

Employer Health Benefits

2005 Summary of Findings

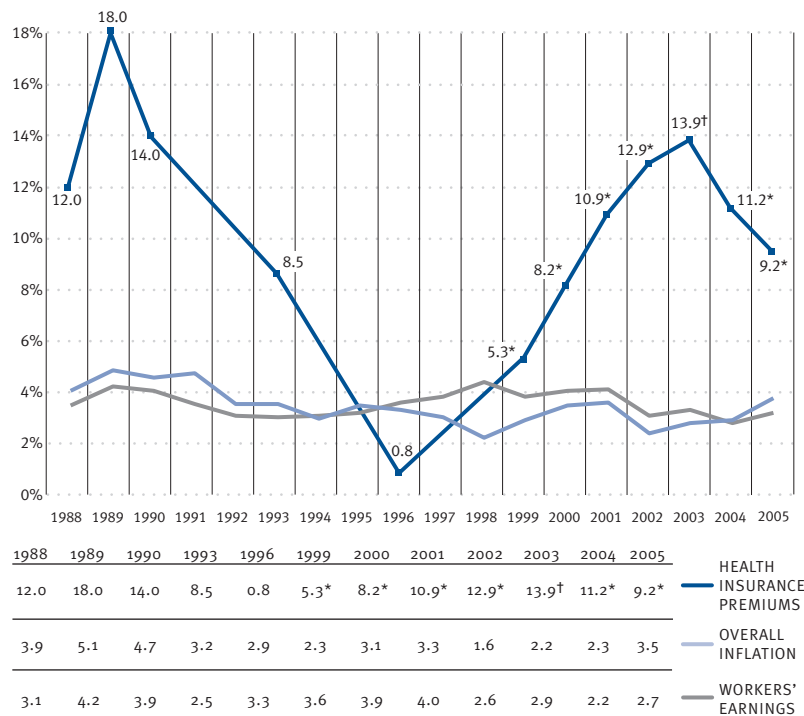
EMPLOYER-SPONSORED HEALTH INSURANCE PROVIDES COVERAGE FOR 160 MILLION AMERICANS, REACHING NEARLY THREE OF EVERY FIVE OF THE NONELDERLY.¹ TO PROVIDE CURRENT INFORMATION ABOUT THE NATURE OF EMPLOYER-SPONSORED HEALTH BENEFITS, THE KAISER FAMILY FOUNDATION (KFF) AND THE HEALTH RESEARCH AND EDUCATIONAL TRUST (HRET) CONDUCT AN ANNUAL NATIONAL SURVEY OF PRIVATE AND PUBLIC EMPLOYERS OF THREE OR MORE WORKERS.

The key findings from this year's survey show that the rate of growth of health insurance premiums declined for the second straight year, slowing to 9.2% in 2005, and that the percentage of all firms offering health benefits to their employees has fallen significantly from 69% to 60% over the last 5 years.

The 2005 findings also show growth in the percentage of firms offering health benefits that offer a high-deductible health plan (HDHP) to at least some of their employees. Twenty percent of firms that offer health benefits offer a high-deductible health plan. These firms are beginning to look at new consumer-driven arrangements. Among all firms that offer health benefits, 1.9% offer an HDHP with a health reimbursement arrangement (HRA), covering 1.6 million workers, and 2.3% offer an HDHP that meets federal requirements enabling a worker to establish a health savings account (HSA), covering 810,000 workers.

EXHIBIT A

Increases in Health Insurance Premiums Compared to Other Indicators, 1988–2005



* Estimate is statistically different from the previous year shown at $p < .05$. No statistical tests were conducted for years prior to 1999.

† Estimate is statistically different from the previous year shown at $p < .10$.

Note: Data on premium increases reflect total health insurance premiums for a family of four. Historical estimates of workers' earnings have been updated to reflect new industry classifications (NAICS).

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits: 1999–2005; 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), 1988–2005; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey (April to April), 1988–2005.

