

Chapter 2: Private Health Coverage

More than six out of every 10 Americans under age 65 had private health coverage in 2005, either through their employment or purchased individually.¹ This is in contrast to countries such as Canada or Great Britain, where people obtain their health coverage through government agencies. Since private coverage (especially employer-sponsored coverage) is the major source of health care coverage within the U.S. health care system, many proposals to expand health coverage in the U.S. have focused on making it more available.

PRIVATE COVERAGE THROUGH EMPLOYERS

More than 162 million individuals under age 65 had some form of employment-based health benefits during 2005, according to the U.S. Census Bureau.² (See chart, “Sources of Health Coverage in the U.S. 2005.”)

Between 2000 and 2004, the number and percentage of individuals with employer-based health benefits declined each year. In 2005, the number grew, while the percentage continued shrinking, to 62.8 percent.³ (See chart, “Trends in Employer-Based Coverage, 2000 - 2005.”). Most of the slippage occurred among small firms. The percentage of firms with 199 or fewer employees offering health benefits declined

from 68 percent in 2000 to 60 percent in 2006. (See chart, “Percentage of Firms Offering Health Benefits, by Firm Size, Selected Years.”)

The rising cost to both employers and employees of paying for health benefits is a key reason for the decline in coverage. Health insurance premiums for a family of four increased 87 percent between 2000 and 2006. Rising costs impact the percentage of employers offering coverage, the percentage of workers eligible for it, and the percentage of workers who take it when offered. (For information on factors behind rising costs, see Chapter 8, “Health Care Costs.”)

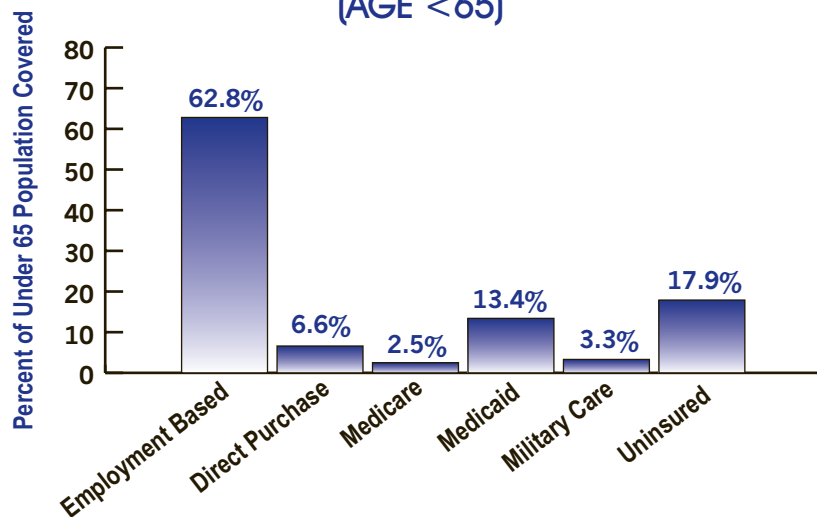
The cost of coverage also affects the bottom line for both businesses and workers, and is prompting some employers to reduce benefits offered and shift more of the costs of coverage to employees. According to Mercer Human Resources Consulting, “A key tactic employers used to lower their 2005 cost increase was again cost shifting.”⁴ This means employees are being asked to pay more out-of-pocket for their care before their insurance begins paying providers. Furthermore, they are being asked to pay a higher percentage of the bill once insurance “kicks in,” as will be discussed later. (See the section titled “Premium Trends and Cost Containment Efforts.”) Shifting the

