Trends in employer-provided health care benefits

Rising health care costs, among other factors, have lead to the growth of nontraditional health care plans and to innovative changes in plan provisions

Thomas P. Burke
and
Rita S. Jain

After a decade of growth, nontraditional health care plans such as health maintenance organizations and preferred provider organizations have emerged as viable alternatives to long-established fee-for-service plans. Virtually nonexistent 10 years earlier, these newer arrangements covered one-fourth of all full-time participants in employer-financed health care benefit plans in medium and large private establishments in 1989.

This development is in part a response to rapid escalation in health care costs as a result of both increases in the prices of medical services and the introduction of expensive new ways of diagnosing and treating illness. From 1979 to 1989, the Consumer Price Index (CPI) for medical care products and services increased 119 percent, compared with a 64-percent rise in the CPI for all goods and services. During the same timespan, the percent of gross national product devoted to medical care rose from 8.6 percent to 11.4 percent.

The response to rising health care costs over the last decade has taken a number of forms. By introducing alternative health care plans, employers are providing employees with a choice as to the type and extent of coverage that best meets individual needs. Alternative plans emphasize preventive care and out-of-hospital services and provide incentives for receiving care at designated locations. Another form of response to rising health care costs has been the introduction of cost control features in traditional health care plans. These features are intended to limit the use of medical care facilities when such use is not considered necessary.

Developments in health care benefit plans during the 1980's have led to the current hybrid situation in which a number of different types of plans exist, each with features of other plans. For example, some health maintenance organization (HMO) plans now offer the option of seeking care from a nonmember provider. And preferred provider organization (PPO) plans now encourage, but do not require, the use of certain medical care providers. On the other side of the coin, traditional plans are restricting access to certain care in much the same way as an HMO might. This article will examine this recent blurring of distinctions between the types of health care benefit plans and discuss some of the similarities and differences in the way these plans provide health care benefits as the 1990's begin.

Information for the study is from the Bureau of Labor Statistics' annual survey of employee benefits in private medium and large establishments. The survey, begun in 1979, provides data on the extent of coverage, types of benefits, and required employee premiums for a variety of health care arrangements. The 1989 survey studied full-time employees in a sample of about 1,600 establishments, which represented more than 110,000 establishments employing 32 million full-time employees. The data cover estab-

Thomas P. Burke and Rita S. Jain are economists in the Division of Occupational Pay and Employee Benefit Levels, Bureau of Labor Statistics.

lishments with 100 or more employees in all States except Hawaii and Alaska.[1]

Survey findings show that participation in alternative health care plans has increased steadily since 1979, the first year Employee Benefits Survey data were collected. In that year, 98 percent of health care participants in medium and large establishments were covered by traditional (fee-for-service) plans, while 2 percent were covered by HMO's. Ten years later, slightly less than 74 percent of participants had traditional health care coverage, 17 percent had HMO coverage, and 10 percent were covered by PPO's. (See chart 1; participation in PPO plans was first tabulated separately in 1986, when 1 percent of health care participants had such coverage.)

Health care benefit providers

Traditionally, health care benefits have been provided on a fee-for-service basis; that is, an individual seeks treatment from his or her own provider, after which the benefit plan reimburses the provider or the patient. In the 1980's, fee-for-service plans began adding cost containment features to their benefit packages in response to the rapid rise in medical costs. Quite often, these cost containment measures are part of a "managed care" program. Such a program will commonly include preadmission hospital testing, certification before hospital admission, hospital utilization review, and required second surgical opinions among its cost containment provisions.

Cost containment features such as those found in a managed care plan typically restrict access to certain kinds of health care, direct health care to less expensive locations (such as outside a hospital), and monitor the use of health care products and services. These features do not in general encourage preventive care, however.

One alternative to fee-for-service health care is the HMO, which provides a wide range of comprehensive health care services to subscribers and dependents on a prepaid basis. Unlike fee-for-service plans, HMO's, as a rule, provide unlimited cover-

Table 1. **Percent of full-time medical care participants, by coverage for selected categories of medical care, medium and large establishments, 1989**

