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MARCH 1990 NUMBER 100

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**Increases in health care costs over the last decade have led to a number of changes in the features of employer-sponsored health plans.**



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### **Features of Employer-Sponsored Health Plans**

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- ◆ Ninety-two percent of full-time employees in medium-sized and large establishments received employer-sponsored health insurance as an employee benefit in 1988.
- ◆ Annual employee contributions to individual health insurance premiums grew four times as fast as employer contributions from 1982 to 1988, reflecting employers' success in shifting some of their growing burden to employees.
- ◆ The proportion of medium-sized and large employers with self-insured health plans grew from 16 percent in 1980 to 42 percent in 1988.
- ◆ During the 1980s, group health plans moved away from first-dollar coverage for basic medical services to comprehensive health plans under which the range of covered services is generally subject to deductibles and copayments.
- ◆ Enrollment in open-ended health maintenance organizations (HMOs) rose 47 percent from July 1988 to July 1989, compared with "pure" HMO enrollment, which grew 4 percent over the same period.
- ◆ In 1988, 54 percent of employees in medium-sized and large establishments were eligible for employer-sponsored health benefits upon retirement before age 65, compared with 63 percent in 1986; the percentage of employees eligible for retiree health benefits at age 65 or over dropped to 45 percent in 1988 from 58 percent in 1986.
- ◆ The continuing rise in health care costs has increased the demand for affordable coverage and has focused policymakers' attention on the major problems currently facing the U.S. health care system, including the situation of 37 million uninsured Americans, the lack of long-term care insurance for the growing elderly population, and poor access to preventive and public health programs.

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## ◆ Introduction

Ninety-two percent of full-time employees in medium-sized and large establishments received employer-sponsored health insurance as an employee benefit in 1988. This represents a slight decline from the near universal coverage among these employees in 1980, when 97 percent had coverage. Average group health insurance costs for employer-sponsored plans grew 40 percent (real costs) from 1984 to 1989.

The increases in health care costs over the last decade have led to a number of changes in the features of employer-sponsored health plans. First-dollar coverage has virtually ceased to exist in all except collectively bargained plans. Beneficiaries have increasingly been called on not only to pay deductibles and copayments but also to pay a portion of the monthly health insurance premiums. Coverage grew for medical services that offer the possibility of more cost-effective treatment (such as home health care and hospice care) as well as for services that promise to reduce future expenditures (such as substance abuse treatment and routine physical examinations). Many plans adopted features that attempt to reduce coverage for procedures or providers deemed inappropriate or unnecessary. These features include various utilization review techniques, financial incentives for participants to use selected providers, and restrictions on specific treatments or treatment sites. Cost management techniques for indemnity plans resemble efforts that have long been used by health maintenance organizations (HMOs) to promote health maintenance and control utilization. While HMOs give providers financial incentives to provide cost-effective care, indemnity health plans encourage cost-conscious behavior by plan participants (for example, by requiring lower copayments if participants use network physicians).

This *Issue Brief* examines the features of employer-based health plans in 1988 and their evolution during the 1980s. Data are predominantly drawn from the Department of Labor (DOL) Bureau of Labor Statistics' (BLS) employee benefits surveys and, to a lesser extent, from

surveys conducted by private employee benefit consulting firms. Although comparable data on small employers are unavailable, the report discusses the problems unique to these employers and presents selected data on their experience drawn from surveys conducted by the National Federation of Independent Business (NFIB). The *Issue Brief* concludes with an overview of health care policy activity that promises to influence group health plans.

## ◆ Plan Costs and Availability

The growth of health care costs, including group health insurance costs per employee, has been the focus of much attention recently. Average total group health costs per employee increased from \$1,645 in 1984 to \$2,748 in 1989 (40 percent real growth) (A. Foster Higgins & Co., Inc., 1989).

Ninety-two percent of full-time employees in medium-sized and large establishments included in the BLS survey were covered by group health insurance in 1988.<sup>1</sup> This represents a slight decline in employee coverage over the previous four years; 97 percent of full-time employees were participants in employer-sponsored health plans from 1980 to 1984. The number of employees with medical coverage for dependents also declined, from 97 percent in 1984 to 92 percent in 1988. The number of employees with employer-financed group health coverage after retirement decreased for both retirees under age 65 (from 63 percent to 54 percent) and Medicare-eligible retirees (from 58 percent to 45 percent). The percentage of employees

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<sup>1</sup>The BLS survey represents U.S. private-sector establishments employing at least 50, 100, or 250 workers, depending on the industry, and includes a broad representation of industries. The 1988 BLS survey represented a significant expansion in the survey coverage over previous years and, specifically, included more establishments with 100 to 250 employees (smaller establishments). Ninety-two percent of employees in the older survey had employer-based medical insurance. Ninety percent of employees in the expanded survey received group medical coverage, but for purposes of comparison, measurements used in the older survey will be used for 1988 except as noted.

retaining coverage after layoff fell from 34 percent in 1986 to 28 percent in 1988.<sup>2</sup>

## ◆ Contributions to Premiums

### Employer Contributions

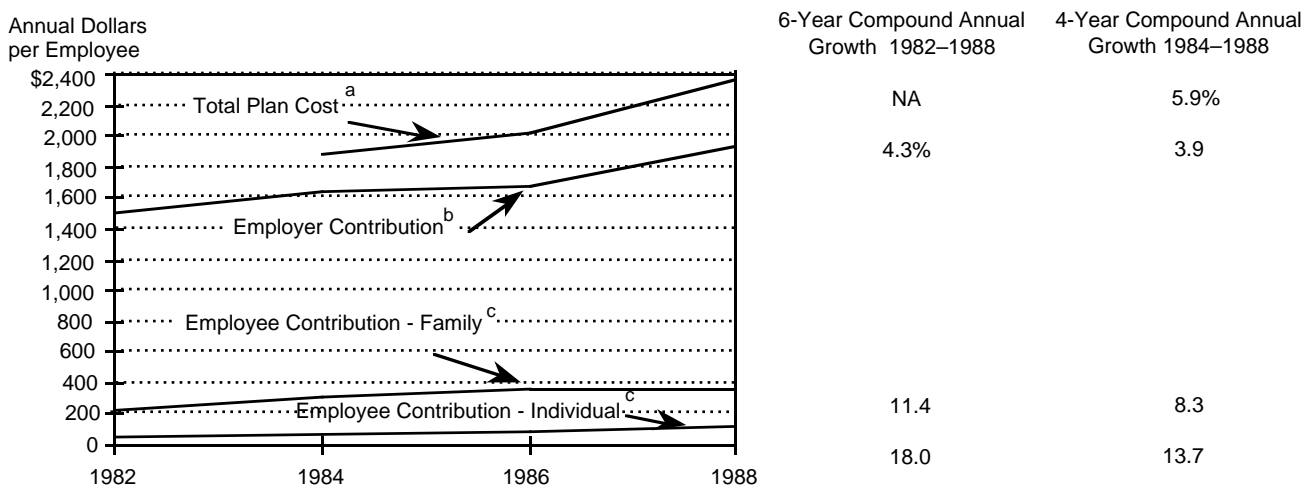
Whereas U.S. average health insurance costs per employee for employer-based groups grew at an annual rate of 5.9 percent above inflation from 1984 to 1988,

<sup>2</sup>Although the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires employers to continue health care benefits for employees who are retired, laid off, or otherwise separated from employment, workers may be charged all of the premium costs (plus 2 percent for administrative expenses, and the continuation period is currently limited to 18 months (29 months for qualified disabled beneficiaries, who can be charged 150 percent of premium costs for the additional 11 months, and 36 months for dependents of a qualified employee who becomes

the average employer contribution per employee to group health plans (including noncontributory plans) exceeded inflation by only 3.9 percent over the same period. This comparatively low average real growth reflects employers' success in shifting some of their burden to employees. The real average annual individual premium contribution for all employees in group health plans (including those in noncontributory plans) grew four times as fast as employer contributions from 1982 to 1988 (from \$36 to \$105), while employee contributions for dependent coverage grew three times as fast (from \$205 to \$391) as employer contributions over the same period (chart 1).

entitled to Medicare as amended by 1989 Omnibus Budget Reconciliation Act). These figures measure the number of employees who receive full or partial financing on retirement or layoff. Most of the 28 percent receiving benefits after layoff, however, do not continue for an extended period, while retiree benefits generally continue indefinitely or until the retiree reaches age 65.

