Who really has access to employer-provided health benefits?

Although employers are the major source of health care coverage for persons under age 65, certain restrictions exclude many employees and their families from coverage, or limit the benefits received

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Two seemingly contradictory facts underlie the relationship between health care benefits and employment. Among nonelderly persons, employers are the most prevalent source of health care benefits. Yet, among those not covered, a large proportion are employed. These facts tend to place the links between employment and health coverage under close scrutiny during debates on health care reform.

Employer-provided health care plans have been the source of health care coverage for many employees and their families since World War II, but several limits on coverage and other restrictions exist.[1] This article explores the relationship between employer-provided health care benefits and the work force, concentrating on answers to the following questions:

- How does the availability of employer-provided health care benefits vary by industry, occupation, establishment size, and other factors?
- To what extent are employer-sponsored health care benefits available to dependents of employees? How are dependents defined and what limits are there on dependent coverage?
- What barriers prevent employees from receiving health care benefits?
- When employers offer health care benefits, do employees elect to take advantage of these benefits?
- What effect does job switching have on the availability of health care benefits? How frequently are service requirements and preexisting condition limitations imposed, and what effect do they have?

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The article is based primarily on two data sources: the Bureau of Labor Statistics Employee Benefits Survey, an establishment survey that includes questions regarding the availability, cost, and provisions of employer-provided health care benefits, and the Current Population Survey (CPS), a household survey that includes questions about the overall extent of health benefit protection.[2]

According to the CPS, 84 percent of the population had health care coverage during 1993. Persons without coverage, about 41 million, were almost all under age 65.[3] Of those with coverage, the most prevalent source of protection is employer-sponsored plans, covering 61 percent of persons under age 65, including employees and dependents. The following tabulation provides a breakdown of the sources of health care coverage. (Note that the sum of sources is more than the total "with coverage" because some individuals had more than one source of coverage.)

Source of coverage	*Percent of nonelderly persons*
Total	100
With coverage	82
Employer	61
Government	16
Individual coverage	9
Without coverage	18

Americans under age 65 who are not currently covered by a health care plan include both individuals in the labor force and those not in the labor force, children, those unable to work, and others. The uninsured fall into the following categories:

Status	Number (in millions)	Percent
Total	40.9	100
Family head, worker	14.6	36
Other worker	8.1	20
Nonworker	7.1	17
Children	11.1	27

These data warrant a closer look into the availability of health care benefits and barriers to such protection among today's workers. To begin, some background data on health care usage and the relationship to health benefits coverage is explored.

Health care usage

How much do Americans use health care services? Data on health expenditures and usage provide some answers. According to the Consumer Expenditure survey, Americans spent, on average, $1,776 per household on health care expenses, including insurance premiums, in 1993.[4] This was about 5.8 percent of total expenditures on all goods and services. Table 1 shows that health care expenditures varied by age and income level.

Americans are frequent users of health services—84 percent used some form of health service in 1987, according to the National Medical Expenditure Survey. Usage varied based on health insurance coverage, with 64 percent of uninsured persons using health services, compared with 87 percent of those persons covered by private health insurance.[5] On average, the uninsured had lower annual health care expenses than those covered by private insurance—$915, compared with $1,316. Part of this difference is accounted for by the payment of insurance premiums, often required of the insured. The difference is also attributable to lower usage of services by persons without insurance. According to the survey results, "The younger uninsured ... were less likely to use services, had lower average expenditures, and spent more out of pocket. [They] may postpone preventive and routine care until health problems become more serious and are more difficult and expensive to treat."[6]

The U.S. population has extensive health care services available, uses these services readily, and relies on insurance to make these services affordable. Employers are a large supplier of health care benefits, although data in the following sections indicate that such benefits are not uniformly available.

Who's covered?

Data from surveys of individuals and employers indicate that about 6 in 10 workers receive health care benefits through their employers, and that the proportion has been declining slightly over the past decade.[7] Traditionally, employers have offered a single health care plan, although increasingly employers give a choice among several plans. These plans are funded by the employer, but in recent years, employees have increasingly been required to contribute toward plan financing.

