EBRI Research Highlights: Health Benefits

by the EBRI research and education team

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Special Report and Issue Brief

The Employee Benefit Research Institute (EBRI) is a nonpartisan, nonprofit public policy research organization based in Washington, DC, that has been researching economic security issues for almost 25 years. Founded in 1978, its mission is to contribute to, encourage, and enhance the development of sound employee benefit programs and sound public policy through objective research and education. EBRI does not lobby and does not take positions on legislative proposals. EBRI receives funding from individuals, employers of all types, unions, foundations, and government.

EBRI's research work has focused on retirement- and health-related issues, particularly involving pension/retirement plan coverage and health insurance coverage in the employment-based benefits system. EBRI is a major source of unbiased data on the uninsured and current trends involving 401(k), IRA, and traditional pension-type retirement plans. EBRI research programs also include economic modeling of Social Security reform proposals and development of the EBRI/ICI 401(k) database, the largest and most detailed of its kind.

This *EBRI Special Report/Issue Brief* (May 2003) synthesizes highlights of recent EBRI research on health issues. The next *Issue Brief* (June 2003) will present recent EBRI research on retirement benefits. It should be stressed that this document contains only *highlights* of EBRI's collection of research and analysis; for greater detail and information, visit EBRI's Web site (www.ebri.org) or contact EBRI directly.

Health data in this document include:

- National health expenditures.
- Employment-based health benefits.
- The uninsured.
- Managed care.
- Consumer-driven health benefits.
- Medicare and retiree health benefits.
- Public opinion.
- Small employers and health benefits.

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This *Issue Brief* was written by EBRI's health research staff, including Ken McDonnell, director of member relations and research analyst; Paul Fronstin, senior research associate; and Rachel Christensen, research analyst; with assistance from the Institute's research and editorial staffs. Any views expressed in this report are those of the authors and should not be ascribed to the officers, trustees, or other sponsors of EBRI, EBRI-ERF, or their staffs. Neither EBRI nor EBRI-ERF lobbies or takes positions on specific policy proposals. EBRI invites comment on this research.

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About EBRI

The Employee Benefit Research Institute (EBRI) is a private, nonpartisan, nonprofit public policy research organization based in Washington, DC. EBRI has provided reliable and objective research, data, and analysis on retirement, health, and other economic security issues for almost 25 years. Its mission is to contribute to, to encourage, and to enhance the development of sound employee benefit programs and sound public policy through objective research and education.

EBRI receives funding from a wide range of sources interested in economic security issues: individuals, employers of all types, unions, health providers, health insurers, foundations, and government. EBRI does not lobby and does not take positions on legislative proposals. Its Web site is www.ebri.org

About This Document

This document covers the major benefits-related topics that EBRI staff most often are asked about by policymakers and the news media. To see the wide range of EBRI research and analysis, visit **www.ebri.org** on the Internet, or contact one of the staff members below.

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EBRI Programs

EBRI's comprehensive program of research and dissemination covers health, retirement, and related economic security topics. This program includes policy forums, round tables, briefings, testimony, interviews, and speeches. Major studies in process include Social Security reform, individual investment education and results, health insurance coverage, health policy reform, and pension design and investment trends. Major surveys include the annual Retirement Confidence Survey and the annual Health Confidence Survey.

- The *EBRI Databook on Employee Benefits*, the *EBRI Health Benefits Databook*, and *Fundamentals of Employee Benefit Programs* are regularly updated as

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- Public education initiatives include EBRI's Web site (www.ebri.org), the EBRI-ERF American Savings Education Council (ASEC) (www.asec.org), the EBRI-ERF Consumer Health Education Council (CHEC) (www.ourhealthbenefits.org), and the Choose to Save® Education Program (www.choosetosave.org).

Some Basics About Health Benefits

[The following material is excerpted from EBRI's upcoming sixth edition of *Fundamentals of Employee Benefit Programs.*]

Introduction: Health Benefits

Employers offer health benefits in order to provide workers and their families with protection from financial losses that can accompany unexpected serious illness or injury. They also offer the benefits to promote health, to increase worker productivity, and as a form of compensation to recruit and retain qualified workers. Health insurance is the benefit most valued by workers and their families. In a 2001 survey, 60 percent of workers ranked health insurance as the most important employee benefit (Christensen, 2002).

Research illustrates the advantages to consumers of having health insurance and the benefits to employers of offering it. In general, the availability of health insurance allows consumers to avoid unnecessary pain and suffering and to improve their quality of life, and employers offering benefits report that they have a positive impact on worker recruitment, retention, health status, and productivity (Fronstin and Helman, 2000).

Employment-based health benefit programs have existed in the United States for more than 130 years. In the 1870s, for example, railroad, mining, and other industries began to provide the services of company doctors to workers. In 1910, Montgomery Ward entered into one of the earliest group insurance contracts for its employees.

Prior to World War II, few Americans had health insurance, and most policies covered only hospital room, board, and ancillary services. During World War II, the number of persons with employment-based health insurance coverage started to increase. When the National War Labor Board froze wages and a shortage of workers occurred, employers sought ways to get around the wage controls in order to attract scarce workers, and health insurance often was used in this way. Health insurance was an attractive means to recruit and retain workers during a labor shortage for two reasons: unions supported employment-based health insurance and workers' health benefits were not subject to income tax or Social Security payroll taxes as were cash wages.

Currently, employment-based health insurance is the most common form of health insurance coverage in the United States. In 2001, 104.4 million workers ages 18–64 were covered by employment-based health benefits (Fronstin, 2002c). Seventy-seven percent of these workers had coverage through their own employer, while the remainder had coverage through a family member's employer. The employment-based health benefits system also covers 13.7 million nonworking adults, ages 18–64, and 44.2 million children under age 18. In 2002, virtually all employers with 200 or more employees offered health benefits to their workers, compared with 61 percent of employers with three to 199 employees

(Kaiser Family Foundation/Health Research and Educational Trust, 2002).

Health Insurance Premiums

Under the current tax code, health insurance premiums paid by employers are deductible as a business expense (see Internal Revenue Code (IRC) Sec. 162(a)), and generally are excluded, without limit, from workers' taxable income.

Employers may choose to pay for the entire health insurance premium, a portion of the premium, or none of the premium, offering the plan but not contributing to its cost. The employee shares of the premiums generally are paid through payroll deduction and may be paid with pretax dollars under IRC Sec. 125(a). In 2002, employees paid an average of $38 per month for employee-only coverage (16 percent of the premium), while they paid an average of $174 per month for family coverage (27 percent of the premium) (Kaiser Family Foundation/ Health Research and Educational Trust, 2002).

Benefit Plan Types

According to a 2002 Kaiser Family Foundation study (www.kff.org), 95 percent of Americans with employment-based health insurance coverage were enrolled in some kind of managed care plan. Health maintenance organizations (HMOs) and preferred provider organizations (PPOs) accounted for 78 percent of that enrollment. A managed care system typically provides, arranges for, and finances medical services using provider payment methods that encourage cost containment by contracting with select networks of providers.

Before the spread of managed care in the 1990s, insurance coverage was mostly based on a fee-for-service (FFS) system. Beneficiaries in the plan picked their doctors and hospitals at will. Payment was made by the beneficiary when a service was rendered, or the health care provider accepted assignment of the claim from the beneficiary, and afterward claim forms were submitted to the insurers (or self-insured plan sponsor) for reimbursement. Under managed care, enrollees are often required to follow utilization review and disease management procedures in order to secure coverage for services received.

Other types of employment-based health benefits include different types of accounts through which workers can pay for health care services. Flexible spending accounts (FSAs) allow employees to pay for noncovered or nonreimbursed health care expenses with pretax dollars; they are not taxed on the amount of money that is put into the FSA (see IRC Secs. 105(h)(6) and 125(a)). Medical savings accounts (MSAs) allow small employers (with up to 50 employees) and the self-employed to contribute pretax dollars to accounts used to pay for medical expenses, which are coupled with a high-deductible health insurance plan. There are limits on the number of these plans that may be established, and the legislation authorizing MSAs is set to expire in December 2003, unless renewed by Congress. MSAs were instituted originally in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and have since been reauthorized.

Some employers are considering ways in which they can restructure health benefits. A few employers have turned to, and many others are considering, a trend that started in the 1980s to give employees more choice among different types of benefit arrangements, while at the same time exposing employees more directly to the cost of providing health benefits and health care services. The terms *defined contribution* and *consumer-driven* have been used to describe a wide range of possible approaches to giving employees more incentive to control the cost of either their health benefits or health care and to reduce the amount and volatility of employer spending. Many of these plans include tax-advantaged accounts, called *health reimbursement accounts*, *personal care accounts*, and other names, out of which employees pay for their health care needs (Fronstin, 2002b).

Employee Cost-Sharing

Virtually all covered services in health care plans are subject to payment limitations and require the employee to share in the costs of coverage. These cost-sharing features generally include premium contributions, deductibles, copayments, coinsurance, and caps on benefits. These plan features are intended to reduce plan costs, encourage employee cost consciousness, and lower administrative expenses.

A *deductible* is a specified amount of initial medical costs that would otherwise be treated as covered expenses under the plan, which each beneficiary must pay before any expenses are reimbursed by the plan. Deductibles typically range from $100 to $500 per year per person, although they can be higher.

Copayments are set dollar amounts that a plan participant pays when he or she seeks medical services, such as a $10 payment for seeing their primary care physician or a $20 payment for seeing a specialist. The most common copayment amount for a doctor visit in all types of plans is $10; however, copayment amounts appear to be increasing (Kaiser Family Foundation/ Health Research and Educational Trust, 2002).

Coinsurance provisions require the plan participant to pay a portion of recognized medical expenses; the plan pays the remaining portion. Commonly, the employee pays 20 percent, with the plan paying the remaining 80 percent of recognized charges. Most major medical plans include both deductibles and coinsurance provisions. Thus, once the plan participant pays the deductible (e.g., the first $200 in medical expenses), the plan pays 80 percent of all other covered charges. Most plans limit beneficiaries' out-of-pocket expenditures for covered services; once a beneficiary has reached the out-of-pocket maximum, covered expenses are reimbursed in full for the remainder of the year.

Most medical plans also impose a *maximum annual* or *lifetime dollar limit* on the amount of health insurance coverage provided. Individual lifetime maximums are usually set at very high levels, such as $1 million or more. Although less common, plans that impose limits may do so on an episodic (or per episode) basis, such as per hospital admission or per disability.

Services Covered

The term *health insurance* refers to a wide variety of insurance policies. These range from policies that cover the costs of doctors and hospitals for treating general illnesses to those that meet a specific need, such as paying for dental or vision care. In the past, health insurance that covered medical bills, surgery, and hospital expenses was typically referred to as a *comprehensive* or *major medical* policy. Today, when individuals talk about an insurance program, instead of using the term *major medical*, they are more likely to refer to FFS (e.g., indemnity), PPO, POS, HMO, or some other type of insurance program.

Most insurance programs cover medical expenses for hospital and physician fees, surgical expenses, anesthesia, x-rays, laboratory fees, emergency care, and maternity care. Some programs cover physical exams; preventive care (e.g., vaccinations); health screenings (e.g., mammograms); chemical dependency treatment; prescription drugs; dental; vision; mental health or other psychiatric care; and home health, nursing home, and hospice care. For certain services, there may be limits on how much is covered or how many visits are covered annually.

Most health insurance programs do not cover treatment that is experimental or investigational. Insurance programs typically cover only medically necessary care. A typical definition of *appropriate and medically necessary care* is the standard for health care services as determined by physicians and health care providers in accordance with prevailing practices and standards of the medical profession and community.

Medical plans generally exclude services that are not considered medically necessary, including most types of dental, vision, and hearing care. As a result, stand-alone plans providing these benefits are growing in popularity. Because of their highly elective nature,

various limits are placed on the benefits provided. When these benefits are offered by or through a vendor other than the health insurer, they are referred to as being "carved out."

Federal Protections, Laws, and Regulations

The Employee Benefits Security Administration (EBSA), formerly the Pension and Welfare Benefits Administration (PWBA), an agency within the Department of Labor (DOL), is responsible for protecting the integrity of pensions, health plans, and other employee benefits for more than 150 million people. The agency assists workers in getting the information they need to protect their benefit rights, assists plan officials to understand the requirements of the relevant statutes in order to meet their legal responsibilities, develops policies and regulation that encourage the growth of employment-based benefits, and deters and corrects violations of the relevant statutes.

Several federal laws affect how workers and their families receive health benefits from employment. Two of the major laws are ERISA and COBRA:

- *The Employee Retirement Income Security Act of 1974 (ERISA)*—Offers protections for individuals enrolled in health benefit plans sponsored by private-sector employers, provides rights to information, and outlines a grievance and appeals process for participants to get benefits from their plans.
- *The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)*—Contains provisions giving certain former employees, retirees, spouses, and dependent children the right to purchase temporary continuation of group health plan coverage at group rates in specific instances. An employer may charge the departing employee the full cost of the coverage plus 2 percent to cover administrative costs. In 2002, about 16 percent of beneficiaries eligible for COBRA benefits actually elected to take the coverage, and claims costs for COBRA were about 150 percent of active employee claims costs (Charles D. Spencer & Associates, 2002).

Both of these laws are administered/enforced by the DOL. Other federal agencies with responsibility for health benefits laws include the Internal Revenue Service, the Department of Justice, and others. Additional laws pertaining to health insurance include: *The Family and Medical Leave Act of 1993 (FMLA), The Health Insurance Portability and Accountability Act of 1996 (HIPAA)*, *The Newborns' and Mothers' Health Protection Act of 1996 (NMHPA), The Women's Health and Cancer Rights Act of 1998 (WHCRA)*. In addition, the Equal Employment Opportunity Commission (EEOC) administers several laws that pertain to employment-based health benefits.

Trends in Health Benefits Coverage

In February 2001, 77.4 percent of workers ages 18–64 were offered health insurance by their employer, up from 73.8 percent in 1993. However, in 2001, 82 percent of those workers who were offered it took the insurance, down from 85.2 percent in 1993. As a result, the percentage of workers covered by their own employer remained largely constant from 1993 (62.9 percent) to 2001 (63.5 percent) (Fronstin, 2002a).

In 2001, rising health benefit costs coupled with the weak economy began to have an effect on health insurance coverage. According to one survey, health benefits costs increased 11 percent overall in 2001 (Kaiser Family Foundation/Health Research and Educational Trust, 2002). As a result of these cost increases, between 2000 and 2001, the percentage of nonelderly Americans with employment-based health benefits declined from 67.1 percent to 65.6 percent, the first decline since the early 1990s (Fronstin, 2002c). The Kaiser survey found that costs rose even faster in 2002, at a rate of 12.7 percent overall. This could lead to even further decreases in coverage rates for employment-based health benefits.

Retiree Health Benefits

In addition to health benefits for current workers, some employers offer health benefits to retirees. Retiree health benefits originally were offered on a very limited basis in the late 1940s and 1950s. The number of employers offering these benefits expanded in the late 1960s in conjunction with the creation of the Medicare program. The benefits were provided as part of the health plan for active workers, generally without a separate premium structure or separate accounting. In subsequent years, the changing demographics of the work force, coupled with increasing life spans and rising health care costs, left many employers with higher retiree-to-active-worker ratios, increasing the costs and liabilities of retiree medical benefits.

In 1989, the Financial Accounting Standards Board (FASB) issued Statement No. 106 (FAS 106), "Employers' Accounting for Postretirement Benefits Other Than Pensions," which required companies that file public accounting statements to account for these benefits and report liabilities for the future value of all promised benefits on their corporate balance sheets, beginning with fiscal years after Dec. 15, 1992. For the first time, the true cost of the benefits was understood (Employee Benefit Research Institute, 1988, 1989). Prior to FAS 106, companies were required to disclose information only on the existence of plans and amounts of benefit outflows.

As a result of FAS 106, and the increasing cost of providing retiree health benefits in general, many employers began a major overhaul of their retiree health benefit programs. Some employers placed caps on what they were willing to spend on retiree health benefits. Some added age and service requirements, while others moved to some type of "defined contribution" health benefit. Some completely dropped retiree health benefits for future retirees, while others dropped benefits for current retirees, although this happened less frequently. While these changes do not appear to be having much impact on current retirees, they are likely to be felt most by future retirees who are not yet or may never become eligible for retiree health benefits.

Retiree Health Benefits Design and Coverage

There are two basic designs for retiree health benefit plans: one for plans covering retirees under age 65 (early retirees) and one covering older retirees. Employers are looking to reduce their FAS 106 liability by redesigning their retiree health benefit plans. In general, the percentage of employers offering health benefits to future retirees seems to be declining. An annual survey of employers with 500 or more workers shows that the percentage that currently expect to continue offering health benefits to future early retirees declined from 46 percent in 1993 to 29 percent in 2001 (William M. Mercer, 2002). The percentage of employers offering health benefits to Medicare eligible retirees today and planning to offer them to future Medicare eligible retirees is also declining. A survey which followed a constant sample of employers shows a less dramatic drop of 7 percentage points in the likelihood that employers offered retiree health benefits to early retirees and a 9 percentage point drop for Medicare-eligible retirees (McArdle et al., 1999).