Category	HMO plans			Fee-for-service plans		
	Care provided	Covered in full	Covered with limtations	Care provided	Covered in full	Covered with limitations
Hospital room and board	100	92	8	100	5	95
Hospital miscellaneous[1]	100	92	8	100	5	95
Extended care facility[2]	93	32	61	80	2	77
Home health care	99	86	13	72	7	65
Hospice care	30	26	4	46	5	40
Inpatient surgery	100	98	2	100	20	80
Outpatient surgery[3]	100	97	3	100	26	74
Physician visits:						
In hospital	100	99	1	100	8	92
Office	100	44	56	98	2	96
Diagnostic x ray and laboratory	100	98	2	100	15	85
Private-duty nursing	93	89	5	87	1	85
Mental health care:						
In hospital	95	8	87	99	2	96
Outpatient	100	1	99	93	([4])	93
Alcohol abuse care:						
Inpatient detoxification	99	55	44	97	3	94
Inpatient rehabilitation	55	10	46	68	1	67
Outpatient	59	7	52	57	([4])	57
Drug abuse care:						
Inpatient detoxification	99	55	44	96	3	93
Inpatient rehabilitation	53	10	43	63	1	62
Outpatient	57	7	50	53	([4])	53
Prescription drug, nonhospital	90	9	81	98	2	96

[1] Services provided during a hospital confinement.

[2] Some plans provide care in an extended service facility only to a patient who was previously hospitalized and is recovering without the need of the extensive care provided by a general hospital.

[3] Charges incurred in the outpatient department of a hospital and outside of the hospital.

[4] Less than 0.5 percent.

NOTE: Because of rounding, sums of individual items may not equal totals.

Table 2. **Percent of full-time participants in health maintenance organization medical plans, by copayment provisions for selected categories of medical coverage, medium and large establishments, 1989**

Amount copayment limits	Office visit with physician	Nonhospital mental health care	Vision examination
All	100	100	100
Covered with:			
Copayment provision	56	66	45
Copayment per visit	55	44	45
$1.00	2	1	2
$2.00	8	2	3
$3.00	10	1	10
$4.00	2	1	1
$5.00	27	4	18
$6.00–$9.00	(1)	(1)	(1)
$10.00	5	5	8
$11.00–$14.00	(1)	—	(1)
$15.00	1	4	1
$16.00–$19.00	—	(1)	(1)
$20.00	—	19	—
$21.00–$24.00	—	—	—
$25.00	—	4	1
Greater than $25.00	—	3	(1)
Copayment varies by days	1	22	—
Copayment per year	—	(1)	(1)
No copayment provision	44	34	55

[1] Less than 0.5 percent.

NOTE: Because of rounding, sums of individual items may not equal totals. Dash indicates that no workers were covered under this category.

age for hospital-related care, such as room and board, surgical care, and doctors' visits, with no charges over subscriber premiums. HMO participants may be required to pay a copayment, or nominal fee, for certain items, such as physicians' office visits and out-of-hospital prescription drugs.

There are two basic types of HMO's: group/staff and individual practice association (IPA). The group/staff HMO delivers health services at one or more facilities through groups of physicians working on a salaried or contractual basis. The IPA contracts with physicians in the community, who maintain their own independent offices and usually are paid by the HMO on an agreed-upon fee-for-service schedule. An HMO can also combine elements of the two basic models. Such HMO's are organized predominantly around a group network, but may contain a few individual physician practices.[2]

Alternative kinds of HMO's have appeared in recent years, the most popular being the "open-ended enrollment plan." Under an open-ended HMO, members are allowed to use providers outside of the HMO but incur a cost, typically in the form of deductibles (dollar amounts paid by the patient before the plan begins paying) and coinsurances (a percent of charges paid by the patient) beyond those imposed if an HMO provider were used. The flexible nature of these plans is currently making them popular. Data on open-ended HMO's were first tabulated in 1989 by the Employee Benefits Survey; 5 percent of participants in HMO's were enrolled in this type of plan. Other hybrid HMO plans work in much the same way.[3]

Although overall enrollment in HMO's has stabilized in recent years, the proportion enrolled in open-ended HMO's has risen. The number of HMO's peaked at 653 in January 1988 and has been declining since then as the HMO industry has become consolidated through mergers.[4] During 1989, the number of HMO's declined to 591 plans. Membership in traditional HMO's rose only slightly, from 32.6 million in 1988 to 34.7 million in 1989.[5] Over the same period, the number of open-ended HMO's grew to 78 plans in July 1989 from 48 in June 1988, and enrollment in these plans rose 40 percent, from just below 500,000 to approximately 700,000 individuals.[6]

Key differences between HMO's and fee-for-service plans include the following:

- HMO's serve as both health care insurers and health care providers. Fee-for-service plans focus on financing health care, with subscribers seeking out their own providers.
- HMO's stress preventive health care by paying for periodic physical examinations and other routine care. Fee-for-service plans focus on acute care and may not pay for routine preventive care.
- HMO's have built-in cost containment features. Fee-for-service plans may or may not include these features.
- HMO's usually limit the patient's choice of providers. Fee-for-service plans do not have such restrictions.[7]

Another, newer alternative to traditional health care coverage is the PPO. Under PPO's, insureds are provided coverage on a fee-for-service basis and have a choice of providers. However, out-of-pocket expenses for medical care are lower if designated hospitals, physicians, or dentists are used. Subscribers are penalized by way of higher deductibles, lower plan coinsurances, or other limitations when care is not obtained from the designated provider. Most often, PPO plans include mandatory cost containment features, such as required certification for hospital admission, concurrent reviews by the physician and plan "gatekeeper" regarding the length of stay in a hospital, and mandatory second surgical opinions.

A few PPO's have "lock-in" features and are known as "exclusive provider organizations." These plans require participants to use the designated services and providers and will furnish no benefits if

other services or providers are used. Exclusive provider organizations thus resemble HMO's in this respect, although they provide benefits on a fee-for-service rather than a prepaid basis.

Coverage and limitations

In addition to generating data on participation in various types of medical care plans, the Employee Benefits Survey provides detailed information on plan provisions. Using this information, one can examine how evolving competition between the various health care plans has affected similarities and differences among their provisions. In the following discussion, data from the 1989 survey are used to contrast traditional and nontraditional plans with respect to (1) coverage for specified categories of care, such as hospital room and board, home health care, and mental health care; (2) limitations on coverage through deductibles, copayments, and plan maximums; and (3) employee contributions for plan premiums. Because PPO participation is small, separate data are not available for such plans; instead, data for PPO's are combined with data for fee-for-service plans.

Virtually all full-time employees in HMO and fee-for-service health plans had coverage in 1989 for the major categories of medical care, such as hospital room and board, surgery, in-hospital physician visits, and x-ray and laboratory services. Physician care in a doctor's office was always included in HMO's and nearly always in other plans. Private-duty nursing and mental health care were nearly always provided by all plans. (See table 1.)

Federally qualified HMO's, which include a large majority of HMO participants, must provide certain health services that may not be included in other plans. Among these services are home health care, routine physical examinations, care for hearing disorders, and well-baby care. As a result, these benefits are more common in HMO, as opposed to other, plans.

In 1989, home health care services were provided to virtually all HMO participants, whereas 72 percent of fee-for-service plan participants had such coverage. HMO's provided coverage to 97 and 95 percent of participants for physical examinations and well-baby care, respectively, compared with 14 and 22 percent for the same categories of care under fee-for-service plans. Care for hearing disorders was provided to 93 percent of HMO participants and 12 percent of fee-for-service plan participants. While coverage in an extended care facility is not required of federally qualified HMO's, it is typically provided to HMO participants. Ninety-three percent of HMO participants had extended care provisions, compared with 80 percent of fee-for-service plan participants.

Table 1 also indicates whether a health care category is covered in full or requires sharing of costs by the patient. For most categories listed, HMO's usually provide full coverage, that is, coverage without cost to the employee beyond the monthly plan premium. In contrast, other plans often limit the extent of benefits paid, commonly requiring employees to pay a portion of the hospital or medical bill.

Quite often, HMO's limit certain inpatient services, such as mental health care and treatment for alcohol and drug abuse, by restricting the number of

Table 3. **Percent of full-time participants in contributory medical care plans,[1] by type and amount of employee contribution, medium and large establishments, 1989**

Type and amount of contribution	All plans		Health maintenance organizations		Fee-for-service plans	
	Employee coverage	Family coverage[2]	Employee coverage	Family coverage[2]	Employee coverage	Family coverage[2]
All participants						
Total	100	100	100	100	100	100
Flat monthly amount	80	80	79	80	80	81
Less than $5.00	5	1	4	(3)	5	2
$5.00–$9.99	9	4	12	3	9	5
$10.00–$14.99	16	4	19	4	16	4
$15.00–$19.99	11	4	8	3	12	4
$20.00–$29.99	16	7	16	5	16	7
$30.00–$39.99	9	6	12	6	8	6
$40.00–$49.99	3	6	2	9	3	5
$50.00–$59.99	1	5	3	4	1	6
$60.00–$69.99	(3)	8	1	7	(3)	8
$70.00–$79.99	(3)	5	(3)	7	(3)	4
$80.00–$89.99	6	5	(3)	7	8	4
$90.00–$99.99	—	4	—	5	—	3
$100.00–$124.99	(3)	6	(3)	5	(3)	6
$125.00–$149.99	(3)	4	—	4	(3)	4
$150.00–$174.99	—	6	—	4	—	7
$175.00–$199.99	(3)	1	—	1	(3)	1
$200.00 or greater	—	2	—	3	—	2
Composite rate[4]	3	2	(1)	(1)	3	2
Amount varies by employee[5]	12	8	9	8	12	8
Amount varies by earnings	1	2	—	(3)	1	2
Not determinable	8	10	12	13	7	9