A small portion of employees with health care benefits through their workplace are covered by plans sponsored by someone other than the employer. For example, some labor unions offer health care benefit plans to which several employers contribute to provide protection for their employees. Similarly, several employers in the same industry or location may band together to form a cooperative arrangement; in this case, employee health care benefits are actually sponsored by the employer group, and not the individual employers.

Regardless of plan sponsorship, coverage varies widely based on industry, union status, and other factors. The industry in which an employee works is a major factor in determining whether or not health care benefits will be available. Workers in the public sector (including Federal, State, and local governments) are more likely to have health care benefits than are their counterparts in the private sector. Within the private sector, workers in goods-producing industries, such as manufacturing and mining, more often have health care benefits than do workers in certain service-

Table 1. **Health care expenditures by age and income, 1993**

Characteristic	Annual expenditure	Percent of all expenditures
Average	$1,776	5.8
Age:		
Under 25	349	2.0
25–34	1,128	3.9
35–44	1,673	4.5
45–54	1,817	4.4
55–64	2,176	6.6
65 and older	2,733	12.8
Annual income		
Less than $5,000	739	5.6
$5,000–$9,999	1,165	8.4
$10,000–$14,999	1,511	8.4
$15,000–$19,999	1,803	8.6
$20,000–$29,999	1,732	6.8
$30,000–$39,999	1,881	5.8
$40,000–$49,999	2,012	5.1
$50,000–$69,999	2,054	4.4
$70,000 and more	2,703	3.8

producing industries, especially retail trade and services. Table 2 indicates the percentage of workers in establishments that provide health care benefits, by industry.[8]

The data on establishments providing health care benefits mirror information from the Employee Benefits Survey, which provides data on the percent of workers actually covered by employer-provided health care benefits. According to the 1993 survey, 87 percent of full-time workers in private goods-producing establishments with 100 workers or more participated in a health care plan, compared with 78 percent of their service-producing counterparts. In general, the industries in which health care benefits are most prevalent are declining in their share of total U.S. employment. While workers in goods-producing industries frequently receive health care coverage, the proportion of workers employed in these industries has declined dramatically. In 1960, about two-fifths of all workers were employed in goods-producing industries. By 1990, these industries employed slightly fewer than one-fourth of U.S. workers. (See table 3.) Alternatively, those industries increasing their share of total employment, most notably services (such as personal and hospitality services) and retail trade, have among the lowest health care coverage rates.

Not only are industries that frequently offer health care benefits, such as mining and manufacturing, declining in their percent of total employment, but that decline is expected to continue. BLS projects that between 1992 and 2005, about 24 million additional workers will be added in service-producing industries, while jobs in goods-producing industries will see little growth.[9]

Limited data are available on differences in health care coverage by occupation. In general, white-collar and blue-collar workers are about equally likely to be covered by an employer-provided health care plan. In contrast, service workers, such as waitresses, cosmetologists, and cleaning personnel, are less likely to be covered by employer-provided health care benefits. Just as with industry variations, those occupations less likely to have health care benefits from their employer are the occupations increasing in their share of total employment, and projected to gain further.[10]

Union status is also a determinant of health care coverage. Ninety-two percent of full-time employees covered by a collective bargaining agreement in the 1991–92 period received health care benefits from their employer.[11] In comparison, 75 percent of full-time nonunion workers received employer-provided health care benefits. Differences in the receipt of health care benefits by union status may be related to industry and occupation differences: those industries and occupations that have the highest health care coverage are the ones that tend to have the highest union concentration.[12]

Just as goods-producing industries are no longer as dominant in the U.S. economy as they once were, so too are unionized workers a lower percent of the total labor force. From a high of 36 percent in 1945, the percent of the labor force covered by a collective bargaining agreement has dropped gradually, to about 17 percent.[13]

Table 2. Percent of workers in establishments that sponsor employer-provided health care benefits, by industry, 1993

Industry	Percent covered
All industries	78
Private sector	74
Agriculture	42
Mining	93
Construction	55
Manufacturing, durable	93
Manufacturing, nondurable	86
Transportation	80
Communications and public utilities	83
Retail trade	62
Finance, insurance, and real estate	86
Services	68
Public sector	95

SOURCE: *Pension and Health Benefits of American Workers* (U.S. Department of Labor, Social Security Administration, U.S. Small Business Administration, and Pension Benefit Guaranty Corporation, 1994).

