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The National Compensation Survey: a look at variable premium medical care plans

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After the passage of the Affordable Care Act (ACA), the U.S. Bureau of Labor Statistics National Compensation Survey (NCS)[1] program researched the potential effects of the law on published measures. The NCS program conducted a feasibility test to closely examine the ability to collect data on plan features, such as the factors involved in variable medical care premium plans.

The results of the feasibility test led to new survey questions on the extent to which employer and employee premiums were based on factors such as tobacco, (employee participation in) wellness programs, salary, and age. For example, an employer may offer all employees the same medical plan, but require those who use tobacco to pay higher premiums because they incur higher medical cost risks. From September 2016 to June 2017, the NCS

program collected data on medical care premium factors and number of variations (e.g., salary levels or age brackets) from a survey of 6,700 private industry and 1,400 state and local government establishments in the United States. This article provides a summary of data collection efforts and results for the March 2017 reference period.

Background

Prior to the ACA, insurance companies varied premiums by factors such as age, gender, and geographic location.[2] With the passage of the ACA, insurance companies were allowed to vary their plan premiums by additional factors, such as employee salaries and participation in wellness programs. Consequently, the decision to vary medical plan premiums can be made by the health insurance company, the establishment, or both. Employers' and employees' premiums can vary with these characteristics, making the data collection of medical care insurance costs considerably more complex.

The NCS program collects premiums on the basis of a fixed flat dollar amount, and the share of premiums for civilian workers has remained relatively stable for the past 10 years. For single-coverage medical plans, approximately 20 percent of the cost was paid by employees and 80 percent by employers; for family-coverage medical plans, approximately 30 percent of the cost was paid by employees and 70 percent by employers. The NCS program also publishes the percentage of workers participating in medical care benefits by type of employee contribution. For civilian workers participating in single-coverage plans with variable premiums, the participation rate was 12 percent in 2011 and 17 percent in 2017; for family-coverage plans, the participation rate was 11 percent in 2011 and 17 percent in 2017.[3]

The NCS program conducted a feasibility test on 200 establishments in order to understand the changes that employers made in, or expected to incorporate into, their medical care plans because of the ACA. As part of the test, the NCS program investigated the frequency and availability of variable premiums and features (e.g., the grandfathered status of a plan, the "metal levels" of a plan[4]) related to the ACA.[5] NCS field economists asked additional survey questions to respondents when premiums varied. In these instances, economists asked whether the variations were based on tobacco use, wellness programs, age, salary, or other factors. In addition, they requested information on the number of variations (i.e., the distinct set of premiums) for each factor. In order to minimize respondent burden, the test included establishments that previously had provided data to the NCS.

From September 2016 to June 2017, field economists collected data on variable medical premium factors and variations based on the results obtained from the feasibility test. They interviewed respondents and reviewed plan documentation, such as Summary Plan Descriptions and Summary of Benefits and Coverage, for sampled establishments. The next section presents a summary of those efforts.

Results

Estimates of variable medical premium factors and variations cover civilian workers (both private industry and state and local government workers), as well as individual private industry and state and local government worker categories. In addition, estimates are provided only for the "all workers" category, because of the limited number of results on detailed worker and establishment characteristics (e.g., occupational group, industry).

There were challenges in collecting both employer and employee premium data classifications, but efforts to capture data on employee premiums and related provisions proved more successful.

Table 1 provides data on variable premium factors by ownership, and table 2 identifies the number of variations used for each factor. In table 1, a “yes” response identifies the factor (e.g., tobacco) involved in setting premium rates, and more than one variable premium factor could be used in setting rates (e.g., tobacco and age). When field economists were unable to collect information from respondents (either because the respondents did not know or were unwilling to provide the information), the field economists coded these instances as “not determinable.” Rates classified as “not determinable” exceeded the publication criteria limits for some estimates. In addition, rates classified as “not determinable” were higher for the full-sample collection than for the feasibility test. Data on variable premiums for employer contributions did not meet reliability and confidentiality criteria for publications; therefore, the results that follow are for employee variable premiums.[6]

Tobacco use

Programs designed to reward employees who do not use tobacco or who decrease their tobacco use are an allowed variable premium factor within the ACA. Because the cost of premiums may vary by as much as 50 percent for tobacco users, this factor was made a distinct category.[7] For the tobacco-use factors, a total of two variations typically signifies smoking versus not smoking. A total of three or more variations may include smoking, not smoking, never smoked, and cessation-related options or programs.

Tobacco use was the most prevalent factor found in variable medical care premiums. Nearly half of all civilian workers participating in single and family coverage had different premium costs based on tobacco use, with no significant differences between private industry workers and state and local government workers. (See table 1.)

