GLOSSARY

Fee-for-service health care plan. In fee-for-service plans, a premium is paid to a private insurance carrier to provide a specific package of health benefits. The plan only finances, it does not deliver, the health care services. Some employers may choose to self-fund a fee-for-service plan in which case the employer, as opposed to an insurance company, assumes responsibility for payment of physician or hospital services.

In-network provider. An in-network provider is a group of hospitals and physicians that contract with an insurance company to provide comprehensive medical services. Many plans require the plan participant to go to these providers to get coverage. Other plans will allow the participant to receive medical services outside the network from out-of-network providers at a higher cost. Preferred provider organizations, point-of-service, and exclusive provider organization medical plans will have incentives, and in some cases, require the participant to use in-network providers. A traditional fee-for-service plan will not have a network, so patients may visit the physician or hospital of their choice.

Access to a benefit plan. Employees are considered to have access to a benefit plan if it is available for their use. For example, if an employee is permitted to participate in a medical care plan offered by the employer, he or she is placed in a category with those having access to medical care, regardless of whether he or she chooses to participate.

Deductible. The deductible is the amount of covered expenses that an individual or family must pay before any charges are paid by the medical care plan. Deductibles that apply separately to a specific category of expenses, such as deductible for each hospital admission, are excluded.

Coinsurance. Coinsurance is the percentage of covered health care costs that the plan pays during the plan year until the participant reaches the out-of-pocket maximum.

Out-of-pocket maximum. The out-of-pocket maximum is the annual limit of covered expenses that a participant or family must pay after the deductible has been satisfied. Once reached, covered expenses are fully reimbursed by the insurer for the rest of the year.

TABLE 2

Median coinsurance rates for fee-for-service plans, private industry, National Compensation Survey, 2008, in percent

Characteristic	Fixed coinsurance	Variable coinsurance	
		In-network	Out-of-network
All workers	80	80	60
By bargaining status			
Union workers	80	85	70
Nonunion workers	80	80	60
By full-time/part-time status			
Full-time	80	80	60
Part-time	80	80	60

annual individual out-of-pocket maximum. For all private industry workers, the median individual out-of-pocket maximum is $2,000, and the 10th to 90th percentile values are $800 and $3,500, respectively. (See table 1.) The median individual out-of-pocket maximum for full-time workers is $2,000, and the median family out-of-pocket maximum is $4,000, while for part-time workers the median is $1,700 for individual and $3,500 for family. Union workers have a median individual out-of-pocket maximum of $1,750 and a median family out-of-pocket maximum of $4,000, while the median for nonunion workers is $2,000 for individual and $4,000 for family. Once the out-of-pocket maximum is reached, the insurer pays all covered expenses until the end of the plan year. ●

The next *Program Perspectives* will feature defined contribution retirement plans.

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FEE-FOR-SERVICE PLANS

Features and associated costs of fee-for-service medical plans

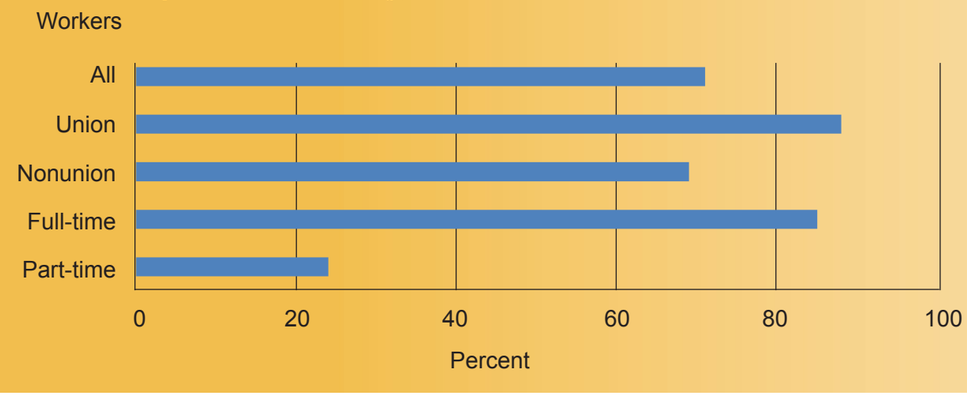
In 2008, medical care benefits were available to 71 percent of private industry workers through their employers. Fee-for-service medical plans make up the majority (78 percent) of employer provided medical plans in private industry. Health maintenance organizations (HMOs) (both traditional and open access) make up the remaining 22 percent. This issue of *Program Perspectives* takes a closer look at the components of private industry fee-for-service plans and what the typical provisions and costs are for each component. Fee-for-service medical plans come in several forms, the most common type is preferred provider organizations (PPOs), but other forms include point-of-service, exclusive provider organizations, and traditional plans without networks. In addition to annual premiums (the costs of which are usually shared by employer and employee), a fee-for-service plan typically requires the worker to pay an annual deductible before the plan pays for medical coverage. After the deductible is reached, the medical plan pays a percentage of costs, called coinsurance, and the worker must pay the health care provider the remaining percentage until the worker reaches an annual out-of-pocket maximum, after which the plan pays 100 percent of most charges.