Taken alone, each factor—industry, occupation, and union status—indicates shifts in employment away from those workers more likely to receive health care benefits from their employer. The intersection of two of these variables—industry and occupation—provides further evidence. For example, about two-thirds of white-collar and blue-collar workers in goods-producing industries have health care coverage from their employer. In contrast, about one-fourth of service workers in service-producing industries have such coverage. Thus, employment has shifted, and is projected to continue to shift, toward those jobs less likely to provide health care benefits.[14]

Another factor influencing the availability of health care benefits is location. Employer-provided health care benefits protection is slightly more prevalent in the Northeast and North Central States—traditional manufacturing locations—than in the South and West sun-belt areas. The following tabulation from the Employee Benefits Survey shows the percent of full-time workers in medium and large private establishments participating in employer-provided health care benefits in 1993, by geographic region:

Region	*Percent of participating workers*
North Central	84
Northeast	83
South	80
West	79

While these differences are quite small, shifts in employment over the past two decades have been toward those areas with lower health care coverage.[15]

Establishment size also influences the availability of health care benefits. In general, employees in larger esta-blishments are more likely to be covered by health care benefits than are their counterparts in smaller establishments. For example, in 1993, 82 percent of full-time employees in private establishments with 100 or more workers participated in health care plans offered by their employer; in contrast, 71 percent of workers in smaller private establishments were covered in 1992. The proportion of the private sector labor force found in small establishments has been slowly increasing over the past two decades; currently, a little more than half of all private sector employees work in establishments with fewer than 100 workers.

Contingent workers

Despite the variations just described, attachment to the labor force remains a primary factor in the availability of health care benefits—61 percent of non-elderly Americans receive employer coverage. But what about those workers whose attachment to an employer is not permanent, or not full-time, or not the traditional employer-employee relationship? There is considerable interest in such "contingent workers" and the benefits available to them.

While there is much debate on how to classify certain workers, one definition of contingent work is "any arrangement which differs from full-time, permanent, wage and salary employment."[16] This can include a wide range of employment practices, such as part-time employment, temporary employment, seasonal employment, leasing arrangements, self-employment, contracting out, and home-based employment.

Part time. In 1993, about 21 million persons (17 percent of the labor force) worked part time, about one-fifth of them for "economic reasons," meaning they could not find for full-time employment.[17] While part-time workers choose such employment for a variety of reasons, including family commitments, such workers are frequently not provided health care benefits through their employer. In 1991–92, only 16 percent of part-time workers in private industry and State and local governments participated in a health care benefits plan provided by their employer, compared with 79 percent of full-time workers.[18] Of course, these workers could have health care coverage from other sources, including employer-based coverage as a dependent of another worker.

Temporary help. Another portion of the contingent work force is temporary help employees, those workers who are assigned on a temporary basis to a variety of employers.[19] In 1994, about 2 million Americans worked for temporary help employers, 3 times as many as in 1984. Benefits provided through a temporary help agency are frequently tied to hours worked. For example, a temporary worker may be required to work at least 300 hours in the first 6 months of employment to be eligible for health care benefits; in addition, the worker must continue to work at least 200 hours in each quarter thereafter to maintain eligibility. Depending upon the availability of temporary jobs and the individual's schedule, attaining such a threshold may be difficult. According to a 1989 BLS survey of temporary help establishments, about 50 percent of temporary help workers were in jobs in which health care benefits would be available, if the hour threshold were met. However, fewer than 10 percent of temporary help workers were employed by establishments in which any workers actually participated in a health care plan.[20]

Self-employed. Approximately 9 million Americans were self-employed in 1994. In most cases, these individuals provide their services for a negotiated fee; benefits are typically not provided. About 73 percent of self-employed individuals have health care coverage, much of which comes from a spouse's employer or from individually purchased coverage.[21]

Dependent coverage

Nearly 140 million persons under age 65 receive health care coverage through an employer-provided benefit plan. About half of these individuals have indirect coverage, that is, they receive coverage as a dependent of a worker whose employer provides a plan.[22] Dependent coverage is often subject to strict definitions, which may not always correspond with the variety of family relationships that

Table 3. **Percent distribution of U.S. nonagricultural payroll employment, by industry, 1920–90**