Chart 1  
Growth of Employer and Employee Contributions to Health Insurance Premiums, 1988 Dollars, 1982–1988



Source: EBRI analysis based on U.S. Department of Labor, Bureau of Labor Statistics, *Employee Benefits in Medium and Large Firms, 1980–1988* (Washington, DC: U.S. Government Printing Office); U.S. Department of Commerce, Bureau of Economic Analysis, *Survey of Current Business* (Washington, DC: U.S. Department of Commerce, 1989); A. Foster Higgins & Co., Inc., *Health Care Benefits Survey, 1988* (Princeton, NJ: A. Foster Higgins & Co., Inc., 1988); and U.S. Department of Commerce, Bureau of the Census, *Receipt of Selected Noncash Benefits, 1982–1988*, unpublished.

Note: Numbers are measured in 1988 real dollars as per the general urban consumer price index.

<sup>a</sup>Figures based on A. Foster Higgins Survey.

<sup>b</sup>Figures based on Department of Commerce data: total employer spending on health benefits (NIPA) divided by the number of civilian workers over age 15 with employer/union-provided health insurance.

<sup>c</sup>Figures based on BLS survey.

## Employee Contributions

The growth in average employee contributions indicated in chart 1 reflects the increasing prevalence of contributory plans as well as the increasing dollar amount of contributions. The proportion of health plan participants in medium-sized and large establishments who were required to pay part of the premium for individual coverage grew by 55 percent between 1980 and 1988 (from 29 percent to 45 percent), and the proportion of employees making contributions for family coverage increased from 52 percent to 63 percent. The BLS survey found that technical and clerical employees and, to a lesser extent, professional and administrative employees were more likely than production workers to be participants in contributory group health plans (chart 2).

Monthly contributions for participants in plans requiring contributions for individual coverage doubled from an average of \$9 in 1982 to \$18 in 1988 (63 percent real growth). Monthly contributions for participants in plans requiring contributions for dependent coverage

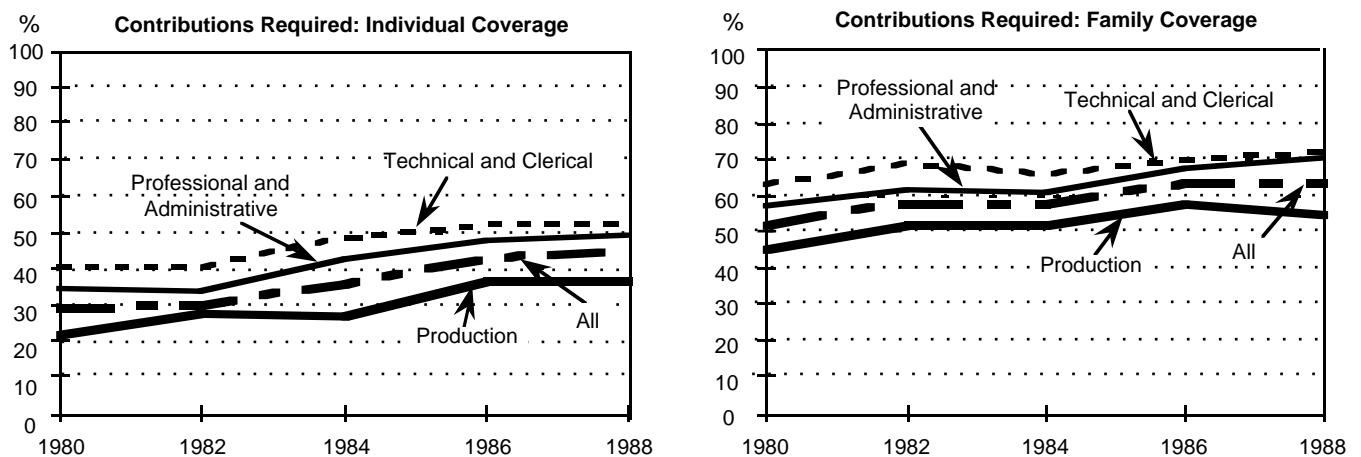
nearly doubled, increasing from \$27 to \$52 over the same period (57 percent real growth). In 1988, 16 percent of employees represented in the expanded BLS survey were able to make contributions on a pretax basis under flexible benefit plans or other salary reduction arrangements.

## ◆ Plan Funding

Medium-sized and large employers have increasingly opted to fund health expenses themselves, frequently by means of 501(c)(9) trusts. In most cases, the employer contracts for the services of a third party to adjudicate and pay medical claims. Table 1 illustrates the trend toward self-insured group health plans among establishments represented in the BLS survey. The proportion of participants in commercially insured major medical group plans dropped from 68 percent in 1980 to 34 percent in 1988, while the proportion in self-insured health plans increased to approximately 42 percent from 16 percent.

Self-funded health insurance plans offer employers a number of advantages. Self-insured plans are exempt

Chart 2  
Percentage of Participants in Contributory Plans, Individual and Family Coverage, Medium-Sized and Large Establishments, 1980-1988



Source: U.S. Department of Labor, Bureau of Labor Statistics, *Employee Benefits in Medium and Large Firms, 1980-1988* (Washington, DC: U.S. Government Printing Office).

Table 1  
**Percentage of Participants with Major Medical Coverage, by Type of Plan Funding, 1980–1988**

Type of Funding	1980	1982	1984	1986	1988 <sup>a</sup>
Self Insured	16%	22%	36%	45%	42%
Commercial	68	62	48	40	34
Blue Cross	14	14	14	11	18
Combination	2	2	2	4	6

Source: U.S. Department of Labor, Bureau of Labor Statistics, *Employee Benefits in Medium and Large Firms, 1980–1988* (Washington, DC: U.S. Government Printing Office).

<sup>a</sup>1988 percentages refer to all fee-for-service medical plans, as opposed to major medical only, and represent participants in the Bureau of Labor Statistics' expanded survey.

under the Employee Retirement Income Security Act of 1974 (ERISA) from state insurance premium taxes and mandated coverages. According to a recent study, 51 percent of the firms that converted to self insurance from 1981 to 1984 indicated that state mandated benefits were the primary motivation for the change (Gabel and Jensen, 1990). Moreover, self-insured employers are able to earn interest on their reserves and retain any surplus in their trusts, whereas this money is retained by the insurer in commercially purchased plans. By the same token, self-insured employers also bear the risks of the health plan.

Larger employers can better bear the risk and thus are more likely to self insure than smaller ones. A recent survey calculates that 65 percent of large employers (with 1,000 or more employees) self fund, while only 41 percent of smaller employers (with fewer than 1,000 employees) do so (A. Foster Higgins & Co., Inc., 1988). Since firms that self insure often wish to limit their exposure, the use of stop-loss coverage, or reinsurance, to cap losses has accompanied the growth in self funding. Consistent with their greater ability to pool the risk of such events, in 1988, 32 percent of employers with 5,000 or more employees in 1988 purchased stop-loss insurance (up from 26 percent in 1986), 76

percent of those with 1,000 to 4,999 employees purchased this insurance (up from 70 percent), and fully 89 percent of self-insured employers with fewer than 1,000 employees purchased it (up from 81 percent in 1986).

