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HEALTH INSURANCE

Cost Increases Lead to Coverage Limitations and Cost Shifting

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The Honorable John D. Dingell
Chairman, Committee on Energy and Commerce
House of Representatives

The Honorable Henry A. Waxman
Chairman, Subcommittee on Health
and the Environment
Committee on Energy and Commerce
House of Representatives

This report, prepared at your request, discusses the major health care cost-cutting measures being adopted by U.S. firms. It includes an overview of current trends and an assessment of the potential effects that such actions have on the employees of these firms.

We are sending copies of this report to interested committees, the Director of the Office of Management and Budget, and the Secretary of Health and Human Services, and are making copies available to others on request.

Please contact me on (202) 275-6109 if you or your staff have any questions concerning the report. Other major contributors are listed in appendix I.

Mark V. Nadel

Mark V. Nadel
Associate Director, National
and Public Health Issues

Executive Summary

Purpose

American firms are reconsidering the level and structure of health care benefits provided to their employees. Among the impelling forces are the rapid pace of inflation in health care over the last decade, growing competition from foreign firms, and fundamental changes in the health insurance marketplace.

The Chairmen of the House Committee on Energy and Commerce and its Subcommittee on Health and the Environment expressed concern that the restructuring of health care plans by private firms may reduce health insurance coverage for American workers and their families. Such restrictions, they felt, could exacerbate the already serious problems of lack of insurance and under-insurance of the American population. They asked GAO to examine (1) the effects of private sector cost containment on employee access, costs, and benefit patterns for covered employees and (2) the special problems small firms confront in the health insurance market.

Background

The United States has relied on the private marketplace to provide health insurance for the majority of its citizens. Except for the aged and disabled through Medicare and the lowest income groups through Medicaid, most individuals are insured through employer-sponsored health plans. However, the provision of health benefits has become increasingly burdensome to these firms.

Business health care costs as a percentage of total wages and salaries more than doubled between 1970 and 1987. In response to these trends, both large and small firms adopted a wide variety of cost-cutting measures during the 1980s.

For this study, GAO reviewed literature on employee health benefits, interviewed experts in the field and union representatives, and visited several large employers.

Results in Brief

Increasingly, employers are restricting the health insurance coverage available to their employees. Some cost savings have been achieved, but some costs have been shifted to households, health care providers, and insurers.

For most full-time employees of larger companies, health benefits still are widely available. Nevertheless, health benefits provided by some large firms are beginning to erode. Firms are reassessing who and what

are covered and how services are provided or insured. Four broad strategies have been used to reduce costs. Variously, firms

1. limit the number of people covered by their plans by expanding use of temporary, part-time, and contract employees for whom no employer-provided health benefits are offered and/or limiting or eliminating retiree and in some cases dependent coverage;

2. ask employees to pay a larger share of health care costs;

3. introduce managed care or utilization review programs to reduce utilization of health services; and/or

4. in the case of large firms, self-insure.

Self-insurance has frustrated attempts by states to expand health benefits through state requirements specifying mandatory coverage of specific health services or types of providers. Under the provisions of the Employee Retirement Income Security Act of 1974, employers that self-insure are exempt from these state mandates and other forms of state regulation.

Problems are more serious for small firms. The current system of employer-provided health insurance does not serve their employees well. Because of the relatively high cost of insurance for small firms, less than half of companies with 10 or fewer employees offer health insurance to their workers. For firms offering insurance, medical underwriting—the assessment of insurability based on health status—by insurers is common. Consequently, many workers with costly health conditions or illnesses either cannot obtain or lose health insurance coverage because of preexisting condition exclusions.

Principal Findings

Limitations on Who Is Covered

Most medium- or large-sized firms continue to offer health benefits to their permanent, full-time employees. Some of these firms, however, have begun to offer less attractive health benefits to dependents. In part, this is because in two-earner families, the families gravitate to the better of the two employers' health plans. As a result, employers providing better plans shoulder a disproportionate share of the cost.

Health care benefits frequently are not provided to contingent workers. These are the estimated 30-37 million part-time, contract, temporary, or self-employed workers in the U. S. labor force. Contingent workers constitute one of the most rapidly growing segments of the labor force and form a major part of the working uninsured population.

Retirees' health insurance coverage is beginning to undergo change as firms respond to proposals to include the liability for retiree health on their balance sheets. Some firms have limited or eliminated retiree coverage while many others are contemplating making such changes.

Employees' Share of Costs Increasing

Many employers have attempted to control the health care component of employee compensation by requiring employees to contribute a larger share of the costs. More employers now require employee contributions to health insurance premiums, and the average required contribution is increasing more rapidly than the price of health care services. There has been, however, little change in the level of deductibles in health insurance plans, after adjusting for inflation, or in coinsurance rates. (See pp. 18-20.)

Self-Insurance on the Rise

Over the past decade, firms increasingly have self-insured, rather than purchase health insurance. Among large firms, the fraction self-insuring rose from about 20 percent in 1980 to about 65 percent in 1988. Under provisions of the Employee Retirement Income Security Act of 1974, self-insured employer plans are not subject to state insurance regulation. Consequently, self-insured firms not only gain control over use of their reserve funds, but can reduce costs by avoiding state-mandated benefits and state-imposed insurance premium taxes. The large proportion of plans not subject to state regulation limits the ability of states to deal with the changing health insurance environment. (See pp. 21-22.)

Controlling Utilization Through Managed Care

Most larger firms have attempted to reduce costs by adopting systems to control and coordinate employee use of health care services—and thereby lessen their use. These managed care options include health maintenance organizations or preferred provider plans, which restrict the range of health care providers from which the employee may receive insured services. Larger firms also have adopted such utilization management devices as mandatory second opinion programs. (See p. 23.)

Health Insurance a Severe Problem for Small Firms

Almost half of the working uninsured, or 3.9 million workers, are employed by a firm with fewer than 25 employees. More than half of firms with fewer than 10 employees and about one-fourth of firms with 10- 24 employees do not offer group health insurance to their workers.

Most employees of small firms are subject to medical underwriting. That is, insurers may deny coverage to individuals with specified preexisting medical conditions. The result is a growing number of workers with no health insurance or inadequate insurance that excludes conditions most likely to generate health expenditures for them. (See p. 29.)

Insurers also have begun to base insurance premiums on increasingly narrow risk pools. The broad-based rate determination mechanism called community rating has been replaced by rates based on narrow pools of people, often the employees of an individual firm. As small firms are confronted with rates that mirror their own claims experience, rather than community-wide averages, those with claims experience well above the average are charged premiums they cannot afford.

Recommendations

This report contains no recommendations.

Agency Comments

As no executive branch agency is directly responsible for the matters discussed in this report, we did not obtain comments from any agency.

