

Employer Health Benefits

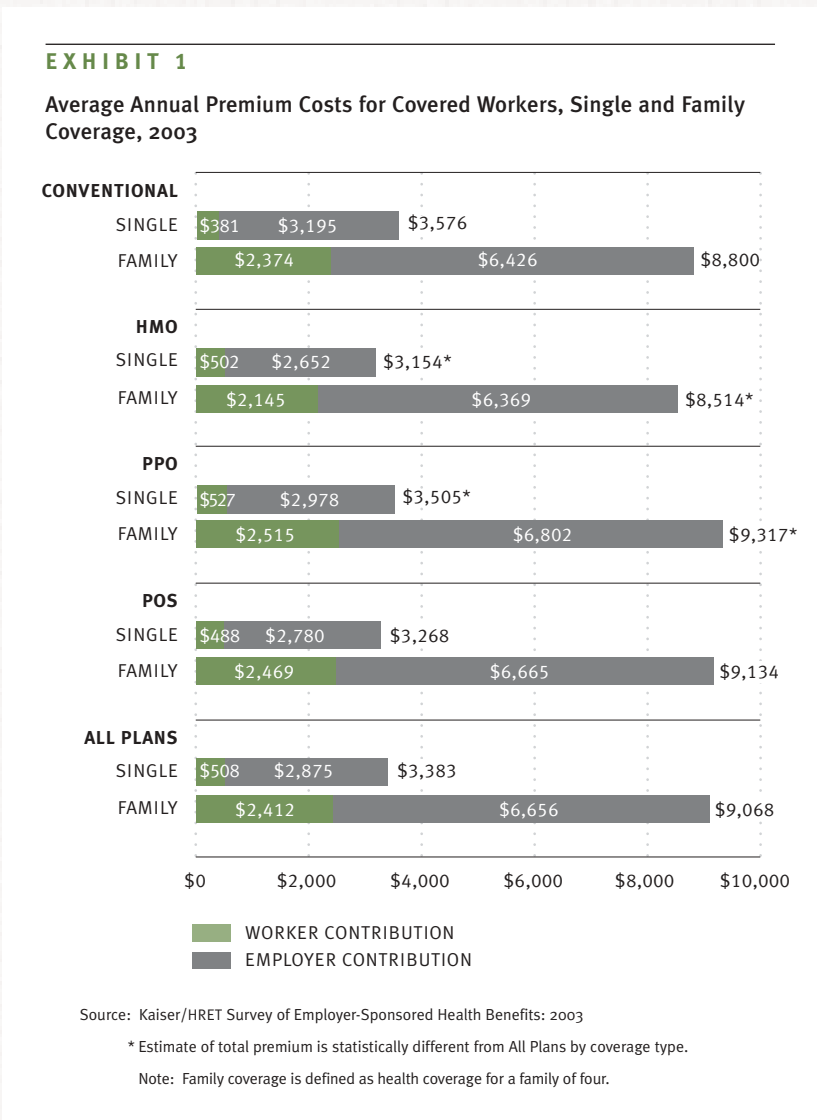
2003 Summary of Findings

EMPLOYER-SPONSORED HEALTH BENEFITS REACH NEARLY THREE OUT OF EVERY FIVE AMERICANS. TO PROVIDE CURRENT INFORMATION ABOUT THE NATURE OF EMPLOYER-PROVIDED HEALTH BENEFITS, THE KAISER FAMILY FOUNDATION AND THE HEALTH RESEARCH AND EDUCATIONAL TRUST CONDUCT AN ANNUAL NATIONAL SURVEY OF EMPLOYERS OF ALL SIZES.

This year's survey reports that despite another year of double-digit premium growth, employers continue to offer health benefits to their workers at the same rate as last year, with few reducing benefits. Workers generally face higher premium contributions for family coverage and higher cost sharing, and the survey finds for the first time that a significant percentage of workers face separate cost sharing for hospital admissions. Looking to the future, many employers, and particularly large employers (200 or more workers), say that they will increase contributions and cost sharing next year, but very few say they will reduce eligibility or drop coverage. A small but significant group of employers say that they are very likely to offer a high-deductible plan in the next year.

