Trends in Health Insurance Costs

Over the past 20 years, employer health insurance costs have increased at widely varying rates. During some periods, such as 1987-95, they increased far more rapidly than wages and salaries or other benefits. At other times, such as 1996-97, they barely increased at all. This article examines these fluctuations, attempts to explain them, and looks at how they have affected overall employer costs for labor.

ALBERT E. SCHWENK

Health insurance is one of the most costly benefits provided by some employers. In March 1998, for example, health insurance cost employers in private industry an average of $1 per hour that employees were at work, 5.4 percent of total compensation costs.[1]

From 1980 to 1983, health insurance costs in private industry as measured by the Employment Cost Index (ECI) accelerated steadily, reaching an annual increase of 23.5 percent in the 12 months ended March 1983. (See chart 1.) From that point, the rate of increase declined, to 3.5 percent in the 12 months ended June 1986. It again accelerated to 14.7 percent in the year ended December 1988, but then slowed, to -0.3 percent in the year ended March 1996. For the 12 months ended September 1998, the rate of increase was 2.2 percent.

Fluctuations in the rate of increase in health insurance costs reflect a number of factors, the most important being changes in the cost of medical care and cost containment efforts by employers. The impact of the former can be gauged by reviewing fluctuations in the medical care segment of the Consumer Price Index (CPI).[2] Chart 2 shows that rates of change in the CPI for medical care (lagged 1 year) roughly paralleled changes in the health insurance index from the ECI, although the ECI measure was much more volatile.[3] This can be expected because the ECI reflects employer-employee choices regarding health insurance plan types, employee contributions, and other factors, in addition to the cost of medical care.

Albert E. Schwenk is an economist in the Division of Compensation Data Analysis and Planning, Bureau of Labor Statistics.
Telephone: (202) 606-6203
E-mail: Schwenk_A@bls.gov

The declines in the rate of increase in employer health insurance costs during 1983-86 and 1993-97 were due in part to slowdowns in the rate of gain in the cost of medical care. Probably more important during those periods, and certainly more important during 1989-93, were employer efforts to contain health care costs. While it is not possible to quantify the effects of each type of cost containment, a review of cost containment efforts does shed light on what employers did to control their health insurance costs.

One approach by employers to contain health insurance costs is to shift some or all of the costs to employees. According to the Bureau's Employee Benefit Survey (EBS), the percentage of employees whose health insurance premiums are wholly paid by employers has declined sharply since 1980.[4] Of full-time workers in medium and large private establishments who participated in medical care plans, 31 percent had individual coverage wholly financed by their employer in 1997, down from 72 percent in 1980. In 1997, 20 percent of full-time medical care plan participants in medium and large private establishments were eligible to receive fully employer-paid coverage for their families, down from 51 percent in 1980.

These changes in employee contributions coincided with a number of changes in health plan design that were expected to curb costs. For example, some health care plans were redesigned to eliminate basic coverage for certain types of care, and placed payment arrangements under a major medical plan. Under such plans, employees are required to pay a deductible or a coinsurance[5] before plan benefits can be used. Plan sponsors introduced the deductible requirement and coinsurance in an attempt to discourage unnecessary use of plan benefits, thus reducing the cost of insurance. Major medical deductibles and coinsurance have

Chart 1. **Percent changes in benefit costs and health insurance costs, private industry workers, 1980-98**