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Abbreviations

BLS	Bureau of Labor Statistics
COBRA	Consolidated Omnibus Budget Reconciliation Act of 1985
ERISA	Employee Retirement Income Security Act of 1974
FASB	Financial Accounting Standards Board
GAO	General Accounting Office
GM	General Motors Corporation
HIAA	Health Insurance Association of America
HMO	health maintenance organization
IOM	Institute of Medicine
PPO	preferred provider organization
SBA	Small Business Administration

Introduction

Private sector employers have introduced a variety of cost-cutting measures to help stem the tide of growing health care costs and respond to a changing health insurance market. This restructuring of health care plans may exacerbate the well publicized problem of some 31.1 million uninsured.[1] It may also contribute to another problem that is receiving less attention—the underinsurance of many individuals, including those who have health insurance but not coverage for expensive conditions such as cancer, heart disease, or diabetes that existed before the effective date of the policy.

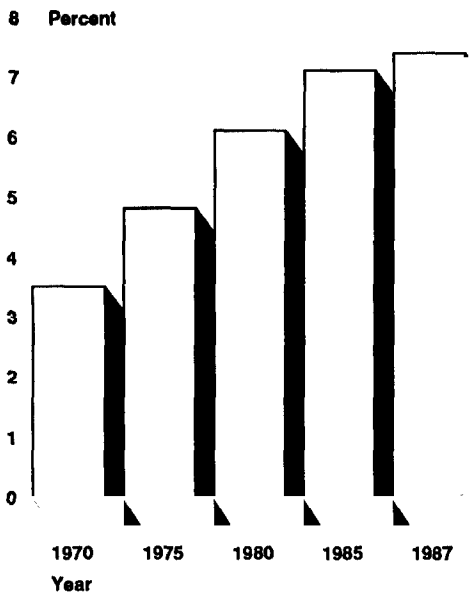
Concerned about these issues of employer-sponsored health insurance, the Chairmen of the House Committee on Energy and Commerce and its Subcommittee on Health and the Environment asked us to examine cost-cutting measures being adopted by the private sector. They requested an overview of current trends and an assessment, based on current data, of the potential effects of these measures on employees. They also asked us to assess the availability and affordability of health insurance for small employers.

Costs and Competition—Impetus for Private Sector Initiatives

Health care costs are the most rapidly growing component of employee compensation in the United States. As a percentage of wages and salaries, business health care costs more than doubled between 1970 and 1987 (see fig. 1.1). In 1987, employee health care costs paid by U.S. corporations were the equivalent of more than 94 percent of total after-tax corporate profits.

[1] Analysis of the Bureau of the Census's March 1988 Current Population Survey indicates that the nonaged uninsured level was 31.1 million or 14.7 percent of the population in 1987. See M. Moyer, "A Revised Look At The Number Of Uninsured Americans," Health Affairs, Vol. 8, No. 2, Summer 1989, pp. 102-110.

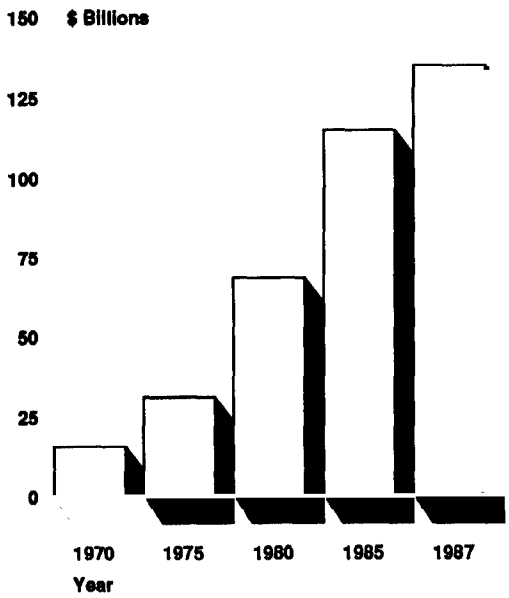
Figure 1.1: Business Health Expenditures as a Percentage of Wages and Salaries (1970-87)



Source: Health Care Financing Administration, Office of the Actuary

Health insurance premiums have increased rapidly for the last several years. Business health spending grew more than eight-fold in nominal terms between 1970 and 1987, from $15.3 billion to $134.6 billion. Between 1980 and 1987, it about doubled, from $68.1 billion to $134.6 billion (see fig. 1.2). In response, American business is looking more closely at a wide range of methods for stemming the impact of such costs on profits.

Figure 1.2: Business Health Expenditures (1970-87)



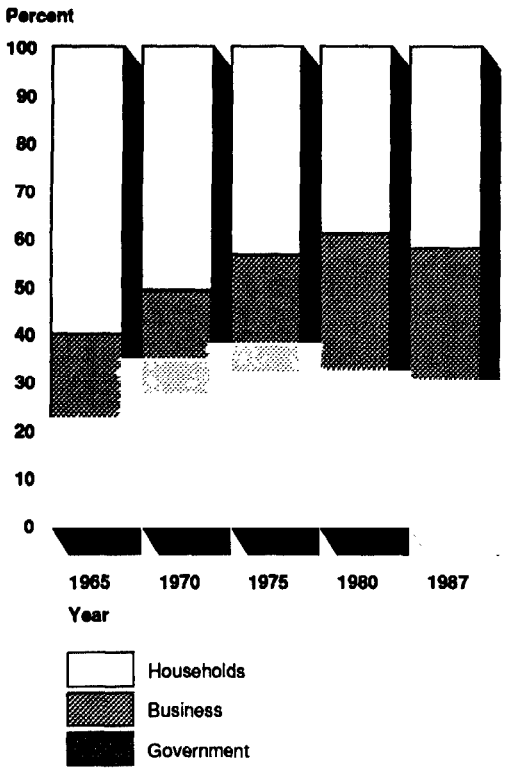
Source: Health Care Financing Administration, Office of the Actuary

Corporations, including the big three U.S. auto manufacturers, are further concerned about the effect of health care costs on their competitive position in world markets. U.S. corporations contend they are disadvantaged relative to firms that operate in countries having national health insurance or a tradition of lower levels of health care, and thus pay a substantially smaller share of their wage bill in health care costs.[2]

While the objective of private sector health initiatives is to reduce costs for the firms, these changes also affect other participants in the health care marketplace. Households' share of health care costs declined between 1965 and 1980, but began to rise in the 1980s (see fig. 1.3). The shares paid by business and especially government rose over the 1965-80 period but began to decline in the 1980s.

[2]Others respond that health costs should not be singled out any more than wages, a much larger part of total employee compensation, as the chief culprit. See U. Reinhardt, "Health Care Spending and American Competitiveness," Health Affairs, Vol. 8, No. 4, Winter 1989, pp. 5-21.

