Tracking Employment-Based Health Benefits in Changing Times

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Most Americans obtain their health care coverage through an employment-related plan. The National Compensation Survey (NCS) provides measures of access, participation, and features for those plans This article discusses some of the issues that the implementation of the Patient Protection and Affordable Care Act will present for the NCS.

Health care in the United States is a complex system consisting of patients, providers, insurers, employers, and governments. Individuals and companies shopping for health coverage face a myriad of choices presenting varying costs and benefits. Since most Americans obtain coverage through an employment-related plan, employers must stay current with laws and regulations and educate their employees about the changing nature of health benefits.

The Bureau of Labor Statistics (BLS), as the principal federal agency charged with reporting labor market activity, disseminates statistical information on the costs to employers for health care benefits. It also reports measures of access, participation, and features for those plans as part of its National Compensation Survey (NCS).

As the BLS continues to produce these measures, it is in a unique position to track changes as provisions of the Patient Protection and Affordable Care Act (PPACA) are implemented. Changes to BLS measures may be needed as well. For example, the BLS recently published a report on selected medical benefits that presents previously unavailable estimates of certain detailed provisions of employer-provided health plans in private industry.[1] Information on these additional provisions, or others, may be needed in the future to administer and track progress of the new law.

Varying approaches to the delivery of health services to the nation have long been subject to national debate, and they have rapidly evolved to incorporate new technologies and services to meet consumer expectations. The rising costs of these services have posed significant challenges to both private and public policy makers, and several strategies to control costs have been implemented over the last few decades. This article looks at some past efforts to change the nation's health care system, the current landscape, and some issues for the future as the new law is implemented.

Historical Perspective

The role of the federal government in the nation's health care system has long been debated. Theodore Roosevelt raised the issue during his campaign as the Progressive Party candidate for President in the 1912 general election, and in 1935 President Franklin D. Roosevelt considered including legislation to provide health care for all Americans as part of his sweeping economic initiatives. Subsequent efforts kept the subject active until 1965, when President Johnson signed legislation creating the Medicare and Medicaid programs.

Later campaigns to extend health coverage beyond the limits of Medicare and Medicaid took place in the 1970s and again in the 1990s, but no legislation was enacted. In 1997, the Children's Health Insurance Program (CHIP) was enacted to establish matching federal funds to states to provide health care to families with children. Then, around 2008, serious efforts to provide coverage for all Americans began again, leading to enactment of the Patient Protection and Affordable Care Act on March 23, 2010.[2] (See exhibits 1 and 2 on the act's features and tax provisions.) The act has a number of features, implementation of which will take several years, and in the short time since the legislation was enacted, it has continued to be the subject of much national debate.

Today's Health Care Landscape

It is important to review current conditions in the health care marketplace to understand the changes anticipated by the Patient Protection and Affordable Care Act. One measure of the current state of the health care system is the number and percentage of people with access to health insurance coverage. According to March 2011 data from the NCS, 70 percent of all private industry workers had access to health care benefits through their employers; among the lowest 10 percent of wage earners, however, only 20 percent had such access. In addition, 55 percent of all private industry workers participated in an employer-sponsored health care plan, and only 11 percent of the lowest 10 percent of earners participated.[3]

Employees may choose not to participate in an employment-based health plan for a number of reasons, including availability of coverage from another source (such as a spouse's plan) or concerns about the high cost of employee contributions. Cost may be a particular concern for low-wage earners, defined here as those in the lowest tenth wage percentile, which is $8.25 per hour for those in private industry. Note that only 55 percent of these low wage earners in private industry take a health plan when offered, which is substantially lower than the proportion for all workers, who have a 79-percent "take-up rate."

It is important to put data on coverage by employment-based health plans in a larger context. For Americans as a whole, approximately 31 percent of individuals are covered by public sources, mostly Medicare and Medicaid, while employers cover 55.3 percent of individuals. About 16 percent of Americans—nearly 50 million individuals—were uninsured in 2010.[4] (See table 1.)

Table 1. Percent of Americans with health care coverage by source, 2010

Source of coverage	Percent
Employment based	55.3
Direct purchase	9.8
Medicare	14.5
Medicaid	15.9
Military health care	4.2
Uninsured	16.3

Note: The estimates of source of coverage are not mutually exclusive. Some individuals have more than one type of coverage during the year.

Source: U.S. Census Bureau, Current Population Survey

Another topic of interest is cost. Today, almost 1 in 6 dollars in the economy is spent on medical care, which is more than twice the proportion spent in 1970.[5] About half of this cost was through private insurance, which includes employment-based plans. BLS tracks actual employer costs for health benefits as well as the rate of change in these costs.

The cost for employers to provide health benefits to workers in private industry is illustrated in table 2. This cost, expressed on a per-hour-worked basis and recently topping $2.00 per hour worked, has nearly doubled in just over a decade. The rate at which this cost has been changing is shown in chart 1, which depicts the Employment Cost Index (ECI) for health benefits for this same period.

