Employee Health Benefit Plans
A Decade of Change

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Employer-based health insurance plans are the principal source of health insurance in the United States. In 1989, two-thirds of the population under age 65—including both workers and their dependents—were insured by an employer-based health insurance plan. Employer plans cover nearly three-quarters of all workers and 81% of full-time employed workers. In 1989, about one-half of all workers (56%) were covered under their own employer plan; other workers with employer coverage (17% of all workers) were covered only as dependents of other workers' plans (Table 1).

Despite the high rate of employer coverage among workers and their families, the number of workers covered by employer plans eroded over the last decade. While joblessness declined over the decade as the economy recovered from the 1982-84 recession, new jobs were apparently less likely to include health insurance as an employee benefit. As a result, growth in employer-covered workers fell behind growth in employment nationwide, and the number of workers without employer-sponsored coverage climbed. In 1990, 27% of all workers (including 19% of full-time employed workers) reported no coverage from an employer plan. More than one-half of these workers (15% of all workers) reported having no coverage from any source whatever.

Health insurance is an expensive employee benefit. In 1989, private employers spent more for health insurance benefits than any other single employee benefit: an estimated $173 billion. Spending for health insurance benefits equaled nearly one-half of employer spending for all employee benefits (including Social Security and other required benefits, as well as voluntary pension, disability, and life insurance benefits), and more than 8% of wages and salaries. Among the 56% of workers who actually receive health insurance as an employee benefit, the value of their health insurance plan as a share of compensation may average more than 12% of wages and salaries.

Growth in the aggregate cost of health insurance as an employee benefit has slightly exceeded the growth of health care costs nationwide since 1965, despite erosion in the proportion of covered workers since 1980 and ongoing efforts by employers and insurers to control the cost of their plans (Figure 1). While the acceleration of employer spending during the 1970s and early 1980s began to abate in 1985 (generally following the path of health care spending nationally), employer spending as a share of total spending for health care nevertheless continues to rise. In 1989, private business spending for health care via insured and self-insured plans accounted for nearly 30% of national spending for health care services and supplies (Figure 2).

Major Health Insurance Coverages

Survey data from the Bureau of Labor Statistics indicate that the health insurance plans offered by large employers in the U.S. uniformly include coverage for some services, but may vary substantially in their coverage of others. Among covered workers in establishments with 100 or more full-time permanent employees, the set of universally covered services in large employer group health plans includes hospital room and board, inpatient and outpatient surgical expenses, inpatient mental health care and outpatient testing and X-ray services.

Table 1

Number and Percentage of Workers Aged 18-64 with Health Insurance from Selected Sources in 1989, by Worker Status

<table>
<thead>
<tr>
<th>Source of coverage</th>
<th>All workers (in millions)</th>
<th>Full-time workers* (percent of workers)</th>
<th>Other workers (percent of workers)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>123.0</td>
<td>84.1</td>
<td>38.9</td>
</tr>
<tr>
<td>Have private health insurance</td>
<td>100.7</td>
<td>73.6</td>
<td>27.1</td>
</tr>
<tr>
<td>Employer-sponsored plan</td>
<td>89.6</td>
<td>67.9</td>
<td>21.7</td>
</tr>
<tr>
<td>Own coverage</td>
<td>68.8</td>
<td>59.3</td>
<td>9.5</td>
</tr>
<tr>
<td>Dependents' coverage</td>
<td>20.7</td>
<td>8.6</td>
<td>12.1</td>
</tr>
<tr>
<td>Other private insurance</td>
<td>11.1</td>
<td>5.7</td>
<td>5.4</td>
</tr>
<tr>
<td>Have Medicare, Medicaid or other</td>
<td>6.5</td>
<td>2.9</td>
<td>3.6</td>
</tr>
<tr>
<td>public coverage</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have no health insurance from any</td>
<td>18.8</td>
<td>9.4</td>
<td>9.4</td>
</tr>
<tr>
<td>source</td>
<td></td>
<td></td>
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Note: Numbers and percentages may not add to totals due to coverage from more than one source during the year.

a. Employed at least 35 weeks during the year and 35 hours or more in a typical week, and reported no unemployment during 1989.
Although the depth of coverage for these services may vary (especially with respect to mental health care), all plan participants in U.S. establishments with 100 employees or more report at least some coverage for these services.

