Health insurance trends in cost control and coverage

An analysis of changes in company health plans between 1979 and 1984 shows that employers often sought to contain rising expenditures, in some cases, increasing the cost to workers; improvements in benefits, however, continued

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Influenced by rapidly rising costs of health care, companies often raised their employees' share of the total health care bill and also modified plans to encourage use of less costly health services during the 1979–84 period. At the same time, however, some health plans improved benefit features, such as increasing the maximum lifetime payments under major medical plans.

Although cost containment efforts and benefit improvements were common, approaches to achieve these objectives varied. To analyze these efforts, the Bureau of Labor Statistics traced provisions of 209 employee health plans for the 1979–84 period.

These plans were found in 173 establishments and covered at least 1.8 million workers.[1] The plans were mainly those of large companies, with 61 percent covering 1,000 workers or more (6 percent of the plans covered at least 25,000). While clearly not a representative sample of all health insurance plans, they do cover a substantial number of both union and nonunion workers, and offer insights into plan provisions over the 5 years studied. All but 11 of the health plans changed at least one of the features reviewed in this article between 1979 and 1984.

The 209 plans analyzed in this article comprise all plans common to both the 1979 and 1984 Bureau of Labor Statistics Employee Benefits Surveys. This annual survey provides data on the incidence and detailed provisions of benefit plans financed at least partially by medium and large companies. Under health plans, the survey covers provisions for hospital, surgical, medical, major medical, extended care, and other benefits. It also looks at methods of funding benefits (but not actual employer costs) and the incidence and amounts of employee contributions for individual and family coverage.[2]

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Measures taken

Efforts to curb costs stemmed from rapid increases in health care outlays. Total national health expenditures rose from $215.1 billion in 1979 to $387.4 billion 5 years later.[3] This increase reflects both the introduction of new and expensive treatments for many illnesses and a sharp rise in prices for health services. Over the 1979–84 period, the medical care component of the Consumer Price Index rose at a 9.6-percent annual rate, compared with 7.4 percent for the index as a whole. Such cost increases helped to drive up employer financing of group health insurance, from $51.3 billion in 1979 to $96.9 billion in 1984.[4]

Cost containment measures took many forms. Quite noticeable were actions that increased the worker's share of health care costs. For example, a number of the plans were redesigned to eliminate basic coverage for certain types of care and transfer payment arrangements entirely under a major medical plan. (See table 1.) Basic plans, applying to an individual category of care—hospital, surgical, or medical—typically provide "first-dollar" coverage; that is, an insured individual is not required to make an initial payment for care.

Conversely, major medical plans—which cover several categories of expenses—eliminate "first-dollar" coverage and require cost-sharing by the employee through deductibles and coinsurance provisions. A deductible is a specified amount an insured individual must pay toward health care expenses before any benefits are provided by the plan. Slightly more than one-fifth of the plans increased the size of the deductible in existing major medical insurance policies between 1979 and 1984. Expenses in excess of the deductible are shared by the individual and the insurance plan on the basis of a specified coinsurance rate; plans typically pay 80 percent of covered charges, while the insured pays the remaining 20 percent.