Industry	1920	1930	1940	1950	1960	1970	1980	1990
Total	100	100	100	100	100	100	100	100
Goods-producing	47	41	41	41	38	33	28	23
Mining	5	3	3	2	1	1	1	1
Construction	3	5	4	5	5	5	5	5
Manufacturing	39	32	34	34	31	27	22	17
Service-producing	53	59	59	59	62	67	72	77
Transportation and public utilities	15	12	9	9	7	6	6	5
Wholesale trade	–	–	6	6	6	6	6	6
Retail trade	–	–	15	15	15	16	17	18
Finance, insurance, and real estate	4	5	5	4	5	5	6	6
Services	9	11	11	12	14	16	20	26
Government	10	11	13	13	15	18	18	17

NOTE: Dash indicates data not available.

exists in the United States. This section explores definitions and limitations surrounding dependent coverage.

Although the large majority of plans provide identical coverage for dependents and employees, there are some variations in plan characteristics for dependents, as opposed to employees. For example, one union-sponsored plan offers only core protection—such as hospitalization and surgery for dependents, while providing extensive preventive and acute protection for employees. Some plans cover doctors' office visits for employees, but not for dependents. In another case, dependent protection is contingent on proof that the dependents could not have gained health care protection from their own employer.

Beyond direct restrictions on dependent coverage, indirect restrictions can occur through the definition of "eligible dependents." Traditionally, dependent benefits were extended to a spouse—most likely a nonworking wife—and children up through a certain age. In the 1990's, however, such family relationships are not always the norm. Employees may wish to cover a spouse, unmarried partner, same-sex partner, child, adopted or foster child, parent, or other family member. Such protection may not, however, always be available.

Dependent health care coverage will always include provisions for a spouse. In contrast, coverage for unmarried partners is rarely provided by health care plans. According to the Bureau of the Census, approximately 14 million Americans live in households with individuals other than relatives. This may include heterosexual or homosexual partners, or other group arrangements. Workers with such living arrangements are rarely given the opportunity to extend employer-provided health care benefits to members of their household.[23]

Coverage for homosexual partners has been extended by a small number of employers in recent years, in a manner similar to that provided to a married spouse. Employers may require gay partners to sign a statement certifying that they are living together in a relationship akin to marriage, or to prove that they have been living together for a period of time. Most of the employers that have extended such benefits to homosexual couples have not extended the same protection to unmarried heterosexual couples, explaining that heterosexual couples could gain access to dependent protection by marrying.

Protection for an employee's own child is typically provided as part of a health care plan's dependent coverage. Such protection often extends until age 18 or 19, or until age 21 or 22 if the dependent child continues to attend school. Traditionally, such a scheme would protect a noncollege-bound dependent child through high school and until a job —perhaps with health care benefits—was obtained. Similarly, a college-bound dependent child would be protected throughout his or her college years.

To maintain health care benefits for students, restrictions often apply. For example: the student must attend school full time; the school must be accredited; the parent must be providing "support and maintenance"; the student must remain unmarried; and the student must be an eligible dependent of the parent for Federal income tax purposes. Today, many students take longer than 4 years to complete college, work part-time (often without health care benefits) while attending school part-time, and return to reside with parents for several years beyond their early 20's. For example, in 1970, 15 percent of Americans aged 22 to 24 were enrolled in school. By 1991, that figure had risen to 22 percent.[24] In such cases, dependent coverage might expire.

Employer-provided health care benefits are typically not extended to parents and other elderly relatives. In years past, such individuals would often work and receive health care benefits from their employer until retirement age; at that time they would be eligible for medicare and perhaps other sources of retiree health care protection. They did not need to rely on their children for health care assistance. However, a variety of factors have changed this situation to some extent. Americans are living longer; retiree health care benefits from employers are becoming somewhat less prevalent[25]; and acute conditions such as Alzheimer's disease are requiring care beyond that provided by medicare. These factors may often lead to cases in which care of elderly relatives, including financial responsibility, falls upon working-age children.

Employer-provided health care plans rarely allow employees to include parents among the dependents receiving protection. Typically, the only adult to whom protection is afforded is a spouse. Even in the case in which an elderly relative can be claimed as a dependent of an employee for Federal income tax purposes, health care plans often specifically exclude such individuals from coverage.