Figure 1.3: Distribution of Health Expenditures Among Households, Business, and Governments (1965-87)



Source: Health Care Financing Administration, Office of the Actuary

Objectives, Scope, and Methodology

The requesters expressed concern that corporate health care cost containment may be contributing to the nation's expanding uninsured population. They asked us to examine the broad range of effects stemming from health cost containment in the private sector. In accordance with their May 1989 request letter and subsequent discussions with their offices, we focused our review on the following issues:

1. Private sector cost-cutting initiatives that affect employee costs and access to health insurance,

2. Changes in the nature and structure of health benefit plans, and

3. Special problems facing employees of small firms.

To address these issues, we reviewed literature on employee health benefits; interviewed health benefit consultants, researchers, and insurers;

and conducted site visits at several large employers. These included General Motors, Ford, Chrysler, Rockwell International, New York Telephone Company, and Marriott Corporation. We also interviewed representatives of three unions—the United Auto Workers, the AFL-CIO, and the Service Employees International Union. Our work was done between May 1989 and March 1990 in accordance with generally accepted government auditing standards.

Larger Firms Cutting Health Expenditures by Limiting Who Is Covered, Shifting Costs

While most medium-size to large firms traditionally have provided a rich health benefit package to their workers, the continued rise in health care costs has caused a number of these firms to limit who is covered and the benefits provided. Firms with more than 100 employees still are offering health insurance to most employees, but more firms are attempting to shift additional costs to employees, other firms, or federal and state governments. Thus far, changes in employer-provided health coverage for larger firms have been modest. But many benefit consultants and health care analysts are concerned that these emerging trends will intensify if health care costs continue their rise or the economy enters a recession.

Employers Reviewing Who Is Covered

Employer health plans cover three main groups of people—employees, employees' spouse and dependents, and retirees and their dependents. Many firms are reducing or considering reducing coverage levels for each group. Health insurance benefits were a major factor in the majority of strikes and work stoppages in 1989. Also, many employers are screening job applicants for health status.

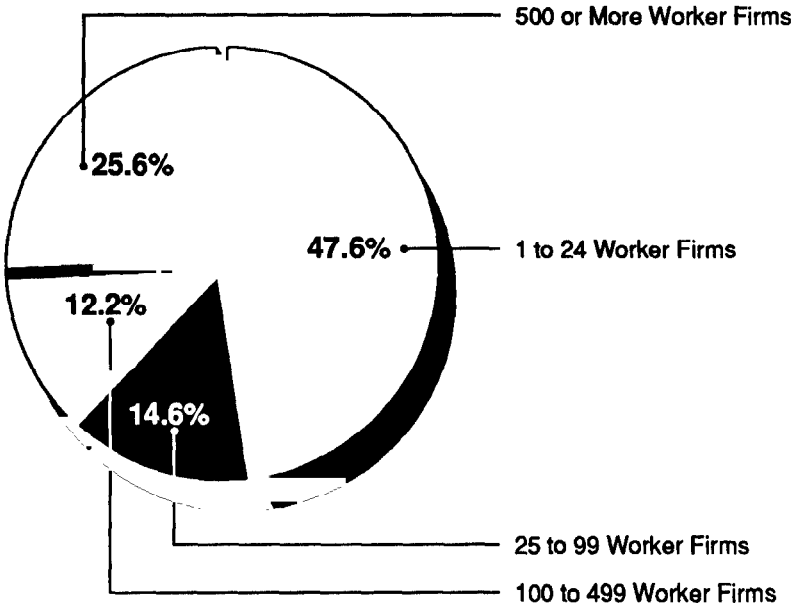
Medium-size and large firms, those with 100 or more employees, employed about two-thirds (65 percent) of the nation's 91 million nongovernment workers in 1986. About 38 percent of uninsured workers in 1984 worked for a medium-size or large firm. Thus, assuming these percentages are stable over time, such firms employ a disproportionately small share of the working uninsured, but a sizeable percentage nevertheless.

Some Employees of Large Firms Not Covered

Some employers are cutting their overall health care costs by limiting the number of workers who receive coverage. The working uninsured include workers in firms that do not offer insurance coverage at all and contingent (temporary, part-time, self-employed, and contract) workers in firms that restrict coverage to permanent, full-time workers. Furthermore, some workers, particularly lower-income workers in firms that do not pay the full costs of health coverage, elect not to participate in the plan because of the cost.

Even though almost all large firms offer health insurance plans, about 38 percent of the working uninsured, or about 3 million workers, work for a firm with 100 or more employees, as shown in figure 2.1.

Figure 2.1: The Working Uninsured, by Firm Size (1984)



Source: SBA

Some of these uninsured workers are in the few larger firms that offer no health benefits; others are in the contingent work force. Such workers are less likely than other workers to have health insurance coverage through their workplace. Between 1980 and 1989, the contingent work force grew at twice the rate of the remainder of the labor force. Each is less likely to receive employer-provided health insurance than are permanent, full-time workers. Some employers cited the lower total compensation, including the cost of health insurance and other benefits, as an important reason for hiring a contingent worker when possible.

Recently hired workers are another group of employees who may lack health insurance because of waiting periods following the beginning of employment. For example, General Motors Corporation (GM) offers a rich health insurance plan to its employees, but the coverage begins only after 7 months of employment. Over the last several years, GM health benefits representatives explained, the waiting period increased from 1-3 months to the current 7 months. The rationale is that GM expects that its new employees can exercise options to obtain coverage from

their previous employer until 7 months have passed with GM.[1] Such a policy may result in no employer-sponsored health insurance coverage for GM employees who are new entrants to the labor force or for those whose previous employer did not offer health insurance.

A 1988 Bureau of Labor Statistics survey showed that about 40 percent of large and medium-sized firms had no waiting time for participation in the company's health plan. Only about 5 percent had a waiting time of over 3 months.

Screening of Job Applicants' Health Status Common

Increasingly, individuals are denied insurance because of preexisting conditions or because they are at high risk for developing costly medical problems. Medical screening of job applicants is prevalent in many industries. In the early 1980s, about half of the nation's employers required job applicants to pass medical screening exams.[2] These are of two types:

- Diagnostic screening attempts to assess whether an individual is free of disease and capable of performing the job.
- Predictive screening attempts to assess whether an individual who is currently capable of performing the job is at risk of developing a medical impairment in the future.