Table 1. Summary of changes in 209 health insurance plans, 1979 and 1984

Change	Number of plans changed	Percent of plans changed
Cost containment		
Basic coverage eliminated for:		
Hospital benefits	27	12.9
Surgical benefits	28	13.4
Medical benefits	23	11.0
Diagnostic x ray and laboratory benefits	21	10.0
Major medical plans:		
Increased deductible	46	22.0
Increased employee's coinsurance payments	4	1.9
Increased maximum limits on employee's expenses	9	4.3
Eliminated maximum limit on employee's expenses	1	.5
Decreased lifetime maximum benefit	7	3.3
Converted to self-insured plan	38	18.2
Converted to partly insured and partly self-insured plan	16	7.7
Converted to comprehensive major medical plan	26	12.4
Reduced first dollar coverage	4	1.9
Added extended care facility benefit[1]	34	16.3
Added home health care benefit[1]	62	29.7
Employee-paid premiums increased or added:		
For employee coverage	30	14.4
For family coverage	68	32.5
Coverage improvements		
Basic hospital benefits:		
Increased duration	18	8.6
Increased daily payments	16	7.7
Basic surgical benefits:		
Increased maximum scheduled allowance	30	14.4
Added full coverage for outpatient care	17	8.1
Basic medical benefits:[2]		
Increased duration	8	3.8
Increased payment per visit	25	12.0
Added payment for office visit	7	3.3
Diagnostic x ray and laboratory benefits:		
Raised ceiling on annual payments	74	35.4
Major medical benefits:		
Decreased deductible	12	5.7
Decreased employee's coinsurance payments	9	4.3
Decreased maximum limits on employee's expenses	25	12.0
Introduced maximum limit on employee's expenses	42	20.1
Increased lifetime maximum benefit	118	56.5
Added benefits	8	3.8
Increased first dollar coverage	14	6.7
Employee-paid premiums reduced or eliminated:		
For employee coverage	16	7.7
For family coverage	22	10.5

[1] Also a coverage improvement.
[2] Includes payments for treatment in hospital and in physician's office.

Some employers also modified their approach to funding benefits. They substituted, either completely or partially, self-funding for the purchase of a health insurance policy from a commercial insurance company, such as Aetna, or an association of hospitals or physicians (Blue Cross-Blue Shield). Employers who insure their own benefits have greater control over plan design and, therefore, can control costs more directly. Growth in this type of funding was most pronounced for major medical benefits, for which the number of self-insured plans more than doubled—from 27 in 1979 to 65 in 1984. (See table 2.) Nevertheless, commercial insurance continued to be the most common method of funding both basic and major medical insurance benefits in 1984.

Still another form of cost containment provided alternatives to care in a hospital. Thirty-four of the plans added coverage for expenses in an extended care facility, such as noncustodial care in a nursing home, and 62 introduced home health care benefits.

Spurred by the passage of the Health Maintenance Organization Act of 1973, more employers have offered the choice of an HMO as an alternative to other health insurance benefits.[5] Usually providing comprehensive health care at a fixed fee, Health Maintenance Organizations have been viewed as a possible lower cost alternative to other health care. These organizations encourage preventative medicine and have lower hospitalization rates for their members. There were 11 HMOs among the 209 plans in both 1979 and 1984.

Changes in benefit financing also affected employees. In both years of this study, the majority of the plans examined were noncontributory, that is, employers paid all of the insurance premiums. The following tabulation shows, however, that in the jointly financed plans, the amount of employee contributions nearly doubled from 1979 to 1984.

	Number of plans		*Average employee monthly contribution*	
	1979	*1984*	*1979*	*1984*
Jointly financed coverage:				
Employee	61	67	$ 6.43	$11.57
Family	100	92	17.07	33.22

Although cost containment efforts attracted most attention, benefit improvements were not ignored between 1979 and 1984, particularly in the area of major medical benefits. Slightly more than half the 209 plans studied increased maximum lifetime benefits under major medical provisions, and 67 improved financial protection against catastrophic illnesses by either introducing a ceiling on employees' "out-of-pocket" expenses (42 plans) or lowering an existing ceiling (25 plans). A third of the plans raised maximum annual payments for diagnostic x ray and laboratory benefits. Table 1 shows the frequency of a variety of other health insurance coverage improvements.

Table 2. Funding media for selected types of coverage in 209 health insurance plans, 1979 and 1984

Funding media	Basic hospital[1]		Basic surgical[1]		Basic medical[1]		Major medical[2]	
	1979	1984	1979	1984	1979	1984	1979	1984
Total	209	209	209	209	209	209	209	209
Coverage provided	187	161	165	156	126	115	186	194
Blue Cross-Blue Shield	53	49	45	37	44	36	20	27
Commercial carrier	99	61	88	68	58	43	139	102
Independent health plans	35	51	32	51	24	36	27	65
Labor/management[3]	24	40	21	40	13	25	27	65
Health Maintenance Organization[4]	11	11	11	11	11	11	–	–
Coverage not provided	22	48	44	53	83	94	23	15

[1] Basic benefits apply to individual categories of expenses such as hospital, surgical, or medical expenses. They generally apply without deductible or coinsurance provisions.