KEY FACTS

- 162.2 million Americans under age 65 were covered by employment-based health benefits during 2005, according to the Census Bureau. This was 62.8 percent of the under-65 population, a decline from 67.7 percent in 2000.^a
- 17.1 million individuals under age 65 purchased health insurance directly from an insurer in 2005, the Census Bureau says.^b
- Some 60 percent of employers with 3 – 199 workers offered health benefits in 2006, compared to 98 percent among employers with 200 or more workers.^c
- A lower percentage of smaller employers offered health benefits in 2006 compared to 2000 – 60 percent vs. 68 percent.^d
- In 1993, 46 percent of employers with 500 or more workers offered health benefits to early retirees and 40 percent offered them to Medicare-eligible retirees. By 2005, only 29 percent offered them to early retirees and 21 percent to Medicare-eligible retirees.^e
- The average premium cost for job-related coverage in 2006 was \$4,242 (\$627 from the worker, \$3,615 from the employer). For family coverage, the average premium was \$11,480 (\$2,973 from the worker, \$8,508 from the employer).^f
- Almost 3.2 million people were covered by health savings accounts linked to high-deductible health plans in January 2006.^g

**For story ideas on private health coverage, see page 27.
A list of experts and websites also begins on page 27.**

SOURCES FOR HEALTH COVERAGE IN THE U.S., 2005 (AGE < 65)



Note: Figures total more than 100% because some individuals have coverage from more than one source.

Source: U.S. Census Bureau (2006). "Table HI-6. Health Insurance Coverage Status and Type of Coverage by State --People Under 65: 1987 to 2005." August 31. (www.census.gov/hhes/www/hlthins/historic/hihist6.html)

cost of coverage to employees results in a lower insurance premium for employers than would otherwise be the case.

Despite employer concerns over health care costs, many employers and workers alike regard health insurance as an important benefit that can be used as a recruitment and retention tool. In a 2005 study, only 2 percent of larger employers reported that they were very or somewhat likely to drop health benefits in 2006.⁵

Sixty percent of workers reported in 2004 that health insurance was the most important benefit in the workplace, followed by 17 percent choosing a retirement savings plan.⁶ Likewise, nearly 60 percent of employers responding to a 2003 survey believed it was very important to make health insurance available to their workers, either by providing it directly or by contributing to a fund to cover the uninsured.⁷

There are many advantages to employer-based coverage. It is generally cheaper to receive the same covered services through employer-based insurance than if the employee were to shop for coverage on his or her own. An employer, representing many employees, naturally has more clout in negotiating

prices with health plans than any individual employee. Insuring a group of employees also represents less overhead cost per person for health plans than insuring an individual.

In addition, buying health coverage for a group of employees means spreading the insurer's financial risk. Most people in the group will have minimal medical expenses, balancing the small number who will need expensive care. This generally leads to lower insurance rates for groups.

There are disadvantages to job-based coverage as well. Since employers aren't required to offer coverage, not all workers have access to it. Losing a job or deciding to start one's own business could result in loss of

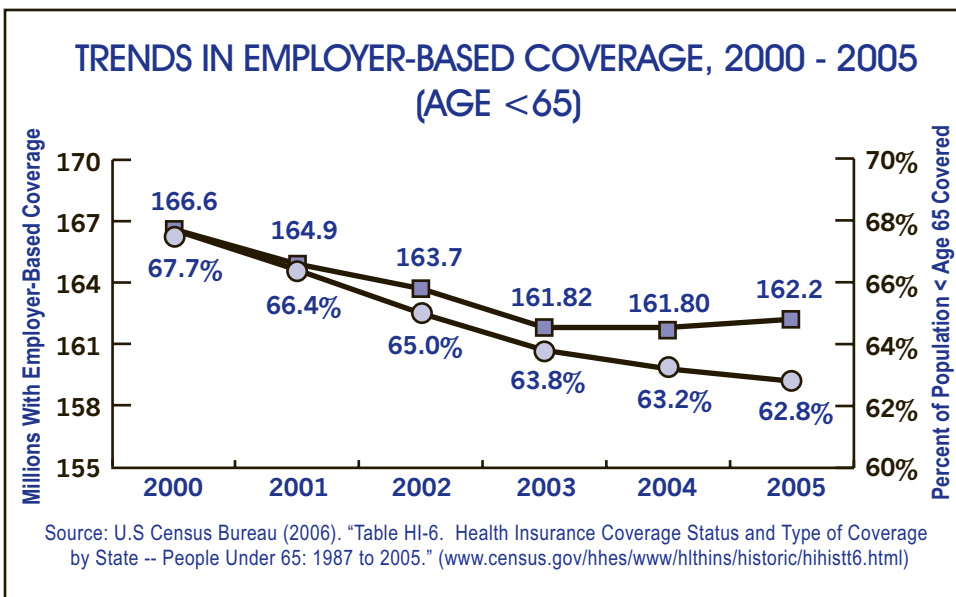
coverage, as could divorce, retirement or shift to part-time status. (In the case of job loss, coverage can be maintained for 18 months or longer if certain conditions are met. See the box, "COBRA: Temporary Health Coverage.")

