# *Questions and Answers on Health Insurance Benefit Issues*

EBRI
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*Issue Brief*

- This *Issue Brief* addresses eight topics in the areas of health insurance and health care costs. Using a question and answer format, the discussion draws largely on EBRI research and the *EBRI Databook on Employee Benefits*, third edition.

- In 1993, U.S. expenditures on health care were $884.2 billion, and they are projected to reach $2,173.7 billion by 2005, increasing at a projected average annual rate of 7.8 percent. Health care spending accounted for 13.9 percent of Gross Domestic Product (GDP) in 1993 and is projected to reach 17.9 percent of GDP by 2005.

- Among the factors contributing to the increase in health care costs are the growth in the number of individuals with traditional reimbursement health insurance coverage, the rapid expansion of technology and treatment options, and demographic factors such as the aging of the population.

- In 1993, employers, both public and private, spent $235.6 billion on group health insurance, accounting for 6.2 percent of total compensation. Group health insurance is the fastest growing component of total compensation, increasing at an average annual rate of 13.7 percent from 1960 to 1993.

- An increasing number of employees are required to make a cash contribution to their health insurance plan premium. In 1993, 61 percent of full-time employees in medium and large private establishments who participated in an employee only health insurance plan were required to make a contribution to the premium, up from 27 percent in 1979.

- In 1993, 185.3 million persons under age 65 had health insurance coverage, while 40.9 million people—or about 18.1 percent of the nonelderly population—received neither private health insurance nor publicly financed health coverage. Of those individuals who had health insurance coverage, 60.8 percent, or 137.4 million persons, received their health insurance through an employment-based plan.

- In 1993, 15.2 percent of the nonelderly population without health insurance coverage were noncitizens. In six states noncitizens represented a higher proportion of the total uninsured population than individuals in the nation as a whole.

- An increasing number of employers are self-funding their health insurance plans. In 1994, 74 percent of employers with 500 or more employees self-funded their health insurance plans, up from 63 percent in 1993. An estimated 22 million full-time employees in private industry and state and local governments participated in a self-funded employment-based health insurance plan.

- In 1993, 45 percent of full-time employees in medium and large private establishments participated in an employment-based health plan that continued coverage in retirement. The average cost per retiree in 1994 was $2,859.

- In 1993, 53 percent of all full-time employees in medium and large private establishments were eligible for flexible benefits and/or a flexible savings account, up from 13 percent in 1988.

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# *Introduction*

Employment-based health insurance is the most common source of health insurance coverage among the nonelderly population in the United States, with nearly two-thirds of the nonelderly population receiving this type of coverage in 1993. In addition, one-third of the elderly population in 1993 had employment-based health insurance mainly as a supplement to Medicare (Snider and Fronstin, 1995). Employment-based health benefits are offered to protect the employee and the employee's family members from catastrophic financial loss that can accompany serious injury or illness and as a form of compensation to attract and retain qualified personnel.

Employment-based health benefits are the fastest growing component of total compensation. In 1993, health benefits accounted for 7.3 percent of total compensation, up from 4.4 percent in 1980 (Silverman, 1995). Employers have developed various cost management strategies to cope with these rising health care costs. One of the more common strategies employers are using is to increase employee cost sharing. Among full-time employees in medium and large private establishments who were participating in an employment-based health plan in 1993, 61 percent were required to pay part of the premium for single coverage, up from 27 percent in 1979. In addition to increased cost sharing, employers have encouraged their employees to select managed care plans instead of fee-for-service plans. In 1993, 105 million individuals were enrolled in a managed care plan. [1]

This *Issue Brief* addresses eight topics in the area of health insurance and health care costs. Using a question and answer format, the discussion draws largely on Employee Benefit Research Institute (EBRI) research and the *EBRI Databook on Employee Benefits*, third edition.

## 1. How much does the United States spend annually on health care, and what percentage of Gross Domestic Product (GDP) goes toward health expenditures? What are the different sources of spending? What are the different types of expenditures?

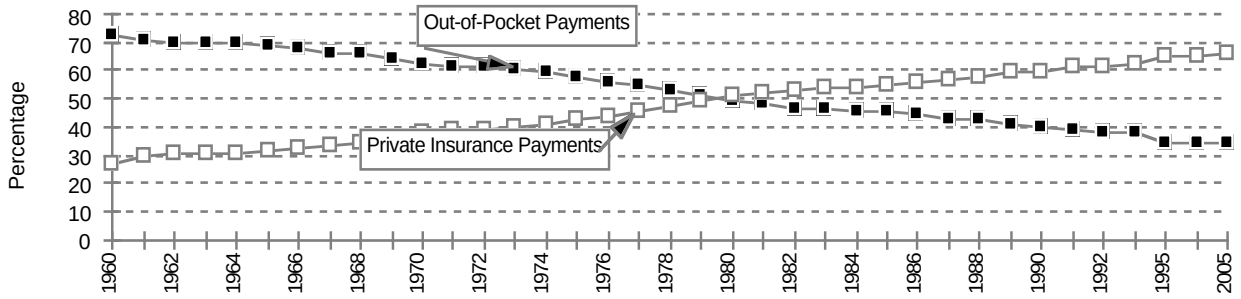
National spending on health care reached $884.2 billion in 1993, or 13.9 percent of GDP (Levit et al., 1994) and is projected to reach $2,173.7 billion by 2005, or 17.9 percent of GDP (Burner et al., 1995), according to the Health Care Financing Administration (HCFA) (table 1). Private sources of funds accounted for slightly more than one-half of total health care spending in 1993 (56.1 percent), compared with 43.9 percent from public sources. By 2005, private sources are projected to account for slightly less, 53.9 percent.

*Private Sources*—In 1993, private sources paid out $496.4 billion for health expenditures (table 1). Among private sources, private health insurance accounted for the largest segment of all private-sector expenditures, paying $296.1 billion, or 59.6 percent of all private source funding. Most business spending on health care is for funding private insurance. The other major component of private source funding is out-of-pocket spending, which accounted for 31.7 percent of all private source funding. Out-of-pocket funding consists of direct consumer payments such as deductibles, copayments, spending for health related items not covered by insurance such as over-the-counter drugs, and uninsured individuals' consumption of health care services. Since

[1] *This number includes employees and their dependents, individuals who purchase private health insurance, and individuals enrolled in public programs such as Medicare and Medicaid.*

Chart 1

**Percentage of Private Health Care Expenditures That Are Direct (Out of Pocket) and Percentage That Are Private Health Insurance Payments, 1960–1993 and Projections, Selected Years 1995–2005**




Source: Katharine R. Levit et al., "National Health Expenditures, 1993" *Health Care Financing Review* (Fall 1994): 247–294; and Sally T. Burner et al., "Projections of National Health Care Expenditures, 1994–2005," *Health Care Financing Review* (Summer 1995), forthcoming.

1960, there has been a gradual shift from direct out-of-pocket spending to private health insurance spending (chart 1).

*Public Sources*—In 1993, public sources paid out $387.8 billion for health expenditures and are projected to pay out $1,002.4 billion by 2005 (table 1). Public source funding consists of payments made by the federal government and state and local governments. The federal government accounts for the majority of public source funding, totaling $280.6 billion, or 72.4 percent of all public source funding in 1993. Most federal government source spending is from two programs, Medicare ($151.1 billion in 1993) and Medicaid ($112.8 billion in 1993[2]). By 2005, projected payments for Medicare are $450.9 billion and $333.4 billion for Medicaid (table 1).

*Types of Expenditures*—The bulk of health care expenditures went toward payments for personal health care expenses. In 1993, payments for personal health care accounted for 88.5 percent of all national health care spending, and they are projected to increase to 90.8 percent by 2005 (calculated from table 1). Hospital care accounted for the largest component of personal health care expenses, $326.6 billion, or 41.7 percent of all personal health care expenses. Physician services were the next largest component at $171.2 billion, or 21.9 percent of all personal health care expenses. Administrative expenses for private health insurance were $48 billion in 1993, accounting for 5 percent of all national health expenditures.

[2]*Approximately 40 percent of Medicaid spending was from state and local governments.*

For more information on national health expenditures, see *EBRI Databook on Employee Benefits*, third edition, and "The Role of the Health Care Sector in the U.S. Economy," *EBRI Issue Brief* no. 142.

## 2. What factors drive health care costs increases? What are the trends in health care cost growth rates by public and private sources?

Spending on health care is one of the fastest growing segments of the U.S. economy. Health care spending has grown at twice the rate of the consumer price index (CPI-U). From 1965 to 1995, health care spending grew at an average annual rate of 11.2 percent, compared with an average annual rate of 5.4 percent for CPI-U (table 2). Growth in the number of individuals with traditional fee-for-service reimbursement health insurance coverage is a primary factor contributing to the increase in health care costs. The availability of insurance effectively lowers the price of health care for individuals, thereby increasing the demand. The insurance term for this behavior is moral hazard. As a result of moral hazard, the full price of consuming health care is transferred from consumers to insurance companies and premium payers. The increase in the demand for services and the absence of price sensitivity, coupled with an increase in the supply of health care services, result in an increase in expenditures. Other factors affecting cost growth include the rapid expansion of treatment options without concurrent research on the relative efficacy of each option and demographic factors such as the aging of the population. Technological innovation has increased health care expenditures, not only because prices have gone up but

