Features of Employment-Based Health Plans

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Issue Brief

- This *Issue Brief* focuses on changes to the health care financing and delivery system as implemented by employers. It discusses health plan costs, cost sharing, plan funding, health care delivery systems, services covered under various health plan types, coverage limitations, and retiree health coverage.

- National health expenditures are estimated at $1.035 trillion, representing 13.6 percent of Gross Domestic Product in 1996, up from $699.5 billion and 12.2 percent in 1990. Rising health care spending is also evident at the employer level: In 1996, employer spending on private health insurance totaled $262.7 billion, up from $61.0 billion in 1980. Business health spending as a percentage of total compensation increased from 3.7 percent in 1980 to a high of 6.6 percent in 1993, and declined to 5.9 percent in 1996.

- Employment-based health plans are the most common source of health insurance coverage among the nonelderly population in the United States, providing coverage to nearly two-thirds of those under age 65.

- Despite the growth of many cost-sharing provisions, individuals are paying a smaller percentage of total health care costs. In 1960, 69 percent of private health care expenditures were paid out of pocket. Between 1993 and 1996, only 37 percent of private health expenditures were paid out of pocket.

- One of the most significant developments of the 1980s, which has continued throughout the 1990s, is the growth of managed care plans. As recently as 1994, traditional indemnity plans were the most commonly offered type of employment-based health plan. As fewer employers offered traditional indemnity plans, participation in these plans declined and participation in managed care plans increased. In 1997, 15 percent of employees participating in a health plan were enrolled in an indemnity plan, compared with 52 percent in 1992.

- Since 1993, employment-based health benefit cost inflation has been virtually nonexistent. Employers have kept cost increases low by using managed care and making other changes. Workers have been shifted to, have been induced to choose, or have voluntarily selected managed care health plans. Preferred provider organization (PPO) and point-of-service (POS) plans have experienced relatively strong gains in enrollment. Employers have also increased the use of utilization review for active workers, and cut back on health benefits for retirees. These changes are in stark contrast to the pre-1993 period, which saw even faster change, with rising health care costs and increasing deductibles and coinsurance for workers in non-HMOs.

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Introduction

Employment-based health plans are the most common source of health insurance among the nonelderly population in the United States, providing coverage to nearly two-thirds of the nonelderly population in 1996 (Fronstin, 1997c). In addition, 34 percent of individuals ages 65 and older had employment-based coverage in 1996, mainly as a supplement to Medicare (Fronstin, 1997b). Employers offer employment-based health benefits for the basic purpose of keeping workers healthy and providing workers and their families with protection from financial losses that can accompany unexpected serious illness or injury. In addition, they offer health benefits as a form of compensation to recruit and retain qualified workers. Health benefits are probably the benefits that are most used and valued by workers and their families. Employment-based health insurance was cited as the most important benefit by 64 percent of respondents to a recent survey (Ostuw, 1996).

Prior to World War II, few Americans had health insurance, and most policies covered only hospital room, board, and ancillary services. During World War II, the number of persons with coverage increased. This increase occurred largely because wages were frozen during the war by the National War Labor Board, whereas health benefits were not restricted or subject to income or Social Security taxes as cash wages were. Twelve million people were covered by private health insurance in 1940 (less than 10 percent of the population). By 1945, 32 million people had private health insurance coverage, and by 1950, 77 million had such coverage (Health Insurance Association of America, 1996). In 1996, nearly 166 million nonelderly Americans were covered by private health insurance (71 percent of the U.S. population), and 150 million of them had employment-based plans (Fronstin, 1997c). Between 1987 and 1993, employment-based coverage of the nonelderly population fell from 69.2 percent to 63.5 percent. Employment-based coverage has been increasing since 1993, in part due to downsizing in the military and efforts to move individuals from welfare to work, and it now covers 64 percent of the nonelderly population.

As the number of persons covered by private health insurance grew, so too did the number of services and delivery systems available. In addition to the traditional hospital room, board, and ancillary services, many health care plans now offer such items as outpatient prescription drug benefits, vision care, and dental benefits. Moreover, one of the most significant changes in the health care financing and delivery system has been the increased use of managed care. The delivery system is now dominated by preferred provider organizations (PPOs), health maintenance organizations (HMOs), point-of-service (POS) plans, and managed indemnity plans. Services may also be offered in a variety of settings such as ambulatory care or birthing centers.

The cost of and access to these services and delivery systems is not equally distributed among all payers or participants. The cost of employment-based health insurance depends on the characteristics of an employer's work force, risk factors attributed to the type of employment, and the local health care service market. There are significant differences in average costs among industries and between large and small employers. In addition, individuals may lose employment-based health insurance coverage because of extended separation from the labor market or through job loss, divorce, or death of a parent or spouse. Furthermore, if workers with health insurance are reluctant to change jobs because of concerns about health insurance, they may forgo opportunities that would increase their productivity. According to the results from the Employee Benefit Research Institute (EBRI)/Mathew Greenwald & Associates 1998 Health Confidence Survey, 27 percent of Americans surveyed in 1998 indicated that they or a family member had passed up a job opportunity solely

Table 1

Employer Spending for Health Insurance

Total Employer Outlays for Group Health Insurance and Employer Health Spending as a Percentage of Total Compensation and Gross Domestic Product (GDP), 1959–1996

Year	Employer Spending on Private Health Insurance ($ billions)	Employer Spending as a Percentage of Total Compensation	Employer Health Care Spending as a Percentage of GDP
1959	$ 3.0	1.1%	a
1960	3.4	1.1	0.1%
1970	12.1	2.0	0.3
1980	61.0	3.7	1.2
1990	188.6	6.2	2.8
1991	205.4	5.9	3.1
1992	228.8	6.3	3.4
1993	249.6	6.6	3.6
1994	259.8	6.5	3.6
1995	256.7	6.1	3.5
1996	262.7	5.9	3.4

Source: Employee Benefit Research Institute tabulations based on U.S. Department of Commerce, Bureau of Economic Analysis, *Survey of Current Business, August 1997* (Washington, DC: U.S. Government Printing Office, 1996); and *The National Income and Product Accounts of the United States: Statistical Supplement 1929–1994* (Washington, DC: U.S. Government Printing Office, 1998).
[a]Not available.

because of health benefits. These considerations have led analysts to consider whether tying the provision of health care to employment results in an equitable distribution of benefits and costs (Custer and Foley, 1992).

From the 1970s to the early 1990s, escalating costs led to ongoing change in health care financing and in the design of employment-based health insurance benefits. In an attempt to control health care cost inflation, Congress changed the way that Medicare reimburses health care providers, which in turn resulted in changes in the design and cost of employment-based retiree health benefits (Fronstin, 1996a, and Fronstin and Copeland, 1997). Employers also changed active employees' health care benefits.

This *Issue Brief* discusses changes to the health care financing and delivery system as implemented by employers. It specifically focuses on cost management trends and other innovations in employment-based health benefit plans. Drawing on data from the Department of Labor (DOL), Bureau of Labor Statistics' (BLS) employee benefits surveys, and from surveys by private employee benefits consulting firms, it analyzes health plan costs, cost sharing, plan funding, health care delivery systems, services covered under various health plan types, coverage limitations, and retiree health coverage. It concludes with an overview of health care policy activity that promises to influence group health plans.

Health Plan Costs

National health expenditures are estimated at $1.035 trillion, representing 13.6 percent of Gross Domestic Product (GDP) in 1996, up from $699.5 billion and 12.2 percent in 1990 (Levit et al., 1998). Rising health care costs are also evident at the employer level. In 1996, employer spending on private health insurance totaled $262.7 billion, up from $61.0 billion in 1980 (table 1). Business health spending as a percentage of total compensation increased from 3.7 percent in 1980 to a high of 6.6 percent in 1993, and declined to 5.9 percent in 1996 (table 1). Among private employers surveyed in another study, health plan costs per employee increased from an average of $3,502 in 1992 to $3,924 in 1997 (table 2). For large employers, the average costs increased from $3,775 in 1992 to $4,369 in 1997.

While health care costs have continued to increase, the annual increases have been relatively small since 1991. For some large employer plans, costs have actually declined. Between 1994 and 1996, the average cost of an indemnity plan increased from $3,497 to $3,928, then declined to $3,759 in 1997, while the average cost for an HMO declined from $3,487 to $3,307 (table 2). Indemnity plan costs increased 4.4 percent during 1995 and 2.4 percent during 1996, while HMO costs declined 3.8 percent in 1995 and 2.2 percent in 1996 (chart 1).

Most employers have covered employee health care costs by purchasing coverage, through insurance premiums, from commercial insurers, Blue Cross and Blue Shield plans, or other managed care plans. These plans are considered to be fully insured. In a fully insured plan, all of the risk associated with health claims

Table 2
Average Annual Health Plan Cost per Employee, by Plan Type, 1992–1997

Plan Type	1992	1993	1994	1995	1996	1997
Total Cost per Employee[a]	$3,502	$3,781	$3,741	$3,821	$3,915	$3,924
Small employers (fewer than 500 employees)[b]	3,058	3,240	3,452	3,448	3,380	3,357
Large employers (500 or more employees)[b]	3,775	4,117	4,040	4,181	4,332	4,369
Total Cost per Active Employee[a]			3,644	3,653	3,703	3,594
Small employers (fewer than 500 employees)			3,448	3,467	3,405	3,280
Large employers (500 or more employees)			3,812	3,795	3,930	3,820
Indemnity[c,d]			3,497	3,686	3,928	3,759
Average employee contribution						
employee-only coverage		420	468	444	516	552
family coverage		1,392	1,476	1,512	1,596	1,692
Health Maintenance Organization (HMO)[c,d]			3,487	3,410	3,350	3,307
Average employee contribution						
employee-only coverage		420	456	456	396	492
family coverage		1,476	1,572	1,704	1,596	1,584
Preferred Provider Organization (PPO)[c,d]			3,334	3,242	3,434	3,518
Average employee contribution						
employee-only coverage		408	468	492	492	492
family coverage		1,464	1,596	1,824	1,764	1,704
Point-of-Service Plan (POS)[c,d]			3,454	3,572	3,584	3,588
Average employee contribution						
employee-only coverage		420	468	432	504	504
family coverage		1,476	1,608	1,572	1,704	1,692

Source: William M. Mercer, *National Survey of Employer-Sponsored Health Plans, 1997* (New York, NY: William M. Mercer, 1998).
[a]For all medical claims costs, including dental, vision, perscription drug costs, and other carve outs.
[b]Total health benefit cost for active and retired employees.
[c]Large employers.
[d]Does not include costs for benefit carve-outs and free-standing plans such as dental care.