Some workers simply can't afford their share of premiums or other cost-sharing even when offered employer-based insurance. A study by the Robert Wood Johnson Foundation found that between 1998 and 2003, the portion of private sector employees offered coverage but declining to enroll rose from 14.7 percent to 19.7 percent.⁸

INDIVIDUAL COVERAGE

The individual (or "non-group") insurance market may be the only alternative for those who do not have access to employer sponsored coverage, cannot afford their share of the premium for employment-based coverage, or do not qualify for government programs.

Compared to the number of Americans with employment-based coverage, the individual market is small. About 17 million Americans under age 65 – 6.6 percent of that population – had individually purchased health insurance in 2005.⁹ One study



concluded that more than one in four working-age adults bought or considered buying coverage in the individual market over a three-year period.¹⁰

Health insurance in the individual market is more expensive than employer-sponsored coverage for several reasons. Almost seven out of 10 people (69 percent) who sought individual coverage in 2001 had difficulty finding a plan they could afford, one survey found.¹¹ Marketing and administrative costs per insured person are much higher for policies sold one-by-one rather than to groups. In addition, people buying individual coverage must pay the full premium. In contrast, those enrolled in employment-based coverage in 2005 paid an average of 16 percent of the total premium for themselves alone or 26 percent for family coverage, with the remainder covered by the employer.¹²

Individuals with health problems have an additional disadvantage. Insurance companies in most states are allowed to engage in "medical underwriting." This involves setting the premium based on the likelihood that an applicant will need a large amount of health services. Thus, insurance companies usually charge more to those who are older or in ill health, than to younger, healthier people. Also, insurers are typically allowed to deny or delay coverage for particular conditions. For instance, a person with diabetes might be offered a policy covering all medical needs except diabetes and its complications. Or insurers can simply deny coverage altogether.¹³

PREMIUM TRENDS AND COST CONTAINMENT EFFORTS

In 2006, premiums increased 7.7 percent for employment-based health insurance, the third straight year of declines in premium growth. Even so, premiums continue to dramatically outpace inflation (3.5 percent), wage increases (3.8 percent) and growth in gross domestic product (2.6 percent).¹⁴ (See

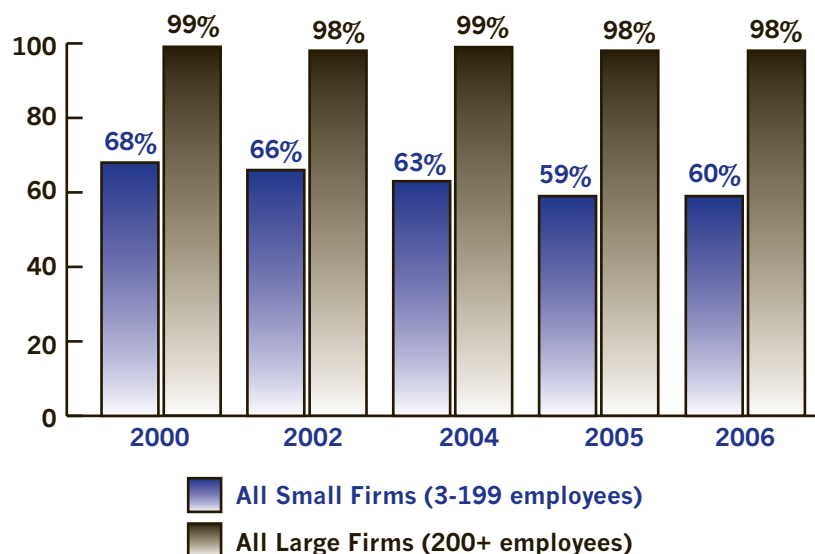
chart, "Cost of Health Insurance Premiums Continues Rising Faster than Earnings, Inflation or GDP.") This means that health costs consume a bigger share of corporate spending and a bigger share of the average household budget.