HEALTH INSURANCE PREMIUMS

Between spring of 2004 and spring of 2005, premiums for employer-sponsored health insurance rose by 9.2%, lower than the 11.2% increase in 2004 and the 13.9% increase in 2003

(Exhibit A).² Despite this slowdown, premiums continued to increase much faster than overall inflation (3.5%) and wage gains (2.7%). Since 2000, premiums for family coverage have increased by 73%, compared with inflation growth of 14% and

wage growth of 15%. Average annual premiums for employer-sponsored coverage rose to \$4,024 for single coverage and \$10,880 for family coverage (Exhibit B).

EXHIBIT B

Average Annual Premiums for Covered Workers for Single and Family Coverage, by Plan Type, 2005

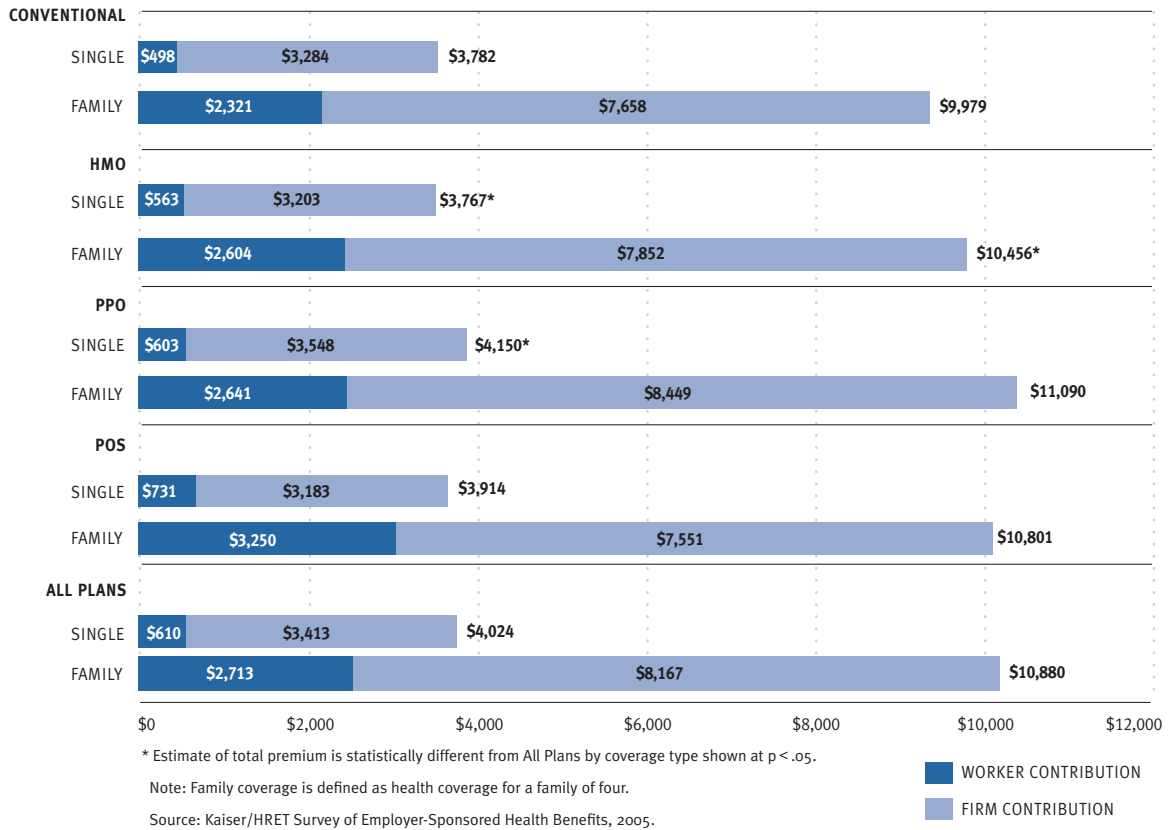
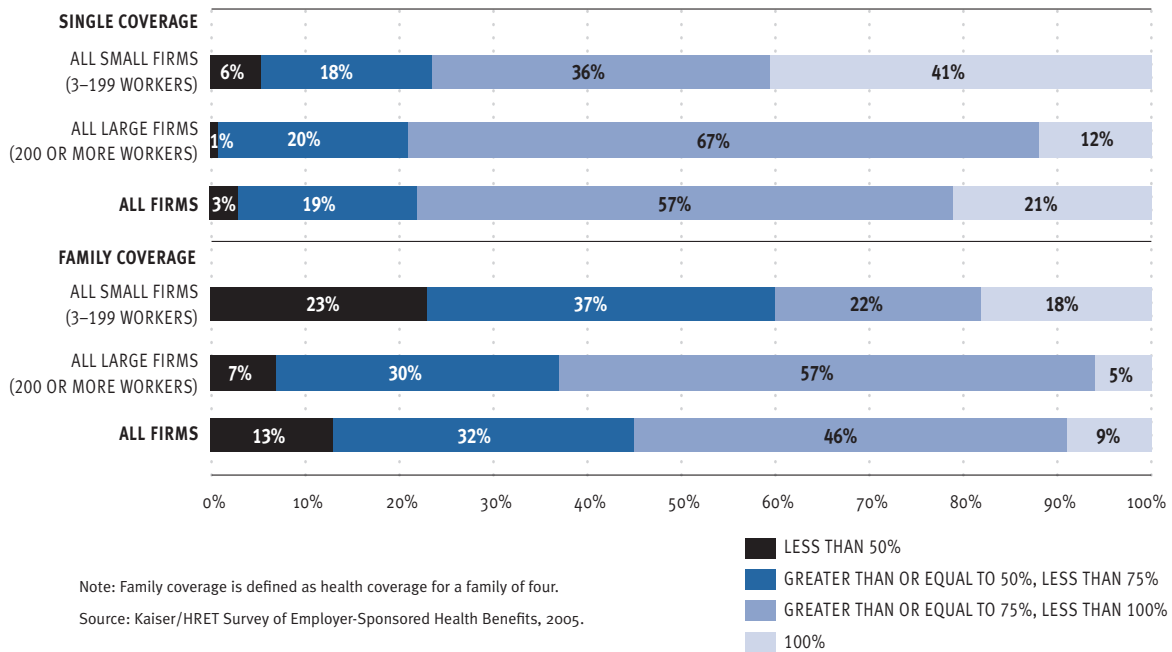