Table 1

**National Health Expenditures by Source of Funds, Type of Expenditure, and as a Percentage of Gross Domestic Product (GDP), Selected Years 1965–1993 and Projections, Selected Years 1995–2005**

| | | | | | Projected | | |
|---|---|---|---|---|---|---|---|
| Type of Expenditure | 1965 | 1975 | 1985 | 1993 | 1995 | 2000 | 2005 |
| | | | | ($ billions) | | | |
| National Health Expenditures | $41.6 | $132.6 | $422.6 | $884.2 | $1,007.6 | $1,481.7 | $2,173.7 |
| Private | 31.3 | 77.5 | 247.9 | 496.4 | 552.7 | 807.9 | 1,171.3 |
| consumer | 29.0 | 71.1 | 228.5 | 453.6 | 506.5 | 743.1 | 1,080.2 |
| direct payments (out of pocket) | 19.0 | 39.1 | 94.4 | 157.5 | 175.2 | 256.4 | 370.6 |
| private health insurance | 10.0 | 32.0 | 134.1 | 296.1 | 331.3 | 486.7 | 709.6 |
| other private | 2.3 | 6.3 | 19.4 | 42.8 | 46.2 | 64.9 | 91.1 |
| Government | 10.3 | 55.1 | 174.8 | 387.8 | 454.9 | 673.7 | 1,002.4 |
| federal | 4.8 | 36.4 | 123.6 | 280.6 | 334.1 | 502.5 | 756.7 |
| state and local | 5.5 | 18.7 | 51.2 | 107.3 | 120.8 | 171.2 | 245.7 |
| Addendum | | | | | | | |
| Medicare[a] | b | 15.7 | 70.3 | 151.1 | 190.0 | 293.5 | 450.9 |
| Medicaid[c] | b | 12.9 | 39.2 | 112.8 | 138.4 | 214.5 | 333.4 |
| | | | | (as a percentage of total national health expenditures) | | | |
| National Health Expenditures | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| Private | 75.3 | 58.4 | 58.7 | 56.1 | 54.9 | 54.5 | 53.9 |
| consumer | 69.7 | 53.6 | 54.1 | 51.3 | 50.3 | 50.2 | 49.7 |
| direct payments (out of pocket) | 45.6 | 29.5 | 22.3 | 17.8 | 17.4 | 17.3 | 17.1 |
| private health insurance | 24.1 | 24.2 | 31.7 | 33.5 | 32.9 | 32.8 | 32.6 |
| other private | 5.5 | 4.8 | 5.0 | 4.8 | 4.6 | 4.4 | 4.2 |
| Government | 24.7 | 41.6 | 41.1 | 43.9 | 45.2 | 45.5 | 46.1 |
| federal | 11.6 | 27.5 | 28.1 | 31.7 | 33.2 | 33.9 | 34.8 |
| state and local | 13.2 | 14.1 | 13.0 | 12.1 | 12.0 | 11.6 | 11.3 |
| Addendum | | | | | | | |
| Medicare[a] | b | 11.8 | 16.6 | 17.1 | 18.9 | 19.8 | 20.7 |
| Medicaid[c] | b | 9.7 | 9.3 | 12.8 | 13.7 | 14.5 | 15.3 |
| | | | | ($ billions) | | | |
| National Health Expenditures | $41.6 | $132.6 | $434.5 | $884.2 | $1,007.6 | $1,481.7 | $2,173.7 |
| Health services and supplies | 38.2 | 124.2 | 418.1 | 855.2 | 977.5 | 1,445.6 | 2,129.2 |
| personal health care expenses | 35.6 | 116.2 | 380.5 | 782.5 | 897.7 | 1,334.3 | 1,973.4 |
| hospital care | 14.0 | 52.6 | 168.2 | 326.6 | 364.5 | 518.3 | 736.8 |
| physicians' services | 8.2 | 23.9 | 83.6 | 171.2 | 198.0 | 309.8 | 483.6 |
| dentists' services | 2.8 | 8.0 | 21.7 | 37.4 | 42.9 | 59.1 | 79.1 |
| other professional services | 0.9 | 2.7 | 16.6 | 51.2 | 62.9 | 103.3 | 166.4 |
| home health care | 0.1 | 0.5 | 4.9 | 20.8 | 27.9 | 45.9 | 68.0 |
| drugs and other medical nondurables | 5.9 | 13.0 | 37.4 | 75.0 | 84.7 | 122.3 | 178.6 |
| vision products and other medical durables | 1.2 | 3.1 | 7.1 | 12.6 | 13.9 | 17.9 | 22.6 |
| nursing home care | 1.7 | 10.0 | 34.9 | 69.6 | 80.2 | 121.2 | 179.6 |
| other health services | 0.8 | 2.5 | 6.1 | 18.2 | 22.7 | 36.5 | 58.7 |
| program administration, net cost of private health insurance | 1.9 | 5.0 | 25.3 | 48.0 | 51.9 | 74.1 | 107.3 |
| government public health activities | 0.6 | 3.0 | 12.3 | 24.7 | 27.9 | 37.2 | 48.6 |
| Research and construction | 3.4 | 8.4 | 16.4 | 29.0 | 30.1 | 36.1 | 44.4 |
| research[d] | 1.5 | 3.3 | 7.8 | 14.4 | 15.9 | 19.6 | 24.4 |
| construction | 1.9 | 5.1 | 8.6 | 14.6 | 14.2 | 16.5 | 20.0 |
| | | | | (as a percentage of GDP) | | | |
| National Health Expenditures | 5.9% | 8.4% | 10.8% | 13.9% | 14.2% | 15.9% | 17.9% |

Source: Katharine R. Levit et al., "National Health Expenditures, 1993," *Health Care Financing Review* (Fall 1994): 247–294; and Sally T. Burner et al., "Projections of the National Health Expenditures 1994–2005," *Health Care Financing Review* (Summer 1995), forthcoming.

[a]Subset of federal funds.

[b]Not applicable.

[c]Subset of both federal and state and local funds.

[d]Research and development expenditures of drug companies and other manufacturers and providers of medical equipment and supplies are excluded from "research expenditures," but they are included in the expenditure class in which the product falls.

Table 2
**Average Annual Growth Rate of National Health Expenditures by Source of Funds, 1965–1995 and Projections 1995–2000**

| Source of Funds | 1965–1970 | 1970–1975 | 1975–1980 | 1980–1985 | 1985–1990 | 1990–1995[a] | 1965–1995[a] | Projections 1995–2000 |
|---|---|---|---|---|---|---|---|---|
| National Health Expenditures | 12.3% | 12.3% | 13.6% | 11.0% | 10.5% | 7.7% | 11.2% | 8.0% |
| Private | 8.3 | 10.7 | 13.5 | 11.2 | 10.6 | 6.2 | 10.0 | 7.9 |
| consumer | 7.8 | 11.0 | 13.4 | 11.4 | 10.4 | 6.2 | 10.0 | 8.0 |
| direct payments (out of pocket) | 6.0 | 9.0 | 9.4 | 9.0 | 7.9 | 4.8 | 7.7 | 7.9 |
| private insurance | 11.1 | 13.6 | 17.6 | 13.2 | 12.1 | 6.9 | 12.4 | 8.0 |
| Public (government) | 21.9 | 14.7 | 13.8 | 10.7 | 10.4 | 9.7 | 13.5 | 8.2 |
| federal | 30.0 | 15.4 | 14.6 | 11.4 | 9.6 | 11.3 | 15.2 | 8.5 |
| state and local | 12.5 | 13.6 | 12.2 | 9.0 | 12.1 | 5.9 | 10.8 | 7.2 |
| Addendum | | | | | | | | |
| CPI-U[b] | 4.3 | 6.8 | 8.9 | 5.5 | 4.0 | 2.5 | 5.4 | 3.2 |
| Medicare | c | 16.6 | 18.3 | 14.1 | 9.3 | 11.1 | 13.2[d] | 9.1 |
| Medicaid | c | 20.4 | 14.0 | 9.6 | 12.8 | 12.9 | 14.1[d] | 9.2 |

Source: Employee Benefit Research Institute tabulations of data from Katharine R. Levit et al., "National Health Expenditures, 1993," *Health Care Financing Review* (Fall 1994): 247–294; Sally T. Burner et al., "Projections of the National Health Expenditures 1994–2005," *Health Care Financing Review* (Summer 1995), forthcoming; U.S. Department of Commerce, Bureau of the Census, *Statistical Abstract of the United States: 1994* (Washington, DC: U.S. Government Printing Office, 1994); U.S. Department of Labor, Bureau of Labor Statistics, *Monthly Labor Review* (May 1995): 106; and Executive Office of the President, Office of Management and Budget, *Analytical Perspectives Budget of the United States Government, Fiscal Year 1996* (Washington, DC: U.S. Government Printing Office, 1995).
[a]1995 data are projections from the Health Care Financing Administration.
[b]Consumer price index for all urban consumers. The data for 1995 CPI-U are from March, the latest number available at the time this *Issue Brief* was written.
[c]Data not available.
[d]Calculation is for 1970 through 1995.

because new health care services are now offered and covered by health insurance. The following discussion highlights trends in health care cost growth.

*Public Sources of Funds* —In 1965, before the implementation of Medicare and Medicaid, public sources of funding accounted for one-quarter of total health care spending. By 1993, public sources accounted for 43.9 percent of total health care spending, and they are projected to account for 46.1 percent in 2005 (table 1). In 1995, Medicare and Medicaid are projected to account for 72.2 percent of all public source spending, and they are projected to account for 78.2 percent in 2005 (calculated from table 1). The average annual growth rate of Medicare and Medicaid from 1970 to 1995 is projected at 13.2 percent and 14.1 percent, respectively (table 2).

*Private Sources of Funds* —Since 1965, direct consumer payments have accounted for a declining share of total private source spending, decreasing from 60.7 percent in 1965 to 31.7 percent in 1993 (calculated from table 1). Private health insurance accounts for most of the balance of private source spending. In 1993, private health insurance accounted for 59.6 percent of all private source spending, up from 31.9 percent in 1965 (calculated from table 1). The average annual growth rate of private source spending on health care increased throughout the 1970s, reaching a peak of 13.5 percent during the period 1975–1980 (table 2). Since 1980, the growth rate of private source spending has slowed. During the period 1980–1985, private source spending's average annual growth rate was 11.2 percent, and in 1985–1990, it was 10.6 percent (table 2). The average annual growth rate for private sources is projected to be 6.2 percent in the 1990–1995 period, the lowest of all time periods. This is likely in large part due to the greater attention paid by employers and insurance companies to cost management and increasing enrollment in managed care plans.