Analysts predict short-term increases in the high single digits. Analysts also suggest that employers in the 2006 – 2011 period will manage costs by promoting "informed and responsible" health spending by their employees, by using disease management programs, and by other cost containment efforts.¹⁵

The cost of health insurance is now a significant item for both the worker and the employer. The average premium for 2006 was \$4,242 for a single worker, with the worker's share at \$627 and the company paying \$3,615. The average cost of family coverage for the year was \$11,480, with the worker paying \$2,973 of this premium, and the employer paying \$8,508.¹⁶

As premiums have increased, employers have increasingly shifted costs to workers. However, since insurers avoid insuring only the sickest workers by requiring high levels of participation in a given firm, employers do not want to deter enrollment by requiring their employees to pay a higher percentage of the total premium.¹⁷ Instead, employers have been structuring policies -- usually through increases in the deductibles and copayments -- so that the worker must spend more of his or her own money when

PERCENTAGE OF FIRMS OFFERING HEALTH BENEFITS, BY FIRM SIZE, SELECTED YEARS



Source: Kaiser Family Foundation and Health Research and Educational Trust (2006).
 "Employer Health Benefits: 2006 Annual Survey," Exhibit 2.2.
 (www.kff.org/insurance/7527/upload/7527.pdf)

using the health care system. (A deductible is the amount a beneficiary must pay directly to a health care provider before the person's health insurance begins paying anything. A copayment is the portion of the person's medical bill that is not covered by insurance, and thus must be paid out-of-pocket.)

For instance, the percentage of employers requiring employees to pay a deductible when using in-network services in a preferred provider organization rose from 73 percent in 2004 to 80 percent in 2005. The portion of employers requiring a copayment for in-network office visits almost doubled – from 5 percent to 9 percent.¹⁸

The amount of the annual deductible has been rising steeply for all type of health plans. For conventional health insurance, the deductible for individual coverage (i.e. not family) was 2.4 times as high in 2005 (\$602) as in 1999 (\$249). For preferred provider organization (PPO) coverage, the deductible was 1.7 times as high in 2005 as six years earlier (\$323 vs. \$106). The deductible for HMOs more than doubled between 2003 and 2005, from \$30 to \$71.¹⁹

Employers also are more likely to encourage

employee cost-consciousness when using prescription drugs. "Tiered" strategies are often used and require employees to pay less for generic drugs, more for brand name drugs; less for mail-ordered drugs, more for drugs from a pharmacy. Similarly some employment-based health plans now include tiered hospital networks, meaning patients pay less to use certain hospitals, more to use other hospitals.

In recent years, the cost-sharing strategy has spawned "consumer-directed health plans" in which high-deductible health plans are combined with health reimbursement arrangements (HRAs) or health savings accounts (HSAs). (See the glossary for definitions.) Almost 3.2 million people were covered by HSAs linked to high-deductible health plans in January 2006.²⁰

These approaches increase patients' financial stake by having them pay for covered services from their account until the high deductible is met. In the case of an HSA, services that are not covered can also be paid from a patient's account. As of mid-2006, there is little research to suggest what impact consumer-directed health plans will have on health spending.

