insured group health plans (including plan type, number of participants, benefits offered, funding arrangements, and benefit arrangements), as well as data from the financial filings of self-insured employers.[2] The U.S. Department of Labor (DOL) engaged Advanced Analytical Consulting Group, Inc. (AACG) to assist with the ACA mandate. This document serves as an appendix to the Secretary's 2025 *Report to Congress*.

As required by the ACA, the primary data source for this report is the information provided to the DOL by health plan sponsors on *Form 5500 Annual Return/Report of Employee Benefit Plans* ("Form 5500") filings. This report also uses financial data for a subset of health plan sponsors that had publicly available financial data in Bloomberg.

This report is the fifteenth installment of a series that began with the 2011 Report to Congress. While the analysis has been refined over time, no major methodological changes affected the current report relative to last year's iteration. The presentation remains largely the same, with the main change being that the analysis of small plans is now presented before that of large plans.

The current report presents results for Form 5500 filings for plan years that ended in 2013–2022 (i.e., a year before and several years after the effective implementation of the ACA in 2014). Growth in the number of small plan filings decelerated sharply from 2021 to 2022. The vast majority of those small plans are self-insured. However, for large plans, the primary findings for 2022 are similar to those for 2021.

Section 2 of this report describes Form 5500 and other data sources, including data quality, consistency issues, and the extent to which financial data were matched to health plan filings. Section 3 defines "funding mechanism" as used in this report. Section 4 presents the results of our data analysis for small health plans, and Section 5 discusses large plans. Section 6 briefly characterizes Group Insurance Arrangements (GIAs), and Section 7 concludes the report.

The views, opinions, and/or findings contained in this report should not be construed as an official Government position, policy, or decision, unless so designated by other documentation issued by the appropriate governmental authority.

[2] H.R.3590 - 111th Congress (2009-2010): Patient Protection and Affordable Care Act. (2010, March 23). https://www.congress.gov/bill/111th-congress/house-bill/3590

2. DATA SOURCES

The quantitative analysis in this report is based on three data sources: Form 5500 group health plan filings, Internal Revenue Service (IRS) *Form 990 Return of Organization Exempt From Income Tax* ("Form 990") filings, and Bloomberg data reflecting corporate financial records. For the purposes of this report, a plan is uniquely identified by the EIN of its sponsor and a plan number (PN). This section discusses the data sources and the algorithms used to match the three sources.

Form 5500 Filings of Health Benefit Plans

The ACA stipulates that the Secretary's Report to Congress on self-insured group health plans be based on Form 5500 filings. The Form 5500 Series was developed to assist employee benefit plans in satisfying annual reporting requirements under Title I and Title IV of the Employee Retirement Income Security Act (ERISA) and under the Internal Revenue Code. The Form 5500, including required schedules and attachments, collects information concerning the operation, funding, assets, and investments of pensions and other employee benefit plans, including employee welfare benefit plans.

Welfare benefits refer to medical, surgical, or hospital care or benefits, or sickness, accident, disability, death or unemployment, or vacation benefits, and other types of benefits described in section 302(c) of the Labor Management Relations Act that are not pension benefits established or maintained for employees by an employer, employee organization, or both.[3] Generally, companies file separate Form 5500s for pension and welfare benefits. This report centers on health benefits only and is thus based on a subset of welfare benefit filings.[4]

The Form 5500 consists of a main Form 5500, schedules and attachments, depending on the type of plan and its features. The main Form 5500 collects general information such as the name of the sponsoring employer, the type of benefits provided (pension, health, disability, life insurance, etc.), the effective date of the plan, and the number of plan participants, along with limited information on funding and benefit arrangements. If the plan sponsor provides some or all plan benefits through external insurance contracts, Form 5500 plan filings must include one or more Schedules A with details on each insurance contract (name of insurance company, type of benefit covered, number of persons covered, expenses, etc.). If the plan holds any assets in a trust, a Schedule H or Schedule I must be attached with financial information. Schedule H applies to large plans, whereas small plans may file the shorter Schedule I. Certain small plans may file a Form 5500-SF (Short Form) with less detailed information.[5]

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[3] See Labor-Management Reporting and Disclosure Act of 1959, As Amended, SEC. 302.

[4] While this report only addresses health benefit information, plans do provide information on other types of benefits on their Form 5500, such as dental and disability benefits.

[5] To be eligible to use the Form 5500-SF, the plan must generally have fewer than 100 participants at the beginning of the plan year, meet the conditions for being exempt from the requirement that the plan's books and records be audited by an

Non-ERISA plans, such as governmental plans and church plans, do not need to file a Form 5500 and are therefore not covered by the analysis in this report. Also, plans with fewer than 100 participants at the beginning of the plan year[6] ("small plans") are generally exempt from filing a Form 5500, unless they operate a trust or are a Multiple Employer Welfare Arrangement (MEWA) that is a single plan.[7] As a result, an estimated 99% of small health benefit plans were not required to file a Form 5500 in 2022 and so were not included in the report's analysis.[8] Therefore, the small plans included in this report are not representative of small plans in the United States.

In contrast, this report should include nearly all large ERISA-covered plans in the United States because plans with 100 or more participants at the beginning of the plan year ("large plans") are generally required to file a Form 5500.

Form 5500 filings were excluded from this report if (1) the filing was followed by another filing of the same plan for a later period in the same year (there were 83 such filings for small plans and 990 such filings for large plans in 2022), (2) the filing was for a small plan that did not hold assets in a trust and was therefore exempt from filing a Form 5500 (there were 1,774 such filings for small plans in 2022), (3) the plan name suggested that it did not offer health benefits that were the subject of the ACA (there were 3 such filings for small plans and 441 such filings for large plans

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independent qualified public accountant, have 100% of its assets invested in certain secure investments with a readily determinable value, hold no employer securities, not be a multiemployer plan, and not be required to file a Form M-1, *Report for Multiple Employer Welfare Arrangements (MEWAs) and Certain Entities Claiming Exception (ECEs)* available at dol.gov/sites/dolgov/files/EBSA/employers-and-advisers/plan-administration-and-compliance/reporting-and-filing/forms/m1-2022.pdf (dol.gov) for the plan year (2022 Instructions for Form 5500-SF, available at https://www.dol.gov/sites/dolgov/files/EBSA/employers-and-advisers/plan-administration-and-compliance/reporting-and-filing/form-5500/2022-sf-instructions.pdf).

[6] "Large" plans are generally those with 100 or more participants as of the beginning of the plan year. Conversely, "small" plans report less than 100 participants as of the beginning of the plan year. An important exception to the definition of "large" plans exists; plans with between 80 and 120 participants at the beginning of the year are eligible to file as the same type of plan as in the prior year. Thus, a plan that filed a Form 5500-SF in the prior year can file the Form 5500-SF as a "small plan" as long as the number of participants at the beginning of the year remains below 120. See section 4 of the 2022 Instructions for Form 5500, https://www.dol.gov/sites/dolgov/files/EBSA/employers-and-advisers/plan-administration-and-compliance/reporting-and-filing/form-5500/2022-instructions.pdf.

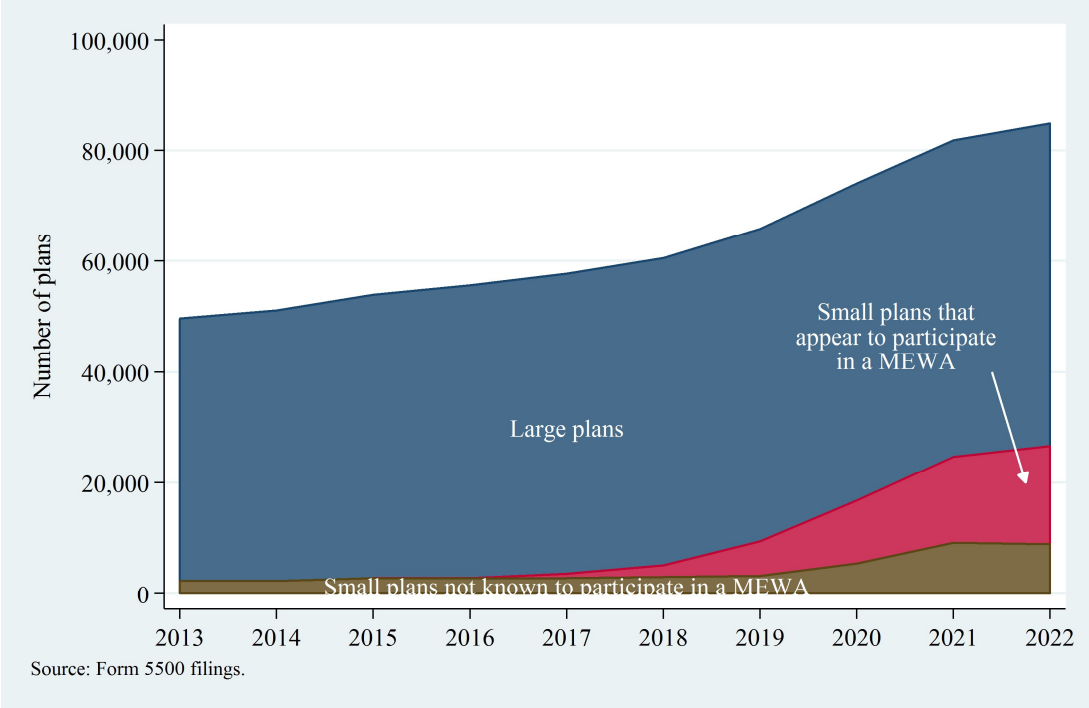
[7] Small plans that are fully insured or pay benefits from the employer's general assets (i.e., unfunded), or a combination of both, are exempt from filing a Form 5500.

[8] The most recent estimate on small plans qualified filers was in 2016. DOL estimated that 2,158,000 health plans covered fewer than 100 participants (See 81 FR47496 47502 (July 21, 2016), available at govinfo.gov/content/pkg/FR-2016-07-21/pdf/2016-14892.pdf). Based on participants at the beginning of the plan year, only 11,039 such plans (0.5%) filed a Form 5500 in 2016.

in 2022)[9], or (4) the filing was submitted by a GIA (there were 2 such filings for small plans and 48 such filings for large plans in 2022). This reduced the number of small plan filings from 28,468 to 26,606 and the number of large plan filings from 59,769 to 58,290.[10]

The number of small health benefit plans that filed a Form 5500 was approximately constant until 2016, but has grown substantially in recent years—see Figure 1.

Figure 1. Number of Small and Large Health Benefit Plans That Filed a Form 5500 (2013-2022)[11]



Plans that participate in a MEWA, which is a vehicle for offering welfare benefits to the employees of two or more employers, appear to have driven the growth in small

[9] Often these plans have names including the following terms, as well as others: "long term disability and voluntary life plan," "associate accident program," "group life", and "AD&D plan."

[10] Following the Form 5500 filing requirements, the distinction between small and large plans is based on participant count at the beginning of the reporting period. For all other purposes (unless specified otherwise), we measured the number of participants at the end of the reporting period, because that count is most up-to-date. The difference between participant counts at the beginning and the end of the reporting period implies that large plans (with 100 or more participants at the *beginning* of the reporting period) may cover fewer than 100 participants at the *end* of the period (see Table 1), and that small plans may cover more than 100 participants at the end of the period.

[11] Plan size is based on the number of participants at the beginning of the year.

plans. A MEWA may or may not be a welfare benefit plan itself.[12] If a MEWA is not a welfare benefit plan, Form 5500 filing requirements apply to the individual employer plans that participate in the MEWA; otherwise, the MEWA itself may file a Form 5500.[13] Based on plan names, we identified 17,645 plans out of the total of 26,606 in our analysis that appear to have participated in 10 non-plan MEWAs in 2022.[14,15]

Form 5500 filings are almost universally available for large ERISA-covered health benefit plans, while small plans generally are not required to file the Form 5500. Because these groups are so distinct, much of this report analyzes "large" and "small" plans separately.

This report includes 26,606 small plans covering 259,798 participants and 58,290 large plans covering 86,620,911 participants at the end of the plan year. Throughout this report, the term "participants" includes active and retired or separated employees, but excludes dependents of employees.[16]

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[12] A plan MEWA meets the ERISA definition of "employee welfare benefit plan" under section 3(1) of ERISA. A non-plan MEWA does not meet the ERISA definition of an "employee welfare benefit plan" under section 3(1) of ERISA. Typically, non-plan MEWAs cover a collection of separate employee welfare benefit plans maintained by individual employers.

[13] A MEWA that is itself an employee benefit plan is required to file a Form 5500. In addition, MEWAs that provide medical coverage, regardless of whether they also constitute employee benefit plans under ERISA, are required to file the Form M-1, "Report for Multiple Employer Welfare Arrangements (MEWAs) and Certain Entities Claiming Exception (ECEs)."

[14] Prior to 2016, we did not examine or report on whether small plan Form 5500 filers participated in non-plan MEWAs.

[15] Form 5500 and 5500-SF filings do not contain direct information about participation in a non-plan MEWA. We infer likely participation from plan names that contain the name of a MEWA. For example, in Ohio many plan names contain the string "SOCA BENEFIT PLAN," which suggests participation in a MEWA sponsored by the Southern Ohio Chamber Alliance (https://www.joinsoca.com/soca-benefit-plan/faqs). Similarly, many plan names contain the names of MEWAs sponsored by the Ohio Farm Bureau, Builders Exchange of Ohio, Ohio State Medical Association, Canton Regional Chamber of Commerce, Missouri Chamber Federation, Community Bankers of West Virginia, Georgia Chamber Federation, Georgia Farm Bureau, and California Association of Realtors.

[16] The number of participants is based on the number reported in Form 5500 filings and may overestimate the number of plan participants who received health benefits. A single Form 5500 filing may reflect multiple welfare benefit types/options available under a single plan, and some participants may opt out of the health benefit option but participate in a different welfare benefit option. An example is a welfare plan that provides multiple types of benefits with 500 employees enrolled for long-term disability benefits and of those 500 employees, only 400 are enrolled for health benefits. In this example, the number of plan participants reported in the Form 5500 would be 500, because the welfare plan overall covers 500 participants.

Table 1 presents the distribution of small plans and large plans for filings in statistical year 2022.[17] Large plans are listed by the size of the plan at the end of the reporting period.

Table 1. Distribution of Health Plans and Plan Participants, By Plan Participant Counts at the End of the Reporting Period (2022)

Participants in plan	Total Plans	Percent	Participants (millions)	Percent
Small Plans	26,606	31.3%	0.3	0.3%
Large Plans by Size				
0–99	2,781	3.3%	0.1	0.1%
100–199	19,728	23.2%	2.9	3.3%
200–499	18,831	22.2%	5.9	6.7%
500–999	7,490	8.8%	5.2	6.0%
1,000–1,999	4,187	4.9%	5.9	6.8%
2,000–4,999	2,935	3.5%	9.1	10.5%
5,000+	2,338	2.8%	57.6	66.3%
Total	84,896	100.0%	86.9	100.0%

Source: Form 5500 health plan filings.
Numbers or percentages may not sum to total due to rounding.

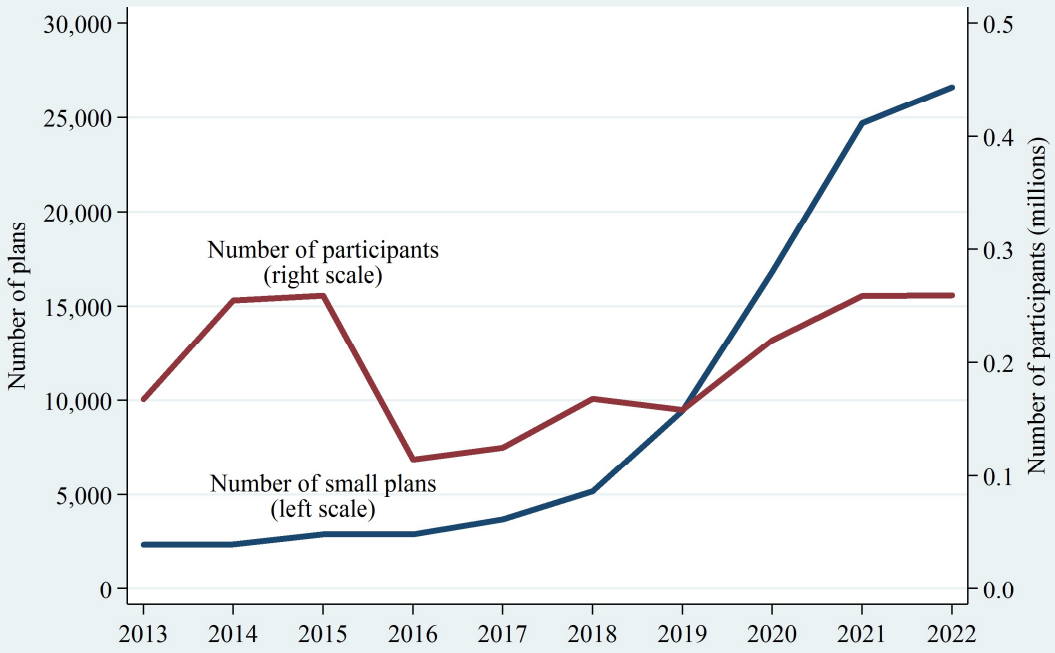
Health plans with fewer than 100 participants at the end of the plan year account for 34.5% of plans in our analysis. The majority of plans have less than 499 participants. The majority of participants, however, are in the largest plans. Plans with 5,000 or more participants make up only 2.8% of all plans in our dataset, but they account for 66.3% of all participants.