This issue includes median costs (the point where half of the workers have a cost that is at or below that level and half of the workers have a cost that is at or above that level) and percentiles—rather than averages—because averages are

continued inside ▶

CHART 1

Percent of workers with access to medical care benefits, private industry, National Compensation Survey, March 2008



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affected more by very large individual costs making comparisons more difficult. At the 10th percentile, 10 percent of the workers have a cost that is at or below that level, while 90 percent are at or above it. At the 90th percentile, 90 percent of the workers have a cost that is at or below that level, while 10 percent are at or above it. The two percentiles provide a range that represents the individual costs for 80 percent of workers that have a medical plan with the particular plan feature being discussed. Estimates in this issue are from the Bureau of Labor Statistics *National Compensation Survey: Health Plan Provisions in Private Industry in the United States, 2008* and *Employee Benefits in the United States, March 2008* (on the Internet at **www.bls.gov/ncs/ebs/detailedprovisions/2008/ebbl0042.pdf** and **www.bls.gov/ncs/ebs/sp/ebnr0014.pdf**). Estimates on premium costs—for single and family coverage—are available at **www.bls.gov/ncs/ebs/benefits/2008/benefits_health.htm**.

How much are deductibles?

Most (93 percent) workers with fee-for-service plans are required to pay an annual deductible before the plan pays for medical expenses. The deductibles for both individual and family coverage vary by medical plan. The median individual deductible for all private industry workers is $500, while the 10th percentile is $150, and the 90th percentile is $1,500. For families, the median deductible is $1,000, with the 10th percentile at $450, and the 90th percentile at $4,000. (See table 1.)

Deductibles tend to be lower for union workers than for nonunion workers. For example, the median individual deductible for union workers is $275, and the median individual deductible for nonunion workers is $500. Union workers also have lower family deductibles than nonunion workers. Family deductibles range from $300 at the 10th percentile to $2,000 at the 90th percentile for union workers, lower than nonunion workers, whose deductible percentiles are $500 and $4,000, respectively. Additionally, union workers are more likely to have access to employer-provided health care benefits than nonunion workers. In the private industry, 88 percent of union workers have access, compared with 69 percent of nonunion workers. (See chart 1.)

Part-time workers have individual deductibles ranging from $100 at the 10th percentile to $1,000 at the 90th percentile; while for full-time workers, the amounts are $200 and $1,500 respectively. However, part-time workers are far less likely to have access to employer-provided medical care. Eighty-five percent of full-time private industry workers have access to medical care through their employers, while only 24 percent of part-time workers benefit from that access.

What happens when the deductible is reached?

After the deductible is reached, plans typically pay a percentage of authorized expenses, called coinsurance, for the remainder of the plan year. Coinsurance can be fixed or variable. When a plan has a fixed coinsurance, it pays the same percentage of the cost for any covered service. In plans with variable coinsurance, the insurer pays a higher percentage for services received from an approved in-network provider than for services received by out-of-network providers not on the approved list. The median fixed coinsurance is 80 percent for all private industry workers, regardless of union status and for both full and part-time workers. In these plans, the health insurance company pays 80 percent of the costs for medical care services, while the worker must pay the remaining 20 percent. (See table 2.)

For plans with variable coinsurance, the median in-network coinsurance for all private industry workers is 80 percent, and median out-of-network coinsurance is 60 percent. Full-time workers, part-time workers, and nonunion workers all have a median in-network coinsurance of 80 percent and a median out-of-network coinsurance of 60 percent. The median in-network coinsurance for union workers is 85 percent, and the out-of-network median coinsurance is 70 percent, which is higher than the 60 percent median coinsurance that nonunion workers receive. Therefore, if union workers decide to use a provider outside the insurer approved network, the insurer will, on average, pay a higher percentage and the union worker will pay a lower percentage than for a nonunion worker.

What is the out-of-pocket maximum?

Workers must continue to pay for a percentage of their medical care cost until they reach the yearly out-of-pocket maximum. Eighty-one percent of workers with fee-for-service plans have an

TABLE 1

Annual individual and family deductibles for fee-for-service medical plans, private industry, National Compensation Survey, 2008

Percentile	Individual					Family				
	All workers	Union	Nonunion	Full-time	Part-time	All workers	Union	Nonunion	Full-time	Part-time
Deductibles										
10	$150	$150	$200	$200	$100	$450	$300	$500	$450	$500
Median	500	275	500	500	400	1000	600	1000	1000	1000
90	1500	750	1750	1500	1000	4000	2000	4000	4000	3000
Out-of-pocket maximums										
10	$800	$750	$800	$800	$750	$2,000	$1,500	$2,000	$2,000	$1,500
Median	2000	1750	2000	2000	1700	4000	4000	4000	4000	3500
90	3500	3300	3500	3500	3500	7200	7200	7200	7200	7000