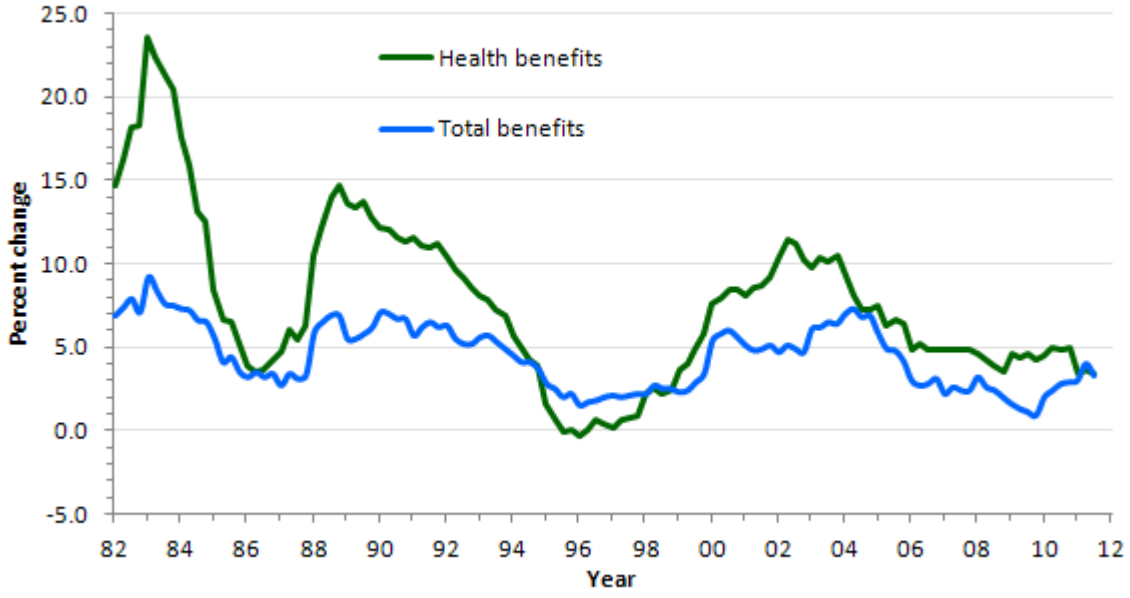
Table 2. Employer costs for health insurance benefits, private industry, 2001—2011

Year	Cost per hour worked
2001	1.16
2002	1.29
2003	1.41
2004	1.53
2005	1.64
2006	1.72
2007	1.83
2008	1.92
2009	2.00
2010	2.08
2011	2.12

Note: Data are for March of each year.

Source: U.S. Bureau of Labor Statistics, Employer Costs for Employee Compensation

Chart 1. Employment Cost Index, private industry, 12-month percent change in employer costs per hour worked, total benefits and health benefits, 1982–2011



Source: U.S. Bureau of Labor Statistics, Employment Cost Index

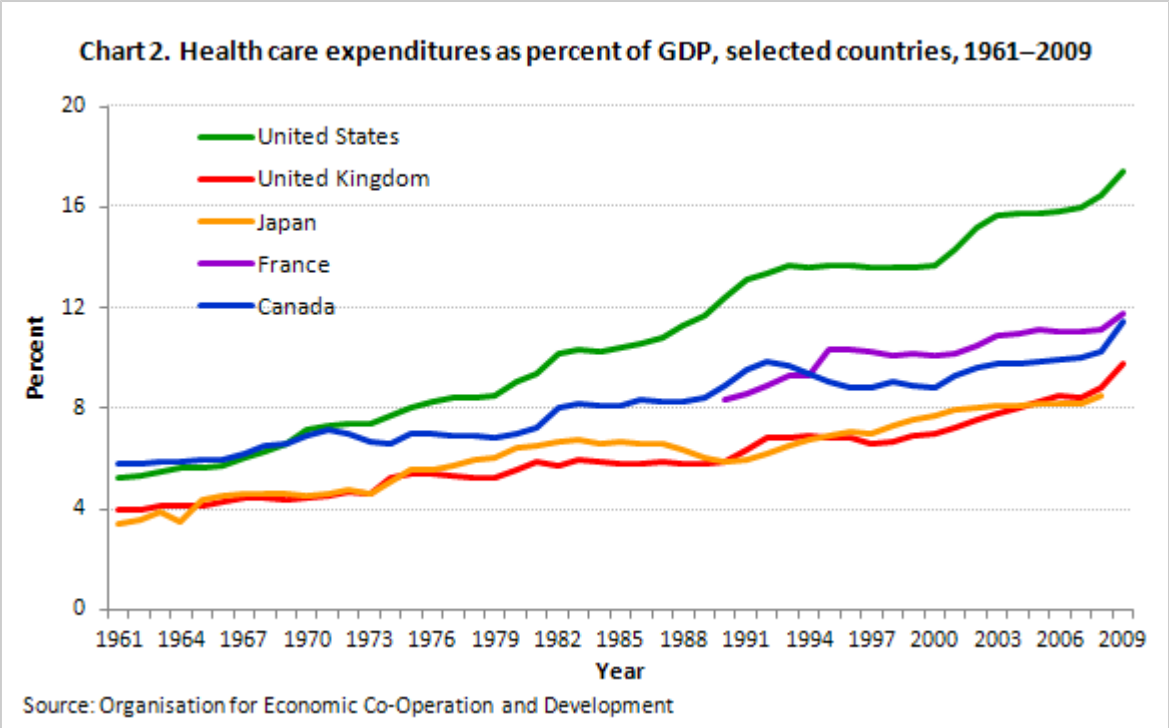
Another item of importance is the share of medical benefit premiums paid by the employee. According to the NCS, the employees' portion of medical insurance has risen from 18 to 24 percent for single coverage since 2004. For family coverage, an employee pays about one-third of the total premium. (See table 3.)