[1] Plans providing services or payments for services rendered in the hospital or by a physician. Excludes plans that provided only dental, vision, or prescription drug coverage.

[2] If the amount of contribution varied by either size or composition of family, the rate for an employee with a spouse and one child was used. For a small percentage of employees, the employee contributes the same amount for single and family coverage.

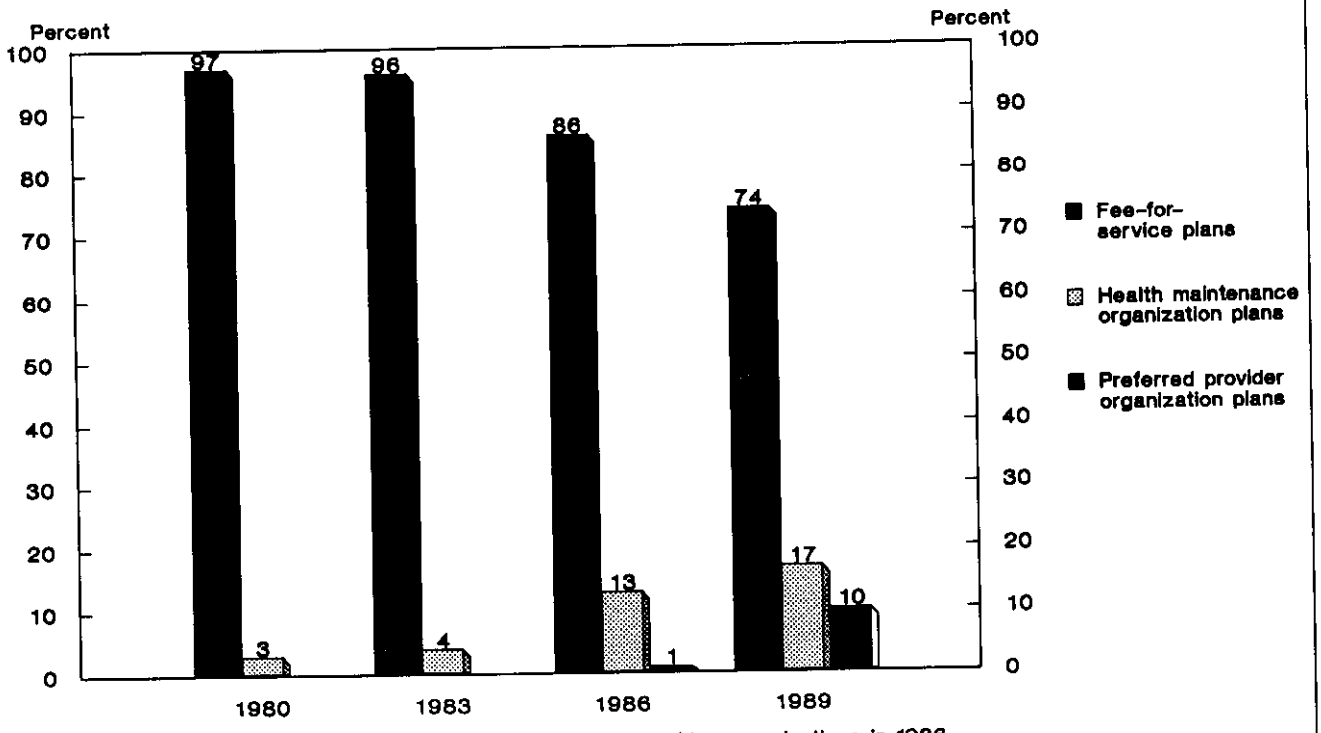
[3] Less than 0.5 percent.

[4] A composite rate is a set contribution covering more than one benefit area, for example, health care and sickness and accident insurance. Cost data for individual plans cannot be determined.