Health information technology also has been touted as a way to reduce costs. One study estimated that if 90 percent of all hospitals and doctors' offices were to adopt electronic medical record systems by 2018, \$77 billion could be saved annually. Most of the savings would come from reduced hospital lengths-of-stay, nurses' administrative time, drug usage in hospitals, and drug and radiology use in the outpatient setting.²¹ This amount, though substantial, is less than 2 percent of projected future health spending by then.²²

Past efforts to trim health care spending have not produced encouraging outcomes. A frequently cited 2002 article, "The Sad History Of Health Care Cost Containment As Told In One Chart," shows that between 1961 and the late 1990s, any progress in

COBRA: Temporary Health Coverage (adapted from U.S. Department of Labor)

Consolidated Omnibus Budget Reconciliation Act (COBRA) provides certain former employees and their families the right to temporary continuation of health coverage at group rates. Group health coverage for COBRA participants is usually more expensive than health coverage for active employees, since COBRA participants generally pay the entire health insurance premium themselves. It is ordinarily less expensive, though, than individual health coverage.

This coverage is only available when previous group coverage is lost due to certain specific events. These "qualifying events" differ for employees, spouses and dependent children. (For details, see "Frequently Asked Questions about COBRA Continuation Health Coverage" at the U.S. Department of Labor website -- www.dol.gov/ebsa/faqs/faq_consumer_cobra.html).

If you are the employee, you are eligible for COBRA if your employment is terminated for reasons other than gross misconduct, or if you lose coverage due to a reduction in the number of hours you work. (This assumes that you were enrolled in your employer's health plan when you worked, and that the health plan continues in effect for active employees. It also assumes that you worked for a private-sector employer with 20 or more employees, an employee organization, or a state or local government.)

In certain cases, a retired employee and family may be qualified beneficiaries. With some exceptions, COBRA coverage is available for up to 18 months.

Source: U.S. Department of Labor. "Frequently Asked Questions About COBRA Continuation Health Coverage." (www.dol.gov/ebsa/faqs/faq_consumer_cobra.html)

reducing the growth in private health spending has been followed by a rebound to previous growth rates in fairly short order.²³

RETIREE COVERAGE

About 10 million retirees ages 55 - 64 have health coverage through their former employers.²⁴ Furthermore, 13 million individuals ages 65 and older have some form of employment-based health benefits – either as an active worker or a retiree.²⁵

But this benefit is becoming much less common. In 1993, 46 percent of employers with 500 or more workers offered health benefits to early retirees and 40 percent offered them to Medicare-eligible retirees. By 2005, only 29 percent offered them to early retirees and 21 percent to Medicare-eligible retirees.²⁶

Employers have cut back on retiree health benefits in part because the Financial Accounting Standards Board²⁷ requires that firms account for retiree health benefits on an accrued basis: they must estimate their total future obligations to retirees, and place this potentially considerable figure on the balance sheet.

To make spending more predictable and affordable, companies have been imposing "caps" – limits on

their obligations even in the face of steadily rising costs each year. Nearly two-thirds (63 percent) of large employers have caps on the share they will spend for the retiree's health coverage for at least one of the plans they offer retirees.²⁸ In contrast, 28 percent of large employers surveyed in 1996 capped their contributions to retiree health plans for retirees younger than 65, and 30 percent capped their contributions for Medicare-eligible retirees.²⁹

When a retiree reaches age 65, Medicare helps cover most health care costs. If the employer continues coverage for the retiree, it typically "wraps around" Medicare, paying for copays, deductibles, and services Medicare doesn't cover. Thus post-65 retiree costs are lower for most employers.