HEALTH INSURANCE PREMIUMS

Between spring of 2002 and spring of 2003, monthly premiums for employer-sponsored health insurance rose 13.9%, the third consecutive year of double-digit premium increases and the highest premium increase since 1990 (EXHIBIT 2).¹ Premiums increased substantially faster than overall inflation (2.2%) and wage gains for non-supervisory workers (3.1%). Average rates of increase were similar across firm sizes and industries, but there was significant variability around the average: 20% of employees worked for firms where premiums increased by five percent or less, while



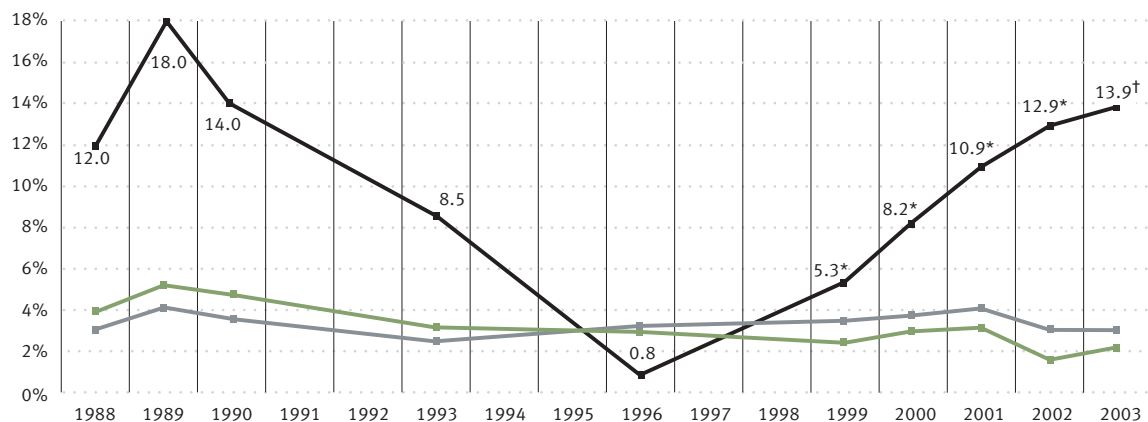
41% of employees worked for firms where premiums increased by more than 15%. Average annual premiums

rose to \$3,383 for single coverage and \$9,068 for family coverage for employer-sponsored coverage (EXHIBIT 1).

¹ The premium increase in 2003 was higher than the increase in 2002 only at the p < 0.1 level.

EXHIBIT 2

Increases in Health Insurance Premiums Compared to Other Indicators, 1988-2003



Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits: 1999, 2000, 2001, 2002, 2003; KPMG Survey of Employer-Sponsored Health Benefits: 1993, 1996; The Health Insurance Association of America (HIAA): 1988, 1989, 1990; Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to April), and Medical Inflation: 1988-2002; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey: 1988-2002.

— HEALTH INSURANCE PREMIUMS
 — OVERALL INFLATION
 — WORKERS' EARNINGS

* Estimate is statistically different from the previous year shown at $p < 0.05$: 1996-1999, 1999-2000, 2000-2001, 2001-2002, 2002-2003.

† Estimate is statistically different from the previous year shown at $p < 0.1$: 2002-2003.

Note: Data on premium increases reflect the cost of health insurance premiums for a family of four.

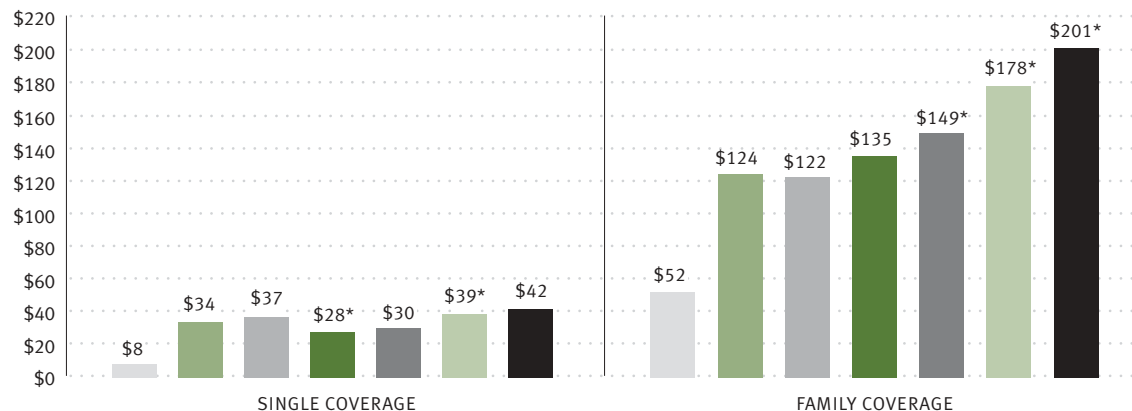
Of all plan types, health maintenance organizations (HMOs) remain the least costly and PPO plans remain the most

expensive for family coverage. Average annual premiums for family coverage in HMO plans are \$8,514 while the

cost for family coverage in Preferred Provider Organization (PPO) Plans – which cover most Americans – is \$9,317.