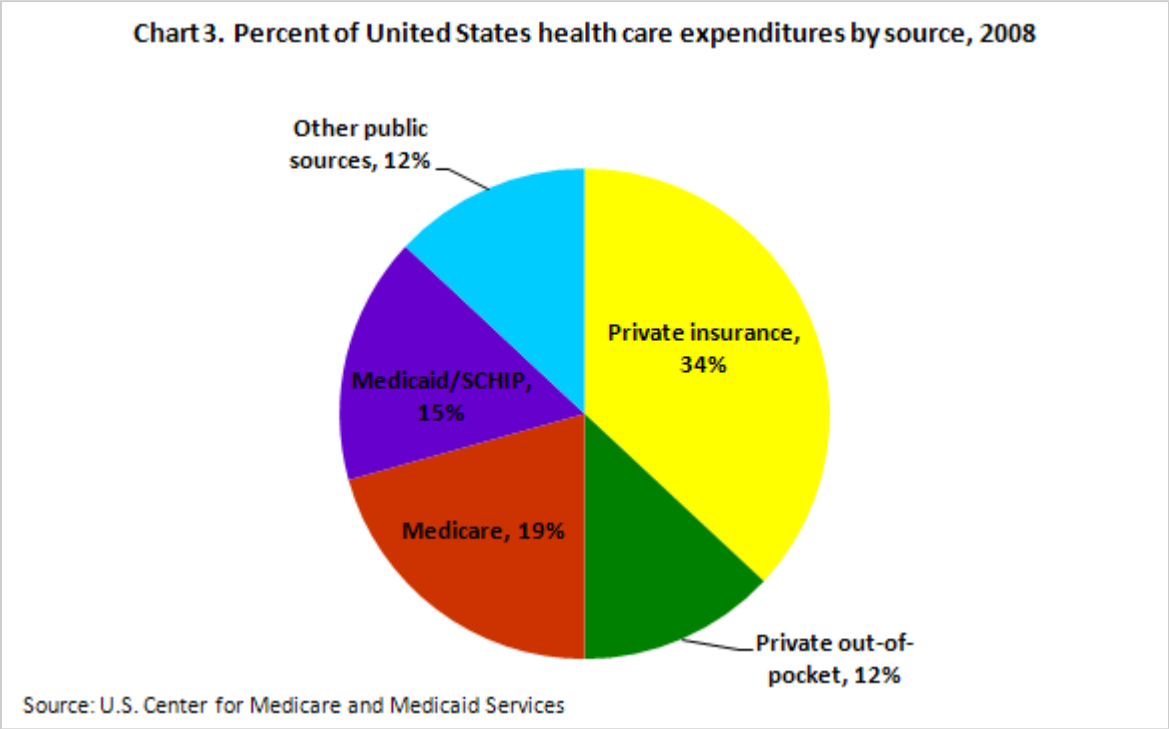
Table 3. Percent of medical insurance premium paid by employer and employee, private industry, 2004—2011

Year	Single coverage		Family coverage	
	Employer share	Employee share	Employer share	Employee share
2004	82%	18%	69%	31%
2005	82%	18%	71%	29%
2006	82%	18%	70%	30%
2007	81%	19%	71%	29%
2008	81%	19%	71%	29%
2009	80%	20%	70%	30%
2010	80%	20%	70%	30%
2011	80%	20%	69%	31%

Source: U.S. Bureau of Labor Statistics, National Compensation Survey

The total amount spent on health care in the United States was about 17 percent of the Gross Domestic Product (GDP) in 2009, or about $2.5 trillion.[6] Chart 2 illustrates that the portion of health care expenditures as a percentage of GDP is increasing for both the United States and the other industrialized nations, but the rate of increase is greater for the United States. For example, in 1970 Canada and the United States each spent approximately 7 percent of their respective GDPs on health care. By 2009, the United States spent 17 percent of GDP on health care, compared with 11 percent by Canada. Nearly half of the $2.5 trillion spent on health care in 2009 was paid by public sources, such as Medicare and Medicaid. Chart 3 provides a breakdown for the sources of health care payments in the United States.