[5] Amount varies by options selected under a "cafeteria plan" or balance of employer-sponsored reimbursement account.

NOTE: Because of rounding, sums of individual items may not equal totals. Where applicable, dash indicates no employees covered under this category.

Chart 1. Percent of full-time medical care participants by type of fee arrangement, medium and large establishments, 1980, 1983, 1986, and 1989



NOTE: Data were first tabulated separately for preferred provider organizations in 1986. Because of rounding, sums of individual items may not equal 100 percent.

days for which benefits are provided—either annually or on a per-illness basis. In addition, HMO's commonly require copayments for such nonhospital services as physician office visits and the purchase of prescription drugs.

Fee-for-service plans typically have limitations that apply to a specific category of care or to a group of medical services under the health plan. A category of care may be limited in regard to the number of days for which services are covered and/or by a ceiling on the maximum dollar amount payable. For example, mental health care may be restricted to a limit of 30 days in the hospital, subject to a lifetime maximum benefit payment of $10,000. A group of categories of care is typically limited by deductibles, coinsurance provisions, and ceilings on overall dollar maximums. Thus, deductibles of $100 or $200 a year were commonly imposed upon fee-for-service plan participants in 1989, usually with a limit per family of 2 or 3 times the individual amount. In regard to coinsurance, the insurer generally pays 80 percent, and the insured 20 percent, of the medical costs incurred during a given year. (The cost is typically split, 50–50, for nonhospital mental health care.) Finally, there is often a lifetime ceiling on plan payments, most commonly $500,000 or $1,000,000.

As shown in table 1, in 1989 the vast majority of HMO's provided unlimited coverage of hospital-related care. In contrast, fee-for-service plans often limited coverage of hospital charges at the full semiprivate rate to 120 or 365 days per confinement, after which deductibles, coinsurances, and dollar maximums took effect. Moreover, while HMO's almost always covered inpatient and outpatient surgical care in full, other plans paid the full cost of coverage for these categories of care for just 20 and 26 percent of participants, respectively. Under fee-for-service plans, surgical care is most commonly limited through deductibles, coinsurances, and dollar maximums.

Coverage for nonhospital services, including visits to a physician's office, purchase of prescription drugs, extended care in a nursing facility, and psychiatric office visits, is often limited in various ways by all plans. Fee-for-service plans typically cover nonhospital benefits only after deductibles and coinsurance provisions are met. HMO limitations involve ceilings on the number of days of coverage or required copayments. Table 2 shows the relative frequency of such HMO copayments in three categories of medical care in which they are commonly found.

In two categories of care (office visits with a physician and nonhospital mental health care),

more than half of the HMO plan participants were required to pay a copayment. For office visits with a physician, a copayment of $3 or $5 was typically required before treatment was given. In general, HMO's did not restrict the number of visits to a physician's office. In contrast, HMO copayments for nonhospital mental health care (for example, office visits with a psychiatrist or psychoanalyst) were much higher—$20 per visit was the most common amount—and the number of visits per year was often limited.

Slightly over one-fifth of the HMO plan participants with coverage for nonhospital mental health care had copayments that varied with the number of visits. For example, a subscriber might be charged $10 per visit for the first 10 visits and $20 for each of the next 20 visits, or up to the maximum number of visits allowed by the plan.

Fee-for-service plans rarely had copayment provisions for nonhospital mental health care. Restrictions were imposed, however, often in the form of a yearly dollar maximum on benefits paid by the plan. In addition, nonhospital mental health care is commonly covered at a coinsurance rate of 50 percent, rather than the usual 80 percent paid by the plan for other illnesses.

Finally, cost containment features, which have been added to medical plans in recent years to limit their usage, were found more frequently in fee-for-service plans than in HMO plans. Of course, HMO's have built-in features to control usage and cost, such as required approval by a primary physician before specialized services are received. In 1989, half of the participants in fee-for-service plans were covered by plans that required certification prior to a hospital stay. The same percentage of participants were offered incentives—typically lower out-of-pocket expenses—to undergo certain hospital admissions tests outside the hospital. Such specific features were rarely found in HMO plans.