EXHIBIT 3

Average Monthly Worker Contribution for Single and Family Coverage, 1988-2003



Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits: 2000, 2001, 2002, 2003; KPMG Survey of Employer-Sponsored Health Benefits: 1988, 1993, 1996.

* Estimate is statistically different from the previous year shown: 1996-2000, 2000-2001, 2001-2002, 2002-2003.

1988
 1993
 1996
 2000
 2001
 2002
 2003

Premiums are generally highest in the Northeast and lowest in the West, although premiums increased faster in the West (16.3%) this year than in the rest of the country.

The high rate of premium growth in 2003 appears to have been driven by a combination of rapid inflation in the costs for health care services and insurers' efforts to emphasize profitability in their pricing. Premium equivalents for self-insured plans (a proxy estimate for medical claims expenses) grew by a lower amount (12.4%) than premiums for fully insured plans, which increased 15.6% this year. This finding may indicate that part of the rise in health care premiums is due to insurers expanding their underwriting gains.²

When employers were asked which factors contributed 'a lot' to increases in health insurance premiums, firms were most likely to point to higher spending for prescription drugs (61%) and higher spending for hospital services (55%).

Rapidly increasing premiums have generated speculation that employers may move to new types of health insurance arrangements in order to help control

future costs. The 2003 results show that employers are looking for alternatives to their health plans, with 62% reporting that they shopped for a different arrangement. Of these, 33% reported that they either changed plan types or insurance carriers (EXHIBIT 7).

Despite this willingness to consider alternatives, enrollment to date in high-deductible health plans – defined as a plan with a deductible of more than \$1,000 for single coverage – has been modest. Nonetheless, a greater level of interest by very large employers, who historically have been innovators in the market, may portend future growth of this option. Five percent of all firms, but 17% of jumbo firms (5,000 or more workers), offer a high-deductible plan to at least some of their workers in 2003. Of firms offering a high-deductible plan in 2003, 12% (or less than one percent of all firms nationally) offered a health savings account in conjunction with the plan. A health savings account is a pre-tax account funded by an employer that gives employees a fixed amount of money with which to pay for more routine health care expenses, and allows unspent funds to roll over from one year to the next.

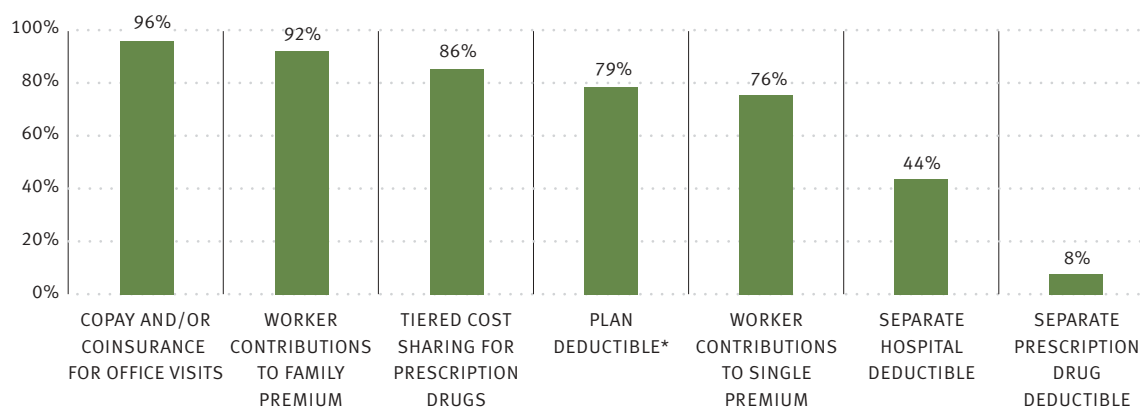
EMPLOYEE CONTRIBUTIONS AND COST SHARING

Most workers pay a portion of the premium cost for job-based coverage. In 2003, workers contributed on average \$508 per year of the \$3,383 annual cost of single coverage and \$2,412 of the \$9,068 cost of premiums for family coverage (EXHIBITS 1 and 3). The percentage of premiums paid by workers is statistically unchanged over the last two years, at 16% for single coverage and 27% for family coverage. The contribution level today for single coverage remains substantially lower than the 21% share of the premium workers were paying in 1996, but the percentage of family premiums paid by employees has been consistent over time.