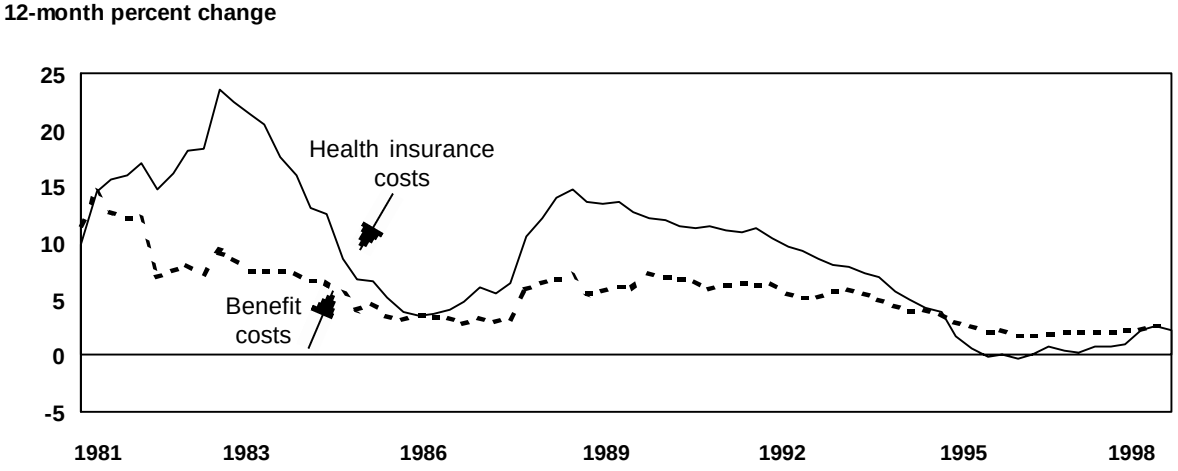
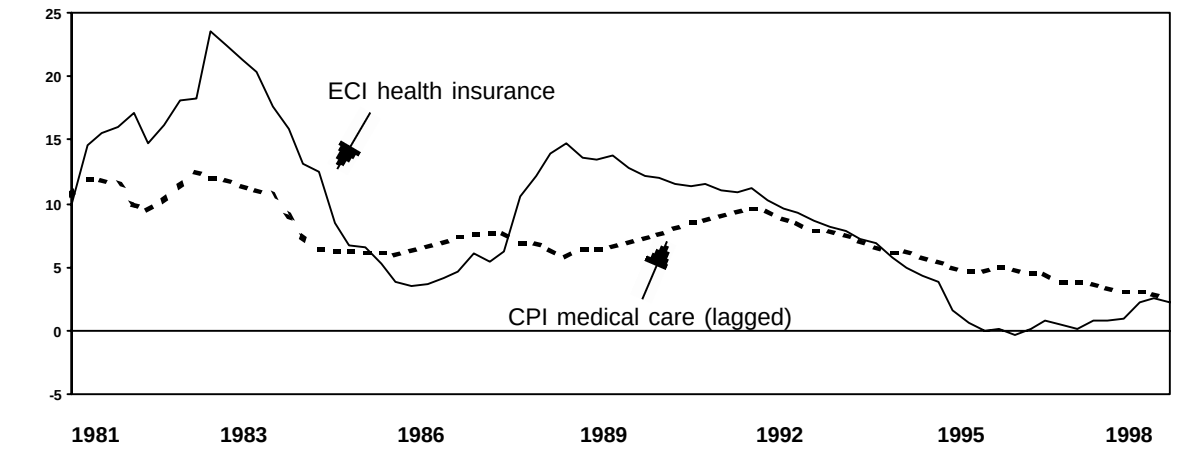


Chart 2. **Percent changes in the Consumer Price Index for medical care (lagged 1 year), and Employment Cost Index for health insurance, 1980-98**