The Number of Health Benefit Plans and Their Participants

Our analysis covers statistical years 2013 through 2022. As shown in Figure 2 below and its underlying counts in Table 2, the rate at which small health plans increased between 2021 and 2022 from 24,693 to 26,606 (7.7%) was notably smaller than in the prior year (2020 to 2021), which saw an increase from 16,809 to 24,693 (over 45%). This was part of a longer trend which saw the number of small plans increased more than 160 percent from 2019 to 2021. The number of plans had exhibited slow growth between 2013 and 2016, followed by acceleration in growth rates from 2017 to 2021. In 2022, small plans covered approximately 260,000 participants, a growth of only 0.28% over 2021.

[17] Through much of this report, plans are defined as "large plans" or "small plans" based on the total participants at the beginning of the plan year ("BOY"). Plans that had 99 or fewer participants at BOY are defined as "small plans." Plans that had 100 or more participants at BOY are defined as "large plans." Table 1 reports both "large plans" and "small plans." The plan sizes listed in the table are the sizes of plans at the end of the plan year ("EOY").

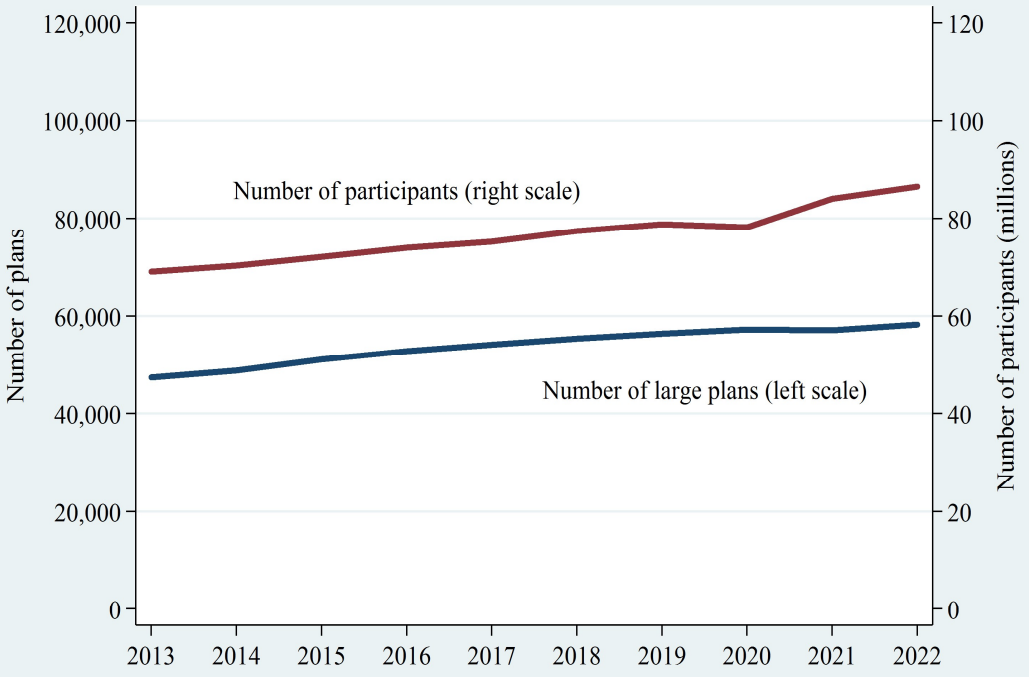
Figure 2. Small Health Plans and Participants, by Statistical Year



Source: Form 5500 filings of small health plans.

Similarly, Figure 3 below and its underlying counts in Table 2 show that between 2013 and 2022, the number of large plans ranged from roughly 47,000 to 58,000 per year. And the number of participants ranged from approximately 69 million to 87 million per year. From 2021 to 2022, the number of large health plans grew slightly, from just over 57,000 to just over 58,000, while the number of participants in large health plans increased from 84.0 to 86.6 million.

Figure 3. Large Health Plans and Participants, by Statistical Year



Source: Form 5500 filings of large health plans.

Table 2. Health Plans and Participants, by Statistical Year

	Small Plans		Large Plans	
Statistical year	Number	Participants (millions)	Number	Participants (millions)
2013	2,358	0.168	47,387	69.1
2014	2,382	0.255	48,759	70.3
2015	2,901	0.259	51,057	72.1
2016	2,900	0.115	52,769	74.0
2017	3,679	0.125	54,071	75.2
2018	5,169	0.168	55,361	77.4
2019	9,450	0.158	56,348	78.8
2020	16,809	0.220	57,245	78.2
2021	24,693	0.259	57,113	84.0
2022	26,606	0.260	58,290	86.6

Source: Form 5500 health plan filings.

Table 3 shows the percentage of health plan filings that were matched to their corresponding filing in the previous year. It covers both large and small plans. The match rate ranged from 81.0% in 2020 to 89.0% in 2013. In 2022, the match rate was 85%. In order to gauge consistency in the reporting of the number of participants, the table illustrates to what extent participant counts of matched pairs of plan filings changed from one year to the next. At the median, plans reported approximately the same plan size as in the prior year, suggesting that the matches were generally accurate and that there was consistency in the reporting. The

distributions were fairly stable over time and the interquartile range (the difference between the 75th and 25th percentiles of plan sizes) was about 19 percentage points in 2022.

Table 3. Distribution of Year-on-Year Participation Increases in Plans Matched across Years

Statistical year	Number of plans in year t	Percentage matched to a plan in t-1	Year-on-year increase		
			25th pct	Median	75th pct
2013	49,745	89.0%	-6.0%	0.5%	8.2%
2014	51,141	87.9%	-5.6%	1.0%	9.2%
2015	53,958	86.0%	-5.8%	1.3%	9.8%
2016	55,669	87.1%	-6.1%	1.1%	9.6%
2017	57,750	86.7%	-5.8%	1.0%	9.2%
2018	60,530	86.3%	-5.7%	1.1%	9.6%
2019	65,798	83.3%	-6.4%	0.7%	9.2%
2020	74,054	81.0%	-10.4%	0.0%	7.0%
2021	81,806	81.6%	-9.1%	0.0%	9.0%
2022	84,896	85.0%	-8.5%	0.0%	10.6%

Source: Form 5500 health plan filings.
Match rates based on all Form 5500 health plan filings.
Participant increases based on the matched sample only.

Financial Information from IRS Form 990 and Bloomberg

The ACA directs the Department to examine the relationship between a plan sponsor's financial health and the plan's funding mechanism. To address these questions, we matched Form 5500 health plan filings with two sources of financial information: IRS Form 990 and Bloomberg corporate financial data. We obtained plan sponsors' not-for-profit status from the Form 990 and financial information for a subset of large plans from Bloomberg. This section describes our approach and the number of Form 5500 filers for which we achieved a statistical year 2022 match with Form 990 or Bloomberg records.

Not-for-Profit Status from Form 990

Tax-exempt organizations file a Form 990 annually with the IRS unless exempt from filing. On its website, the IRS makes select fields of Form 990 filings, including Employer Identification Numbers (EINs) and the organizations' names, publicly available. We determined whether health plan sponsors (large or small) were for-profit or not-for-profit by matching Form 5500 filings to Form 990 filings. If the corporate sponsor listed on a Form 5500 health plan filing matched to a Form 990 filing, and the entity that filed a Form 990 was not itself a benefit plan, we identified the plan sponsor as a not-for-profit organization; otherwise, we considered it for-profit.[18]

[18] Some welfare benefit plans of for-profit corporations were themselves not-for-profit entities. For example, a Form 5500 plan sponsor could be listed as XYZ Corporation Employee Benefits Plan, a not-for-profit entity that filed a Form 990. In

We matched entities using the EIN and organization name. To reduce mismatches due to name spelling variations, we normalized names and removed plan labels prior to matching.[19] Of the 28,468 small plan filings, we identified 1,673 (6.3%) as not-for-profit. They covered approximately 23,465 participants, or 9.0% of the total participant count of small plans. Of the 58,290 large plans in 2022, 9,531 (16.4%) had sponsors that filed a Form 990, which we classified as not-for-profit. These not-for-profits covered nearly 15 million participants, or 17.3% of the total participant count of large plans under study.

Financial Metrics from Bloomberg

Corporate financial information comes from Bloomberg, a provider of financial and other data for companies in the United States and elsewhere. Bloomberg culls Form 10-K filings and other sources to collect data about companies with public financial statements, which generally include companies with publicly traded stock or bonds.[20] Our extract from its database contained information on the 2022 financial performance for over 6,400 companies with public financial information that are based in the United States or listed on a US stock exchange.

We extracted the following fields that capture company size and financial health.

- Market capitalization: Total value of outstanding common stock as of the end of the year;
- Revenue: Total revenue net of sales returns and allowances during the year;
- Profit: Amount of profit the company made after paying all of its expenses during the year;
- Cash and cash equivalents: Amount of cash in vaults, deposits in banks, and short-term investments with maturities under 90 days as of the end of the year;
- Total debt: Short-term borrowings, long-term debt, and long-term capital leases as of the end of the year;
- Altman Z-Score: An index commonly used for predicting the probability that a firm will go into bankruptcy within two years.[21] The lower the score, the greater the probability of insolvency; and

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such cases, we ignored the Form 990 entry for XYZ Corporation Employee Benefits Plan and looked for XYZ Corporation among Form 990 filings to determine its for-profit status. To this end, we excluded Form 990 filings by voluntary employees' beneficiary associations (VEBAs), teachers' retirement fund associations, supplemental unemployment compensation trusts or plans, employee-funded pension trusts, multiemployer pension plans, and any filer with names that included such labels as *HEALTH PLAN* or *WELFARE PLAN*. For-profit status thus refers to the plan sponsor, not to the plan itself.

[19] The algorithm removed punctuation, streamlined abbreviations, and removed strings that denote health plans. For example, "ABC Incorporated Employee Benefit Trust" and "ABC Inc." both normalized to "ABCINC."

[20] A Form 10-K is an annual financial report filed with the U.S. Securities and Exchange Commission.

[21] The Altman Z-Score in the Bloomberg data is calculated as 1.2 times the ratio of working capital to tangible assets, plus 1.4 times the ratio of retained earnings to

- Number of employees.

Matching Form 5500 Filings of Large Plans and Bloomberg Records

Form 5500 health plan filings and Bloomberg data both contained the names of sponsor companies. We restricted Bloomberg records to companies that were based in the United States or listed on a US stock exchange. However, mismatches could have occurred from differences between corporate names in Bloomberg (e.g., XYZ Holdings Inc.) and sponsor names on Form 5500 filings (e.g., XYZ Inc.). Therefore, the match rate on name alone was low. Both data sources also contained EINs, but that field was available for only 5.1% of Bloomberg records.

Due to the difficulty of matching Form 5500 data to Bloomberg records, the analysis of corporate financial health focuses exclusively on large plans.[22] Even with this restriction, the matching of large plans' Form 5500 data and Bloomberg records remains challenging. To improve accuracy, we leveraged additional identifiers. Bloomberg records may further identify companies through their Central Index Key (CIK), a number used by the U.S. Securities and Exchange Commission (SEC) to identify corporations and individuals who have filed a disclosure with the SEC. CIKs were available for 99.1% of Bloomberg records. SEC filings, electronically available from the SEC's Electronic Data Gathering, Analysis, and Retrieval (EDGAR) system, generally included both a company's CIK and its EIN. Using an automated algorithm that extracted CIK-EIN combinations from SEC filings, we located EINs from the SEC filing for 78.5% (4,978) of the Bloomberg records based on CIK matches between Bloomberg and the SEC filings.

Next, we defined clusters of EINs, CIKs, and company names that appeared to relate to the same company. For example, a company may have used two EINs, or an EIN may have been associated with multiple (similar) names. To improve the clustering, we normalized the company names and removed plan labels.

We then mapped all related EINs, CIKs, and company names into a unique cluster. Finally, we matched Bloomberg records and Form 5500 health plan filings by cluster.

Corporate fiscal years do not need to correspond to health plan reporting periods. In an effort to accurately match a 2022 Form 5500 health plan filing with its sponsor's 2022 financial information, we required that the end date of the fiscal year captured in Bloomberg and the end date of the Form 5500 plan year differed by no more than 183 days. This allows the fiscal year we use for financials to have the greatest overlap with the filing year for the health plans. Only if the closest fiscal and plan

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tangible assets, plus 3.3 times the ratio of earnings before interest and taxes to tangible assets, plus 0.6 times the ratio of the market value of equity to total liabilities, plus 1.0 times the ratio of sales to tangible assets (source: Bloomberg.)

[22] Insofar as small plans are sponsored by small companies, corporate financial information is rarely available. Financial data is typically only available for large plans that are required to file financials with the SEC. That said, 33 sponsors of small plans were matched to Bloomberg data. However, eight had missing financial data. Almost all matched small plans are sponsored by large companies. Due to the fact that only 33 out of 26,606 small plans have a match to the financial data and only 25 of them have complete data, we do not analyze the financial information of these small plans.

years differed by no more than 183 days did we consider this a match. For example, a health plan sponsor could have a plan year from January 1 to December 31, but a fiscal year that ran from April 1 to March 31 of the next year. Under these circumstances, we matched the Form 5500 health plan filing ending December 31, 2022, with the Bloomberg financial information for fiscal year ending March 31, 2023.

As summarized in Table 4, the process above results in 886 matched plans with 5,000 or more participants (37.9%) and 3,283 plans (5.6%) overall.[23] The 3,283 matched plans covered 30.4 million participants, or 35.1% of all participants in the Form 5500 large health plan data.

Table 4. Form 5500 Large Health Plan Filings Matched with Financial Information, by Plan Size (2022)

	Large Plans			Participants		
Number of participants	Number	Percent	Match rate	Number (millions)	Percent	Match rate
0–99*	94	2.9%	3.4%	0.0	0.0%	2.3%
100–199	319	9.7%	1.6%	0.0	0.2%	1.7%
200–499	538	16.4%	2.9%	0.2	0.6%	3.1%
500–999	454	13.8%	6.1%	0.3	1.1%	6.3%
1,000–1,999	444	13.5%	10.6%	0.6	2.1%	11.0%
2,000–4,999	548	16.7%	18.7%	1.8	5.8%	19.4%
5,000+	886	27.0%	37.9%	27.4	90.3%	47.6%
Total	3,283	100.0%	5.6%	30.4	100.0%	35.1%

Source: Form 5500 large health plan filings and Bloomberg data.
* The definition of a large plan is based on number of participants at the beginning of the reporting period; some large plans have fewer than 100 participants at the end of the period.
Numbers or percentages may not sum to total due to rounding.

The match rate increased with plan size, presumably because larger plans are sponsored by larger companies and larger companies are more likely to be publicly traded, and therefore required to disclose financial information. However, even very large plans did not match universally. Plans that did not match included those of hospitals and universities without public financials, but also US operations of large international firms with public financials. A more inclusive name matching algorithm could boost the matching rate, but it also increases the risk of false matches which in turn could dilute any analysis results based on the matched subset of plans. Instead, we opted for a more conservative approach, with a smaller subset of matched plans but more reliable matches.

[23] While the number of matches for small plans is a relatively small number, many companies that filed a Form 5500 were not represented in Bloomberg data because they have no requirement to issue publicly available financial statements. The sponsor may be privately held and without publicly issued securities, the sponsor may be based overseas, or the plan may be a multiemployer or multiple-employer plan.

3. THE DEFINITIONS OF FUNDING MECHANISMS

The Form 5500 does not require plan sponsors to report the funding mechanism of health benefits with sufficient specificity for us to determine definitively whether we should classify plans that report using both a trust and insurance as self-insured, fully insured, or mixed-funded (also referred to as mixed, below). This section describes how we classified individual plans by funding mechanism for purposes of this report.

Classification of Funding Mechanism Is Driven by Form 5500 Filing Data

For the purpose of this report, the type of funding mechanism was assigned based on information provided by Form 5500 health plan filings. We categorized plans as self-insured, fully insured, or mixed-funded. A mixed-funded plan contained both self-insured and fully insured components. For example, an employer may offer its employees a choice between a fully insured HMO option and a self-insured PPO option.

If the employer reported both plan components on a single Form 5500 filing, the plan would be mixed-funded. In some cases, the data were incomplete or internally inconsistent. For example, while Schedule A was intended to report on insurance contracts, some plans attached a Schedule A for a contract that appeared to be for administrative services only (ASO), rather than for insurance. Given these limitations, the classification in this report should not be interpreted as an official or legal definition.

The classification of funding mechanism is based on data from the main Form 5500, Form 5500-SF, Schedule A, and Schedule H/I. As depicted in Figure 4 below, there were multiple ways a plan may be classified as self-insured, mixed-funded, or fully insured. Two important ways were evidence of an external health insurance contract (on a Schedule A) and of a plan trust (on a Schedule H or I).

> *Evidence of Health Insurance Contract*. Information on insurance contracts needs to be reported on a Schedule A. Many plans use the Schedule A to report dental, vision, disability, or other non-health benefits. Only Schedules A that specify "Health (other than dental or vision)" benefits or reflect an "HMO contract," "PPO contract," or "Indemnity contract" were considered evidence of health insurance. However, some Schedules A may have been filed in error and some health benefits—such as business travel insurance with limited emergency medical care benefits—may be outside the focus of the ACA. The algorithm rejected as evidence of health insurance any Schedule A with per capita annualized premiums that were less than 30% of the average cost of single health coverage in the United States, as documented by the Kaiser Family Foundation's *Employer Health Benefits Annual Survey* ("KFF Survey").[24] In 2022, the average premium for single coverage was

[24] Kaiser Family Foundation, *Employer Health Benefits, 2022 Annual Survey. 2022*. Available at https://files.kff.org/attachment/Report-Employer-Health-Benefits-2022-Annual-Survey.pdf.