For more information on health care cost trends, see *EBRI Databook on Employee Benefits*, third edition, and "The Role of the Health Care Sector in the U.S. Economy," *EBRI Issue Brief* no. 142.

Table 3
**Employer Outlays for Selected Employee Benefits by Function and Average Annual Growth Rates, Selected Years 1960–1993**

| | 1960 | 1970 | 1980 | 1990 | 1991 | 1992 | 1993 | Average Annual Growth Rate 1960–1993[a] |
|---|---|---|---|---|---|---|---|---|
| | | | | ($ billions) | | | | |
| Total Compensation | $296.7 | $618.3 | $1,644.4 | $3,292.3 | $3,399.4 | $3,585.4 | $3,774.4 | 8.0% |
| Wages and salaries[b] | 272.8 | 551.5 | 1,376.6 | 2,745.0 | 2,816.0 | 2,954.8 | 3,100.8 | 7.6 |
| All benefits | 23.7 | 66.2 | 265.8 | 547.3 | 583.4 | 630.6 | 673.6 | 10.6 |
| retirement income benefits | 14.2 | 40.3 | 151.6 | 260.6 | 275.1 | 294.6 | 311.1 | 9.8 |
| health benefits | 3.4 | 14.6 | 73.0 | 211.7 | 230.6 | 254.7 | 275.6 | 14.2 |
| Medicare hospital insurance | 0.0 | 2.3 | 11.6 | 33.6 | 34.7 | 36.5 | 38.2 | 13.0 |
| group health insurance | 3.4 | 12.1 | 61.0 | 176.6 | 194.2 | 216.5 | 235.6 | 13.7 |
| military medical insurance[c] | 0.0 | 0.2 | 0.4 | 1.5 | 1.7 | 1.7 | 1.8 | 10.0 |
| other employee benefits | 6.1 | 11.3 | 41.2 | 75.0 | 77.7 | 81.3 | 86.9 | 8.4 |
| | | | | (percentage of total compensation) | | | | |
| Total Compensation | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | |
| Wages and salaries[b] | 91.9 | 89.2 | 83.7 | 83.4 | 82.8 | 82.4 | 82.2 | |
| All benefits | 8.0 | 10.7 | 16.2 | 16.6 | 17.2 | 17.6 | 17.8 | |
| retirement income benefits | 4.8 | 6.5 | 9.2 | 7.9 | 8.1 | 8.2 | 8.2 | |
| health benefits | 1.1 | 2.4 | 4.4 | 6.4 | 6.8 | 7.1 | 7.3 | |
| Medicare hospital insurance | 0.0 | 0.4 | 0.7 | 1.0 | 1.0 | 1.0 | 1.0 | |
| group health insurance | 1.1 | 2.0 | 3.7 | 5.4 | 5.7 | 6.0 | 6.2 | |
| military medical insurance[c] | 0.0 | 0.0 | 0.0 | 0.0 | 0.1 | 0.0 | 0.0 | |
| other employee benefits | 2.1 | 1.8 | 2.5 | 2.3 | 2.3 | 2.3 | 2.3 | |

Source: Employee Benefit Research Institute tabulations based on U.S. Department of Commerce, Bureau of Economic Analysis, *Survey of Current Business, July 1994* (Washington, DC: U.S. Government Printing Office, 1994); and *The National Income and Products Accounts of the United States: Statistical Supplement, 1959–1988,* Vol. 2 (Washington, DC: U.S. Government Printing Office, 1992).
[a]Average annual growth rates for Medicare hospital insurance and military medical insurance are calculated for 1970–1993.
[b]Includes paid holidays, vacations, and sick leave taken.
[c]Consists of payments for medical services for dependents of active duty military personnel at nonmilitary facilities.

## 3. How much do employers and employees each spend on group health insurance?

According to one survey, the average cost per employee of a group health insurance plan increased 6.8 percent between 1992 and 1994, rising from $3,502 in 1992 to $3,741 in 1994 (A. Foster Higgins & Co., Inc., 1995a). A separate study by the U.S. Department of Commerce, Bureau of Economic Analysis indicates that, compared with other major components of total compensation, group health insurance is the fastest growing component of total compensation (table 3). In 1993, group health insurance accounted for 6.2 percent of total compensation, up from 1.1 percent in 1960, increasing at an average annual rate of 13.7 percent (table 3). Wages and salaries increased at an average annual rate of 7.6 percent, retirement income at 9.8 percent, and other benefits at 8.4 percent.

As employer costs for health care have risen, it appears that some employers have attempted to manage their costs by requiring employees to contribute to individual and/or family health insurance premiums. Among participants in group health plans sponsored by medium and large private establishments, the proportion required to contribute to premiums for individual coverage increased from 27 percent in 1979 to 61 percent in 1993, and the proportion required to contribute to family coverage increased from 46 percent in 1980 to 76 percent in 1993. The average monthly contribution in 1993 was $31.55 for employee coverage and $107.42 for family coverage (table 4).

For more information on employer and employee costs for group health insurance, see *EBRI Databook on Employee Benefits,* third edition; "The Effectiveness of Health Care Cost Management Strategies: A Review of the Evidence," *EBRI Issue Brief* no. 154; and "Features of Employer-Sponsored Health Plans," *EBRI Issue Brief* no. 128.

Table 4

**Percentage of Full-Time Employees Participating in Employer-Sponsored Medical Plans, by Plan Type and Average Monthly Contribution: Medium and Large Private Establishments,[a] Selected Years 1979–1993**

| | (old scope) | | | | | | | | | (new scope) | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Type of Coverage | 1979 | 1980 | 1981 | 1982 | 1983 | 1984 | 1985 | 1986 | 1988 | 1988 | 1989 | 1991 | 1993 |
| Percentage of Employees Participating in Medical Care Plans | 97% | 97% | 97% | 97% | 96% | 97% | 96% | 95% | 92% | 90% | 92% | 83% | 82% |
| Single Employee Coverage | | | | | | | | | | | | | |
| Wholly employer financed | 73 | 74 | 73 | 73 | 67 | 64 | 64 | 57 | 55 | 56 | 53 | 49 | 37 |
| Contributory | 27 | 26 | 27 | 27 | 33 | 36 | 36 | 43 | 45 | 44 | 47 | 51 | 61 |
| Not determinable | b | b | b | b | b | b | b | b | b | b | b | b | 2 |
| Average monthly contribution | b | b | b | b | $10.13 | $11.93 | $12.05 | $12.80 | b | $19.29 | $25.31 | $26.60 | $31.55 |
| Family Coverage | | | | | | | | | | | | | |
| Wholly employer financed | b | 54 | 51 | 49 | 46 | 42 | 44 | 37 | 37 | 36 | 34 | 31 | 21 |
| Contributory | b | 46 | 49 | 51 | 54 | 58 | 56 | 63 | 63 | 64 | 66 | 69 | 76 |
| Not determinable | b | b | b | b | b | b | b | b | b | b | b | b | 3 |
| Average monthly contribution | b | b | b | b | $32.51 | $35.93 | $38.33 | $41.40 | b | $60.07 | $72.10 | $96.97 | $107.42 |

Source: U.S. Department of Labor, Bureau of Labor Statistics, *Employee Benefits in Medium and Large Firms, 1979–1989* (Washington, DC: U.S. Government Printing Office, selected years); *Employee Benefits in Medium and Large Private Establishments,* 1991 and 1993 (Washington, DC: U.S. Government Printing Office, 1993 and 1995).

[a]The Bureau of Labor Statistics' (BLS) survey scope was expanded significantly in 1988 to include private nonfarm establishments employing 100 or more workers. The former survey coverage, which previously included full-time employees in establishments with 50, 100, or 250 workers, depending on industry, is referred to as old scope. The expanded survey coverage, which in 1988 and after includes full-time employees in private nonfarm establishments employing 100 or more workers in the District of Columbia and all states except Alaska and Hawaii, is referred to as new scope. In order to permit comparisons of 1988 findings with those of prior years, BLS also tabulated selected 1988 survey responses for old scope establishments. In 1991 and following years, the survey includes establishments in Alaska and Hawaii.

[b]Data not available.

## 4. By state, how many individuals have health insurance in the United States and how many are uninsured? Among those who have health insurance, what is the source?

In 1993, in four states one-quarter or more of the nonelderly population was without health insurance coverage: Oklahoma (27.4 percent), Louisiana (27.0 percent), New Mexico (26.0 percent), and Texas (25.1 percent) (table 5). No state had less than 10 percent of its nonelderly population without health insurance coverage. The states with the lowest uninsured rates are: Wisconsin (10.0 percent), Iowa (10.9 percent), and Connecticut and Rhode Island (12.1 percent each).

The most common source for health insurance is through the workplace. In 1993, 60.8 percent of the nonelderly population received health insurance coverage through an employment-based plan. Among the states there was a wide range of the nonelderly population who received their health insurance coverage through an employment-based plan. Connecticut (73.1 percent) and Wisconsin (71.6 percent) had the highest percentage of nonelderly population receiving health insurance coverage through an employment-based plan, while Louisiana (46.3 percent) and Mississippi (52.1 percent) had the lowest.

An increasing number of nonelderly individuals are receiving their health insurance coverage through a public source (Medicaid, Medicare, and CHAMPUS/CHAMPUS-VA[3]). In 1993, the states with the highest

[3]*CHAMPUS is the Civilian Health and Medical Program of the Uniformed Services. CHAMPUS-VA is the Civilian Health and Medical Program of the Veterans Administration.*

percentage of nonelderly population covered by a public source of health insurance in 1993 were: Mississippi (24.2 percent), District of Columbia (24.0 percent), and Alaska and Kentucky (22.4 percent each) (table 5).