Most employers continuing to offer retiree health benefits have made changes in the benefit package. Many employers have made modifications to cost-sharing provisions, with employers asking retirees to pick up a greater share of the cost of coverage. Others have tightened eligibility requirements by requiring workers to attain a certain age and/or tenure with the company before they can receive any retiree health benefits. Others have reduced or eliminated the benefits for workers hired (or retiring) after a specific date. Employers have also instituted caps on the total amount they are willing to spend on retiree health benefits, either per retiree or on an aggregate spending basis. In addition to those that have already made changes, more employers also are continuing to consider making changes to retiree health benefits.

It will be a few more years before sufficient data are

available to explain how workers and retirees will be affected by cutbacks in retiree health benefits. The accounting requirements of FAS 106 triggered substantial changes to retiree health benefits. However, the changes that employers have made to these benefits do not appear to be having much impact on current retirees. Between 1994 and 2000, the percentage of retirees ages 55–64 with retiree health benefits was unchanged at roughly 37 percent, although it is likely that many current retirees are paying more to maintain retiree health benefits.

The changes that employers have made to retiree health benefits will likely have a greater impact on future retirees. These changes may not have noticeable effects on trends in insurance coverage until a few years after the baby boom generation starts to retire. Retirement behavior patterns may also change as employees nearing retirement age postpone their decision to retire upon learning that, without a job, they may not be able to obtain health insurance coverage.

By law, employers are under no obligation to provide retiree health benefits, except to current retirees who were promised a specific benefit. In the meantime, it is likely that employers will continue to make changes to retiree health benefits in response to future predicted health care costs and potential federal legislative initiatives.

Conclusion

For many decades, health care benefit plans have played a significant role in employee benefits planning. Modern technology, increased longevity, and a growing emphasis on good physical and mental health make these plans even more important today. The development of managed care plans and dental, prescription drug, vision, and hearing care plans attests to the dynamic nature of this employee benefit area, as does the development of wellness and employee assistance programs. Future innovative efforts in plan design will be influenced strongly by the continuing need for health care cost management, ever-changing medical technology, and constantly changing government regulations.

While an increasing percentage of Americans were being covered by employment-based health plans between 1994 and 2000, this trend has not continued because of the combination of a weak economy and rising health benefit costs. If health care and health benefit costs continue to increase, a greater proportion of the costs may become the responsibility of the employee as employers seek ways to control their spending on health benefits, both for current employees and retirees. As a result, fewer workers and retirees may be covered by health care benefits through their employers.

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Figure 1

NATIONAL HEALTH EXPENDITURES BY SOURCE OF FUNDS AND PERCENTAGE COMPOSITION OF TOTAL EXPENDITURES, BY SOURCE, SELECTED YEARS 1960–2000, AND PROJECTIONS FOR SELECTED YEARS 2003–2012

	Past Years					Projections			
Source of Funds	1960	1970	1980	1990	2001	2003	2005	2008	2012
					($ billions)				
National Health Expenditures	$26.9	$73.2	$245.8	$696.0	$1,424.5	$1,660.5	$1,907.3	$2,354.6	$3,079.8
Private	20.2	45.5	140.9	427.4	777.9	918.3	1,057.9	1,298.4	1,669.5
consumer	19.0	41.3	126.4	384.6	701.6	834.7	964.4	1,187.6	1,534.3
-direct payments (out-of-pocket)	13.1	24.9	58.2	137.3	205.5	231.3	262.4	315.0	396.3
-private health insurance	5.9	16.4	68.2	233.5	496.1	603.4	702.0	872.6	1,138.0
other private	1.3	3.3	14.5	42.8	76.3	83.6	93.5	110.8	135.2
Government	6.6	27.7	104.8	282.5	646.6	742.2	849.5	1,056.1	1,410.3
federal	2.9	17.8	71.3	192.7	454.8	516.8	587.8	726.8	966.3
state and local	3.7	9.9	33.5	89.8	191.8	225.4	261.7	329.3	444.0
					(as a percentage of total national health expenditures)				
National Health Expenditures	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Private	75.1	62.2	57.3	59.4	54.6	55.3	55.5	55.1	54.2
consumer	70.6	56.4	51.4	55.3	49.3	50.3	50.6	50.4	49.8
- direct payments (out-of-pocket)	48.7	34.0	23.7	19.7	14.4	13.9	13.8	13.4	12.9
- private health insurance	21.9	22.4	27.7	33.5	34.8	36.3	36.8	37.1	37.0
other private	4.8	4.5	5.9	6.1	5.4	5.0	4.9	4.7	4.4
Government	24.5	37.8	42.6	40.6	45.4	44.7	44.5	44.9	45.8
federal	10.8	24.3	29.0	27.7	31.9	31.1	30.8	30.9	31.4
state and local	13.8	13.5	13.6	12.9	13.5	13.6	13.7	14.0	14.4

Source: For years 1960 and 1970, see Katharine R. Levit et al., "National Health Expenditures in 1997: More Slow Growth," *Health Affairs* (November/December 1998): 99–110; and EBRI tabulations. For years 1980–2012, see U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, http://cms.hhs.gov/statistics/nhe/

Section 1: National Health Expenditures

Growth in Health Care Spending

According to EBRI tabulations of data from the Centers for Medicare & Medicaid Services (CMS), national health expenditures increased at an annual rate of 6.7 percent between 1990 and 2001 (EBRI calculations from Figure 1). This is down from 11.0 percent between 1980 and 1990. According to data from CMS, the growth rate in spending on health care from 2001 through 2012 is estimated at a 7.3 percent average annual rate (EBRI calculations from Figure 1).

Sources of Health Care Spending

Since 1960, the source of funds for health care spending has changed dramatically. Most noticeable has been the decline in out-of-pocket spending on health care. In 1960, nearly half (48 percent) of health care spending came from out-of-pocket or direct payments by consumers (Figure 2). By 2001, that percentage declined to 14 percent, and it is projected to decline to 13 percent by 2012.

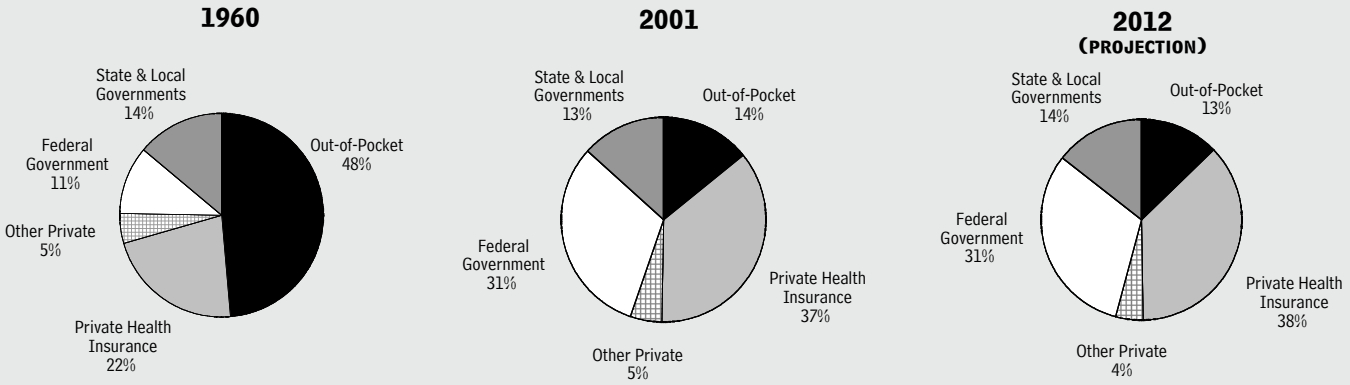
Private health insurance and the federal government as sources of health care spending increased as dramatically as out-of-pocket sources declined. As a portion of total health care spending, private health insurance increased from 22 percent in 1960 to 35 percent in 2001, while the federal government's share of health care spending increased from 11 percent in 1960 to 32 percent in 2001 (Figure 2).

Original Source Funding

While private health insurance and the federal government dramatically increased their roles in health care spending, they are not original sources of funding. For instance, private health insurance is financed by payments from business and individual contributions to health insurance in addition to contributions from the federal government and state and local governments as employers. Private-sector business spending on health care increased from $5.9 billion in 1965 to $334.5 billion in 2000 (Figure 3).

Figure 2

National Health Expenditures by Source of Funds: 1960, 2000, and 2012



Source: For years 1960 and 1970, see Katharine R. Levit et al., "National Health Expenditures in 1997: More Slow Growth," *Health Affairs* (November/December 1998): 99–110; and EBRI tabulations. For years 1980–2012, see U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, http://cms.hhs.gov/statistics/nhe/

Figure 3

Expenditures for Health Services and Supplies, by Type of Payer, Selected Years 1965–2000

Type of Payer	1965	1975	1985	1995	1997	1998	1999	2000
				($ billions)				
Total	$37.7	$122.3	$411.8	$957.7	$1,053.9	$1,111.5	$1,175.0	$1,255.5
Private	29.8	83.7	282.2	607.3	666.3	716.4	754.8	806.3
Private business	5.9	27.5	108.6	251.2	270.1	288.1	307.6	334.5
employer contributions to private health insurance premiums	4.9	19.7	79.1	183.4	197.0	210.5	224.3	246.2
employer contributions to Medicare hospital insurance trust fund	0.0	5.0	20.3	43.1	49.6	53.6	57.4	61.4
workers' compensation and temporary disability insurance	0.8	2.4	7.7	21.4	20.0	20.2	22.0	22.7
industrial in-plant health services	0.2	0.5	1.4	3.3	3.6	3.8	4.0	4.2
Households	23.2	53.8	160.5	314.4	347.7	376.5	393.9	418.8
employee contributions to private health insurance premiums and individual policy premiums	4.7	8.2	30.7	95.6	107.0	116.1	120.0	126.4
employee and self-employment contributions and voluntary premiums paid to Medicare hospital insurance trust fund[a]	0.0	5.7	24.1	55.9	62.9	68.8	74.8	81.5
premiums paid by individuals to Medicare supplementary medical insurance trust fund	0.0	1.7	5.2	16.4	15.4	17.0	14.8	16.3
out-of-pocket spending	18.5	38.1	100.6	146.5	162.3	174.5	184.4	194.5
Public	7.9	38.6	129.6	350.4	387.6	395.1	420.2	449.3
Federal government	3.4	21.2	68.4	196.6	218.9	214.9	223.7	237.1
employer contributions to private health insurance premiums	0.2	1.2	4.3	11.3	11.4	11.4	13.2	14.3
employer contributions to Medicare hospital insurance trust fund	0.0	0.2	1.6	2.3	2.4	2.4	2.5	2.6
adjusted Medicare[b]	0.0	3.0	18.4	59.3	71.4	62.3	58.8	60.0
health program expenditures (excluding Medicare)	3.3	16.9	44.2	123.6	133.4	139.9	151.8	165.0
Medicaid[c]	0.0	7.6	23.1	88.1	97.1	101.9	110.8	120.8
other programs[d]	3.3	9.3	21.1	35.5	36.3	38.0	40.9	44.2
State and Local Governments	4.5	17.4	61.2	153.8	168.7	180.3	196.5	212.1
employer contributions to private health insurance premiums	0.3	2.2	18.2	39.8	44.1	45.2	52.0	56.9
employer contributions to Medicare hospital insurance trust fund	0.0	0.7	2.2	5.6	6.1	6.5	6.9	7.3
health expenditures by program	4.2	14.6	40.8	108.4	118.5	128.6	137.7	147.9
Medicaid[c]	0.0	6.1	18.6	59.2	66.4	73.4	80.1	86.1
hospital subsidies	2.4	4.8	7.0	11.0	10.0	10.7	11.1	11.8
other programs[e]	4.2	8.4	22.2	38.1	42.1	44.4	46.5	50.0

[a] Includes one-half of self-employment contributions to Medicare Hospital Insurance trust fund and taxation of Social Security benefits.

[b] Excludes Medicare Hospital Trust Fund payroll taxes and premiums, Medicare supplementary medical insurance premiums, and Medicaid premium payments..

[c] Includes Medicaid buy-in premiums for Medicare.

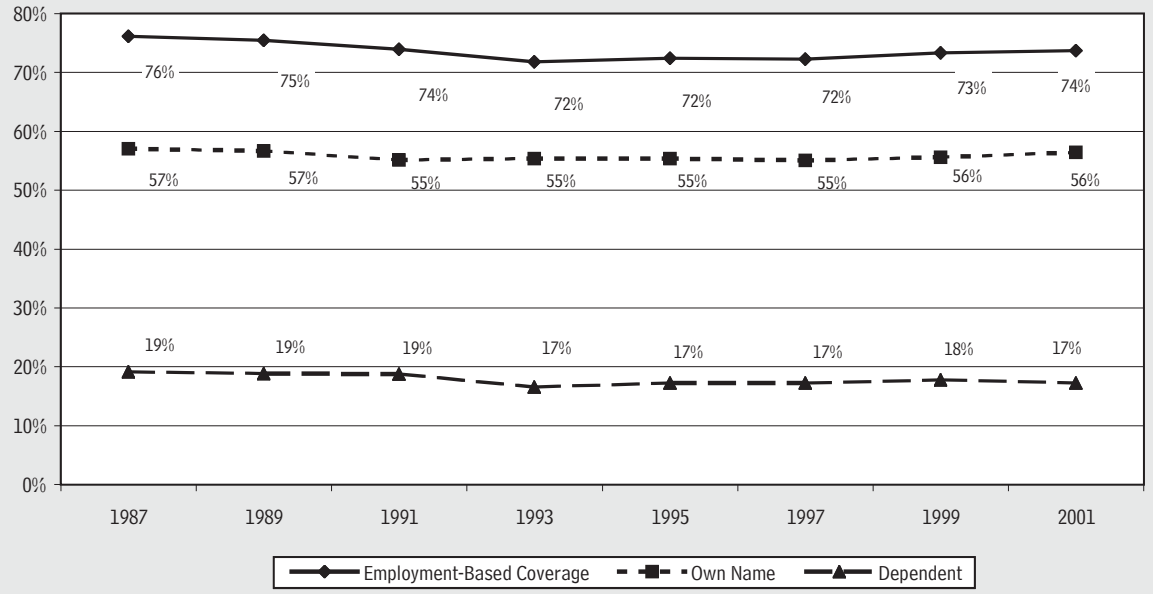
[d] Includes maternal and child health, vocational rehabilitation, Substance Abuse and Mental Health Administration, Indian Health Service, Office of Economic Opportunity (1965–1974), federal workers' compensation, and other miscellaneous general hospital and medical programs, public health activities, Department of Defense, and Department of Veterans Affairs.

[e] Includes other public and general assistance, maternal and child health, vocational rehabilitation, public health activities, and hospital subsidies.

Source: Cathy A. Cowan, et al., "Business, Households, and Government: Health Spending 1994," *Health Care Financing Review* (Summer 1996): 157–178; "Business, Households, and Government: Health Spending 1995," *Health Care Financing Review* (Spring 1997): 195–206; and "Burden of Health Care Costs: Business, Households, and Governments, 1987–2000," *Health Care Financing Review* (Spring 2002): 131–159.

Figure 4

WORKERS AGES 18–64 WITH EMPLOYMENT-BASED COVERAGE, WORKERS WITH COVERAGE IN OWN NAME, AND DEPENDENT COVERAGE, 1987–2001



Source: Employee Benefit Research Institute estimates from the Current Population Survey, March 1988–2002 Supplements.

Section 2: Employment-Based Health Benefits

Employment-based health benefits are the most common source of health insurance coverage of Americans. From 1987 to 1993, the percentage of workers covered by employment-base health insurance steadily eroded, from 76.1 percent to 71.8 percent (Figure 4). From 1994 through 2001, that trend was reversed, increasing to 73.7 percent of workers covered by employment-based health benefits. Coverage for children and adults ages 18–64 followed the same pattern as workers, declining from 1987 to 1993 and increasing from 1994 (Figure 5). The pattern for children and adults ages 18–64 changed from 1999 to 2001 as coverage rates declined.