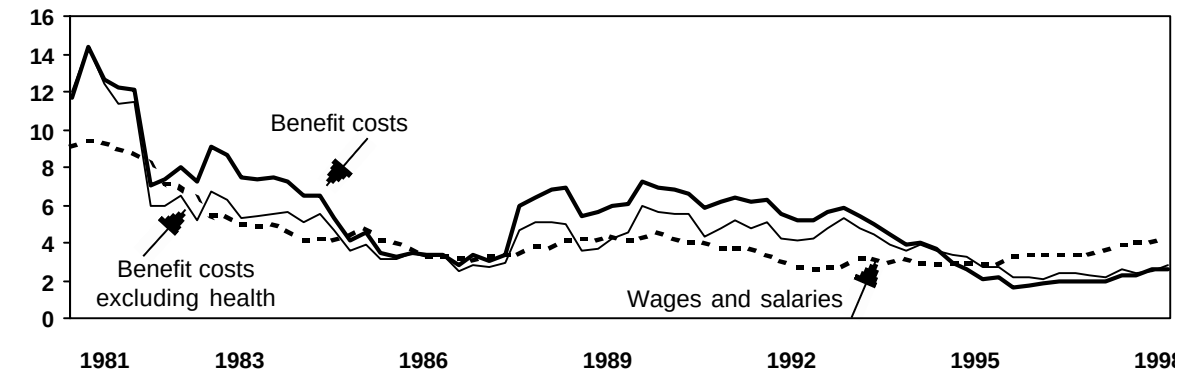
increased over time to keep pace with the rising cost of medical services.

Other cost savings were realized through changes in plan design that increased the employer's control over the type or delivery of employee health care services. Examples of these changes include requiring second opinions for surgical procedures and prehospitalization testing, as well as creating incentives to use outpatient facilities for surgical procedures, to buy generic prescription drugs, and to audit hospital bills.[6]

Creating self-funded plans instead of using commercial health care insurance plans was another method employers used to reduce their costs. Self-funded plans were viewed as a way to save money by allowing companies to retain funds that would otherwise be used to pay insurance premiums and taxes on those premiums, and to give the companies more control over plan design and expenditures. In 1979, 11 percent of medical plan participants in medium and large private establishments were covered by self-insured plans; by 1988, the proportion had approximately tripled to 34 percent; by 1997, approximately half of medical plan participants (47 percent) were in self-funded plans.

In addition to self-funding, there was a greater reliance on managed care programs, such as health maintenance programs (HMOs) and preferred provider organizations (PPOs). HMOs are prepaid health care plans that deliver

Chart 3. **Percent changes in wages and salaries, benefit costs, and benefit costs excluding health insurance, private industry workers, 1980-98**



comprehensive medical services to members for a fixed periodic fee. According to the Bureau's EBS, 5 percent of employees participating in medical care plans in medium and large establishments were covered by HMOs in 1984, 13 percent in 1986, 23 percent in 1993, 27 percent in 1995, and 33 percent in 1997.

PPOs provide coverage for individuals on a fee-for-service basis and offer a choice of providers, with incentives to enrollees to use certain providers. According to the EBS, 1 percent of employees participating in medical care plans in medium and large private establishments were covered by PPOs in 1986 (the first year the data were tabulated), 26 percent in 1993, 34 percent in 1995, and 40 percent in 1997.

Health insurance compared to other employer labor costs

Health insurance is only one of the employee benefits for which information is collected in the ECI, but it is among the most costly. The ECI covers wages and salaries and five major categories of benefits. The following tabulation shows the cost per hour worked for the components of compensation and each of the components' percent of total compensation for private industry in March 1998. Benefits largely related to the wage rate—legally required benefits and paid leave—account for over half of total benefit costs. Of the other benefit categories, insurance accounts for just under one-quarter of total benefit costs; health insurance by itself accounts for about one-fifth of benefit costs. Retirement and savings accounts for about one tenth of total benefits.

Given the importance of health insurance and the observed volatility in health insurance costs, it would be expected that fluctuations in the rate of change in health insurance costs affect total benefit costs. Chart 3 shows that when health insurance is excluded, benefit cost gains typically are closer to wage and salary increases.