[2] Major medical benefits cover many categories of expenses, some of which are not covered under basic benefits, and others for which basic coverage limits have been exhausted. Major medical benefits are characterized by deductible and coinsurance provisions that are applied across categories of care.

[3] Includes plans that are financed by general revenues of a company on a pay-as-you-go basis, plans financed through contributions to a trust fund established to pay benefits, and plans operating their own facilities if at least partially financed by employer contributions. Includes plans that are administered by a commercial carrier through Administrative Services Only contracts.

[4] Includes federally qualified (those meeting standards of the Health Maintenance Organization Act of 1973, as amended) and other HMOs delivering comprehensive health care on a prepayment rather than fee-for-service basis. All HMOs are included here regardless of sponsorship, for example, Blue Cross-Blue Shield or a commercial insurance carrier.

NOTE: Dash indicates no plans in this category.

The following sections of this article explore the interplay between cost containment and benefit improvements as found in individual health insurance areas.

Hospital benefits

The average expense for a day of hospital care increased from $217 in 1979 to $411 in 1984, according to the American Hospital Association.[6] Over this period, more employees were required to share in the cost if hospitalized. For example, 27 of the 209 plans studied adopted this requirement by eliminating basic coverage. This raised the number of plans studied with only major medical coverage for hospitalization from 22 to 48. (See table 3.)

Also, more employees with basic hospital benefits were required to pay a deductible before their confinements were covered. In 1984, 17 of the plans imposed a deductible, compared with 12 plans in 1979. The type of deductible varied from no benefit coverage for the first day in the hospital to a specified dollar amount. The most common deductible was $100 for the first day in the hospital.

The average daily cost for a semiprivate room rose from $134 in 1979 to $209 in 1984.[7] As in 1979, most plans in 1984 based payment for a hospital confinement on the semiprivate room rate, automatically allowing benefit levels to keep pace with inflation. Roughly 10 percent of the plans in both years paid a cash room-and-board allowance, for a daily average of $68 in 1979 and $113 in 1984.

Eighteen of the plans increased the maximum duration of hospital coverage. At least half of the plans, 68 in 1979 and 62 in 1984, provided hospital benefits for 365 days or more; nearly all plans covered at least 70 days.

Extended care benefits

To counter the sharp rise in hospital costs, benefit provisions for medical care outside hospitals are becoming more prominent. Benefits may cover medical treatment at an extended care facility or at home, both less costly than long-term hospitalization. As noted, a day's cost for hospitalization averaged $411 in 1984, compared with $150 for confinement in an extended care facility and $40 for home care.[8]

The potential cost advantages of alternative health care over hospitalization prompted a net increase in the number of plans providing coverage for extended care facility (28 plans) and home care (59). (See table 4.) Two-fifths of the plans covering extended care facilities in 1979 modified their terms by 1984, changing either a benefit provision (such as duration or dollar amount of coverage) or type of coverage (such as converting from major medical to basic benefits), or both. Extended care benefits commonly are available only after hospitalization, however.

Surgical benefits

Cost containment also affected surgical benefits. Twenty-eight of the plans eliminated first-dollar coverage for surgery in 1984. (See table 1.) Also, as an incentive to reduce costs, 17 plans with deductibles or coinsurance, or both, for surgery performed on an inpatient basis offered full payment for surgery performed on an outpatient basis.

In 1984, 153 of the plans paid all or a percent of the "usual, customary, and reasonable" charges for surgical procedures, up 14 plans from 1979.[9] This approach automatically links benefit levels to rising costs. The remaining 56 plans specified cash allowances for covered surgical procedures; of these, 30 had increased the allowance after 1979, raising the average allowance for the most expensive covered procedure from $925 to $1,400.