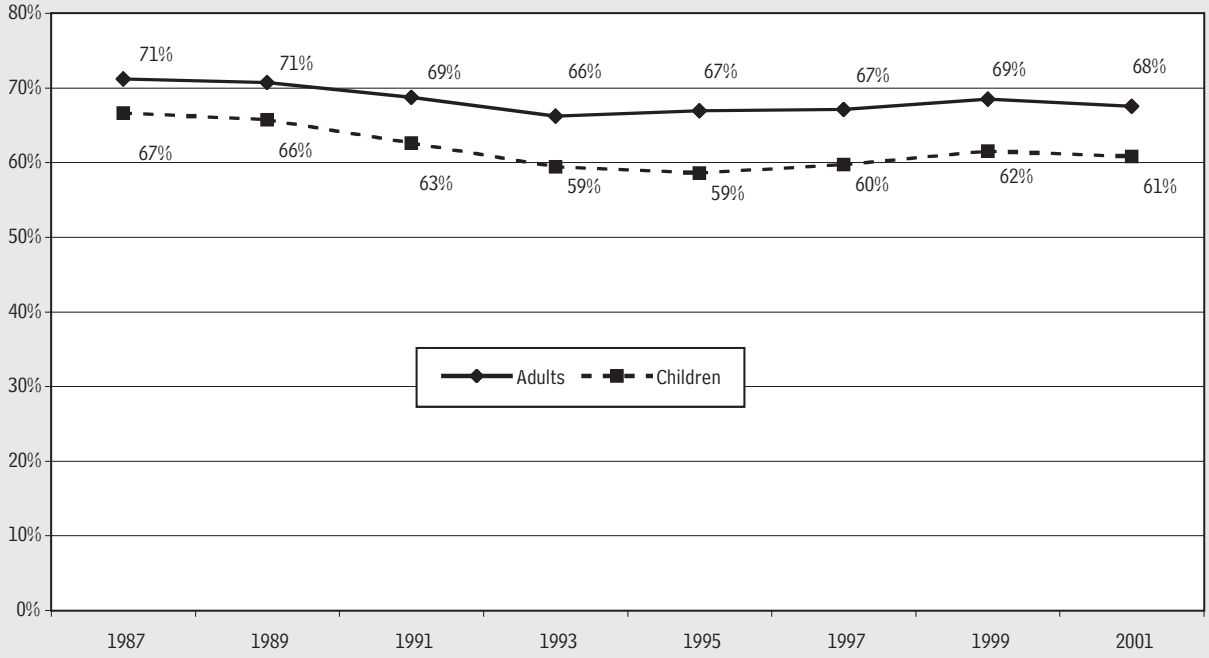
The increase in the percentage of Americans with employment-based health benefits, particularly between 1997 and 2000, is both surprising and not surprising. It is not surprising because the strong economy and low unemployment rates caused more employers to provide health benefits in order to attract and retain workers, and also may have resulted in more workers being able to afford health benefits. It is surprising because 1998 saw the return of health care cost inflation, and this inflationary trend accelerated in 1999 and 2000. The increase does not appear to have affected the percentage of Americans with employment-based health benefits during this period, although it also could be argued that the percentage of those with employment-based health benefits would have increased even faster had it not been for the rising costs of providing those benefits.

Take-Up Rates

Since 1993, an increasing percentage of workers have been offered health benefits from their employer, from 73.8 percent in 1993 to 77.4 percent in 2001 (Figure 6). Over the same time period, a slightly increasing percentage of workers were covered by health benefits through their own employer, from 62.9 percent in 1995 to 63.5 percent in 2001 (Figure 7). Yet the decline from 1988 (67.8 percent) to 1993 (62.9 percent) was steep. An increasing percentage of workers are being offered health benefits by their own employer, and a slightly increasing percentage were covered by their own employer's health plan, yet fewer workers are taking health benefits when they are offered (Figure 8).

Figure 5

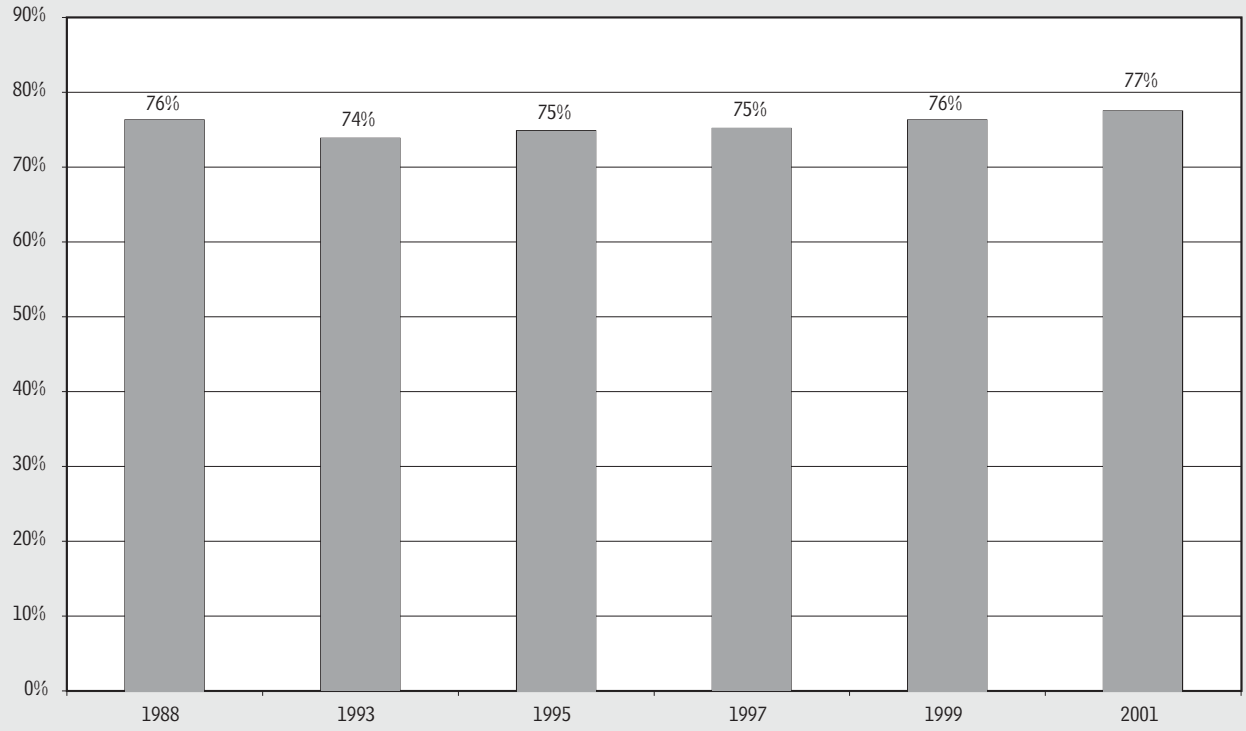
ADULTS AGES 18–64 AND CHILDREN UNDER AGE 18 WITH EMPLOYMENT–BASED HEALTH BENEFITS COVERAGE, 1987–2001



Source: Employee Benefit Research Institute estimates of the Current Population Survey, March 1988–2002 Supplements.

Figure 6

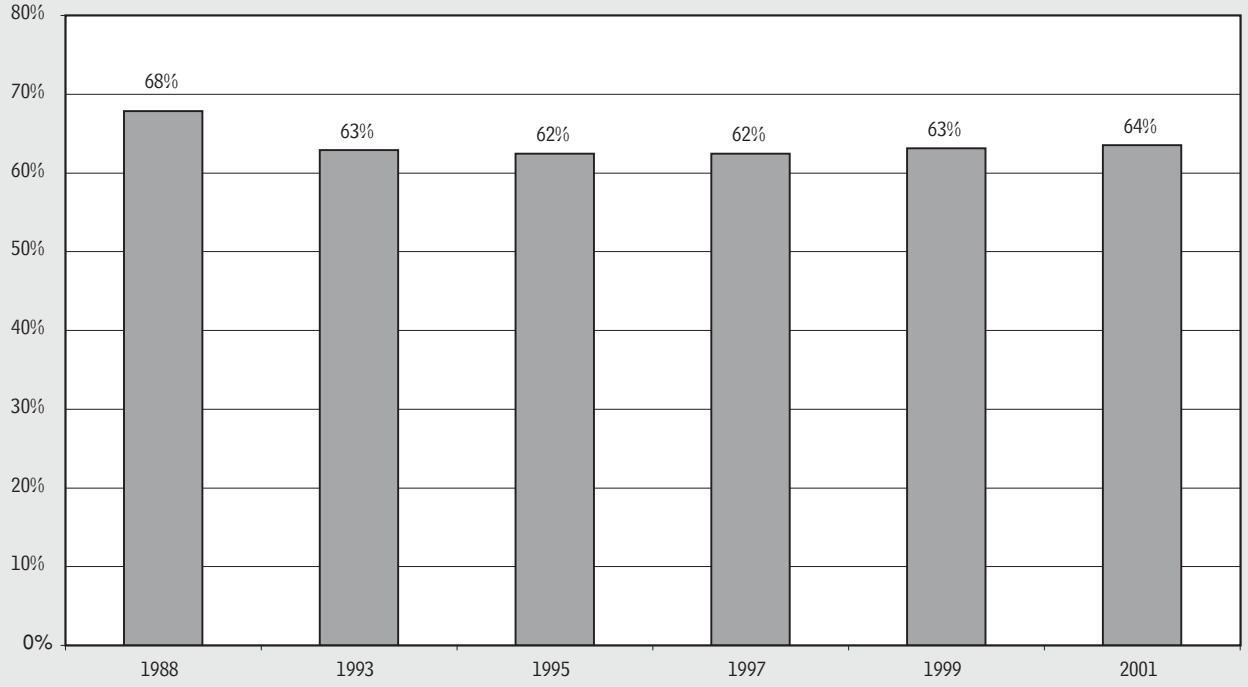
HEALTH INSURANCE OFFER RATE AMONG WAGE AND SALARY WORKERS, SELECTED YEARS, 1988–2001



Source: Employee Benefit Research Institute estimates of the U.S. Bureau of the Census, February Current Population Survey, various years.

Figure 7

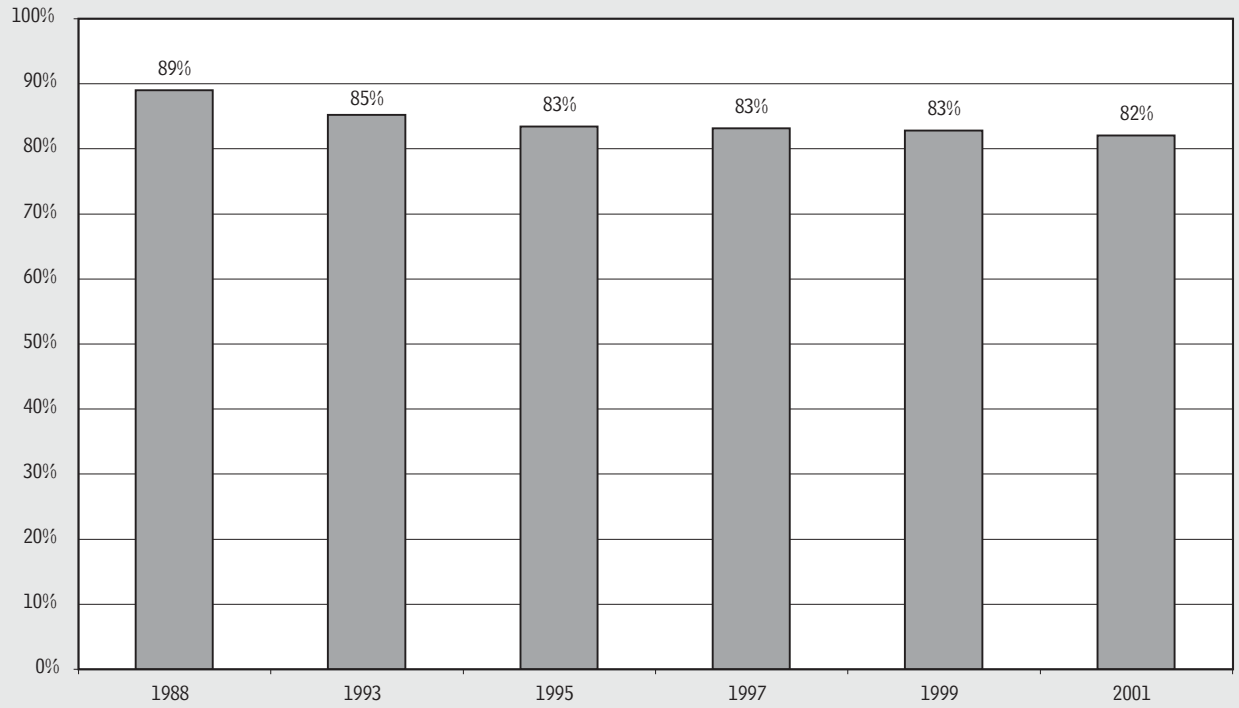
HEALTH INSURANCE COVERAGE RATE AMONG WAGE AND SALARY WORKERS, SELECTED YEARS, 1988–2001



Source: Employee Benefit Research Institute estimates of the U.S. Bureau of the Census, February Current Population Survey, various years.

Figure 8

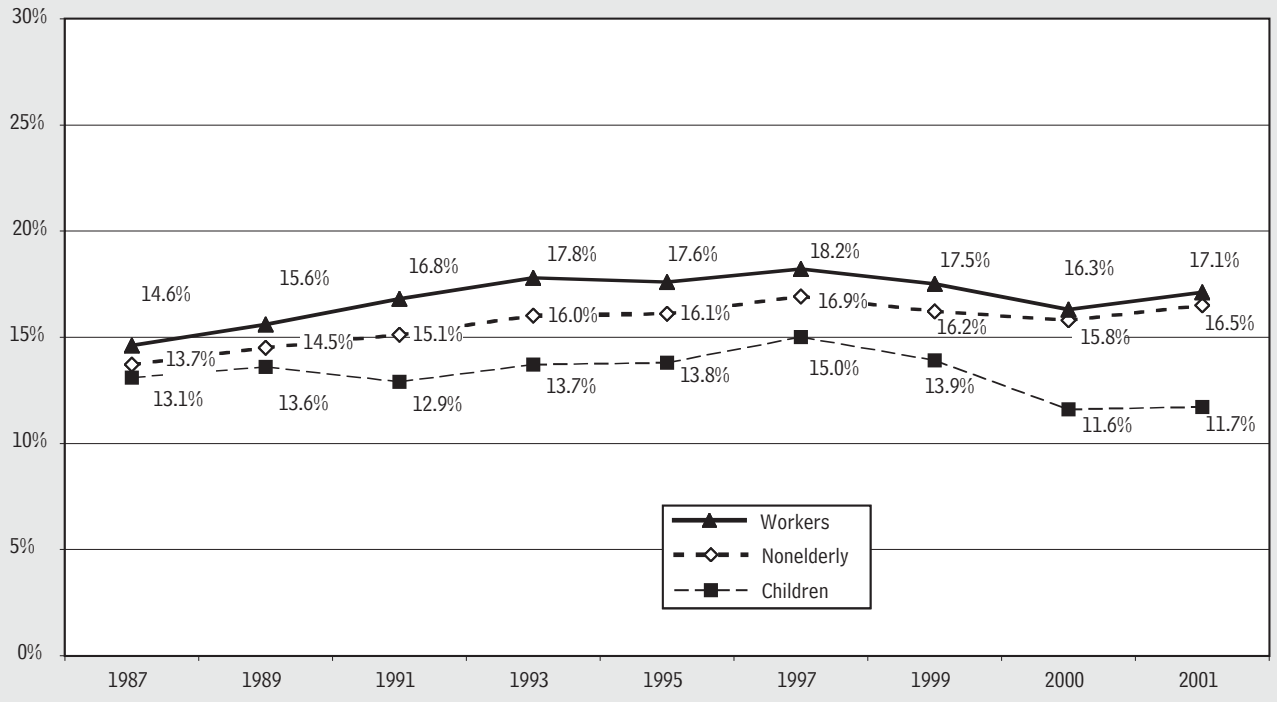
HEALTH INSURANCE TAKE-UP RATES AMONG WAGE AND SALARY WORKERS, SELECTED YEARS, 1988–2001



Source: Employee Benefit Research Institute estimates of the U.S. Bureau of the Census, February Current Population Survey, various years.

Figure 9

PERCENTAGE UNINSURED AMONG NONELDERLY,[a] CHILDREN UNDER AGE 18, AND WORKERS AGES 18–64, SELECTED YEARS, 1987–2001



Source: Employee Benefit Research Institute estimates of the Current Population Survey, March 1988–2002 Supplements.

[a] Under age 65.

Section 3: The Uninsured

Uninsured Time Trends

Rising health care costs coupled with a weak economy are the primary reasons for the increase in the percentage of Americans without health insurance coverage from 2000 to 2001. These factors explain the increase in the percentage of Americans, particularly workers, without health insurance coverage. The percentage of children without health insurance coverage increased only 0.1 percent from 2000 to 2001 (Figure 9). The low rate is most likely due to the State Children's Health Insurance Programs (S-CHIP).

Profile of Uninsured Americans

Several factors determine whether or not an individual has health insurance.

***Employment-Related Factors*—**Individuals who work full time or were dependents of full-time workers were about half as likely as nonworkers, part-time workers, or dependents of nonworkers or part-time workers to be without health insurance (Figure 10).