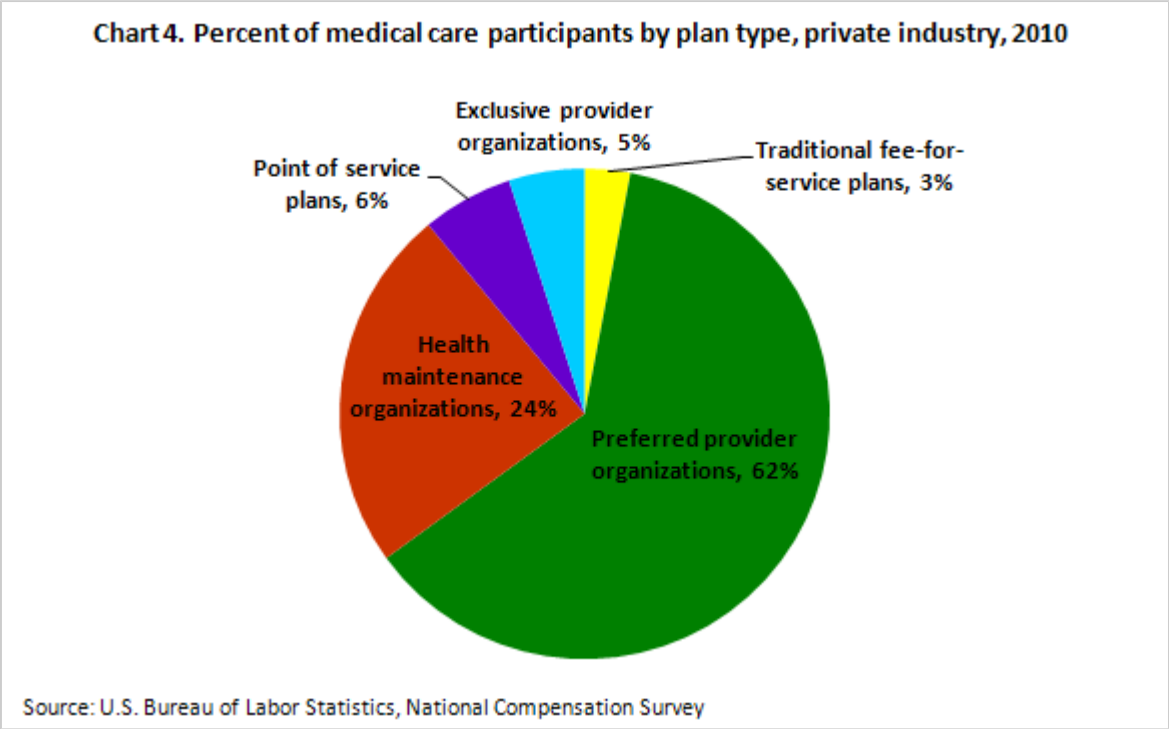




Mechanisms To Control Costs

Efforts to control the rising cost of health care have taken many forms in recent years, including the introduction and growth of new health delivery mechanisms. One such effort involved the growth of health maintenance organizations (HMOs).[7] The HMO model differs from traditional indemnity plans by attempting to maintain the health of its members through preventive benefits offered at little or no cost. HMOs typically assign a primary care physician to each member for routine office visits, but the primary care physician also acts as a gatekeeper by coordinating the patient's access to specialists. More recently, various hybrid plans have been introduced that provide greater incentives to use health care services efficiently. BLS has tracked the emergence of various health delivery mechanisms over several years.

The majority of current employer-sponsored health plan enrollment is in preferred provider organizations (PPOs). A PPO plan pays the medical provider on a fee-for-service basis and has a network of providers that members can see at discounted rates. Also, the patient is not assigned a primary care physician. The choice of providers may be an attractive feature of these plans. In 2010, PPOs covered 62 percent of participants in employment-based plans, while HMOs accounted for 24 percent. (See chart 4.)



A new approach to providing health care benefits falls under the heading of consumer-driven health plans (CDHP), in which plan members choose the best combination of cost and quality when utilizing medical services. Such plans often come with high deductibles, but they are linked to a variety of health savings accounts, the funds in which can be used to offset the high out-of-pocket expenses. The less the individual consumer spends, the more funds will accumulate in his or her account. Although CDHPs are relatively new to the marketplace, the NCS reported that high-deductible plans account for 15 percent of employer-sponsored health plan enrollment, with a median deductible of $1,600.

The approaches outlined by the Patient Protection and Affordable Care Act differ from those used by both health maintenance organizations and consumer-driven plans. The new law aims to reduce overall costs by expanding coverage and increasing competition. To increase competition, there will be two new types of plan providers: the accountable care organization (ACO) and the consumer operated and oriented provider (CO-OP). According to the U.S. Department of Health and Human Services website healthcare.gov, ACOs create incentives for health care providers to work together to treat an individual patient across care settings—including doctor's offices, hospitals, and long-term care facilities. CO-OPs are nonprofit health insurers run by their customers and designed to offer consumer-friendly, affordable health insurance options to individuals and small businesses.[8]