Employee contributions

Although the Employee Benefits Survey does not collect data on employer expenditures for benefit plans, it does collect information on the extent of worker contributions toward the cost of premiums. The percent of workers required to contribute toward the cost of premiums increased for all health plans throughout the 1980's. However, variations exist by type of plan. In 1989, 55 percent of all participants in fee-for-service plans were in plans with coverage fully paid for by their employers; 36 percent had their family coverage wholly employer financed. In contrast, 40 percent of HMO participants had their coverage fully paid for by their employers, and 26 percent had their family coverage wholly employer financed.

When employee contributions were required in 1989, HMO plans required lower payments, on average, for employee-only coverage, but higher payments for family coverage, as shown in the following tabulation:

	Employee coverage	*Family coverage*
All plans	$25.31	$72.10
HMO's	21.62	75.09
Fee-for-service plans	26.32	71.41

Eight percent of the participants in contributory fee-for-service plans had a monthly employee premium of $80 or more for individual coverage, compared with 1 percent in HMO plans. (See table 3.) However, monthly employee premiums for family coverage were more evenly distributed for all contributory plans.

A full comparison of the different types of health care plans must consider a variety of factors. Total health care costs borne by the employee include employee premiums, out-of-pocket expenses at the time services are rendered, and charges for services not covered by a health care plan. The Employee Benefits Survey focuses on benefit provisions, and not on usage or other comparative factors, such as quality of care, physician-patient relationships, and the general health of the employee and his or her family. Any choice made from among the variety of health care plans that are available today must take into account each of these factors. □

Footnotes

[1] The Employee Benefits Survey is an annual study of the incidence and characteristics of employee benefits. The survey provides data on health care benefits, life and disability insurance, retirement and capital accumulation plans, paid and unpaid leave, and a variety of other benefits. The results of the most recent survey are presented in *Employee Benefits in Medium and Large Firms, 1989*, Bulletin 2363 (Bureau of Labor Statistics, 1990). Data are presented for all full-time workers and separately for three broad occupational groups: professional and administrative, technical and clerical, and production and service workers.

[2] For details on different types of HMO's, see Allan Blostin and William Marclay, "HMO and other health plans: coverage and employee premiums," *Monthly Labor Review*, June 1983, p. 28.

[3] CIGNA's hybrid HMO plan, FlexCare, requires members to receive services only from its own network, similarly to a traditional HMO. However, a difference between the traditional HMO and CIGNA's FlexCare exists in the design of the plan and employee cost sharing. For further information, see InterStudy, *The InterStudy Edge*, Vol. 4, July 1989, pp. 4–7.

[4] InterStudy, p. 1.

[5] *National Directory of HMO's, 1990* (Washington, Group Health Association of America, Inc., June 1990). Additional information on the availability of HMO's is in Michael Bucci, "Health maintenance organizations: plan offerings and enrollments," *Monthly Labor Review*, forthcoming.

[6] InterStudy, p. 11.

[7] Federal legislation has influenced HMO development in recent years. The HMO Act of 1973 set standards for care provided by HMO's and provided incentives for HMO development. Due in part to rapid HMO growth following enactment of this legislation, HMO amendments enacted in 1988 relaxed some of the regulations concerning the operation of HMO's. Among the provisions of these amendments are the following: (1) The "dual choice" imposed by the 1973 Act, which required employers to offer their employees certain HMO options if a traditional health plan were also offered, was repealed, effective in 1993. (2) The "equal contribution clause" of 1973, which required employers to contribute at least the same amount toward the cost of an HMO plan as is contributed to a regular health insurance plan, was amended. The new standard increases employers' flexibility in determining their contributions to HMO's, while protecting employees against discriminatory contribution practices. Among the additional methods the employer can follow in making contributions to the HMO is that an employer's contribution may be a percentage of the HMO premium equal to the percentage paid for the regular health care plan. (3) Patients are allowed to obtain physician services from outside their HMO networks and still have their costs covered by the HMO.

Nontraditional work patterns of women

Studies have shown that the demands of coordinating both work and family life fall largely on women and can play a major role in determining women's work patterns. Women are twice as likely as men to work part time (that is, less than 35 hours per week) and to work a reduced work week (that is, less than five days per week.) In fact, reduced-week, part-time employment is particularly prevalent for women with young children (under age 14), suggesting that this may be one way in which women attempt to meet their childcare needs. Weekend and evening work is surprisingly common for a substantial segment of the labor force. Because the growing service sector accounts for most of the non-day and weekend jobs, more Americans are likely to follow these nontraditional work patterns in the future.

—CAROL J. DE VITA

America in the 21st Century: Human Resource Development (Washington, Population Reference Bureau, Inc., 1989), p. 19.