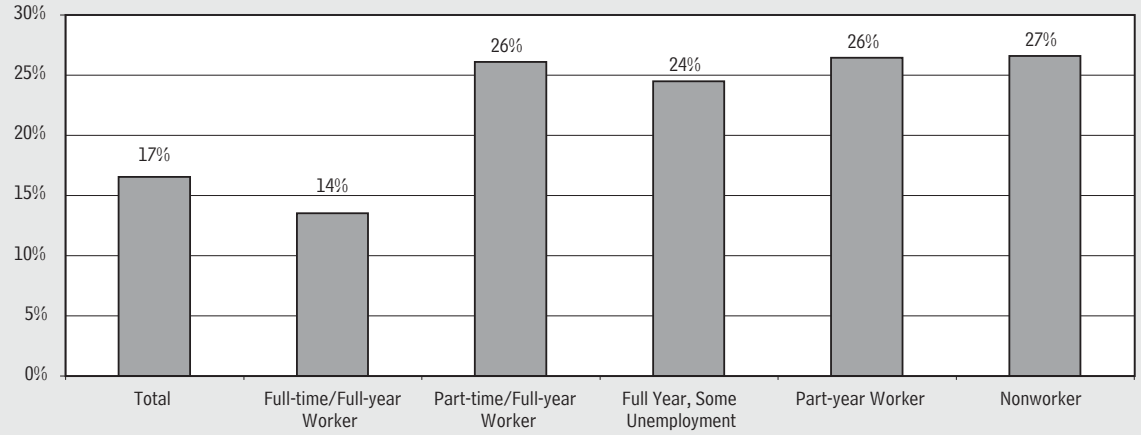
Workers and dependents of workers in the public sector (6.8 percent); finance, insurance, and real estate (9.0 percent); and manufacturing (10.9 percent) had a low uninsured rate compared with those in agriculture/mining (30.7 percent) and construction (26.8 percent) (Figure 11). Workers in the public sector and in manufacturing are more likely to be covered by a union than workers in other industries. The presence of unions in an industry has a positive impact on whether workers and their dependents have access to employment-based coverage.

Firm size is one of the other most important determinants of whether a worker or dependent of a worker is uninsured. Slightly more than 31 percent of workers and dependents of workers who work for an employer with 10 or fewer employees were without health insurance, compared with 9.8 percent among those in firms with 1,000 or more employees (Figure 12).

***Demographic-Related Factors*—**Individuals who live in the Midwest or Northeast, have a family income of $50,000 or more, are over age 45 or under 18, and are white are least likely to be without health insurance (Figures 13–18).

Figure 10

PERCENTAGE OF NONELDERLY[a] WITHOUT HEALTH INSURANCE, BY WORK STATUS OF FAMILY HEAD, 2001

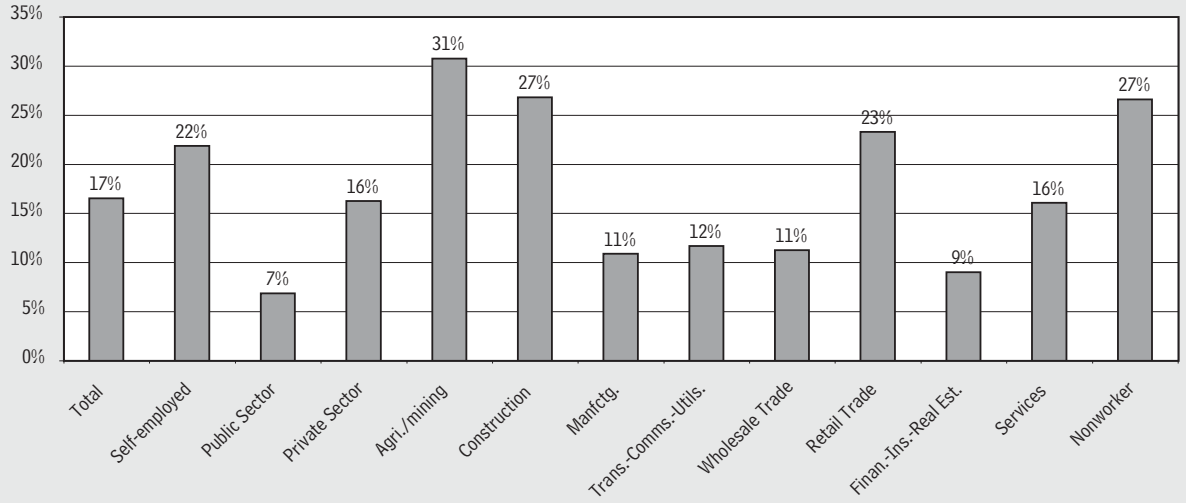


Source: Employee Benefit Research Institute estimates from the Current Population Survey, March 2002 Supplement.

[a] Under age 65.

Figure 11

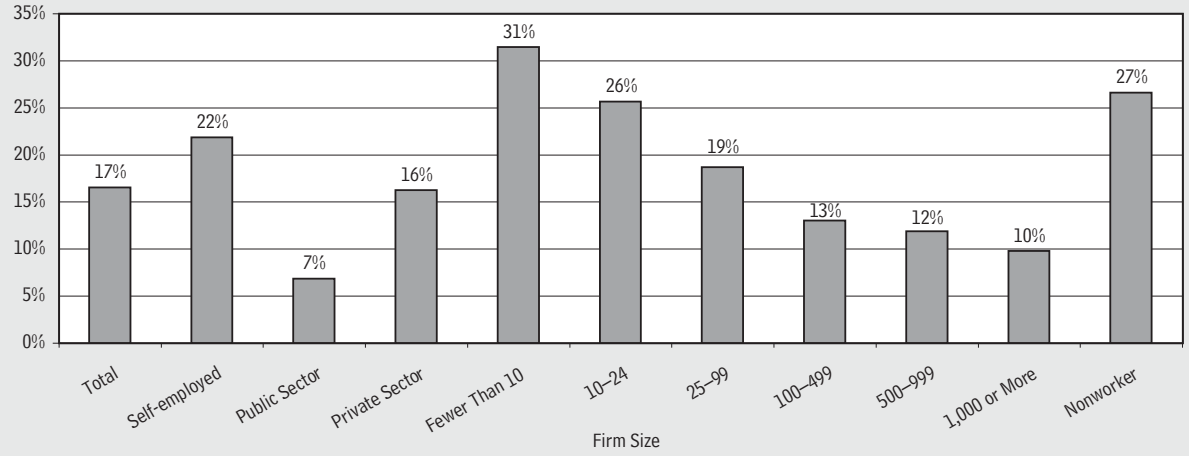
PERCENTAGE OF NONELDERLY WITHOUT HEALTH INSURANCE, BY INDUSTRY OF FAMILY HEAD, 2001



Source: Employee Benefit Research Institute estimates from the Current Population Survey, March 2002 Supplement.

Figure 12

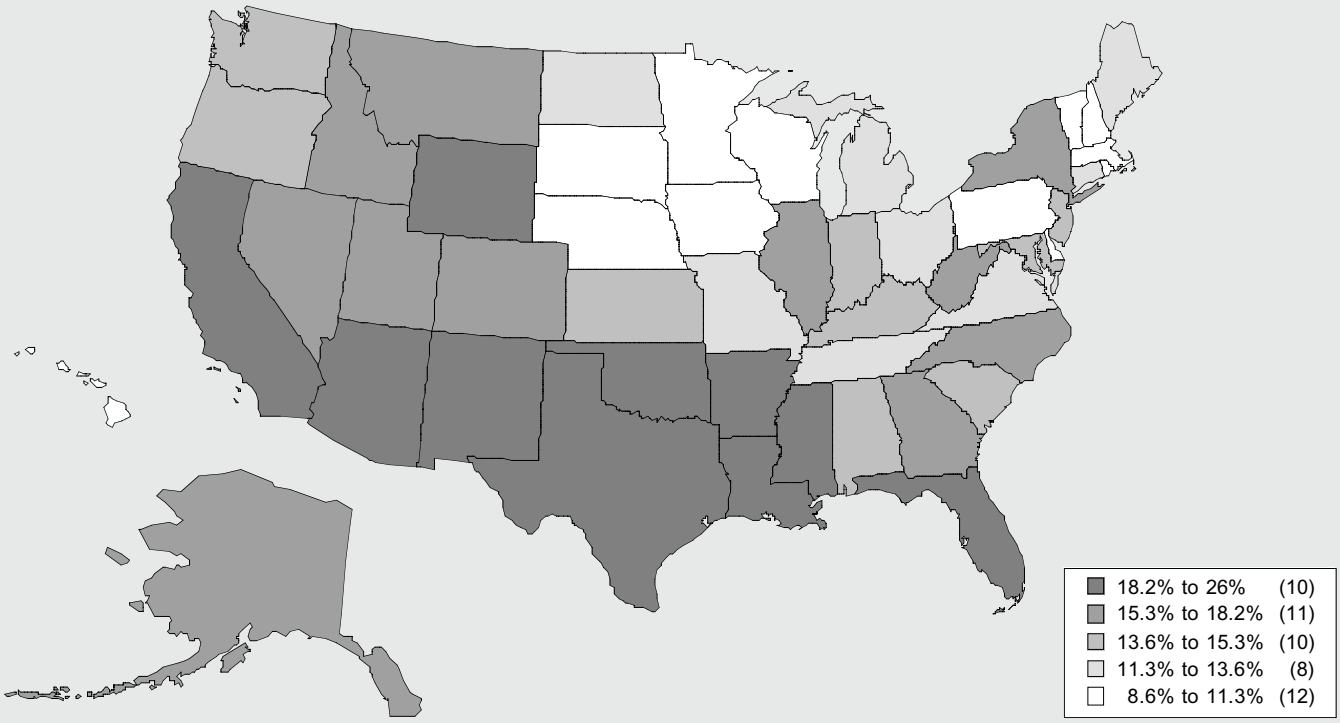
PERCENTAGE OF NONELDERLY WITHOUT HEALTH INSURANCE, BY FIRM SIZE OF FAMILY HEAD, 2001



Source: Employee Benefit Research Institute estimates from the Current Population Survey, March 2002 Supplement.

Figure 13

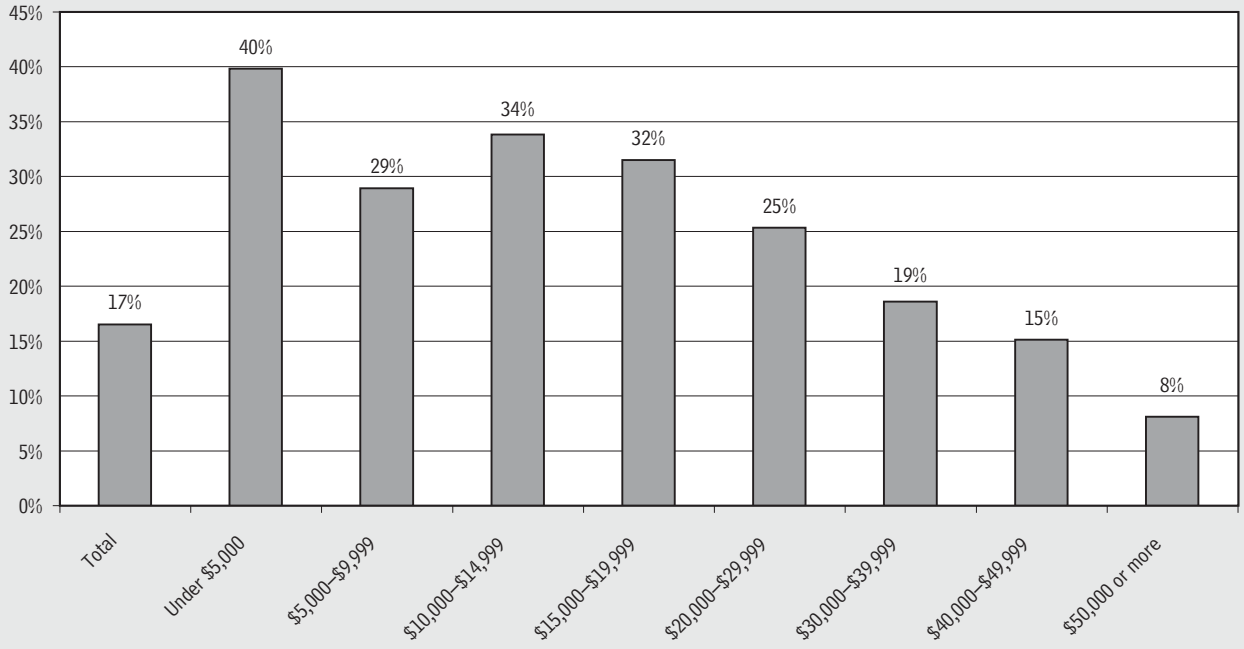
PERCENTAGE UNINSURED, BY STATE, 2001



Source: Employee Benefit Research Institute estimates from the Current Population Survey, March 2002 Supplement.

Figure 14

PERCENTAGE OF NONELDERLY[a] WITHOUT HEALTH INSURANCE, BY FAMILY INCOME 2001

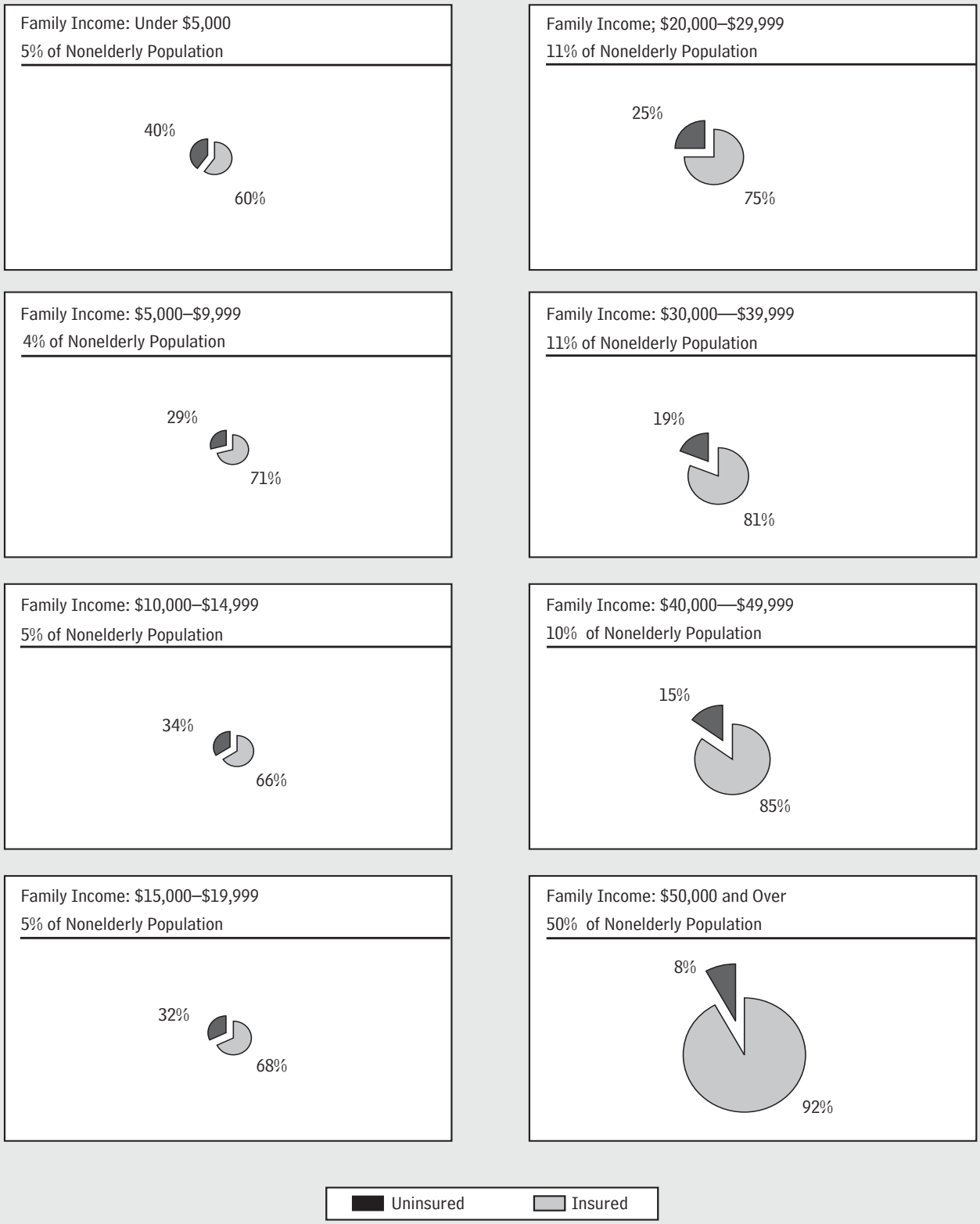


Source: Employee Benefit Research Institute estimates from the Current Population Survey, March 2002 Supplement.

[a] Under age 65.