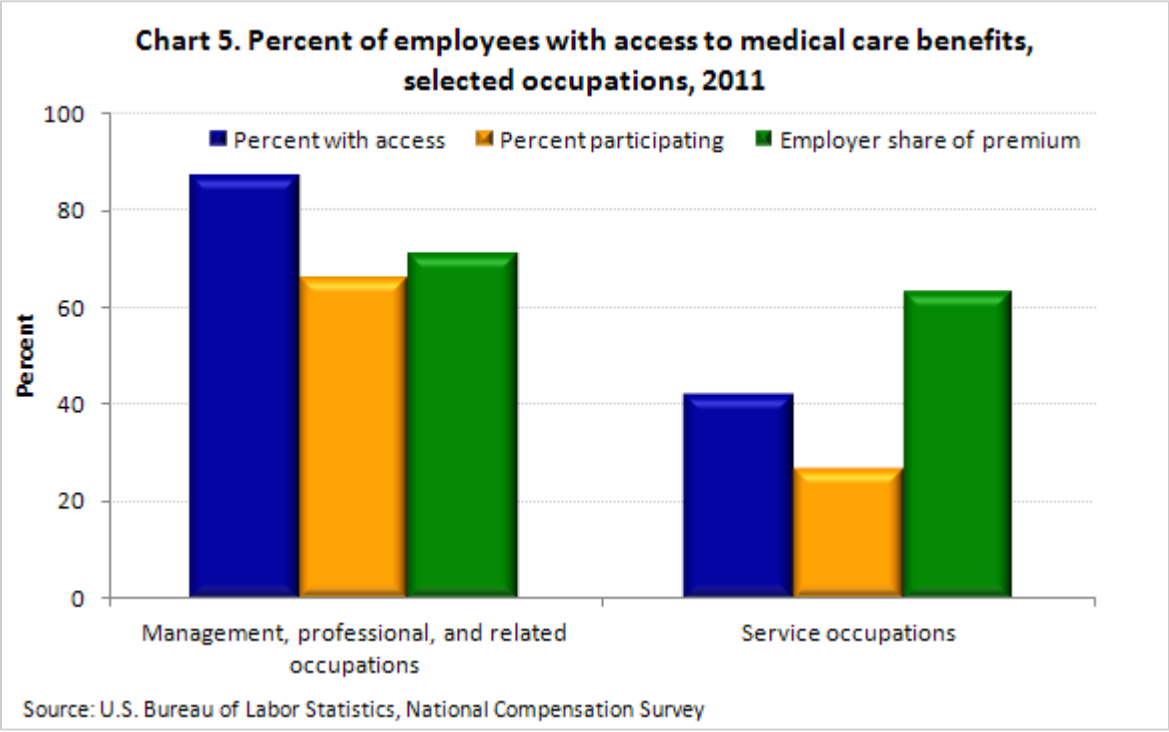
The Patient Protection And Affordable Care Act And The NCS

The Patient Protection and Affordable Care Act, which will be implemented over the next few years, will have a broad impact on employment-related health insurance plans. Some of the major impacts include changes to plan provisions—such as the elimination of lifetime dollar limits on coverage and designating a set of "essential benefits"—and changes to plan administration requirements. Other features of the act aim to extend coverage to more people by providing incentives to businesses to offer health insurance or by imposing penalties on businesses that do not provide coverage. The act's provisions create new organizations geared toward increasing competition and controlling costs. Other means of extending coverage and increasing competition include establishing health insurance exchanges and requiring individuals to obtain coverage.

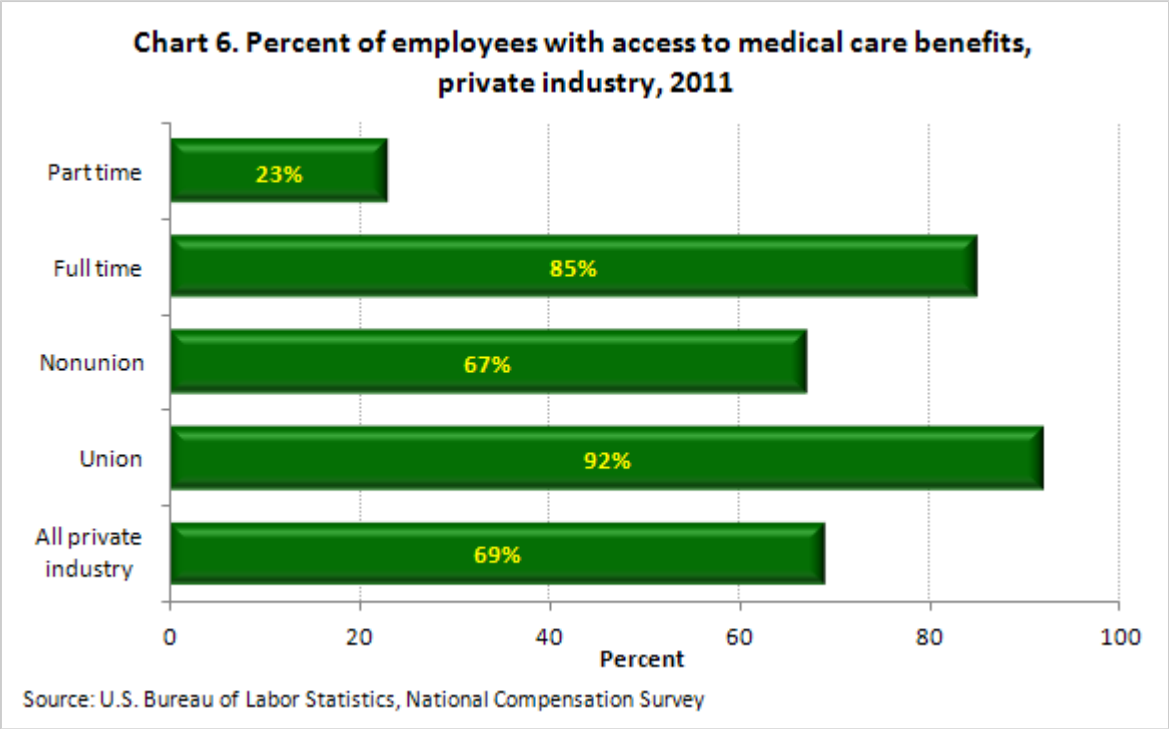
The NCS will continue to monitor the costs employers incur for health insurance through the publication of its quarterly Employment Cost Index (ECI) and Employer Costs for Employee Compensation (ECEC). Similarly, information on

employment-based health insurance coverage, plan provisions, and plan premiums will continue to be published annually through the NCS Employee Benefits Survey. One advantage of these sources is the amount of detail that can be tracked through time, such as data by occupational groupings, union status, and full- or part-time work.