### ◆ Plan Type/Design: Indemnity Plans

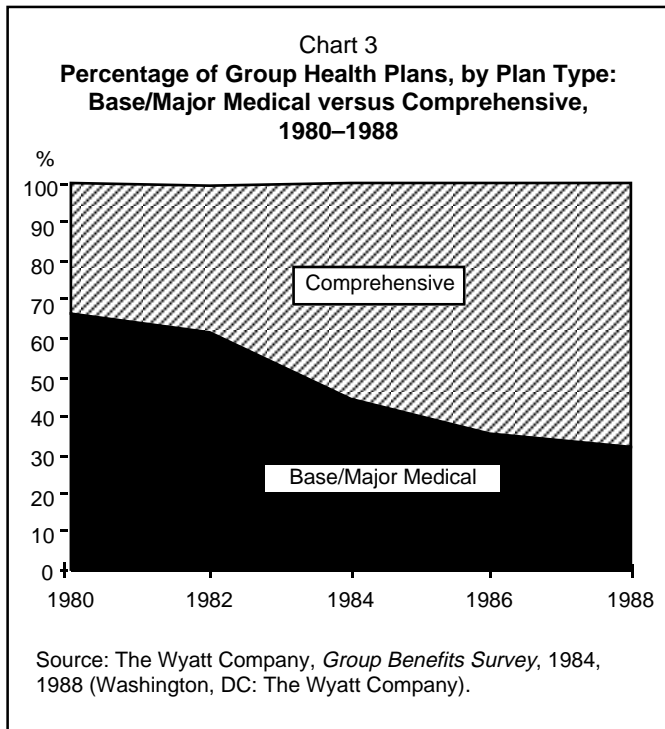
During the 1980s, the design of medical indemnity insurance changed from a model based on a basic medical insurance plan with a superimposed major medical umbrella to a comprehensive medical plan that includes all covered medical services (chart 3). Formerly, the base coverage/major medical scheme usually included first-dollar coverage for basic medical services. The major medical policy covered expenses beyond the basic level and some items excluded from the basic plan. The major medical portion generally required that the beneficiary meet an initial deductible before the plan began to pay coinsurance, usually at a rate of 80 percent. Coinsurance frequently increased to 100 percent after a certain dollar amount of covered expenses was attained. Sixty-six percent of group health plans followed this pattern in 1980 (chart 3).



**Insurers have expanded coverage . . . for services that are believed to promote health and for medical care in alternative service settings that may be more cost effective.**



Group health plans have increasingly moved away from the base coverage/major medical scheme to a comprehensive model under which the range of covered services is generally subject to deductibles and copayments, and first-dollar coverage is rare. By 1988, 68 percent of group health plans were comprehensive medical plans.



### Deductibles, Coinsurance, Stop Loss

Comprehensive plans are subject to overall limitations (deductibles, coinsurance, and/or maximum benefit provisions) much like the major medical policies that preceded them. Virtually all covered services are subject to these limitations. In addition to reducing costs to the insurer by increasing out-of-pocket costs to participants, deductibles and coinsurance have the effect of reducing participants' demand for services, thereby containing expenditures for all payers in the short term (Custer, 1989).

The 1988 BLS survey shows that among participants in health plans with overall limitations, 95 percent were required to meet a specified deductible amount before claims were reimbursed. The prevalence and dollar levels of deductibles have increased with the advent of comprehensive plans. In 1988, 44 percent of employees (in the expanded survey) who participated in plans with overall limitations had deductibles greater than \$100 annually (\$153, on average), whereas only 8

percent had deductibles greater than \$100 in 1980 (table 2).<sup>3</sup> While a typical medium-sized or large group health plan included in the 1988 survey specified an annual deductible that applied to both hospital and other covered expenses (79 percent of plans with overall limitations), some beneficiaries were in plans in which the deductible did not apply to hospital expenses, (21 percent of plans with overall limitations) and 10 percent of plan participants had separate deductibles for hospital services. (Some plans also specified a family deductible equal to two to three times the individual deductible.)

After a deductible is satisfied, covered services are generally paid on the basis of usual, customary, and reasonable charges, frequently at a coinsurance rate of 80 percent. Increasingly, coinsurance reverts to 100 percent when claims for covered services reach a certain level. Provisions for such out-of-pocket maximums became a more common feature of group health plans during the 1980s; in 1980, 55 percent of employees in the BLS survey had coinsurance that reverted to 100 percent at a certain level, whereas in 1988, 82

<sup>3</sup>The real growth in deductible levels is less dramatic than it seems; the 1988 average deductible as calculated by BLS, \$153, equals \$107 in 1980 dollars.

**Table 2**  
**Percentage of Participants in Plans**  
**Specifying Flat Deductible, by Amount of**  
**Deductible, 1980–1988**

Deductible Amount	1980	1982	1984	1986	1988 <sup>a</sup>
>\$150	3%	3%	13%	22%	30%
\$101–\$150	5	4	11	17	14
\$51–\$100	62	66	54	49	45
\$1–\$50	29	26	22	12	11

Source: U.S. Department of Labor, Bureau of Labor Statistics, *Employee Benefits in Medium and Large Firms, 1980–1988* (Washington, DC: U.S. Government Printing Office).

<sup>a</sup>1988 percentages represent participants in the Bureau of Labor Statistics' expanded survey.

percent of employees (in the expanded survey) were subject to out-of-pocket maximums.<sup>4</sup> According to BLS, in 1988, the annual maximum for out-of-pocket expenses averaged \$957 for individuals and \$2,004 for families.

In order to limit their own liability, insurers generally cap the maximum benefit level—usually at \$500,000 to \$1 million per lifetime. According to the 1988 BLS survey, 77 percent of participants in plans with overall limitations were in plans specifying maximum benefits. The prevalence of a maximum benefit remained constant throughout the 1980s.

### Specific Benefits

Sharing the medical cost burden with employees through deductibles and copayments is not the only way that insurers have modified indemnity plan design to address rising medical costs. Insurers have expanded coverage to medium-sized and large groups for services

<sup>4</sup>The growth in maximum out-of-pocket provisions probably reflects the increase in comprehensive plans that require out-of-pocket expenditures more frequently than base/major medical plans.

Table 3  
**Percentage of Participants with Coverage for Selected Medical Services, 1980–1988, Selected Years**

Medical Service Covered	1980	1982	1984	1986	1988
Hospital, Surgery, X-Ray and Lab	100%	100%	100%	99%	99%
Mental Health:					
Inpatient	98	99	100	99	96
Mental Health:					
Outpatient	93	91	97	97	97
Physicians' Office					
Visits	94	95	96	96	98
Private Duty Nursing	93	94	96	94	97
Prescription Drugs	97	97	98	97	95
Vision	21	22	30	40	37
Dental	56	68	77	71	72

Source: U.S. Department of Labor, Bureau of Labor Statistics, *Employee Benefits in Medium and Large Firms, 1980–1988, selected years* (Washington, DC: U.S. Government Printing Office).

that are believed to promote health and for medical care in alternative service settings that may be more cost effective (chart 4). Expanding coverage to include services such as routine physical examinations and extended care facility expenses are cost saving strategies that were first introduced in HMOs. Coverage for basic medical services (hospital, physicians' and surgeons' fees, x-ray and laboratory, and prescription drugs) has remained stable for the most part (table 3).