Figure 15

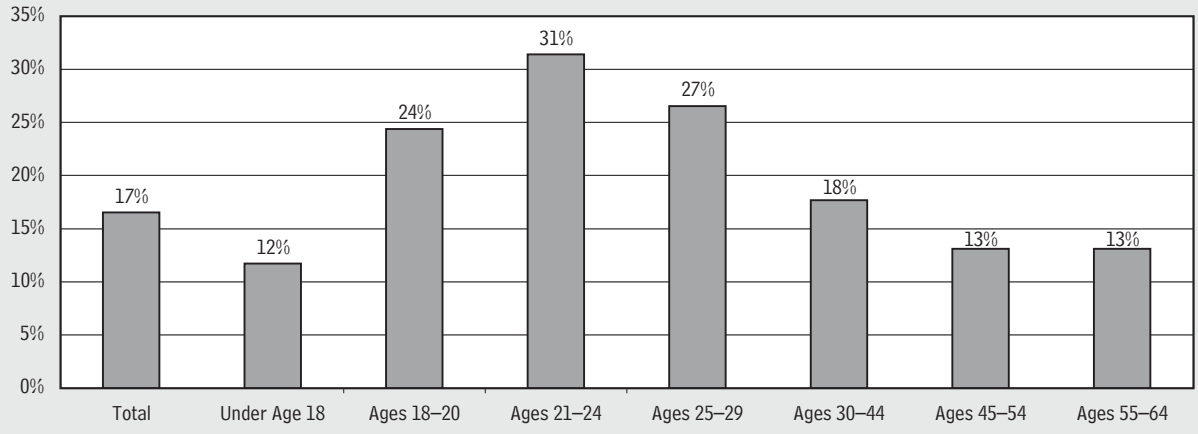
INSURANCE STATUS, BY FAMILY INCOME COHORT, 2001



Source: Employee Benefit Research Institute estimates of the Current Population Survey, March 2002 Supplement.

Figure 16

PERCENTAGE OF NONELDERLY[a] WITHOUT HEALTH INSURANCE, BY AGE, 2001

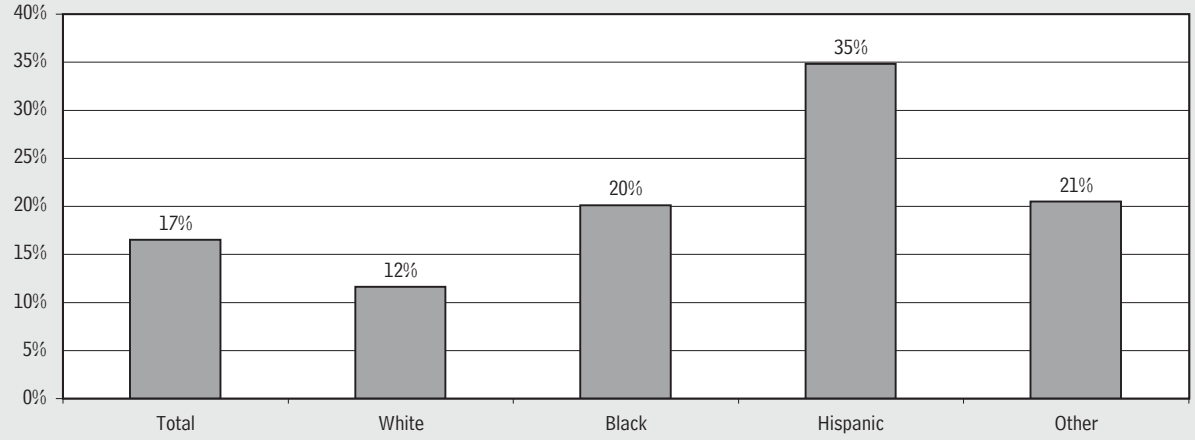


Source: Employee Benefit Research Institute estimates from the Current Population Survey, March 2002 Supplement.

[a] Under age 65.

Figure 17

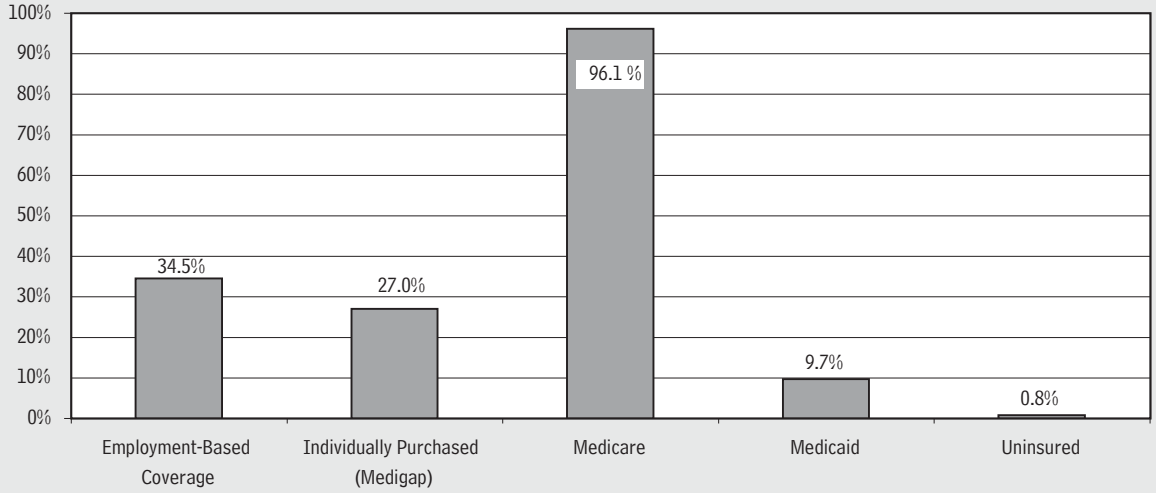
PERCENTAGE OF NONELDERLY WITHOUT HEALTH INSURANCE, BY RACE, 2001



Source: Employee Benefit Research Institute estimates from the Current Population Survey, March 2002 Supplement.

Figure 18

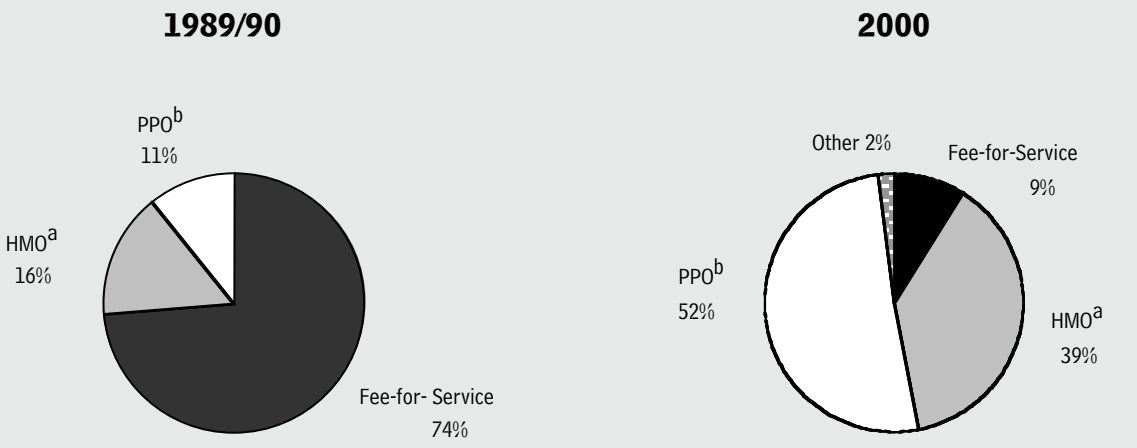
SOURCES OF HEALTH INSURANCE, ELDERLY POPULATION AGE 65 AND OVER, 2001



Source: Employee Benefit Research Institute estimate from the Current Population Survey, March 2002 Supplement.

Figure 19

PERCENTAGE OF FULL-TIME EMPLOYEES PARTICIPATING IN AN EMPLOYMENT-BASED HEALTH PLAN, BY PLAN TYPE, 1989/90 AND 2000



Source: U.S. Department of Labor, Bureau of Labor Statistics, Employee Benefits in Medium and Large Private Establishments, 1989 (Washington, DC: U.S. Government Printing Office, 1990); Employee Benefits in Small Private Establishments, 1990 (Washington, DC: U.S. Government Printing Office, 1991); and National Compensation Survey: Employee Benefits in Private Industry in the United States, 2000 (www.bls.gov/ebs).

[a] Health maintenance organization.

[b] Preferred provider organization.

Section 4: Managed Care

The managed care industry developed in response to inflation in the cost of health care. Prepaid group practices have been in existence since the 19th century in the mining and lumber industries, but they did not become a major alternative to traditional fee-for-service health plans until passage of the Health Maintenance Organization (HMO) Act of 1973. Although managed care arrangements are often thought to include only HMOs, they consist of any type of intervention in the provision of health care services or reimbursement of health care providers that is intended to provide health care services in the most efficient manner.

In general, managed care arrangements range from fully integrated models, such as staff and group model HMOs, which limit patient choice of health care providers to less restrictive arrangements, such as independent practice associations (IPAs), preferred provider organizations (PPOs), and point-of-service (POS) plans. Traditional indemnity health plans also have begun to incorporate features of managed care into their plans. Indemnity plans with utilization review (UR) are known as managed indemnity plans.

Basically, managed care uses groups or networks of providers, has explicit criteria for selecting providers, and/or subjects providers to UR. Participants in managed care plans usually are given financial incentives to use selected health care providers. Enrollment in managed care plans has increased substantially. The percentage of full-time workers in the private-sector enrolled in a fee-for-service plan declined from 74 percent in 1989/1990 to 9 percent in 2000 (Figure 19). Correspondingly, enrollment in HMOs increased from 16 percent in 1989/1990 to 39 percent in 2000 and enrollment in PPOs increased from 11 percent in 1989/1990 to 52 percent in 2000.

Health care delivery systems can be arranged on a spectrum according to the degree of financial control the employer (payer) has over patient choice. At one end of the spectrum is the fee-for-service (or traditional indemnity) plan with no managed care elements. At the other end is the staff model HMO, with the most strict managed care elements. Between these two extremes are fee-for-service plans with managed care features, PPOs, and less restrictive HMOs. Finally, as health care delivery systems evolve and employers become more involved in the design of corporate benefit plans, hybrid plans are developing that combine elements of the HMO and PPO in an attempt to balance freedom of choice for the employee and financial control for the employer.

Section 5: Consumer-Driven Health Benefits

A number of health policy analysts have suggested that employers are rethinking their entire approach to managing employee health benefits. The terms *defined contribution* and *consumer driven* are used to describe a range of potential health benefit options available to employers. These terms generally connote programs in which employees are treated as *direct purchasers* of health coverage and health care services rather than the *indirect beneficiaries* of purchases made by the employer. It is assumed that they will be more careful purchasers and will be more satisfied with the choices they make on their own, rather than having someone else make those choices for them. The options for employers include giving employees a fixed amount of money that they could use to purchase insurance or allowing them to choose from an array of health benefits offered by the employer.

Employer interest in these health benefits continues to grow for a number of reasons. First, employers continually look for more cost-effective ways to provide health benefits for their work force, and are concerned about future cost increases; these arrangements would allow them to set a monetary contribution for health benefits regardless of the size of cost increase of providing the benefit. Second, many employers sponsoring health plans are concerned that the public and political "backlash" against managed care will result in new restrictions or laws that will entangle them in litigation. Employers could distance themselves from health care coverage decisions by only contributing to the cost of health benefits and not being involved in the actual coverage or delivery of the health care services. Third, employers may be able to provide workers more choice, control, and flexibility through these arrangements.

Further Reference

EBRI Issue Briefs *on Consumer-Driven Health Benefits*—EBRI has published several *Issue Briefs* on this topic. Following is a list of these papers with a brief description. They can be found on EBRI's Web site www.ebri.org

- *EBRI Issue Brief* no. 231, March 2001—"Defined Contribution Health Benefits." Paul Fronstin, EBRI.

  This *Issue Brief* discusses the emerging issue of "defined contribution" (DC) health benefits. It examines the factors driving employers to consider DC health benefits, presents background information on the movement to DC *retirement* plans, outlines a number of DC health benefits models, discusses related issues, and presents similarities and differences between DC health benefits and DC retirement plans. Finally, it examines insurance and policy issues as they relate to DC health benefits. The two appendices present findings of various employer and employee surveys on their attitudes toward DC health benefits and research literature on the topic.

- *EBRI Issue Brief* no. 241, January 2002—"Consumer Health Care Finances and Education: Matters of Values." Lois A. Vitt, Jurg K. Siegenthaler, Linda Siegenthaler, Deanna M. Lyter, and Jamie Kent, Institute for Socio-Financial Studies.

  This report analyzes recent literature about 1) trends in the employment-based health care benefits system, 2) proposed "market-driven" approaches to health care financing, and 3) the current implications for consumers of the impact of rising costs on the employment-based system (including the situation of the underinsured and the uninsured as well as the shift away from traditional employment-based benefits). This report uses a "values" framework within which to review the literature in order to better define some

frequently used vague concepts. For example, this report considers briefly the meaning of *responsibility*, since the health benefits literature refers often to a "shift in responsibility" for payment and selection of health care services from employers and other employment-based plan sponsors to individual consumers.

- *EBRI Issue Brief* no. 244, April 2002—"A Temporary Fix? Implications of the Move Away From Comprehensive Health Benefits." Laura Tollen and Robert M. Crane, Kaiser Permanente Institute for Health Policy.

  This report provides an overview of available research and issues that might be considered in light of current market trends toward higher consumer cost sharing and less comprehensive coverage. It draws heavily from the insights gleaned from an expert roundtable discussion, "Connecting Public Policy to Health Benefit Design," sponsored in 2001 by *Health Affairs* and Kaiser Permanente Institute for Health Policy.

  This report begins with a review of the evidence regarding a trend toward increased cost sharing and/or reduced benefits. This is followed by a description of how insurers use these mechanisms to contain costs and an analysis of the most common plan types currently available in Northern California's small group market. The following section presents information on the effects of cost sharing and exclusions on utilization of services. The next section provides an analysis of the policy implications of the current trends. The report concludes by outlining potential policy interventions to address some of the concerns raised by current trends, focusing on delivery system reforms and the proper scope of coverage in light of technological and scientific advances.

- *EBRI Issue Brief* no. 246, June 2002—"Can Defined Contribution Health Insurance Reduce Cost Growth?" Len M. Nichols, Center for Studying Health System Change and EBRI Fellow.

  This report focuses on one key question: Can a widespread shift to defined contribution health plan arrangements lower the growth rate of health care costs? In order to answer this question, two other questions must be answered first: 1) What are the root causes of health care cost inflation? 2) What will be the price responsiveness of workers with structured incentives to choose among health plans?

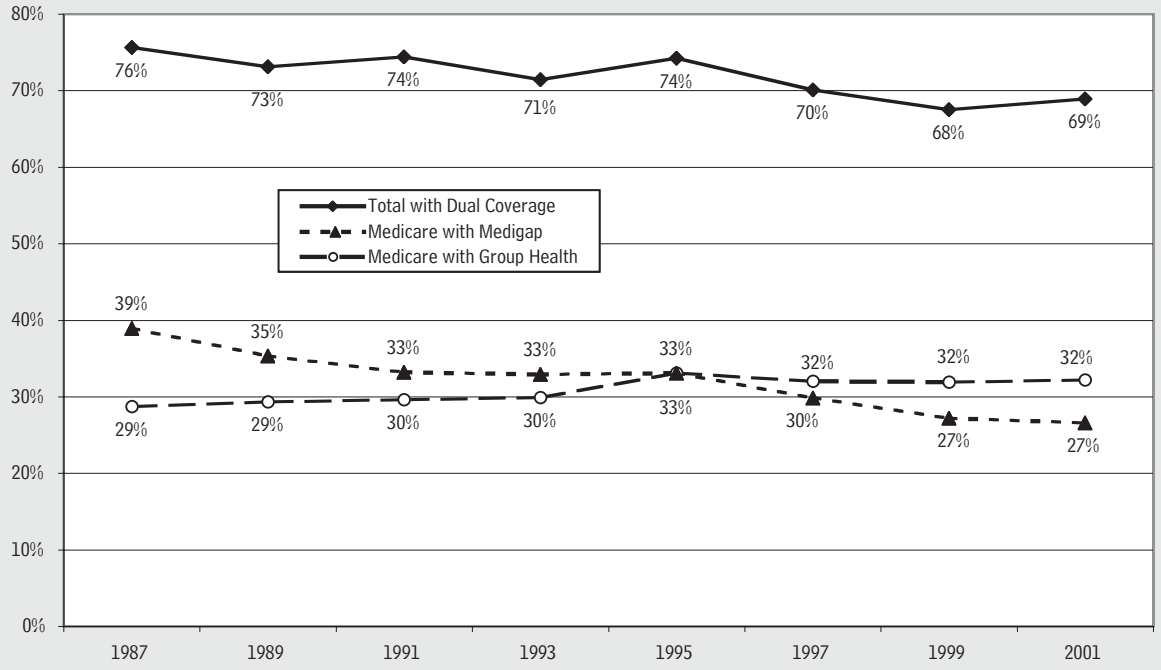
  The first section of this *Issue Brief* describes recent trends that have intensified employer interest in DC health plans, followed by an explanation of how employers came to embrace managed care and how interest in DC health flows from the subsequent disappointment over managed care. The following section outlines how certain kinds of DC plans could—theoretically—help contain health care cost growth; this section also identifies the necessary conditions, including institutional development, for DC health plan effectiveness. The final section explains the limits on DC plans' ability to constrain cost growth over time and the additional research that is needed.

- *EBRI Issue Brief* no. 247, July 2002—"Can 'Consumerism' Slow the Rate of Health Benefit Cost Increases?" Paul Fronstin, EBRI

  This *Issue Brief* explores the spectrum of various health benefit options—some of which are new and are being used, others that are not being used, and some that employers have already been using for years—and the issues involved with these options. The first section includes a discussion of why the cost of providing health benefits is increasing, and is followed by a section that presents the spectrum of health plan options. The concluding section discusses how increased consumer involvement may affect the cost of providing health benefits.