For example, chart 5 compares access and participation in employer sponsored medical plans between service-related occupations and management, professional, and related occupations. The percentage of managers and professionals that have access to employer-provided medical coverage is more than twice that of service workers. Two-thirds of managers and professionals participate in their employer's plan, compared with just over a quarter of the workers in service occupations. In addition, employees in service-related occupations are required to contribute a higher proportion of their benefit premiums, on average, than are management workers.



The NCS data are often used to track differences between categories of workers. In the case of health care coverage, these data might be helpful in understanding where coverage is least prevalent and to track how such coverage changes as the new law is enacted. For example, chart 6 shows that access to medical care benefits is greater for union workers than for nonunion workers—92 percent versus 67 percent. Similarly, access is greater for full-time workers (85 percent) than for part-time workers (23 percent).



The changes brought by the Patient Protection and Affordable Care Act will present challenges for the NCS, as an establishment-based survey, in terms of measuring the incidence and costs of employment-related health insurance. For example, the development of health insurance exchanges may bring up questions about the concept of employer-provided coverage. In some cases, employers will be able to meet their obligation by providing funds to employees to purchase their own insurance through the exchange. Is this employer-provided health coverage? How will employer cost data change if employers are simply providing funds to employees? Is providing funds equivalent to giving “access” to health care? If employees purchase plans from the exchange, are they participating in an employer-sponsored plan? Can the NCS ascertain the detailed provisions of plans that are selected by individual employees from the exchange when the employer may not know which plan the employee chose?

As an ongoing statistical program, the NCS provides a benchmark for the state of employment-based health benefits prior to and as the Patient Protection and Affordable Care Act is implemented. To continue to track these benefits in changing times, the NCS may have to refine some of its concepts, definitions, and collection procedures to adapt to new plan types and new cost structures.

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Notes

1 See *Selected Medical Benefits: A Report from the Department of Labor to the Department of Health and Human Services* (U.S. Department of Labor, April 15, 2011), http://www.bls.gov/ncs/ebs/sp/selmedbensreport.pdf.

2 See *Patient Protection and Affordable Care Act*, Public Law 111-148, 111th Cong., 2d sess. (January 5, 2010), http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf.

3 See *National Compensation Survey: Employee Benefits in the United States, March 2011*: Private Industry, table 9, “Health care benefits: Access, participation, and take-up rates, private industry workers, National Compensation Survey, March 2011,” http://www.bls.gov/ncs/ebs/benefits/2011/ownership/private/table05a.pdf.

4 See Carmen DeNavas-Walt, Bernadette Proctor, and Jessica Smith, *Income, Poverty, and Health Insurance Coverage in the United States: 2010*, Current Population Reports: Consumer Income (U.S. Census Bureau, September 2011), p. 23, http://www.census.gov/prod/2011pubs/p60-239.pdf.

5 See *Health Care Costs, A Primer: Key Information on Health Care Costs and Their Impact* (The Henry J. Kaiser Family Foundation, March 2009), p. 2, fig. 1, http://www.kff.org/insurance/upload/7670_02.pdf.

6 See Centers for Medicare and Medicaid Services, National Health Expenditure Accounts, "Historical," http://www.cms.gov/NationalHealthExpendData/02_NationalHealthAccountsHistorical.asp#TopOfPage.

7 For a detailed discussion of various health delivery mechanisms, see Jerry S. Rosenbloom, *The Handbook of Employee Benefits*, 6th ed. (New York: McGraw Hill, 2005).

8 More information about ACOs and CO-Ops, including definitions and detailed descriptions, can be found at http://www.healthcare.gov/. For a detailed discussion of the development of the Patient Protection and Affordable Care Act, see Staff of the Washington Post, *Landmark: The Inside Story of America's New Health-Care Law and What It Means for Us All*, (New York: PublicAffairs Books, 2010).

Exhibit 1. Selected features of the Affordable Care Act, by year of implementation

Complete information on the ACA is available at www.healthcare.gov. The following highlights are taken from that website.

2010

- Prohibit denying coverage of children based on pre-existing conditions
- Eliminate lifetime limits on insurance coverage
- Provide small business health insurance tax credits
- Provide free preventive care
- Expanded coverage for young adults up to age 26

2011

- Offer prescription drug discounts to certain senior citizens
- Test new delivery mechanisms to improve health care quality and efficiency

2012

- Link hospital payments to quality outcomes
- Encourage physicians to join together to form Accountable Care Organizations

2013

- Improve preventive health coverage in state Medicaid programs
- Provide additional funding for the Children's Health Insurance Program

2014

- Prohibit discrimination due to pre-existing conditions
- Eliminate annual limits on insurance coverage
- Ensure coverage for individuals participating in clinical trials
- Provide tax credits to lower income individuals to make care more affordable
- Establish affordable insurance exchanges
- Mandate individual coverage

2015

- Pay physicians based on value rather than volume

For more information, go to **http://www.healthcare.gov/law/timeline/full.html#2010**.

Exhibit 2. Selected tax provisions of the Affordable Care Act

Complete information on the ACA tax provisions is available at www.irs.gov. The following highlights are taken from that website.