Medical benefits

One plan in the study added in-hospital medical benefits after 1979, resulting in all having this benefit by 1984. Ninety-four plans, up from 82 in 1979, covered in-hospital medical visits under major medical benefits only; consequently, they did not provide first-dollar coverage. (See table 3.) Payments were based on usual, customary, and reasonable arrangements in 171 plans, 11 more than in 1979. Visits to a physician's office were covered by 206 plans in 1984, up 6 plans from 1979. Coverage for 1984 was

through major medical benefits in 171 plans and through combined basic and major medical benefits in 21. All major medical arrangements were on a usual, customary, and reasonable basis.

In 1984, 16 plans included some form of cost sharing other than a general deductible or coinsurance requirement for visits to a doctor's office, up 5 plans from 1979. Devices ranged from co-payments by the insured of from $1 to $10 per visit to no payment by the insurance plan for the first visit or a specified number of visits. Employee co-payments were generally associated with Health Maintenance Organizations, with the most common being $2 per visit.

Diagnostic x ray and laboratory benefits

All of the health insurance plans in the study provided diagnostic x ray and laboratory benefits in both 1979 and 1984. However, the number of plans providing this service through both basic and major medical benefits declined from 144 to 93; 28 additional plans provided this service through basic benefits only in 1984, and 23 provided it through major medical benefits only. (See table 3.)

Plans usually paid for diagnostic care on a usual, customary, and reasonable basis in both years. Of the 60 plans designating cash allowances in 1984, 34 had increased scheduled payments for this service over the 5 years studied; consequently, the average maximum allowance increased from $175 to $310 per year. If diagnostic care were done on an outpatient basis, 63 plans paid the full cost in 1984, compared with 35 plans in 1979.

Major medical benefits

All but 15 of the plans studied provided major medical benefits in 1984; 23 plans did not provide this benefit in 1979. The 11 Health Maintenance Organizations by their nature preclude separate major medical provisions and the remaining four plans provided basic benefits only, but were sufficiently comprehensive to counter the need for a separate major medical plan. Changes that reduced costs or improved benefits were made more often to major medical provisions than to any other health benefit examined.[10]

Major medical plans typically include two cost-sharing features—deductibles and coinsurance requirements. All but two of the major medical plans in 1984 called for a deductible, as did all such plans studied in 1979. Deductibles were typically established on a yearly basis and were commonly $100 per person in 1979 and 1984. By 1984, however, 41 plans required more than $100, compared with 16 plans in 1979. Also, four plans changed to a deductible of 1 percent of earnings. Previously, two of these plans had a deductible of $50 and two, a deductible of $100.

There are two types of major medical insurance: supplemental and comprehensive. Supplemental benefits provide additional coverage to the separate basic plans. Comprehensive plans stand alone and combine the types of benefits found in basic and major medical plans. Because comprehensives eliminate nearly all first-dollar coverage, they offer greater savings opportunities in insurance premiums than basic/supplemental plans. From 1979 to 1984, the number of comprehensive plans in the study nearly doubled, from 31 to 57 plans.

Coinsurance provisions were found in all of the major medical plans studied in both years. The coinsurance rate paid by the plans, most commonly 80 percent, changed very little during this period. In 1984, 20 of 194 major medical plans paid more than 80 percent of the health care expenses, while one plan paid less; this compared with 16 and none, in 1979.

A significant improvement in major medical benefits was adding financial protection against catastrophic illnesses. This provision limits the yearly "out-of-pocket" expenses an insured individual must pay. It was part of 156 plans in 1984, compared with 106 in 1979. In both years, the majority of plans set the limit at $1,000 a year.

Maximum benefits payable under a major medical plan are specified on a per disability or, more commonly, on a lifetime basis. In 1979 and 1984, the most common lifetime maximum benefit was $250,000 among the plans studied. Since 1979, however, 118 plans raised their benefit ceilings, while eight eliminated them entirely. The results are as follows:

Table 3. Distribution of 209 health insurance plans by benefit arrangement for selected categories of care, 1979 and 1984

Category	Benefit arrangement							
	Basic benefit only		Major medical benefit only		Basic and major medical benefits		Care not provided	
	1979	1984	1979	1984	1979	1984	1979	1984
Hospital care	41	34	22	48	146	127	–	–
Extended care facility	46	58	39	56	20	19	104	76
Home health care	23	51	10	37	7	12	169	109
Surgical care	74	70	44	53	91	86	–	–
Medical care-in hospital	32	22	82	94	94	93	1	–
Medical care-office visit	15	14	165	171	20	21	9	3
Diagnostic x ray and laboratory benefit	40	68	25	48	144	93	–	–

[1]Basic benefits apply to individual categories of expenses, such as hospital, surgical, or medical expenses. They generally apply without deductible or coinsurance provisions.