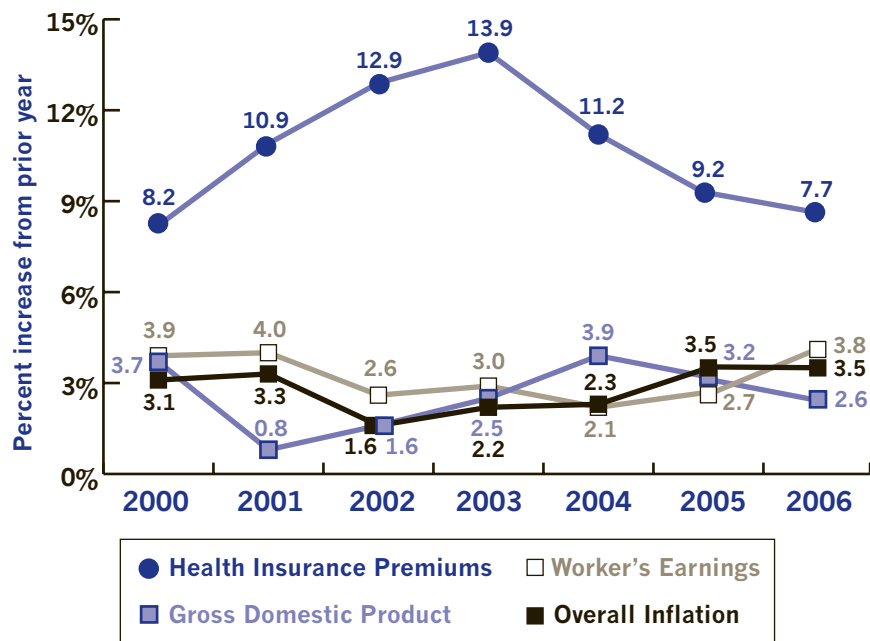
Historically, the cost of outpatient prescription drugs for retirees has concerned employers. Medicare prescription drug benefits will ease some of this burden. (For details, see Chapter 5, "Medicare Prescription Drugs.")

IDEAS TO EXPAND PRIVATE COVERAGE AND REDUCE COSTS³⁰

Tax Credits

The Bush Administration has in the past proposed making tax credits available for individuals to

COST OF HEALTH INSURANCE PREMIUMS CONTINUES RISING FASTER THAN EARNINGS, INFLATION, OR GDP



Note: GDP figure for 2006 is as of the second quarter, annually adjusted (2000 dollars).

Source: Kaiser Family Foundation and Health Research and Educational Trust (2006). "Employer Health Benefits: 2006 Annual Survey." Exhibit 1.1 (www.kff.org/insurance/7527/upload/7527.pdf) and U.S. Department of Commerce, Bureau of Economic Analysis (2006). "Gross Domestic Product: Percent Change from Preceding Period." (www.bea.gov/bea/dn/gdpchg.xls)

Consumer-Directed Health Plans

Proposals have been made to expand the use of HSAs, the fastest-growing type of consumer-directed plan, by allowing individuals who purchase HSA-based plans in the non-group market to deduct the full premiums from taxable income, and by providing tax incentives (such as tax credits) to individuals and small businesses to take up HSA-based plans. The availability of HSAs may expand health insurance coverage if previously uninsured individuals value such plans, and if the lower premiums (with or without the tax credits) make insurance more affordable. Recent estimates, however, indicate that HSAs would have a minimal net impact on the overall rate of uninsured.³³

purchase high deductible health insurance. Such tax credits would be refundable, so that individuals who pay little or no taxes would be eligible for the full credit, and advanceable, so that funds would be available to pay premiums before annual tax filing. Tax credits could be used by workers or others who lack access to health insurance to purchase individual insurance, to pay premiums for workers who are in between jobs, or to help defray the costs of enrolling in employer, public, or other group insurance pools.

Proposed credits typically target people with low or moderate incomes. But it is not clear how attractive these proposals would be to those with more limited incomes. While the average individual and family premiums in 2006 were \$4,242 and \$11,480 respectively,³¹ the maximum credits available in the administration's latest proposal were \$1,000 and \$3,000 respectively.³²

Association Health Plans

Federal legislation designed to promote the formation of association health plans (AHPs) seeks to encourage small businesses to band together to offer health insurance without having to comply with most state regulations. The goal of AHPs is to lower the cost of providing health insurance by allowing broad flexibility in benefit design, financial reserves, and eligibility terms. To the extent that their premiums would be seen as more affordable, AHPs are a possible means to expand the net number of people covered. Critics contend that the absence of state regulation would leave consumers vulnerable to fraud, and would lead to "bankruptcy, delayed or foregone medical care, and loss of coverage for America's small businesses and workers."³⁴

The Congressional Budget Office (CBO) has estimated that by 2010, about 620,000 more people would be insured through small employers offering AHPs. In total, about 8.5 million people would obtain coverage in this way, CBO estimates.³⁵ Future prospects for this strategy are unclear, however. As

What's ERISA?

