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
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

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 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 from 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 85 percent, and median out-of-network 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