Predictive screening, the newer type of exam, is likely to grow in importance for employee selection.[3] Advances in both diagnostic and predictive medical testing have increased health insurers' capability to identify those who have or are likely to develop costly health conditions. Increasingly, insurers are using this information to refuse to insure, or to exclude coverage for specific conditions for, individual employees. An example of this is the practice of firms attempting to limit or restrict coverage for employees either with or likely to develop

[1]For firms with 20 or more employees, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires that employers offering health insurance benefits offer certain employees separating from the firm (other than for gross misconduct) the option of continuing health coverage for up to 18 months. For employees electing this option, the premium will be no higher than 102 percent of the group rate, payable by the employee. The Omnibus Budget Reconciliation Act of 1989 extends the period for continuing group health insurance coverage for the disabled for an additional 12 months. During the added period, the premium will be no higher than 150 percent of the group rate, payable by the employee.

[2]Office of Technology Assessment, Medical Testing and Health Insurance, Summary, OTA-H-384, Aug. 1988.

[3]M. A. Rothstein, Medical Screening and the Employee Health Cost Crisis (Washington, D.C.: The Bureau of National Affairs, Inc., 1989).

AIDS. Future refinement and development of diagnostic and predictive tests may make private health insurance less available or more costly for many employees.

However, employment-based screening for health status is potentially subject to legal challenge under antidiscrimination laws. The Rehabilitation Act of 1973 prohibits discrimination on the basis of handicap under any program or activity either receiving federal financial assistance or conducted by a federal executive agency or by the U.S. Postal Service. In addition, states have enacted laws prohibiting handicap discrimination in private sector employment. Definitions and judicial interpretations of what constitutes a handicap under these laws vary by state.

Employers Paying Smaller Share of Family Coverage

Most large firms offer coverage for spouses and dependents of workers, though they are beginning to ask employees to contribute a larger share of premiums for dependent coverage. Between 1986 and 1988, among employers with required employee contributions the average annual employee contribution to family health insurance premiums rose from $435 to $605. This data came from surveys conducted by the Wyatt Company, a benefit consulting firm. Also, the percentage of employers requiring employee contributions for family coverage increased 20 percent over the same period.

Typically, employers contribute a greater share of the total insurance premium for individual than for family policies, according to a survey conducted in 1987 by the Health Insurance Association of America. On average, employers paid 95 percent of the individual premium, compared with 77 percent of the family plan. The average masks the fact that some firms provide little or no contribution to dependent coverage. For lower-income families, the high cost of family coverage can lead to decisions to forego dependent coverage.

One factor influencing changes in dependent coverage is the growing number of dual-worker families. Some firms contend that their richer benefit packages induce dual-worker families to obtain coverage for both their employee and the spouse and other dependents through their plan. Dual-worker families will select coverage from the firm offering the better benefit package, even if only slightly better in their view. Thus, the firm offering the better benefit package will get a disproportionate share of the costs of covering dependents. This puts them at a competitive disadvantage, they feel, relative to firms that either do not offer health benefits or offer poorer benefit coverage for dependents.

Coverage of Retirees Becoming a Major Employer Concern

Retiree health benefits constitute another area in which companies are seeking to control or avoid costs. In 1988, companies paid $9 billion for health care for about 7 million retirees and their dependents. Retiree health costs have become a major concern for employers for at least three reasons:

1. There are now more retirees as a result of economic and demographic trends—workers retire earlier and live longer.

2. Rising medical costs have pushed up the average cost per retiree.

3. A proposed change in accounting standards would require companies to compute and report on their financial statements the present value of their liabilities for future retiree health benefits. This would alter the present practice, in which companies account for costs of retiree health benefits on a pay-as-you-go basis. As of 1988, American corporations had significant total liabilities of about $227 billion for retiree health benefits.[4]

Some industries may be under more pressure than others to reduce retiree health costs because there is a disproportionate impact of rising retiree health costs for firms with an aging workforce. Because retirees and those nearing retirement age are not uniformly spread across the work force, some industries have been more heavily impacted than others. The domestic automakers, for example, contend that Japanese auto assembly facilities located in the United States enjoy considerable savings in health care costs because they have few retirees to cover and few older workers who raise the claims experience for the firm. Telephone companies that operated before deregulation cite a similar cost disadvantage as they compete with newer entrants in the industry.

Where retiree health benefits have not yet vested, companies may have latitude to modify such benefit plans, federal court decisions indicate. This includes requiring the retiree to pay more of plan costs.

Some companies are introducing changes in plan provisions that reduce coverage for retirees or continue to shift a portion of the cost of the coverage to them. Other companies simply do not offer retiree health insurance benefits. A recent survey by a benefit consulting firm indicated that about 1 percent of responding firms had dropped retiree

[4]Employee Benefits: Companies' Retiree Health Liabilities Large, Advance Funding Costly (GAO/HRD-89-51, June 1989).

health coverage and over 40 percent had changed retiree benefit provisions. The recently settled 9-month strike by the United Mine Workers against the Pittston Coal Company was in part caused by a company decision to cancel health and pension benefits for disabled and retired miners and their dependents.

Many companies are moving from a defined benefit to a defined dollar contribution plan for health benefits for retirees. Doing so allows a company to limit future liability to the amount of the defined dollar contribution rather than pay the open-ended amount required for defined benefits. Under a defined dollar contribution plan, a retiree assumes the financial risk for the difference between the employer contribution and the actual cost of health benefits. Under defined benefit, the employer is responsible for costs for all covered benefits.

Employers Try to Reduce Their Proportion of Health Costs

Employers are increasing the share of health insurance premiums paid by the employee and attempting to restructure health insurance plans to increase the employee-paid proportion of covered medical expenses. Such restructuring has included increases in employees' share of premiums and in deductibles[5] and coinsurance.[6]

More Employees Paying a Larger Share of Premium Costs

During the 1980s, an increased proportion of employees who chose coverage under company-sponsored health plans were required to contribute to the premiums and the premiums were higher. Between 1980 and 1988, fewer employers in medium-size and large firms[7] paid the full cost of the premium. For individual coverage plans, 55 percent of employees worked for firms that paid the full cost of coverage in 1988, compared with 74 percent in 1980. For those with family coverage plans, the rates fell from 54 to 37 percent.

Employee contributions to premiums also have risen. Between 1982 (the first year for which the Bureau of Labor Statistics [BLS] compiled data)

[5]A deductible is a specified amount (e.g., $100) that must be paid by an insured person for covered services during a given time period (usually a year) before the insurer assumes liability for additional costs of covered services.

[6]Coinsurance is a form of cost sharing under which a person covered by a health insurance plan is required to pay a fixed percentage (e.g., 20 percent) of the charges or costs for covered services received.

[7]BLS, Employee Benefits in Medium and Large Firms, 1988, Bulletin 2336, Aug. 1989. For the 1988 survey, BLS included firms of at least 100 employees in their sampling frame.

and 1988, the average monthly employee contribution for individual coverage rose from about $9 to about $18 a month. For family coverage, the average monthly employee contribution rose from about $27 to about $52 a month. This approximate doubling of employee contributions to premiums exceeded the 23-percent, economy-wide inflation that occurred between 1982 and 1988.