Figure 20

DUPLICATE SOURCES OF HEALTH INSURANCE COVERAGE, ELDERLY POPULATION AGE 65 AND OLDER, 1987–2001



Source: Employee Benefit Research Institute estimates from the Current Population Survey, March 1988–2002 Supplements.

Section 6: Medicare and Retiree Health Benefits

Medicare

Medicare, enacted in 1965, is responsible for the near-universal coverage of those age 65 and over (Figure 18). Although Medicare gives the elderly coverage for a large number of health care benefits, not all services are covered. Furthermore, the cost-sharing provisions of Medicare can be expensive. As a result, most of the elderly have more than one source of health insurance coverage (Figure 20). In 2001, 68.9 percent of the elderly had more than one source of health insurance coverage. Most common was Medicare coverage plus employment-based coverage (24.9 percent in 2001) or Medicare coverage plus individually purchased Medigap policies (26.6 percent in 2001). For more details on Medicare, see Figure 21.

Employment-Based Retiree Health

An annual survey of employers with 500 or more employees shows that the percentage that currently expect to continue to offer health benefits to future early retirees and Medicare-eligible retirees declined from 1993 to 2001 (Figure 22). In 2002, the data shows an increase. Part of the explanation for this is a change in the wording of the possible responses to the question asked about retiree coverage. The new wording was intended to help better distinguish employers offering retiree coverage on a continuing basis (to employees currently being hired) from those who offer coverage only to a closed group of retirees or to employees retiring before (or hired after) a specified date. Despite the very recent increase shown in the data, it is unlikely that the long-term trend of declining offer rates of retiree health care coverage has been reversed. However, it is possible that offer rates have plateaued. Another explanation is that prior results may have been understated because employers with retiree-pay-all coverage indicated in the past they did not offer retiree health benefits.

Savings Needed for Health Care in Retirement

The combination of the erosion of retiree health benefits and limited benefits from Medicare and Medigap means that retirees should expect to pay a significant amount of money for health insurance and health care services

Figure 21

THE BASICS OF MEDICARE UPDATED WITH THE 2003 BOARD OF TRUSTEES REPORT

History

- In 1965, Title 18, "Health Insurance for the Aged," of the Social Security Act created the Medicare program. Medicare consists of two parts: Part A, Hospital Insurance (HI), covers hospital services and some home health care and skilled nursing facility services, and Part B, Supplemental Medical Insurance (SMI), covers physician care, outpatient hospital services, and independent laboratory services.
- In 1972, the Medicare program was expanded to include disabled persons who qualified for benefits under the Disability Insurance (DI) program and certain individuals with end-stage renal (kidney) disease.
- In 1986, all state and local government employees hired after Mar. 31, 1986, and not covered under Social Security, were required to be covered by Medicare.
- In 1997, the Balanced Budget Act of 1997 expanded the delivery of health care under Medicare with the Medicare+Choice program. See below for more details.
- In 1997, under the Balanced Budget Act of 1997, home health services not associated with a hospital or skilled nursing facility stay for individuals enrolled in both HI and SMI were transferred from the HI program to the SMI program, effective January 1998.
- In 2000, Congress enacted the Benefits Improvement and Protection Act (BIPA) to increase payments to plans in an effort to stop plans from withdrawing from the Medicare+Choice program. See below for more details.

Covered Beneficiaries

- Medicare serves elderly and disabled workers who qualify for DI benefits. Enrollment in Part A (HI) is mandatory, while enrollment in Part B (SMI) is voluntary. In 2002, 34.6 million elderly and 6.0 million disabled individuals were enrolled in Part A, and 32.9 million elderly and 5.2 million disabled individuals were enrolled in Part B.

Financing

Part A: Hospital Insurance (HI)

- The Balanced Budget Act of 1997 contained numerous provisions affecting the Medicare program. These provisions were designed in part to postpone the imminent depletion of the HI trust fund, which, according to the 1997 Board of Trustees' report, had been projected for 2001. Under this legislation, fund exhaustion is postponed until 2026, based on the intermediate assumptions used in the 2003 Board of Trustees' report.

(continued)

during retirement. If a person were to try to save for these expenses, the amount of money needed would vary with a number of factors such as:

- The source of insurance, premium level, and benefits covered.
- Annual increases in insurance premiums.
- Age at time of death.
- Retirement age.
- Rate of return on investments.
- Out-of-pocket expenses and health status.
- Medicare Part B premiums.

Figure 23 provides estimates of savings needed under various assumptions to pay for health insurance premiums, Medicare Part B premiums, and maximum out-of-pocket health care costs during retirement for a person with access to coverage through an employer.

Figure 24 provides estimates of savings needed under various assumptions to pay for health insurance premiums and average out-of-pocket health care costs during retirement for a person who buys Medigap Plan J directly from an insurer. Footnote 1 in Figure 24 gives the details of benefits available in Medigap Plan J.

In February 2003, EBRI published an *Issue Brief* that used various assumptions about these factors to provide a set of illustrations of the savings level that may be needed to pay for insurance premiums and out-of-pocket expenses. A copy of this *Issue Brief* can be obtained from EBRI's Web page, www.ebri.org

- HI payroll taxes for 2003 were based on a combined employer/employee rate of 2.9 percent. The Omnibus Budget Reconciliation Act of 1993 removed any wage base limit for the HI payroll tax, effective Jan. 1, 1994. For years 2004 and afterward, the payroll tax is scheduled to be 2.9 percent. In 2002, total income for the HI trust fund was $178.6 billion: $152.7 billion came from payroll taxes, $8.3 billion from taxation of Social Security benefits, $14.4 billion from interest and other income,[1] and $1.6 billion from premium payments, and $1.6 billion from miscellaneous revenue.
- In 2002, the average amount reimbursed per enrollee in Part A was $3,689.
- Administrative costs for the Medicare program are low. In 2002, administrative costs for Part A were $2.6 billion, or 1.7 percent of expenditures.

Part B: Supplementary Medical Insurance (SMI)

- The SMI trust fund is financed on a year-by-year basis. The SMI program derives its revenues from premium payments by beneficiaries and general revenues from the federal budget. Under current law, no more than 25 percent of SMI's revenues can come from premium payments.
- The average amount reimbursed per enrollee in Part B was $2,915.
- Administrative costs for the Medicare program are low. In 2002, administrative costs for Part B were $2.2 billion, or 1.9 percent of expenditures.

Federal Budgetary Processes

- Currently, the U.S. Department of the Treasury credits the Medicare and Social Security trust funds with any annual excess of Medicare and Social Security tax revenues over the amount spent for current benefits. By law, these assets must be invested in special securities issued by the Treasury. The government then spends these "assets" to ease fiscal pressures on other programs. The trust fund surpluses are not reserved for future Medicare and Social Security benefits but are bookkeeping entries showing how much the Medicare and Social Security programs have lent to the Treasury (or alternatively, what is owed to Medicare and Social Security, including interest, by the Treasury). When the trust funds go into negative cash flow, the Treasury must start repaying the money.
- For budgetary purposes, the date on which the trust funds go into negative cash flow (i.e., the benefit payments exceed the income from payroll taxes and the taxation of benefits) is significant because it marks the point at which the government must provide cash from general revenues to the programs rather than receive surplus cash from them to fund other current spending.

Cost-Sharing Provisions

Part A Hospital Insurance (HI)

- Part A requires an enrolled individual to pay various deductibles and co-pays, depending on the facility where the service is provided and the length of stay.
- In-patient Hospital Deductible—For a hospital stay of 1–60 days in 2003, a patient is liable for an $840 deductible. For a hospital stay of 61–90 days in 2003, the patient is liable for a $210 co-pay per day. For a hospital stay of more than 90 days in 2003, a patient is liable for a $420 co-pay per day.
- Skilled Nursing Facility—There is no deductible or co-pay for the first 20 days of a skilled nursing facility stay. If the stay lasts for 21 days or longer, the patient is liable for a $105 co-pay per day in 2003.
- Part A Premium—For an individual who is age 65 or older and not otherwise covered by the Medicare program, the monthly premium in 2003 to be covered by Part A is $316.
- The use of Medicare benefits is calculated based on benefit periods and reserve days. The benefit period is the block of time used to determine how much of a deductible and/or co-pay the beneficiary owes. A benefit period begins and ends when he or she has been out of the hospital for 60 consecutive days. For example, if a beneficiary enters the hospital on November 10, 2003, and is released on November 24, 2003, he or she is

liable for $840. If the beneficiary is re-admitted to the hospital on December 20, 2003, and released on December 26, 2003, he or she does not have to pay another $840. The beneficiary is liable to pay the deductible per benefit period, not per admission. The benefit period on this example runs until January 24, 2004.

- There is no limit on the number of benefit periods a beneficiary may use in a lifetime, except for hospice care, which entitles a beneficiary to two 90–day periods and one 30–day period.
- Reserve days are used for hospital stays beyond 90 days. A beneficiary is entitled to only 60 reserve days.

Part B: Supplementary Medical Insurance (SMI)

- Since Part B of Medicare is voluntary, participants are required to make a monthly premium payment. Part B premiums are automatically deducted from the enrollee's Social Security benefit, provided the enrollee receives Social Security benefits. Under current law, no more than 25 percent of SMI's revenues can come from premium payments.
- Premiums—In 2003, the monthly premium is $58.70.
- Annual Deductible—This is applied to all Part B services except home health care services. In 2003, the annual deductible is $100.
- Coinsurance—Coinsurance amount in 2003 is 20 percent.

Medigap

- Although Medicare eases many financial worries for the elderly, it does not cover 100 percent of all medical services. Medicare's deductibles and co-payments can be high, particularly for long hospital stays.
- Medicare does not cover all medical services. Most notable are outpatient prescription drugs, eye exams and glasses, hearing aids, and dental services.
- To help meet these additional expenses, Medicare beneficiaries frequently purchase what is known as Medigap policies. A Medigap policy is purchased in the individual market.
- In the 1970s and 1980s, Medicare enrollees encountered problems with purchasing health insurance to supplement Medicare. In the Omnibus Budget Reconciliation Act of 1990 (OBRA '90), Congress charged the National Association of Insurance Commissioners (NAIC) with developing a variety of Medigap policies. NAIC developed 10 policies ranging from a basic coverage plan, Plan A, to comprehensive coverage, Plan J. Insurance carriers are not required to offer all 10 policies, but if a carrier offers Medigap policies, they must be from the 10 policies designed by NAIC. Exceptions to this rule are for carriers in Massachusetts, Minnesota, and Wisconsin, states that had Medigap laws in place before OBRA '90.
- The Centers for Medicare and Medicaid Services maintains an interactive Web page designed to assist an enrollee in obtaining Medigap coverage. The Web site is at the following link: www.medicare.gov/MGCompare/Home.asp

Covered Services

Part A: Hospital Insurance (HI)

- Hospitalization—Covered services include semiprivate room and board, general nursing, miscellaneous hospital services and supplies, inpatient psychiatric hospital care.
- Posthospital Skilled Nursing Facility Care—To receive this service, the individual must have been in the hospital for at least three days and enter facility within 30 days after hospital discharge.
- Home Health Care—Covered services include part-time skilled nursing care, physical therapy, occupational therapy, speech-language therapy, home health aide services, medical social services, durable medical equipment (such as wheelchairs) and medical supplies.
- Hospice Care—Covered services include medical and support services from a Medicare-approved hospice for people with a terminal illness, drugs for symptom control and pain relief, and other services not otherwise

covered by Medicare. Hospice care is usually given in the home. However, short-term hospital and inpatient respite care (care given to a hospice patient by another caregiver so that the usual caregiver can rest) are covered when needed.

- Blood—Covered services include blood received at a hospital or skilled nursing facility during a covered stay.

Part B: Supplementary Medical Insurance (SMI)

- Medical and Other Services—Covered services include doctors' services (not routine medical exams), outpatient medical and surgical services and supplies, diagnostic tests, ambulatory surgery center facility fees for approved procedures, and durable medical equipment (such as wheelchairs). Part B covers second surgical opinions, outpatient mental health care, outpatient physical and occupational therapy, including speech-language therapy.
- Clinical Laboratory Services—Services include blood tests, urinalysis, and more.
- Home Health Care—Services include part-time skilled nursing care, physical therapy, occupational therapy, speech-language therapy, home health aide services, medical social services, durable medical equipment (such as wheelchairs) and medical supplies, and other services.
- Outpatient Hospital Services—Services include hospital services and supplies received as an outpatient as part of a doctor's care.
- Blood—Covered services include blood received as an outpatient or as part of a Part B covered service.

Medicare+Choice

- The Medicare+Choice program was created by Congress in the Balanced Budget Act of 1997 to constrain costs and to allow more types of health insurance plans, including managed care plans, to serve Medicare beneficiaries. As of March 2003, 5.3 million Medicare beneficiaries (approximately 14 percent of Medicare beneficiaries) were enrolled in a Medicare HMO. Since 1998, most HMO contracts with the Centers for Medicare and Medicaid Services have operated under the Medicare+Choice program.
- In 1999, 97 plans either withdrew or reduced their service areas, directly affecting 407,000 enrollees. In 2000, 99 plans withdrew, affecting 327,000 enrollees. In 2001, withdrawals and service area reductions affected an estimated 934,000 enrollees. In 2002, 536,000 enrollees were affected by withdrawals and service area reductions.
- In late 2000, Congress enacted the Benefits Improvement and Protection Act (BIPA) to increase payments to plans in an effort to stop plans from withdrawing from the Medicare+Choice program. Under BIPA, as of March 1, 2001, the floor or minimum payment for Medicare+Choice plans in counties in large urban areas is $525 while for all other counties it is $475. Early data suggest that the BIPA minimum payments are having a greater impact in the large urban areas than in the counties with the lower minimum payment.

Trustees in 2003

- Treasury Secretary John W. Snow acts as the Managing Trustee and Thomas A. Scully, Administrator and Chief Operating Officer of the Centers for Medicare & Medicaid Services, serves as acting Secretary of the Medicare trust funds. The other trustees include: Elaine Chao, Secretary of Labor; Tommy G. Thompson, Secretary of Health and Human Services; Jo Anne B. Barnhart, Commissioner of Social Security; John L. Palmer, and Thomas R. Saving.

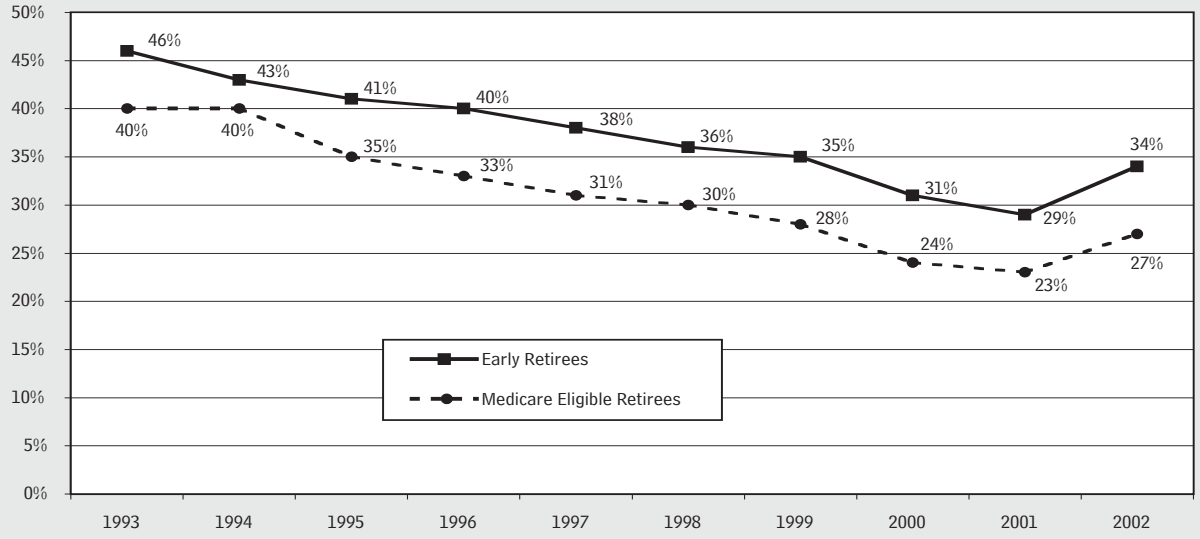
For additional detailed information on the Medicare program, go to www.medicare.gov/ which is maintained by the Centers for Medicare and Medicaid Services, part of the U.S. Department of Health and Human Services.

Source: U.S. Social Security Administration, *2000 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund* and *2003 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund and Supplementary Medical Insurance Trust Fund* (Washington, DC: U.S. Government Printing Office, 2000 and 2003).

[1] Other income includes recoveries of amounts reimbursed from the trust fund that are not obligations of the trust fund, receipts from the fraud and abuse control program, and a small amount of miscellaneous income.