One of the determinants of the likelihood of an individual having health insurance coverage was citizenship. Noncitizens (43 percent) were more likely to be uninsured than citizens (16.4 percent). In six states, California (37.8 percent), New York (26.6 percent), Florida (21.7 percent), New Jersey (20.8 percent), Illinois (19.9 percent), and Texas (17.8 percent), noncitizens represented a higher proportion of the nonelderly population without health insurance coverage than individuals in the nation as a whole (15.2 percent).

For more information on sources of health insurance and characteristics of the uninsured, see *EBRI Databook on Employee Benefits,* third edition, and "Sources of Health Insurance and Characteristics of the Uninsured," *EBRI Issue Brief* no. 158.

## 5. What is a self-insured or self-funded plan? What percentage of employers have self-insured plans?

The terms *self-insured* and *self-funded* are generally used interchangeably. A self-funded health benefit plan is one in which the employer assumes the risk of payment for medical benefits for its employees. Employers with self-funded health plans may administer their own plans or purchase administrative services contracts for their administrative needs. There are two basic reasons why an employer might choose to self-fund its health benefits plan: financial and plan design.

- Financial reasons: Although some companies establish a reserve of funds for the health plan, most companies that self-fund their health benefits pay claims as they arise, with no advance funding. Thus the employer retains complete control over cash flow and investments pending the need to pay actual claims. Also, self-funded plans are not subject to state premium taxes and insurance company charges to cover risk and profit.

- Plan design reasons: Self-funded plans are exempt from state mandated benefit laws, which specify certain types and levels of coverage that policies must include. As a result, self-funded plans may offer a single plan to employees in several states. Self-funded plans have greater freedom to design the benefit package to fit the needs of the company and its employees.

The passage of the Employee Retirement Income Security Act of 1974 (ERISA) provided employers with a uniform federal regulatory framework for employee benefits. Sec. 514 of ERISA provides that ERISA generally supersedes or preempts all state laws that relate to pension and welfare plans covered by ERISA, with the exception of state law regulating insurance, banking, and securities. This clause is often referred to as the "saving" clause. All employer health benefit plans, except those plans maintained by churches and governments (federal, state, and local), are ERISA plans. However, there is an important distinction between self-funded plans, where the employer assumes the risk of medical claims, and insured plans, where the insurer assumes the risk. Because of the "saving" clause, insured plans are indirectly regulated by the states (states regulate the insurance contract not the benefit plan).

A company that self-funds its health benefit plan may not be *fully* self-funded. Many companies carve out sections of their health benefit plan (e.g., prescription drug benefits) in an effort to reduce overall health benefit costs. The carved out sections may be insured. States may, by their retained power to regulate insurance, be able to regulate the insured portions indirectly. In some situations, the issue may be one of whether

Table 5

**Nonelderly Population with Selected Sources of Health Insurance, by Region and State, 1992 and 1993**

| Region and State | 1992 Total | 1992 Total private | 1992 Employer coverage | 1992 Total public | 1992 No health insurance coverage | 1993 Total | 1993 Total private | 1993 Employer coverage | 1993 Total public | 1993 No health insurance coverage |
|---|---|---|---|---|---|---|---|---|---|---|
| | (millions) | | | | | | | | | |
| Total | 223.8 | 157.5 | 138.7 | 34.3 | 39.8 | 226.2 | 157.7 | 137.4 | 36.3 | 40.9 |
| New England | 11.3 | 8.9 | 7.9 | 1.4 | 1.4 | 11.5 | 8.8 | 7.8 | 1.5 | 1.5 |
| Maine | 1.1 | 0.8 | 0.7 | 0.2 | 0.1 | 1.1 | 0.8 | 0.7 | 0.2 | 0.1 |
| New Hampshire | 1.0 | 0.8 | 0.7 | 0.1 | 0.1 | 1.0 | 0.8 | 0.7 | 0.1 | 0.1 |
| Vermont | 0.5 | 0.4 | 0.4 | 0.1 | 0.1 | 0.5 | 0.4 | 0.3 | 0.1 | 0.1 |
| Massachusetts | 5.1 | 4.0 | 3.5 | 0.6 | 0.6 | 5.2 | 3.9 | 3.4 | 0.7 | 0.7 |
| Rhode Island | 0.8 | 0.6 | 0.6 | 0.1 | 0.1 | 0.8 | 0.6 | 0.6 | 0.1 | 0.1 |
| Connecticut | 2.9 | 2.4 | 2.1 | 0.3 | 0.3 | 2.8 | 2.3 | 2.1 | 0.3 | 0.3 |
| Middle Atlantic | 32.7 | 24.1 | 21.5 | 4.8 | 4.7 | 33.0 | 23.8 | 21.0 | 5.1 | 5.1 |
| New York | 15.7 | 10.9 | 9.6 | 2.7 | 2.6 | 15.8 | 10.9 | 9.5 | 2.8 | 2.6 |
| New Jersey | 6.8 | 5.2 | 4.7 | 0.7 | 1.1 | 7.0 | 5.2 | 4.5 | 0.8 | 1.1 |
| Pennsylvania | 10.2 | 8.0 | 7.2 | 1.4 | 1.1 | 10.3 | 7.7 | 7.0 | 1.4 | 1.4 |
| East North Central | 38.1 | 28.8 | 25.8 | 5.4 | 5.0 | 38.4 | 28.7 | 25.4 | 5.8 | 5.1 |
| Ohio | 9.8 | 7.5 | 6.8 | 1.4 | 1.3 | 9.9 | 7.4 | 6.6 | 1.6 | 1.3 |
| Indiana | 5.0 | 3.9 | 3.5 | 0.7 | 0.6 | 5.1 | 3.9 | 3.4 | 0.7 | 0.7 |
| Illinois | 10.5 | 7.6 | 6.7 | 1.5 | 1.6 | 10.4 | 7.6 | 6.5 | 1.5 | 1.5 |
| Michigan | 8.2 | 6.3 | 5.6 | 1.2 | 1.0 | 8.5 | 6.2 | 5.6 | 1.5 | 1.1 |
| Wisconsin | 4.5 | 3.7 | 3.2 | 0.6 | 0.5 | 4.5 | 3.6 | 3.2 | 0.5 | 0.4 |
| West North Central | 15.5 | 11.9 | 10.0 | 2.0 | 2.0 | 15.5 | 11.9 | 9.1 | 2.1 | 2.1 |
| Minnesota | 3.8 | 3.0 | 2.5 | 0.6 | 0.4 | 3.9 | 3.0 | 2.6 | 0.5 | 0.5 |
| Iowa | 2.5 | 2.0 | 1.7 | 0.3 | 0.3 | 2.4 | 2.0 | 1.6 | 0.2 | 0.3 |
| Missouri | 4.5 | 3.2 | 2.9 | 0.6 | 0.7 | 4.5 | 3.3 | 3.0 | 0.7 | 0.6 |
| North Dakota | 0.5 | 0.4 | 0.3 | 0.1 | 0.1 | 0.5 | 0.4 | 0.3 | 0.1 | 0.1 |
| South Dakota | 0.6 | 0.4 | 0.3 | 0.1 | 0.1 | 0.6 | 0.4 | 0.4 | 0.1 | 0.1 |
| Nebraska | 1.4 | 1.1 | 0.9 | 0.2 | 0.2 | 1.4 | 1.1 | 0.9 | 0.2 | 0.2 |
| Kansas | 2.2 | 1.8 | 1.5 | 0.2 | 0.3 | 2.2 | 1.6 | 1.4 | 0.3 | 0.3 |
| South Atlantic | 38.6 | 26.0 | 22.9 | 6.3 | 7.8 | 39.1 | 26.6 | 23.1 | 6.2 | 7.9 |
| Delaware | 0.6 | 0.5 | 0.4 | 0.1 | 0.1 | 0.6 | 0.5 | 0.4 | 0.1 | 0.1 |
| Maryland | 4.2 | 3.2 | 2.9 | 0.5 | 0.6 | 4.2 | 3.0 | 2.7 | 0.6 | 0.7 |
| District of Columbia | 0.5 | 0.3 | 0.3 | 0.1 | 0.1 | 0.5 | 0.3 | 0.2 | 0.1 | 0.1 |
| Virginia | 5.5 | 4.0 | 3.6 | 0.7 | 1.0 | 5.6 | 4.2 | 3.7 | 0.7 | 0.9 |
| West Virginia | 1.5 | 1.0 | 0.9 | 0.3 | 0.3 | 1.5 | 0.9 | 0.8 | 0.3 | 0.3 |
| North Carolina | 5.9 | 4.2 | 3.7 | 0.9 | 1.0 | 5.8 | 4.1 | 3.6 | 0.9 | 1.0 |
| South Carolina | 3.3 | 2.1 | 1.8 | 0.7 | 0.7 | 3.2 | 2.1 | 1.9 | 0.6 | 0.6 |
| Georgia | 5.8 | 3.8 | 3.3 | 1.0 | 1.3 | 6.0 | 4.1 | 3.5 | 0.9 | 1.3 |
| Florida | 11.3 | 7.0 | 6.0 | 2.0 | 2.8 | 11.7 | 7.4 | 6.2 | 2.1 | 2.8 |
| East South Central | 13.7 | 9.3 | 8.3 | 2.5 | 2.5 | 13.6 | 9.1 | 7.8 | 2.8 | 2.4 |
| Kentucky | 3.2 | 2.2 | 2.0 | 0.6 | 0.6 | 3.2 | 2.2 | 1.9 | 0.7 | 0.5 |
| Tennessee | 4.4 | 3.0 | 2.7 | 0.9 | 0.7 | 4.6 | 3.1 | 2.7 | 0.9 | 0.7 |
| Alabama | 3.7 | 2.6 | 2.4 | 0.5 | 0.7 | 3.6 | 2.4 | 2.1 | 0.6 | 0.7 |
| Mississippi | 2.4 | 1.5 | 1.3 | 0.5 | 0.5 | 2.2 | 1.4 | 1.2 | 0.5 | 0.5 |
| West South Central | 24.6 | 15.1 | 13.2 | 3.8 | 6.4 | 25.0 | 15.3 | 13.4 | 4.3 | 6.4 |
| Arkansas | 2.1 | 1.3 | 1.2 | 0.3 | 0.5 | 2.1 | 1.3 | 1.1 | 0.4 | 0.5 |
| Louisiana | 3.8 | 2.2 | 1.9 | 0.7 | 1.0 | 3.8 | 2.0 | 1.8 | 0.8 | 1.0 |
| Oklahoma | 2.8 | 1.7 | 1.5 | 0.4 | 0.7 | 2.9 | 1.7 | 1.6 | 0.5 | 0.8 |
| Texas | 15.9 | 9.8 | 8.6 | 2.4 | 4.2 | 16.2 | 10.2 | 8.9 | 2.6 | 4.1 |
| Mountain | 12.6 | 9.0 | 7.9 | 1.9 | 2.2 | 13.1 | 9.4 | 8.1 | 1.8 | 2.5 |
| Montana | 0.7 | 0.5 | 0.4 | 0.1 | 0.1 | 0.7 | 0.5 | 0.4 | 0.1 | 0.1 |
| Idaho | 1.0 | 0.7 | 0.6 | 0.1 | 0.2 | 1.0 | 0.7 | 0.6 | 0.2 | 0.2 |
| Wyoming | 0.4 | 0.3 | 0.3 | 0.1 | 0.1 | 0.4 | 0.3 | 0.3 | 0.1 | 0.1 |
| Colorado | 3.0 | 2.3 | 2.0 | 0.4 | 0.4 | 3.1 | 2.3 | 1.9 | 0.4 | 0.5 |
| New Mexico | 1.4 | 0.9 | 0.8 | 0.3 | 0.3 | 1.4 | 0.9 | 0.7 | 0.2 | 0.4 |
| Arizona | 3.2 | 2.2 | 1.9 | 0.6 | 0.6 | 3.4 | 2.3 | 2.1 | 0.5 | 0.8 |
| Utah | 1.7 | 1.3 | 1.2 | 0.2 | 0.2 | 1.8 | 1.4 | 1.3 | 0.2 | 0.2 |
| Nevada | 1.2 | 0.8 | 0.7 | 0.1 | 0.3 | 1.3 | 0.9 | 0.8 | 0.1 | 0.3 |
| Pacific | 36.7 | 24.2 | 21.1 | 6.2 | 7.6 | 36.9 | 24.0 | 20.6 | 6.6 | 7.8 |
| Washington | 4.4 | 3.4 | 2.9 | 0.6 | 0.6 | 4.4 | 3.4 | 2.8 | 0.6 | 0.7 |
| Oregon | 2.6 | 2.0 | 1.8 | 0.3 | 0.4 | 2.7 | 2.0 | 1.7 | 0.3 | 0.5 |
| California | 28.2 | 17.7 | 15.4 | 5.0 | 6.5 | 28.4 | 17.5 | 15.1 | 5.5 | 6.4 |
| Alaska | 0.5 | 0.3 | 0.3 | 0.1 | 0.1 | 0.5 | 0.3 | 0.3 | 0.1 | 0.1 |
| Hawaii | 1.0 | 0.8 | 0.7 | 0.2 | 0.1 | 0.9 | 0.7 | 0.6 | 0.2 | 0.1 |