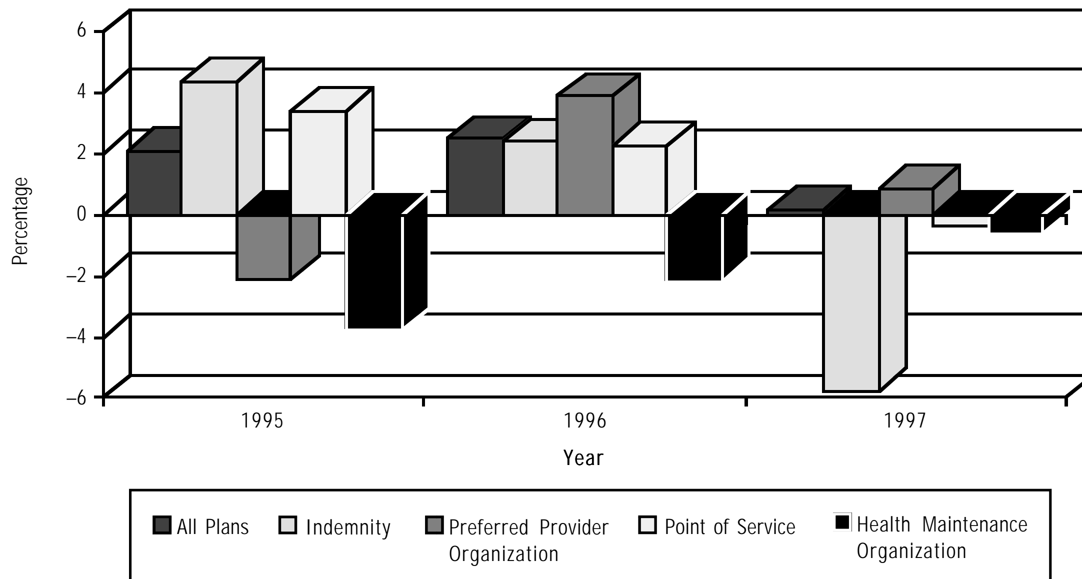
is borne by the insurance company. The insurance company generally sets premiums high enough to maintain some cash reserves, cover administrative costs, and cover state premium taxes. In an effort to reduce health care costs, some employers choose to self-fund, or self-insure, health care plans. This occurs particularly among large firms, which experience less volatility in total dollars spent on claims than smaller firms and are able to more effectively spread the risk of bearing their own health care costs. In a self-funded plan, the employer uses funds normally designated for premiums to pay employee health care claims. Thus the employer essentially acts as its own insurance company and bears the financial risk of making payments to providers. Firms began moving to self-funding to avoid state premium taxes and state-mandated benefits and to retain funds for investment or other purposes. Self-funding also allows multi-state employers to offer the same health benefits to all workers in all states. Under fully insured plans, on the other hand, insurance companies are required to comply with individual state health mandates, pay state premium taxes, and maintain reserve funds to pay claims. Thus, firms acting independently can often finance benefits for less than insurance companies would charge them. The move to self-funding accelerated following passage of the Employee Retirement Income Security Act of 1974 (ERISA), which was enacted in response to continuing increases in health care premiums and the acceleration of state-mandated benefits for insured plans.[1] Recently, however, the move to self-funding has moderated with the growth of managed care.

Cost Sharing

As health care plan costs continue to rise, employers increasingly are changing the design of cost-sharing features. For example, employees are being required to contribute toward routine health care plan cost expenses such as premiums. By increasing employees' share of routine health care costs, or by imposing

[1] *For a more detailed discussion about self-funded health plans, see Copeland and Pierron (1998).*

Chart 1
Percentage Change in Employer Health Care Costs, by Plan Type, 1995–1997



Source: William M. Mercer, *National Survey of Employer-Sponsored Health Plans, 1997* (New York, NY: William M. Mercer, 1998).

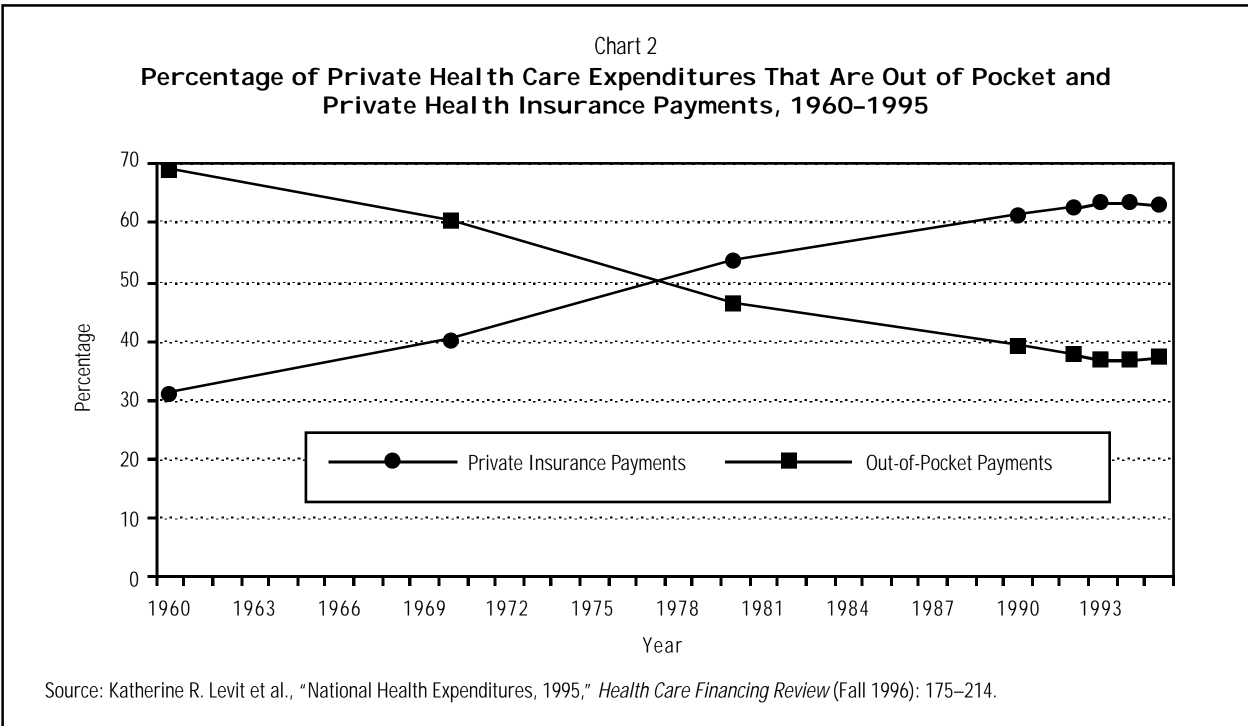
stricter coverage limitations, employers seek to lower their overall health care expenditures in two ways. First, their required short-term outlay of funds for employees' health care needs is reduced.[2] Second, cost sharing may lower health care expenditures by reducing the utilization of health care services. However, it has been argued that when cost sharing is increased, some of the care forgone by employees may include preventive or other necessary care, the lack of which may result in greater long-term costs. In addition, increased cost sharing may create negative feelings among workers, leading to lower productivity.

Despite the growth of many cost-sharing provisions, studies indicate that, in the aggregate, individuals are paying a smaller *percentage* of *total* health care costs than in the past. In 1960, 69 percent of private health care expenditures were paid out of pocket, and 31 percent were paid by private insurance (chart 2). Between 1993 to 1996, only 37 percent of private health expenditures were paid out of pocket, compared with 63 percent paid by private insurance.

Contributions to Premiums

According to EBRI estimates from the March 1988–1997 Current Population Surveys, since at least 1987 employees have been increasingly likely to pay at least a portion of the cost of their health insurance coverage. In 1987, 44.2 percent of workers with employee-only coverage were in plans that were fully financed by their employer, compared with 32.5 percent in 1996 (chart 3). In addition, 36.7 percent of workers with family coverage had that coverage fully financed by their employer in 1987, compared with 25.9 percent in 1996. In contrast, *average* employee contributions to various types of health plans, measured as a percentage of the premium, have shown no upward or downward trend (table 3). While overall costs increased and the percentage of workers whose employer fully financed coverage decreased, some employees experienced an increase in annual health care plan costs and others experienced a decrease. For example, a recent survey shows that the average annual employee contribution toward health care for employee-only coverage increased in indemnity plans and PPOs between 1993 and 1997 (table 2). In contrast, the average annual employee contribution toward health care for employee-only HMO coverage increased between 1993 and 1994, stayed constant between 1994 and 1995, declined between 1995 and 1996, and increased between 1996 and 1997. Similarly, employee contributions for a POS plan increased be-

[2] *Although the employer's health care costs may increase relative to the prior year, the increase is less than if the employer absorbed the entire cost increase.*