[2]Major medical benefits cover many categories of expenses, some of which are not covered under basic benefits, and others for which basic coverage limits have been exhausted. Major medical benefits are characterized by deductible and coinsurance provisions that are applied across categories of care.

NOTE: A given plan may offer categories of care under different types of payment, for example, hospital care as a benefit (typically no initial payment by the employee), visits to a physician's office as major medical benefit (cost shared by employer and employee), and surgical care as first a basic benefit and then as a major medical benefit. Dash indicates no plans in this category.

Table 4. Extended care benefit changes in 209 health insurance plans, 1979 and 1984

Action taken by 1984	Extended care facility		Home health care[1]	
	Number of plans	Percent of plans	Number of plans	Percent of plans
Total	209	100.0	209	100.0
Added benefit	34	16.3	62	29.7
Eliminated benefit	6	2.9	3	1.4
Changes in existing benefits[2]	44	21.1	14	6.7
Basic benefits provision[2]	30	14.4	9	4.3
Duration	15	7.2	8	3.8
Dollar amount	14	6.7	1	.5
Other[3]	3	1.4	–	–
Changes in type of coverage	21	10.0	8	3.8
From basic only to major medical only	4	1.9	–	–
From basic only to basic and major medical	2	1.0	1	.5
From major medical only to basic only	6	2.9	3	1.4
From major medical only to basic and major medical	1	.5	1	.5
From basic and major medical to basic only	2	1.0	1	.5
From basic and major medical to major medical only	6	2.9	2	1.0
Benefit unchanged	49	23.4	21	10.0
No benefit in either year	76	36.4	109	52.2

[1] Includes care provided by a Visiting Nurse Association and related benefits.

[2] The total is less than the sum of the individual items because more than one change may have occurred for one benefit.

[3] Includes an addition of a basic benefits deductible, elimination of a copayment, and a change from a first-dollar coverage to a limit on the number of days covered.

NOTE: Dash indicates no plans in this category.

	1979	1984
Plans with maximum lifetime benefits	156	156
Below $250,000	86	36
$250,000	58	55
Above $250,000	12	65
Plans with unlimited lifetime benefits	30	38
Average lifetime maximum benefit	$193,000	$450,000

Other health benefits

Other health insurance benefits examined in this study included provisions for mental health care, prescription drugs, private duty nursing, dental care, and vision care. As the following tabulation shows, mental health care, prescription drugs, and private duty nursing were found in 95 percent or more of the plans. Dental coverage was prevalent in 1979 and showed substantial growth by 1984, but vision care continued to be covered in a minority of the plans.

Coverage	1979	1984
Number of plans with—		
Mental health	208	209
Basic benefits only	26	19
Major medical only	24	50
Basic and major medical	158	140
Prescription drug	205	204
Basic benefits only	29	25
Major medical only	170	170
Basic and major medical	6	9
Private duty nursing	199	203
Basic benefits only	15	7
Major medical only	181	192
Basic and major medical	3	4
Dental	116	173
Vision care	53	62

Major medical plans, rather than basic plans, generally provide coverage for private duty nursing and prescription drug care. Both dental and vision care benefits were provided either as part of a comprehensive health insurance package or as a free-standing plan. In nearly all cases, dental benefits entailed a deductible separate from that for other health benefits, and covered at least a portion of usual, customary, and reasonable charges, or provided scheduled cash allowances.