In addition to their premium contributions, most workers also make additional payments when they use health care services (EXHIBIT 4). Nearly four in five workers face a deductible before health care expenses are covered under their plan. For PPOs, the most common plan type, preferred provider deductibles average \$275 for single coverage, although average deductibles for workers in small firms are considerably higher (\$492).

EXHIBIT 4

Percentage of Covered Workers With the Following Types of Cost Sharing for Health Benefits, 2003



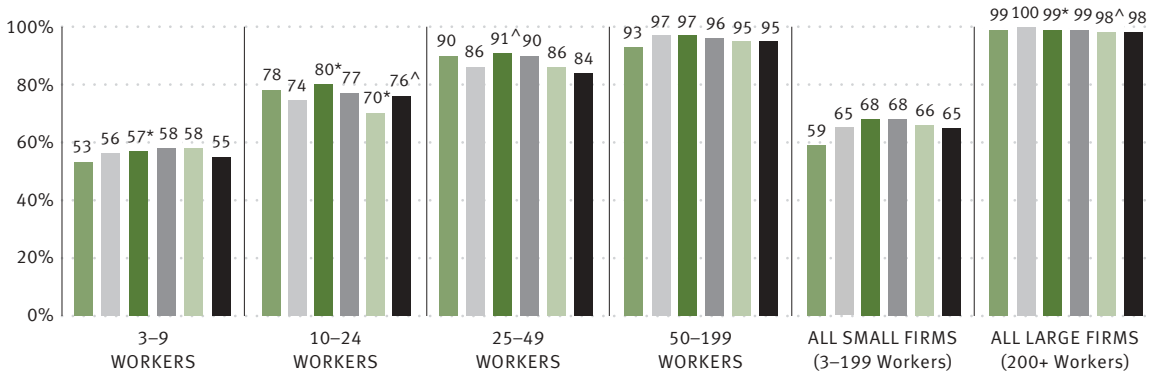
Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits: 2003.

* The percentage of covered workers with a plan deductible is calculated for workers with single coverage. For PPO and POS plans, the deductible for services received from preferred providers is used in the calculation.

² Kipp, R., et al., "Health Insurance Underwriting Cycle Effect on Health Premiums and Profitability," Milliman USA, April 10, 2003.

EXHIBIT 5

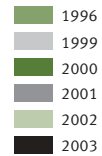
Percentage of Firms Offering Health Benefits, by Firm Size, 1996-2003



Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits: 2000, 2001, 2002, 2003; KPMG Survey of Employer-Sponsored Health Benefits: 1996, 1999.

* Estimate is statistically different from the previous year shown at $p < 0.05$: 1996-1999, 1999-2000, 2000-2001, 2001-2002, 2002-2003.

^ Estimate is statistically different from the previous year shown at $p < 0.1$: 1996-1999, 1999-2000, 2000-2001, 2001-2002, 2002-2003.



More than two in five workers face a separate deductible, copayment or coinsurance when they are admitted to a hospital, averaging about \$200 per admission. Virtually all workers face a copayment or coinsurance for physician office

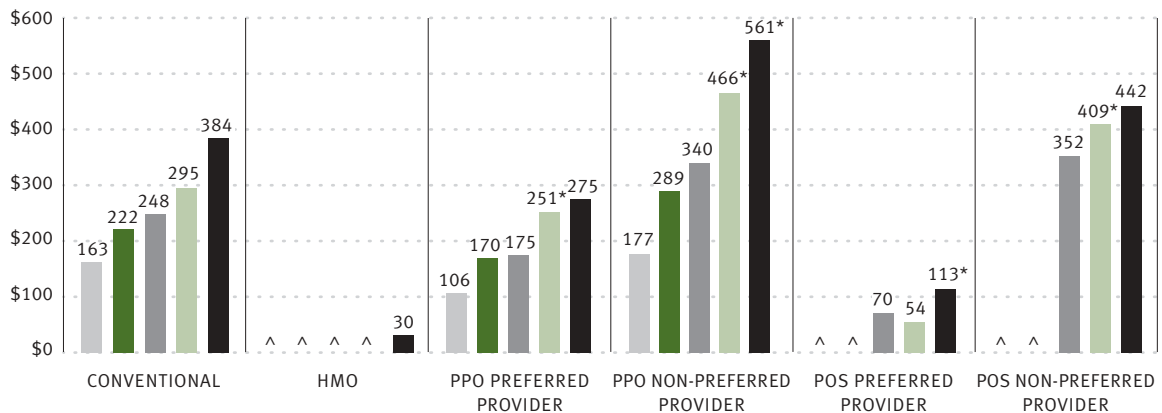
visits, and the vast majority of workers are in a plan that has a tiered cost sharing arrangement for prescription drugs.