ERISA – the Employee Retirement Income Security Act – was enacted by Congress in 1974, mainly to protect workers' pensions. But the law also sets uniform standards for private multi-state, employer-sponsored health plans, such as the self-insured plans mentioned above. The intent was to give workers some minimum procedural protections, while allowing large employers to offer the same health insurance package in multiple states by clearing away the obstacles posed by conflicting state laws. Its supporters credit ERISA with helping expand health insurance to millions of workers by easing administrative and regulatory burdens on large employers. Yet some policymakers view a number of provisions in ERISA as anti-consumer.

For example, if a worker covered by an ERISA-regulated plan believes he or she has been wrongly denied a benefit, for instance a cancer test, and subsequently is diagnosed with cancer, he or she cannot sue for resulting damages in state court. This is because ERISA preempts any state law related to the wrongful denial or delay of health benefits in a health plan sponsored by a private employer.

ERISA does allow suits against health insurers and employers, but only in federal court, and only for the immediate value of the medical care denied, not for resulting economic loss, or for non-economic or punitive damages. Given the expense and difficulty of the legal process, those provisions have effectively closed off

of mid-2006, AHP legislation had passed in the U.S. House of Representative eight times, but never in the Senate, where opponents have more influence.

Small Business Health Plans

A congressional proposal that built on AHPs was the Health Insurance Marketplace Modernization and Affordability Act of 2005. This bill, which stalled in Congress in 2006, sought to make health coverage more affordable for small businesses by allowing small firms to join together nationwide to purchase coverage.

Proponents said such plans could save 15 to 20 percent in insurance costs for participating firms.³⁶ Supporters of the bill said its provisions to preempt state-mandated benefits would promote more affordable health insurance choices, and more lenient rating rules would make coverage more affordable for most small employers whose workers are healthy.

Critics claimed that small business plans would attract healthier workers. This would leave sicker workers with more expensive health needs to be covered through other plans, forcing premiums for these plans to increase. And as with AHPs, critics feared the loss of state-mandated benefits and the consumer protections that come with state regulation. Critics also pointed out that small business health plans, as described in the legislation, could refuse to cover employees for conditions such as cancer or diabetes, and could offer services without being licensed.³⁷

Reinsurance

Reinsurance – insurance designed to limit losses for insurers and for employers with self-insured plans – has been proposed as a way to make insurance more affordable and expand coverage. A government-backed reinsurance program would assume responsibility for the bulk of health care expenses above a given, comparatively high, threshold. This would mean that insurers and employers would not have to bear the full risk for aggregate or individual expenses that exceed some predetermined level. Like tax credits, a reinsurance program aims to lower the costs of health insurance premiums.

Reinsurance factors into proposals on both sides of the political aisle. Sen. John Kerry (D – Mass.) and Senate Majority Leader William H. Frist (R-Tenn.) both have spoken favorably of the idea.^{38,39}

Senator Kerry says his plan would “reimburse a percentage of the highest cost cases if you (the employer) include preventative care and health promotion benefits in your plan and implement practices proven to make care affordable. This means lower costs and lower premiums for both employers and employees.” Senator Frist calls for “a new national publicly-chartered, privately-run ‘Healthy Mae.’ This would help insurers more broadly share risk, reduce administrative costs, and create a vibrant secondary market for health insurance just as we have done for home mortgages. It would make health insurance—particularly in the individual market—more stable and affordable.”