(continued)

Table 5 (continued)

**Nonelderly Population with Selected Sources of Health Insurance, by Region and State, 1992 and 1993**

| Region and State | 1992 Total | 1992 Total private | 1992 Employer coverage | 1992 Total public | 1992 No health insurance coverage | 1993 Total | 1993 Total private | 1993 Employer coverage | 1993 Total public | 1993 No health insurance coverage |
|---|---|---|---|---|---|---|---|---|---|---|
| | (percentages within state and region categories) | | | | | | | | | |
| Total | 100.0% | 70.9% | 62.5% | 15.1% | 17.4% | 100.0% | 69.7% | 60.8% | 16.1% | 18.1% |
| New England | 100.0 | 78.8 | 70.0 | 12.1 | 11.9 | 100.0 | 76.6 | 67.8 | 12.8 | 13.4 |
| Maine | 100.0 | 74.4 | 64.0 | 17.6 | 13.1 | 100.0 | 71.7 | 61.0 | 19.3 | 13.1 |
| New Hampshire | 100.0 | 77.5 | 68.7 | 11.0 | 14.9 | 100.0 | 79.2 | 70.8 | 9.0 | 14.1 |
| Vermont | 100.0 | 77.8 | 70.9 | 15.5 | 11.1 | 100.0 | 72.9 | 61.8 | 15.4 | 14.6 |
| Massachusetts | 100.0 | 78.4 | 69.7 | 11.3 | 12.6 | 100.0 | 75.4 | 66.4 | 13.4 | 14.1 |
| Rhode Island | 100.0 | 77.7 | 69.0 | 13.1 | 11.3 | 100.0 | 75.7 | 68.2 | 15.4 | 12.1 |
| Connecticut | 100.0 | 82.1 | 73.3 | 10.9 | 9.7 | 100.0 | 80.7 | 73.1 | 9.0 | 12.1 |
| Middle Atlantic | 100.0 | 73.8 | 65.9 | 14.6 | 14.5 | 100.0 | 72.1 | 63.6 | 15.5 | 15.5 |
| New York | 100.0 | 69.9 | 61.4 | 17.2 | 16.4 | 100.0 | 68.7 | 60.4 | 18.0 | 16.5 |
| New Jersey | 100.0 | 76.5 | 68.6 | 10.2 | 15.6 | 100.0 | 74.8 | 64.6 | 11.7 | 16.2 |
| Pennsylvania | 100.0 | 78.4 | 70.9 | 13.5 | 10.8 | 100.0 | 75.5 | 67.8 | 14.1 | 13.4 |
| East North Central | 100.0 | 75.7 | 67.8 | 14.2 | 13.2 | 100.0 | 74.8 | 66.2 | 15.2 | 13.4 |
| Ohio | 100.0 | 75.8 | 69.2 | 14.6 | 13.1 | 100.0 | 74.7 | 66.9 | 15.7 | 13.1 |
| Indiana | 100.0 | 77.7 | 69.9 | 13.3 | 12.6 | 100.0 | 75.8 | 67.0 | 14.4 | 14.3 |
| Illinois | 100.0 | 72.0 | 63.5 | 14.6 | 15.6 | 100.0 | 73.2 | 63.1 | 14.3 | 14.9 |
| Michigan | 100.0 | 76.4 | 68.6 | 14.8 | 12.0 | 100.0 | 73.2 | 66.1 | 18.0 | 13.1 |
| Wisconsin | 100.0 | 81.0 | 71.3 | 12.3 | 10.5 | 100.0 | 81.0 | 71.6 | 11.7 | 10.0 |
| West North Central | 100.0 | 76.9 | 64.8 | 13.2 | 13.1 | 100.0 | 76.9 | 65.2 | 13.4 | 13.5 |
| Minnesota | 100.0 | 77.9 | 65.1 | 15.7 | 10.0 | 100.0 | 77.5 | 66.7 | 12.9 | 12.7 |
| Iowa | 100.0 | 80.0 | 67.1 | 11.6 | 11.9 | 100.0 | 83.1 | 66.6 | 9.8 | 10.9 |
| Missouri | 100.0 | 72.4 | 63.6 | 13.4 | 16.6 | 100.0 | 74.0 | 65.6 | 15.5 | 14.2 |
| North Dakota | 100.0 | 80.7 | 59.1 | 13.4 | 10.4 | 100.0 | 75.4 | 56.9 | 12.3 | 16.6 |
| South Dakota | 100.0 | 70.5 | 55.2 | 13.9 | 18.7 | 100.0 | 73.7 | 58.6 | 15.7 | 15.8 |
| Nebraska | 100.0 | 79.8 | 66.4 | 12.4 | 11.4 | 100.0 | 77.2 | 62.9 | 13.8 | 14.3 |
| Kansas | 100.0 | 79.8 | 67.1 | 10.4 | 12.8 | 100.0 | 76.0 | 65.3 | 13.4 | 14.6 |
| South Atlantic | 100.0 | 67.5 | 59.3 | 16.4 | 20.2 | 100.0 | 68.2 | 59.2 | 16.0 | 20.3 |
| Delaware | 100.0 | 77.5 | 70.8 | 11.8 | 13.6 | 100.0 | 76.2 | 69.6 | 12.4 | 15.6 |
| Maryland | 100.0 | 75.9 | 68.9 | 12.2 | 14.1 | 100.0 | 72.7 | 65.3 | 13.8 | 17.2 |
| District of Columbia | 100.0 | 55.4 | 47.6 | 20.2 | 25.7 | 100.0 | 54.1 | 46.3 | 24.0 | 23.5 |
| Virginia | 100.0 | 73.5 | 65.5 | 12.7 | 17.5 | 100.0 | 75.8 | 67.0 | 12.7 | 15.9 |
| West Virginia | 100.0 | 64.0 | 56.6 | 22.0 | 18.5 | 100.0 | 60.6 | 55.2 | 21.4 | 22.5 |
| North Carolina | 100.0 | 71.3 | 63.2 | 16.0 | 16.6 | 100.0 | 71.2 | 62.5 | 15.8 | 17.0 |
| South Carolina | 100.0 | 64.3 | 55.7 | 21.9 | 20.9 | 100.0 | 66.4 | 58.8 | 18.0 | 19.9 |
| Georgia | 100.0 | 64.8 | 57.0 | 16.8 | 22.5 | 100.0 | 68.7 | 58.6 | 14.5 | 22.0 |
| Florida | 100.0 | 62.2 | 53.1 | 17.3 | 24.5 | 100.0 | 62.8 | 52.8 | 17.7 | 24.1 |
| East South Central | 100.0 | 67.8 | 60.7 | 17.9 | 18.6 | 100.0 | 66.9 | 57.6 | 20.7 | 17.6 |
| Kentucky | 100.0 | 68.6 | 61.4 | 17.1 | 17.1 | 100.0 | 67.0 | 58.7 | 22.4 | 14.7 |
| Tennessee | 100.0 | 68.6 | 60.8 | 21.1 | 15.9 | 100.0 | 68.6 | 58.7 | 20.3 | 15.6 |
| Alabama | 100.0 | 70.4 | 64.5 | 13.2 | 20.3 | 100.0 | 67.0 | 58.7 | 17.4 | 20.7 |
| Mississippi | 100.0 | 61.2 | 53.5 | 20.5 | 22.8 | 100.0 | 62.8 | 52.1 | 24.2 | 21.1 |
| West South Central | 100.0 | 61.4 | 53.5 | 15.6 | 26.1 | 100.0 | 61.2 | 53.5 | 17.4 | 25.5 |
| Arkansas | 100.0 | 63.7 | 54.8 | 15.8 | 23.7 | 100.0 | 62.5 | 53.2 | 19.2 | 23.5 |
| Louisiana | 100.0 | 59.1 | 50.6 | 17.2 | 25.8 | 100.0 | 53.9 | 46.3 | 22.1 | 27.0 |
| Oklahoma | 100.0 | 62.1 | 52.0 | 16.0 | 26.3 | 100.0 | 59.7 | 54.1 | 16.7 | 27.4 |
| Texas | 100.0 | 61.5 | 54.3 | 15.1 | 26.4 | 100.0 | 62.9 | 55.1 | 16.2 | 25.1 |
| Mountain | 100.0 | 71.7 | 62.8 | 14.8 | 17.9 | 100.0 | 71.4 | 61.7 | 14.0 | 19.3 |
| Montana | 100.0 | 73.3 | 59.5 | 19.5 | 12.4 | 100.0 | 71.5 | 57.6 | 16.3 | 18.4 |
| Idaho | 100.0 | 73.4 | 62.1 | 11.2 | 19.2 | 100.0 | 73.4 | 61.7 | 15.9 | 17.0 |
| Wyoming | 100.0 | 76.3 | 67.4 | 14.1 | 13.7 | 100.0 | 71.9 | 60.2 | 13.9 | 17.7 |
| Colorado | 100.0 | 76.0 | 65.7 | 13.1 | 14.9 | 100.0 | 76.0 | 62.5 | 12.6 | 15.2 |
| New Mexico | 100.0 | 61.2 | 53.4 | 22.4 | 23.0 | 100.0 | 60.8 | 52.5 | 17.5 | 26.0 |
| Arizona | 100.0 | 67.5 | 59.7 | 17.6 | 19.2 | 100.0 | 65.7 | 59.8 | 15.1 | 24.1 |
| Utah | 100.0 | 81.1 | 73.8 | 10.8 | 13.2 | 100.0 | 81.0 | 71.2 | 11.2 | 12.4 |
| Nevada | 100.0 | 67.8 | 61.0 | 7.8 | 27.0 | 100.0 | 72.7 | 65.1 | 11.1 | 21.5 |
| Pacific | 100.0 | 65.9 | 57.4 | 16.9 | 20.8 | 100.0 | 64.9 | 55.9 | 17.9 | 21.0 |
| Washington | 100.0 | 77.7 | 65.4 | 14.0 | 12.6 | 100.0 | 77.0 | 64.0 | 12.6 | 14.8 |
| Oregon | 100.0 | 75.1 | 68.7 | 13.0 | 15.9 | 100.0 | 73.6 | 63.9 | 12.5 | 17.2 |
| California | 100.0 | 62.8 | 54.5 | 17.7 | 23.0 | 100.0 | 61.8 | 53.3 | 19.2 | 22.7 |
| Alaska | 100.0 | 65.9 | 59.1 | 18.2 | 19.9 | 100.0 | 69.4 | 59.3 | 22.4 | 15.8 |
| Hawaii | 100.0 | 80.0 | 73.9 | 19.2 | 8.1 | 100.0 | 75.2 | 68.8 | 16.8 | 13.7 |