- Health Coverage for Older Children: Effective March 30, 2010, health coverage for an employee's children under 27 years of age is now generally tax-free to the employee.
- Medicare Part D Coverage Gap "donut hole" Rebate: Provides a one-time $250 rebate in 2010 to assist Medicare Part D recipients who have reached their Medicare drug plan's coverage gap.
- Changes to Flexible Spending Arrangement: Effective Jan. 1, 2011, the cost of an over-the-counter medicine or drug cannot be reimbursed from Flexible Spending Arrangements or health reimbursement arrangements unless a prescription is obtained.
- Annual Fee on Branded Prescription Pharmaceutical Manufacturers and Importers: Creates an annual fee payable beginning in 2011 by certain manufacturers and importers of brand name pharmaceuticals.
- Employer-Provided Health Coverage: For informational purposes, employers will be required to report the cost of coverage under an employer-sponsored group health plan on employee W-2 forms (annual wage and tax statements). Originally to be effective for tax year 2011, this requirement is currently being refined.
- Health Insurance Premium Tax Credit: Starting in 2014, individuals and families can take a premium tax credit to help them afford health insurance coverage purchased through an Affordable Insurance Exchange.
- Employer Shared Responsibility Payment: Starting in 2014, certain employers must offer health coverage to their full-time employees or a shared responsibility payment may apply.

For More Information, go to **http://www.irs.gov/newsroom/article/0,,id=220809,00.html?portlet=6**.

Data for Chart 1. Employment Cost Index, private industry, 12-month percent change in employer costs per hour worked, total benefits and health benefits

Yr.Qtr	Total benefits	Health benefits
1982-03-01	6.9	14.7
1982-06-01	7.4	16.2
1982-09-01	7.9	18.1
1982-12-01	7.1	18.3
1983-03-01	9.2	23.5
1983-06-01	8.4	22.4
1983-09-01	7.6	21.3
1983-12-01	7.5	20.4
1984-03-01	7.3	17.6
1984-06-01	7.2	15.9
1984-09-01	6.6	13.1

Source: U.S. Bureau of Labor Statistics, Employment Cost Index

Yr.Qtr	Total benefits	Health benefits
1984-12-01	6.5	12.5
1985-03-01	5.5	8.5
1985-06-01	4.1	6.7
1985-09-01	4.4	6.5
1985-12-01	3.5	5.2
1986-03-01	3.2	3.9
1986-06-01	3.5	3.5
1986-09-01	3.2	3.6
1986-12-01	3.4	4.1
1987-03-01	2.7	4.7
1987-06-01	3.4	6.1
1987-09-01	3.1	5.5
1987-12-01	3.3	6.3
1988-03-01	5.9	10.5
1988-06-01	6.5	12.2
1988-09-01	6.9	13.9
1988-12-01	6.9	14.7
1989-03-01	5.5	13.6
1989-06-01	5.5	13.4
1989-09-01	5.8	13.7
1989-12-01	6.2	12.8
1990-03-01	7.1	12.2
1990-06-01	7.0	12.0
1990-09-01	6.7	11.5
1990-12-01	6.7	11.3
1991-03-01	5.7	11.5
1991-06-01	6.2	11.1
1991-09-01	6.5	10.9
1991-12-01	6.2	11.2
1992-03-01	6.3	10.3
1992-06-01	5.5	9.6
1992-09-01	5.2	9.2
1992-12-01	5.2	8.6
1993-03-01	5.6	8.1
1993-06-01	5.7	7.8
1993-09-01	5.3	7.2
1993-12-01	4.9	6.9
1994-03-01	4.5	5.7
1994-06-01	4.1	5.0
1994-09-01	4.1	4.3
1994-12-01	3.7	3.9
1995-03-01	2.8	1.6

Source: U.S. Bureau of Labor Statistics, Employment Cost Index

Yr.Qtr	Total benefits	Health benefits
1995-06-01	2.5	0.6
1995-09-01	2.0	-0.1
1995-12-01	2.2	0.1
1996-03-01	1.5	-0.3
1996-06-01	1.7	0.1
1996-09-01	1.8	0.7
1996-12-01	2.0	0.4
1997-03-01	2.1	0.2
1997-06-01	2.0	0.7
1997-09-01	2.1	0.8
1997-12-01	2.2	0.9
1998-03-01	2.2	2.2
1998-06-01	2.7	2.6
1998-09-01	2.5	2.2
1998-12-01	2.5	2.5
1999-03-01	2.3	3.7
1999-06-01	2.4	4.0
1999-09-01	2.9	5.0
1999-12-01	3.4	5.8
2000-03-01	5.4	7.6
2000-06-01	5.8	8.0
2000-09-01	6.0	8.5
2000-12-01	5.6	8.5
2001-03-01	5.1	8.1
2001-06-01	4.8	8.6
2001-09-01	4.9	8.7
2001-12-01	5.1	9.2
2002-03-01	4.7	10.5
2002-06-01	5.1	11.4
2002-09-01	4.9	11.2
2002-12-01	4.7	10.2
2003-03-01	6.1	9.8
2003-06-01	6.2	10.3
2003-09-01	6.5	10.1
2003-12-01	6.4	10.5
2004-03-01	7.0	9.3
2004-06-01	7.3	8.1
2004-09-01	6.8	7.3
2004-12-01	6.9	7.3
2005-03-01	5.8	7.5
2005-06-01	4.9	6.3
2005-09-01	4.8	6.7