Figure 22

PROVISION OF RETIREE HEALTH BENEFITS FOR CURRENT AND ALL FUTURE RETIREES, BY EMPLOYERS WITH 500 OR MORE EMPLOYEES, 1993–2001



Source: William M. Mercer, Mercer/Foster Higgins. *National Survey of Employer-Sponsored Health Plans, 2002: Report on Survey Findings* (William M. Mercer, Inc., New York, NY, 2003).

Figure 23

SAVINGS NEEDED FOR EMPLOYMENT-BASED HEALTH BENEFITS FOR RETIREMENT AT AGE 65 IN 2003 (INCLUDES PREMIUM,[a] MEDICARE PART B PREMIUM,[b] AND OUT-OF-POCKET EXPENSES)[c]

	Annual Increase in Premiums								
	Illustration #1 7%			Illustration #2 14%			Illustration #3 14% Grading Down to 5% Over 10 Years[d]		
	50% of Premium ($1,316) + Part B Premium	100% of Premium ($2,631) + Part B Premium	100% of Premium ($2,631) + $1,500 Maximum Out-of-Pocket + Part B Premium	50% of Premium ($1,316) + Part B Premium	100% of Premium ($2,631) + Part B Premium	100% of Premium ($2,631) + $1,500 Maximum Out-of-Pocket + Part B Premium	50% of Premium ($1,316) + Part B Premium	100% of Premium ($2,631) + Part B Premium	100% of Premium ($2,631) + $1,500 Maximum Out-of-Pocket + Part B Premium
Age at Death									
80	$37,000	$62,000	$80,000	$56,000	$100,000	$117,000	$42,000	$73,000	$90,000
85	52,000	88,000	109,000	93,000	171,000	192,000	58,000	100,000	121,000
90	69,000	117,000	141,000	151,000	281,000	305,000	75,000	128,000	152,000
95	88,000	150,000	176,000	239,000	453,000	479,000	92,000	158,000	185,000
100	109,000	188,000	216,000	377,000	722,000	750,000	111,000	190,000	218,000

Source: EBRI estimates based on various assumptions.

[a] Benefits package for the $2,631 premium was developed by PricewaterhouseCoopers LLP on behalf of the Mellon College Retirement Project. It contains the following benefits: Major Medical Benefit: $150 annual preventive care benefit, $250 deductible, 80% coinsurance. Outpatient Prescription Drug Benefit: $50 deductible, 70% coinsurance. Maximum out-of-pocket: $1,500 (medical and prescription drug combined).

[b] Medicare Part B premiums are from cms.hhs.gov/publications/trusteesreport/2002/tabivc1.asp. In years 2012 and beyond an annual increase of 5.5 percent was assumed.

[c] All estimates assume a 4 percent after-tax rate of return on investments.

[d] A grading down to 5% is currently the most common assumption in corporate disclosures under FAS 106 guidelines. See Deloitte and Touche (2001).

Figure 24

SAVINGS NEEDED FOR MEDIGAP COVERAGE FOR RETIREMENT AT AGE 65 IN 2003 (INCLUDES PREMIUM,[a] MEDICARE PART B PREMIUM,[b] AND OUT-OF-POCKET EXPENSES[c])[d]

Annual Increase in Premiums

	Illustration #1 7% (includes 3% health inflation + 4% age effect)			Illustration #2 14% (includes 10% health inflation + 4% age effect)			Illustration #3 14% Grading Down to 5% Over 10 Years (includes 4% age effect)		
	50% of Premium ($1,818) + Part B Premium	100% of Premium ($3,635) + Part B Premium	100% of Premium ($3,635) + Average Out-of-Pocket Expenses+ Part B Premium	50% of Premium ($1,818) + Part B Premium	100% of Premium ($3,635) + Part B Premium	100% of Premium ($3,635) + Average Out-of-Pocket Expenses + Part B Premium	50% of Premium ($1,818) + Part B Premium	100% of Premium ($3,635) + Part B Premium	100% of Premium ($3,635) + Average Out-of-Pocket Expenses + Part B Premium
Age at Death									
80	$47,000	$82,000	$116,000	$73,000	$133,000	$194,000	$54,000	$98,000	$137,000
85	66,000	115,000	164,000	123,000	230,000	335,000	74,000	135,000	189,000
90	87,000	153,000	219,000	200,000	380,000	558,000	95,000	173,000	243,000
95	112,000	197,000	282,000	321,000	615,000	907,000	117,000	214,000	300,000
100	139,000	247,000	354,000	508,000	985,000	1,458,000	141,000	257,000	359,000

Source: EBRI estimates based on various assumptions.

[a] Benefits package for a $3,635 premium for Medigap Plan J in Florida priced at www.aarphealthcare.com for a 65 year old in 2002 living in Florida, after all possible discounts are taken. The plan contains the following benefits:
- Inpatient Hospital Care: Covers the cost of Part A coinsurance and the cost of 365 extra days of hospital care during your lifetime after Medicare coverage ends.
- Medical Costs: Covers the Part B coinsurance (generally 20% of Medicare-approved payment amount) or copayment amount which may vary according to the service.
- Blood: Covers the first 3 pints of blood each year.
- Also covers the Part A Inpatient Hospital Deductible, the Part B Deductible, 100% of the Part B Excess Charges, the Skilled Nursing Facility Coinsurance, Emergency Foreign Travel, At-Home Recovery, Preventive Care and Extended Prescription Drug Coverage ($3,000 limit)

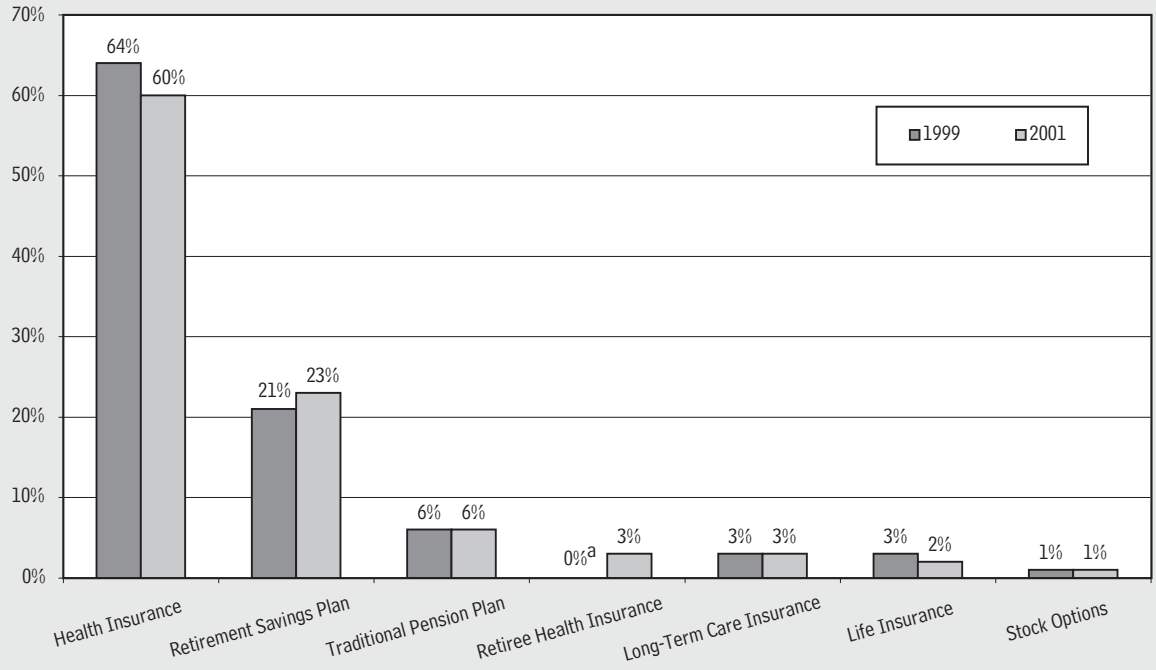
[b] Medicare Part B premiums are from cms.hhs.gov/publications/trusteesreport/2002/tabivc1.asp. In years 2012 and beyond we assume an annual increase of 5.5 percent.

[c] Based on estimates from the 1999 Medical Expenditure Panel Survey, $1,100 is used for average out-of-pocket expenses for prescription drugs and $700 as the average out-of-pocket expenses for other health care services for people who used health care services.

[d] All estimates assume a 4 percent after-tax rate of return on investments.

Figure 25

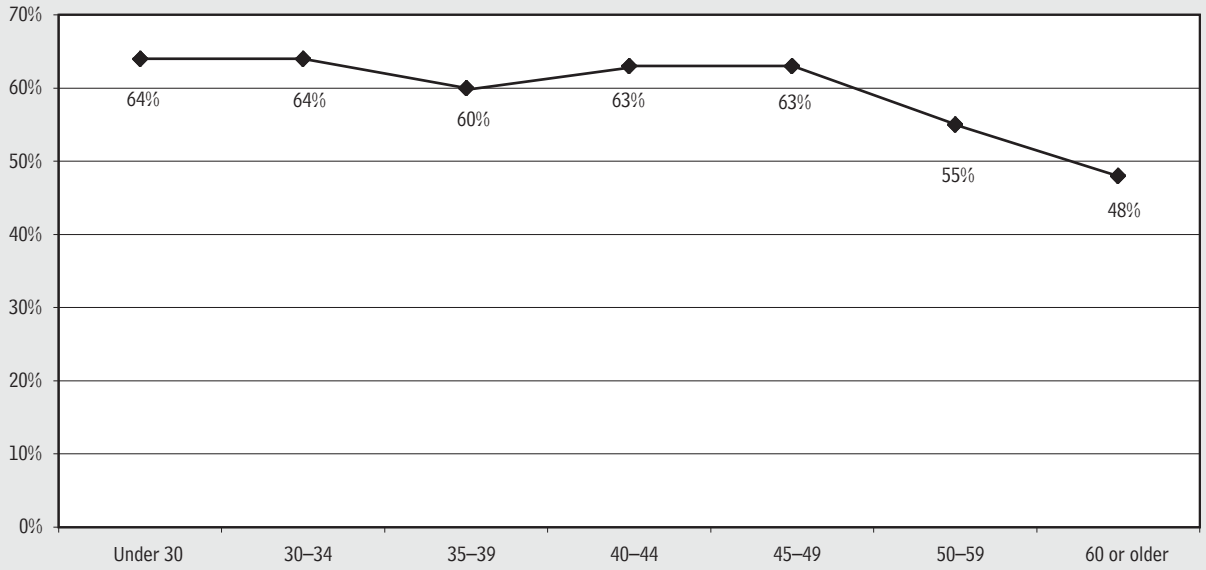
MOST IMPORTANT EMPLOYEE BENEFIT, 1999 AND 2001



Source: Employee Benefit Research Institute and Matthew Greenwald & Associates, Inc., 2001 Value of Benefits Survey.

[a] Not asked in 1999.

Figure 26
PERCENTAGE OF WORKERS WHO RANKED HEALTH INSURANCE AS THE MOST IMPORTANT BENEFIT, BY AGE, 2001



Source: Employee Benefit Research Institute and Matthew Greenwald & Associates, Inc., 2001 Value of Benefits Survey.

Section 7: Public Opinion

Since any change in the health care system will likely affect the large percentage of the U.S. population with employment-based health benefits, it is important to understand how the public currently feels about employment-based health insurance, alternatives to the employment-based system, and the health care system in general.

Benefits Offered

Health insurance is the benefit most used and valued by workers and their families. Sixty percent of workers responding to a 2001 survey rated employment-based health insurance as the most important benefit (Figure 25). A retirement savings plan was the second most highly valued employee benefit, with 23 percent of workers choosing that option. When looked at by the worker's age, the older the worker, the less likely he or she was to cite employment-based health benefits as the most valuable benefit (Figure 26).

The Health Care System

Even though the United States spends almost 14 percent of its gross domestic product on health care, less than half, 44 percent, of Americans who used the health care system in the past two years are extremely or very satisfied with the system in general in 2002 (Figure 27). Among individuals who utilized the health care system in the past two years, 26 percent were extremely or very satisfied with the quality of the health care they received but only 8 percent were not too or not satisfied at all with the quality of care received (Figure 28).

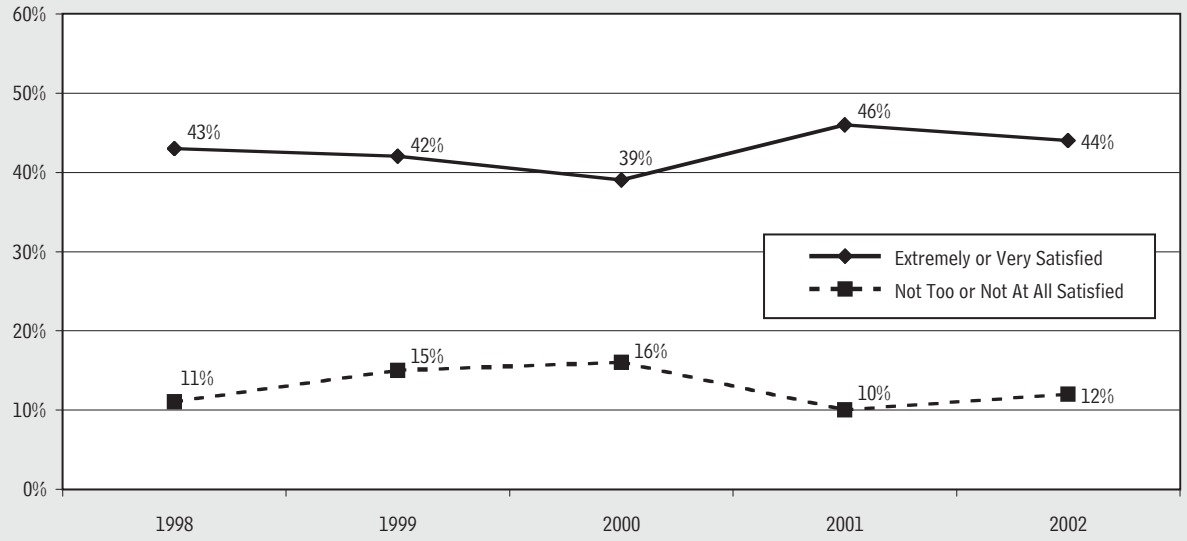
As Americans look to the future, they become less confident in the health care system (Figure 29). Just one-third are extremely or very confident that they will be able to get the treatment they need over the next 10 years or until they are eligible for Medicare (34 percent), and only 30 percent are extremely or very confident of having enough choice about who provides their medical care during this period. Roughly one-fourth each are extremely or very confident of being able to afford health care without financial hardship (25 percent) and being able to afford prescription drugs without financial hardship (24 percent).

Perhaps not surprisingly, respondents who describe their health as fair or poor are more likely than those who describe it as excellent, very good, or good to say they are not too or not at all confident of being able to afford future health care (Figure 30).

Women (41 percent) are more likely than men (26 percent) to be not too or not at all confident they will be able to get the treatments they need once they are eligible for Medicare (Figure 31).

Figure 27

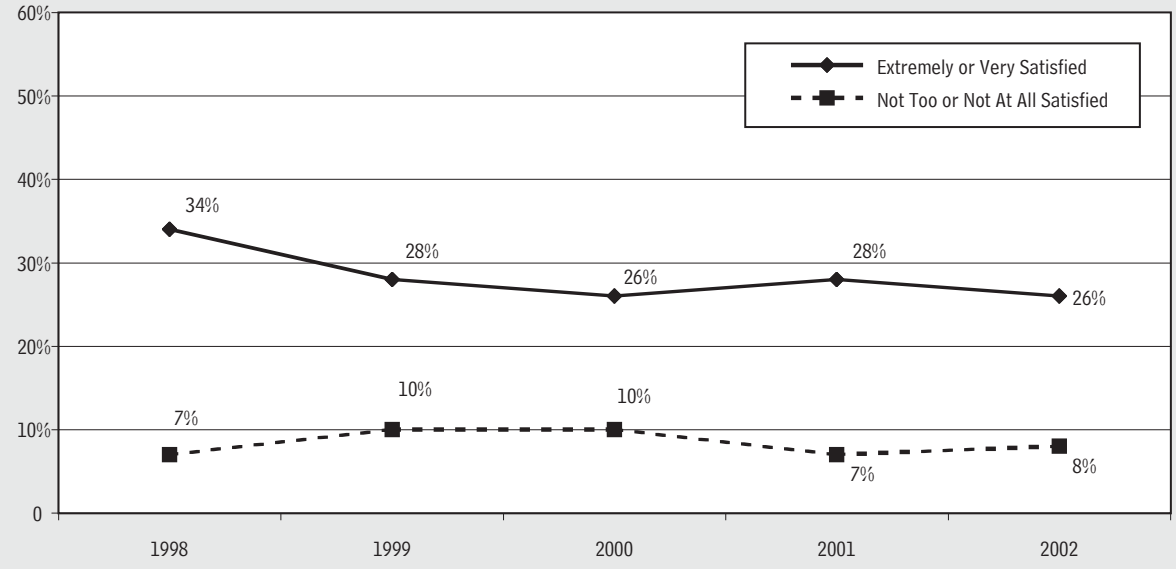
SATISFACTION IN GENERAL WITH HEALTH CARE RECEIVED IN THE PAST TWO YEARS



Source: Employee Benefit Research Institute, Consumer Health Education Council, and Matthew Greenwald & Associates, Inc., 1998–2002 Health Confidence Surveys.