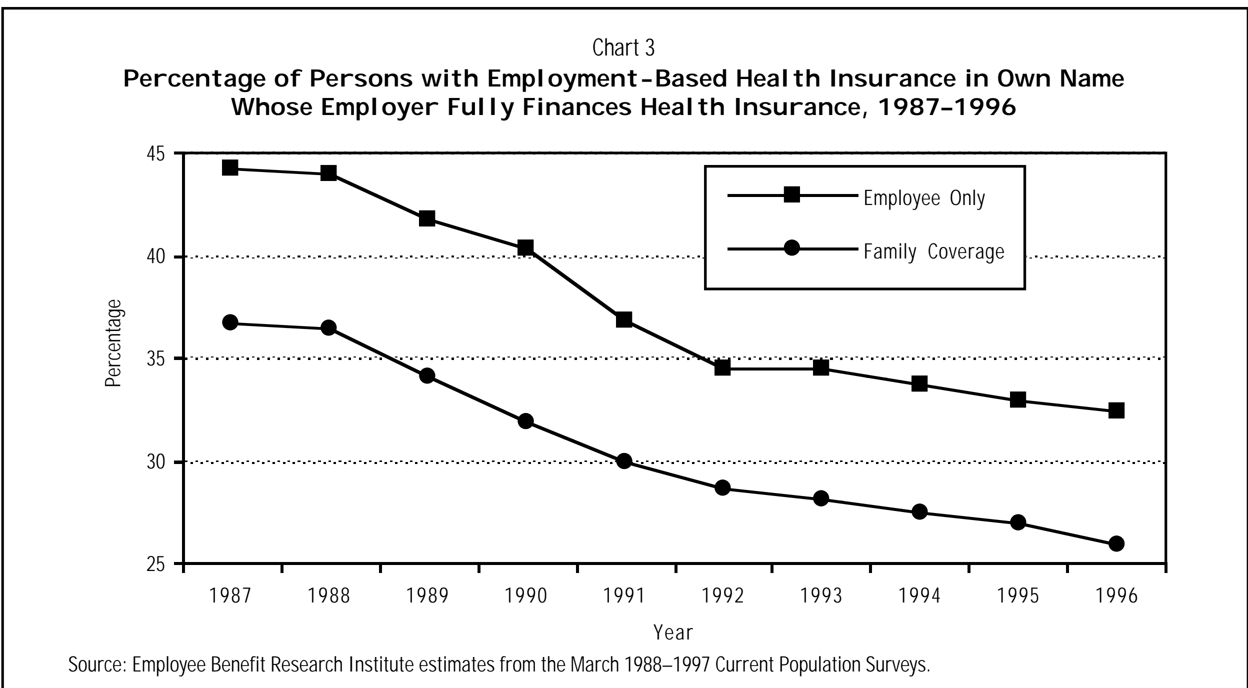


Source: Katherine R. Levit et al., "National Health Expenditures, 1995," *Health Care Financing Review* (Fall 1996): 175–214.

tween 1993 and 1994, declined between 1994 and 1995, and increased between 1995 and 1996.

Deductibles

Over the past decade, the percentage of employees participating in non-HMO plans who are subject to a deductible has steadily decreased. Forty-nine percent of full-time participants in non-HMO plans sponsored by medium and large private establishments had deductibles of more than $150 in 1995, compared with 53 percent in 1989 (table 4). In contrast, 23 percent had no deductible in 1995, compared with 5 percent in 1989. As HMOs compete with non-HMOs (traditional insurance plans and other managed care plans), it appears that non-HMOs have begun to offer plans without deductibles. While these plans are more likely to provide "first-dollar" (no deductible) coverage, premiums are typically higher.



Source: Employee Benefit Research Institute estimates from the March 1988–1997 Current Population Surveys.

Table 3
Average Percentage of Medical Plan Premium Paid by Employee in Firms of 500 or More Employees, by Plan Type, 1993–1997

Type of Plan	1993	1994	1995	1996	1997
Indemnity[a]					
Employee-only coverage	24%	20%	23%	24%	24%
Family coverage	33	25	33	32	32
Health Maintenance Organization (HMO)[a]					
Employee-only coverage	23	22	22	22	23
Family coverage	33	29	35	33	34
Preferred Provider Organization (PPO)[a]					
Employee-only coverage	24	20	25	24	23
Family coverage	31	28	41	36	36
Point-of-Service Plan (POS)[a]					
Employee-only coverage	19	20	20	22	22
Family coverage	35	29	32	34	31

Source: William M. Mercer, *National Survey of Employer-Sponsored Health Plans, 1997* (New York, NY: William M. Mercer, 1998).
[a]Large employers.

Coinsurance

Plan participants are often required to pay a portion of their medical expenses up to a maximum annual limit. Commonly, the plan pays 80 percent of recognized charges, and the employee pays the remaining 20 percent.[3] Among full-time employees participating in non-HMO plans sponsored by medium and large private establishments, 60 percent were in plans with an 80 percent coinsurance rate in 1995, compared with 79 percent in 1989 (table 4). While the percentage of workers with a 90 percent coinsurance rate increased from 8 percent to 16 percent between 1989 and 1995, the percentage with no coinsurance also increased from 3 percent to 16 percent. As mentioned above, as HMOs compete with non-HMOs, it appears that non-HMOs have begun to offer plans without coinsurance.

Out-of-Pocket Limits and Lifetime Maximum Limits

Most major medical plans impose a maximum dollar limit on the amount of health insurance coverage provided. Plans that impose limits may do so on a per episode basis, such as per hospital admission or per disability, or they may impose an annual and/or lifetime maximum on payments for all covered services. Individual lifetime maximums are generally set between $250,000 and $1 million. The percentage of full-time employees in medium and large private establishments participating in medical plans with lifetime maximums has fallen over the last decade. In 1995, 71 percent of full-time employees in medium and large private establishments who participated in non-HMO plans had a maximum lifetime benefit, compared with 79 percent in 1989 (table 4). For those with a maximum lifetime benefit, the level has increased. Forty-seven percent of those in non-HMO plans had lifetime benefits of $1 million in 1995, compared with 40 percent in 1989.

Because 20 percent of a large medical claim may pose a significant burden for many individuals and families, most plans limit participants' out-of-pocket expenditures for covered services. After a certain level of spending is reached, coinsurance reverts to 100 percent, meaning that the insurance company will pay all covered costs above a certain threshold. The percentage of full-time employees participating in medical plans in medium and large private establishments with out-of-pocket maximums remained fairly steady over the last decade. Between 1989 and 1995, the percentage of employees with an out-of-pocket maximum remained at 83 percent. In 1995, the annual maximum for out-of-pocket expenses averaged $1,358 for individuals and $2,858 for families.

Delivery Systems

Health care delivery systems can be arranged in a spectrum according to the degree of

[3] *The 80 percent coinsurance is often based on usual, customary, and reasonable (UCR) charges. UCR charges are defined as follows: The covered amount is the provider's usual fee for the service, the customary or prevailing fee for the service or product in that geographic region, and a reasonable amount based on the circumstances involved. Hence, the plan will pay 80 percent of the UCR, not of the total charge, and the employee will pay any disallowed charge in addition to 20 percent of the UCR.*

Table 4
Percentage of Full-Time Employees Participating in Non-Health Maintenance Organization (HMO) Plans,[a] by Type of Cost-Sharing Provision, Selected Years

	Medium and Large Private Establishments				State and Local Governments			Small Private Establishments		
	1989	1991	1993	1995	1990	1992	1994	1990	1992	1994
Deductible										
Under $100	6%	4%	3%	2%	11%	9%	5%	2%	1%	1%
$100–$149	35	28	22	17	41	37	33	35	29	17
$150 or higher	53	53	54	49	38	37	46	56	60	66
None	5	9	12	23	9	15	16	6	9	14
Based on earnings	2	5	6	8	b	b	b	b	b	1
Coinsurance										
80 percent	79	74	71	60	71	82	64	80	90	72
85 percent	4	3	3	4	2	2	3	2	1	2
90 percent	8	11	12	16	14	10	17	10	2	13
Other	4	5	3	3	4	3	3	4	5	7
None	3	7	10	16	8	3	13	4	2	7
Lifetime Maximum Limits										
Less than $250,000	5	4	3	2	3	b	2	2	2	1
$250,000	6	7	7	4	8	4	2	7	6	3
$250,001–$499,999	3	2	1	1	1	b	b	b	b	1
$500,000	12	11	12	6	10	4	5	4	3	3
$500,001–$999,999	3	2	1	1	2	1	b	1	1	1
$1 million	40	43	46	47	51	53	57	50	51	49
More than $1 million	2	2	6	9	2	4	6	5	8	14
Other maximum	8	3	5	1	4	1	2	3	4	3
No maximum	21	24	20	27	20	30	24	27	26	24
Out-of-Pocket Limits										
Percentage with limit	83	83	83	83	88	83	92	89	88	87
Average dollar maximum on individual out-of-pocket expense	$1,077	$1,170	$1,319	$1,358	$992	$908	$941	$934	$1,108	c
Average dollar maximum on family out-of-pocket expense	$2,298	$2,326	$2,642	$2,858	$1,859	$1,856	$1,947	$2,054	$2,262	c

Source: U.S. Department of Labor, Bureau of Labor Statistics, *Employee Benefits in Medium and Large Firms, 1989* (Washington, DC: U.S. Government Printing Office, 1990); *Employee Benefits in Medium and Large Private Establishments,* 1991, 1993, and 1995 (Washington, DC: U.S. Government Printing Office, 1993, 1995, and 1997); *Employee Benefits in State and Local Governments*, 1990, 1992, and 1994 (Washington, DC: U.S. Government Printing Office, 1992, 1994, and 1996); *Employee Benefits in Small Private Establishments*, 1990 and 1992 (Washington, DC: U.S. Government Printing Office, 1991 and 1994).
Note: Details may not sum to 100 percent due to rounding.
[a]1993 data include only non-HMO medical plan participants. Prior years include participants in nonqualified HMOs but exclude participants in federally qualified HMOs. In federally qualified HMOs, allowable cost-sharing provisions are limited.
[b]Less than 0.5 percent.
[c]Data not available.

financial control the employer or payer has over such plans and to the degree of control such plans have over patient choice. At opposite ends of the spectrum are the traditional fee-for-service indemnity plan, with no managed care elements, and the staff model HMO. Between these two extremes lie fee-for-service plans with managed care features (known as managed indemnity plans), PPOs, and HMOs with greater choice of physicians. Finally, as health care delivery systems evolved and employers became more involved in the design of corporate benefit plans, hybrid plans (known as point-of-service or POS plans) were developed 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.

