2022 Survey of Collectively Bargained Health Benefit Plans in the USA

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Summary

This report includes the results from a survey of large collectively bargained health insurance plans. These plans cover many employees who work in unions. The survey found that such health plans generally have more generous benefits than employer-sponsored health insurance (ESI). These plans, for example, cover a higher percentage of the premium and have lower average deductibles than ESI.

The objectives of this study were to:

1. Document the current state of health benefits in collectively bargained plans
2. Compare union-sponsored trusts' current health benefits with those of employer-based plans

Background

In 2020, approximately 11 percent of U.S. wage and salary workers were union workers.[1] Virtually all union workers receive health benefits through either their employer or union. NORC conducted a survey on behalf of The Pacific Maritime Association on the health benefits offered by collectively bargained plans, which are often called union-sponsored trusts. These data will allow the Pacific Maritime Association to assess the health benefits currently offered through these trusts and compare them to those offered through employer-sponsored insurance (ESI) where possible.

ESI has changed substantially in the last decade. For example, 28% of those covered by ESI in 2021 were enrolled in a high-deductible health plan with a savings option, such as a health savings account (HSA) or health reimbursement arrangement (HRA), compared to 17% in 2011.[2] These plans always include a deductible, unlike other plan types such as HMOs or PPOs, where deductibles are common but not universal. Moreover, average deductibles and many other out-of-pocket costs such as copayments and premium contributions have increased steadily over this timeframe as well. Less is known about the current state of health benefits in collectively bargained plans or how they might have changed. The frequently cited employer surveys often do not include collectively bargained plans in the sample or do so in a limited manner.[3]

Results

Collectively bargained health plans fall into two categories: multi-employer plans, also called Taft-Hartley plans, and single-employer plans. This survey was limited to multi-employer plans with at least 200 covered lives. In addition to general information about each plan (i.e., number of participants and type of coverage offered), data related to eligibility, premiums, employee contributions and cost-sharing, coverage of ancillary services and prescription drugs, and long-term care insurance were collected.

ELIGIBILITY AND COVERAGE

Most collectively bargained health plans offer family coverage to employees. The percentage of employed individuals offered family coverage is similar between collectively bargained and all employer-sponsored plans (97.7 percent and 96 percent, respectively). Eligibility and coverage were lower for temporary workers and retirees.

Fewer than one in five collectively bargained plans (16.9 percent) offer coverage to temporary workers, compared to fewer than one in ten (7 percent) ESI plans. Temporary workers are more likely to be offered coverage under plans with 1,000 or more covered lives (26.5 percent) compared to the average for all plans.

Approximately half of collectively bargained health plans (49.2 percent) offer coverage to retirees, including both early retirees and Medicare-age retirees. Similar to temporary worker coverage, larger collectively bargained health plans with 1,000 or more covered lives were more likely to offer coverage to retirees (57.5 percent) when compared to the average for all plans. This is a higher rate of retiree coverage than all large (200 or more covered lives) employer-sponsored health plans (27 percent).

Health plans have a variety of eligibility requirements in order for employees to receive health care coverage. This survey gathered information on waiting periods (the amount of time an employee must wait before some or all coverage comes into effect) and requirements regarding a minimum number of hours worked prior to eligibility. 83 percent of all collectively bargained health plans have a waiting period. The average waiting period for these plans is two-and-a-half months. Only 67.4 percent of employees enrolled in large plans of 1,000 or more covered lives are subject to a waiting period, and the average waiting period for this population is 2.6 months. Table 1 includes data on eligibility and coverage. ESI data for comparing waiting periods and required hours to maintain eligibility are not available because the Kaiser Family Foundation 2021 Employer Health Benefits Survey Annual Report did not report data on these topics.

Table 1. Eligibility and Coverage in Collectively Bargained Health Plans and Employer-sponsored Health Plans

	Collectively Bargained Health Plans		ESI Health Plans[2]
	All	Large Plans	
Percentage of individuals offered family coverage	99%	97.7%	96%*
Percentage of employees subject to waiting period	83%	67.4%	-
Average waiting period (months)	2.5	2.6	-
Average number of hours of employment before coverage begins	407.6	410.2	-
Average number of hours to maintain coverage as an active employee	1,029.9	1,183.5	-
Coverage of temporary workers	16.9%	26.5%	7%**
Coverage of retirees	49.2%	57.8%	27%

Note. ESI health plan data are from the Kaiser Family Foundation 2021 Employer Health Benefits Survey Annual Report. *Kaiser Family Foundation 2021 Employer Health Benefits Survey Annual Report describes this measure as the percentage of firms that offer family coverage to employees, not the percentage of individuals offered family coverage. **Data from the Kaiser Family Foundation 2019 Report.