One area where employers are beginning to address concerns for elderly dependents is long-term care coverage. Long-term care is non-acute, custodial care provided to individuals who cannot meet basic needs—such as feeding and clothing themselves. Such care may be required for individuals whose medical conditions do not require close supervision, but have little likelihood of improvement. Alzheimer's patients frequently require such care. Medicare does not cover long-term custodial care, nor do most health care plans. A few employers have started to offer the opportunity for their employees to purchase long-term care insurance for themselves, a spouse, or an elderly relative. Such plans are often financed entirely by the employee, but are provided at group rates that are less costly than individually purchased policies.[26] This is one of the few cases in which elderly

dependents may receive benefits through their child's employer.

Restrictions imposed by plans

Many workers without health care coverage actually work for employers who provide coverage. For a variety of reasons, employees may not be eligible for coverage, or may not choose to be covered. The following data indicate coverage patterns among workers:[27]

Coverage	*Percent of workers*
Employer sponsors plan	73
Employee participates	58
Employee does not participate	15
Not eligible	5
Declined coverage	8
Other reason or unknown	2

Health care benefits coverage within an establishment may be subject to a variety of conditions. First, plan eligibility may be limited to certain workers. For example, health care benefit eligibility may be extended to full-time workers, but not part-time workers. Less frequently, benefits may be extended to salaried workers and not hourly workers.

For employees who are in occupations eligible for coverage, other restrictions may apply. According to BLS data from 1993, 44 percent of full-time participants in health care plans were subject to an eligibility requirement, typically 1 to 3 months. During this eligibility period, coverage may not be available at all, or may be available only if the employee agrees to pay the entire cost. Similarly, a plan may provide employees with immediate coverage, but impose a waiting period before dependents can be covered. Eligibility requirements are imposed as a hedge against a new employee leaving the employer soon after starting. Because the administrative costs of enrolling a new employee can be high, employers may wait a few months to avoid enrolling employees who choose not to remain with the establishment.

Once employees have completed all service requirements for plan eligibility, they frequently are required to pay part of the cost of coverage. Such employee contribution requirements have become more prevalent in recent years. For example, in 1979, fewer than 3 in 10 full-time employees in medium and large private establishments with health care coverage were required to contribute toward their health care coverage. By 1993, that rate had increased to 6 in 10 employees with coverage. For family coverage, required employee contributions are even more prevalent. Three of four health care plan participants were required to contribute toward the cost of family coverage in 1993. For full-time employees in medium and large private establishments, average monthly contributions for single and family coverage have risen steadily over the past several years, as shown in the following tabulation:

	Contribution	
Year	*Single coverage*	*Family coverage*
1983	$10.13	$32.51
1985	12.05	38.33
1988	19.29	60.07
1991	26.60	96.97
1993	31.55	107.42

Both the average single and family premiums increased a little more than 200 percent between 1983 and 1993. In contrast, the Consumer Price Index (CPI) for all items increased 45 percent over the same period, and the CPI for medical services and supplies doubled. Thus, the rate of growth in employee premiums has outpaced inflation, which might suggest that premiums may be difficult for some workers to afford, causing them to decline coverage.

New benefit arrangements do exist to temper the burden for employees. Section 125 of the Internal Revenue Code authorizes flexible benefits plans, one feature of which allows employees to pay their required health care contributions with pretax funds. This feature, also known as premium conversion, is often part of a flexible spending account. In these plans, employees pay their health care premiums through payroll deductions prior to the imposition of Federal and State income taxes or Social Security taxes. Thus, the employee's contribution is actually less—by the employee's marginal tax rate—than is actually paid. These pretax arrangements have become increasingly common in recent years. In 1993, approximately one third of full-time participants in health care plans in medium and large private establishments had the opportunity to make contributions using pretax funds.

From coverage to care

Preexisting conditions. Being covered by an employer-provided health care plan may not automatically provide an individual with payment for all needed coverage. Preexisting condition clauses, included in traditional health care plans covering about three-fifths of participants, limit the care provided to newly enrolled individuals who have a medical condition that existed prior to their enrollment in the plan.[28] For example, if care for a particular condition were received within 6 months prior to joining the new plan, the preexisting condition clause is triggered. Once triggered, the new plan

will limit care for the condition for a particular period. The new plan may not pay for any services connected with the condition for 6 months following enrollment, or the plan may only pay for services up to a specified dollar maximum for a specified time.