Traditional fee-for-service plans reimburse insured persons for covered charges they incur, using various methods to calculate provider payments.[4] When a person covered by a traditional fee-for-service health

[4] *Payments may be based on usual, customary, and reasonable (UCR) charges; a fixed schedule of fees; or a combination of these methods. Fee schedules, also called a "table of allowances" recognize charges for covered services only up to a fixed dollar amount for the specified medical procedure. This limit can take many forms. For example, a plan may limit hospital benefits to a fixed dollar amount per day and reimburse surgical changes according to a schedule of payments by procedure.*

Currently, there are five different HMO models. Each of these models differs with respect to its rules for patients and the financial incentives it imposes on health care providers to limit services and costs.

plan needs medical care, he or she seeks the services of a physician, who attempts to diagnose the illness and choose the appropriate course of treatment. The physician decides whether surgery or drug therapy is needed and whether the illness should be treated in a hospital or in an outpatient setting. The traditional insurance system finances the cost of treatment choices without attempting to influence the treatment setting. Thus, there are generally no outside incentives for providers or patients to pursue the most cost-effective treatment or setting.

Until the mid-1980s, the typical HMO model was a fairly homogeneous staff or group model. In a staff 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 to see a primary care physician first, who then refers them to specialists within the HMO when this is considered medically necessary and appropriate. A group model HMO is similar to a staff model HMO, except that it 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.[5] Group model HMO providers of health care usually spend most of their time serving HMO patients, but they may devote some time to private practice.

The recent expansion of HMOs has been dominated by heterogeneous network model HMOs. Currently, there are five different HMO models: staff model, group model, independent practice association (IPA), network model, and mixed model. Each of these models differs with respect to its rules for patients and the financial incentives it imposes on health care providers to limit services and costs.

Independent Practice Associations

IPAs are groups of physicians in private practice who provide some services to HMO participants, but they primarily provide services to patients not enrolled in an HMO. The non-HMO patients are treated on a fee-for-service basis. 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 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 employees more choice among providers.

Network Model HMO

In the network model, HMOs contract with two or more independent physician groups that often provide specialty services as well as general services. The HMO typically pays these groups on a capitated basis, but the groups also spend some time in private practice, operating on a fee-for-service basis.

Mixed Model HMO

A mixed model HMO will initially adapt one type of model, such as a staff model, and then expand either its capacity and/or its geographic region at a later date by adding another type of model, such as an IPA.

The financial incentives within a health plan can affect physicians' decision-making process and how that process ultimately affects patients, as well as the cost of providing health care. Within the network-based models mentioned above, reimbursement schemes have evolved from a salaried or capitated basis to one in which physicians share less of the risk associated with treating

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[5] *Providers that are reimbursed on a capitated basis are reimbursed at a fixed rate per HMO patient.*

patients. In addition, some HMOs use withholding accounts[6] and bonus programs based on productivity to reimburse providers. Research on the effectiveness of the various financial incentive models has recently become available.

Preferred Provider Organizations/ Point-of-Service Plans

PPOs and POS plans have emerged as strong alternatives to fee-for-service plans and HMOs. 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. They usually choose their providers 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 greatly from the HMO structure, they both combine three broad cost-management strategies: a limited provider panel, negotiated fee schedules, and utilization review (UR).[7] In addition, some PPOs have a physician who acts as a gatekeeper to the system.

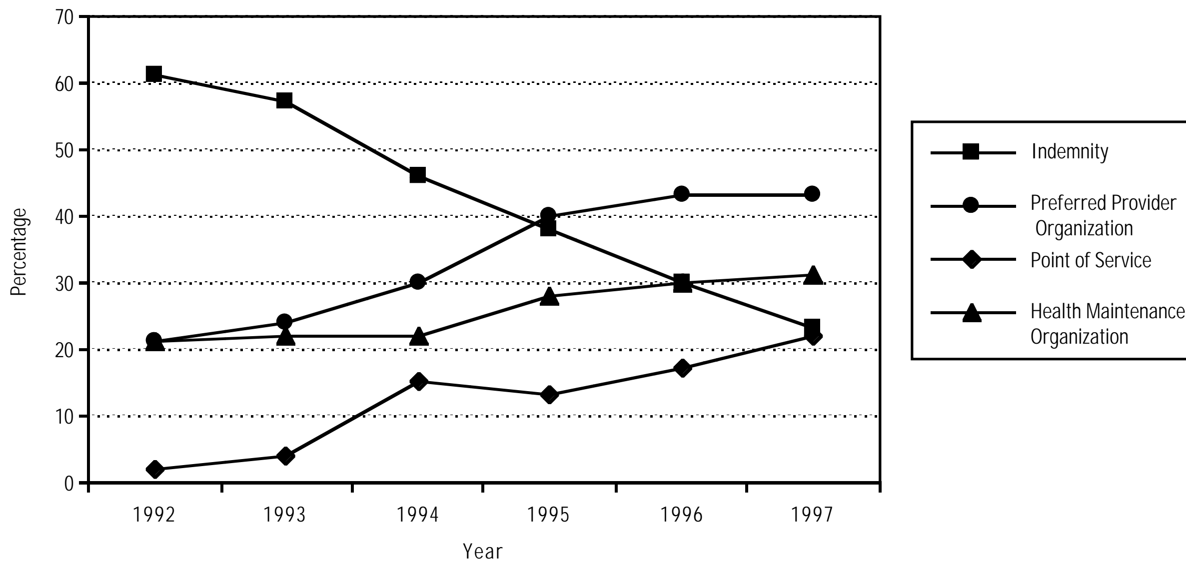
Until 1988, a traditional feature of HMOs was a requirement that employees use network providers. POS plans are essentially HMOs that allow participants to choose a provider from outside the list of network providers. Enrollees are required to select a primary care physician, who then acts as a gatekeeper, essentially controlling referrals to specialists. The enrollee's cost-sharing responsibilities vary with the choice of provider—the highest cost sharing is associated with the use of nonnetwork providers. 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.

One of the distinguishing features of a network of providers is the way the plan selects its providers. Some plans evaluate candidates against a set of predetermined selection criteria. Providers must be able to achieve the network's goals for cost control and quality improvement by successfully managing health care delivery. Candidates can also be chosen according to their location. Providers must be able to provide health services to an adequate geographic area. Networks must be available where employees live and work. In addition, most networks require providers to agree to accept UR procedures, refer patients only to other providers in the network, and accept the network's reimbursement procedures. Many networks also monitor their providers' practice patterns in order to identify unjustifiably high costs, and then alter these patterns through education and financial incentives.

Some employment-based plans use objective information on the quality of care to identify potential providers for their network. Employers contract with specific networks of health care facilities for high-cost procedures such as open-heart surgeries and transplants. These facilities, known as centers of excellence, are selected according to a number of criteria, including experience; efficiency; effectiveness; and outcomes, such as mortality (death) and morbidity (disease) rates. In selectively contracting on the basis of these criteria, employment-based plans are explicitly using outcome measures for determining reimbursement.

[6] In a withholding account arrangement, a percentage of the payment is withheld until the end of the year. Premiums are set aside in a referral fund which is used to pay for the services of primary care physicians, specialists, hospitals, and outpatient testing. If the referral fund runs a surplus, then physicians receive the amount that accumulated in the withholding account. If the referral fund runs a deficit, nothing is returned to the provider.

[7] UR is a process of systematically reviewing care to determine its necessity and appropriateness. There are three general types of UR: prospective review, concurrent review, and retrospective review. UR is discussed in more detail later in the paper.

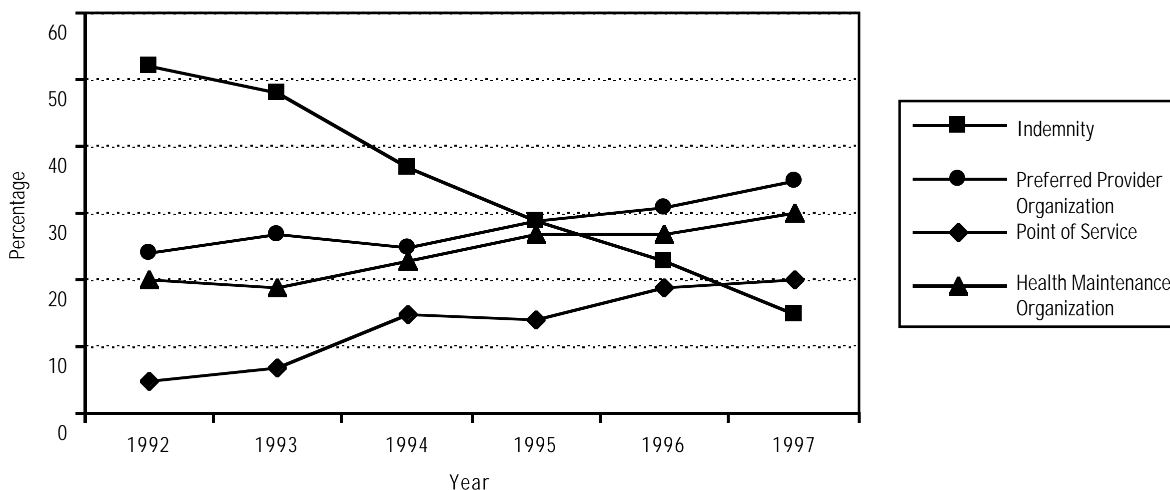


Source: William M. Mercer, 1998, *National Survey of Employer-Sponsored Health Plans, 1997* (New York, NY: William M. Mercer, 1998).

Providers have challenged the use of unadjusted outcome measures as criteria for selection because providers with sicker patients will appear to be of poorer quality. In response, health care organizations have developed systems to analyze medical records that adjust for the severity of the case mix. The outcomes achieved by physicians and hospitals can potentially allow health plans and plan sponsors to objectively compare and assess the quality and cost effectiveness of care. Selectively contracting with providers using objective criteria such as these begins for the first time to directly reward providers for low-cost, high-quality health care.