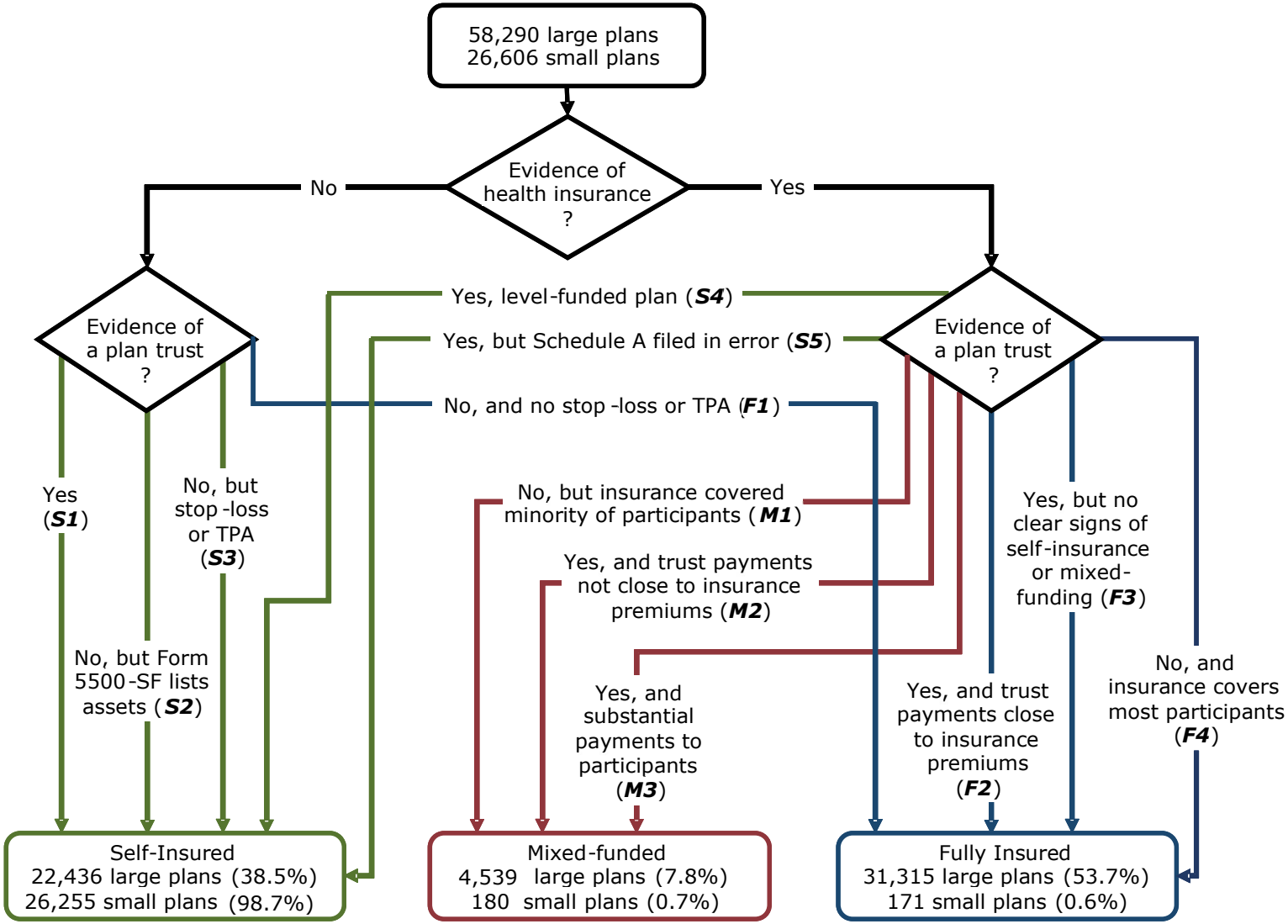
$7,911 per year, so the algorithm required annualized premiums to be at least 30% × $7,911 = $2,373.30 per covered person.[25]

Evidence of a Plan Trust. Information on a plan's trust, if any, is required to be reported on a Schedule H or I. In addition to assets and liabilities, the Schedules H and I report contributions and expenses (such as benefit payments directly to participants and payments to insurance carriers). Some plans attached a Schedule H or I that was blank (not common since the introduction of electronic filing) or reported on compliance issues only. The algorithm accepted as evidence of a trust only Schedules H/I with at least some information on assets, liabilities, income, or expenses.

Figure 4 illustrates the algorithm that classified plans by funding mechanism based on detailed information on the main Form 5500, Schedules A, and Schedules H/I. The main issues were whether plans provided evidence of a health insurance contract or a plan trust. Of the 26,606 small plans, 26,255 (98.7%) were classified as self-insured, 180 (0.7%) as mixed-funded, and 171 (0.6%) as fully insured. Of 58,290 large plans in the 2022 analysis file, 22,436 (38.5%) were classified as self-insured, 4,539 (7.8%) as mixed-funded, and 31,315 (53.7%) as fully insured.

[25] The average annual premiums for single coverage rose from $5,049 in 2010 to $7,911 in 2022.

Figure 4. Classification of Plans by Funding Mechanism



The branches in Figure 4 are labeled and described in detail in the sections below. The Technical Appendix lists the data fields that the algorithm uses.

Self-Insured Plans

S1: No Evidence of Health Insurance; Evidence of a Plan Trust

All plans in the analysis reported sponsoring health benefits. If there was no evidence of health insurance, and financial information for a plan trust was provided, then the plan was classified as self-insured.

S2: Short Form Filers with Fewer Than 100 Participants or with Assets

Some plans with fewer than approximately 100 participants at the beginning of the year may file a Form 5500-SF. Such filings were not required to attach any schedules, and any financial information would be entered on the Form 5500-SF itself.[26] Due to this lack of information, plans that filed a Form 5500-SF and reported fewer than 100 participants at the beginning of the year were presumed to be self-insured. Further, if they reported between 100 and 120 participants at the beginning of the year and listed plan assets, they also were classified as self-insured.

S3: No Evidence of Health Insurance or of a Plan Trust; Indicators of Self-Insurance

Some plans provided no evidence of either health insurance or a plan trust. If the funding or benefit arrangement was through a trust or from general assets, then we classified the plan as self-insured. Also, if the only Schedules A attached to the filing were for stop-loss coverage or non-health benefits, or a Schedule A indicated third-party administrator services rather than insurance,[27] then we classified the plan as self-insured.

S4: Evidence of Health Insurance and of a Plan Trust; Financial Information Indicates Self-Insurance

Some plans provided evidence of health insurance and of a plan trust that listed payments both directly to participants and to insurance carriers. Depending on the magnitude of certain trust payments and insurance premiums, such plans may be self-insured, mixed-funded, or fully insured. The algorithm sequentially checked for various scenarios, including the possibility that the Schedule A reflected a level-funded plan contract.[28] In such cases, we classified the plans as self-insured.

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[26] Small plans that filed a Form 5500-SF without financial information are presumed to be exempt from filing and excluded from the analysis.
[27] Some plans attached a Schedule A for administrative services only despite directives to the contrary (2022 Instructions for Form 5500).
[28] A level-funded plan is a nominally self-funded option for small or mid-sized employers that incorporate stop-loss insurance with relatively low attachment points. Often, the insurer calculates an expected monthly expense for the employer, which includes a share of the estimated annual cost for benefits, premium for the stop-loss protection, and an administrative fee. The employer pays this "level premium" amount, with the potential for some reconciliation between the employer and the

S5: Evidence of Health Insurance, but Schedule A May Have Been Filed in Error

Some plans provided evidence of health insurance and of a plan trust that listed payments both directly to participants and to insurance carriers. In addition to the possibility discussed under branch *S4*, the Schedule A may have been filed in error. Having excluded certain other scenarios, if Schedule A reported experience-rated charges but no corresponding premiums, it presumably did not reflect an insurance contract. We then assumed that the Schedule A was filed in error and classified the plan as self-insured.

Mixed-funded Plans

M1: Evidence of Health Insurance; No Evidence of a Plan Trust; Funding through Trust or General Assets and Insurance Covered a Minority of Participants

In principle, when a plan provided evidence of health insurance and not of a plan trust, we classified the plan as fully insured. However, the plan may additionally cover some participants in a self-insured plan component, namely from general assets or through a trust (for which no information was provided). The algorithm first accounted for funding and benefit arrangements. If both arrangements involved insurance only, we classified the plan as fully insured (discussed below under branch *F4*). However, if the funding or benefit arrangements mentioned a trust or general assets, and fewer than one-half of plan participants (indicated on the main Form 5500) were covered by health insurance (indicated on Schedule A), we classified the plan as mixed-funded.

M2: Evidence of Health Insurance and of a Plan Trust; Trust Payments Not Close to Insurance Premiums

Some plans provided evidence of both health insurance and of a plan trust. The trust may serve to funnel insurance premiums to insurance carriers, in which case we generally classified the plan as fully insured (discussed below under branch *F3*). However, if trust payments to insurance carriers differed by more than 20% from insurance premiums, the trust presumably funded self-insured benefits, in which case we classified the plan as mixed-funded.

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insurer at the end of the year, if claims differ significantly from the estimated amount. These policies are sold as self-funded plans, so they generally are not subject to state requirements for insured plans and, for those sold to employers with fewer than 50 employees, are not subject to the rating and benefit standards in the ACA for small firms. Due to the complexity of the funding (and regulatory status) of these plans, and because employers often pay a monthly amount that resembles a premium, respondents may be confused as to whether or not their health plan was self-funded or insured. See Kaiser Family Foundation, *Employer Health Benefits, 2022 Annual Survey, 2022,* p.156.

M3: Evidence of Health Insurance and of a Plan Trust; Substantial Payments Directly to Participants

Some plans provided evidence of health insurance and of a plan trust that listed payments both directly to participants and to insurance carriers. We classified these plans as mixed-funded if payments directly to participants were substantial enough to plausibly reflect health benefit payments. We used the same monetary criterion for determining whether a Schedule A plausibly reflected health insurance ($2,373.30 per participant per year in 2022; see above).[29]

Fully Insured Plans

F1: No Evidence of Health Insurance or of a Plan Trust; No Indicators of Self-Insurance

Some plans provided no evidence of either health insurance or a plan trust. If such plans met the criteria discussed above under branch *S3*, we classified them as self-insured. Otherwise, we classified them as fully insured.

F2: Evidence of Health Insurance and of a Plan Trust; Trust Payments Close to Insurance Premiums

Some fully insured plans used a trust to funnel premiums to insurance carriers. Oftentimes, this applied to plans with multiple contributing parties, such as multiple employer and multiemployer plans. If a plan provided evidence of both health insurance and a plan trust, and trust payments to insurance carriers were within 20% of insurance premiums, we classified the plan as fully insured.[30] An exception existed in the case of substantial trust payments directly to participants; see branch *M3*.

F3: Evidence of Health Insurance and of a Plan Trust; No Clear Indicators of Self-Insurance or Mixed-Funding

Consider again plans that provided evidence of health insurance and of a plan trust that listed payments both directly to participants and to insurance carriers. Trust payments and insurance premiums may indicate self-insurance (discussed above under branches *S4* and *S5*) or mixed-funding (discussed above under branch *M3*). In the absence of clear indicators of self-insurance or mixed-funding, we classified such plans as fully insured.

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[29] The per-participant payment calculation may understate the actual average payment to participants in the self-insured component of the plan because it is based on the number of participants as reported on the main Form 5500, which likely overstates the number of participants in the self-insured component of the plan.

[30] To accommodate scenarios in which non-health insurance premiums were paid outside of the trust, the algorithm checks all insurance premiums separately from all health insurance premiums. If trust payments were within 20% of either amount, branch *F3* applies.

F4: Evidence of Health Insurance; No Evidence of a Plan Trust; Funding through Insurance Only or Insurance Covered Most Participants

In principle, when a plan provided evidence of health insurance but not of a trust, we classified it as fully insured. Branch *M1* allows for the possibility that the plan additionally covered some participants in a self-insured plan component. If the plan did not meet the criteria specified under branch *M1*, we classified the plan as fully insured.

While this approach was subject to some data quality issues (further discussed below), we believe it resulted in a meaningful characterization of health plans' funding mechanism.

Issues in Defining Funding Mechanism

The information on the Form 5500 may be incomplete, ambiguous, or inconsistent for some plans with respect to the funding mechanism. Some of the issues affecting the funding mechanism definition were as follows:

- An employer may set up a subsidiary that acts as an in-house or "captive" insurance company or rent an outside "captive" to offer health insurance. These "captive" insurance companies were subject to state regulations regarding insurance companies. Plans purchasing health insurance from a captive insurance company should file a Schedule A, which does not require disclosing that the insurance company is captive. In the classification, such plans would thus be considered fully insured, even though the employer group to which they belong may incur a risk substantially similar to that of a self-insured plan. Since nothing on the Form 5500 permitted the identification of captive insurance companies, we were not able to quantify how frequently this issue arises.
- As explained above, 7.8% of large group health plans contained a combination of both externally insured and self-insured health components in 2022. While the distinction may be clear conceptually, Form 5500 data limitations implied that the health plan as a whole must be categorized as mixed-funded. The issue arises in part because Forms 5500 were required for each plan, not for each type of benefit offered under a plan. Where a plan provided multiple types of welfare benefits or multiple types of health benefit options, it was not always possible to attribute responses to the health benefit component(s) of the filer's welfare plan. Also, a plan may indicate funding benefits through insurance contracts and from general assets without specifying which benefits were funded using which funding type. Separately, Form 5500 data limitations arise from the fact that the Form 5500 does not ask for details about self-insured plan components.
- As noted above, plans may offer self-insured health benefits to some participants and fully insured benefits to others, but the Form 5500 provided little insight about the number of participants in the self-insured component. Reflecting such scenarios, plans may also be classified as mixed-funded if fewer than one-half of plan participants were covered by health insurance contracts. The comparison is less than perfect. First, the number of "persons covered" by insurance contracts, as reported on Schedule A, was inclusive of

dependents,[31] whereas the definition of "participant" for Form 5500 explicitly excluded dependents (see 2022 Instructions for Form 5500, available at https://www.dol.gov/sites/dolgov/files/ebsa/employers-and-advisers/plan-administration-and-compliance/reporting-and-filing/form-5500/2022-instructions.pdf). Second, the total number of people whose benefits were provided through the insurance policy or contract was reported on the Schedule A. However, some of these people were in plans that provide multiple types of benefits and the participants in those plans may not have selected the health benefit in the plan, opting only for some other benefit.

- The classification may not recognize mixed-funding where only "carve-out services" were covered by insurance. For example, a plan may have purchased insurance coverage for mental health benefits and self-insured other health benefits. Its Form 5500 filing would include a Schedule A with details of the mental health carve-out but might list the benefits provided under the contract as "Health (other than dental or vision)" because there is no separate category for "mental health" benefits on Schedule A, as there is for "Dental," "Vision," and "Prescription drugs."
- Among large plans that reported a funding or benefit arrangement through insurance, 0.1% did not file a Schedule A with insurance contract details. Another 0.5% did not file Schedule A for health benefits but filed one or more Schedules A without listing the type of benefit that the insurance contract covered. In such cases, we assumed that the insurance contract provided health benefits.
- While sponsors of self-insured plans generally bear the financial risks of health benefits and claims, some self-insured group health plans purchased insurance against particularly large losses (catastrophic or "stop-loss" insurance). Stop-loss coverage generally mitigates financial risks. However, we considered a health plan that has no insurance for health benefits other than stop-loss insurance to be self-insured.

For more details on data anomalies that stood in the way of unambiguous funding mechanism classifications, see the report on *Strengths and Limitations of Form 5500 Filings for Determining the Funding Mechanism of Employer-Provided Group Health Plans.*[32]

[31] Although the Schedule A specifically called for filers to enter the approximate number of persons covered, it is our understanding that there were some filers who entered only the number of participants, even if there were more covered persons, such as beneficiaries.