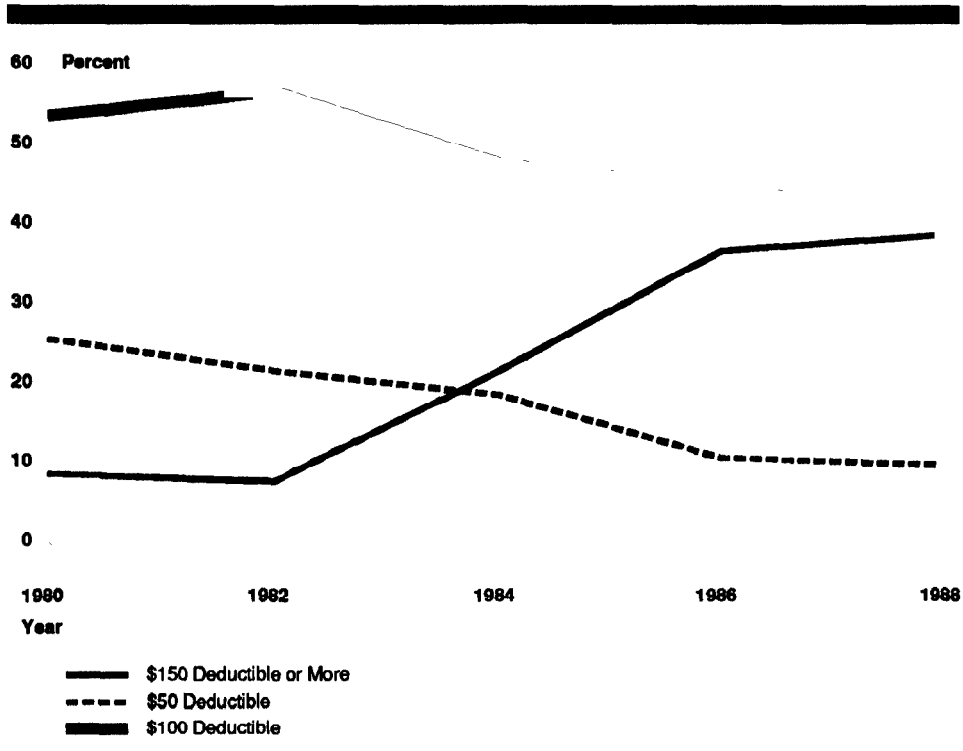
Deductible, Coinsurance Rate Changes Modest

Several major studies have shown that increased consumer cost-sharing can reduce health expenditures.[8] Deductibles and coinsurance can reduce a firm's health costs by giving the employee a financial incentive to use fewer services and by reducing the firm's costs at any given level of use. But overall, between 1980 and 1988 private sector initiatives to increase either deductibles or coinsurance appear to have been modest. Further, maximum out-of-pocket provisions limited the applicability of deductibles or coinsurance whenever such limits were exceeded.

Throughout the period 1980-88, a $100 deductible has remained the most prevalent level of deductible for employer-sponsored individual health insurance plans, as shown in figure 2.2. However, between 1980 and 1988 the percentage of participants with a deductible of $150 or more (typically $150 or $200) rose from fewer than 10 percent to about 40 percent.

[8]See A Primer On Competitive Strategies For Containing Health Care Costs (GAO/HRD-82-92, Sept. 24, 1982) and W.G. Manning, et al., "Health Insurance and the Demand for Medical Care: Evidence from a Randomized Experiment," The American Economic Review, Vol. 77, No. 3 (June 1987), pp. 251-277.

Figure 2.2: Trends in Deductible Amounts in Medical Plans With Deductible in Medium-Size and Large Firms (1980-88)



Source: BLS

Cost-sharing provisions of employer-sponsored major medical plans[9] increased slightly between 1981 and 1985,[10] according to a study of inflation-adjusted changes in deductibles based on BLS data. Between 1981 and 1985, the inflation-adjusted average individual deductible rose by about $15, the family deductible about $36.

The coinsurance rate has remained relatively constant during the 1980s. Employees of medium-size and large firms who participated in the company-sponsored health insurance plan usually were required to pay a 20-percent coinsurance rate. Over this period, an increasing proportion of these workers were in plans requiring no coinsurance after the individual paid out a specified dollar amount for covered expenses. In 1980, about 50 percent were covered by such maximum out-of-pocket provisions; in 1988 about 80 percent were covered.

[9]Major medical insurance is designed to offset the heavy medical expenses resulting from illness or injury.

[10]G. Jensen, et al., "Cost Sharing and the Changing Pattern of Employer-sponsored Health Benefits," The Milbank Quarterly, Vol. 65, No. 4, 1987.

Larger Firms Changing Health Coverage, Management of Services

Firms are using two management approaches to obtain greater control over their health insurance costs: self-insurance and utilization control mechanisms that limit employees' use of insured medical services.

Rather than purchase health insurance from commercial health insurance companies, the majority of firms with more than 1,000 employees now self-insure. Firms that do so are not subject to state-mandated benefits, which require insurers to cover specific services, types of providers, or groups of individuals. To limit employees' utilization of services, larger firms use health maintenance organizations (HMOs) or other mechanisms to review such utilization. These measures give the employer greater potential control over costs by limiting the health care choices available to the employee.

Self-Insuring Avoids State Regulation, Limits Costs

Rather than purchase health insurance to protect themselves and their worker against health costs, most large firms accept the risks themselves and rely on the insurance industry for administrative services. Many self-insuring companies purchase insurance to limit their loss in the event of catastrophic claims. Such policies are called reinsurance or stop-loss policies.[1]

About 50 percent of firms responding to a 1987 benefit consulting firm survey were self-insured. Among companies that employed 1,000 or more people, 65 percent self-insured.[2] Surveys by another benefit consulting firm indicate that the level of self-insurance rose from about 20 percent in 1980 to about 66 percent in 1988.

States regulate the insurance industry in an effort to assure that insurers are financially solvent, consumers are protected, and minimum standards of coverage are met. To help assure minimum coverage, many states mandate certain benefits. Mandated benefits include requirements for health insurance to cover specific services, specific types of providers, or certain populations, such as persons who have recently lost their employer-sponsored group health plan. States variously compel insurers to provide coverage for services ranging from acupuncture to in vitro fertilization and for conditions ranging from AIDS to drug abuse.

[1] About 50 percent of self-funded health plans operated with a stop loss, according to a 1988 survey by a health benefit consulting firm.

[2] Some small companies also self-insure, even though they have less predictability of claims and less ability to spread risk. The Society of Professional Benefit Administrators, which represents independent third-party administrators, reports a growing trend to self-insure among firms of under 100 employees.