EXHIBIT C

Distribution of Covered Workers by Percentage of Premium Contributed by Their Firm for Single and Family Coverage, by Firm Size, 2005



Although the average premium increase for 2005 is 9.2%, many covered workers are in firms that experienced premium changes that were substantially above or below the average: 32% of covered workers work for firms where premiums increased by 5% or less, while 17% of covered workers work for firms where premiums increased by more than 15%. Premiums in fully insured plans and premium equivalents in self-funded plans grew at similar rates.

Preferred provider organizations (PPOs) cover a majority of covered workers, but health maintenance organizations (HMOs) remain less expensive. The average annual PPO premium is \$4,150 for single coverage and \$11,090 for family coverage, compared to average annual HMO premiums of \$3,767 for single coverage and \$10,456 for family coverage.

Almost 80% of covered workers with single coverage, and over 90% of covered workers with family coverage make a contribution toward premiums

in 2005 (Exhibit C). Workers on average contribute \$610 of the \$4,024 annual cost of single coverage and \$2,713 of the \$10,880 annual cost of family coverage (Exhibit B). Covered workers in small firms (3–199 workers) on average make a significantly higher contribution toward family coverage than covered workers in large firms (200 or more workers) (\$3,170 vs. \$2,487). The average percentage of premiums paid by workers is statistically unchanged over the last several years, at 16% for single coverage and 26% for family coverage (Exhibit D).

EMPLOYEE COST SHARING

In addition to their premium contributions, most workers make payments when they use health care services. Fifty-six percent of covered workers are in a health plan that requires that a deductible be met for single coverage before most plan benefits are provided. In PPOs, the most common plan type, the average deductible for in-network services is