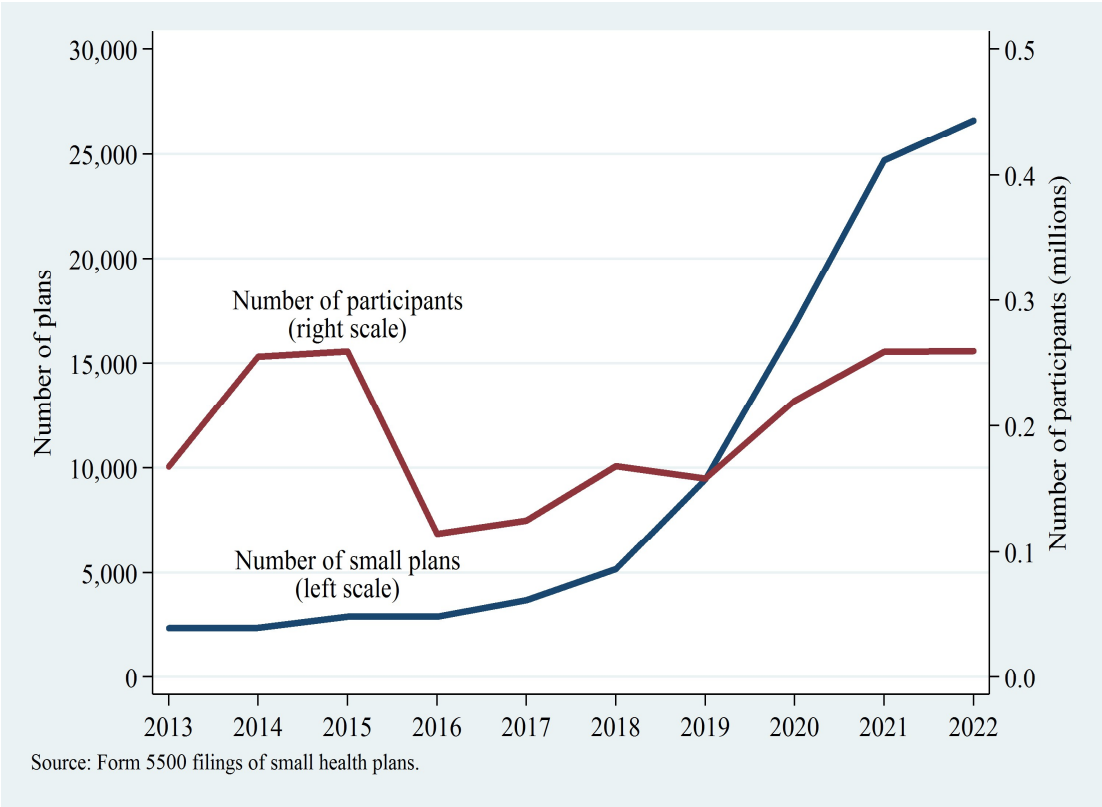
[32] Available at https://www.dol.gov/sites/default/files/ebsa/researchers/analysis/health-and-welfare/strengths-and-limitations-of-form-5500-filings-for-determining-the-funding-mechanism-of-employer-provided-group-health-plans.pdf.

4. SMALL GROUP HEALTH PLANS

In this Section we discuss findings for small group plans (see Section 5 for large plans and Section 6 for GIAs.). Small group health plans are those health plans with fewer than 100 participants at the beginning of the year. Recently, small plans have exhibited significant change in the number of plans, number of new entrants, and number of plans ceasing to file. This year there is a notable moderation in the rate of growth of small group plan filing. As discussed above (see Figure 1 and following text), small group health plans that filed a Form 5500 or 5500-SF are a non-representative subset of all small group health plans in the United States because group health plans with fewer than 100 participants that are not MEWAs generally are required to file a Form 5500 only if they used a trust or a separately maintained fund to hold plan assets (or act as a conduit for the transfer of plan assets), which is generally associated with self-insurance.

Aside from amended filings and filings with zero participants at both the beginning and the end of the reporting period, there were 28,468 filings of small plans that reported covering health benefits in 2022. Filings were excluded if (1) the filing was followed by another filing of the same plan for a later period in the same year (83 filings in 2022), (2) a Form 5500 was filed even though the plan was exempt from filing (1,774 filings in 2022), (3) the plan name suggested that it did not offer health benefits that were the subject of the ACA (3 filings in 2022), or (4) the filing was submitted as a GIA (2 filings in 2022). This section focuses on the remaining 26,606 small plans. These remaining small plans covered about 260,000 participants at the end of the plan year. As noted before, most small plans in the United States are not required to file a Form 5500 and, therefore, were not included in this analysis. Figure 2 (on page 7), reproduced below as Figure 5, documents the number of small plans and their participants for 2013–2022.

Figure 5. Small Health Plans and Participants, by Statistical Year



The blue line in Figure 5 shows the growth in the number of small plans over time.

Most (92.5%) of the 26,606 small plans filed a Form 5500-SF rather than the Form 5500. The rate of growth in small plans fell from 46.9% to 7.7% between 2021 and 2022 and the number of participants in small plans remained almost flat during that time, with an increase of only 0.28% from 2021 to 2022. As Figure 5 shows, this deceleration of growth is a notable change in the trend since 2016, where growth in plans had been at least 40% per year and as much as 80% between 2018 and 2019. The rate of increase in the number of plans has been faster than that of the number of participants, indicating that the average size of these small plans is decreasing.

Funding Mechanism

As expected, based on Form 5500 filing requirements, only 0.6% of small plans were classified as fully insured (Table 5). Presumably, these plans used a trust as a conduit for premium payments. A large majority (98.7%) were self-insured and 0.7% were mixed-funded.

Table 5. Distribution of Funding Mechanism for Small Plans (2022)

	Small Plans		Participants	
	Number	Percent	Number	Percent
Fully insured	171	0.6%	5,369	2.1%
Mixed	180	0.7%	13,060	5.0%
Self-insured	26,255	98.7%	241,369	92.9%
Total	26,606	100.0%	259,798	100.0%

Source: Form 5500 small health plan filings.
Numbers may not sum to total due to rounding.

Weighted by plan participants at the end of the plan year, 2.1% of small-plan participants were in a fully insured plan, 92.9% in a self-insured plan, and 5.0% in a mixed-funded plan.

To put our analysis in context, consider recent findings on self-insurance according to an external source: the Insurance Component of the Medical Expenditure Panel Survey (MEPS-IC), an annual survey of employers about their health benefit plans.[33] The MEPS-IC survey estimated that between 15.1% and 19.1%[34] of private-sector establishments at firms with fewer than 100 employees self-insured at least one plan in 2022, compared with 98.7% of small plans that filed a Form 5500 or Form 5500-SF that self-insured. This large discrepancy underscores the selective nature of small plans that filed a Form 5500.

Figure 6 shows the funding mechanism distribution for small health plans by statistical year for 2013–2022; see Table 6 and Table 7 for the underlying percentages, plan counts, and participant counts. The fraction of small plans with a self-insured component (self-insured or mixed-funded) generally increased from 90.6% in 2013 to 99.4% in 2022. Weighted by participants, the trend was subject to volatility over time because the definition of a small plan is based on having less than 100 employees at the beginning of the year, while counts of participants are at the end of the year, when some plans may have grown significantly.

[33] Agency for Healthcare Research and Quality, *Chartbook #27: Medical Insurance Component Chartbook 2022*. https://meps.ahrq.gov/data_files/publications/cb27/cb27.pdf.
[34] Agency for Healthcare Research and Quality, *Chartbook #27: Medical Insurance Component Chartbook 2022*. https://meps.ahrq.gov/data_files/publications/cb27/cb27.pdf, "Appendix ES.7 Percentage (standard error) of private-sector establishments that offer health insurance that self-insure at least one plan, overall and by detailed firm size, 2010–2022"

Figure 6. Distribution of Funding Mechanism among Small Plans, by Statistical Year

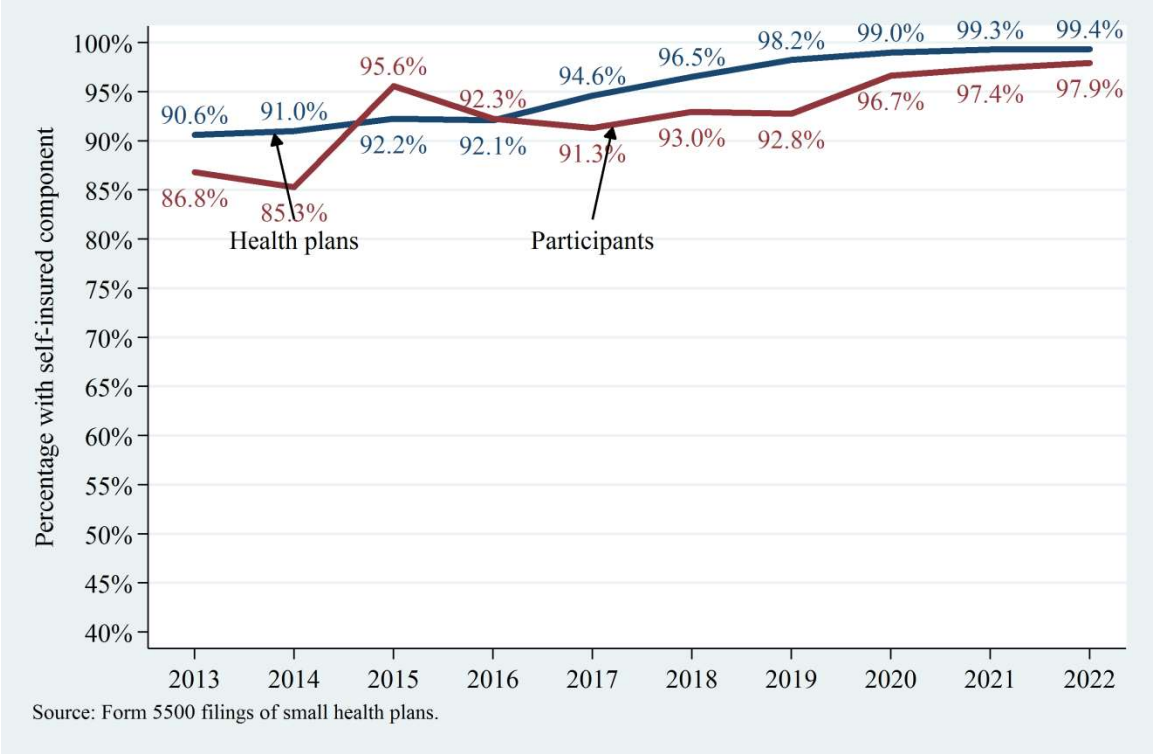


Table 6. Distribution of Funding Mechanism for Small Plans, by Statistical Year

Statistical	Small Plans			Participants		
year	Fully insured	Mixed	Self-insured	Fully insured	Mixed	Self-insured
2013	9.4%	8.0%	82.6%	13.2%	32.8%	54.0%
2014	9.0%	7.6%	83.5%	14.7%	10.8%	74.5%
2015	7.8%	12.1%	80.1%	4.4%	60.7%	34.8%
2016	7.9%	5.7%	86.4%	7.7%	9.8%	82.5%
2017	5.4%	4.5%	90.1%	8.7%	7.3%	84.1%
2018	3.5%	4.1%	92.4%	7.0%	10.4%	82.6%
2019	1.8%	2.8%	95.5%	7.2%	5.3%	87.5%
2020	1.0%	1.7%	97.2%	3.3%	5.4%	91.2%
2021	0.7%	0.6%	98.7%	2.6%	11.9%	85.5%
2022	0.6%	0.7%	98.7%	2.1%	5.0%	92.9%

Source: Form 5500 small health plan filings.
Percentages may not sum to 100% due to rounding.

Table 6 shows an increase in the percentage of mixed-funded plans in 2015, to 12.1%, and then a decline in 2016. Similarly, the percentage of participants in mixed-funded plans increased by a factor of 6 in 2015 and then declined to approximately its previous level in 2016. In 2015, 159 small, mixed-funded plans

entered, making a total of 351 total small mixed-funded plans. None of the 159 plans that entered in 2015 appear in the data again, resulting in the one-year jump in mixed-funded plans in 2015.

Additionally, there were 2 small, mixed-funded plan that entered in 2015 that had a large number of participants at the end of the year. Though still stayed in the data in the following year (2016), they were reclassified as large plans, contributing to the jump in percent of participants in small, mixed-funded plans in 2015, followed by the decline.

Table 7. Number of Small Plans and Their Participants, by Funding Mechanism and Statistical Year

Statistical	Small Plans			Participants		
year	Fully insured	Mixed	Self-insured	Fully insured	Mixed	Self-insured
2013	221	189	1,948	22,157	55,053	90,660
2014	214	180	1,988	37,488	27,572	189,934
2015	225	351	2,325	11,476	157,612	90,408
2016	229	164	2,507	8,852	11,209	94,447
2017	198	166	3,315	10,841	9,104	105,108
2018	180	213	4,776	11,821	17,435	138,643
2019	167	260	9,023	11,445	8,401	138,399
2020	171	294	16,344	7,358	11,902	200,691
2021	176	150	24,367	6,747	30,879	221,450
2022	171	180	26,255	5,369	13,060	241,369

Source: Form 5500 small health plan filings.

We reiterate that the *distribution* of funding mechanism among small plans that filed a Form 5500 does not reflect that of small plans nationwide because the analysis generally included small plans only if they operated a trust. If small plans complied with Form 5500 filing requirements, the data does provide information about the *number* of small self-insured and mixed-funded plans that operated a trust (Table 7). While we observe trends toward increasing self-insurance in small health plans over time within the Form 5500 data, it is difficult to say whether similar trends are occurring in the general population of small health plans due to the selectivity created by the filing requirements, mentioned above. As a result, small plans in the analysis are a non-random subset of small plans nationwide

Making the simplifying assumption, which is plausible but not observable from form 5500 data, that the fraction of self-insured small plans in the economy that operated a trust was approximately constant throughout the time period we analyze, the plan counts may be compared over time, across industries, etc. In that light, the number of self-insured small plans increased rapidly between 2014 and 2021. The number of small plans that are self-insured increased by more than 80 percent in both 2019 and 2020, and by nearly 50 percent in 2021. However, that rate of increase has not continued from 2021 to 2022, see Table 7. The pattern of the small plans filing numbers appears to be driven by small plans participating in non-plan MEWAs. The trend in mixed-funded small plans has been more volatile.

The numbers of participants covered by self-insured or mixed-funded small plans need to be interpreted subject to the caveat that participants are counted as of the end of the reporting period, and small plans may cover many participants at the end

of the reporting period. Specifically, some new plans may experience significant growth over a plan year, although relatively few reported zero participants at the beginning of the reporting period and many at the end.[35] The resulting aggregate participant counts are volatile, as illustrated in Figure 3 and Table 7.

Funding Mechanisms by Industry

Table 8 shows the number of small plans and the participants they covered by funding mechanism and industry, as identified by the business code provided on Form 5500 filings. More than half of small self-insured plans and participants were in the services and construction industries, with manufacturing and finance, insurance and real estate the next largest industries based on plan counts and participants.

Table 8. Number of Small Plans and Their Participants, by Funding Mechanism and Industry (2022)

	Small plans			Participants		
	Fully insured	Mixed-funded	Self-insured	Fully insured	Mixed-funded	Self-insured
Agriculture	1	0	774	20	0	2,866
Communications & information	5	3	720	216	94	6,930
Construction	40	20	3,743	1,203	726	38,663
Finance, insurance & real estate	18	21	2,094	685	6,871	18,164
Manufacturing	17	30	2,650	673	1,328	33,544
Mining	1	1	90	39	8	1,401
Retail trade	2	10	2,149	88	417	17,862
Services	64	75	10,615	1,341	2,639	86,378
Transportation	6	4	725	222	232	8,408
Utilities	5	4	146	301	194	2,891
Wholesale trade	2	7	1,469	58	253	15,125
Misc. organizations	10	5	1,078	523	298	9,132
Industry not reported	0	0	2	0	0	5
Total	171	180	26,255	5,369	13,060	241,369

Source: Form 5500 small health plan filings.

Small Plans by Life Cycle Stage

Table 9 presents the number of plans that were new, established, or ceased filing in each year from 2013 to 2022. Typically, only those small plans that have trusts or MEWAs would file a Form 5500 in a given year. Therefore, these figures could be a reflection of the extent to which small plans are organized as a trust as much as the number of new small plans are being offered.

Plans were categorized as follows:

[35] For example, from 2013 to 2022 there were 25,093 new large plans that started the year (BOY) with more than 99 participants. During that same period, there were only 274 new plans that started the year (BOY) with 0 participants that grew to over 199 participants in their "new" year, and only 50 that grew to over 2,000 participants.

- New—We identified the beginning of a plan's life cycle based on the Form 5500's "first return/report" check box and the plan's effective date. We considered a plan new if it checked the "first return/report" box and the start of the reporting period differed by no more than two years from the plan's effective date.[36] In 2022, 6,159 small plans were new.

- Cease filing—We attempted to capture the end of a plan's life cycle in two ways. First, a plan may have indicated on its Form 5500 that it was terminating, namely by checking the "final return/report" box, by reporting a resolution to terminate the plan, or by documenting that all assets were transferred out of the plan.[37] Second, a plan may stop filing a Form 5500 without the required prior indication. Doing so does not necessarily imply that the plan terminated; it may be non-compliant or it may have shrunk and become exempt but incorrectly neglected to note this by writing "4R" on Line 8b of the Form 5500. To mitigate this issue, we ignored gaps in filings. Recognizing that some plans in this category have in fact not reached the end of their life cycle, we labeled them as plans that "ceased filing."[38] In 2022, 4,763 small plans fell into this category (including plans that last filed in 2021 without indicating that it was their final filing), down from 5,473 in 2021 as in the 2024 Self-insured Report.[39]

- Established—This category captured the middle of a plan's life cycle. Plans that were neither "new" nor "ceased filing" were labeled "established" plans. In 2022, 16,825 small plans fell into this category (including plans that first filed in 2022 but reported a plan effective date more than two years before the start of the reporting period). The established small plans are up slightly from 2021, which saw 13,553 such plans as in the 2024 Self-insured Report.

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[36] Some plans never checked the "first return/report" box, or not until later in their life cycle. If the box was not checked until, say, the fourth filing, we excluded the earlier filings from the analysis. This is consistent with the plan becoming effective when the "first return/report" box was checked, which we think is the entity's indication that the plan became active. If the box was checked in more than one filing, we identified the plan as "new" only for the first filing.

[37] Some plans repeatedly indicated filing of a final return, but continued submitting filings. We ignored indications of plan termination if the plan continued filing in subsequent years. Separately, plans that reported termination on their initial filing were included in both the "new" and "ceased filing" categories (See Figure 11, below).