The cost sharing amounts paid by workers and their families have been increas-

ing in recent years, and this trend continued in 2003. In PPO plans, the average deductible for services received from non-preferred providers is now \$561, an increase of 20% (EXHIBIT 6). In HMOs, almost one-half of workers now face a

EXHIBIT 6

Average Annual Deductibles for Single Coverage in Conventional, HMO, PPO, and POS Plans, 1988-2003

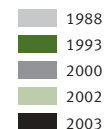


Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits: 2000, 2002, 2003; KPMG Survey of Employer-Sponsored Health Benefits: 1988, 1993.

* Estimate is statistically different from the previous year shown: 2000-2002, 2002-2003.

^ Information was not obtained for HMO plans prior to 2003 or POS plans in 1988 and 1993.

Note: Average deductibles include covered workers who do not have a deductible or report a \$0 deductible. For example, 32% of covered workers in PPOs do not have a deductible for preferred providers. Among single workers enrolled in a PPO who do have a deductible, the average annual preferred provider deductible is \$384.



copayment for outpatient physician services of \$15 or more, up from 37% last year. Copayments for prescription drugs continue to edge upward, averaging \$9 for generic drugs, \$19 for preferred drugs (e.g., brand name drugs with no generic substitutes), and \$29 for non-preferred drugs (e.g., brand name drugs with generic substitutes). In addition, 15% of covered workers are in firms that increased out-of-pocket limits on cost sharing in 2003, which effectively means that these workers now pay more out of pocket before their health plan picks up all of their health care costs.

COVERAGE

For now, the weakened economy and escalating premiums do not appear to have caused a drop in the percentage of employers offering health insurance coverage from last year, but the percentage of firms offering coverage is lower than its pre-recession high (69%) in 2000. In 2003, 66% of all firms offered health coverage to their workers (EXHIBIT 5).

Employer decisions to offer health benefits continue to vary substantially by firm size. Health benefits are offered by only 55% of the smallest companies (three to

nine workers) while 76% of firms with 10 to 24 workers, 84% of firms with 25 to 49 employees, and nearly all firms with 50 or more workers (93%) offer health benefits. Firms with many part-time workers are less likely to offer health benefits – only 32% of firms with a high percentage (35% or more of the workforce) offer health coverage to their employees, compared with 70% of firms with fewer part-time workers. Most firms that employ union workers offer health benefits (91%).

Even when a firm offers health insurance, not all workers get covered. Some employees are not eligible to enroll as a result of waiting periods or minimum work-hour rules, and others choose not to enroll because they must pay a share of the premium or can get coverage through a spouse. In firms that offer coverage, 81% of workers are eligible for coverage, and 83% of those eligible elect to take it. Overall, among firms offering health benefits, 68% of workers have job-based health insurance coverage through their own employer.

RETIREE COVERAGE

The debate over expanding Medicare to cover prescription drug benefits has

brought retiree coverage to the forefront of policy considerations in 2003. While virtually all Medicare beneficiaries with retiree benefits have coverage for prescriptions, the availability of employer-provided retiree health benefits has fallen significantly. In 2003, 38% of all large firms (200 or more workers) offer retiree health coverage, virtually the same percentage as last year but down from 66% in 1988.