PREMIUMS AND EMPLOYEE CONTRIBUTION

The average total monthly premium for single coverage under collectively bargained plans is $658 (Table 2), which is similar to the monthly premium to ESI plans ($645). Family coverage premiums are lower for collectively bargained plans ($1,632) compared with ESI plans ($1,852). Employees under collectively bargained plans are also responsible for a smaller share of their premiums relative to those in ESI plans. Employees with single coverage contribute 12 percent of the monthly premium, compared to 17 percent for those with ESI plans. Employees with family coverage contribute 21 percent, compared to 28 percent for those with ESI plans.

Table 2. Premiums and Employee Contributions for Premiums in Collectively Bargained Health Plans and Employer-sponsored Health Plans

	Collectively Bargained Health Plans		ESI Health Plans[2]
	All	Large Plans	
Average monthly premium			
Single coverage	$658	$731	$645
Family coverage	$1,632	$1,605	$1,852
Monthly employee contribution			
Single coverage	$78	$86	$108
Family coverage	$347	$454	$497
Percentage employee contribution			
Single coverage	12%	12%	17%
Family coverage	21%	28%	28%

Note. ESI health plan data are from the Kaiser Family Foundation 2021 Employer Health Benefits Survey Annual Report.

WORKER COST-SHARING

Worker cost-sharing in the form of deductibles is less common among collectively bargained health plans than in

ESI (Table 3). Approximately half of the members with single coverage under collectively bargained health plans (55.3 percent) have deductibles compared to 85 percent of single coverage recipients under ESI plans. Of those in collectively bargained plans who have a deductible, the average was $1,495 for in-network providers and $2,522 for out-of-network providers. Cost-sharing data for ESI plans were only available for in-network providers (Tables 3 and 4). The average deductible for in-network providers for all collectively bargained plans ($1,495) is similar to the average deductible for ESI plans ($1,669).

Table 3. Worker Cost-Sharing in Collectively Bargained Health Plans and Employer-Sponsored Health Plans-Deductibles

	Collectively-Bargained Health Plans		ESI Health Plans[2]
	All	Large Plans	
Percentage with a deductible, single coverage			
In-network providers	55.3%	53.9%	85%
Out-of-network providers	51.4%	53.4%	-
Average deductible among those with one			
In-network providers	$1,495	$616	$1,669
Out-of-network providers	$2,522	$1,082	-
Employee has to meet the deductible before receiving coverage for office visits	19.6%	16.1%	44%
Employee has to meet the deductible before receiving coverage for prescription drugs	28.1%	30.4%	30%

Note. ESI health plan data are from the Kaiser Family Foundation 2021 Employer Health Benefits Survey Annual Report.

The survey also gathered information on cost-sharing for primary care services. Overall, almost 10 percent of all collectively bargained plans reported no cost-sharing for primary care office visits. 70.2 percent of plans reported having a copayment for office visits with a primary care physician. This is slightly lower than the rate for all ESI plans (74 percent). Coinsurance percentages are similar for all ESI plans (18 percent) compared to collectively bargained plans (19.4 percent). The average out-of-pocket limit for in-network providers under single coverage collectively bargained plans ($3,888) is lower than the limit for all ESI single coverage plans ($4,272).

Table 4. Worker Cost-Sharing in Collectively Bargained Health Plans and Employer-Sponsored Health Plans-Copayments and Coinsurance

	Collectively-Bargained Health Plans		ESI Health Plans[2]
	All	Large Plans	
Percentage with a copayment for office visits with a primary care physician	70.2%	73.8%	74%
Average copayment	$23	$22	$23
Percentage with coinsurance for office visits with a primary care physician	18.6%	21.0%	20%
Average coinsurance	19.4%	19.7%	18%
Percentage with no cost-sharing for office visits with a primary care physician	9.6%	-	6%
Percentage with an out-of-pocket limit for in-network providers, single coverage	88.3%	79.9%	99%
Average out-of-pocket limit for in-network providers	$3,888	$3,879	$4,272
Percentage with an out-of-pocket limit for out-of-network providers, single coverage	50.7%	60.3%	-
Average out-of-pocket limit for out-of-network providers	$6,609	$5,678	-

Note. ESI health plan data are from the Kaiser Family Foundation 2021 Employer Health Benefits Survey Annual Report.