[38] In terms of timing, if a plan indicated on its 2013 filing that it was terminating, we considered it as having ceased filing in 2013. If a plan submitted filings through 2013 but not in any later year, we considered it as having ceased filing in 2014.

[39] In every year's Self-insured Report, we will modify the lifecycle stage status of previous years. Because the new data each year will change our identification of lifecycle stage for certain plans. For example, in the 2024 Self-insured Report, a plan was identified as "Ceased Filing" in 2021. In 2022 Form 5500 data, it might show up again. Our algorithm reclassified this plan's status in 2021 to "Established."

It is worth noting that in every year's Self-insured Report, we reclassify the lifecycle stages of records from previous years based on the newly available data. For example, in the 2024 Self-insured Report, a plan was identified as "Ceased Filing" in 2021. However, this plan reappeared in the 2022 data, resulting in the algorithm reclassifying the plan's lifecycle stage in 2021 as "Established." As a result, this table is not comparable across Reports.

Table 9. Number of Small Plans, by Lifecycle Stage and Statistical Year

Statistical year	New	Established	Ceased filing	Total
2013	186	1,967	307	2,460
2014	300	1,923	224	2,447
2015	594	1,979	476	3,049
2016	518	2,129	427	3,074
2017	1,066	2,380	387	3,833
2018	1,805	3,078	487	5,370
2019	4,779	4,243	692	9,714
2020	7,853	8,302	995	17,150
2021	9,148	13,692	5,047	27,887
2022	6,159	16,825	4,763	27,747

Source: Form 5500 small health plan filings.

The number of new plans filing steadily increased from 2017 through 2021. However, the number of new plans filing in 2022 is down about a third, to 6,159, from the previous year.

Table 9 also shows that in 2020, 995 small plans ceased filing. In the following year, 2021, more than five times that number ceased filing. In 2022, 4,763 small plans ceased filing.[40]

Table 10 shows the funding distribution of new small plans in 2022. Of the 6,159 new plans, only 0.1% were fully insured, 0.5% were mixed-funded, and 99.4% were self-insured. The new small plans covered 56,560 participants of whom 0.4% were in a fully insured plan, 12.5% in a mixed-funded plan, and 87.1% in a self-insured plan.

[40] Plans are defined as ceased filing if they meet either one of two conditions. The first is if they declare their plan filing in year t was their final filing. The second is that they existed in year t but not in year t+1. The total number of small plans filing in a given year does not include the plans in the second category. Therefore, the total number of small plans in a given year in Table 9 exceeds the number of small plan filings in that year.

Table 10. Funding Distribution of New Small Plans (2022)

	Small Plans		Participants	
	Number	Percent	Number	Percent
Fully insured	7	0.1%	247	0.4%
Mixed	29	0.5%	7,045	12.5%
Self-insured	6,123	99.4%	49,268	87.1%
Total	6,159	100.0%	56,560	100.0%

Source: Form 5500 small health plan filings.

Stop-Loss Coverage of Small Plans

Table 11 shows the fraction of mixed-funded or self-insured small plans that reported stop-loss coverage. The table is based on the subset of small plans that filed a Form 5500 rather than a Form 5500-SF, as the Form 5500-SF does not ask about stop-loss insurance. The subset represents roughly 7 percent of all small plans.

Table 11. Fraction of Small Health Plans Reporting Stop-Loss Insurance, by Funding Mechanism and Statistical Year

Statistical	Small Plans		Participants	
year	Mixed	Self-insured	Mixed	Self-insured
2013	47.1%	18.9%	9.3%	14.7%
2014	53.3%	23.4%	27.1%	8.8%
2015	70.1%	29.0%	3.7%	27.0%
2016	45.7%	30.7%	32.9%	33.3%
2017	48.8%	33.0%	52.2%	35.7%
2018	37.1%	34.4%	70.8%	28.0%
2019	32.7%	38.6%	45.3%	42.7%
2020	33.0%	41.9%	53.4%	46.0%
2021	69.3%	48.3%	89.9%	60.0%
2022	65.0%	54.2%	33.3%	60.6%

Source: Form 5500 small health plan filings.
Reflects stop-loss coverage as reported on Form 5500.

It is important to keep in mind that in 2022, only 180 small mixed-funded plans and 1,635 small self-insured plans filed a Form 5500, requiring provision of stop-loss information, rather than a Form 5500-SF, which does not.[41] Furthermore, stop-loss information only needs to be included in Form 5500 filings if the plan is the beneficiary. The small number of mixed-funded plans may explain the volatility in the percentage of mixed-funded plans reporting stop-loss coverage in Table 11. Subject to the caveat that stop-loss coverage was underreported on Form 5500 filings (see pages 43-44), 65.0% of the 180 small mixed-funded plans and 54.2% of 1,635 small self-insured plans that filed a Form 5500 indicated having purchased stop-loss insurance in 2022. Through 2020 small mixed-funded plans had become less likely over time to report stop-loss coverage. As discussed above, percentages in 2015 are influenced by an influx of small mixed-funded plans that are seen only in

[41] The corresponding numbers in the prior year were 150 for mixed-funded small plans and 1,476 self-insured small plans.

that year. Some of the large plans that entered and exited did not have stop-loss coverage. In recent years that pattern has reversed, with higher percentages, over 65%, reported in 2021 and 2022. Small self-insured plans have become steadily more likely to report stop-loss coverage.

Table 11 also reports participant-weighted rates of stop-loss coverage. Because the determination that a firm is "small" (less than 100 participants) is based on the number of participants at the beginning of the year ("BOY"), but the number of participants for the participant-weighted figures in Table 11 are based on the number of participants at the end of the year ("EOY"), the insuring decisions of a firm that has grown rapidly within a year will receive a heavy weighting in the participant-weighted figure in Table 11. This may explain some of the rapid change over time in the participant-weighted figures in Table 11.

Table 12 shows the annual per-person cost of stop-loss coverage for small plans, calculated as the ratio of premiums to "number of persons covered" by the stop-loss policy on Schedule A—both the premium and the number of people covered thus refer to the stop-loss policy only and not to the overall plan. The numbers are not adjusted for inflation. These results should also be interpreted with caution because the Form 5500 filing contained no information on attachment points or other stop-loss policy features that may reflect the amount of coverage provided by the policies.[42,43]

The median per-person stop-loss premiums for small plans were substantially higher than those for large plans (Table 22), presumably because the volatility of medical expenses is greater for small plans than for large plans. Of course, overall stop-loss premiums and costs may interact with the "attachment points," the dollar amount of claims above which the insurer incurs the responsibility for paying, that are set within plans and may change over time. These attachment points may be evolving differently for small plans than large plans.

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[42] Per-person premiums were calculated from Schedules A that specified stop-loss coverage only or in combination with health benefits. Approximately 15% of such Schedules A specified additional benefits (e.g., prescription drugs in addition to stop-loss and health). The per-person premium may thus reflect stop-loss coverage for benefits in addition to health benefits. Separately, since the analysis is based on "Stop-loss (large deductible)" benefits reported on Schedule A, it may include high-deductible health contracts rather than just stop-loss policies. However, even at the 75th percentile, the average premium, $1,453 per person per year in 2022, was well below market rates for high-deductible health plans, suggesting this potential issue does not substantially affect the results. According to the 2022 KFF Survey, the average premium for single coverage on high-deductible health plans was $7,288 in 2022.

[43] The distributions are calculated over small mixed-funded and self-insured plans that filed a Form 5500 (as opposed to a Form 5500-SF) and reported stop-loss coverage. In 2022, there were 180 and 1,635 such plans, respectively. In 2013-2021, the distributions were calculated based on at least 75 and 152 plans, respectively.

Table 12. Per-Person Annual Premiums for Stop-Loss Insurance (Small Plans)

	Mixed-funded			Self-insured		
Year	25th pct	Median	75th pct	25th pct	Median	75th pct
2013	$1,952	$2,745	$3,626	$853	$1,469	$2,192
2014	$1,972	$2,831	$3,715	$1,075	$1,733	$2,439
2015	$1,509	$2,610	$3,715	$900	$1,526	$2,450
2016	$2,556	$3,337	$4,652	$1,108	$2,038	$3,039
2017	$2,328	$3,158	$4,407	$1,198	$2,302	$3,154
2018	$2,441	$3,440	$4,312	$1,394	$2,636	$3,486
2019	$2,509	$3,875	$4,601	$1,622	$2,849	$3,700
2020	$2,387	$3,297	$4,919	$1,718	$2,940	$4,038
2021	$2,657	$3,443	$4,645	$1,575	$2,794	$3,952
2022	$2,825	$3,841	$5,058	$1,680	$3,160	$4,429

Source: Form 5500 small health plan filings.
Reflects stop-loss coverage as reported on Form 5500.

Funding Mechanisms and Financial Metrics

As described above at page 9, we matched the Form 5500 health plan data to Form 990 filings to identify whether a group health plan sponsor was a for-profit or a not-for-profit entity. Among the sponsors of small plans, 6.3% were found to be not-for-profit entities. These plans covered 9.0% of participants. Table 13 shows the number of small plans and the participants covered by for-profit and not-for-profit entities.

Table 13. Number of Small Plans and Their Participants, by Funding Mechanism and For-Profit Status (2022)

	Small plans			Participants		
	Fully insured	Mixed-funded	Self-insured	Fully insured	Mixed-funded	Self-insured
For-profit	150	162	24,621	4,425	11,932	219,976
Not-for-profit	21	18	1,634	944	1,128	21,393
Total	171	180	26,255	5,369	13,060	241,369

Source: Form 5500 large health plan filings, Form 990 filings

Only 33 sponsors of small plans were matched to Bloomberg data. Almost all sponsors that filed multiple health plans are large companies. We did not compare financial health of fully insured, mixed-funded, and self-insured small plans because of the low number and unusual nature of small-plan sponsors for which financial information was available.

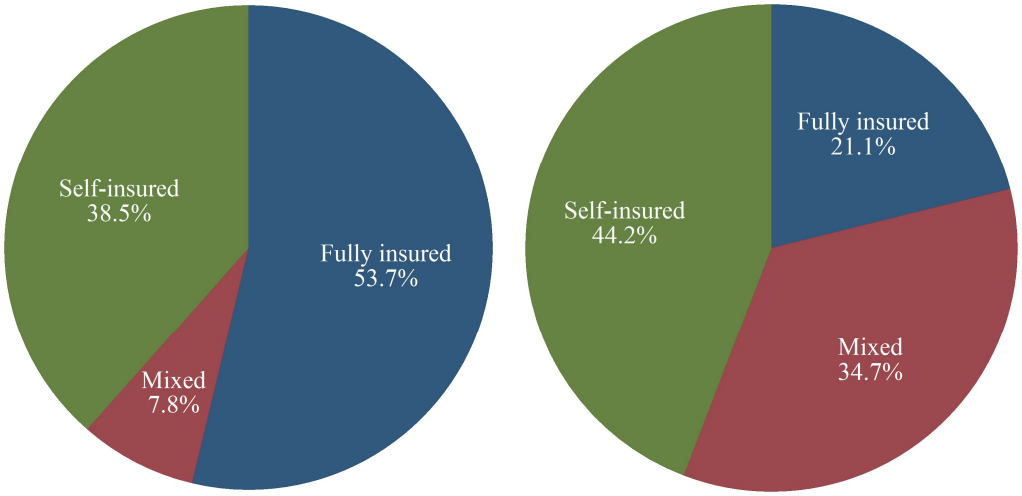
5. LARGE PLAN ANALYSIS

This section documents the findings of our analyses of large group health plans, defined as plans with 100 or more participants at the beginning of the year. We first present the Form 5500 distribution of funding mechanism by plan and plan sponsor characteristics. Next, we follow plan filings over time and document the rates at which plans have switched funding mechanisms. We then discuss stop-loss coverage of self-insured and mixed-funded plans. Finally, we turn to health plan sponsors for which external financial information was available and present summary statistics for these sponsors by plan funding mechanism.

Funding Mechanisms for Large Plans and Their Participants

For statistical year 2022, Figure 7 shows the overall distribution of funding mechanisms among the 58,290 large health plans: 53.7% of plans were fully insured, 38.5% were self-insured, and 7.8% were mixed-funded. As shown further below, funding varies by plan size, so the funding distribution across participants is quite different than it is across plans: 21.1% of the 86.6 million participants were in fully insured plans, 44.2% were in self-insured plans, and 34.7% were in mixed-funded plans.

Figure 7. Distribution by Funding Mechanism (2022)



Large Plans **Participants of Large Plans**

To put our analysis in context, consider recent findings on self-insurance according to an external source: the Insurance Component of the Medical Expenditure Panel Survey (MEPS-IC), an annual survey of employers about their health benefit plans.[44] The findings were not strictly comparable, in part because the unit of observation was an establishment in the MEPS-IC and a plan in the Form 5500 data and in part

[44] Agency for Healthcare Research and Quality, *Chartbook #27: Medical Insurance Component Chartbook 2022*. https://meps.ahrq.gov/data_files/publications/cb27/cb27.pdf.

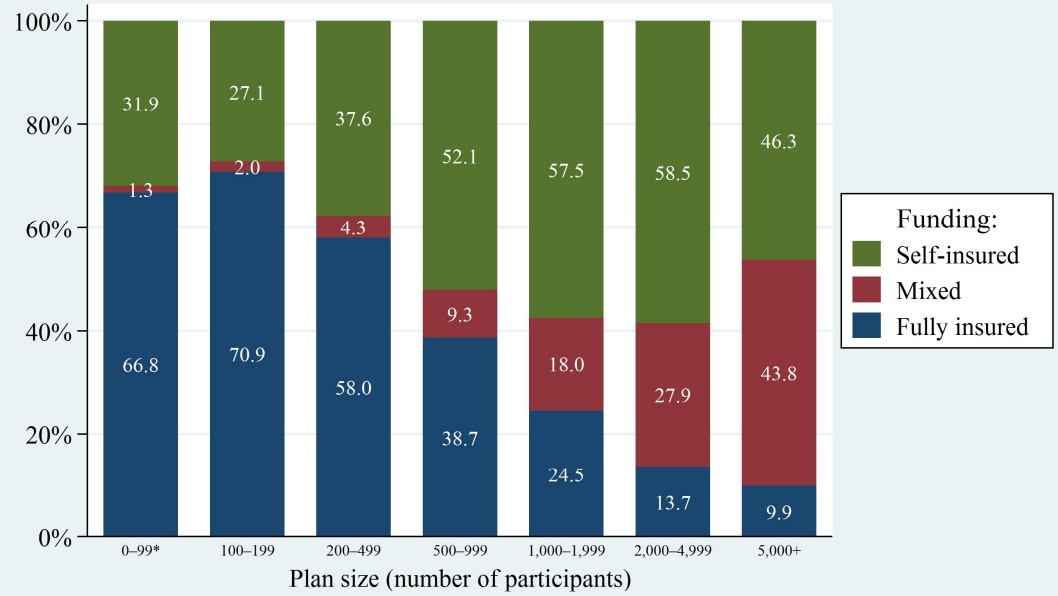
because size was measured in covered employees in the MEPS-IC and plan participants in the Form 5500. That said, the results were similar. According to MEPS-IC estimates, 41.2% of establishments at firms with 100–999 employees self-insured at least one plan in 2022, whereas we found that 39.6% of plans with 100–999 participants were self-insured or mixed-funded in 2022 (calculated from the numbers underlying Table 14 below). Weighted by employees (MEPS-IC) or participants (Form 5500), the shares of employees in health plans with some elements of self-insurance were 44.8% and 47.7%, respectively. For entities with 1,000 employees or more, 74.6% self-insured at least one plan in 2022 according to the MEPS-IC, while 82.5% of plans with 1,000 or more participants were self-insured or mixed-funded according to Form 5500 filings. Weighted by employees (MEPS-IC estimates) or participants (Form 5500), the shares were 74.5% and 85.0%, respectively.

Funding Mechanisms by Plan Size

Figure 8 shows the distribution of funding mechanism by plan size for large health plans in 2022. Among large plans, the likelihood that a plan is self-insured or mixed-funded generally increased with plan size.[45] The pattern was particularly pronounced for mixed-funded plans, presumably because larger plans may offer multiple benefit options, some of which were fully insured and some of which were self-insured. The share of plans with 5,000 or more participants that were self-insured or mixed-funded was 90.1%, compared with 29.1% among plans with 100–199 participants. Table 14 shows the numbers underlying Figure 8.

[45] Large plans with 0–99 participants do not fit this pattern. These plans had 100 or more participants at the beginning of the reporting period, but fewer than 100 by the end of the plan year. The category thus reflects a mix of other plan-size categories.

Figure 8. Distribution of Funding Mechanism for Large Plans, by Plan Size (2022)



Source: Form 5500 filings of large health plans.
* The definition of a large plan is based on number of participants at the beginning of the reporting period; some large plans have fewer than 100 participants at the end of the period.
Percentages may not sum to 100% due to rounding.

Table 14. Distribution of Funding Mechanism for Large Plans, by Plan Size (2022)

Participants	Large Plans			Participants		
in plan	Fully insured	Mixed	Self-insured	Fully insured	Mixed	Self-insured
0–99*	66.8%	1.3%	31.9%	72.8%	2.1%	25.1%
100–199	70.9%	2.0%	27.1%	70.6%	2.0%	27.3%
200–499	58.0%	4.3%	37.6%	56.5%	4.6%	38.9%
500–999	38.7%	9.3%	52.1%	37.7%	9.6%	52.7%
1,000–1,999	24.5%	18.0%	57.5%	24.0%	18.6%	57.4%
2,000–4,999	13.7%	27.9%	58.5%	13.0%	28.9%	58.1%
5,000+	9.9%	43.8%	46.3%	14.4%	44.3%	41.3%
All	53.7%	7.8%	38.5%	21.1%	34.7%	44.2%

Source: Form 5500 large health plan filings.
* The definition of a large plan is based on number of participants at the beginning of the reporting period; some large plans have fewer than 100 participants at the end of the period.
Percentages may not sum to 100% due to rounding.