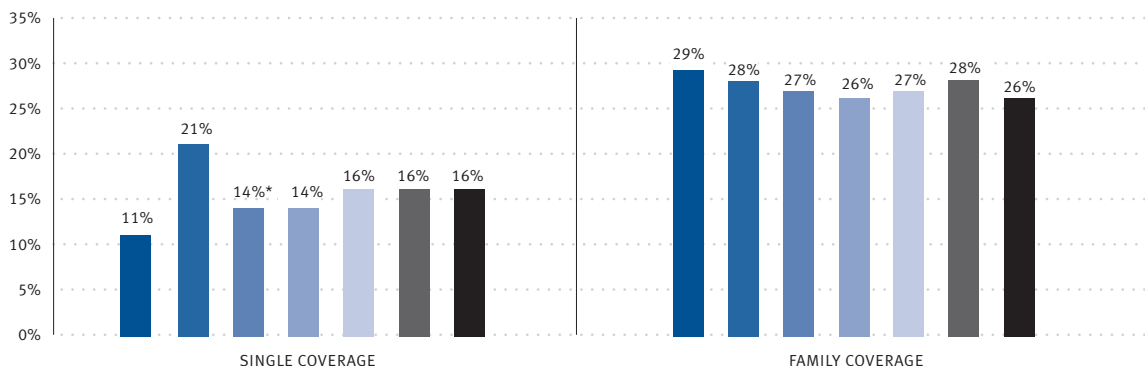
\$323 for single coverage and \$679 for family coverage. Across all plan types, average deductibles for single coverage in small firms (3–199 workers) are substantially higher than average deductibles in large firms (200 or more workers).

More than half of covered workers face separate cost sharing when they are admitted to a hospital. Thirty-six percent of covered workers face a separate deductible or copayment for each hospital admission, with an average payment of \$241. Ten percent of workers face separate coinsurance when they are hospitalized, with an average coinsurance rate of 16%. An additional 3% of workers face both a deductible or copayment and coinsurance when hospitalized.

The vast majority of covered workers face copayments when they go to the doctor or fill a prescription. Copayments for physician office visits changed little in 2005. Forty-four percent of covered workers are in a plan with a \$20 or \$25

EXHIBIT D

Average Percentage of Premium Paid by Covered Workers for Single and Family Coverage, 1988–2005



* Estimate is statistically different from the previous year shown at p < .05. No statistical tests were conducted for years prior to 1999.

Note: Family coverage is defined as health coverage for a family of four.

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999–2005; KPMG Survey of Employer-Sponsored Health Benefits, 1996; The Health Insurance Association of America (HIAA), 1988.

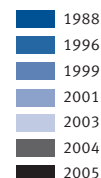
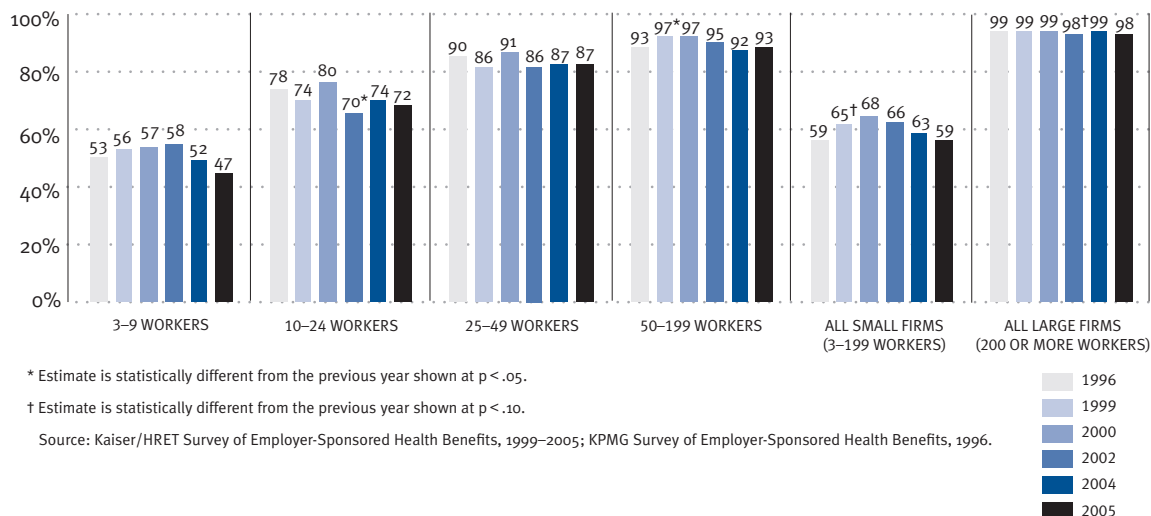


EXHIBIT E

Percentage of Firms Offering Health Benefits, by Firm Size, 1996–2005



copayment. For workers covered by multi-tier drug plans, the average copayments are \$10 for generic drugs, \$22 for preferred drugs, and \$35 for nonpreferred drugs. A small percentage of plans have added a fourth tier of prescription drug cost sharing, with an average copayment in that tier of \$74.