Table 1. Percentage of workers, by variable premium factors and type of coverage, March 2017 (all workers participating in medical care plans with variable premiums = 100 percent)

Characteristic	Factor				
	Tobacco	Wellness	Salary	Age	Other[1]
Civilian workers[2]					
Single coverage					
Yes[3]	47	28	24	5	12
No	35	53	58	77	70
Not determinable	18	18	18	18	18
Family coverage					
Yes[3]	46	27	23	6	14
No	37	55	59	76	69
Not determinable	18	18	18	18	17
Private industry workers					
Single coverage					
Yes[3]	48	26	23	7	12
No	31	52	56	72	67
Not determinable	21	21	21	21	21
Family coverage					
Yes[3]	46	25	22	8	14
No	33	54	57	72	66
Not determinable	21	21	21	20	20
State and local government workers					

See footnotes at end of table.

Table 1. Percentage of workers, by variable premium factors and type of coverage, March 2017 (all workers participating in medical care plans with variable premiums = 100 percent)

Characteristic	Factor				
	Tobacco	Wellness	Salary	Age	Other[1]
Single coverage					
Yes[3]	45	34	27	-	11
No	45	56	63	-	79
Family coverage					
Yes[3]	44	32	26	-	14
No	46	57	65	-	76
Not determinable	10	10	9	-	10

[1] All other variable premium factors not listed (e.g., spousal surcharges).
[2] Private industry and state and local government workers.
[3] "Yes" response refers to whether the specific factor affects premium rates. More than one factor may be identified in responses.
Note: Because of rounding, sums of individual items may not equal 100 percent. Dash indicates no data were reported or data do not meet publication criteria.
Source: U.S. Bureau of Labor Statistics, National Compensation Survey.

For those civilian workers with variable premiums based on tobacco use, the majority of workers (68 percent) participated in plans with two variations. Higher levels of private industry workers than state and local government workers participated in plans with three or more variations. Among state and local government workers, nearly all (98 percent) had plans with two variations. There were no significant differences between plans with single versus family coverage. (See table 2.)

Table 2. Percentage of workers, by variable premium factors and number of variations, March 2017 (all workers participating in medical care plans with variable premiums = 100 percent)

Characteristic	Factor			
	Tobacco	Wellness	Salary	Other[1]
Civilian workers[2]				
Single coverage				
2 variations	68	66	17	61
3 or more variations	29	26	68	18
Not determinable	3	8	14	21
Family coverage				
2 variations	68	65	18	68
3 or more variations	29	27	68	14
Not determinable	3	9	14	18
Private industry workers				
Single coverage				
2 variations	58	72	23	57
3 or more variations	38	17	63	18
Not determinable	4	12	14	25
Family coverage				
2 variations	57	71	24	63
3 or more variations	39	17	63	15
Not determinable	4	12	13	22
State and local government workers				

See footnotes at end of table.

Table 2. Percentage of workers, by variable premium factors and number of variations, March 2017 (all workers participating in medical care plans with variable premiums = 100 percent)

Characteristic	Factor			
	Tobacco	Wellness	Salary	Other[1]
Single coverage				
2 variations	98	52	4	73
3 or more variations	2	46	80	19
Not determinable	-	2	16	8
Family coverage				
2 variations	98	52	4	83
3 or more variations	2	47	80	11
Not determinable	-	2	16	6

[1] All other variable premium factors not listed (e.g., spousal surcharges).
[2] Private industry and state and local government workers.
Note: Because of rounding, sums of individual items may not equal 100 percent. Dash indicates no data were reported or data do not meet publication criteria.
Source: U.S. Bureau of Labor Statistics, National Compensation Survey.

Wellness programs

Health-contingent wellness generally requires employees to participate in a program to meet a specific standard related to their health (e.g., weight, cholesterol levels, blood pressure).[8] The NCS field economists collected data on participation in wellness programs and on the number of variations in those plans. Overall, for 28 percent of civilian workers participating in single-coverage variable premium plans, the contribution was determined by wellness program provisions, and most workers participated in plans with two variations. (See tables 1 and 2.)

Employee salary

Employers can vary premiums by setting different tiers of premiums for workers in different salary bands. Having different premiums by salary level may improve the ability of lower paid workers to participate in employer-sponsored medical care plans. Employee salary was a factor for 24 percent of all civilian workers participating in single-coverage variable premium plans and for 23 percent with family coverage. (See table 1.)

For approximately 80 percent of state and local government workers, three or more salary class variations were present in variable premium plans. By contrast, just 63 percent of private industry workers had three or more salary class variations in such plans. (See table 2.)