COVERED BENEFITS

The survey also assessed specific covered benefits for collectively bargained health plans. These included: dental, dental implants, vision, podiatric, chiropractic, occupational therapy, physical therapy, speech therapy, massage therapy, aquatic therapy, osteopathic manipulative therapy, in-vitro fertilization, other fertility, contraceptive, cosmetic health, and home health. The most commonly covered benefits are chiropractic, occupational/physical therapy, contraceptive, and home health. The least commonly covered benefits are cosmetic breast surgery, massage therapy, dental implants, and bariatric surgery. None of the collectively-bargained health plans participating in this survey offer long-term care insurance to their beneficiaries. Table 5 includes the breakdown by all plans and large plans with 1,000 or more covered lives and includes the maximum amounts of coverage for each benefit.

Table 5. Covered Benefits

	Collectively Bargained Health Plans	
	All	Large Plans
Dental benefit	63.2%	67.0%
Maximum dental coverage	$1,619	$1,986
Dental implants	28.2%	29.5%
Maximum dental implants coverage	$1,839	$1,896
Vision benefit	63.7%	65.1%
Podiatric benefit	71.7%	78.5%
Maximum for podiatric services	$4,130	$4,506
Chiropractic	95.0%	90.9%
Maximum for chiropractic services	$641	$744
Bariatric	42.0%	39.6%
Bariatric limitation, annual	2.2%	-
Bariatric limitation, lifetime	9.2%	8.5%
Occupational therapy	82.2%	93.2%
Prior authorization required for OT	48.4%	52.8%
Maximum for OT	$3,884	$4,282
Physical therapy	88.0%	100.0%
Prior authorization required for PT	38.0%	36.1%
Maximum for PT	$2,348	$1,401
Speech therapy	74.9%	81.2%
Prior authorization required for speech therapy	40.7%	29.8%
Maximum for speech therapy	$2,870	$2,258
Acupuncture	38.5%	49.5%
Prior authorization required for acupuncture	16.4%	26.5%
Maximum for acupuncture	$903	$1,141
Massage therapy	16.9%	15.0%
Prior authorization required for massage therapy	3.7%	-
Maximum for massage therapy	$3,125	$1,200
Aquatic therapy	4.9%	5.1%
Osteopathic manipulative therapy	24.7%	36.1%
In-vitro fertilization	23.8%	24.6%
In-vitro limitation, annual	2.1%	1.6%
In-vitro limitation, lifetime	4.0%	8.9%
Other fertility	31.8%	24.3%
Other fertility limitation, annual	1.8%	1.6%
Other fertility limitation, lifetime	2.6%	5.8%
Contraceptive	83.0%	76.6%
Cosmetic breast surgery	8.8%	9.8%
Home health	80.0%	69.5%
Prior authorization for home health services	63.0%	53.8%
Long-term care insurance	0.0%	0.0%

PRESCRIPTION DRUG COVERAGE

The average prescription drug co-payment in collectively bargained plans was $13 for generic drugs, $26 for preferred drugs, $58 for non-preferred drugs, and $40 for 4th tier drugs. The co-payments for collectively bargained health plans were similar or slightly lower than those for ESI plans in each drug category. Similarly, the coinsurance percentages for all collectively bargained plans are slightly lower compared to ESI plans. Table 6 includes details on co-payments and coinsurance for all tiers of drugs.

Table 6. Prescription Drugs

	Collectively Bargained Health Plans		ESI Health Plans[2]
	All	Large Plans	
Average co-pay			
1st tier generic drugs	$13	$11	$12
2nd tier preferred drugs	$26	$27	$36
3rd tier non-preferred drugs	$58	$48	$66
4th tier drugs	$40	$100	$124
Average coinsurance			
1st tier generic drugs	18.9%	15.5%	20%
2nd tier preferred drugs	23.3%	27.5%	25%
3rd tier non-preferred drugs	29.4%	36.7%	35%
4th tier drugs	21.0%	18.3%	32%

Note. ESI health plan data are from the Kaiser Family Foundation 2021 Employer Health Benefits Survey Annual Report.

Results Summary

Overall, the collectively bargained health plans surveyed often reported more generous coverage and cost-sharing for covered individuals when compared to ESI plans. These plans, for example, cover a higher percentage of the premium and have lower average deductibles. Compared to ESI plans, a higher percentage of collectively bargained health plans also have no cost-sharing for office visits with a primary care physician.