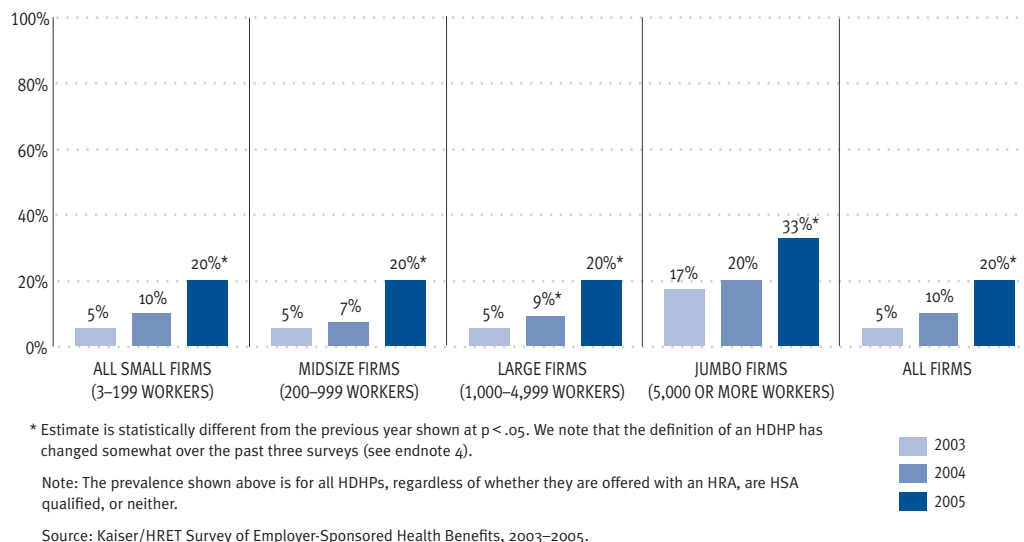
AVAILABILITY OF EMPLOYER-BASED COVERAGE

While the percentage of firms offering health benefits is statistically unchanged from last year, it has declined over the last few years. Annual changes have been small, but the cumulative result is a statistically significant decline in the percentage

of firms offering health benefits, from 69% in 2000 to 60% in 2005. This drop is driven largely by a significant decline in the percentage of small firms (3–199 workers) offering coverage, which has fallen from 68% to 59% over the same period.

EXHIBIT F

Among Firms Offering Health Benefits, Percentage That Offer an HDHP, by Firm Size, 2003–2005



The health benefits offer rate continues to vary substantially by firm size: only 47% of the smallest companies (3–9 workers) offer health benefits, compared to 72% of firms with 10–24 workers, 87% of firms with 25–49, and over 90% of firms with 50 or more workers (Exhibit E).

Even when a firm offers health insurance, not all workers get covered. Some workers 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. Within offering firms, 80% of workers are eligible for coverage, and 83% of those eligible elect to enroll.

HEALTH PLAN ENROLLMENT

Enrollment in PPOs grew over the last year, while HMO enrollment declined. PPOs continue to be

the most common plan in 2005, enrolling 61% of employees with health coverage, up from 55% in 2004.³ HMO enrollment fell to 21% of covered workers from 25% in 2004. POS enrollment, which has been declining in recent years, remained stable this year at 15%.

UTILIZATION MANAGEMENT AND DISEASE MANAGEMENT

About eight-in-ten workers (81%) with job-based coverage are in a health plan that uses case management for large claims. Prior certification for inpatient services (75% of covered workers) and outpatient surgery (55% of covered workers) also apply to most covered workers.

Over half of covered workers (56%) are in a plan with at least one disease management program. Among workers in these plans, virtually all are in a plan that provides management for diabetes, and high percentages are

in plans that provide management for asthma (86%), hypertension (82%), and high cholesterol (66%).