Cost containment. Beyond preexisting condition clauses, certain cost containment features in employer-provided health care plans may limit an individual's access to care. For example, for payment to be received, the plan administrators may have to determine that nonemergency hospitalization is necessary, and evaluate how long a hospital stay should be, or require a surgery candidate to seek a second opinion. Patients may also be encouraged to have certain procedures performed on an outpatient basis to reduce the costs associated with a hospital stay. Outpatient services may be required for certain procedures, or may be reimbursed at a higher rate than inpatient services as an incentive for the patient to avoid hospitalization.[29]

A relatively new phenomenon is for employers to identify particular health risks among their employees and to either charge higher premiums for such care, exclude preexisting conditions relating to the identified risks, or deny coverage altogether. For example, employers may screen their applicants for medical risks, work-related accident history, and risky activities, such as motorcycle riding. Employee premiums for smokers may be higher than those for nonsmokers, or premiums may be lower if employees participate in certain wellness activities, such as fitness classes or regular physical examinations. And, premiums may be reduced if use of health care benefits has been limited in the past.

Out-of-pocket expenses may also act to limit employee access to care; employees may be unable or unwilling to pay the required costs associated with seeking medical care. Typical out-of-pocket expenses include deductibles (a required payment by the patient before any services are reimbursed by the health care plan) and coinsurances (a shared payment between the plan and the patient).

Individuals can end up paying a large portion of their medical care bills because of out-of-pocket expense requirements. This is most noticeable when overall medical expenses are low.[30] The following tabulation shows the percent of charges that would be paid by the plan and the patient for certain assumed levels of medical care services received during 1989–90:[31]

Cost of services received	*Percent paid by plan*	*Percent paid by individual*
$87	29	71
7,085	86	14
41,504	94	6

Thus, access to employer-provided health care benefits may not ensure that the care desired by the patient or recommended by a physician will be reimbursed by the insurer.

Benefits and mobility

Americans may have a number of different jobs and employers throughout their worklife. In 1991, the median job tenure for workers aged 25 and older was 5.6 years, meaning half had worked with their present employer more than 5.6 years and half had worked less than 5.6 years.[32] Workers who switch jobs often take into account whether subsequent employers have health care benefits, what eligibility requirements might be imposed by a new employer, and how preexisting conditions will be treated under a new employer's plan. In addition, employees moving to a new employer may face different rules for dependent eligibility, different required contributions, and changes in required out-of-pocket expenses.

Loss of employer-provided health care benefits, due to job switching and a number of other circumstances, is governed by Federal health care continuation rules. These rules are commonly referred to as COBRA, for the Consolidated Omnibus Budget Reconciliation Act of 1985. The act requires employers to make health care benefits available to employees and dependents who have lost coverage because of certain qualified circumstances such as voluntary separation (quitting or retiring from a job), layoffs, divorce (in the event that coverage was provided through a former spouse), and dependent children exceeding the age of eligibility.

COBRA specifies limited amounts of time during which coverage must be offered (typically 18 months), and allows employers to charge the former employee or dependent up to 102 percent of the total premium. While coverage may continue up to the specified time limit, rights to coverage are terminated when another plan becomes available. Thus, a job-switcher may typically maintain coverage from a prior employer until meeting eligibility requirements for a new employer's plan.

Loss of employer-provided health care coverage can occur despite protections under COBRA. According to one survey, the majority of persons who lose employer-provided health care coverage do so because they have changed jobs. Such coverage loss may be a qualifying event under the act, allowing coverage continuation. However, employees may not in fact continue their coverage, because of either incomplete information or inability to pay required premiums.[33]

Individuals retiring from a job with employer-provided health care benefits are likely to see such coverage disappear after retirement. According to the Employee Benefits Survey,

about 2 in 5 full-time workers in medium and large private establishments with health care benefits could expect their employer to continue to finance at least part of those benefits into retirement. In small establishments, a lower percent of covered employees had such protection. Under COBRA, benefits are available to retirees for a limited period, and such eligibility ends when individuals become eligible for medicare. In those cases where employer-provided benefits do continue into retirement, coverage is coordinated with medicare to avoid duplicate benefits.