The set of least common coverages includes all preventive services (vision care, well-baby care, physical exams, immunizations, and hearing care) and at least some types of specialty pediatric care (for example, coverage for orthoptic care). "Core" benefits (those enjoyed by at least 90% of workers in large group plans) include all of the universal benefits plus coverage for mental health and substance abuse, physician office visits for acute care and prescription drugs.5

The changes in service coverage in large-employer plans over the last decade variously reflect compliance with the growing volume of state insurance regulations that mandate particular benefit coverages in insured plans, employer and insurer efforts to control plan costs, and, occasionally, simple improvements in coverage. At least three areas showed significant expansion during the last decade:

**Mental health benefits.** Between 1980 and 1989, large-group coverage for mental health benefits increased substantially, especially in outpatient settings. In 1980, 93% of covered workers in large employer plans had at least some coverage for outpatient mental health care. By 1985, this proportion had risen to 97%; and by 1989, this coverage (as well as inpatient mental health care) was universal among workers in very large group medical plans, although still less than universal among workers in medium-sized or small plans.*

Casual examination of state legislation affecting insured benefits during those years, however, suggests that at least some of this expansion may have been induced by growing state regulation. Between 1980 and 1989, 21 states legislated some provision requiring insured health plans to include mental health coverage either as a required or as an optional benefit.†

At the same time employer plans were generally expanding coverage to include outpatient mental health benefits as well as inpatient care. However, large-group plans increasingly placed internal limits on the use of this care. In 1980, 44% of participants in large group plans that covered inpatient mental health care limited days and/or dollars of covered care separately from the limits that applied to other illnesses.1 By 1989, 88% had internal limits on inpatient mental health care. Similarly, the proportion of participants with internal limits on outpatient care (among those with coverage for these services) grew from 89% in 1990 to 97% in 1989.

**Extended care.** Employer coverage of services provided in an extended care facility also improved markedly, presumably as a measure to reduce patient lengths of stay in acute hospitals. While only about one-half of large employer group plans covered extended-care facility services in 1979, 64% covered such care in 1984 (Frumkin, 1990). By 1989, 80% (weighted by plan participation) covered such services.2

Similarly, home health care coverage in large employer group plans apparently improved over the decade—from 19% (unweighted) in 1979 to 75% (weighted) in 1989. However, 1 of the 18 states that require coverage or optional coverage of home health care services legislated that provision since 1979.3

**Dental benefits.** Perhaps most clearly representing a simple improvement in employee benefit packages among at least some employers, dental benefits grew significantly as an employee benefit over the last decade. In 1980, just over one-half of workers in large group plans (56%) had dental coverage provided by their employer. By 1986, 71% participated in an employer-sponsored dental plan.*

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* In 1989, 89% of covered workers in establishments with 100 or more employees had coverage for outpatient mental health care.
† To date 28 states have such requirements in law.
* Based on a larger sample that includes smaller establishment sizes (establishments with 100 to 250 workers as well as those of 250 or more), dental coverage appears to be less prevalent nationally than in very large establishments. In 1989, 66% of health plan participants in establishments of 100 or more reported employer-provided coverage for dental care.5 In establishments with fewer than 100 workers, only 30% of covered workers reported dental coverage in 1990.6
Cost-sharing and Limits on Coverage

Changes in employee premium-sharing required by large employer plans during the 1980s are perhaps the clearest manifestation of employers' ongoing concern about plan cost. Since 1980, large employers have increased employee contributions for coverage significantly, shifting to employees at least some of the decade-long growth in health plan costs. In 1980, only 28% of covered workers in establishments of 250 or more were required to contribute for their own coverage; just less than one-half were required to contribute for dependents' coverage (Table 2). By 1989, one-third (34%) contributed for employee coverage and two-thirds (66%) contributed for dependents' coverage.