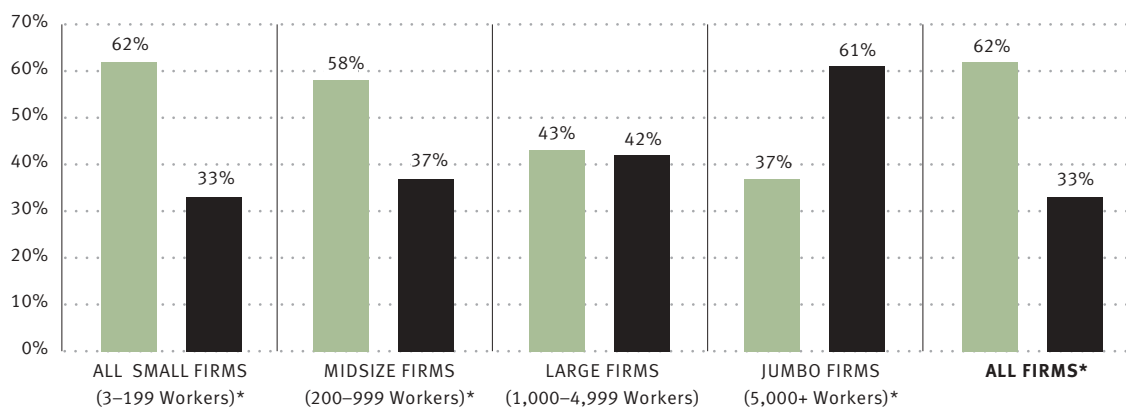
HEALTH PLAN ENROLLMENT AND CHOICE

PPOs continue to be the most common plan in 2003, enrolling just over one-half of all employees with health coverage. HMO enrollment remained stable this year, enrolling 24% of covered workers. Conventional indemnity insurance has all but disappeared, enrolling just 5% of employees.

Most workers with health coverage through their employers continue to have a choice of health plans, with just under one-half having a choice of three or more plans. PPO coverage is available to 77% of workers offered health benefits while the percentage of covered workers with an

EXHIBIT 7

Percentage of Firms That Shopped for a New Plan, and the Percentage of Firms Reporting That They Changed Health Plan Types or Insurance Carriers in the Last Year, by Firm Size, 2003



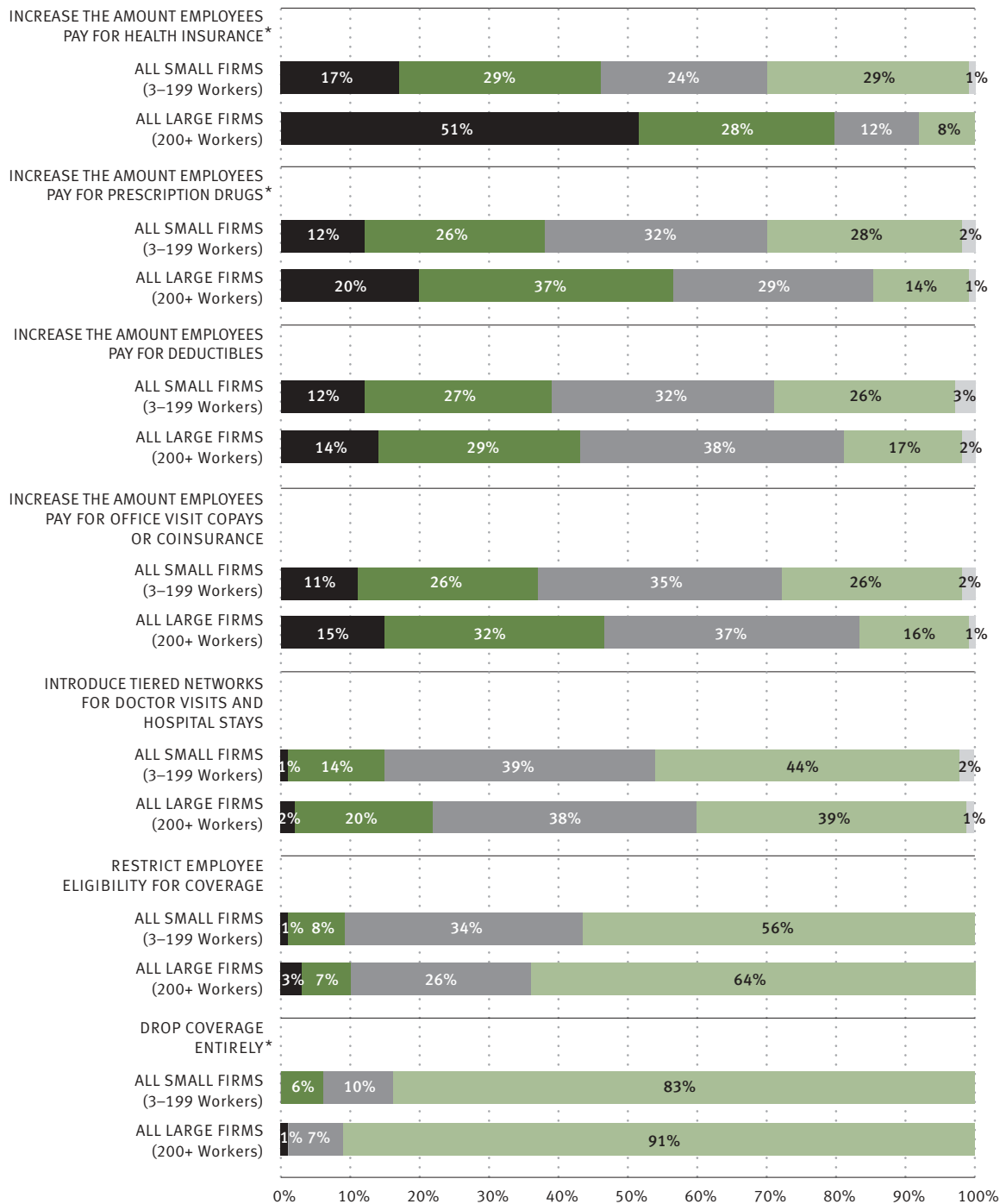
Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits: 2003.