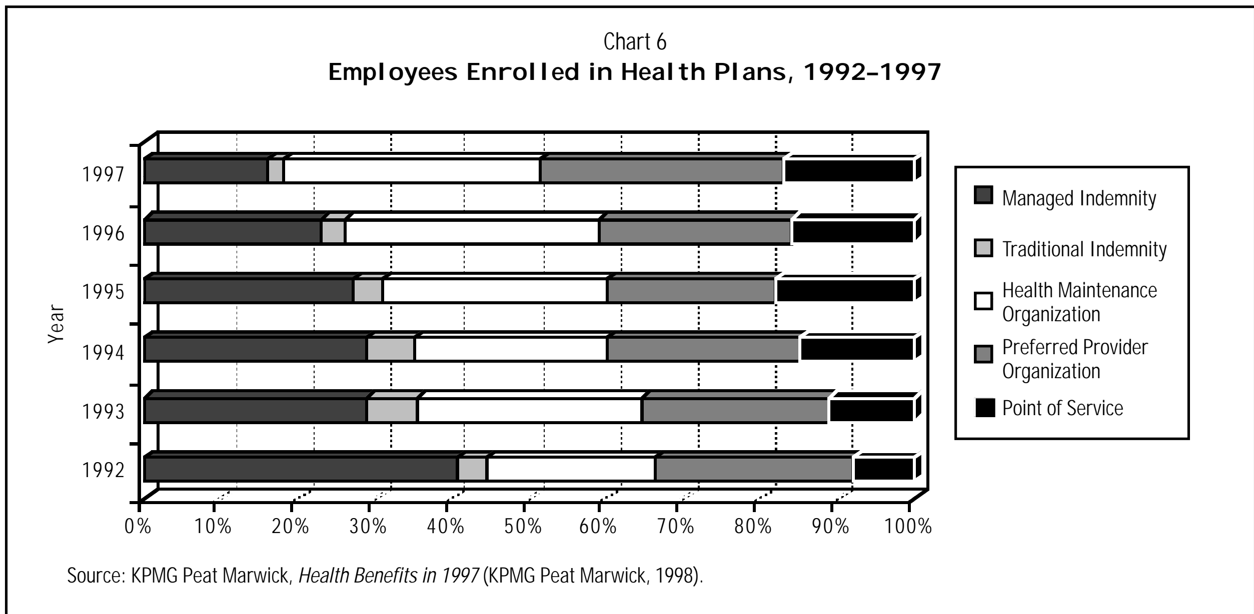
Plan Prevalence

One of the most significant developments of the 1980s, which has continued throughout the 1990s, is the growth of managed care plans. As recently as 1994, traditional indemnity plans were the most commonly offered health plan among employers that offered health plans



Source: William M. Mercer, 1998, *National Survey of Employer-Sponsored Health Plans, 1997* (New York, NY: William M. Mercer, 1998).

Chart 6
Employees Enrolled in Health Plans, 1992–1997



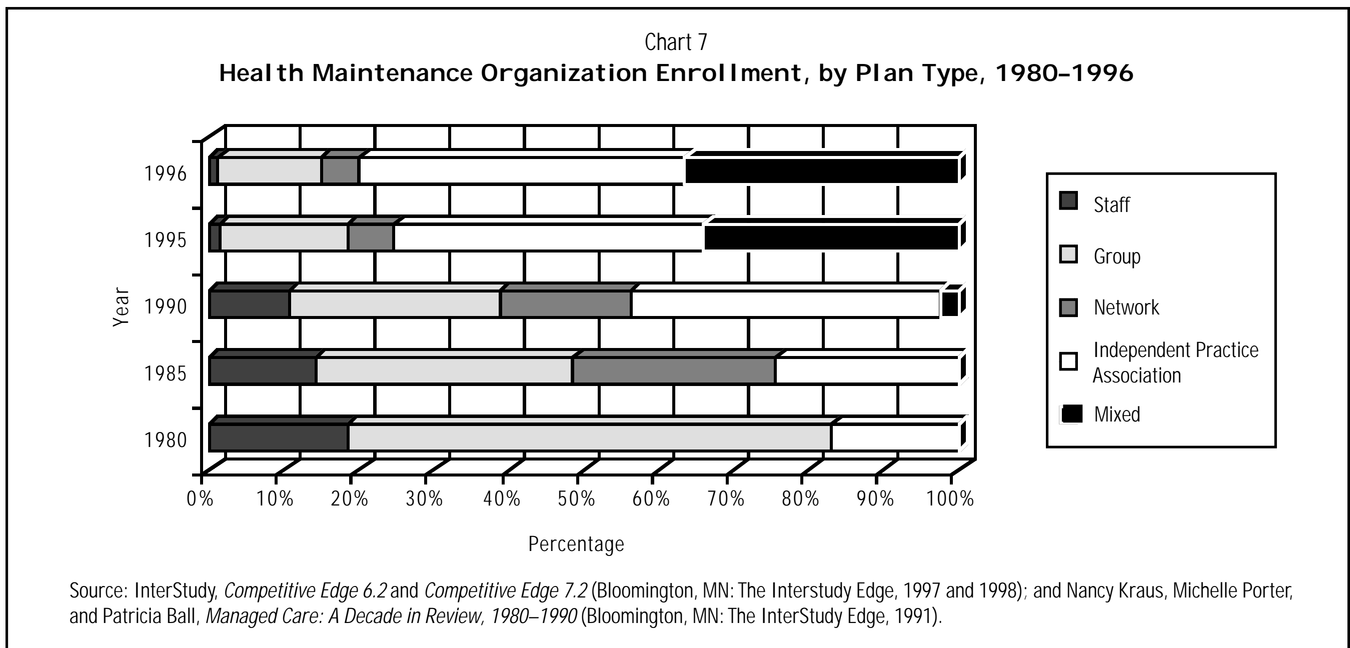
Source: KPMG Peat Marwick, *Health Benefits in 1997* (KPMG Peat Marwick, 1998).

(chart 4). As fewer employers offered traditional indemnity plans, participation in these plans declined and participation in managed care plans increased. In 1997, 15 percent of employees participating in a health plan were enrolled in an indemnity plan, compared with 52 percent in 1992 (chart 5). During the same period, enrollment in managed care plans increased from 48 percent to 85 percent. Enrollment in PPOs increased from 24 percent to 35 percent. Enrollment in HMOs increased from 20 percent to 30 percent, and enrollment in POS plans increased from 5 percent to 20 percent.

In addition to the decline in participation in fee-for-service indemnity plans, the structure of these plans has changed as employers and insurers have added managed care features to them. In 1997, only 2 percent of employees were enrolled in traditional indemnity plans, compared with 6 percent in 1993 (chart 6). In contrast, 16 percent of employees were enrolled in managed indemnity plans in 1997, compared with 26 percent in 1993. A similar survey found that 92 percent of employees in traditional fee-for-service plans were in plans with UR in 1990, compared with 44 percent in 1987 (Hoy et al., 1991).

Enrollment in HMOs grew from 9.1 million in 1980 to 33.6 million in 1990, a 269 percent increase (Interstudy, 1997). Yet, overall HMO growth between 1990 and 1996 was 88 percent. In addition, the number of enrollees in staff and group model HMOs has fallen as

Chart 7
Health Maintenance Organization Enrollment, by Plan Type, 1980–1996



Source: InterStudy, *Competitive Edge 6.2* and *Competitive Edge 7.2* (Bloomington, MN: The Interstudy Edge, 1997 and 1998); and Nancy Kraus, Michelle Porter, and Patricia Ball, *Managed Care: A Decade in Review, 1980–1990* (Bloomington, MN: The InterStudy Edge, 1991).

a percentage of all HMO enrollees. In 1996, staff and group model HMO enrollees accounted for 15 percent of all HMOs, compared with 82 percent in 1980 (chart 7). Similarly, the percentage of HMO enrollees in IPA and mixed-model HMOs increased from 19 percent in 1980 to 79 percent in 1996.

One reason for the decline in staff and group model HMO enrollment may be the lack of flexibility afforded the employee. Employers offer health benefits as a form of compensation in order to recruit and retain qualified employees. Locking employees into a plan that limits their choice and perhaps reduces their satisfaction may be less costly but may not be cost-effective in terms of an employer's recruitment and retention costs. If employees could enroll in a plan with greater flexibility, in many cases they could retain their family physician or specialist (Gabel, 1997). A second reason for the steady decline in staff and group model HMO enrollment may be that employers' disappointment with expected cost savings has caused them to experiment with other plan types. Another reason may be that staff and group model HMOs were not as aggressive as IPAs and network plans at increasing market share because they were more likely to be owned by less aggressive nonprofit organizations (Gabel, 1997).

Coverage of Services

Both indemnity plans and managed care plans generally include coverage for care associated with an episode of hospital care, including hospitalization, in-hospital professional care, surgery, and many outpatient services. However, these plans sometimes have coverage limitations, such as preexisting condition clauses and service requirements. In addition, non-HMO plans are less likely than HMO plans to offer preventive services and services that are predictable or not considered medically necessary, such as immunizations or physical exams (table 5). This is partly due to requirements that federally qualified HMOs offer such services.[8] Some argue that this focus on preventive care by the HMO encourages patients to receive such care and potentially avoids costly medical conditions, although the evidence on savings is not clear-cut.

Table 5

Percentage of Full-Time Employees Participating in Health Care Plans, by Type of Plan and Coverage for Selected Services and Preventive Benefits, Medium and Large Private Establishments, 1995

Benefit Item	All Plans	HMO[a] Plans	Non-HMO[a] Plans
Hospital Room and Board	100%	100%	100%
Inpatient Surgery	100	100	100
Outpatient Surgery	100	100	100
Inpatient Physician Visits	100	100	100
Office Physician Visits	100	100	100
Diagnostic X-ray and Laboratory	100	100	100
Extended Care	73	80	71
Home Health Care	78	91	73
Hospice Care	56	44	61
Inpatient Mental Health	97	94	98
Outpatient Mental Health	91	95	90
Inpatient Alcohol Detoxification	98	100	97
Inpatient Alcohol Rehabilitation	77	66	81
Outpatient Alcohol Rehabilitation	81	80	81
Inpatient Drug Detoxification	97	98	97
Inpatient Drug Rehabilitation	76	65	80
Outpatient Drug Rehabilitation	80	80	81
Hearing Care	33	87	12
Physical Exam	56	98	40
Well-Baby Care	60	97	46
Immunization and Inoculation	47	91	31

Source: U.S. Department of Labor, Bureau of Labor Statistics, *Employee Benefits in Medium and Large Private Establishments, 1995* (Washington, DC: U.S. Government Printing Office, 1997).
[a]Health maintenance organization.