ALTHOUGH ACCESS TO EMPLOYER-PROVIDED HEALTH CARE benefits is widespread among employees and dependents in the United States, there are limitations. Coverage is most prevalent among workers in occupations, industries, and locations that have been declining in their share of employment in recent years. Employer-provided health care benefits are widely available to dependents, but not always to those dependents that stem from newer family arrangements. Access to coverage may not guarantee payment for services, as preexisting condition clauses, eligibility requirements, contribution requirements, and required out-of-pocket expenses may limit benefits. Finally, individuals who are covered by employer-provided plans may find that their benefits are discontinued because of a variety of circumstances, and to maintain coverage, they would have to pay higher premiums.

Footnotes

[1] For more information on the history of employer-provided health care coverage, see Laura A. Scofea, "The development and growth of employer-provided health insurance," *Monthly Labor Review*, March 1994, pp. 3–10.

[2] The Employee Benefits Survey (referred to as the "establishment survey") is an annual survey of private businesses and State and local governments conducted by the Bureau of Labor Statistics to provide estimates of the percent of workers covered by health care and other benefits, and the features of those benefits. It does not include data on numbers of dependents or nonworkers covered by health care benefits. The Current Population Survey is a monthly survey of households conducted by the Bureau of the Census for the Bureau of Labor Statistics. Estimates indicate health coverage for Americans by a variety of demographic characteristics regardless of work status; details on benefit provisions are not available.

[3] The Current Population Survey, a monthly survey of 60,000 households selected to represent the U.S. population 16 years of age and older, provides a wide range of data on the economic well-being of Americans, including statistics on employment and unemployment. Each March, special questions are asked on the health insurance status of Americans. To be classified as uninsured or without coverage, individuals must indicate that they did not have health insurance during all of calendar year 1993. For a discussion of this question, see "Sources of Health Insurance and Characteristics of the Uninsured," *Employee Benefit Research Institute Brief No. 158* (EBRI, February 1995).

[4] The Bureau of Labor Statistics Consumer Expenditure Survey, comprised of a quarterly interview survey and a weekly diary or recordkeeping survey, provides continuous, comprehensive information on the buying habits of American consumers. For recent data on health care spending, among others, see *Consumer Expenditures in 1993*, USDL 94–546 (U.S. Department of Labor, Nov. 7, 1994).

[5] Data are for Americans under age 65. In this article, health services are defined to encompass a wide range of items, including hospitalization, doctor and dentist visits, prescription drugs, and medical equipment. Use of these services is calculated regardless of the source of payment. See *Use and Cost of Health Services: Effect of Health Insurance and Other Factors*, Highlights No. 22 (U.S. Department of Health and Human Services, National Medical Expenditure Survey), April 1993.

[6] See *Use and Cost of Health Services: Effect of Health Insurance and Other Factors*.

[7] See *Employee Benefits in the United States, 1991–92*, Bureau of Labor Statistics, June 1994.

[8] In addition to data on health care benefits for all Americans, special data are available periodically from the Current Population Survey on health care coverage of American workers. See *Pension and Health Benefits of American Workers* (U.S. Department of Labor, Social Security Administration, U.S. Small Business Administration, and Pension Benefit Guaranty Corporation), 1994.

[9] For more information on employment projections, see James C. Franklin, "Industry output and employment," *Monthly Labor Review*, November 1993, pp. 51–57.

[10] Data on health care coverage by occupation are from unpublished tabulations of the Current Population Survey. Trends in occupational employment, and projections for the future, may be found in George T. Silvestri, "Occupational employment: wide variations in growth," *Monthly Labor Review*, November 1993, pp. 58–86.

[11] In the Employee Benefits Survey, workers are defined as "unionized" if they meet the following three criteria: (1)a labor organization must be recognized as the bargaining agent for workers in an occupation even though it is not necessary for all workers in that occupation to belong to the union; (2) wage and salary rates must be determined through collective bargaining or negotiations; and (3) settlement terms must be embodied in a signed, mutually binding collective bargaining agreement.

[12] For data on benefits coverage by union status, see *Employee Benefits for Union and Nonunion Workers, 1991–92*, Summary 94–12 (Bureau of Labor Statistics, September 1994).