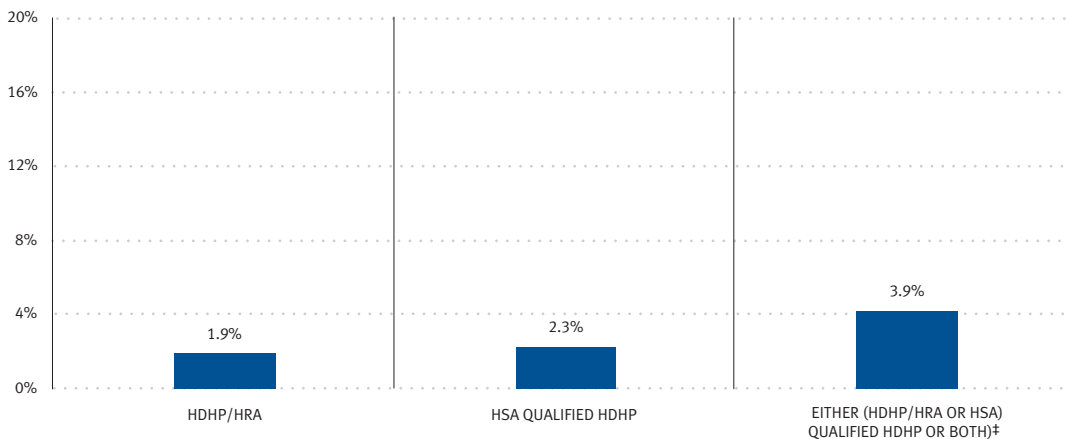
HIGH-Deductible Health PLANS

Employers appear to be embracing increased consumer responsibility and higher cost sharing as strategies for reducing the growth in health care costs. Twenty percent of firms offering health benefits offer an HDHP (defined for 2005 as having a deductible of at least \$1,000 for single coverage and \$2,000 for family coverage) (Exhibit F). Jumbo firms (5,000 or more workers) offering health benefits are more likely than all firms to offer such a plan. We note that the definition of an HDHP has changed somewhat over the past three surveys.⁴

We asked employers offering an HDHP whether they offer either (1)

EXHIBIT G

Among All Firms Offering Health Benefits, Percentage That Offer an HDHP/HRA and/or an HSA Qualified HDHP, 2005



† This includes 0.3% of all firms offering health benefits that offer both an HDHP/HRA and an HSA qualified HDHP.

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2005.

an HRA to their employees (referred to here as an “HDHP/HRA”) or (2) an HDHP that permits their employees to establish an HSA (referred to here as an “HSA qualified HDHP”). Among all firms offering health benefits, 1.9% offer an HDHP/HRA, with 1.6 million workers enrolled in the HDHP/HRA, and 2.3% offer an HSA qualified HDHP, with 810,000 workers enrolled in the HSA qualified HDHP (Exhibit G).⁵ About 25% of workers offered an HDHP/HRA and about 15% of workers offered an HSA qualified HDHP participate in the arrangement that is offered.

As expected, deductibles in these arrangements are relatively high: in HDHP/HRAs, annual deductibles average \$1,870 for single coverage and \$3,686 for family coverage; in HSA qualified HDHPs, annual deductibles average \$1,901 for single

coverage and \$4,070 for family coverage. The average premiums for the HDHPs in these arrangements are generally lower than average health plan premiums overall, although these differences lessen or disappear when employer contributions to the spending accounts are added to the premium. The average total annual spending for HDHP/HRAs (premiums plus employer contributions to the HRA) is not statistically different than average annual health plan premiums for either single or family coverage. In contrast, the average total annual spending for HSA qualified HDHPs is significantly lower for both single and family coverage than annual average premiums for health plans generally (Exhibit H).

On average, workers enrolled in an HDHP/HRA receive an annual employer contribution to their HRA of \$792 for single coverage and \$1,556 for

family coverage. Workers enrolled in an HSA qualified HDHP on average receive an annual employer contribution to their HSA of \$553 for single coverage and \$1,185 for family coverage.⁶ About one-in-three employers offering an HSA qualified HDHP (covering about 35% of workers enrolled in these plans) does not contribute to HSAs established by their employees.