**Mental health coverage became significantly more restrictive during the 1980s.**

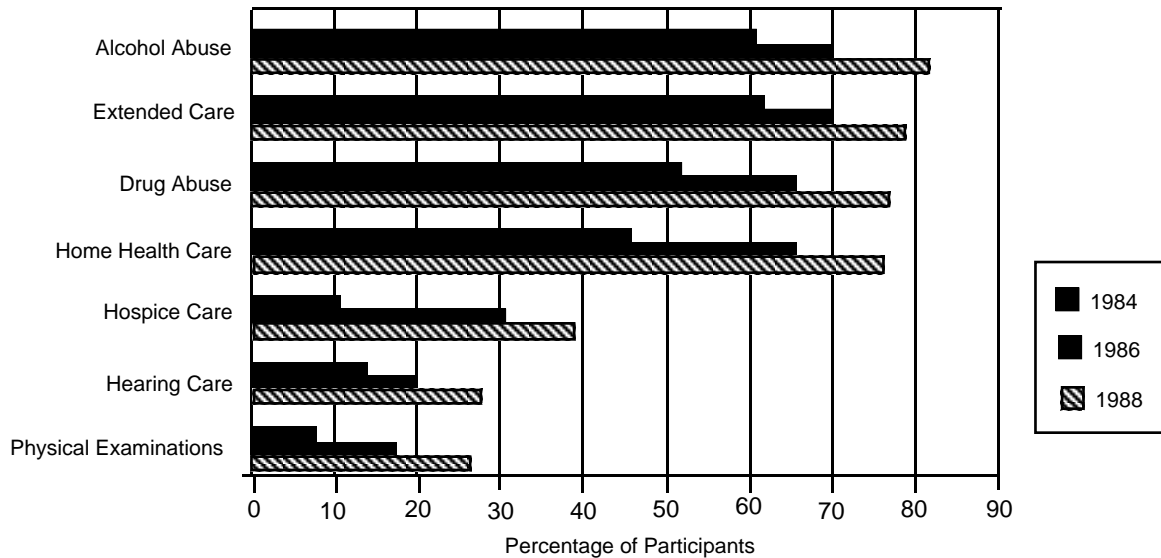


### Mental Health Benefits

In addition to changes in overall plan design, indemnity insurers have modified the coverage of specific medical services whose costs are considered difficult to control. Mental health services are a case in point.<sup>5</sup> Although almost universally available to medium-sized and large group plan participants, mental health coverage became significantly more restrictive during the 1980s. While special limits already governed the majority of outpatient mental health benefits in 1980 (89 percent), inpatient benefits were treated the same as other illnesses for a majority of participants (55 percent). By 1988, only 26 percent of participants were in plans that provided the same benefits for inpatient mental health care that they provided for other illnesses (chart 5). Benefits for the treatment of substance abuse are often similar to mental health benefits in that they are subject to special limits specific to that benefit category.

<sup>5</sup>Mental health services represent an extreme example of a problem common to all types of health care: it is difficult to determine with certainty what services are most effective (and cost effective) in treating medical problems (Custer, 1990).

Chart 4  
**Percentage of Participants with Coverage for Selected Nontraditional Medical Services, 1984–1988**



Source: U.S. Department of Labor, Bureau of Labor Statistics, *Employee Benefits in Medium and Large Firms, 1980–1988* (Washington, DC: U.S. Government Printing Office).

## ◆ Cost Management Strategies

Rising health care costs have led employers to incorporate a number of cost management techniques into their health care plans. Neither the providers nor the participants in traditional indemnity plans have a financial interest in managing utilization.<sup>6</sup> Most cost management techniques employed in indemnity plans are intended to create such an incentive. These techniques include lower or no coinsurance for nonemergency weekend hospital admissions (11 percent of fee-for-service plan participants in 1988) and for failure to obtain prehospitalization certification (32 percent), and higher reimbursement for mail order drugs (9 percent),

<sup>6</sup>In fact, if the provider faces any economic incentive, it is the opposite: to provide more and more expensive care (because his or her revenues will increase) and to provide more care to defend against malpractice litigation.



**Nineteen percent of medium-sized and large employer group plan participants were enrolled in HMOs in 1988, compared with 2 percent in 1980.**

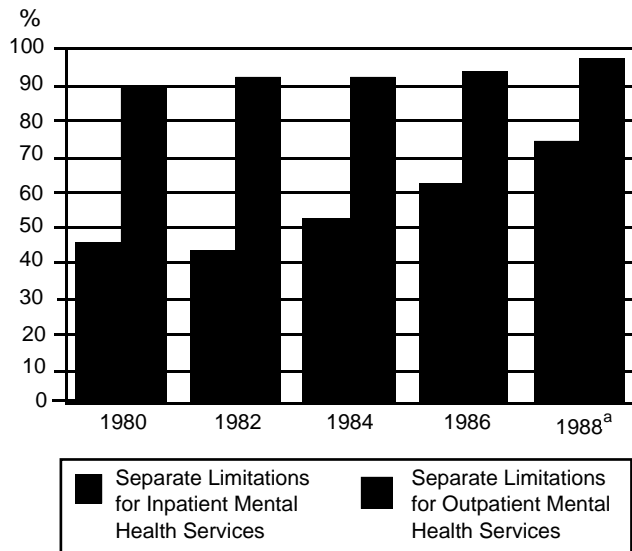


prehospitalization testing (45 percent), and delivery at a birthing center (19 percent). Chart 6 illustrates the prevalence of cost management techniques that give the beneficiary the financial incentive (or disincentive) to seek certain types of medical services.<sup>7</sup>

<sup>7</sup>Because the insurers and providers have different interests, certain utilization review practices have been received with great resentment and remain a source of controversy in medical circles.



Chart 5  
**Percentage of Participants in Plans with Mental Health Benefits that Specify Separate Limitations for Inpatient and Outpatient Mental Health Coverage, 1980–1988, Selected Years**



	1980	1982	1984	1986	1988
<b>Inpatient:</b>					
Limit on Dollars	23%	16%	25%	27%	32%
Limit on Days/Visits	34	31	29	38	47
<b>Outpatient:</b>					
Limit on Dollars	62	69	72	70	67
Limit on Days/Visits	20	19	23	33	38

Source: U.S. Department of Labor, Bureau of Labor Statistics, *Employee Benefits in Medium and Large Firms, 1980–1988*, selected years (Washington, DC: U.S. Government Printing Office).

<sup>a</sup>1988 figures represent participants in the Bureau of Labor Statistics' expanded survey.

## Alternative Delivery Systems

One of the most dramatic developments of the 1980s was the growth of health maintenance organizations and their increasing share of the health care market. While the number of employers offering HMOs appears to have peaked, the number of HMO participants is still growing. Nineteen percent of medium-sized and large employer group plan participants (in the expanded survey) were enrolled in HMOs in 1988, compared with 2 percent in 1980 (table 4).

The 1980s also saw the emergence of preferred provider organizations (PPOs). PPOs are groups of providers who are under contract to provide medical services to their members at discounted prices. Providers enter these agreements in the hope they will generate a higher volume of business. PPOs may be offered on a stand-alone basis or as an option within a traditional indemnity plan. In the latter case, insurers usually encourage participants to use the preferred providers by waiving

deductibles or offering more attractive coinsurance provisions. In 1988, 7 percent of participants in medium-sized and large establishments' group health plans (in the expanded survey) were in PPOs.