Source: Sarah C. Snider and Paul Fronstin, "Sources of Health Insurance and Characteristics of the Uninsured, Analysis of the March 1994 Current Population Survey," *EBRI Issue Brief* no. 158 (Employee Benefit Research Institute, February 1995).
Note: Details may not add to totals because individuals may receive coverage from more than one source.

Table 6
**Percentage of Employers with Self-Funded Plans, 1993 and 1994**

| | 1993 | | | 1994 | | |
|---|---|---|---|---|---|---|
| | Total | Self-funded with stop loss | Self-funded without stop loss | Total | Self-funded with stop loss | Self-funded without stop loss |
| All Employers | 19% | 14% | 5% | 20% | 16% | 4% |
| Large Employers | 63 | 54 | 10 | 74 | 61 | 13 |
| By region | | | | | | |
| West | 51 | 43 | 7 | 76 | 62 | 14 |
| Midwest | 61 | 52 | 9 | 94 | 73 | 21 |
| Northeast | 57 | 49 | 8 | 54 | 48 | 6 |
| South | 78 | 64 | 13 | 83 | 15 | 67 |
| By industry | | | | | | |
| manufacturing | 74 | 61 | 13 | 81 | 66 | 15 |
| wholesale and retail trade | 75 | 61 | 14 | 66 | 15 | |
| services | 52 | 51 | 2 | 46 | 37 | 9 |
| transportation, communications, and utilities | 64 | 51 | 14 | a | a | a |
| health care | 81 | 68 | 13 | a | a | a |
| finance | 34 | 22 | 12 | 63 | 56 | 7 |
| government | 46 | 42 | 4 | 67 | 59 | 7 |
| By number of employees | | | | | | |
| 500–999 | 52 | 47 | 5 | 67 | 64 | 3 |
| 1,000–4,999 | 69 | 63 | 6 | 78 | 63 | 15 |
| 5,000–9,999 | 86 | 50 | 36 | 82 | 46 | 35 |
| 10,000–19,999 | 84 | 36 | 49 | 84 | 49 | 35 |
| 20,000 or more | 89 | 24 | 64 | 91 | 17 | 74 |
| Small Employers[b] | 17 | 12 | 5 | 18 | 15 | 4 |

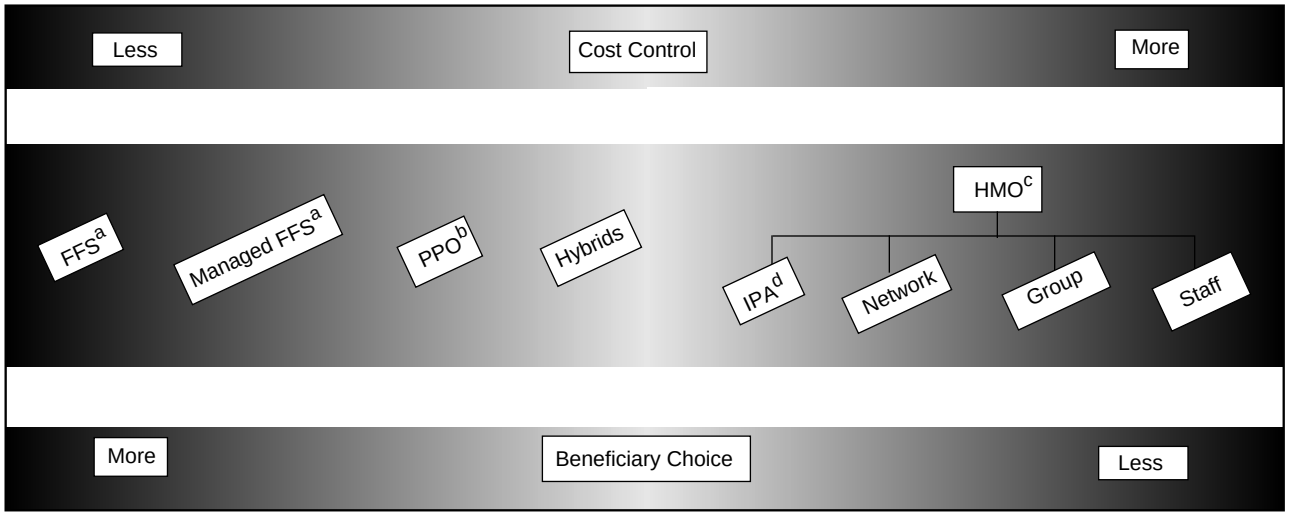
Source: A. Foster Higgins & Co., Inc., *Tables: National Survey of Employer-Sponsored Health Plans: 1993 and 1994* (New York, NY: Foster Higgins, 1994 and 1995).
[a]Insufficient data available.
[b]Employers with 10–499 employees.

what the state is attempting to regulate is insurance. Another way self-funded plans may be partially insured is through the purchase of stop-loss coverage. To cover against catastrophic losses, some companies that self-fund their health benefit plans purchase stop-loss coverage. There are two types of stop-loss coverage: specific stop-loss coverage, which insures against the risk that any one claim will exceed a certain amount, and aggregate stop-loss, which insures against the entire plan's losses exceeding a certain amount. Most plans purchase both types of stop-loss coverage.

According to a survey by A. Foster Higgins and Co., in 1994, among firms with 500 or more employees, 74 percent self-funded their health benefit plan, up from 63 percent in 1993 (table 6). Larger employers were more likely to self-fund their health benefit plan. In 1994, 91 percent of employers with 20,000 or more employees self-funded their health benefit plan, compared with 18 percent of small employers (those with 10–499 employees). Data on the number of Americans covered by a self-funded health benefit plan are not available. The data set that comes closest to providing this information is the Bureau of Labor Statistics (BLS) employee benefits surveys. In survey years 1992 and 1993, 21,983,900 full-time employees, or 29.1 percent of all full-time employees in private industry and state and local governments, participated in a self-funded health benefit plan. Data on the number of dependents covered are not available from these surveys.