It also shows that, among the large plans, as plans get larger, there is a trend toward more self-insured. This trend toward self-insured is consistent with the

findings of 2022 KFF Survey,[46] which found that, in 2022, firms with 3-199 employees have 20% of covered workers enrolled in self-insured plans, while for firms with 1,000 or more employees, 88% of covered workers enrolled in self-insured plans.

Funding Mechanisms by Year

Figure 9 shows the funding mechanism distribution for large health plans by statistical year for 2013–2022; see Table 15 and Table 16 for the underlying percentages, plan counts, and participant counts. The percentage of large plans that were self-insured or mixed-funded (i.e., plans with a self-insured component) generally increased slowly from 42.9% in 2013 to 46.3% in 2022.

The participants in large plans that had some self-insured component fell from 82.1% in 2021 to 78.9% in 2022, which is the largest single year change in the past decade, up or down. These changes are predominantly driven by movement of two plans out of mixed-funded. One plan moved from mixed-funded to fully insured as it experienced reduction in total premiums/subscription charges paid to carrier of about a third, triggering the change in defined status per the algorithm. The second plan had a roughly stable amount of premiums/subscription charges across 2021 and 2022, but its level of premiums/subscription charges did not keep up the increase in the cut-off to remain in the mixed-funded category, and the algorithm reclassified it as fully insured.[47] These movements away from self-insurance appear to be anomalies to the overall trend.

The KFF Survey documented a similar, relatively slight increase over the same time period. Thus, the overall trend toward self-insurance among participants—which began well before 2010—appears to have flattened out and perhaps exhibited a slight decline over the last year, based on findings from both this study and the KFF study.

[46] Kaiser Family Foundation, *Employer Health Benefits, 2022 Annual Survey.* Available at https://kff.org/health-costs/report/2022-employer-health-benefits-survey. Available at https://www.kff.org/report-section/ehbs-2022-section-10-plan-funding/.

[47] The cut-off for being in mixed-funded category requires that the total premiums or subscription charges paid to carrier per capita be at least 30 percent of the average costs of single health coverage in the United States as reported in KFF 2022 Annual Survey. In 2022, this 30% cut-off increased by $50, leaving one large plan $11 below the cut-off.

Figure 9. Distribution of Funding Mechanism for Large Plans, by Statistical Year

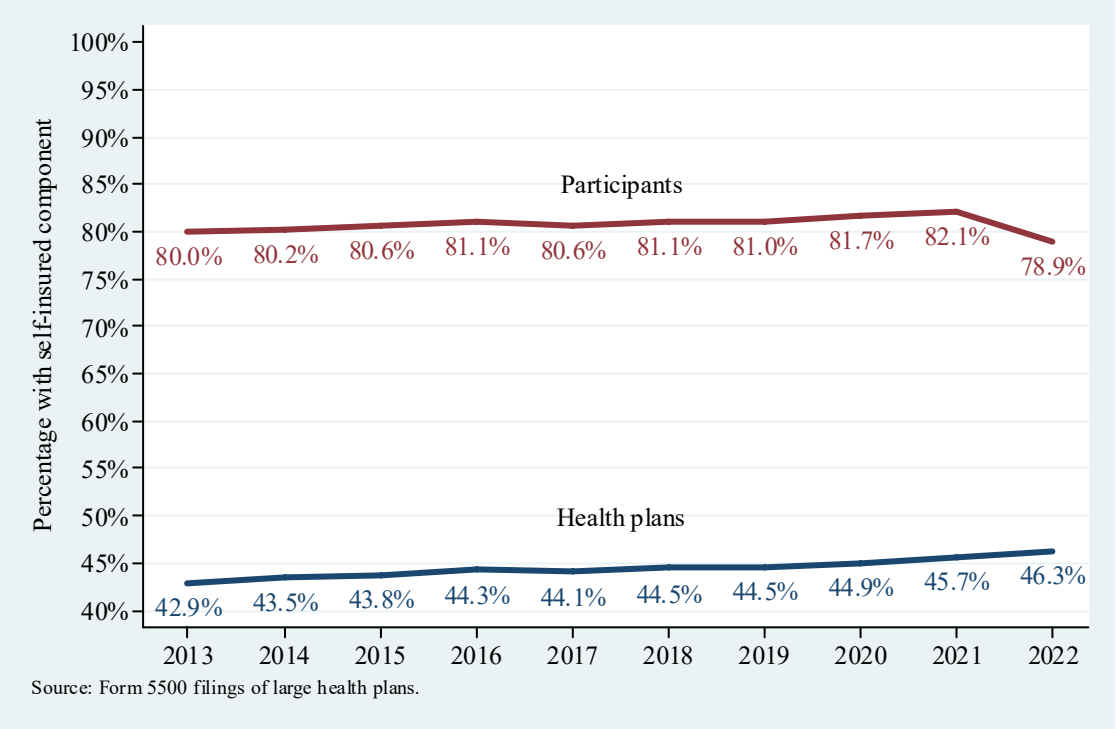


Table 15. Distribution of Funding Mechanism for Large Plans, by Statistical Year

Statistical	Large Plans			Participants		
year	Fully insured	Mixed	Self-insured	Fully insured	Mixed	Self-insured
2013	57.1%	7.0%	35.9%	20.0%	35.2%	44.8%
2014	56.5%	6.8%	36.7%	19.8%	33.6%	46.5%
2015	56.2%	6.7%	37.1%	19.4%	33.9%	46.7%
2016	55.7%	6.8%	37.5%	18.9%	34.9%	46.2%
2017	55.9%	6.7%	37.4%	19.4%	35.0%	45.6%
2018	55.5%	7.0%	37.5%	18.9%	35.9%	45.2%
2019	55.5%	7.0%	37.5%	19.0%	36.0%	45.1%
2020	55.1%	7.2%	37.7%	18.3%	36.8%	44.9%
2021	54.3%	7.6%	38.1%	17.9%	39.5%	42.6%
2022	53.7%	7.8%	38.5%	21.1%	34.7%	44.2%

Source: Form 5500 large health plan filings.
Percentages may not sum to 100% due to rounding.

Table 16. Number of Large Plans and Their Participants, by Funding Mechanism and Statistical Year

Statistical	Plans			Participants (millions)		
year	Fully insured	Mixed	Self-insured	Fully insured	Mixed	Self-insured
2013	27,042	3,311	17,034	13.8	24.3	31.0
2014	27,549	3,330	17,880	13.9	23.6	32.7
2015	28,706	3,423	18,928	14.0	24.4	33.7
2016	29,409	3,597	19,763	14.0	25.8	34.2
2017	30,246	3,601	20,224	14.6	26.3	34.3
2018	30,740	3,877	20,744	14.6	27.8	35.0
2019	31,261	3,929	21,158	15.0	28.4	35.5
2020	31,527	4,128	21,590	14.3	28.8	35.1
2021	31,027	4,352	21,734	15.0	33.2	35.8
2022	31,315	4,539	22,436	18.3	30.1	38.3

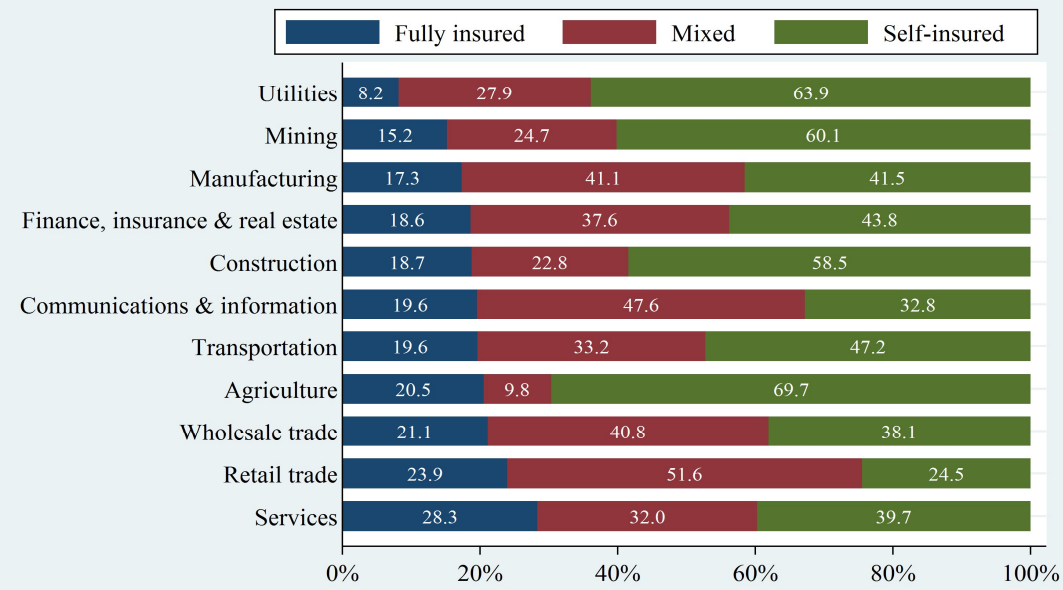
Source: Form 5500 large health plan filings.

Funding Mechanisms by Industry

Figure 10 shows the participant-weighted distribution of funding mechanism by industry for large plans, as identified by the business code provided on Form 5500 filings. Participants in the utilities and mining industries were the most likely to be in a mixed-funded or self-insured large plan, whereas those in the services and retail trade industries were the most likely to be in a fully insured large plan. The smallest proportion of participants in fully insured plans, 8.2%, was in the utilities industry. The largest proportion of participants in fully insured plans, accounting for 28.3% of participants, was in the services industry. Some of the relationship between funding mechanism and industry may be due to variation across industries in health plan sizes, but differences across industries remained after controlling for plan size. A notable change from 2021 was in the retail trade industry where the participant-weighted percentage of fully insured plans rose from 6.6% to 23.9%.[48]

[48] Contributing to this shift was the change at three large service sector firms that added fully insured plans.

Figure 10. Participant-Weighted Distribution of Funding Mechanism, by Industry for Large Plans (2022)



Source: Form 5500 filings of large health plans.
Percentages may not sum to 100% due to rounding.

Funding Mechanisms over the Life Cycle of Plans

Figure 9, above, shows the aggregate trends in self-insured for large group health plans at the plan and participant levels over time. It does not show the switching patterns of individual plans. Next, we turn to the switching behavior of large plans between funding mechanisms.[49]

We distinguished between plans at the beginning of their life, at the end of their life, and during the years in between. For example, it was unclear whether the observed trends in self-insured were due to the funding mix of new plans, the funding mix of terminating plans, net switches among established plans, or a combination of factors. The categorization of plans is detailed above in the section covering small plans. The analysis was somewhat hampered by the fact that some Form 5500 filings contained incomplete information about the beginning and end of plans' lives. As with the small plans, the following describes the categorization of plans and the numbers of plans in these categories:

- *New*—We identified the beginning of a plan's life cycle based on the Form 5500's "first return/report" check box and the plan's effective date. We considered a plan new if it checked the "first return/report" box and the start

[49] For the life cycle perspective in this section, we follow filings of individual plans over time. Plans' life cycle status is based on all filings, including voluntary filings and prior filings in the same year. A plan is uniquely identified by the EIN of its sponsor and a plan number (PN). Some EIN/PN combinations appear to have been used for more than one plan. As in our prior reports, the analysis in the life cycle portion of this report excludes all filings of such EIN/PN combinations.

of the reporting period differed by no more than two years from the plan's effective date.[50] In 2022, 2,866 large plans were new.

- *Cease filing*—We attempted to capture the end of a plan's life cycle in two ways. First, a plan may have indicated on its Form 5500 that it was terminating, namely by checking the "final return/report" box, by reporting a resolution to terminate the plan, or by documenting that all assets were transferred out of the plan.[51] Second, a plan may stop filing a Form 5500 without the required prior indication. Doing so does not necessarily imply that the plan terminated; it may be non-compliant or it may have shrunk and become exempt but incorrectly neglected to note this by writing "4R" on Line 8b of the Form 5500. To mitigate this issue, we do not view a plan as terminated if it misses filing for one or more years and then appears again in the filings in a later year. Similarly, we do not view a plan as new if it filed again after missing a number of years since its previous filing. Recognizing that some plans in this category have in fact not reached the end of their life cycle, we labeled them as plans that "ceased filing."[52] In 2022, 5,052 large plans fell into this category (including plans that last filed in 2021 without indicating that it was their final filing), down from 5,343 in 2021.
- *Established*—This category captured the middle of a plan's life cycle. Plans that were neither "new" nor "ceased filing" were labeled "established" plans. In 2022, 52,912 large plans fell into this category (including plans that first filed in 2022 but reported a plan effective date more than two years before the start of the reporting period). The established large plans are up slightly from 2021, which saw 52,237 such plans.

Table 17 shows the funding distribution of new large plans in 2022. Of the 2,866 new plans, 71.0% were fully insured, 4.5% were mixed-funded, and 24.5% were self-insured. The new plans covered 1.02 million participants, of whom 46.5% were in a fully insured plan, 20.4% in a mixed-funded plan, and 33.0% in a self-insured plan.

[50] Some plans never checked the "first return/report" box, or not until later in their life cycle. If the box was not checked until, say, the fourth filing, we excluded the earlier filings from the analysis. This is consistent with the plan becoming effective when the "first return/report" box was checked, which we think is the entity's indication that the plan became active. If the box was checked in more than one filing, we identified the plan as "new" only for the first filing.

[51] Some plans repeatedly indicated filing of a final return, but continued submitting filings. We ignored indications of plan termination if the plan continued filing in subsequent years. Separately, plans that reported termination on their initial filing were included in both the "new" and "ceased filing" categories (See Figure 11, below).

[52] In terms of timing, if a plan indicated on its 2013 filing that it was terminating, we considered it as having ceased filing in 2013. If a plan submitted filings through 2013 but not in any later year, we considered it as having ceased filing in 2014.

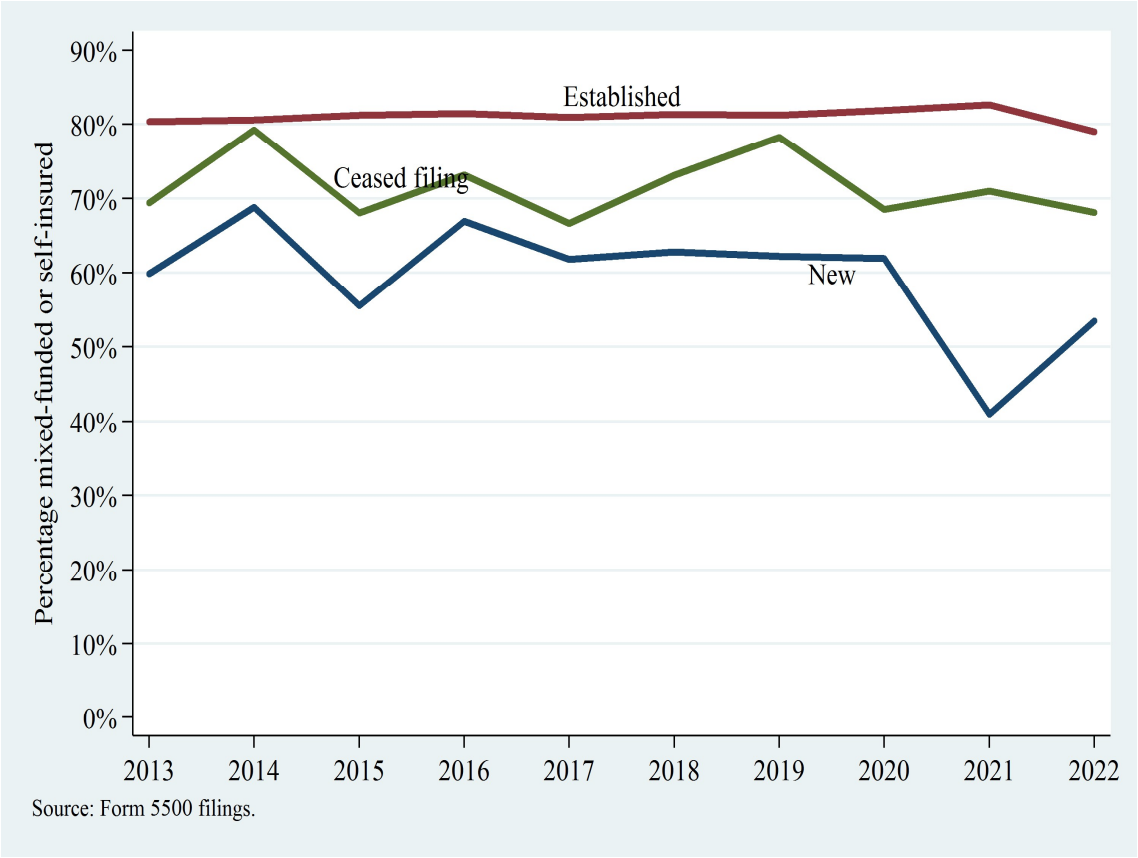
Table 17. Funding Distribution of New Large Plans (2022)

	Large Plans		Participants	
	Number	Percent	Number (millions)	Percent
Fully insured	2,034	71.0%	0.47	46.5%
Mixed	129	4.5%	0.21	20.4%
Self-insured	703	24.5%	0.34	33.0%
Total	2,866	100.0%	1.017	100.0%

Source: Form 5500 large health plan filings.
Percentages may not sum to 100% due to rounding.