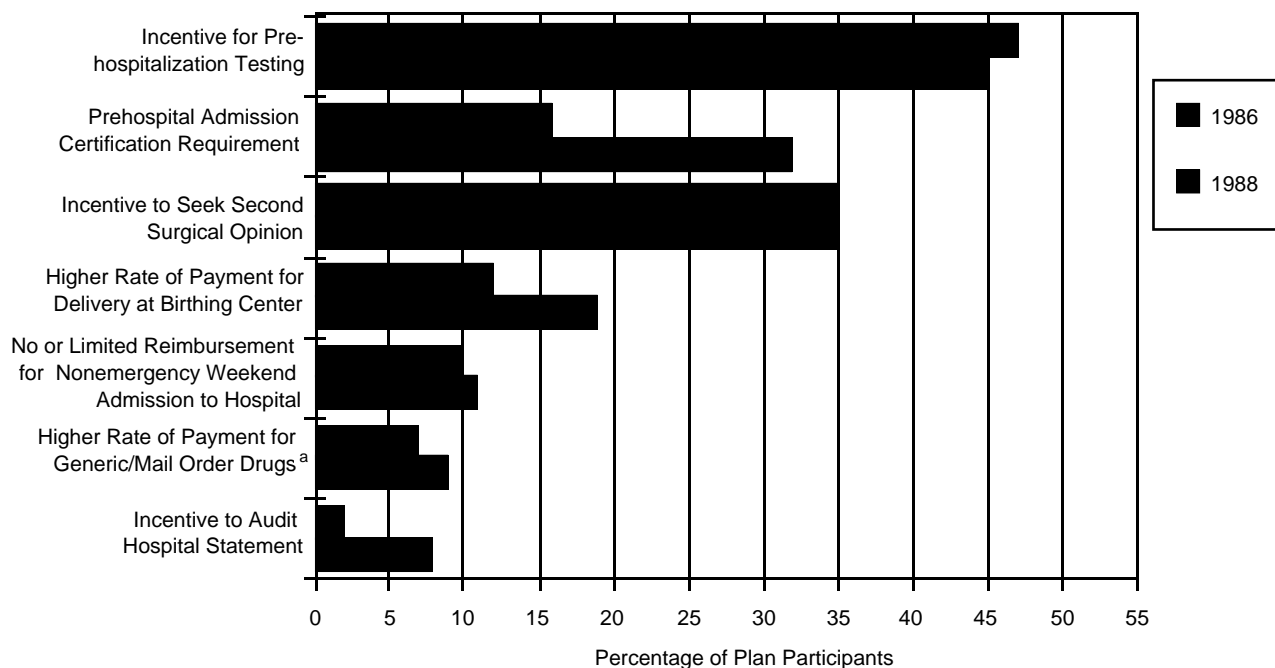
Table 4  
**Percentage of Participants by Medical Care Delivery System, 1980–1988, Selected Years**

Type of Plan	1980	1982	1984	1986	1988 <sup>a</sup>
Fee-for-Service	98%	96%	95%	86%	74%
HMO	2	4	5	13	19
PPO	—	—	—	1	7

Source: U.S. Department of Labor, Bureau of Labor Statistics, *Employee Benefits in Medium and Large Firms, 1980–1988*, selected years (Washington, DC: U.S. Government Printing Office).

<sup>a</sup>1988 percentages represent participants in the Bureau of Labor Statistics' expanded survey.

Chart 6  
**Percentage of Participants in Plans with Selected Cost Management Strategies, 1986 and 1988**



Source: U.S. Department of Labor, Bureau of Labor Statistics, *Employee Benefits in Medium and Large Firms*, 1986, 1988 (Washington, DC: U.S. Government Printing Office).

<sup>a</sup>1986 refers to higher payment for generic drugs; 1988 refers to higher payment for mail order drugs (which are usually generic).

From the participant's perspective, the relative attractiveness of the various types of plans often depends on the value the individual assigns to freedom of choice in the selection of providers. Since Americans have long been accustomed to fee-for-service medicine, many place a high value on freedom of choice. For this reason, some plan sponsors have found that plans that preserve the ultimate right to choose while giving powerful incentives to use a specified group of providers are more successful in the market. These plans allow the employee to choose a fee-for-service or HMO delivery mode (some have a PPO option) within a single plan at the point of service. In these plans, participants incur fewer out-of-pocket expenses when using designated HMO or PPO providers than when they choose fee-for-service delivery. While they are a relatively new phenomenon, point-of-service plans are

gaining in popularity. A recent study found that enrollment in open-ended HMOs, which allow enrollees to opt for care from nonnetwork providers, rose 47 percent (from 476,788 enrollees to 702,648 enrollees) from July 1988 to July 1989, compared with 4 percent growth in "pure" HMO enrollment (InterStudy, 1990). Likewise, the number of HMOs offering open-ended products increased 63 percent over the same period (from 48 HMOs to 78 HMOs), while there was an 8 percent decrease in the total number of HMOs.<sup>8</sup>

Southwestern Bell and Allied-Signal are among companies that have developed customized, open-ended health care plans in an attempt to control their medical

<sup>8</sup>The numbers of open-ended HMOs represent survey respondents only.

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expenses. In 1987, Southwestern Bell, together with The Prudential Insurance Company of America, developed a point-of-service health plan (CustomCare) based on PPO networks in major cities. Prudential administers the plan and has a risk-sharing agreement with Southwestern Bell whereby the carrier seeks to achieve a target for expenditures (including nonnetwork claims) and shares in the differential from the target (positive or negative). Approximately 65 percent of Southwestern Bell employees have access to the CustomCare network. Those using network providers pay \$5 per office visit and receive 100 percent coverage for the remaining costs. When participants decide to use nonnetwork providers, they pay a higher per visit charge plus a 20 percent copayment. CustomCare also includes coverage for preventive services, including routine health assessments and immunizations.



**CIGNA reports that after 18 months, average per capita expenditures were \$2,450 for network participants, compared with \$3,200 for nonnetwork participants.**



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The Allied-Signal plan, administered by the CIGNA Corporation, is a self-funded, open-ended health benefits program based on CIGNA's national network of physicians, with annual deductibles tied to gross salary for employees who seek care outside the network. The plan (The Health Care Connection), put into effect in 1988, is innovative in several respects. CIGNA guarantees the rate of Allied-Signal's expenditure increases for three years. Annual deductibles equal 1 percent of annual base pay for individual coverage and 3 percent of annual base pay for family coverage for employees who use nonnetwork providers. Additionally, employees opting to use nonnetwork providers must pay a 20 percent copayment, with a maximum out-of-pocket expense equal to 12 percent of their

annual base pay, and are not covered for vision, hearing, and preventive care services. Employees who use network providers have broader coverages and pay only a fixed dollar copayment on some services. Likewise, network users pay less out of pocket for dental services than nonnetwork users.

CIGNA reports that after 18 months, average per capita expenditures were \$2,450 for network participants, compared with \$3,200 for nonnetwork participants. The Health Care Connection has achieved single digit (6 percent to 7 percent) annual growth since its implementation.

Other employers, including Southern California Edison, Fidelity Investments, and First Interstate Bancorp, have recently implemented similar point-of-service networks. AT&T is reviewing various proposals for a similar innovative insurance program that would cover the largest number of employees to date in such a plan. It seems likely that employer needs for controlled health care cost increases and consumer preferences for freedom of provider choice will result in a continued replacement of inflexible delivery systems with open-ended employer health plans (HMO and PPO networks) that are tailored to the needs of individual employers and their employees.

### ◆ Retiree Health Coverage

Trends in employer-based retiree health plans are similar to those for active group plans but more pronounced. Features of retiree health plans for retirees under age 65 should be distinguished from plans for Medicare-eligible retirees (who are aged 65 years or over).