For more information on self-insured plans, see *EBRI Databook on Employee Benefits,* third edition, and EBRI Fact Sheet, "Employers Self-Funding Health Benefits," February 1995.

Chart 2
**Health Care Delivery System Spectrum**




Source: Sarah Snider, Employee Benefit Research Institute.
[a]Fee for Service
[b]Preferred provider organization
[c]Health maintenance organization
[d]Independent practice association

## 6. What are the different types of managed care plans? What percentage of individuals are enrolled in a managed care plan?

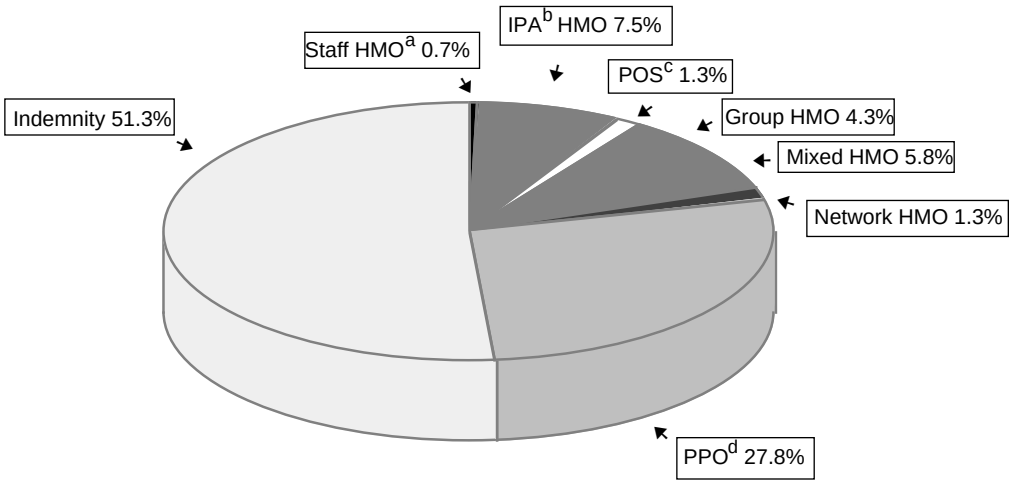
Health care delivery systems can be arranged on a spectrum according to the degree of financial control the employer (or payer) has over such plans and to the degree of control such plans have over patient choice (chart 2). At one end of the spectrum is the traditional fee-for-service indemnity plan with no managed care elements, and at the other end is the staff model health maintenance organization (HMO). Between these two extremes lie fee-for-service plans with managed care features, preferred provider organizations (PPOs), and less restrictive HMOs. Finally, as health care delivery systems evolve and employers become more involved in the design of corporate benefit plans, hybrid plans are developing that combine elements of the HMO and PPO in an attempt to balance freedom of choice for the employee and financial control for the employer.

*HMOs* —In recent years, the use of HMOs has been one of the most prevalent methods utilized by employers to control rising health care costs. HMOs manage health care costs by altering the incentive structure from a fee-for-service or cost-plus reimbursement to a payment system in which the provider is paid a salary or is reimbursed on a capitated basis.[4] Basically, the goal of the HMO is to alter financial incentives in such a way that providers move away from the provision of more care and toward weighing the costs of care in their medical decision making. Currently, there are five different HMO models: staff, group, independent practice association, network, and mixed model. Each of these models differs with respect to its rules for patients and financial incentives it imposes on health care providers to manage services and costs.

- *Staff Model* —In this type of model, the HMO owns its health care facility and employs health care providers on a salaried basis. Patient choice is limited: enrollees are restricted to network providers and are required first to see a primary care physician, who then refers them to specialists within the HMO when this is considered medically necessary and appropriate.
- *Group Model* —In this type of model, the HMO contracts with a single physician group to provide services to the HMO participants. The physician group is managed independently and is usually paid on a capitated basis. Group model HMO providers usually spend most of their time with HMO partici-

[4]*Providers who are reimbursed on a capitated basis are reimbursed at a fixed rate per health maintenance organization (HMO) patient.*

Chart 3
**Percentage Distribution of Individuals with Private or Public Health Insurance Coverage, 1993**




Source: Employee Benefit Research Institute tabulations based on March 1994 supplement to the Current Population Survey; Interstudy Publications, *The Interstudy Competitive Edge: Biannual Report of the Managed Care Industry,* Vol. 4, no. 1, 1994 (St. Paul, MN: *InterStudy Publications*, 1994); and AMCRA Foundation Managed Health Care Database.
[a]Health maintenance organization
[b]Independent practice association
[c]Point-of-service (plan)
[d]Preferred provider organization

pants but may spend some time in private practice.

- *Independent Practice Associations (IPAs)*—IPAs are groups of physicians in private practice who provide some services to HMO participants but primarily provide services to patients not enrolled in an HMO. The IPA may contract with more than one insurer or HMO. The non-HMO patients are treated on a fee-for-service basis. IPA providers working with HMOs are generally paid on a fee-for-service basis; therefore, they do not have strong incentives to provide cost-effective care. However, there has been a movement toward reimbursing IPAs on a discounted fee-for-service basis or a capitated basis. The advantage of an IPA is that contracting with physicians practicing in their own offices allows the HMO to offer services in a broader geographic area, requires less capital investment than a staff or group model HMO of similar size, and generally offers patients more choice among providers.
- *Network Model* —In the network model, the HMOs contract with two or more independent physician groups that often provide general and specialty services. These groups are typically paid on a capitated basis by the HMO, but the physicians also spend some time in private practice operating on a fee-for-service basis.
- *Mixed Model* —A mixed model HMO initially adopts one type of model, such as a staff model, and then expands either its capacity and/or geographic region later by adding another type of model such as an IPA.

*PPOs*—A PPO is a panel of health care providers who individually contract with insurance companies and/or employers to offer health care benefits to their members. PPO network physicians generally do not assume financial risk for the provision of health care services. Typically, PPOs reimburse their physicians on a negotiated fee schedule or a discounted fee-for-service basis. Providers are usually chosen on the basis of their performance, but many plans choose physicians to fit geographic and specialty areas, often in response to employer requests. Enrollees can receive health care services from PPO providers or non-PPO providers, but they usually face higher cost-sharing requirements when receiving care from a non-PPO provider. While the PPO structure differs broadly from the HMO structure, they both combine three broad cost management strategies: a limited provider panel, negotiated fee schedules, and utilization review. In addition, some PPOs have a physician who acts as a gatekeeper to the system.

*Point-of-Service (POS) Plan* —POS plans feature networks of health care providers who agree to provide health care services in a managed care environment at a reduced rate. Enrollees are required to select a primary care physician, who then acts as a gatekeeper, essentially controlling referrals to specialists. The enrollee is then free to choose services from a participating HMO, a PPO network provider, or a nonnetwork provider. The enrollee's cost-sharing responsibilities vary with the choice of provider. The single major difference between POS plans and HMOs is that POS participants can seek nonnetwork treatment and receive benefits just as they would under a fee-for-service plan, with higher cost sharing under the fee-for-service option.

In 1993, slightly more than one-half (51.3 percent) of the U.S. population with private and/or public health insurance was enrolled in an indemnity plan (chart 3). Most managed care enrollees were enrolled in the open-ended plans: 27.8 percent in a PPO, 7.5 percent in an IPA-HMO, 1.3 percent in a network HMO, and 1.3 percent in a POS plan. Together, these plans accounted for 77.8 percent of all managed care plan enrollees (calculated from chart 3).

As the health care delivery system evolves in response to new competitive pressures from employers and other payers of medical services, new types of organizations are emerging. The physician/hospital organization (PHO) is one of the latest to develop. Under a PHO arrangement, physicians and hospitals organize to provide employers with customized benefit packages. PHOs provide integrated networks that can include a full range of medical services, including, for example, in/out patient services and prescription drugs. As the health care delivery system evolves, some analysts believe that PHOs represent a transitional stage in the development of a more integrated health delivery system.

For more information on managed care plans, see *EBRI Databook on Employee Benefits,* third edition; "The Effectiveness of Health Care Cost Management Strategies: A Review of the Evidence," *EBRI Issue Brief* no. 154; and "Physician Practice in a Dynamic Environment: Implications for the Health Care System," *EBRI Issue Brief* no. 162.

## 7. What percentage of employees participate in an employment-based health plan that offers benefits in retirement? What is the average cost per retiree?

According to data from the BLS, the portion of full-time employees in medium and large private establishments who participated in an employment-based health plan that continued benefits in retirement remained at 45 percent from 1988 to 1993 (table 7). Employees in state and local governments were more likely to have health benefits in retirement (51 percent in 1992) than those in medium and large private establishments and small private establishments (18 percent in 1992).

According to one survey, between 1993 and 1994, the cost of retiree health benefits increased 3.9 percent, from $2,751 per retiree to $2,859 per retiree. In 1994, the costs per retiree for large employers, those with 500 or more employees, was $2,859, and that for small employers, those with 10–499 employees was $2,484 (A. Foster Higgins, Inc., 1995a).

For more information on retiree health insurance, see *EBRI Databook on Employee Benefits,* third edition, and "Employment-Based Health Benefits: Analysis of the April 1993 Current Population Survey," *EBRI Issue Brief* no. 152.