Employee age

The provisions of the ACA allow insurers and employers to vary premiums by the age of the employee. For the age category, there are two age bands, one comprising those less than 15 years old and another those ages 64 and older. There are also separate subcategories for workers ages 15 through 63, with the number of variations based on single ages.[9] Overall, only 5 percent of employees with single-coverage variable premium plans and 6 percent of those with family coverage had age as a variable premium factor. The number of variations provided for employee age did not meet publication criteria.

Other

This category included other ways that premiums might vary beyond tobacco use, wellness programs, employee salary, and age. For example, one type of variation designated as “other” is spousal surcharges,[10] in which employees must pay an additional cost to cover working spouses who have declined health coverage from their employer. The purpose of this additional fee is to lower costs to the employer by providing an incentive for employees’ spouses to enroll in coverage elsewhere. Other variations identified included length of service and work schedule (e.g., work shift, weekends worked). Overall, 12 percent of workers participating in single-coverage plans, and 14 percent of workers with family-coverage plans, had “other” as a factor involved in determining variable premium rates. (See table 1.)

Summary

The use of variable premium health plans has been increasing, and the NCS program expected to add to its extensive portfolio of medical care data by identifying the prevalence of variable premium factors (e.g., tobacco use, age, wellness program) and related variations. According to the estimation results, tobacco use was the most prevalent factor involved in variable premium rates for civilian workers, with plans based on typically having two variations. Employee wellness programs and salary were identified as factors in approximately 1 in 4 variable premium plans for civilian workers.

Feasibility testing showed that respondents were willing and able to provide information regarding variable premium medical care plan factors and number of variations; however, the added survey questions with a full sample size proved more challenging and burdensome, resulting in high levels of responses that were not determinable, affecting the ability to publish future data. On the basis of these results, the NCS program discontinued the collection of variable premium factor and variations data and will seek future opportunities to continue providing comprehensive health care cost and coverage data.

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RELATED ARTICLES

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NOTES

[1] The National Compensation Survey (NCS) is an establishment survey within the Bureau of Labor Statistics that provides comprehensive measures of employer costs for employee compensation. The NCS also publishes statistics on the incidence and provisions of employer-provided benefits for workers, including medical care. For more information, see www.bls.gov/ncs.

[2] For more information on health insurance market premium factors before the Affordable Care Act, see Mark Newsom and Bernadette Fernandez, "Private health insurance premiums and rate reviews" (Congressional Research Service, January 11, 2011), http://digitalcommons.ilr.cornell.edu/key_workplace/788.

[3] For more information on employer and employee premium sharing and type of contribution for single and family coverage, see *National Compensation Survey: Employee Benefits in the United States, March 2018*, Bulletin 2789 (U.S. Bureau of Labor Statistics, September 2018), on *Employee Benefits Survey* page, www.bls.gov/ebs.

[4] Metal levels refer to how much the plan covers in terms of cost. Gold plans cover 80 percent; Silver, 70 percent; Bronze, 60 percent.

[5] For more information on National Compensation Survey testing of variable premiums, see Jeffrey L. Schildkraut, Cathy A. Baker, Kenneth N. Cho, and Kevin L. Reuss, "The National Compensation Survey and the Affordable Care Act: preserving quality health care data, *Monthly Labor Review*, April 2015, www.bls.gov/opub/mlr/2015/article/the-national-compensation-survey-and-the-affordable-care-act-preserving-quality-health-care-data.htm.

[6] For more information on data reliability and confidentiality, see "National Compensation Measures: Overview," in *Handbook of Methods* (U.S. Bureau of Labor Statistics, December 15, 2017), www.bls.gov/opub/hom/ncs/home.htm.

[7] For more information on how insurance companies set health premiums, see "How insurance companies set health premiums,"*HealthCare.gov* (U.S. Centers for Medicare and Medicaid Services), www.healthcare.gov/how-plans-set-your-premiums.

[8] For a definition of a wellness program, see "Wellness programs," *HealthCare.gov* (U.S. Centers for Medicare and Medicaid Services), www.healthcare.gov/glossary/wellness-programs/.

[9] For additional information on medical insurance age bands, see "Rating restrictions for health insurance premiums" (Orland Park, IL: Horton, October 21, 2013), www.thehortongroup.com/resources/rating-restrictions-for-health-insurance-premiums; and the memorandum from Samara Lorenz titled "Insurance Standards Bulletin Series—INFORMATION," (U.S. Centers for Medicare and Medicaid Services, December 16, 2016), www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-Guidance-Regarding-Age-Curves-and-State-Reporting-12-16-16.pdf.

[10] For more on spousal surcharges, see Kerry Hannon (contributor) and Next Avenue (contributor group), "Employers penalizing spouses for health insurance," *Forbes*, April 25, 2013, www.forbes.com/sites/nextavenue/2013/04/25/employers-penalizing-spouses-for-health-insurance/#2c29454d50bd.

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