Although all 50 states have some form of state mandates, the mandated benefits vary across the states.[3]

With certain exceptions, regulation and taxation of the health insurance industry is a state prerogative.[4] However, the Employee Retirement Income Security Act of 1974 (ERISA) has been interpreted by federal courts as preempting the application of state insurance laws and regulations to self-insured health plans. Consequently, state-mandated benefits are not applicable to employers that self-insure. As most large employers self-insure, they are exempt from state-mandated benefits and state regulation. Under ERISA, most group insurance plans are subject to the federal reporting and disclosure requirements of the law.[5]

Self-insured firms not only avoid state regulation, including mandated benefits, they also gain control over insurance reserves. As a consequence, the self-insured firm, rather than an insurance company, receives use of such funds and can generate interest income from them. Such firms also avoid any state-imposed taxes on insurance premiums and state-imposed contributions to state risk pools.

The move to self-insurance may make it more difficult to use state risk pools for the uninsurable, thus hampering state efforts to deal with insurance gaps. Several states have established state-administered health insurance risk pool programs to provide insurance to individuals who cannot obtain it because of their health condition.[6] Such programs require a subsidy. Many states with risk pools have enacted legislation assessing risk pool deficits against health insurers doing business in the state. Under ERISA, however, self-insured businesses cannot be required to contribute to such pools. Thus, the deficit must be spread among a smaller premium volume, raising costs for commercial insurers and their customers. These increased costs further encourage firms to self-insure.

[3]The Blue Cross and Blue Shield Association tracks the number and type of state-mandated benefits. By 1989, over 700 mandated benefits had been enacted in the various states over a 20-year period.

[4]In 1945, the Congress enacted the McCarran-Ferguson Act of 1945, which reaffirmed and continued the traditional power of the states to preempt the application to the insurance industry of federal laws not specifically dealing with insurance.

[5]The reporting requirements of the law provide for a summary plan description to be filled with the Department of Labor and an annual financial report to be submitted to the Internal Revenue Service. Most plans covering fewer than 100 participants are not required to file either of these reports. The disclosure portion of the law requires that plan participants be given a summary plan description and, if the plan is subject to annual financial reporting, a summary annual report.

[6]Health Insurance: Risk Pools for the Medically Uninsurable (GAO/HRD-88-66BR, Apr. 1988).

Firms Limit Some High-Cost Services, Expand Others

Some firms or their insurers are attempting to constrain rising health care costs by reducing or eliminating coverage for preexisting conditions or some specified types of health care or medical conditions. Among the latter are expensive, long-term medical problems such as substance abuse or mental conditions. Other components of employee health plans are also targets.

On the other hand, benefit consultants indicate that firms in particularly competitive labor markets are adding or expanding insurance coverage in these areas to attract and maintain their labor force. Other firms offer "cafeteria plans" to their employees. These give the employee the option of selecting benefits, including health insurance, from a list of potential benefits.

Limiting Utilization Through Managed Care and Utilization Review

In contrast with attempts to limit who or what is covered or increase employees' share of costs, many employers attempt to reduce costs without changing coverage by limiting utilization of health services. To achieve this, they encourage their employees to enroll in managed care programs[7] and they adopt utilization review programs.

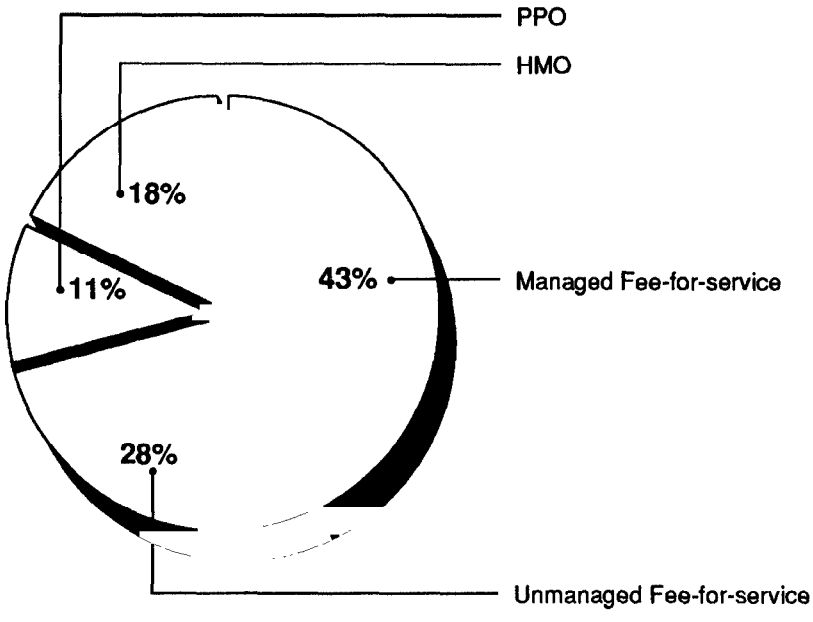
Employers Using Managed Care

Managed care, any of several organized health care delivery systems that controls and coordinates patients' use of services, increased substantially during the 1980s. It is offered by HMOs or preferred provider organizations (PPOs), or through managed fee-for-service providers.[8] Overall, more than 70 percent of workers with employer-sponsored health coverage were enrolled in a managed care plan in 1988, according to a Health Insurance Association of America (HIAA) survey. About 18 percent were enrolled in an HMO, 11 percent in a PPO, and 43 percent in a managed fee-for-service plan, as shown in figure 3.1.

[7]Companies have used lower deductibles and coinsurance rates to encourage employees to participate in HMO options. No or low coinsurance and deductibles for HMO participants are common among firms that are raising deductibles and coinsurance in fee-for-service plans.

[8]An HMO is a health insurer that directly provides or arranges for medical care for its members in return for a fixed per capita payment that is independent of the member's actual use of services. A PPO is an insurer that arranges for the provision of health services through a set of providers (hospital and physicians) that have contracted with fixed, usually reduced rates or fees. The contracting providers have agreed to be subject to utilization controls. Individuals who are insured by the PPO have a financial incentive to obtain their care from the contracting providers. A managed fee-for-service insurance plan pays providers a fee for each service provided, but includes provisions for prospective utilization review of these services. The purpose of such reviews may be to reduce either the number of hospital days or the costs for ambulatory services.

Figure 3.1: Enrollment in Managed and Unmanaged Employer-Sponsored Health Plans (1988)



Source: HIAA

Several employers and benefit consultants identified managed care as one of the key health benefit changes in recent years. Their expectation is not so much that health care costs will fall as a result of its adoption but that employers will gain greater control over increases in costs by changing behavioral patterns of providers and consumers through changed economic incentives.