#### Availability

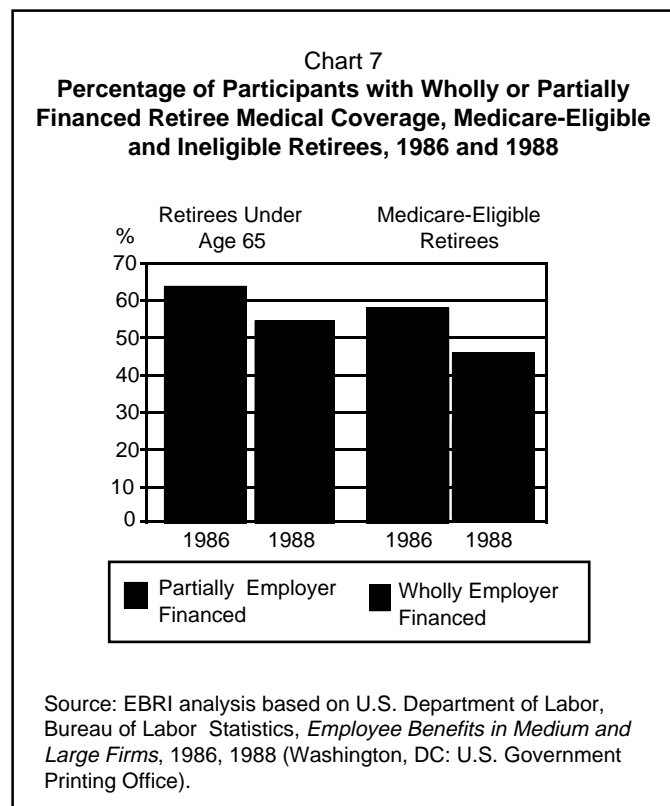
According to the 1988 BLS survey, 54 percent of employees of medium-sized and large establishments who were eligible for health benefits upon retirement before age 65 were in plans that were partially or wholly financed by their employers. This represents a 17

percent decrease from 1986. The percentage of employees with employer-financed health benefits that continue past Medicare eligibility dropped nearly 30 percent over the same period, from 58 percent in 1986 to 45 percent in 1988 (chart 7). The trend toward reduced or terminated coverage for retirees is likely to continue in the coming years as a result of the new disclosure requirements proposed by the Financial Accounting Standards Board, which would require employers to declare the costs of future retiree medical benefits as a liability (and draw attention to the magnitude of these liabilities).

### Design

Plan design is generally the same for retirees under age 65 as it is for active employees, but this varies by industry. A 1987 survey found that 83 percent of employer-sponsored plans covering retirees under age 65 had coverage identical to that for active employees,

while 6 percent dropped coverage for vision, prescription drug, or other “noncore” medical benefits for retirees, 4 percent required higher deductibles and/or copayments, and 7 percent made other changes in plan design (A. Foster Higgins & Co., Inc., 1987). Certain industries are more likely than others to modify plan design for retirees under age 65 (chart 8). In 1987, 75 percent of employers in the transportation industry and 62 percent of those in the mining and construction industries provided retirees under age 65 with health care coverage; only 52 percent of the former and 60 percent of the latter offered their retirees the same coverage as they offered their active employees. Moreover, employers in these industries were much more likely than other employers to require higher deductibles or coinsurance for retirees or to terminate prescription drug or vision coverage at retirement and offer only core medical benefits (A. Foster Higgins & Co., Inc., 1987).

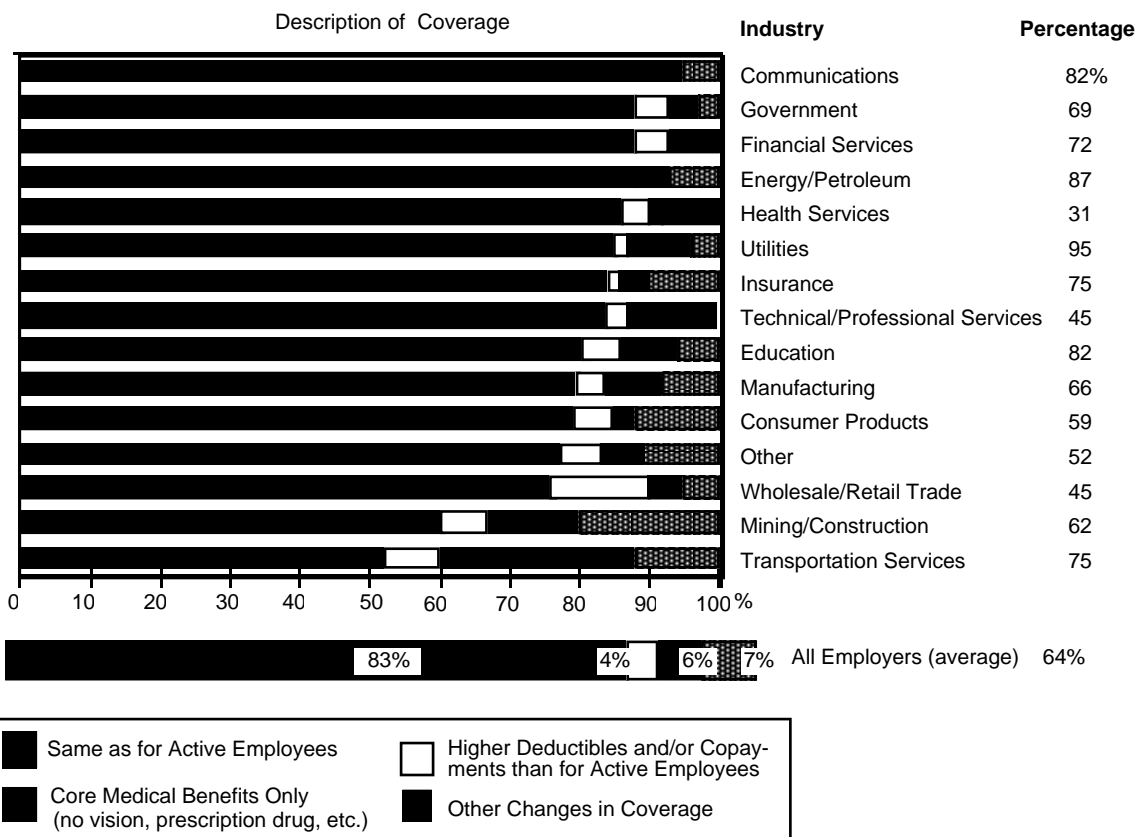


**Employers that provide retiree medical benefits increase retiree contributions to premiums more frequently than they reduce health coverage.**



Health plans designed for Medicare-eligible retirees (Medigap plans), which usually supplement Medicare coverage, are quite different from plans for noneligible retirees. A 1987 survey found that employers who provide health coverage for Medicare-eligible retirees offer one of three types of Medigap plans: Medicare carve-out plans, in which benefits are determined and reduced by Medicare payments (35 percent); plans that coordinate benefits with Medicare so that beneficiaries may receive up to 100 percent of expenses from a combination of Medicare and employer plan benefits (34 percent); or plans that specify supplemental ben-

Chart 8  
**Percentage of Employers Providing Medical Coverage to Retirees under Age 65,  
 by Type of Coverage and Industry, 1987**



Source: A. Foster Higgins & Co., Inc., *Health Care Benefits Survey*, 1987 (Princeton, NJ: A. Foster Higgins & Co., Inc., 1987).