New ways to cut costs

Aside from revising plan provisions, such as increasing major medical deductibles, cost containment efforts have promoted new types of features. None was in a majority of the plans studied in 1984, and because of their relative rarity at the time, these features were not analyzed in 1979. The following tabulation shows the number and percent of plans with a specific cost-containment provision:

	Number	Percent
Second opinion provision before elective surgery	91	44
Higher rate of payment for testing prior to hospital admission	86	41
Hospice care	22	10
Routine physical examination	17	8
Higher rate of payment for generic drugs	7	3
Reduced or no plan coverage for nonemergency weekend hospital admissions	6	3

Cost containment efforts go beyond the provisions considered in this article. Incentives for use of preferred provider organizations, intensified claims review procedures, and introduction of health education and health promotion ("wellness") plans are other approaches that have emerged recently to halt rising health care costs. These items, however, are beyond the current scope of the Bureau's Employee Benefits Survey.[11] □

FOOTNOTES

[1] The number of plans exceeds the number of establishments because some establishments maintained more than one plan, either giving employees a choice of plans or providing distinct plans for different employee groups. The total number of workers covered by the 209 plans is unknown because some of the plans were in multi-establishment companies and covered employees in units other than those surveyed. The employment figure cited in the text reflects plan participation in surveyed establishments only.

[2] Survey results are published in an annual BLS bulletin and special analyses of individual benefit areas, such as health insurance and retirement plans, are featured periodically in the *Monthly Labor Review*.

The survey covers, on a sample basis, private sector establishments in the United States, excluding Alaska and Hawaii, employing at least 50, 100, or 250 workers, depending on the industry. Industrial coverage includes: mining; construction; manufacturing; transportation, communications, electric, gas, and sanitary services; wholesale trade; retail trade; finance, insurance, and real estate; and selected services. The survey analyzes benefit plans paid for wholly or partly by employers; benefits financed entirely by employees are excluded. Findings for 1984 are reported in *Employee Benefits in Medium and Large Firms*, Bulletin 2237 (Bureau of Labor Statistics, 1985). For information on the background and conduct of the survey, see Robert Frumkin and William Wiatrowski, "Bureau of Labor Statistics takes a new look at employee benefits," *Monthly Labor Review*, August 1982, pp. 41–45.

[3] *Health Care Financing Review*, Winter 1984, p. 3; and Fall 1985, p. 3.

[4] Data from the U.S. Department of Commerce, Bureau of Economic Analysis.

[5] Unpublished data from the Bureau of Labor Statistics' 1984 Area Wage Surveys show that 48 percent of office workers and 33 percent of plant workers were in establishments that offered a Health Maintenance Organization plan. The Area Wage Surveys cover a cross-section of industries in metropolitan areas. For more detailed information on these plans, see Allan Blostin and William Marclay, "HMOs and other health plans: coverage and employee premiums," *Monthly Labor Review*, June 1983, pp. 28–33.

[6] *Hospital Statistics 1985* (Chicago, American Hospital Association), text table 8, p. 20.

[7] *Source Book of Health Insurance Data 1980/1981*, Health Insurance Institute, p. 48, and *Source Book of Health Insurance Data 1984/1985*, p. 44.

[8] *Business Insurance*, May 28, 1984, pp. 47–49.

[9] Most commonly found in Blue Shield plans, the usual, customary, and reasonable approach pays all or a percent of the charge of a participating physician for covered services if it is: not more than the physician's usual charge; within the customary range of fees in the given geographic area; and is reasonable, considering medical circumstances.

[10] For a closer look at major medical provisions, see Douglas Hedger and Donald Schmitt, "Major medical coverage during a period of rising costs," *Monthly Labor Review*, July 1983, pp. 11–16.

[11] For more detailed discussions of cost containment, see Richard F. O'Brien, "Health Care Cost Containment: An Employer's Perspective," *Labor Law Journal*, August 1985, pp. 468–73; Karen Ignagni, "Organized Labor's Perspective on Rising Health Costs," *Labor Law Journal*, August 1985, pp. 473–76; William G. Williams, "Health Care Cost-Containment Techniques," in Jerry S. Rosenbloom, ed., *The Handbook of Employee Benefits* (Homewood, Il., Dow Jones-Irwin, 1984), pp. 251–72; and *World of Work Report*, November 1985, pp. 1–2.

A note on communications

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