Coverage Limitations

Coverage limitations include provisions that effectively shorten coverage periods or narrow coverage for individuals. Companies may limit employee coverage based on a previous medical condition or length of service with the company. Companies have also instituted UR programs to review the necessity and appropriateness of care, sometimes with the result of limiting coverage.

[8] *To be federally qualified under the HMO Act of 1973, the HMO plan must include physician and physician referral services; outpatient and inpatient hospital services; medically necessary emergency health services; 20 outpatient mental health visits; treatment and referral services for alcohol and drug addiction or abuse; diagnostic laboratory and diagnostic and therapeutic radiological services; home health services; and preventive health services, including well-child care, children's eye and ear examinations, immunizations, infertility services, and adult periodic health evaluations.*

Table 6
Percentage of Employers with Utilization Review Programs, Among Employers Offering an Indemnity Plan, 1993-1996

Type of Program	1993	1994	1995	1996
Precertification of Elective Admissions	52%	64%	70%	73%
Concurrent Review	37	31	41	a
Catastrophic Case Management	40	23	32	34
Outpatient Utilization Review	28	23	32	39
Second Surgical Opinion	84	92	84	85
Mandatory	43	51	45	44
Voluntary	41	41	39	41
None of These	27	14	13	10

Source: A. Foster Higgins & Co., Inc., *Tables: National Survey of Employer-Sponsored Health Plans, 1993–1996* (Princeton, NJ: A. Foster Higgins & Co., Inc., 1994–1997).
[a]Data for concurrent review are combined with precertification of elective admissions.

Preexisting Conditions—Many health insurance programs will not pay for health services related to conditions that were known to exist at the time the employee joined the plan. However, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) effectively limits an employer's ability to exclude preexisting conditions from coverage. HIPAA prohibits a group health plan from applying preexisting condition limits for periods greater than 12 months (18 months for late enrollees). Furthermore, cases involving pregnancy, newborns, or newly adopted children who become covered under the plan within 30 days of birth or placement for adoption are not subject to preexisting condition limits. HIPAA also prevents group health plans from imposing preexisting condition limits on individuals with a history of prior health insurance coverage. Health plans must reduce the duration of their preexisting condition limits by one month for each month of prior creditable coverage, so long as the individual did not have a break in coverage exceeding 63 days. Waiting periods related to service requirements cannot be counted toward the break in coverage.

Service Requirements—Many employers require employees to satisfy a waiting period on being hired before becoming eligible for health care coverage. Data from the U.S. Department of Labor indicate that at least 64 percent of full-time employees in medium and large private establishments had minimum service requirements for participation in 1995, and 31 percent did not have a service requirement (U.S. Department of Labor, 1998).[9] Fifty-eight percent of those workers with a service requirement were required to work for at least three months before becoming eligible for health benefits. Only 4 percent of participants with service requirements were required to wait more than six months.

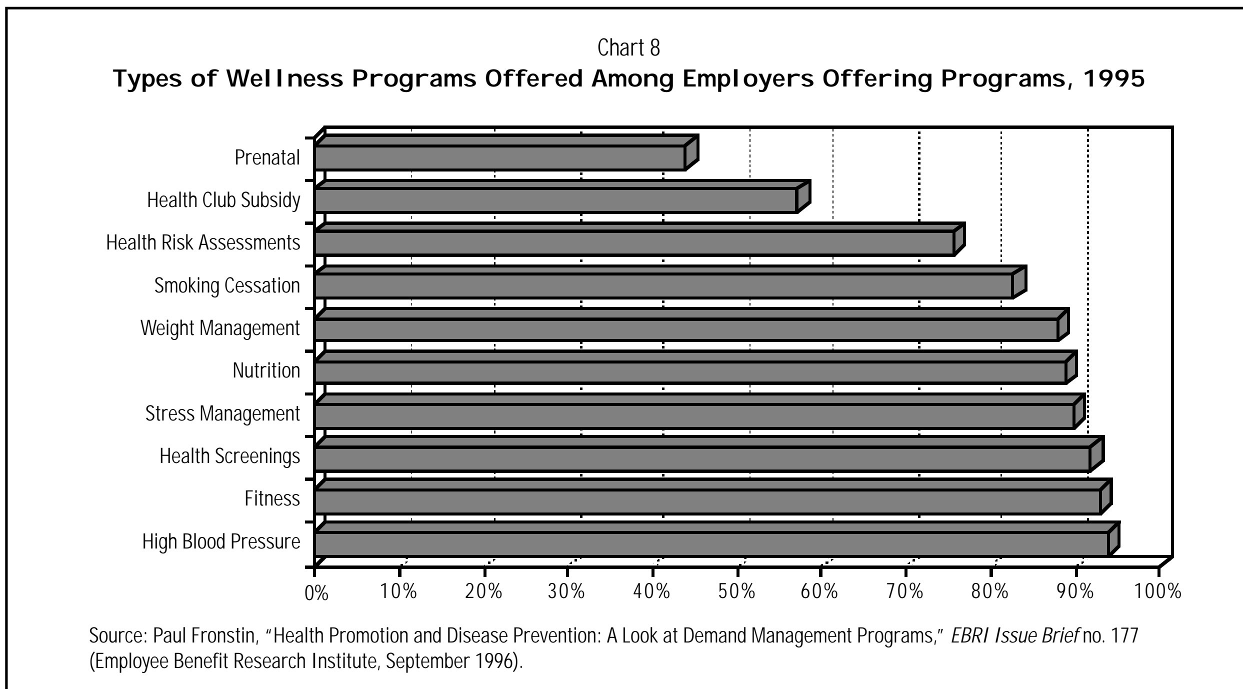
Utilization Review—UR programs are used on a case-by-case basis to monitor the progress and appropriateness of care and limit the volume of unnecessary health care services. As mentioned previously, even traditional indemnity plans are using UR. UR strategies include prospective review, concurrent review, retrospective review, and mandatory second opinion. Prospective review includes evaluation of the appropriateness of an inpatient stay before the individual is admitted. An example of prospective review is hospital preadmission certification, which requires that patients receive prior authorization for certain procedures, nonemergency hospital admissions, and elective surgery, or the insurer may not pay for the full cost of care. Concurrent review monitors care as it is provided. It may include the prior determination of the length of hospital stays and the scope of the treatment during the stay. Under retrospective review, care is reviewed after it is given. Insurers use this strategy primarily to apply what they learn from past experience when implementing UR in future cases. It is also used to give providers an incentive to exercise self-restraint to avoid the potential of a retroactive denial. Under mandatory second opinion, the patient must receive a second opinion about the appropriateness of a proposed treatment from a health care provider other than the one making the original recommendation.

Employers have been increasingly using UR programs. In 1996, 90 percent of surveyed employers used some type of UR program, compared with 73 percent in 1993 (table 6). Second surgical opinion and precertification of elective hospital admissions are by far the most often used UR strategies.

Nontraditional Benefits

As competition among health care plans and market

[9] *The service requirement was not determinable for 5 percent of the sample.*



Source: Paul Fronstin, "Health Promotion and Disease Prevention: A Look at Demand Management Programs," *EBRI Issue Brief* no. 177 (Employee Benefit Research Institute, September 1996).

demand increases, separate services are developing to supplement benefits already offered. For example, many employers and insurers have developed stand-alone plans that cover outpatient prescription drugs, dental care, and vision care services. In addition, in order to offset increases in health care costs, many employers have modified their plan design to expand coverage for health promotion and disease prevention programs. Between 1988 and 1993, the percentage of full-time employees in medium and large private establishments with access to wellness programs increased from 17 percent to 37 percent (U.S. Department of Labor, 1990, 1995).[10] Screening for high blood pressure, physical fitness centers, weight management, and smoking cessation programs are among the programs employers most frequently offer (chart 8).

While employers have been expanding some of the benefits they offer, they have also been cutting back on others. For example, in 1980, 54 percent of full-time workers in medium and large private establishments had the same coverage for inpatient mental health benefits as they did for other health care services, compared with 19 percent in 1995 (chart 9). A similar trend has occurred with outpatient mental health benefits as compared with other health care services.

The Mental Health Parity Act of 1996 requires employers with more than 50 employees to offer identical annual and lifetime dollar limits for mental and physical health care services. However, employers are still allowed to offer health plans with fewer covered inpatient days for mental illness than for other illnesses. In addition, employers are allowed to offer plans that do not provide any benefits for mental illness. A recent survey found that employers have begun to change mental health care provisions in response to this legislation (William M. Mercer, 1998). The survey found that the use of limits on covered inpatient days has increased. For example, in traditional indemnity plans, the use of limits on covered inpatient days increased from 27 percent of plans to 30 percent. At the same time, the use of annual dollar limits fell from 31 percent to 28 percent, and the use of lifetime dollar limits fell from 36 percent to 28 percent.

Retiree Health Benefits

Retiree health benefits were originally offered in the late 1940s and the 1950s, when business was booming as a result of post-war economic expansion and there were very few retirees in relation to the number of active workers. Retiree health benefits were simple to provide. These benefits emerged as part of collective bargaining agreements, and employers were more than willing to provide them because the cost was such a small proportion of total compensation. With the enactment of Medicare in 1965, the employer obligation

[10] Between 1993 and 1995, the percentage of full-time workers employed in medium and large private establishments with access to a wellness program declined slightly, from 37 percent to 34 percent (U.S. Department of Labor, 1998).