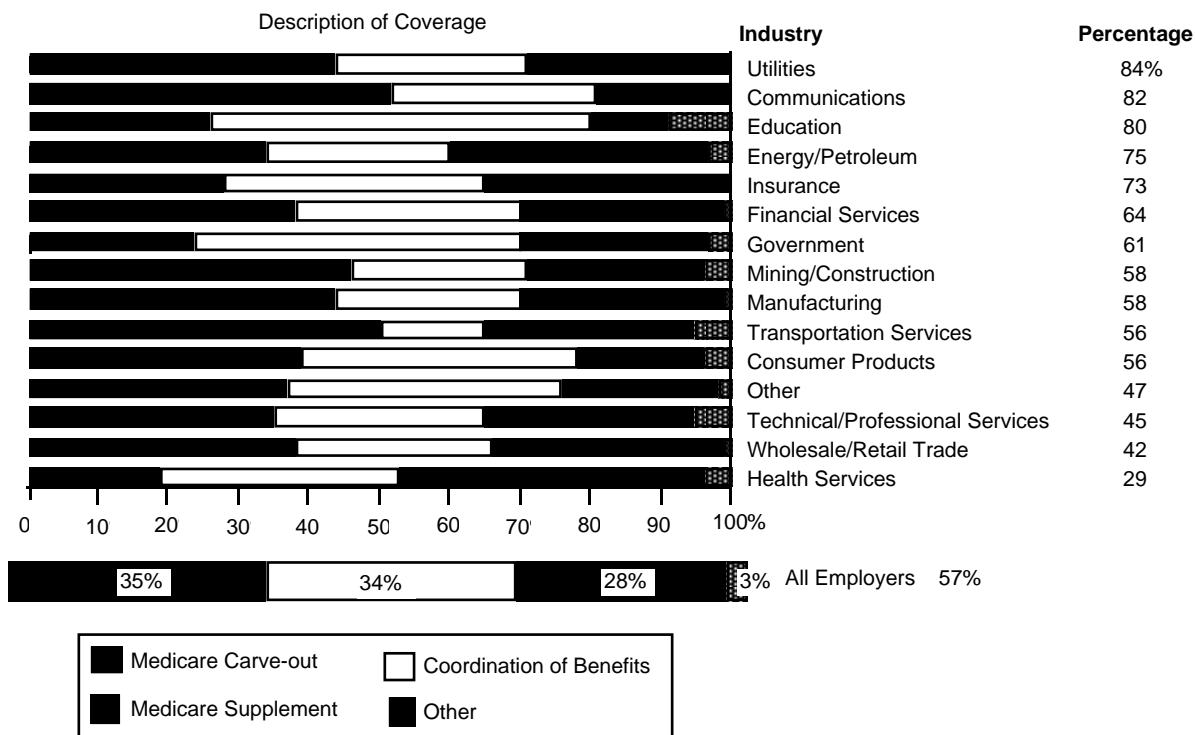
efits to Medicare (28 percent) (A. Foster Higgins & Co., Inc., 1987). Again, the percentage of employees covered by such plans varies greatly by industry (chart 9).

### Financing

Employers that provide retiree medical benefits increase retiree contributions to premiums more frequently than they reduce health coverage. Chart 10 compares the average contribution levels of non-Medicare-eligible retirees with the average contributions among active

employees in 1987 (The Wyatt Company, 1988b). In many instances, health plans that are noncontributory for active employees become contributory on retirement. The Wyatt survey calculated that 44 percent to 47 percent of noncontributory group plans require contributions upon retirement for retirees under age 65. Also, retirees are seldom able to make contributions on a pretax basis. Forty-nine percent of contributions to health premiums by active salaried employees are paid on a pretax basis, compared with only 6 percent of contributions by retirees from salaried positions who are under age 65 (The Wyatt Company, 1988c).<sup>9</sup>

Chart 9  
**Percentage of Employers Providing Medical Coverage to Medicare-Eligible Retirees,  
 by Type of Coverage and Industry, 1987**



Source: A. Foster Higgins & Co., Inc., *Health Care Benefits Survey, 1987* (Princeton, NJ: A. Foster Higgins & Co., Inc., 1987).

The percentage of contributory Medigap plans is increasing as well. The foregoing 1988 survey found that 59 percent of Medigap plans required contributions in 1987, compared with 53 percent in 1985. Contributions for Medigap plans are generally lower, however, because Medicare provides a significant amount of coverage.

### ◆ Small Business Sponsorship

While all employers face growing health insurance

<sup>9</sup>This figure (49 percent) represents the percentage of employers included in the Wyatt survey that allow retirees from salaried positions to make pretax contributions and is therefore much higher than the 16 percent figure cited earlier that measured all employees (salaried and hourly) of firms in the BLS survey (which includes a greater proportion of firms with 100–500 employees).

expenses, small employers have been particularly adversely affected in recent years. Indemnity insurance premiums have always been higher for smaller groups because the small pool of employees increases the insurer's risk.<sup>10</sup>

### Availability

A recent survey found that 63 percent of small employers sponsored a group health plan in 1989, compared with 65 percent in 1985<sup>11</sup> (National Federation of Independent Business, 1985 and forthcoming). The

<sup>10</sup>Attempts by insurers to pool small groups fail in the market because insurers realize greater profits by pooling low-risk groups. Any pool that includes higher-risk groups will have a higher premium, and the low-risk groups will therefore be vulnerable to lower bids from other insurers.

percentage of small employers providing medical insurance benefits varies by industry (table 5). Health benefits were least likely to be provided by employers in agriculture (50 percent), retail (52 percent), services (53 percent), and professional services (61 percent). The decline in small group health insurance was most pronounced in the construction industry (66 percent in 1989 versus 73 percent in 1985) and in the retail industry (52 percent in 1989 versus 58 percent in 1985).

### Reasons for Lack of Sponsorship and Future Prospects for Sponsorship

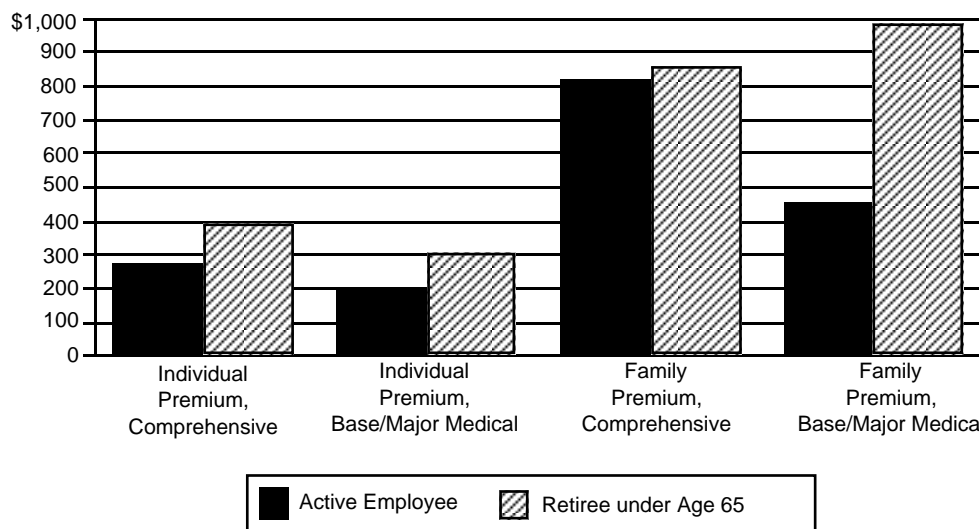
When asked why they failed to offer a group health plan to employees, 33 percent of small employers in the

<sup>11</sup> Although this decrease is statistically insignificant, the change in small business coverage from 1985 to 1989 varied by industry.

foregoing survey answered that they did not do so because premiums were too high, and 19 percent answered that they were unable to qualify for group coverage. These two reasons were cited more frequently than they were in a similar survey in 1985 (27 percent and 12 percent, respectively). Fewer employers gave as a reason that employees were covered under another family member's health plan (26 percent in 1989 versus 29 percent in 1985 and 38 percent in 1978).