Utilization Management Widely Used

Companies have adopted several techniques to assess, on a case-by-case basis, the appropriateness of care prior to its provision. Collectively, this set of techniques is called utilization management. The Institute of Medicine (IOM) has found that, while there is no single or common definition of utilization management, the dominant utilization management strategy relies on prior review of proposed medical services. A second strategy is management of high-cost cases.[9]

[9]Institute of Medicine, Controlling Costs and Changing Patient Care? The Role of Utilization Management (Washington, D.C.: National Academy Press, 1989).

Utilization management techniques for prior review include mandatory second opinion programs and preadmission review.[10] Mandatory second opinion is a requirement that participants consult another physician after one has recommended nonemergency or elective surgery. Under preadmission review, the insurer reviews the appropriateness of hospital admission. Surveys conducted by a private benefit consulting firm and by the HIAA indicate that over 60 percent of employer-sponsored plans in the United States had preadmission review requirements in 1988.

For some purchasers, utilization management has reduced inpatient use and limited inpatient costs, the IOM study concludes. Beyond that, however, results are less clear. Increased spending for program administration and to cover services moved from an inpatient to an outpatient setting have at least partially offset inpatient savings. The study also points out that, at least until very recently, the site, duration, and timing of medical care have been the primary focus of utilization management, rather than whether a particular service is needed at all.

[10]Admission review also may be required within 24 to 72 hours to assess the appropriateness of the hospital admission for emergency or urgent hospital admissions. Continued-stay review attempts to assess the appropriate length of hospital stay for both urgent and nonurgent admissions. Discharge planning assists the patient by identifying and arranging for care after hospital discharge, thereby facilitating discharge.

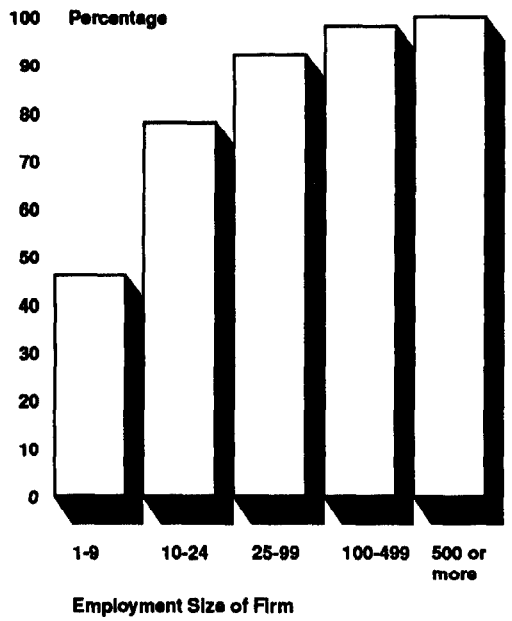
Availability and Affordability Major Problems for Small Businesses

While there are increasing restrictions in coverage offered by large firms, availability and affordability of health insurance is a much greater problem for many small firms and their employees. Small firms are having an increasingly difficult time offering health insurance that meets their employees' needs. This is partly the result of changes in the insurance market, especially competition among insurers to insure only healthy people and insurers' use of strict underwriting standards. Such standards can lead to the exclusion not only of particular preexisting medical conditions or individuals, but also of entire firms, or high-risk industries.

Fewer Than Half of Small Firms Offer Health Benefits

The smaller the firm, the less likely it is to offer health insurance. In 1984, only 46 percent of businesses with fewer than 10 employees offered health coverage, a Small Business Administration (SBA) survey showed (see fig. 4.1). In contrast, almost all businesses with 100 or more employees offered health insurance. Almost half of the working uninsured are employed by businesses with fewer than 25 employees. Of the 8.2 million uninsured private wage and salary workers in 1984, 3.9 million were employed by firms with fewer than 25 employees.

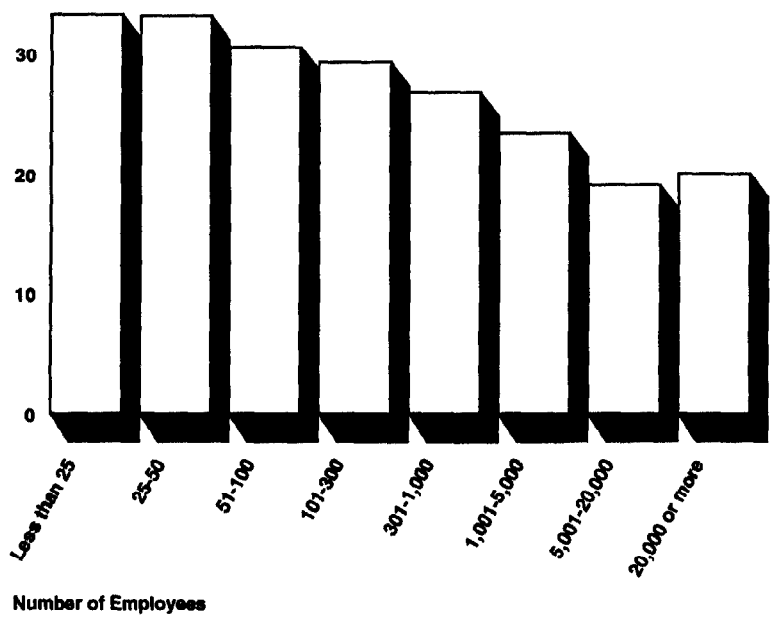
Figure 4.1: Percentage of Firms That Offer Health Benefits, by Firm Size (1985)



Source: SBA

The major reasons small employers give for not offering health insurance are cost and insufficient profits. For comparable plans and benefits, health plan costs are 10 to 40 percent higher for small employers, according to a study funded by the SBA.[1] Not only were sales and administrative costs higher for small firms, such employers pose greater risks for insurers because of employee turnover and adverse selection (that is, higher-risk individuals joining the firm). Also, small firms are less able to adopt health care cost containment techniques. The rate of increase in premiums has been higher for small firms, as indicated in figure 4.2.

Figure 4.2: Rate of Increase in Premiums, by Firm Size (1988)



Source: National Association of Manufacturers

Small Business Health Insurance Market Eroding

In large part, problems with the cost and availability of health insurance for small businesses reflect the nature of this market. A confluence of four factors is leading to erosion of the market:

[1]ICF Incorporated, Health Care Coverage and Costs in Small and Large Businesses, prepared for SBA, Office of Advocacy (Washington, D.C.: Apr. 15, 1987).

- Inability of small employers to spread risks of substantial health care costs over a large number of employees,
- Decline in the availability of health insurance products with community-rated premiums,
- Use of restrictive medical underwriting practices by insurers as they compete for the best risks, and
- Rapid turnover of firms insured by an insurance company.