Competition Across State Lines

One congressional proposal sought to override state regulations governing health insurance to enable groups and individuals to purchase coverage across state lines. Insurance purchased out of state would be exempt from the laws and regulations of the purchaser's state with respect to consumer protections, mandated coverage of services or benefits, financial reserves, and other rules affecting the sale of individual health insurance. After weighing the offsetting effects, the Congressional Budget Office estimated that such a proposal would produce "no substantial effect" on the number of people with health coverage.⁴⁰

State High-Risk Pools

State high-risk pools serve as a safety net for individuals who are unable to purchase health insurance coverage in the private market due to their preexisting conditions. At the end of 2004, 32 states operated high risk pools, collectively providing coverage for 180,879 individuals.⁴¹ (See box, "States with High-Risk Pools as of December 2004.") These pools provide a safety net for some individuals with high health risks and can reduce reliance on Medicaid programs in these states.

Limited funding has meant that some states have caps or waiting lists to restrict eligibility and stay within budget. (Florida's program, for instance, has been closed to new enrollees since 1991.) High-risk pools often apply waiting periods for those who qualify before benefits begin or for preexisting conditions.⁴² Premiums in high-risk pools tend to be high, and they often have considerable front-end deductibles. As a result, many eligible individuals find that they cannot afford the premiums, which can be as high as 150 percent of the average for comparable plans.

State Encouragement of Private Coverage

Several states have developed innovative insurance expansion strategies that encourage or require private coverage. For example, Massachusetts has passed a law requiring all uninsured persons to buy health insurance by July 1, 2007. Uninsured persons making less than 300 percent of the federal poverty level but not eligible for Medicaid will be able to buy policies on an income-based sliding scale with no deductibles. All state residents will be able to purchase "affordable" policies in the private market through a state-run clearinghouse called the

States with High-Risk Pools as of December 2004

Alabama	Missouri
Alaska	Montana
Arkansas	Nebraska
California	New Hampshire
Colorado	New Mexico
Connecticut	North Dakota
Florida*	Oklahoma
Illinois	Oregon
Indiana	South Carolina
Iowa	South Dakota
Kansas	Texas
Kentucky	Utah
Louisiana	Washington
Maryland	West Virginia
Minnesota	Wisconsin
Mississippi	Wyoming

*Florida's pool has been closed to new enrollment since 1991.

Source: Communicating for Agriculture and the Self-Employed, Inc. (2005). "Comprehensive Health Insurance for High-risk Individuals: A state-by-state analysis." (www.selfemployedcountry.org)

Commonwealth Care Health Insurance Connector. Employers with 11 or more full time equivalent employees (FTEs) that don't offer coverage and pay a "fair and reasonable" portion of the premium must pay an annual fee of \$295 per FTE. ^{43,44,45}

Vermont has taken a different approach to encourage the purchase of private coverage. The state will offer a voluntary plan for uninsured residents called Catamount Health. Offered by private insurers, annual premiums are expected to be about \$340 for an individual. Those with incomes below 300

percent of the poverty level will get premium subsidies. Costs to enrollees are fixed; an office visit will cost \$10, for instance, and enrollees will pay 20 percent coinsurance for medical services. Out-of-pocket expenses are capped at \$800 yearly for an individual and \$1,600 for a family using provider in a preferred provider network, and almost double those amounts for out-of-network providers.⁴⁶

Maine's Dirigo program offers a new, privately insured group option and integrates the choices of coverage with publicly supported insurance.⁴⁷ Rhode Island has expanded public insurance options to low income working adults and families through RItE Care. At the same time, Rhode Island created the RItE Share program, which provides premium payment assistance for workers participating in coverage offered by their employers.⁴⁸

States that have included provisions to help low income workers participate in employer plans indicate that such efforts have been "unexpectedly difficult," as one study by The Commonwealth Fund put it. "One reason for low enrollment numbers is that businesses have been less-willing partners than initially anticipated by policymakers," the study said.⁴⁹ Several states are considering support of health insurance purchasing cooperatives.

STORY IDEAS

- What effects are consumer-driven health plans in your area having on covered services, and on costs to workers and employers?
- What actions are retirees in your area taking to compensate for the loss of retiree health benefits?
- What do employers plan to do going forward about their retiree prescription drug coverage programs?
- What actions are employers taking to control health insurance costs? Are these any different from the past?
- What is your state legislature doing to expand private health coverage and hold down costs?

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