Figure 11 shows the percentage of participants who were covered by a mixed-funded or self-insured large plan, by plan life cycle stage from 2013 to 2022. Participants in new large plans were generally less likely to be in mixed-funded or self-insured large plans than those in established large plans or large plans that ceased filing. If large plans never switched funding mechanisms, this should drive down the overall fraction of participants in large plans with a self-insured component. However, self-insurance among participants generally increased until 2016 and remained approximately level thereafter, until 2022. Through 2021 this pattern points to a switch in funding mechanism as the main cause of the observed pattern. But then in in 2022 as the new plans from 2021, with their low rates of self-insured and mixed-funded, become established plans, we see a decline in the percent of established plans with self-insured or mixed-funded. This is consistent with those new plans in 2021 simply aging into "established" plans and bringing their low rates of mixed-funded and self-insured into the group of plans labeled as established. As discussed above, in 2022, there were also two large plans that transitioned from mixed-funded to fully insured.

Figure 11. Participant-Weighted Percentage Mixed-Funded or Self-Insured among Large New Plans, Established Plans, and Plans That Ceased Filing, by Statistical Year



Before turning to switching patterns, consider that most participants were covered by very large health plans (Table 1 and Table 18). As Table 18 shows, among the new plans from 2018 through 2022, only 0.9% covered 5,000 or more participants, but those plans covering 5,000 or more participants accounted for 34.8% of participants in all new large plans.[53] Among established plans, 65.9% of participants were in plans with 5,000 or more participants. The behavior of plans with more than 5,000 participants is therefore key to understanding participant-weighted trends in funding.

[53] A manual review indicated that such plans commonly were successor plans to prior plans that were replaced or consolidated, for instance after a corporate merger. Likewise, plans that ceased filing may have been replaced with other plans and secured continuing health benefit coverage for their participants.

Table 18. Distribution of Large Health Plans and Plan Participants, by Plan Participant Counts (2018-2022)

Participants	New Plans		Established Plans		Plans That Ceased Filing	
in plan	Plans	Participants	Plans	Participants	Plans	Participants
0-99*	8.9%	1.0%	2.7%	0.1%	44.3%	2.9%
100–199	55.6%	17.6%	34.2%	3.3%	26.9%	9.0%
200–499	24.2%	16.6%	33.1%	6.8%	17.6%	13.0%
500–999	5.9%	9.4%	13.0%	6.0%	5.5%	9.2%
1,000–1,999	3.0%	9.7%	7.5%	7.0%	2.9%	10.1%
2,000–4,999	1.5%	10.8%	5.3%	10.9%	1.7%	12.6%
5,000+	0.9%	34.8%	4.2%	65.9%	1.1%	43.1%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Source: Form 5500 large health plan filings.

* The definition of a large plan is based on number of participants at the beginning of the reporting period; some large plans have fewer than 100 participants at the end of the period. Percentages may not sum to 100% due to rounding.

Table 19 shows the *annual rate* of funding mechanism switching among the subset of new and established large plans between 2018 and 2022. Overall, 6.5% of new large plans that started as fully insured switched to mixed-funded or self-insured during the following reporting period. However, new large plans of larger size (more than 500 participants at EOY[54]) were much more likely to make that switch than smaller new large plans (less than 500 participants at EOY).

For example, 22.2% of fully insured new plans with 5,000 or more participants at EOY changed funding mechanism to mixed or self-insured in the following year. In contrast, for fully insured new plans with fewer than 100 participants only 4.0% made this funding mechanism change. Conversely, between 2018 and 2022, the new large plans of smaller size that were mixed-funded or self-insured were more likely to switch to fully insured in their second year, compared to their larger counterparts.

A similar pattern existed among established large plans. During the same time period (2018-2022), established large plans of larger size that were fully insured in the current year were more likely to switch to mixed or self-insured in the following year than the large plans of smaller size[55], and established large plans of smaller size in the current year that were mixed or self-insured were more likely to switch to fully insured in the following year than the large plans of larger size. Since most participants were in very large plans, the implication was that, on net, participants in both new and established large plans migrated to mixed-funded or self-insured.

[54] EOY means the end of reporting year.

[55] In Table 19, only plans with filing records for any year between 2018 and 2022 are included. However, the calculation of funding mechanism changes is based on data from 2017 to 2022. This is because, to identify a plan's funding mechanism change, we use its funding mechanism and life stage from the current year and compare it to the funding mechanism in the following year. For plans with records starting in 2018, we need their 2017 records to complete the identification process.

Table 19. Annual Rates of Funding Switching among New and Established Large Plans, by Plan Size (2018-2022)

	New Plans		Established Plans	
Plan participants	Switch to mixed or self-insured	Switch to fully insured	Switch to mixed or self-insured	Switch to fully insured
0-99*	4.0%	14.7%	5.8%	12.5%
100–199	5.3%	13.6%	4.5%	7.6%
200–499	7.9%	10.2%	6.2%	4.9%
500–999	12.2%	4.2%	9.9%	3.0%
1,000–1,999	16.7%	3.0%	12.7%	1.8%
2,000–4,999	8.2%	3.1%	17.2%	1.3%
5,000+	22.2%	1.6%	14.8%	1.2%
Total	6.5%	9.7%	6.3%	4.3%

Source: Form 5500 large health plan filings.
* The definition of a large plan is based on number of participants at the beginning of the reporting period; some large plans have fewer than 100 participants at the end of the period.
Rates are conditional on the appropriate universe. For example, the denominator for the first column is fully insured new plans.

Rates at which plans ceased filing also varied by plan size (Table 20), with very large plans generally less likely to stop filing in 2018–2022 than smaller plans.[56] Among plans with 5,000 or more participants, fully insured new plans ceased filing at a higher rate than mixed-funded or self-insured plans. But for established plans with over 5,000 participants, the rate at which plans ceased filing was nearly the same for fully insured and those with some self-insurance.

Table 20. Annual rates at which New and Established Large Plans Ceased Filing, by Plan Size (2018-2022)

	New Plans		Established Plans	
BOY plan participants	Mixed or self-insured	Fully insured	Mixed or self-insured	Fully insured
100–199	20.4%	17.9%	10.6%	10.6%
200–499	13.7%	11.4%	6.7%	6.6%
500–999	11.2%	14.4%	5.3%	5.5%
1,000–1,999	6.8%	12.3%	5.2%	5.2%
2,000–4,999	11.3%	14.0%	4.2%	4.7%
5,000+	7.1%	10.0%	3.4%	3.1%
Total	15.6%	16.1%	6.6%	8.4%

Source: Form 5500 large health plan filings.

In conclusion, large plans that existed between 2018 and 2022 on net switched away from being fully insured. However, in 2022 three of the larger large plans either

[56] Given the focus on the end of the life cycle, Table 20 lists plans by the number of participants at the beginning (rather than the end) of the reporting period. The majority of large plans that covered fewer than 100 participants at the end of the reporting period ceased filing (not shown), which likely was reverse causality (i.e., plans tend to shrink as they prepare to close).

switched from mixed-funded to fully insured leading to an increase of the number of large plan participants in fully funded plans in 2022 compared to 2021. Large fully insured plans were nearly equally likely to cease filing as large mixed-funded or self-insured plans. The overall result was to decrease the share of participants with some element of self-insurance from 82.1% to 78.9% between 2021 and 2022, the largest single year change in the past decade, which pushed the percentage of participants in large plans with some form of self-insurance below the lowest value in the past decade, 80.0% seen in 2013.

Stop-Loss Coverage of Large Plans

Table 21 examines the presence of stop-loss insurance for large plans. However, these figures must be interpreted with caution. First, stop-loss insurance only needs to be reported on the Form 5500 Schedule A if the health plan is the beneficiary and/or the insurance was purchased with plan assets.[57] Accordingly, if the employer/sponsor purchased stop-loss insurance with itself as the beneficiary (rather than the plan), then it does not need to be reported on the Form 5500. Second, Table 21 is based on the "Stop loss (large deductible)" benefit type reported on Schedule A, but that benefit type may reflect a health insurance contract with a high deductible rather than stop-loss insurance. External studies indicate that Table 21 understates the prevalence of stop-loss insurance.[58]

[57] The analysis of stop-loss coverage excludes Form 5500-SF filings because Schedule A was not required to be attached to the Form 5500-SF.

[58] AACG, *Anomalies in Form 5500 Filings: Lessons from Supplemental Data for Group Health Plan Funding*, 2012. AACG's report shows that as many as four out of five self-insured or mixed-funded plans and roughly 55% of participants in such plans were covered by stop-loss insurance, possibly purchased for the benefit of the plan sponsor. These stop-loss coverage levels are consistent with those in the 2013 KFF/HRET study. More recent KFF studies (2022 Employer Health Benefits Survey) documented that, in larger firms, 59% of participants in self-funded plans were in a plan that had purchased stop-loss insurance in 2018 and that figure was 72% in 2022. We note that stop-loss insurance reported on a Form 5500 filing does not necessarily relate to health benefits but could protect other self-insured benefits, such as disability benefits.

Table 21. Percentage of Large Health Plans Reporting Stop-Loss Insurance by Funding Mechanism and Statistical Year

Statistical	Large Plans		Participants	
year	Mixed	Self-insured	Mixed	Self-insured
2013	19.1%	25.7%	14.2%	13.4%
2014	18.2%	26.2%	14.7%	19.5%
2015	18.8%	25.4%	15.5%	19.4%
2016	18.9%	24.7%	15.5%	19.1%
2017	18.6%	23.2%	15.7%	18.6%
2018	17.3%	22.6%	13.8%	18.9%
2019	17.3%	22.2%	14.4%	18.5%
2020	16.9%	21.8%	8.7%	17.8%
2021	16.4%	21.2%	14.8%	17.1%
2022	14.8%	20.7%	9.6%	16.6%

Source: Form 5500 large health plan filings.
Reflects stop-loss coverage as reported on Form 5500.

In 2022, 14.8% of mixed-funded and 20.7% of self-insured large plans reported stop-loss coverage on a Schedule A, down from 2013 rates of 19.1% and 25.7%, respectively. Weighted by the number of participants, 9.6% of mixed-funded and 16.6% of self-insured large plans reported stop-loss coverage for 2022.[59,60]

Table 22 shows the annual per-person cost for large plans of stop-loss coverage, calculated as the ratio of premiums to "number of persons covered" by the stop-loss policy on Schedule A—both the premium and the number of people covered thus refer to the stop-loss policy only and not to the overall plan. The numbers are not adjusted for inflation. These results should also be interpreted with caution because the Form 5500 filing contained no information on attachment points or other stop-loss policy features that may reflect the amount of coverage provided by the policies.[61]

[59] The annual KFF Survey collects information about stop-loss coverage, including for the benefit of the plan sponsor. From KFF 2022 Employer Health Benefits Survey, weighted by workers covered by self-insured health plans, for large firms, stop-loss coverage was 72% in 2022. For smaller firms in that group (200-999 workers), stop-loss coverage was 91% in 2022.

[60] Between 2019 and 2020 a single large mixed-funded plan with more than 1.5 million participants stopped reporting stop-loss coverage, contributing to the fall of the percentage of large mixed-funded plans with stop-loss to 8.7%, but then restarted reporting stop-loss coverage in 2021, pushing that percentage to 14.8%. In 2022, this same plan then switched from mixed-funded to fully insured contributing to the decline in this percentage to 9.6%.

[61] Per-person premiums were calculated from Schedules A that specified stop-loss coverage only or in combination with health benefits. Approximately 15% of such Schedules A specified additional benefits (e.g., prescription drugs in addition to stop-loss and health). The per-person premium may thus reflect stop-loss coverage for benefits in addition to health benefits. Separately, since the analysis is based on "Stop loss (large deductible)" benefits reported on Schedule A, it may include high-deductible health contracts rather than just stop-loss policies. However, even at the 75th percentile, the average premium, $1,453 per person per year in 2022, was well

Table 22. Per Person Annual Premiums for Stop-Loss Insurance (Large Plans)

	Mixed-funded			Self-insured		
Year	25th pct	Median	75th pct	25th pct	Median	75th pct
2013	$189	$427	$893	$283	$647	$1,167
2014	$186	$444	$921	$302	$685	$1,234
2015	$227	$470	$930	$334	$730	$1,301
2016	$219	$524	$993	$337	$774	$1,408
2017	$235	$529	$982	$370	$836	$1,503
2018	$246	$548	$1,103	$414	$897	$1,601
2019	$300	$611	$1,191	$437	$989	$1,736
2020	$300	$641	$1,331	$493	$1,077	$1,901
2021	$314	$702	$1,383	$523	$1,133	$1,980
2022	$308	$762	$1,453	$561	$1,193	$2,135

Source: Form 5500 large health plan filings.

Reflects stop-loss coverage as reported on Form 5500.

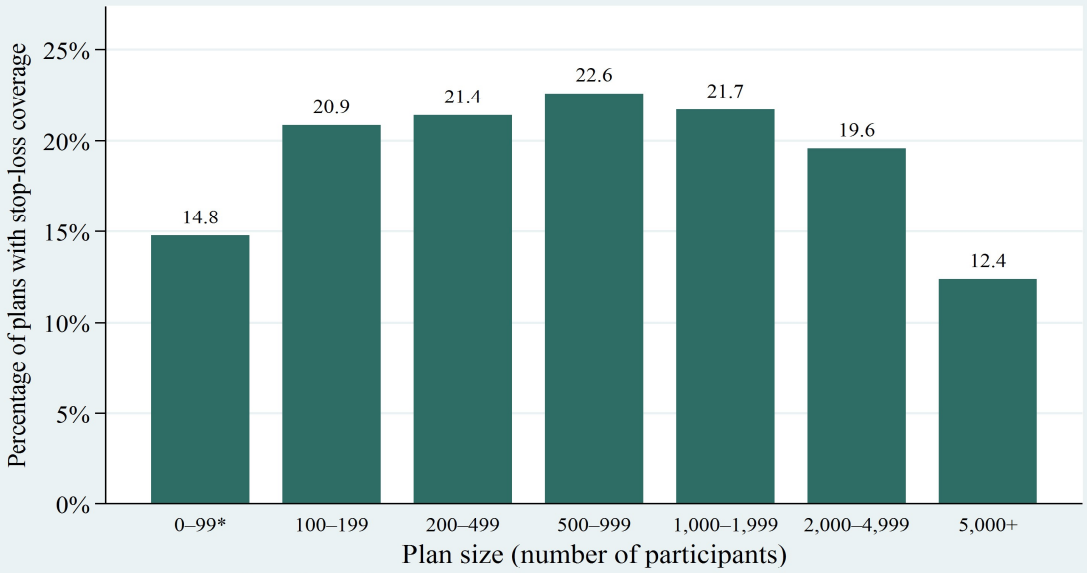
Figure 12 shows the rate of stop-loss coverage among large, self-insured plans by plan size at the end of the year.[62] The likelihood of a plan having stop-loss coverage increased with plan size, measured at end of year, up to 500–999 participants and decreased with plan size among larger plans. Lower stop-loss coverage for smaller plans was not consistent with the notion that smaller plans faced greater financial risks and should thus be more likely to purchase stop-loss coverage. Part of the explanation may relate to the fact that stop-loss coverage with the plan sponsor (rather than the plan) as beneficiary need not be reported on Form 5500; smaller employers may be more likely to designate the plan sponsor as the beneficiary than larger employers. The lower prevalence of stop-loss insurance among smaller large plans may also reflect market realities: insurance companies may not offer stop-loss insurance to small employers, or offer it only at very high prices. The 2022 KFF Survey also documented lower stop-loss coverage rates among very large plans than among mid-sized plans.[63]

below market rates for high-deductible health plans, suggesting this potential issue does not substantially affect the results. According to the 2022 KFF Survey, the average premium for single coverage on high-deductible health plans was $7,288 in 2022.

[62] The corporate determination of whether to purchase stop-loss coverage may be influenced by both the company's knowledge of what the plan size is likely to be by the end of the year and the participant counts at the beginning of year.

[63] Kaiser Family Foundation, 2022 Employer Health Benefits Survey, 2022, Figure 10.8. https://files.kff.org/attachment/Report-Employer-Health-Benefits-2022-Annual-Survey.pdf

Figure 12. Self-Insured Large Health Plans' Rate of Stop-Loss Coverage, by Plan Size (2022)

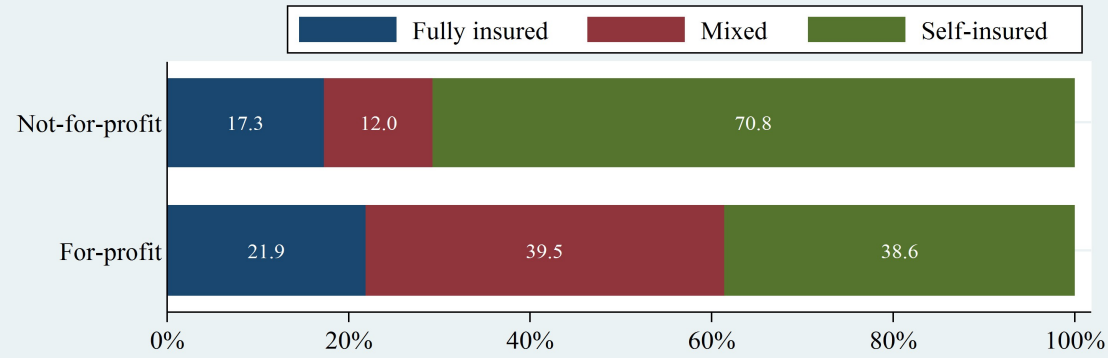


Source: Form 5500 filings of large health plans.
Reflects stop-loss coverage as reported on Form 5500; see text.
* The definition of a large plan is based on number of participants at the beginning of the reporting period; some large plans have fewer than 100 participants at the end of the period.