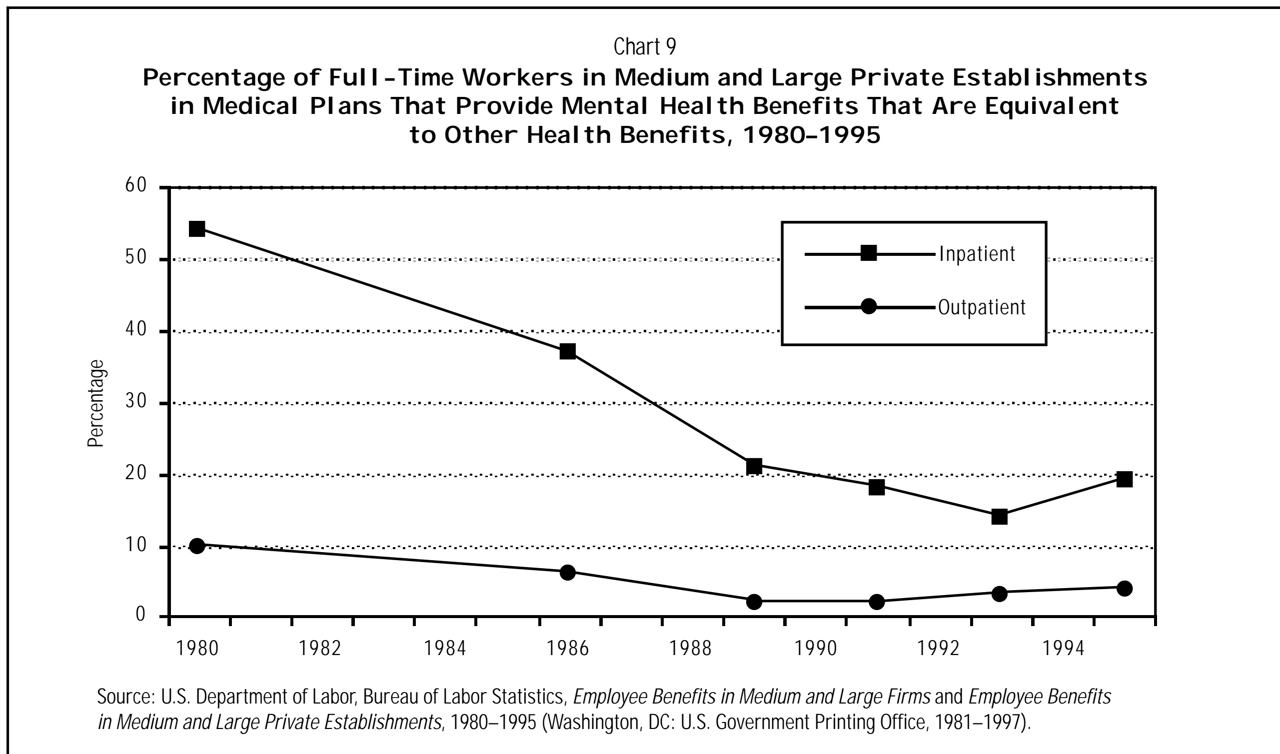


Chart 9
Percentage of Full-Time Workers in Medium and Large Private Establishments in Medical Plans That Provide Mental Health Benefits That Are Equivalent to Other Health Benefits, 1980–1995

Source: U.S. Department of Labor, Bureau of Labor Statistics, *Employee Benefits in Medium and Large Firms* and *Employee Benefits in Medium and Large Private Establishments*, 1980–1995 (Washington, DC: U.S. Government Printing Office, 1981–1997).

became even less significant, and costs declined even further because employers were able to integrate their retiree health benefit programs with Medicare. The resulting liabilities were not substantial, and the financing of these benefits was not of concern. However, in more recent years, the changing demographics of the work force, combined with increasing life spans, rising health care costs, downsizing, and early retirement, have left many employers with higher retiree-to-active worker ratios. As a result, employers' retirement liabilities have grown.

In December 1990, the Financial Accounting Standards Board (FASB) approved Financial Accounting Statement No. 106 (FAS 106), "Employers' Accounting for Postretirement Benefits Other Than Pensions." FAS 106 requires companies to record unfunded retiree health benefit liabilities on their financial statements in order to comply with generally accepted accounting

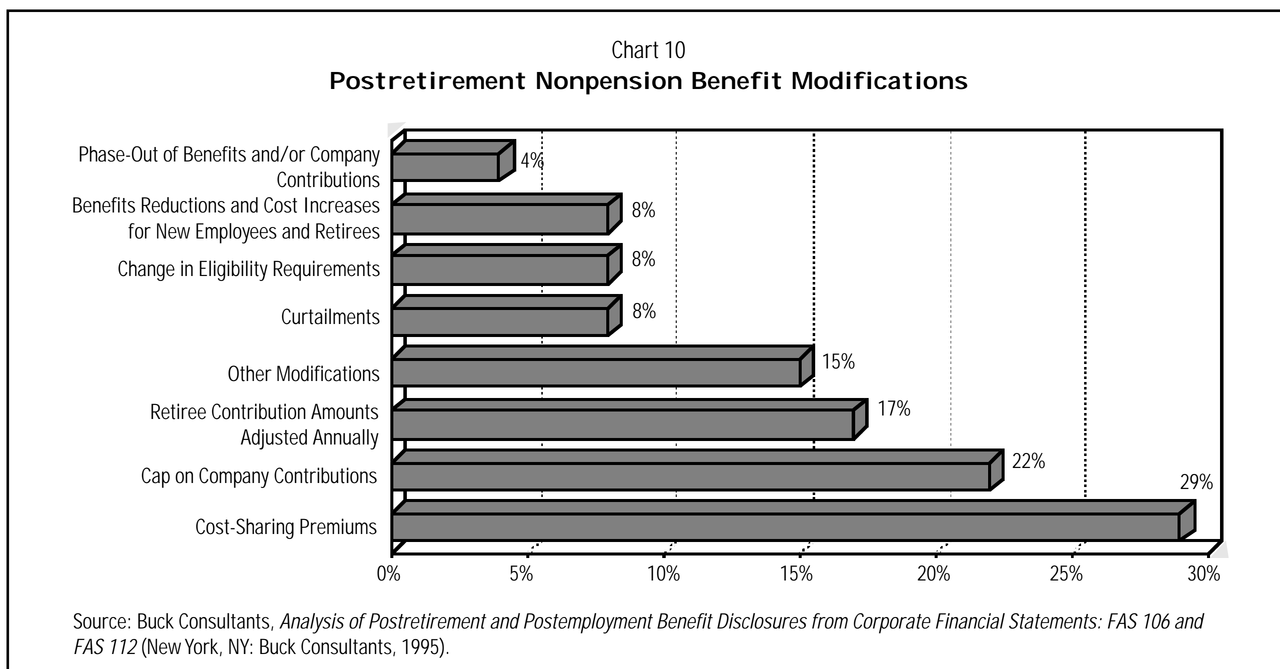
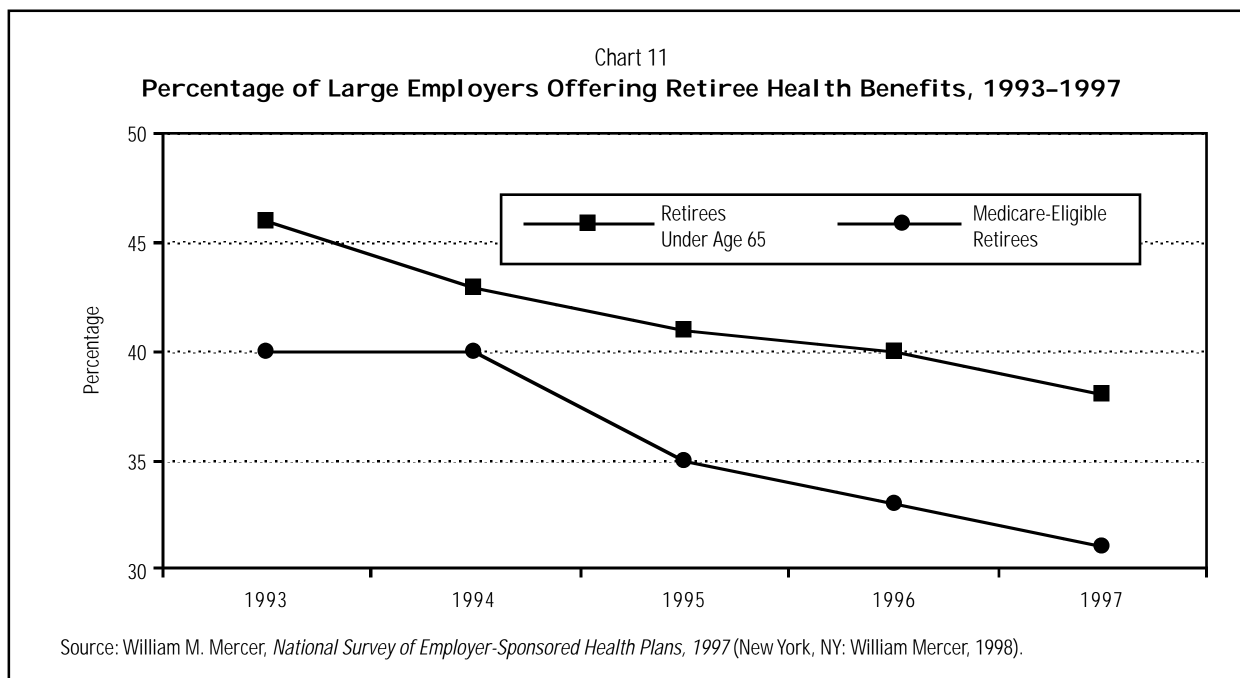


Chart 10
Postretirement Nonpension Benefit Modifications

Source: Buck Consultants, *Analysis of Postretirement and Postemployment Benefit Disclosures from Corporate Financial Statements: FAS 106 and FAS 112* (New York, NY: Buck Consultants, 1995).