Compensation component	*Cost per hour worked*	*Percent*
Total	$18.50	100.0
Wages and salaries	13.47	72.8
Total benefits	5.02	27.1
Legally required	1.63	8.8
Paid leave	1.16	6.3
Insurance	1.10	5.9
Health insurance	1.00	5.4
Supplemental pay	.56	3.0
Retirement and savings	.55	3.0
Other benefits	.03	.2

The tabulation below shows the cumulative percent changes in private industry wages and salaries, benefit costs, health insurance costs, and benefit costs excluding health insurance for selected time periods.[7]

	Cumulative percent changes for 3/4			
Time period	*Wages and salaries*	*Benefit costs*	*Health insurance costs*	*Benefit costs excluding health insurance costs*
Dec. 1980-Sep. 1998	103.6	143.3	336.7	115.0
Dec. 1980-Dec. 1984	26.4	37.5	87.8	30.4
Dec. 1984-Dec. 1987	11.0	10.8	16.5	9.5
Dec. 1987-Dec. 1992	20.0	35.0	73.9	26.5
Dec. 1992-Sep. 1998	21.0	18.2	14.8	19.0

Over the entire December 1980-September 1998 period, health insurance costs increased over three times as much as wages and salaries, and nearly three times as much as the other ECI benefits. This pattern held in the December 1980-December 1984 and December 1987-December 1992 periods. In the December 1984-December 1987 period, health insurance costs increased about 50 percent more than wages and salaries and 75 percent more than other benefit costs. During December 1992-September 1998, however, health insurance costs lagged both wages and salaries and other benefit costs.

Measuring health insurance costs in the ECI

The health insurance component of the ECI includes medical, major medical, dental, vision, and prescription care. It includes the three basic providers of health care benefits—Fee for Service Organizations (FFSs), HMOs, and PPOs.

Ideally, the ECI uses a current cost approach to measure the cost of health insurance (as well as the other ECI benefits). The ECI estimates the cost to the employer for health insurance given the current premiums, benefit provisions, and number of workers covered by and participating in each of the health care plans offered by the employer. To compute the cost (which is expressed as dollars per hour worked), the premiums are first expressed as an annual cost per employee and then that cost is divided by the annual hours worked—the annual work schedule (hours per week times weeks per year) minus paid leave hours plus overtime hours.

In some cases, however, information necessary to compute a current cost per hour worked is not available. For example, an employer may have a self-funded health care plan where the employer assumes all or a portion of the risk of providing health insurance instead of contracting with an insurance carrier. The expenditure picked up for the ECI would then include the costs of actual benefit claims and outside plan administration. In other cases, expenditures (for example, total annual cost) for health insurance are used as a fallback when premium rates and associated plan usage data are unavailable.

Where the employer can provide only an expenditure figure for health insurance, that expenditure is first allocated across employment in the company by dividing the expenditure by employment in the establishment (including both eligible and ineligible employees) to obtain an annual benefit cost per employee. That annual cost is then divided by annual hours worked to yield the cost per hour worked.

Calculating benefit cost changes

The Employment Cost Indexes for benefits, like those for wages and salaries, are fixed-weight Laspeyres measures of the change in the cost of employing a fixed set of labor inputs. The fixed weights—currently industry and occupational employment counts for 1990 that come largely from the Bureau's Occupational Employment Survey—ensure that changes measured are unaffected by employment shifts among industries and occupations with different wage and benefit levels.

It is important to emphasize that benefit cost indexes are not price indexes for a fixed market basket of benefits. Rather, they measure the change in an employer's cost for providing a benefit package. For the ECI, the cost for benefits may change in four primary ways:

- The cost for an unchanged benefit plan may increase or decrease (for example, an insurance carrier raises its rates or the proportion of the insurance cost paid for by the employee rises)
- A benefit plan may be added or eliminated (for example, a dental plan is added)
- The provisions of a benefit plan may be modified (for example, the type of work covered by the dental plan is enhanced)
- Usage of the benefit may change because of changes in the plan (for example, more employees elect health insurance because of improved dental benefits)

In general, changes in health insurance costs are not likely to be directly related to changes in wages and salaries because, for workers covered by a plan, the cost of a plan is going to be the same regardless of the level of earnings.[8] This is in contrast to other types of employee benefit plans, such as paid holiday and vacation plans, that are tied directly to wages. ■