Funding Mechanisms and Financial Metrics

As described above, we matched the Form 5500 health plan data to Form 990 filings to identify whether a health plan sponsor was a for-profit or a not-for-profit entity. We found about one in six large plans (16.4%) were sponsored by a not-for-profit entity. These not-for-profit plans also covered approximately one in six of all participants (17.3%). Figure 13 presents the participant-weighted breakdown in funding status for for-profit and not-for-profit firms. For-profits had 21.9% of participants in fully insured plans, while not-for-profits had 17.3%. They differed mostly in mixed-funded and self-insured: 70.8% of participants in not-for-profit entity plans were covered by a self-insured plan, compared with 38.6% of participants in for-profit firms' plans. Conversely, mixed-funded was far less prevalent at not-for-profit entities than at for-profit firms.

Figure 13. Participant-Weighted Distribution of Funding Mechanism, by For-Profit and Not-for-Profit Sponsors of Large Plans (2022)



Source: Form 5500 filings of large health plans and Form 990 filings of their sponsors.
Percentages may not sum to 100% due to rounding.

Focusing on the subset of Form 5500 large health plan filers that were matched to financial information in Bloomberg, Table 23 presents 2022 information about company size as measured by revenue, market capitalization, profit, and number of employees (and the number of observations on which each calculation is based). The table shows that, among these large firms that tend to be publicly traded, companies offering fully insured health plans tended to be smaller than companies with self-insured or mixed-funded health plans. Companies offering mixed-funded health plans tended to be the largest.

Table 23. Characteristics of Companies Matched to Form 5500 Health Plan Filings, by Funding Mechanism (2022)

		All	Fully insured	Mixed	Self-insured
Revenue ($ millions)	25 pct	566	150	2,020	885
	Median	2,670	510	5,800	3,280
	75 pct	14,100	2,880	19,800	17,100
	# Obs	3,262	898	941	1,423
Market capitalization ($ millions)	25 pct	797	301	2,330	1,020
	Median	3,930	1,220	7,820	4,380
	75 pct	21,100	6,180	39,800	23,600
	# Obs	3,203	897	924	1,382
Profit ($ millions)	25 pct	-3	-68	34	22
	Median	155	11	406	223
	75 pct	1,040	227	1,770	1,150
	# Obs	3,280	910	944	1,426
Number of employees	25 pct	1,350	348	4,288	1,860
	Median	6,271	1,106	13,474	6,893
	75 pct	27,700	7,920	46,600	28,000
	# Obs	3,090	831	914	1,345

Source: Form 5500 large health plan filings and Bloomberg data.

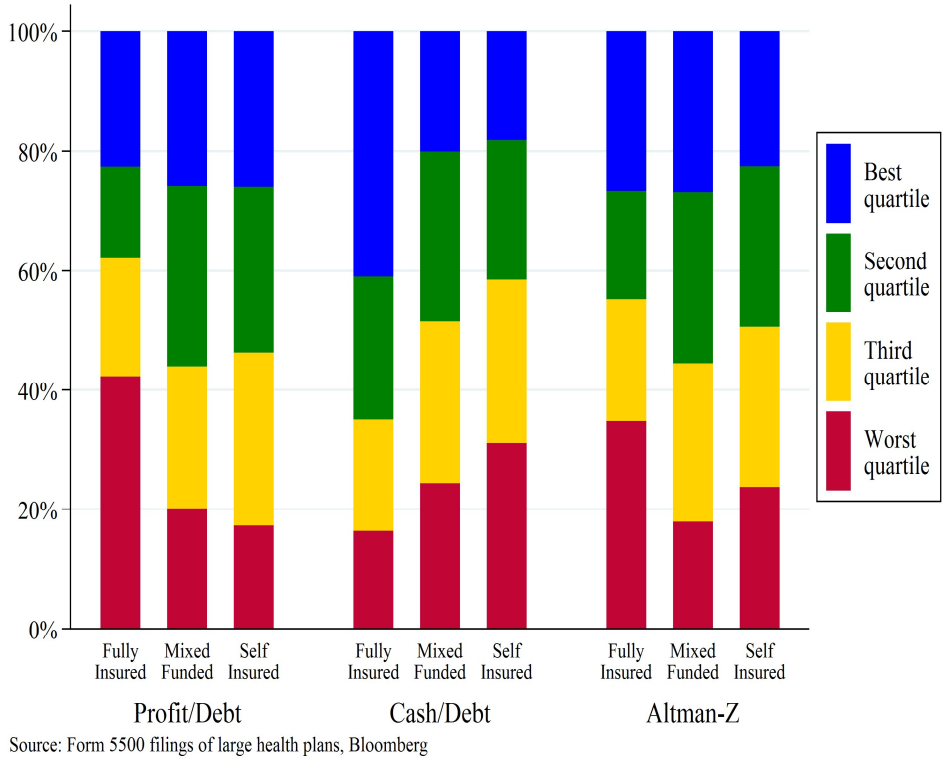
Figure 14 presents three metrics of the financial health of matched companies: the ratio of profit to total debt, the ratio of cash and cash equivalent holdings to total debt, and the Altman Z-Score.[64] Across the three metrics and based on the approximately 5.6% of the health plans for which we could match financial data, the results are mixed. For all three, higher values are generally considered an indicator of better financial health.

We grouped all matched plans into quartiles; Figure 14 shows the share of fully insured, mixed-funded, and self-insured large plans in each quartile. The three financial metrics provide a mixed picture. Consider first the ratio of profit to total debt. If financial health was unrelated to funding mechanisms, all bars would be approximately equal-sized. Instead, 42.3% of fully insured sponsors were in the bottom quartile, compared with 20.1% of mixed-funded and 17.3% of self-insured sponsors; see the red bars in the bottom-left portion of Figure 14. Based on how frequently their ratios of profit to total debt were in the bottom quartile, mixed-funded and self-insured companies may appear to be in better financial health than

[64] The Altman Z-Score is an index summarizing five financial measures that are used to predict bankruptcy risk; see footnote 21 on page 10. A Z-Score greater than 2.99 is considered the "safe" zone, between 1.80 and 2.99 is the "grey" zone, and less than 1.80 is the "distress" zone. The 25th percentile of Altman Z-Scores of plan sponsors in our analysis was 1.53, i.e., all companies in the bottom quartile and some in the third quartile were considered to be in the "distress" zone. For details, see E.I. Altman, "Financial Ratios, Discriminant Analysis and the Prediction of Corporate Bankruptcy." *Journal of Finance* 23(4) (1968), Pp. 589–609.

fully insured companies by this metric alone. However, the other two financial metrics present a different picture.

Figure 14. Financial Health of Companies Matched to Form 5500 Health Plan Filings, by Funding Mechanism (2022)



Source: Form 5500 filings of large health plans, Bloomberg

The ratio of cash holdings to total debt suggests that sponsors of fully insured plans were in better financial health than sponsors of mixed-funded and self-insured plans, while the Altman Z-Score ranks sponsors of fully insured and self-insured plans lower than sponsors of mixed-funded plans. In short, there is no consistent evidence that mixed-funded or self-insured sponsors were in better or worse financial health than fully insured sponsors in this set of 5.6% of the plan sponsors whose financial data we have obtained. These findings are generally consistent with those in prior reports. Finally, as in prior years, fully insured plans showed a wider dispersion of financial health (as measured by the share of plans in the bottom and top quartiles combined) than mixed-funded and self-insured plans.

Table 24 shows the percentages and sample sizes corresponding to Figure 14.

Table 24. Financial Health of Companies Matched to Form 5500 Health Large Plan Filings, by Funding Mechanism (2022)

		All	Fully insured	Mixed	Self-insured
Profit over total debt	Best quartile	25.0%	22.6%	25.8%	25.9%
	Second quartile	25.0%	15.3%	30.2%	27.7%
	Third quartile	25.0%	19.8%	23.9%	29.1%
	Worst quartile	25.0%	42.3%	20.1%	17.3%
	# Obs	3,241	895	939	1,407
Cash (equivalent) holdings over total debt	Best quartile	25.0%	41.0%	20.0%	18.1%
	Second quartile	25.0%	24.0%	28.4%	23.4%
	Third quartile	24.9%	18.7%	27.2%	27.4%
	Worst quartile	25.1%	16.3%	24.4%	31.1%
	# Obs	3,239	893	939	1,407
Altman Z-Score	Best quartile	24.9%	26.6%	26.8%	22.5%
	Second quartile	25.0%	18.2%	28.7%	26.9%
	Third quartile	25.0%	20.5%	26.6%	26.8%
	Worst quartile	25.0%	34.8%	17.9%	23.8%
	# Obs	2,723	748	827	1,148

Source: Form 5500 large health plan filings and Bloomberg data.
Percentages may not sum to 100% due to rounding.

6. GROUP INSURANCE ARRANGEMENTS

The analysis above excludes GIAs because GIAs are not group health plans. However, they may be of interest for their role in securing employer-sponsored health benefits. A GIA provides benefits to the employees of two or more unaffiliated employers (not in connection with a multiemployer plan or a collectively bargained multiple-employer plan), fully insures one or more welfare plans of each participating employer, uses a trust or other entity as the holder of the insurance contracts, and uses a trust as the conduit for payment of premiums to the insurance company (See 2022 Instructions for Form 5500, available at dol.gov/sites/dolgov/files/ebsa/employers-and-advisers/plan-administration-and-compliance/reporting-and-filing/form-5500/2022-instructions.pdf). Welfare plans that use a GIA to provide benefits do not have to file a Form 5500 as long as the GIA files. By definition, GIAs are fully insured.[65]

For 2022, 50 arrangements covering about 343,719 participants submitted Form 5500 filings as GIAs, compared with 58,290 large group health plans that covered 86.6 million participants. GIAs (which are generally comprised of multiple plans) tend to be larger than group health plans. For example, 84.0% of GIAs covered 500 or more participants, compared with 29.1% of large group health plans.

GIAs further differ from group health plans in their distribution of industry sectors. Perhaps due to the diversity of their contributing employers, as many as 42.0% of GIAs reported a "Miscellaneous" industry or none at all. Also 28.0% were active in the finance, insurance, and real estate industries, and their participants accounted for 63.1% of all GIA participants, compared with just 10.3% of large group health plans and 9.9% of participants in such plans.

[65] The plans participating in a GIA must fully insure one or more welfare plans. In rare situations, a dental or small vision plan in the GIA could be self-insured, but the medical benefits are fully insured.

7. CONCLUSION

The ACA was enacted in 2010 and has brought about far-reaching changes to health care financing and coverage. This report and its counterparts from prior years aim to monitor any changes in employer-sponsored health benefit coverage and its funding mechanism that employers have made in the years since the ACA became law. While in the past we identified several time trends, with the exception of the increase in self-insurance by small plans, those changes tended to be moderate, generally started prior to 2010, and largely flattened out in recent years. This year we note that many of these trends are following a similar pattern, but the increase in the number of small plans filing has slowed and the percentage of participants in large plans with some component of self-insurance has fallen.

The number of health plans that filed a Form 5500 and the number of participants they covered grew between 2021 and 2022. The number of participants overall has continued to grow since 2013 except for the decline between 2019 (79.0 million) and 2020 (78.4 million), reaching 86.9 million in 2022. These overall changes in the population covered are driven primarily by the growth in large plans, which have been relatively steady over the past ten years, with the exception of 2020. We note that most small health benefit plans were exempt from filing a Form 5500, so no conclusions should be drawn based on this report with respect to the number of small employers that offered health benefits or the number of participants they covered. However, a notable change occurred in the rate of growth in number of small health plans filing in 2022. Small plans filing Form 5500 increased by about 7.7% from 24,693 in 2021 to 26,606 in 2022. This is a notable departure from the more rapid growth in the number of small plans filing of 46.9% from 16,809 in 2020 to 24,693 in 2021, and an even larger percentage increase (77.9%) in the number of small plans filing between 2019 and 2020. The number of participants in small health plans that filed in 2022 grew by only 0.28% to 259,798, a marked decrease from growth rates of 17.8% in 2021 and 39.0% in 2020.

Among mixed-funded small plans, stop-loss coverage declined from 69.3% in 2021 to 65.0% in 2022. Among self-insured small plans filing, stop-loss coverage continued an upward trend, from 48.3% in 2021 to 54.2% in 2022. For large plans, the observed trend in reported Form 5500 data toward less stop-loss coverage may be flattening and starting to decline. Among mixed-funded large plans, stop-loss coverage declined slightly to 14.8% in 2022, while among self-insured large plans there was a slight decrease to 20.7% in 2022 from 21.2% in 2021. It is unclear whether these findings reflect trends in overall stop-loss coverage. Form 5500 filings are known to be an incomplete source of information about stop-loss coverage. Insofar as reported, stop-loss coverage was much greater for small plans than for large plans, and has increased significantly over time.

Among large plans, the overall distribution of funding mechanism was largely unchanged from 2021, with a slight increase in mixed-funded plan participants. At the plan level, self-insured or mixed-funded increased by 0.6 percentage points to 46.3%. At the participant level, self-insured or mixed-funded decreased from 82.1% in 2021 to 78.9% in 2022. These changes are predominantly driven by movement of two plans out of mixed-funded. One plan moved from mixed-funded to fully insured as it experienced reduction in total premiums/subscription charges paid to carrier of about a third, triggering the change in defined status. The second plan had a roughly stable amount of premiums/subscription charges across 2021 and 2022, but their

level of premiums/subscription charges did not keep up the increase in the cut-off to remain in the mixed-funded category.

The data offer little insight into the funding distribution among small plans as most small plans are exempt from filing a Form 5500. However, the number of self-insured or mixed-funded small plans that filed increased by 7.8% from 2021 to 2022. Most of that increase is due to small plans that appear to participate in a non-plan MEWA.

Overall, the Form 5500, despite some known limitations, continues to be a useful data source to better understand the type and range of health benefits that employers provide to American workers. The relatively long history of these data can help inform important policy debates surrounding these benefits. It can be anticipated that future versions of this report will continue to document these important trends.

TECHNICAL APPENDIX

The definitions of funding mechanism rely upon the fields of Form 5500 and its Schedules as outlined in Table 1.

Table 1. Data Fields Used to Determine Plan Funding Type

Source	Description
Form 5500, Line 5; Form 5500-SF, Line 5a	Total number of participants at the beginning of the plan year
Form 5500, Line 6d; Form 5500-SF, Line 5b	Number of participants at the end of the plan year who are active, retired, separated, or retired/separated and entitled to future benefits
Form 5500, Line 9a	The ''funding arrangement'' is the method for the receipt, holding, investment, and transmittal of plan assets prior to the time the plan actually provides benefits. Plan funding arrangement (check all that apply) 1. Insurance 2. Section 412(e)(3) insurance contracts 3. Trust 4. General assets of the sponsor
Form 5500, Line 9b	The ''benefit arrangement'' is the method by which the plan provides benefits to participants. Plan benefit arrangement (check all that apply) 1. Insurance 2. Section 412(e)(3) insurance contracts 3. Trust 4. General assets of the sponsor
Schedule A, Line 1e	Approximate number of persons covered at the end of the plan year
Schedule A, Line 2a	Total amount of commissions paid
Schedule A, Line 2b	Total fees paid
Schedule A, Line 3e	Organization code of agents, brokers, or other persons to whom commissions or fees were paid: 1. Banking, Savings & Loan Association, etc. 2. Trust Company 3. Insurance Agent or Broker 4. Agent or Broker other than insurance 5. Third party administrator 6. Investment Company/Mutual Fund 7. Investment Manager/Adviser 8. Labor Union 9. Foreign entity 0. Other
Schedule A, Line 6b	Premiums paid to carrier

Source	Description
Schedule A, Line 8	Type of benefit and contract types: A. Health (other than dental or vision), I. Stop-loss (large deductible), J. HMO contract, K. PPO contract, L. Indemnity contract, M. Other and other codes for dental, vision, life, disability, etc. More than one code may be checked
Schedule A, Line 8m	Description of "Other" benefit and contract type
Schedule A, Line 9a(4)	Total earned premium amount for experience-rated contracts
Schedule A, Line 9b(3)	Incurred claims
Schedule A, Line 9b(4)	Claims charged
Schedule A, Line 9e	Dividends or retroactive rate refunds due
Schedule A, Line 10a	Total premiums or subscription charges paid to carrier for nonexperience-rated contracts
Schedule H, Line 1f; Form 5500-SF, Line 7a	Total assets at the beginning of the plan year and at the end of the plan year
Schedule H, Line 1k; Form 5500-SF, Line 7b	Total liabilities at the beginning of the plan year and at the end of the plan year
Schedule H, Line 1l; Form 5500-SF, Line 7c	Net assets at the beginning of the plan year and at the end of the plan year
Schedule H, Line 2e	Benefit payment and payments to provide benefits: 2e(1) Directly to participants or beneficiaries, including direct rollovers 2e(2) To insurance carriers for the provision of benefits 2e(3) Other 2e(4) Total benefit payments
Schedule I, Line 2e; Form 5500-SF, Line 8d	Benefits paid (including direct rollovers)

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