RETIREE COVERAGE

The implementation of the new Medicare Part D drug benefit, combined with cutbacks in coverage by several large national firms, has put a spotlight on retiree health benefits. In 2005, 33% of large firms (200 or more workers) offer retiree health coverage, virtually the same percentage as last year, but down from 66% in 1988. Among large firms

EXHIBIT H

Average Annual Premiums and Contributions to Spending Accounts For Covered Workers in HDHP/HRAs and HSA Qualified HDHPs Compared to All Plans, 2005

	HDHP/HRA		HSA Qualified HDHP		All Plans [‡]	
	Single	Family	Single	Family	Single	Family
Total Annual Premium	\$3,503*	\$8,530*	\$2,700*	\$7,909*	\$4,024	\$10,880
<i>Worker Contribution to Premium</i>	\$423	\$2,654	\$431	\$1,664*	\$610	\$2,713
<i>Firm Contribution to Premium</i>	\$3,080	\$5,876*	\$2,270*	\$6,245*	\$3,413	\$8,167
Total Annual Firm Contribution (Firm Share of Premium Plus Contribution to HRA or HSA)	\$3,872*	\$7,538	\$2,850	\$7,337	\$3,413	\$8,167
Total Annual Spending (Total Premium Plus Firm Contribution to HRA or HSA)	\$4,295	\$10,193	\$3,280*	\$9,001*	\$4,024	\$10,880

* Estimate is statistically different from All Plans by coverage type at $p < .05$.

[‡] All Plans refers to all conventional, HMO, PPO, and POS plans in the survey, not just HDHP/HRAs or HSA qualified HDHPs.

Note: Average Firm Contributions to the HSA or HRA cannot be calculated by subtracting the average Total Annual Premium from the average Total Annual Spending due to varying sample sizes. Some firms provided data for premiums and worker contributions that were inconsistent with other data they provided about their HDHP/HRA or HSA qualified HDHP. These data were excluded from estimates of the average premium, worker contribution, and firm contribution for the HDHP; therefore there are fewer cases used in calculating those averages than for the average firm contribution to the HSA or HRA.

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2005.

offering retiree benefits, virtually all (94%) offer benefits to early retirees, while just over 81% offer benefits to Medicare-age retirees.

OUTLOOK FOR THE FUTURE

Although growth in health insurance premiums has moderated in each of the last two years, it continues to outpace inflation and average wage growth by wide margins. Over the last five years (since 2000), health insurance premiums have grown by 73%, compared with cumulative inflation of around 14% and cumulative wage growth of 15%.

This rapid growth of health care premiums relative to the rest of the economy appears to be placing significant strains on the employer-sponsored health insurance system. Over the past five years, the percentage of employers offering health benefits has fallen from 69%

to 60%, with the decline occurring predominantly among small firms (3-199 workers). This decline has helped drive a reduction in the percentage of workers covered by health insurance offered through their own employer, which has fallen from 63% of workers in 2000 to 60% in 2005.

To address cost issues, employers are broadly making use of disease management and utilization management, but continue to move away from HMOs, whose premiums are generally below more prevalent PPOs. Employers also have looked to higher cost sharing over the past few years, first through increases in deductibles and copayments, and more recently in the form of new plan types. While cost sharing grew little on average over the past year, we do see an increase in the offering of HDHPs and the emergence of new consumer-driven plans. We expect the prevalence of these consumer-driven approaches to grow, despite the fact

that only 16% of employers say that they believe that these plans will be “very effective” in controlling health care costs.

Health insurance premiums for a family of four now average almost \$11,000 a year, about equal to the full time earnings for a minimum wage worker.⁷ It is not surprising then that firms with a relatively high percentage of lower-wage workers are less likely to offer health insurance—given the cost of coverage relative to what their workers earn; nor is it surprising that smaller firms, who on average pay their workers less than larger firms, are having an increasingly hard time offering health benefits to their workers. Unless cost increases moderate substantially, or new ways are found to finance health care for lower income workers, we may well see the downward trends in offer rates and coverage continue.