*Estimates are statistically different within firm size.

■ SHOPPED FOR A NEW PLAN
 ■ CHANGED HEALTH PLAN TYPES OR INSURANCE CARRIERS

EXHIBIT 8

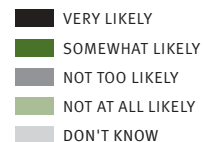
Percentage of Firms That Report They Are Likely to Make the Following Changes in the Next Year, by Firm Size, 2003



Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits: 2003.

* Distributions are statistically different by firm size.

Note: Data for All Firms are nearly identical to data reported for All Small Firms.



HMO option has declined in recent years, from 68% in 1993 to 47% this year. The percentage of workers with an option to enroll in a Point of Service (POS) plan or a conventional plan remains statistically unchanged in 2003, at 30% and 14%, respectively. Small firms (3–199 workers) are much less likely to offer workers a choice of health plans than larger companies — 69% of all small firms that provide coverage offer just one health plan compared to 20% of the largest businesses with 5,000 or more workers.

HEALTH BENEFITS

Most workers experienced no change in benefits (other than cost sharing changes) in 2003, although 13% of covered workers were in firms that reported benefit cuts in the last year and seven percent of covered workers were in firms that experienced benefit increases. In general, larger firms offer somewhat more generous benefits than smaller firms.

This year's survey also added questions about whether the firm offers dental benefits or a flexible spending account. Overall, 39% of firms offer dental benefits, with nine in ten jumbo firms (5,000 or more workers) offering dental coverage (91%). Flexible spending accounts (FSAs) — which allow employees to set aside pre-tax dollars for health-related expenses — are also widely available among the largest firms. In 2003, 83% of jumbo firms (5,000 or more workers) offered an FSA to their workers, compared to 69% of jumbo firms in 1999, while only 14% of small firms (3–199 workers) offered an FSA option.

OUTLOOK FOR THE FUTURE

Despite multiple years of accelerating premium increases and a third straight year of double-digit premium growth, employers made only modest changes to

their health plans in 2003, demonstrating perhaps their reluctance to significantly change the benefits and arrangements that most workers and their families have come to rely upon. Although worker contributions and cost sharing continue to grow, the changes in 2003 were relatively modest given the continued weak job market and magnitude of premium increases.

Although employers made relatively few changes in their health benefit plans, this should not be taken as a sign that they are satisfied with the performance of the current health care system. Rather, the lack of change may well reflect their ambivalence about the options that they have. In the early 1990s, when costs were rising very rapidly, employers turned quickly to managed care, which was portrayed as an alternative that offered more and better benefits at lower costs. In a few short years, however, workers were demanding greater choice and costs began to rise again.³ During this current period of rising premiums, there are few easy or attractive cost-containment choices. Returning to managed care means that employers have to reintroduce management techniques that were extremely unpopular with the public. Consumer-driven health care approaches are unproven and require employers to substantially increase out-of-pocket costs for some of their employees, a move that may be even less popular than managed care.

Employers, however, do not have a high level of confidence that current market strategies can reduce premium growth. This may explain why more significant changes in the marketplace are not being seen. When employers were asked which strategies might be very effective in reducing future cost growth, the most commonly identified approach was disease management, identified by fewer than one-quarter (22%) of employers as very effective in addressing cost increases. Other approaches investi-

gated were: consumer driven health plans (identified as very effective by 14% of employers), higher cost sharing (10% of employers), and tighter managed care networks (six percent of employers). While employers see some benefit in all of these approaches (most employers said each approach would at least be somewhat effective), no approach stands out from the others. This suggests that employers have not identified a future direction for their benefit plans that they believe would relieve current cost pressures.