Source: William M. Mercer, *National Survey of Employer-Sponsored Health Plans, 1997* (New York, NY: William Mercer, 1998).

standards, beginning with fiscal years after December 15, 1992. As a result, the retiree health care liabilities required to be listed on a balance sheet in accordance with FAS 106 far exceed the costs that appeared prior to this standard.

In response to FAS 106 and increases in health care costs, some firms have dropped retiree health benefits, while others still have no plans to change their existing benefit provisions. However, the vast majority of companies have made numerous modifications to their retiree health benefits programs. For example, one study found that 51 percent of responding employers have modified or are considering modifications to their postretirement nonpension benefit programs (Buck Consultants, 1995). This survey studied the year-end 1993 and 1994 annual reports of 489 Fortune 1000 companies that adopted FAS 106. Of those companies indicating that they had modified or were considering modifying their plans, the most common modification was a change in cost-sharing provisions, followed by a cap on company contributions (chart 10). Only 4 percent of surveyed employers had made or were considering making modifications that would entirely phase out retiree health benefits and/or company contributions.

Some employers have completely eliminated retiree health benefits. A recent survey of employers with 500 or more workers found that 38 percent offered retiree health benefits to retirees under age 65 in 1997, compared with 46 percent in 1993 (chart 11). The survey also found that 31 percent of employers offered retiree health benefits to Medicare-eligible retirees in 1997, compared with 40 percent in 1993.

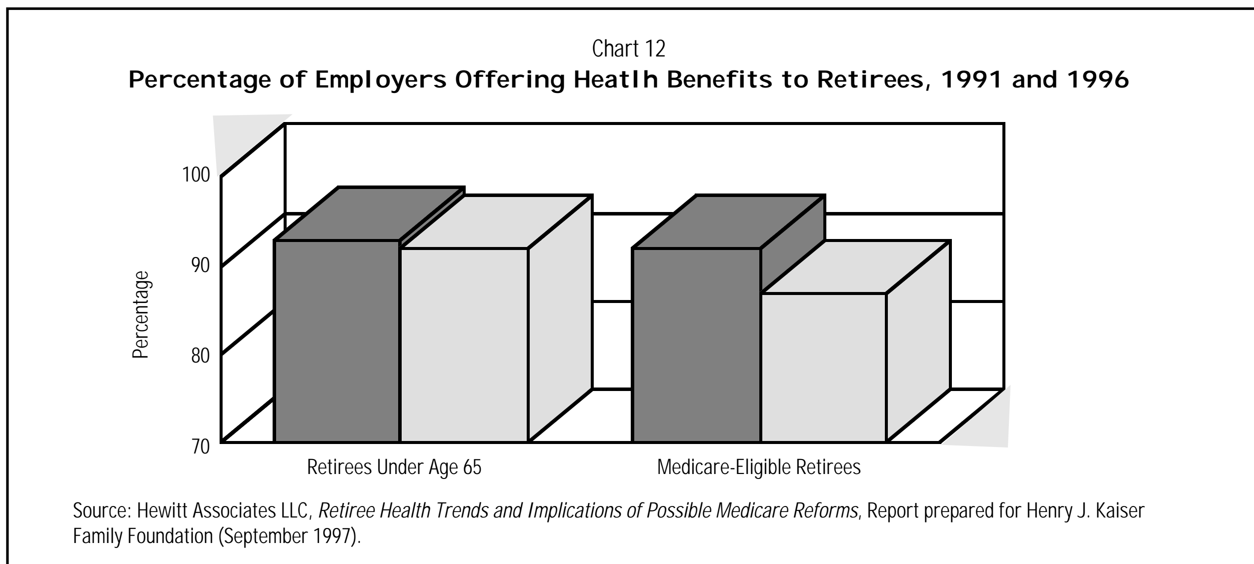
Trends in retiree health benefits can also be measured by looking at a constant sample of employers instead of a random sample. A recent study of the same large employers in 1991 and 1996 found that virtually none of the employers had eliminated retiree health benefits for retirees under age 65 (chart 12). In contrast, employers were found to eliminate retiree health benefits for Medicare-eligible retirees.

Any change in plan design alters an employer's obligation to employees. While reduced or changed benefits may be beneficial from a bottom-line standpoint, this action may lower employee morale and reduce a firm's ability to recruit and retain employees. In addition, reducing or eliminating retiree health benefits affects employees' retirement decisions (Fronstin, 1997a). Thus, changes in retiree health care plans may hinder employers' attempts to reduce their work force by offering early retirement incentives in lieu of layoffs. [11]

Policy Implications

The ongoing rise in enrollment of insured individuals in managed care plans—the direct result of increasing health care costs during the late 1980s and early 1990s—continues to focus policymakers' attention on the issue of access to health care for individuals

[11] *For a more complete discussion of retiree health benefits, see Fronstin, 1996a.*



Source: Hewitt Associates LLC, *Retiree Health Trends and Implications of Possible Medicare Reforms*, Report prepared for Henry J. Kaiser Family Foundation (September 1997).

without coverage and health care quality issues for the insured population. Policy initiatives at the state and federal levels may affect the design and availability of employment-based group health insurance plans.

Since insurance is regulated primarily at the state level, the states have been actively pursuing health care reform issues. By mid-1997 in the legislative year, state legislatures had debated approximately 1,000 bills concerning issues of health care and managed care regulation, and had enacted almost 20 percent of them (*Healthcare Trends Report*, 1998). Each of these proposals will have a significant impact on employment-based health plans, especially among nonexempt small employers. Furthermore, many of the health care mandate initiatives being debated at the state level are also being debated at the national level.

Quality of health care and consumer protections have been key concerns among policymakers, and a number of bills have been introduced to address these issues. President Clinton's Consumer Bill of Rights and the bipartisan Patient Access to Responsible Health Care Act (PARCA) (S. 644/ H.R. 1415), co-sponsored by Rep. Norwood (R-GA) and Sen. D'Amato (R-NY), are just two examples of the types of legislation that policymakers are considering. The Consumer Bill of Rights, for example, includes provisions on information disclosure, choice of health care providers and health plans, access to emergency care, patient participation in treatment decisions, medical records privacy, and a complaints and appeals process that includes an independent system of external review. PARCA includes many of the same provisions as the Consumer Bill of Rights. The legislation would prohibit: (a) all employment-based health plans from limiting discussion of patient options, (b) requiring preliminary authorization for emergency treatment, and (c) giving incentives to physicians and other providers to limit necessary care or access to specialists when recommended by health care professionals. All plans would also be required to offer point-of-service options for patients who want to go off-network. In addition, PARCA would allow health plans now preempted by ERISA to be liable for compensatory and punitive damages under state tort laws.

These proposed reforms could have a significant impact on employment-based health plans, if enacted. For example, one recent analysis of PARCA finds that health care costs could increase between 7 percent and 39 percent, depending on which provisions of the legislation are passed and various other assumptions (Lee et al., 1997). In addition, the U.S. Congressional Budget Office (CBO) predictions of modest increases in health care costs assume that federal laws on health care remained unchanged (U.S. Congressional Budget Office, 1998). However, another recent study estimates that insurance premiums would increase between 0.7 percent and 2.6 percent (Nystrom et al., 1998).[12]

Conclusions

Between 1993 and 1997, employment-based health benefit cost increases have been virtually nonexistent. Employers have kept cost increases low by using managed care and making other changes. For

[12] *For an examination of the differences behind these studies, see Paul Fronstin, "The Patient Access to Responsible Care Act of 1997: How Much Will It Cost?"* EBRI Notes *no.6 (June 1998): 1–6.*

> *The CBO predicts that the cost of employment-based health plans will increase 5.6 percent in 1998, but also that health care cost inflation will once again decline in the following few years.*

example, fewer employees with health insurance coverage are in plans that are fully financed by their employer. Workers have been shifted to, have been induced to choose, or have voluntarily selected managed care health plans, with the result that PPO and POS plans have experienced relatively strong gains in enrollment. Employers have increased the use of UR for active workers and cut back on health benefits for retirees. These changes are in stark contrast to the pre-1993 period, which saw even faster change (Snider, 1992). During that time, health care costs increased rapidly, and deductibles and coinsurance for workers in non-HMOs also increased, as compared with the declines experienced in the post-1993 period.

There are strong signals that health care cost inflation is increasing in 1998. For example, the Federal Employees Health Benefits Program announced in the Fall 1997 that premiums would increase, on average, 8.5 percent in 1998 if worker enrollment selections remained unchanged from 1997. The California Public Employees Retirement System, CalPERS, also announced a relatively large increase in premiums for 1998: After four years of declining premiums, 1998 premiums will increase 3 percent. While William M. Mercer found that overall cost increases in 1997 were less than 1 percent for employers, this was in large part due to the increased use of managed care. For employers with the same health plan in 1996 and 1997, average costs increased 4 percent (William M. Mercer, 1998). In addition, the survey found that 67 percent of surveyed employers expect health care costs to increase in 1998, and are budgeting for an average increase of 7 percent.

It is too early to predict whether these increased costs represent a one-time change or a return to sustained high health care cost inflation. The CBO predicts that the cost of employment-based health plans will increase 5.6 percent in 1998, but also that health care cost inflation will once again decline in the following few years (U.S. Congressional Budget Office, 1998). In 1999, costs are expected to increase 5.2 percent, and in 2000 they are expected to increase 4.9 percent. In addition, health care costs are not expected to increase by more than 6 percent until at least 2008. The CBO analysis attributes future cost increases to an emphasis on quality, a strong economy, and a short-term profit cycle in the health insurance industry. The CBO analysis also assumes that current federal laws concerning health care will remain unchanged. The projections do not account for the effects that future passage of legislation mandating health care quality, consumer protections, and provider protections might have on the cost of employment-based health plans. While the CBO predicts that the percentage of the nonelderly population with employment-based health benefits will continue to decline over the next 10 years, we can also expect that workers with health insurance will experience a continuing trend in higher premium contribution requirements, an increased use of flexible managed care arrangements, and other plan design changes.

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