¹ Kaiser Family Foundation, Kaiser Commission on Medicaid and the Uninsured. *Health Insurance Coverage in America, 2003 Data Update*, November 2004.

² Data on premiums reflect the cost of health insurance premiums for a family of four.

³ A portion of the change in enrollment is likely attributable to incorporating more recent Census Bureau estimates of the number of state and local workers and removing federal workers from the weights. See the *Survey Design and Methods* section in the full report for additional information.

⁴ In 2003 and 2004 the survey used a different definition and asked firms if they offered a health plan with a deductible of *more than* \$1,000 for single coverage. The 2003 and 2004 surveys did not specify a minimum deductible for family coverage. Some of the change in the percentage of firms offering an HDHP between 2003 and 2005 may be due to this change in the definition of an HDHP.

⁵ This estimate of the number of workers enrolled in an HDHP/HRA or an HSA qualified HDHP does not include federal workers because the federal government is not included in the survey.

⁶ The average firm contributions to HSAs for single coverage (\$553) and family coverage (\$1,185) include covered workers whose firm makes no contribution to the account. Average Firm Contributions to the HSA or HRA cannot be calculated by subtracting the average Total Annual Premium from the average Total Annual Spending (Exhibit H) due to varying sample sizes. Some firms provided data for premiums and worker contributions that were inconsistent with other data they provided about their HDHP/HRA or HSA qualified HDHP. These data were excluded from estimates of the average premium, worker contribution, and firm contribution for the HDHP; therefore there are fewer cases used in calculating those averages than for the average firm contribution to the HSA or HRA.

⁷ Gross earnings for someone earning the federal minimum wage in 2005 and working 2,080 hours are \$10,712.

METHODOLOGY

The Kaiser Family Foundation/Health Research and Educational Trust 2005 Annual Employer Health Benefits Survey (Kaiser/HRET) reports findings from a telephone survey of 2,013 randomly selected public and private employers. Firms range in size from small enterprises with a minimum of three 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. Findings in this report draw on the 1999–2005 Kaiser/HRET Survey of Employer-Sponsored Health Benefits, the 1993, 1996, and 1998 KPMG Surveys of Employer Sponsored Health Benefits, and the 1988, 1989 and 1990 studies conducted by HIAA. 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 2005. In 2005 our overall response rate is 48%, which includes firms that offer and do not offer health benefits. Among firms that offer health benefits, the survey's response rate is 51%.

From previous years' experience, we have learned that firms that decline to participate in the study are more likely not to offer health coverage. Therefore, we asked one question to all firms in the study with which we made phone contact where the firm declined to participate. The question was, "Does your company offer or contribute to a health insurance program as a benefit to your employees?" A total of 2,995 firms responded to this question (including 2,013 who responded to the full survey and 982 who responded to this one question). Their responses are included in our estimates of the percentage of firms offering health coverage.

The response rate for this question was 72%. Since firms are selected randomly, it is possible to extrapolate from the sample to national, regional, industry, and firm size estimates using statistical weights. In calculating weights, we first determined the basic weight, then applied a nonresponse adjustment, and finally applied a post-stratification adjustment. We used the Statistics of the U.S. Census Bureau as the basis for the stratification and the post stratification adjustment for firms in the private sector, and we used the Census of U.S. Governments as the basis for post stratification for public sector firms. All statistical tests are performed at $p < .05$ except where otherwise noted.

For more methodology information, please visit our Survey Design and Methods Section at www.kff.org/insurance/7315/.

Sponsors

The Kaiser Family Foundation, based in Menlo Park, California, is a nonprofit, private operating foundation dedicated to providing information and analysis on health care issues to policymakers, the media, the health care community, and the general public. The Foundation is not associated with Kaiser Permanente or Kaiser Industries.

The Health Research and Educational Trust is a private, not-for-profit organization involved in research, education, and demonstration programs addressing health management and policy issues. Founded in 1944, HRET collaborates with health care, government, academic, business, and community organizations across the United States to conduct research and disseminate findings that help shape the future of health care.



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The full report of survey findings (#7315)
is available on the Kaiser Family Foundation's website at www.kff.org.

Additional copies of this summary (#7316) are also available at www.kff.org.