This lack of consensus among employers makes it difficult to predict what the future will hold. When employers were asked what they are likely to do in 2004, their responses were similar to last years'. Significant percentages (but less than a third) reported that they will increase contributions and cost sharing, but very few say that they will reduce eligibility or drop coverage (EXHIBIT 8). These responses suggest that 2004 may be another year where costs and cost sharing drifts upwards, without dramatic changes in availability of coverage in the market. There are significant indications of employer interest in alternative approaches to health benefit design, with 17% percent of jumbo firms (5,000 or more workers) now offering a high-deductible plan, and another 16% of such firms saying they are highly likely to add such a plan next year. Nine percent of covered workers now work for a firm offering a high-deductible plan and another 11% of covered workers are employed by a firm that is "very likely" to add a high-deductible plan next year. It is not known, however, if employers offer high-deductible plans to all their workers. Jumbo firms (5,000 or more workers) have historically been the catalyst of change in the market. Their interest and any success in reducing premium growth they experience may lead to these plans becoming more widespread.

³ Altman, D. and Levitt, L., "The Sad Story of Cost Containment Told in One Chart", *Health Affairs* Web Exclusive, January 23, 2002.

METHODOLOGY

The Kaiser Family Foundation/Health Research and Educational Trust (Kaiser/HRET) 2003 Annual Employer Health Benefits Survey reports findings from a telephone survey of 2,808 randomly selected public and private employers, including 1,856 who responded to the full survey and 952 who indicated whether or not they provide health coverage. Firms range in size from small enterprises with as few as 3 workers to corporations with more than 300,000 employees. The Kaiser/HRET Employer Health Benefits Survey is based on previous surveys sponsored by the Health Insurance Association of America from 1986–1991 and Bearing Point (KPMG at the time of the surveys) from 1991–1998.

Researchers at Health Research and Educational Trust and the Kaiser Family Foundation designed and analyzed the survey. National Research LLC conducted the fieldwork between January and May, 2003 with an overall response rate of 50%.

This year several changes were made to the survey methodology in order to strengthen the validity of the results. For 2003, the most recently released statistics from the U.S. Census Bureau were used as the basis for calculating the employer weight rather than the Dun & Bradstreet database of the nation's firms used in past surveys. Census data are drawn from a more representative sample of the nation's firms, and indicate that 59% of firms have 3-9 workers, as compared to 74% reported in the Dun & Bradstreet sample. This change had little impact on worker-based estimates since the smallest firms represent less than 10% of all workers.

This year a non-response adjustment was added to reflect the fact that small firms that do not participate in the full survey are less likely to offer health benefits and, consequently, are less likely to answer the single question about whether or not the firm offers health benefits. To make this adjustment, Kaiser/HRET conducted a follow-up survey of all firms with 3-49 workers that did not participate in the full survey. Each of these 1,744 firms was asked the single question, "Does your company offer or contribute to a health insurance program as a benefit to its employees?"

Conducting the follow-up survey accomplished two objectives. First, statistical techniques (a McNemar analysis which was confirmed by a

chi-squared test) demonstrated that the approach used on the follow-up survey – speaking with the person answering the phone rather than a benefits manager – did not bias the results of the follow-up survey. Analyzing firms who responded to the offer question twice, in both the original and follow-up survey, proved that there was no difference in the likelihood that a firm offers coverage based on which employee answered the question about whether a firm offers health benefits.

Second, the follow-up survey demonstrated that very small firms not offering health benefits to their workers are less likely to answer the one survey question about coverage. Kaiser/HRET analyzed the group of firms that only responded to the follow-up survey and performed a t-test between the firms who had responded to the initial survey as well as the follow-up, and those who only responded to the follow-up. Tests confirmed the hypothesis that the firms that did not answer the single offer rate question in the original survey were less likely to offer health benefits. To adjust the offer rate data for this finding, an additional non-response adjustment was applied to increase the weight of firms in our sample that do not offer coverage.

All statistical tests are performed at the 0.05 levels except where otherwise noted. A select set of data were tested at the 0.1 level to explore the possibility of emerging changes in health care premiums, the health benefits offer rate, employee share of premium, and coverage rates.

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