Table 7

**Percentage of Full-Time Employees Participating in Medical Plans by Provision for Coverage after Retirement: Medium and Large Private Establishments, 1988, 1989, 1991, and 1993; State and Local Governments, 1990 and 1992; Small Private Establishments, 1990 and 1992**

| | Medium and Large Private Establishments[a] | | | | State and Local Governments[b] | | Small Private Establishments[c] | |
|---|---|---|---|---|---|---|---|---|
| Benefit Provision | 1988 | 1989 | 1991 | 1993 | 1990 | 1992 | 1990 | 1992 |
| Total | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| With Employer-Sponsored Retiree Coverage[d] | 45 | 42 | 45 | 45 | 58 | 51 | 15 | 18 |
| For retirees under age 65 only | 9 | 7 | 4 | 4 | 4 | 4 | 2 | 2 |
| For retirees aged 65 and over only | 1 | 2 | 2 | 1 | e | e | 2 | e |
| For all retirees | 36 | 33 | 38 | 40 | 54 | 47 | 11 | 16 |
| Benefits Canceled on Retirement or Financed Wholly by Retirees | 54 | 57 | 54 | 55 | 42 | 49 | 83 | 82 |
| Data Not Available | 1 | 1 | 1 | e | e | e | 2 | e |

Source: U.S. Department of Labor, Bureau of Labor Statistics, *Employee Benefits in Medium and Large Private Firms,* 1988 and 1989 (Washington, DC: U.S. Government Printing Office, 1989, 1990); *Employee Benefits in Medium and Large Private Establishments*, 1991 and 1993 (Washington, DC: U.S. Government Printing Office, 1993 and 1995); and *Employee Benefits in State and Local Governments,* 1990 and 1992 (Washington, DC: U.S. Government Printing Office, 1991 and 1994); and *Employee Benefits in Small Private Establishments,* 1990 and 1992 (Washington, DC: U.S. Government Printing Office, 1991 and 1994).

[a]These tabulations provide representative data for full-time employees in private nonagricultural establishments with 100 or more employees in the District of Columbia and all states except Alaska and Hawaii. In 1991 and following years, the survey includes establishments in Alaska and Hawaii.

[b]The Bureau of Labor Statistics' survey scope was expanded significantly in 1990 to include part-time workers, all governments regardless of size, and Alaska and Hawaii. The former survey coverage, which included only full-time workers in government units employing 50 or more workers in the 48 contiguous states and the District of Columbia, is referred to as old scope. The expanded survey coverage is referred to as new scope.

[c]These tabulations provide representative data for full-time employees in private, nonagricultural establishments with fewer than 100 employees.

[d]Includes plans financed wholly by employers and plans financed jointly by employers and employees.

[e]Less than 0.5 percent.

## 8. How common are flexible benefits plans, and what types of benefits are typically included?

Flexible benefits plans, also known as cafeteria plans or sec. 125 plans, allow employees some choice in their employee benefits package. Employees can select the benefits they value most and that meet their specific family or lifestyle needs and forgo benefits that are less important to them.

Established in 1978 under Internal Revenue Code (IRC) sec. 125, flexible benefits plans did not experience much growth until 1981, when regulations interpreting the legislation were released. Since then, they have generated increasing attention, and many large companies have established them. Among full-time employees working for medium and large private establishments in 1993, 53 percent were eligible for a cafeteria plan and/or a flexible spending account (FSA), compared with 13 percent in 1988 (table 8).

In a flexible benefits plan, an employer typically allocates a specified amount of money to each employee with which to buy benefits. Each type of benefit or benefit level is associated with a value, or cost. If the cost exceeds employer contributions, many plans permit employee contributions—usually pretax—to help purchase the benefit.

The rising cost of health care has been a key factor driving flexible benefits plan growth. Often a flexible benefits plan is designed to allow employees to choose certain cost-saving provisions that in turn generate extra credits the employee can use to purchase coverage otherwise not obtainable. In addition, when flexible benefits plans are first implemented, cost control mechanisms are usually added or increased as well, shifting some costs from employer to employee. Flexible benefits

Table 8

**Percentage of Full-Time Employees Eligible for Cafeteria Plans and Flexible Spending Accounts (FSAs): Medium and Large Private Establishments, 1988, 1989, 1991, and 1993; Small Private Establishments, 1990 and 1992; and State and Local Governments, 1987, 1990, and 1992**

| | Medium and Large Private Establishments[a] | | | | Small Private Establishments[b] | | State and Local Governments[c] | | |
|---|---|---|---|---|---|---|---|---|---|
| | 1988 | 1989 | 1991 | 1993 | 1990 | 1992 | 1987 | 1990 | 1992 |
| | | | | | | | (old scope) | (new scope) | |
| Total | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| Provided Cafeteria Benefits and/or FSAs | 13 | 24 | 37 | 53 | 8 | 14 | 9 | 32 | 51 |
| Cafeteria benefits with FSA | 4 | 8 | 9 | 11 | 1 | 2 | 1 | 3 | 4 |
| Cafeteria benefits with no FSA | 1 | 1 | 1 | 1 | d | d | 5 | 2 | 1 |
| Freestanding FSA | 8 | 15 | 27 | 41 | 6 | 12 | 3 | 28 | 46 |
| Not Provided Cafeteria Benefits or FSA | 87 | 76 | 63 | 47 | 92 | 86 | 91 | 68 | 49 |

Source: U.S. Department of Labor, Bureau of Labor Statistics, *Employee Benefits in Medium and Large Firms*, 1988 and 1989 (Washington, DC: U.S. Government Printing Office, 1989, 1990); *Employee Benefits in Medium and Large Private Establishments, 1991 and 1993* (Washington, DC: U.S. Government Printing Office, 1993 and 1995); Employee Benefit Research Institute tabulations of *Employee Benefits in Medium and Large Private Establishments, 1993* (Washington, DC: U.S. Government Printing Office, 1995); *Employee Benefits in Small Private Establishments,* 1990 and 1992 (Washington, DC: U.S. Government Printing Office, 1991 and 1994); and *Employee Benefits in State and Local Governments,* 1987, 1990, and 1992 (Washington, DC: U.S. Government Printing Office, 1988, 1992, and 1994).

[a]These tabulations provide representative data for full-time employees in private nonagricultural establishments with 100 or more employees in the District of Columbia and all states except Alaska and Hawaii. In 1991 and following years, the survey includes establishments in Alaska and Hawaii.

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[d]Less than 0.5 percent.

plans typically include a variety of health options such as indemnity plans, health maintenance organizations, and dental care; life insurance; long-term disability; and other options, including spending accounts, vacation trading, and 401(k)s.

*FSAs*—Another type of flexible benefits arrangement is a flexible spending account (also called a reimbursement account) that may supplement a flexible benefits plan or stand alone. FSAs provide a way for employees to pay for expenses not covered by their existing benefit plan, such as dependent care expenses [5] or health insurance deductibles, coinsurance, or other out-of-pocket expenses. FSAs are usually funded through employee pretax contributions, which are designated prior to the plan year and withheld in equal amounts from the employee's paychecks. When employees incur an expense, they are reimbursed with pretax dollars. Some employers also contribute to these accounts.

FSAs (either freestanding or as part of flexible benefits plans) appear to be more common than flexible benefits plans alone. In 1993, 11 percent of full-time employees working for medium and large private employers were eligible for FSAs as part of a flexible benefits plan, while 41 percent were eligible for stand-alone FSAs, according to the U.S. Department of Labor (table 8).

There is no statutory limit on annual contributions to medical care FSAs, unless an individual benefit has its own limit or the plan has an established limit. However, dependent care FSAs have a $5,000 limit on contributions. In practice, most employers set an upper limit. Employees must be careful when designating annual contributions because unused portions are forfeitable at the end of the plan year. A recent survey reports that, in 1994, average annual employee contributions to FSAs were $681 for health care accounts and $2,533 for dependent care accounts (A. Foster Higgins, 1995a).

For more information on flexible benefit plans, see *EBRI Databook on Employee Benefits*, third edition, and "Flexible Benefits, Choice, and Work Force Diversity," *EBRI Issue Brief* no. 139.

[5]*Dependent care expenses are under sec. 129 of the Internal Revenue Code.*

This *Issue Brief* was written by Ken McDonnell of EBRI with assistance from the Institute's research and education staffs.

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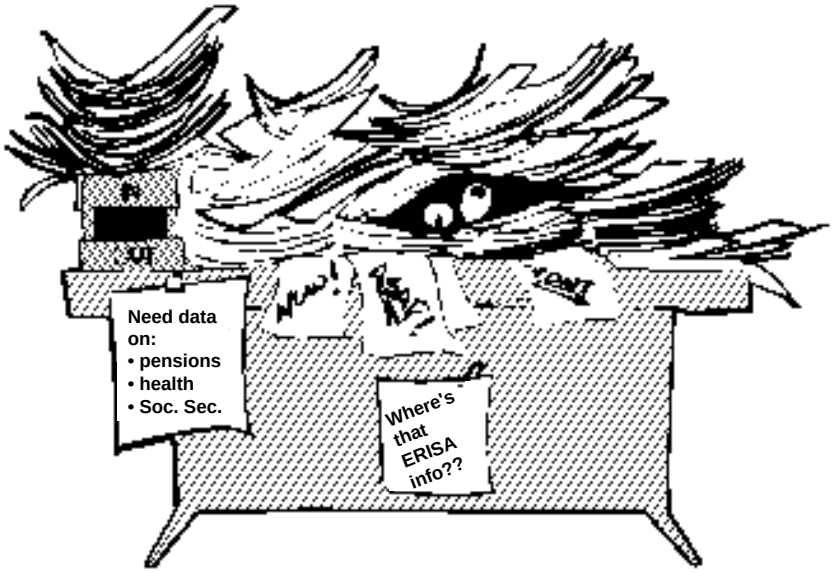


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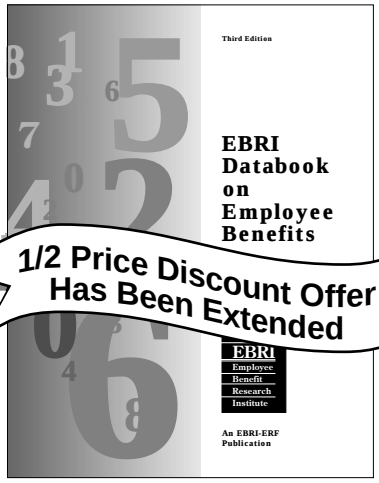


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