Furthermore, future prospects for small employer sponsorship of group health plans are not encouraging. When employers who did not sponsor group health insurance as an employee benefit in 1989 were asked what would induce them to offer it (for example, increased ability to attract good employees, qualifying for a plan at group rates, making business more profitable or stable, reducing insurance costs, cutting administrative costs, etc.), 15 percent answered that under no circumstances would they offer group health insurance.

Chart 10  
Annual Dollar Contributions to Medical Plans, Active Employees and Retirees under Age 65, 1987



Source: The Wyatt Company, *Medical Benefits for Active and Retired Employees, 1987* (Washington, DC: The Wyatt Company, 1988b).

Table 5  
**Percentage of Small Employers Sponsoring  
 Group Medical Plans,  
 by Industry, 1978, 1985, and 1989**

Industry	1978	1985	1989
Total	57%	65%	63%
Wholesale	73	73	88
Manufacturing	81	83	81
Financial Services	56	65	70
Transportation	60	73	69
Construction	66	73	66
Professional Services	49	62	61
Services	48	52	53
Retail	46	58	52
Agriculture	52	48	50

Source: National Federation of Independent Business, *Small Business Employee Benefits*, 1978, 1985, 1989 (Washington, DC: NFIB).

In 1985, 95 percent of respondents without group health plans had indicated at least *one* factor that would cause them to offer a plan.

### ◆ Policy Activity

The continuing rise in health care costs has increased the demand for affordable coverage and served to focus policymakers' attention on the major problems currently facing the U.S. health care system, including the situation of 37 million uninsured Americans (and many more with inadequate coverage), the lack of long-term care insurance coverage for the growing elderly population, and poor access to preventive and public health programs. Policy initiatives at the state and federal levels may affect the design and availability of employer-based group health insurance plans.

#### State Initiatives

Every state currently mandates one or more specific benefits or coverages that insurers must include in health insurance policies (Gabel and Jensen, 1989).

Unfortunately, these mandates may exacerbate the problem of access to care (by causing health insurance premiums to rise because more benefits are required), particularly for employees of smaller firms that can seldom bypass the increased costs through self insurance. Moreover, mandates may contravene private initiatives to encourage cost effective provision of medical services, and they do not recognize the constraint of limited resources.



**Every state currently mandates specific benefits or coverages that insurers must include in health insurance policies.**



In April 1988, Massachusetts enacted a comprehensive state plan to provide universal access to health care. The plan (scheduled for implementation beginning in 1992) does not require employers to provide health insurance but establishes a public fund for the unemployed and workers who are not covered by their employers. Support for universal access appears to be broadening; Republican Governor George Deukmejian has just unveiled a universal health care proposal in California. Although his proposal does not include coverage for the uninsured, it would require all employers to provide health insurance for their workers.

#### Federal Initiatives

Diverse parties support federal comprehensive reform of the health care system, including large businesses, which are increasingly bearing the burden of providing for the uninsured; organized labor, where health benefits disputes was the main reason for 78 percent of strikes in the first 10 months of 1989 (Service Employees International Union, 1990); and health care providers, who are finding themselves squeezed between uninsured individuals and third party payers that are limiting reimbursements (and effectively refusing to



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subsidize the costs of care for the uninsured). Senator Edward Kennedy (D-MA) and Congressman Henry Waxman (D-CA) first introduced a universal health care bill in 1987 to require employers to provide health insurance benefits. Kennedy recently introduced the Health Care for All Workers Act, similar legislation that would require virtually all employers to provide health care insurance to their employees and to contribute at least 80 percent of the cost. The Kennedy bill includes mandates for specific benefit coverages, which would preempt individual state mandates. It is likely, however, that any comprehensive reform of the health care system would take into consideration the reports of three special commissions chartered to make health care policy recommendations: the U.S. Bipartisan Commission on Comprehensive Health Care (the Pepper Commission), the Advisory Council on Social Security, and the Health and Human Services Task Force.

The Pepper Commission recently released its preliminary recommendations for health care and long-term care policies. The report called for a proposal for universal access to health care that would require all businesses with more than 100 employees to provide private health insurance for all employees and their nonworking dependents (for a specified benefit package) or pay into a public plan. Employers would contribute a minimum of 80 percent of premiums for full-time workers and their nonworking dependents and a share of the premium for part-time workers and their working and nonworking dependents to a health plan that would include at least those benefits covered under the public plan.

The proposed public plan would include benefits for basic services; preventive services; and early, periodic screening, diagnosis, and treatment services for children. It would require \$250 deductibles for individuals (\$500 per family) and maximum out-of-pocket expenditures of \$3,000. Working individuals in the public plan would pay a percentage of their wages for their premiums, while self-employed and nonworking individuals would pay a portion of the cost of the plan according to their ability to pay. Low-income individuals, whether covered by the public plan or private insurance, would receive federal

government subsidies for premiums and cost sharing, depending on their income. The proposal calls for a five-year phase-in period for small employers, with provisions for tax subsidies. The Pepper Commission report also calls for reform of the insurance industry that would prohibit the exclusion of persons with preexisting conditions and/or individual group members from coverage and guarantee small groups access to community rated policies.

In addition to the proposal for universal access to health care, the Pepper Commission report recommends a proposal for universal access to long-term care coverage. The long-term care recommendations include home- and community-based long-term care services and protection against impoverishment for people in nursing homes and would be financed by federal and state governments, with contributions from individuals. The report does not offer a method of financing for either the health proposal or the long-term care proposal, which would cost the federal government an estimated \$65 billion (\$23.4 billion for health care and \$42.8 billion for long-term care).

The Pepper Commission report precedes expected recommendations on health care reform from the bipartisan Advisory Council on Social Security later in 1990, after which President Bush's Health and Human Services Task Force will make an administration report. President Bush acknowledged the need for health care system reform in his State of the Union Address and in his budget proposal (submitted to Congress on January 29), which included proposed alternative delivery systems in the Medicare and Medicaid programs.

## ◆ Conclusion

The design of employer-sponsored group health plans has changed in recent years in response to rapidly rising health care costs. The number of participants in traditional indemnity health plans has declined, while the number enrolled in HMOs and PPOs continues to increase. Insurers are becoming increasingly more sophisticated in tailoring their plans to market prefer-

ences in the form of multiple option and point-of-service plans that reward what is believed to be cost effective behavior. Employers are trying to control their burden by requiring employees to contribute to monthly health insurance premiums.

Insurers have modified health coverages to reduce employers' and/or their own burdens. Changes include features that increase employees' share of the medical cost burden (deductibles, copayments); reduce medical expenditures by limiting allowed expenses or days for certain types of care such as mental health and substance abuse; control unnecessary medical expenditures (utilization review, incentives for generic prescription drugs); and promote health or offer more cost effective delivery (coverages of routine physical examinations, hospice care). These changes have resulted in controversy among labor unions, which have seen health care benefits replace wages as the number one negotiating issue, and among medical providers, many of whom feel that their autonomy and freedom to practice effective medicine have been restricted by managed care provisions. Moreover, although plan modifications have effectively shifted some of the burden from insurers and employers to employees, some employers are dubious of cost containment results, and national health expenditures and health insurance premiums are increasing at unprecedented rates.

Dissatisfaction among insurers, providers, employers, and consumers has prompted many employers and insurers to continue developing new strategies for controlling health care costs and compelled governments to address this cost escalation and the increasing problem of access to care. The future of employer-sponsored health plans is certain to be affected by upcoming federal policy decisions.

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This *Issue Brief* was written by Jean Barber and Karen Horkitz of EBRI, with assistance from the Institute's research, education, and communications staffs.