Community Rating Down, Experience Rating Up

Intensified price competition in the insurance industry in the 1980s has led to a decline in the availability of community-rated health insurance products. Under community rating, health insurance premiums are based on the average cost of actual or anticipated health care by all subscribers in a particular geographic area or industry. The premiums do not vary for subscribers within these broad groupings. When community-rated health insurance was widely available, a small firm could obtain insurance with a premium that was not adjusted for such factors as its own claims or the health status of individual workers, age, or occupation. But now, few Blue Cross and Blue Shield plans continue to offer community-rated health insurance plans.

Experience-rated health insurance has displaced community-rated health insurance through the operation of a competitive market. Over time, commercial insurers were able to select from the community pool firms that were better risks and to offer them lower rates based on their individual experience. As the pool shrunk and rates rose for firms remaining in it, commercial insurance companies continued to siphon off remaining firms with the lowest expected health costs. The ability to spread risk in the pool diminished, and community-rated insurance products became less available. This shrinkage of the risk pool has adversely affected small firms whose employees have higher-than-average expected medical costs.

Small Firms Less Able to Pool Risks

The smaller the firm, the more difficult it is to pool risks through insurance, in which the losses of a few are shared among many. Covered individuals (or their employers) make regular payments into an insurance fund from which payments can be made. In a sizable population, it is probable that relatively few people will incur substantial health care costs. In contrast, when insurance premiums are based on the experience of one small company, even a single employee with high health expenses can cause it to be adversely affected.

Restrictive Medical Underwriting Prevalent

Some insurers are attempting to move costly industries, firms, or individuals out of their risk pool through restrictive medical underwriting. In insurance, underwriting is the process of selecting, classifying, evaluating, and assuming risks according to their insurability. Medical underwriting thus refers to a process for assessing the medical condition and expected health care costs of those to be insured. This assessment often results in the exclusion of employees from coverage if they have preexisting conditions such as cancer, diabetes, heart disease, or other high-cost illnesses. In some cases, such individuals may be denied any coverage; in others only the specific preexisting condition is excluded. This underwriting also may limit the coverage available to spouses and dependents of the employee. Similar problems occur for workers who are changing jobs or who have recently lost their job.

Policies are written for a set time. At the end of that term, some insurance companies may subject covered individuals to medical underwriting criteria. This practice, known as "renewal underwriting," can result in exclusion of coverage for any person who has developed an expensive medical condition while he or she is insured.

Not all firms that would like to offer health insurance have the option to do so. Small companies in entire industries sometimes are excluded from coverage by insurers. While the list of excluded industries varies by insurer, there is considerable overlap (See table 4.1). Among the many types of businesses that various insurers exclude are logging, mining, or roofing companies, taverns, hair stylists, and medical offices.

Table 4.1: Examples of Industries Ineligible for Health Insurance Under Selected Insurer Plans

Amusement parks	Hotels/motels
Aviation	Insurance agencies
Auto dealers	Janitorial services
Barber and beauty shops	Junkyards/refuse collection
Bars and taverns	Law firms
Car washes	Liquor stores
Commercial fishing	Logging or mining operations
Construction	Moving companies
Convenience stores	Parking lots
Domestic help	Physicians' practices
Entertainment/athletic groups	Restaurants
Exterminators	Roofing companies
Foundries	Security guard firms
Grocery stores	Trucking firms
Hospitals and nursing homes	

Source: American Hospital Association, Promoting Health Insurance in the Workplace: State and Local Initiatives to Increase Private Coverage (Chicago: 1988) and interviews with insurance companies.

Some insurers do not cover a number of industries where the risk of illness or injury appears to be greater than average, such as logging or roofing. With high-risk occupations, the concern is not only with health care costs but also the legal expense of determining whether workers' compensation or health insurance is to be the primary payer. For instance, some insurers do not cover

- physicians or lawyers because they believe it is too expensive to deal with fraud, abuse, and litigation for small firms in these areas;
- entertainment or sports industries because of the high risk of drug abuse treatment costs; and
- barbers, beauticians, and decorators because of concerns with the higher potential costs of AIDS and sexually transmitted diseases.

In some instances, a firm may find that while excluded by one insurer, another is willing to write an insurance policy. Even so, insurance exclusion practices may increase the employer's effort necessary to find an insurer or otherwise increase the cost of insurance, thereby reducing the likelihood of coverage.

Rapid Turnover of Firms

About 30 percent of insured firms leave their insurance companies each year. Some firms fail and go out of business. But insurers told us that

one of the major contributors to this turnover is durational rating or the "wear off of underwriting." Because of medical underwriting and preexisting conditions exclusions, first-year costs for a small business insurance policy usually are considerably lower than the costs for subsequent years. In the second and subsequent years, some preexisting condition exclusions expire and the covered population begins to develop new conditions leading to higher costs and higher premiums. In the face of higher premiums, many small businesses seek a new insurer who will offer them a lower first-year rate.

For employees with a serious illness or a pregnancy, coverage problems may arise when their employer changes insurers. The employees may find these conditions excluded from coverage under the new insurance company, even though the condition would have been covered under the lapsing insurance contract.

Conclusions

Employer-provided health insurance is eroding in the United States. Rapidly rising health care costs have impacted both insurers and employers. Competition among insurers has encouraged the use of practices that exclude some employees with potentially expensive health care costs. Competition among employers has caused some to eliminate or reduce health benefits for employees, dependents, or retirees.

For both large and small firms, the concept of insurance has changed. About 65 percent of large firms are self-insured and thus no longer subject to state insurance regulation. This allows them to avoid state-mandated health benefits. For the small firm desiring to provide health benefits for its workers, health insurance is increasingly unavailable or unaffordable.

In the United States, with its extensive reliance on employer-provided health insurance, workers' access to such health insurance is shaped largely by their place of employment. While there has been some erosion of health benefits, full-time employees of large firms generally have access to comprehensive health insurance coverage. However, even when employed by large firms, part-time and part-year workers often are excluded from employer-sponsored health insurance plans.

The access to adequate health insurance coverage is a more severe problem for employees of small firms. Even full-time permanent workers often are denied access to employer-sponsored health insurance, as insurance companies compete to serve the best risks. The problems are compounded for individual workers with potentially costly medical conditions such as diabetes or AIDS, which lead to preexisting condition exclusions, loss of coverage through renewal underwriting, and potential limitations on labor force mobility because of employee screening. State-mandated benefits and state premium taxes fall primarily on the smaller firms, which are unable to self-insure.

Major Contributors to This Report

Human Resources Division, Washington, D.C.

Janet L. Shikles, Director, Health Financing and Policy Issues
(202) 275-5451
Sheila M. Smythe, Chief Health Policy Advisor
Michael Gutowski, Assistant Director
James R. Cantwell, Senior Health Economist

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