Table 2
Percent of Workers in Large-Group Health Insurance Plans That Require Premium-Sharing, Selected Years 1980-1989

<table>
<thead>
<tr>
<th>Year</th>
<th>Employee coverage</th>
<th>Family coverage</th>
</tr>
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<tbody>
<tr>
<td>1989a</td>
<td>34</td>
<td>66</td>
</tr>
<tr>
<td>1988b</td>
<td>49</td>
<td>68</td>
</tr>
<tr>
<td>1986</td>
<td>46</td>
<td>65</td>
</tr>
<tr>
<td>1985</td>
<td>35</td>
<td>53</td>
</tr>
<tr>
<td>1983</td>
<td>31</td>
<td>50</td>
</tr>
<tr>
<td>1980</td>
<td>28</td>
<td>49</td>
</tr>
</tbody>
</table>


In contrast, other changes in large employer-plan cost-sharing provisions over the decade served to raise the value of employer coverage for workers (Table 3). While the proportion of workers with plan deductibles of $100 or less dropped significantly (from 79% in 1983 to 45% in 1989), plan deductibles nevertheless remain quite low for most workers. In 1989, only 16% of covered workers in establishments of 100 or more workers have a plan deductible that exceeds $200.

Furthermore, for most workers, out-of-pocket limits on coverage remain relatively low. In 1989, 61% of covered workers in establishments with 100 or more workers were in plans that limited participants' out-of-pocket expenses for covered services at less than $1,500 per year. At the other extreme, however, 17% were in plans that placed no limit on participants' out-of-pocket costs for covered services.

Limits on covered workers' lifetime limits on coverage actually improved over the decade, perhaps reflecting workers' increasing concerns about catastrophic health care costs. The proportion of covered workers in large-group plans with plan limits of less than $500,000 dropped from 59% in 1983 to 29% in 1989, while the proportion with a limit of at least $1,000,000 rose from 30% to 63%.

Provider Relationships, Insurance Status, and Flexible Benefits

Among the most notable changes in employer-provided health insurance benefits over the last decade have been changes in how employer plans interact with providers, the growing use of self-insured health plans, and, to a lesser extent, use of flexible benefit plans. In each case, cost-containment is the likely motivation behind the changes that have occurred.
influenced employers decisions to convert to a self-insured plan, one often-mentioned reason has been the persistent growth of state-mandated benefits and their cost implications for insured employer plans.

The growth of flexible benefit (or cafeteria) plans is worthy of mention. At the start of the decade, many analysts considered flexible benefit plans (then recently authorized by Section 125) to be a model for controlling the employer cost of health insurance benefits, and of health insurance benefits in particular. While participation in flexible benefit plans has grown quite fast, the number of large-group workers that participate in such a plan is still relatively low: 9% in 1989. Nevertheless, the rate of growth in flexible benefit plan participation over the decade suggests that this area continues to be of considerable interest to employers seeking to control benefits costs and still serve the demands of a diverse work force.

Finally, the use of reimbursement accounts over the last decade (a vehicle also authorized by Section 125) has also grown quickly. In 1989, 23% of covered workers in large establishments had access to a reimbursement account. Of these workers, 40% were able to use the reimbursement account to pay employee premiums for coverage; 79% were able to use the account to pay cost-sharing on covered services or to pay for care not covered by the plan.3

Concluding Remarks

Employee group health insurance plans have changed markedly over the last decade. Many of these changes reflect employers’ ongoing concerns about the cost of health insurance. However, some reflect employees’ growing concern about the adequacy of their benefits as health care costs soar beyond the reach of middle-income families.

The next decade is likely to be a period of equal or even accelerated change in employer-sponsored health insurance plans. The potential for federal action requiring employers to offer health insurance benefits, and defining the content of qualified health insurance plans, could force significant changes in existing employer plans—including greatly increased coverage of preventive care services. At this writing, 10 states have already legislated the minimum content of health insurance plans available to small employers without plans already in place.

Changes in the way federal and state programs pay providers will also have repercussions for employer-based health plans. The advent of Medicare’s Prospective Payment System (PPS) for paying hospitals changed hospital practices dramatically, reducing hospitalizations and lengths of stay not only for Medicare patients, but also for privately insured patients. Medicare’s impending revision of payments to physicians (using a Resource-Based Relative Value Scale, or RBRVS) may also affect employers who sponsor health plans, although not necessarily favorably if increased cost-shifting results.

These kinds of policies emanating from federal and state government present major challenges to employers and health plan administrators to adjust and thrive. Continued growth in the national cost of health care, however, remains the single greatest challenge to the survival of private health insurance in the coming decade.

REFERENCES