[13] For information on the percent of employees covered by collective bargaining agreements by industry, see *Union Members in 1993*, USDL 94–58 (U.S. Department of Labor, Feb. 9, 1994.)

[14] Data on occupation and industry health coverage are unpublished estimates from the Current Population Survey. Union data could not be tabulated with occupation and industry data because of high variability in such data when related to health coverage data. Independent union coverage data indicate that coverage among private sector workers is concentrated in goods-producing industries and blue-collar occupations, further supporting the argument that service workers and service-producing industries are less likely than others to have employer-provided health care benefits. See *Union Members in 1993*.

[15] According to the BLS Office of Employment and Unemployment Statistics, the South and West now account for a little more than 54 percent of private sector employment, up from 48 percent in 1976.

[16] For more information on contingent workers, See Anne E. Polivka and Thomas Nardone, "On the definition of 'contingent work,' " *Monthly Labor Review*, December 1989, pp. 9–16.

[17] In the household survey, which provides data on the number of part-time workers, part-timers are defined as those workers employed less than 35 hours in a week. Data from the household survey on the number and percent of workers in part-time employment may be found in *Employment and Earnings*, a monthly publication of employment data from the Bureau of Labor Statistics. In the establishment survey, which provides data on health care benefits and contributions for part-time workers, part-timers are defined in accordance with the practices of surveyed establishments. Typically, a part-time worker is one who does the same job as someone in a full-time position, but works fewer

hours and may receive different compensation—such as fewer benefits—than the comparable full-time worker.

[18] For health care benefits incidence data for full-time and part-time workers, see Ann C. Foster, "Employee Benefits in the United States, 1991–92," *Compensation and Working Conditions*, July 1994, pp. 1–6.

[19] Temporary help employees are those who receive one or more temporary job assignments through a temporary help agency or personnel services agency. They are distinct from "leased employees," who may be assigned to a single employer on a more permanent basis. In many cases, a group of leased employees take over the duties of an organization, but are paid by a leasing agency. Data in this paragraph refer to temporary help employees.

[20] *Industry Wage Survey: Help Supply Services, October 1989*, Bulletin 2430 (Bureau of Labor Statistics, September 1993).

[21] For tax purposes, self-employed individuals are allowed to deduct from their income 25 percent of the cost of purchasing health care coverage. See Internal Revenue Code section 162l.

[22] See, "Sources of Health Insurance."

[23] For population data, see *Statistical Abstract of the United States, 1993*, table 71.

[24] *Statistical Abstract of the United States, 1993*, table 227.

[25] According to data from the Employee Benefits Survey, 40 percent of full-time employees in medium and large private establishments in 1993 who participated in an employer-sponsored health care plan while an active employee could expect such coverage at least partially financed by their employer when they retired. This was down from 45 percent in 1988.

[26] According to the Employee Benefits Survey, 6 percent of full-time employees in medium and large private establishments had group long-term care insurance available to them in 1993.

[27] Data are from the April 1992 Current Population Survey of the health care coverage of American workers. See *Pension and Health Benefits* (U.S. Department of Labor, and others, 1994).

[28] Data on provisions for preexisting conditions are from the 1993 Employee Benefits Survey of full-time employees in medium and large private establishments. See *Employee Benefits in Medium and Large Private Establishments, 1993*, Bulletin 2456 (Bureau of Labor Statistics, November 1994).

[29] Robert B. Grant, "Outpatient surgery: helping to contain health care costs," *Monthly Labor Review*, November 1992, pp. 33–36.

[30] Individuals covered by health care plans typically pay a higher proportion of smaller than larger medical bills because more of the smaller expense will be part of the deductible and because many plans have catastrophic provisions, which limit an individual's out-of-pocket expenses for costly services.

[31] Allan P. Blostin, Robert B. Grant, and William J. Wiatrowski, "Employee payments for health care services," *Monthly Labor Review*, November 1992, pp. 17–32.

[32] For information on job tenure, see "Employee Job Tenure and Occupational Mobility in the Early 1990s," USDL 92–386 (U.S. Department of Labor, June 26, 1992).

[33] See "How Americans Become Uninsured," *The Washington Post*, July 5, 1994, p. H5.