Methods

SAMPLE

We drew the sample for the survey from a publicly available database maintained by the U.S. Department of Labor of Form 5500s, which unions and self-insured plans file annually as a part of their financial reports. The target population for the survey included collectively bargained health plans with 200 or more covered lives. Plans with fewer than 200 covered lives were not included because, after weighting, they would have a very small influence on the results since they represent the experience of so few individuals.

NORC constructed the sampling frame from the 2019 Form 5500 database.[i] We limited the frame to multi-employer plans with a plan benefit arrangement classified as a trust that provides health insurance to at least two hundred participants, which yielded a total of 19,149 plans nationwide (excluding U.S. territories).[ii] The database includes information such as: plan name, sponsor name, address, and phone number; administrator name, address, and phone number; form preparer name, address, and phone number; number of plan participants; and standard industrial classification code (SIC).

By calling in advance to obtain updated contact information for the survey mailings, we learned that a large share of these plans were not in fact collectively bargained health plans, revealing some limitations to the Form 5500 data. As a result, we included all 19,149 plans that seemed to meet our participation criteria based on the Form 5500 data (that is, a collectively bargained health plan with 200 or more covered lives, to ensure an adequate number of eligible plans to attempt to survey. As a result, we attempted to contact a census of all eligible plans, rather than a sample. Given the screener questions that were built into both the web and telephone surveys, only collectively bargained health plans with 200 or more covered lives were able to participate in the survey.

INSTRUMENT

NORC created the instrument in collaboration with The Pacific Maritime Association. We drew from the 2021 Kaiser Family Foundation (KFF) Annual Employer-Health Benefits Survey report to allow for comparisons of costs and benefit design between union trusts and ESI. The instrument included questions covering the following topics:

1. General characteristics of union trusts such as number of participants, eligibility and coverage, plan types offered, and plan enrollments.
2. Plan characteristics for various plan types (HMO, PPO, POS, HDHP), including deductibles, office visit cost-sharing, out-of-pocket maximums, premiums, worker contribution amounts, and prescription drug cost-sharing.

DATA COLLECTION

NORC contracted with Reconnaissance Market Research, a survey research firm, to program and field the survey. We called the share of the sample with phone numbers up to two times each in an effort to determine their eligibility to

[i] We used the 2019 Data Set because the 2020 data were not due to the Department of Labor until July 15, 2021, and were incomplete at the time of sampling.

[ii] The frame included database records where data on multi-employer status, plan benefit arrangement, type of insurance, and/or number of participants were missing.

participate and request updated contact information. NORC also used a locating firm to add email addresses to the sample, where available. Data collection started on December 3, 2021, and ended on February 2, 2022. We mailed an invitation letter to 7,382 plans and emailed the invitation to 12,468 plans. In total, 73 plans completed the survey, 45 on the phone and 28 on the web. We began contacting respondents by phone on January 3, 2022, following up by phone up to 10 times each and leaving voicemails when possible. We also sent up to 8 reminder emails to respondents. Using information about eligibility among the plans we were able to contact, and applying this rate to the plans which we could not contact or obtain any information about, the adjusted response rate is 7%. The characteristics of the plans that responded to the survey appear in Table 8 and 9.

Table 7. Plan Size

Plan Size	Number of Plans
Small Plans (200-999 covered lives)	41%
Large Plans (1,000+ covered lives)	59%

Table 8. Census Region of Plans

Census Region	Number of Plans
West	25%
South	48%
Northeast	15%
Midwest	12%

WEIGHTING AND ANALYSIS

We calculated a nonresponse adjustment weighting factor to account for differences in response rates, using the weighting class method. As a last stage of adjustment, we applied post-stratification factors so that the weights sum to the total number of plans in each region. Finally, we normalized these weights to sum to the total number of respondents. These weights simplify the weighted analysis of survey results without greatly understating standard errors of estimates. We conducted the analyses using the weighted data in SAS.

References

1. U.S. Bureau of Labor Statistics, “Union Members Summary, 2020,” Economic News Release, January 2021.
2. Kaiser Family Foundation 2021 Employer Health Benefits Survey Annual Report.
3. Gabel, J.R., Whitmore, H., Satorius, J.L., Pickreign, J., Stromberg, S.T. (2015). Collectively Bargained Health Plans: More Comprehensive, Less Cost Sharing Than Employer Plans. *Health Affairs, 34*(3). https://doi.org/10.1377/hlthaff.2014.0952

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