Source: U.S. Bureau of Labor Statistics, Employment Cost Index

Yr.Qtr	Total benefits	Health benefits
2005-12-01	4.2	6.4
2006-03-01	3.0	4.8
2006-06-01	2.7	5.2
2006-09-01	2.8	4.9
2006-12-01	3.1	4.9
2007-03-01	2.2	4.9
2007-06-01	2.6	4.8
2007-09-01	2.4	4.8
2007-12-01	2.4	4.8
2008-03-01	3.2	4.6
2008-06-01	2.6	4.2
2008-09-01	2.4	3.9
2008-12-01	2.0	3.5
2009-03-01	1.6	4.6
2009-06-01	1.3	4.4
2009-09-01	1.1	4.6
2009-12-01	0.9	4.3
2010-03-01	2.0	4.5
2010-06-01	2.4	5.0
2010-09-01	2.8	4.8
2010-12-01	2.9	5.0
2011-03-01	3.0	3.4
2011-06-01	4.0	3.6
2011-09-01	3.3	3.4

Source: U.S. Bureau of Labor Statistics, Employment Cost Index

Data for Chart 2. Health care expenditures as percent of GDP, selected countries, 1961—2009

Year	Canada	France	Japan	United Kingdom	United States
1961	5.80		3.39	3.99	5.26
1962	5.76		3.58	3.99	5.32
1963	5.87		3.84	4.10	5.48
1964	5.85		3.49	4.11	5.66
1965	5.92	4.75	4.39	4.14	5.67
1966	5.94		4.49	4.25	5.71
1967	6.23		4.61	4.44	6.05
1968	6.48		4.62	4.46	6.30
1969	6.59		4.58	4.37	6.60
1970	6.88	5.38	4.50	4.47	7.11

Source: Organisation for Economic Co-Operation and Development

Year	Canada	France	Japan	United Kingdom	United States
1971	7.16		4.62	4.55	7.28
1972	7.01		4.73	4.64	7.41
1973	6.68		4.60	4.61	7.36
1974	6.57		5.05	5.20	7.69
1975	6.97	6.37	5.59	5.41	8.02
1976	6.97		5.59	5.42	8.25
1977	6.93		5.73	5.29	8.44
1978	6.92		5.92	5.26	8.39
1979	6.79		6.04	5.22	8.52
1980	7.03	7.02	6.45	5.58	9.04
1981	7.22		6.52	5.87	9.37
1982	8.03		6.68	5.72	10.18
1983	8.20		6.79	5.93	10.33
1984	8.09		6.58	5.86	10.22
1985	8.12	8.00	6.65	5.77	10.42
1986	8.36		6.60	5.78	10.57
1987	8.29		6.61	5.86	10.83
1988	8.22		6.31	5.79	11.28
1989	8.43		6.06	5.82	11.68
1990	8.87	8.37	5.90	5.88	12.36
1991	9.56	8.62	5.94	6.32	13.08
1992	9.83	8.87	6.20	6.79	13.39
1993	9.71	9.33	6.48	6.82	13.68
1994	9.37	9.29	6.76	6.89	13.58
1995	9.03	10.37	6.90	6.83	13.71
1996	8.82	10.37	7.05	6.84	13.67
1997	8.79	10.23	6.99	6.61	13.56
1998	9.04	10.13	7.28	6.66	13.58
1999	8.90	10.15	7.55	6.89	13.58
2000	8.84	10.07	7.71	7.01	13.66
2001	9.32	10.20	7.93	7.24	14.33
2002	9.60	10.52	7.98	7.56	15.15
2003	9.78	10.89	8.13	7.76	15.67
2004	9.78	11.01	8.08	7.99	15.71
2005	9.82	11.10	8.22	8.24	15.74
2006	9.97	11.04	8.19	8.48	15.83
2007	10.04	11.02	8.19	8.42	16.02
2008	10.28	11.10	8.50	8.78	16.42
2009	11.41	11.78		9.78	17.38

Source: Organisation for Economic Co-Operation and Development

Data for Chart 3. Percent of United States health care expenditures by source, 2008

Source	Percent
Private insurance	34%
Private out-of-pocket	12%
Medicare	19%
Medicaid/SCHIP	15%
Other public sources	12%
Other private sources	8%

Source: U.S. Center for Medicare and Medicaid Services

Data for Chart 4. Percent of medical care participants by plan type, private industry, 2010

Plan type	Percent
Traditional fee-for-service plans	3%
Preferred provider organizations	62%
Health maintenance organizations	24%
Point of service plans	6%
Exclusive provider organizations	5%

Source: U.S. Bureau of Labor Statistics, National Compensation Survey

Data for Chart 5. Percent of employees with access to medical care benefits, selected occupations, 2011

Occupation	Percent with access (offered a plan)	Percent participating (currently covered)	Employer share of premium for family coverage
Management, professional, and related occupations	87	66	71
Service occupations	42	27	63

Source: U.S. Bureau of Labor Statistics, National Compensation Survey

Data for Chart 6. Percent of employees with access to medical care benefits, private industry, 2011

Characteristics	Percent
All private industry	69
Union	92

Source: U.S. Bureau of Labor Statistics, National Compensation Survey

Characteristics	Percent
Nonunion	67
Full time	85
Part time	23

Source: U.S. Bureau of Labor Statistics, National Compensation Survey

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