Figure 28

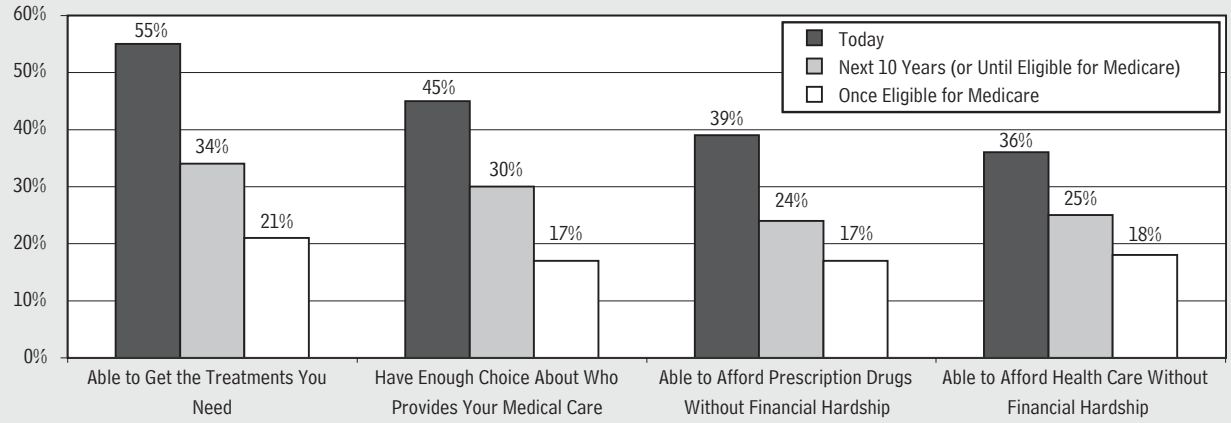
SATISFACTION WITH QUALITY OF CARE RECEIVED AMONG THOSE RECEIVING CARE IN THE PAST TWO YEARS



Source: Employee Benefit Research Institute, Consumer Health Education Council, and Matthew Greenwald & Associates, Inc., 1998–2002, Health Confidence Surveys.

Figure 29

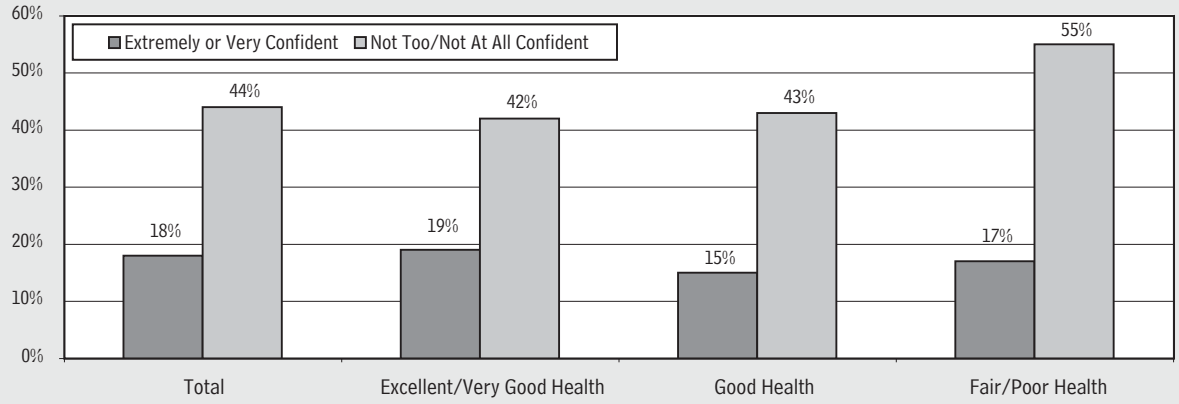
EXTREMELY OR VERY CONFIDENT IN CERTAIN ASPECTS OF HEALTH CARE TODAY, IN THE NEXT 10 YEARS, AND ONCE ELIGIBLE FOR MEDICARE



Source: Employee Benefit Research Institute, Consumer Health Education Council, and Matthew Greenwald & Associated, Inc., 2002 Health Confidence Survey.

Figure 30

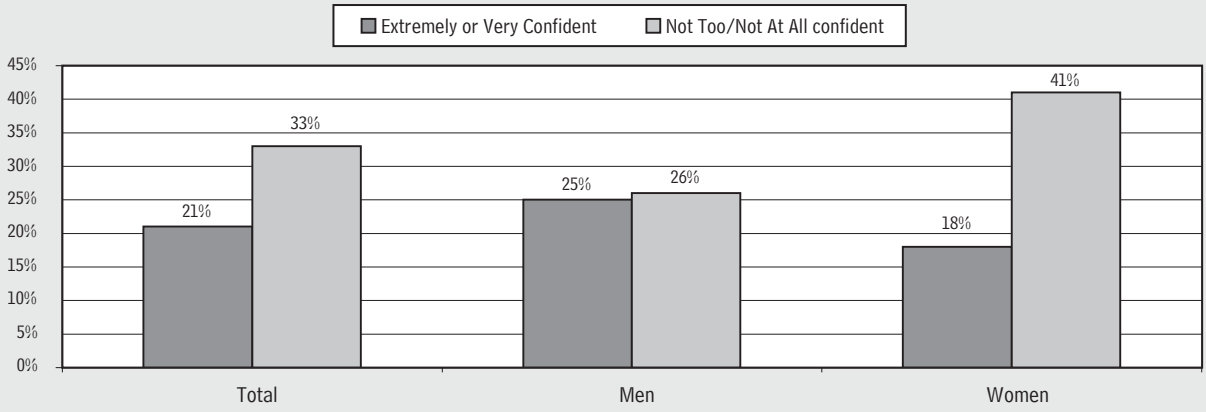
CONFIDENCE IN ABILITY TO AFFORD HEALTH CARE WITHOUT FINANCIAL HARDSHIP ONCE ELIGIBLE FOR MEDICARE, BY HEALTH STATUS



Source: Employee Benefit Research Institute, Consumer Health Education Council, and Matthew Greenwald & Associates, Inc., 2002 Health Confidence Survey.

Figure 31

CONFIDENCE IN ABILITY TO GET NEEDED TREATMENTS ONCE ELIGIBLE FOR MEDICARE, BY GENDER



Source: Employee Benefit Research Institute, Consumer Health Education Council, and Matthew Greenwald & Associates, Inc., 2002 Health Confidence Survey.

Figure 32
REASONS FOR OFFERING A HEALTH PLAN, 2000 AND 2002

	Major Reasons		Minor Reasons	
	2000	2002	2000	2002
It is the right thing to do	71%	77%	17%	15%
It helps with employee recruitment	58	45	22	30
It increases loyalty and decreases turnover	53	52	27	26
It increases productivity by keeping employees healthy	37	28	33	36
Employees demand or expect it	38	34	31	28
It reduces absenteeism by keeping employees healthy	31	24	37	34
Competitors offer it	35	29	30	28
Tax deductible for the employer	23	18	38	42
Not included in taxable income for employees	11	15	35	32
One or more employees have medical problems	11	11	23	19

Source: Employee Benefit Research Institute, Consumer Health Education Council, Blue Cross/Blue Shield Association, 2002 Small Employer Health Benefits Survey.

Section 8: Small Employers and Health Benefits

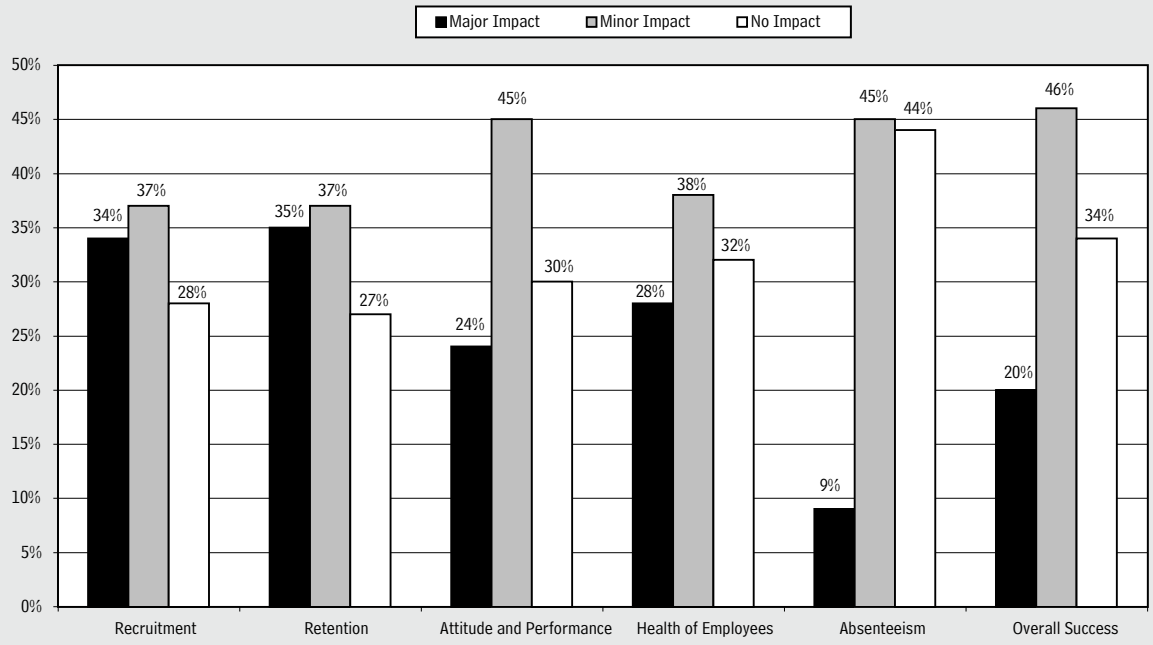
In 2002, EBRI, the Consumer Health Education Council, and Blue Cross/Blue Shield Association commissioned a survey of small employers—defined as those with 50 employees or less. The goal of the survey was to gather information to better understand how to get more small employers to offer health benefits.

Most small employers that do offer health benefits do so for sound business reasons. Many report that it helps with employee recruitment and retention and increases productivity. More than three-quarters report that offering health benefits is "the right thing to do" (Figure 32).

Most employers that do offer health benefits report that it has a positive impact on various aspects of the business, such as recruitment, retention, employee attitude and performance, employee health status, and the overall success of the business (Figure 33). Most employers that do not offer health benefits tend to think that not offering them has no negative impact on the above aspects of their business or the overall success of the business. However, those not offering benefits have higher turnover and their employees tend to stay on the job only a few months (Figures 34 and 35).

Figure 33

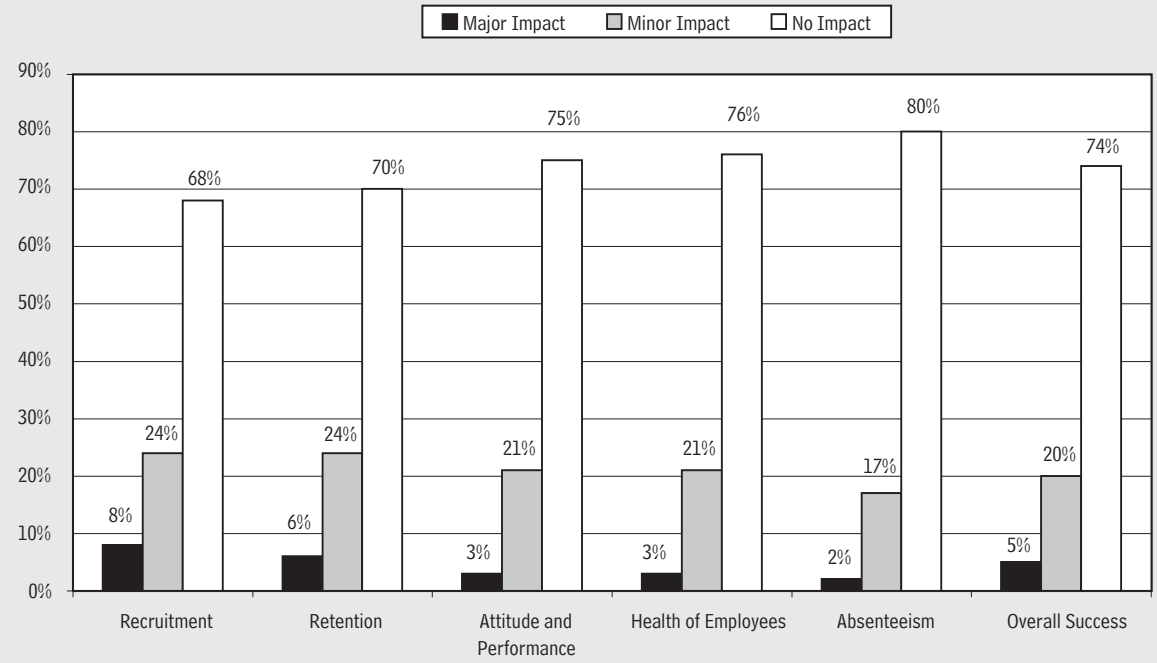
IMPACT OF OFFERING A HEALTH PLAN AMONG FIRMS WITH 50 OR FEWER WORKERS, 2002



Source: Employee Benefit Research Institute, Consumer Health Education Council, and Blue Cross/Blue Shield Association, 2002 Small Employer Health Benefits Survey.

Figure 34

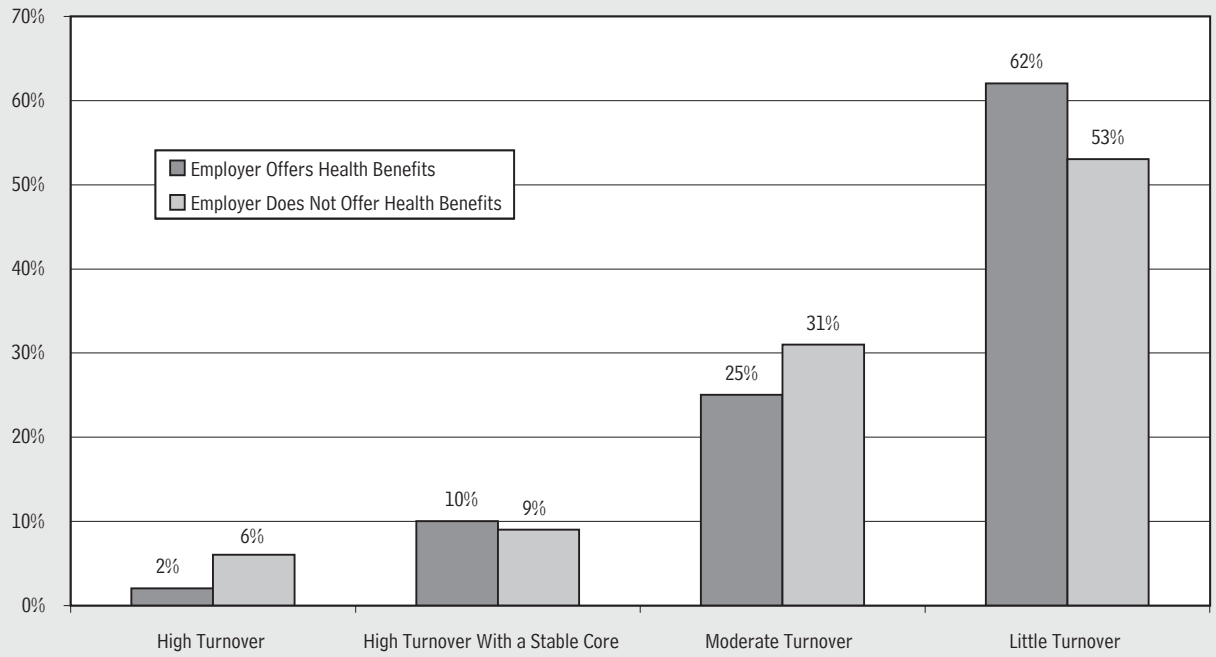
IMPACT OF NOT OFFERING HEALTH BENEFITS AMONG FIRMS WITH 50 OR FEWER WORKERS



Source: Employee Benefit Research Institute, Consumer Health Education Council, Blue Cross/Blue Shield Association, 2002 Small Employer Health Benefits Survey.

Figure 35

EMPLOYEE TURNOVER BY WHETHER EMPLOYER OFFERS HEALTH BENEFITS, 2002



Source: Employee Benefit Research Institute, Consumer Health Education Council, and Blue Cross/Blue Shield Association, 2002 Small Employer Health Benefit Survey.

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The Employee Benefit Research Institute (EBRI) was founded in 1978. Its mission is to contribute to, to encourage, and to enhance the development of sound employee benefit programs and sound public policy through objective research and education. EBRI is the only private, nonprofit, nonpartisan, Washington, DC-based organization committed exclusively to public policy research and education on economic security and employee benefit issues. EBRI's membership includes a cross-section of pension funds, businesses, trade associations, labor unions, health care providers and insurers, government organizations, and service firms.

What we do

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