Special Services in Employer-sponsored Health Plans, 1993 and 1997

Coverage for mental health services, prescription drugs, dental care, and vision care in employer-sponsored health insurance plans expanded between 1993 and 1997; by 1997, these services comprised nearly one-quarter of health care spending. This article examines the prevalence of coverage for these services, recent trends in coverage rates, and the generosity of benefits based on data from the National Employer Health Insurance Survey and the 1997 Robert Wood Johnson Foundation Employer Health Insurance Survey.

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Employer-sponsored health insurance plans often cover a number of special services, in addition to the physician and hospital services that form their common core of benefits. These special services—including mental health, prescription drugs, dental, and vision—comprise a significant portion of spending for all personal health services, and many of them are growing at rates well above average. National personal health care expenditures for these four special services combined were almost $219 billion, or 22.6 percent of all personal health service spending, in 1997. (See table 1.) Total spending for these services grew by 9.2 percent from 1996 to 1997, or at nearly twice the rate of increase for all personal health services. Coverage for some of these special services also is the subject of recent policy attention.[1]

The literature provides some information about the prevalence of coverage for special services. G. A. Jensen and others reported that coverage of mental health services is high—93 percent of insured workers were covered for these benefits in 1995.[2] They found that coverage rates are strongly related to firm size, with only 81 percent of workers covered for mental health in firms with fewer than 50 employees, compared with 97 percent in firms with 200 or more employees. Moreover, employer-sponsored coverage for mental health services grew by 6 percentage points between 1991 and 1995.

Information on the remaining three services comes from another source that is limited to medium and large employers. For employees participating in the employer-sponsored medical plans of these establishments, the prevalence of prescription drug, dental, and vision coverage was 96 percent, 77 percent, and 33 percent, respectively, in 1997.[3] Prescription drug

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TABLE 1. National personal health care expenditures by selected special services, 1997

Service	Expenditures (In billions)	Percent of total expenditures	Growth rate, 1996-97 (Percent)
Total	$969.0	100.0	4.9
Special services	218.9	22.6	9.2
Mental health[1]	75.5	7.8	7.2
Prescription drug	78.9	8.1	14.1
Dental	50.6	5.2	6.5
Vision products and other medical durables [2]	13.9	1.4	3.6

[1] The 1997 estimates were calculated using 1996 estimates and 1986-96 average annual growth rates reported by McKusick and others. To avoid double-counting, data exclude retail prescription drugs.

[2] Vision was not reported separately in the original source.

SOURCE: Levit and others, "National Health Expenditures in 1997: More Slow Growth," *Health Affairs,* November/December 1998, pp. 99-110; McKusick and others, "Spending for Mental Health and Substance Abuse Treatment in 1996," *Health Affairs,* September/October 1998, pp. 147-57.

coverage in these establishments was essentially as likely in 1989 as it was in 1997.[4]

The purpose of this article is to examine the prevalence of coverage for special services among insured workers, recent trends in coverage rates, and the generosity of the benefits provided. Our estimates are based on two large national employer health insurance surveys.

Data and concepts

Data from the National Employer Health Insurance Survey (NEHIS) and the 1997 Robert Wood Johnson Foundation (RWJF) Employer Health Insurance Survey were used to measure special services coverage. The NEHIS completed interviews with 34,604 private employers nationwide, and the RWJF survey interviewed 21,545 private business establishments in the continental United States. The NEHIS was administered during 1994; employers were asked to report characteristics of coverage as of the end of 1993. The RWJF survey was administered during 1997, with employers being asked to report coverage as of the date of the interview.

Both samples were drawn from the Dun's Market Identifiers national census of employment establishments. The NEHIS sample was stratified by State and, within State, by firm and establishment size.[5] The RWJF sample was concentrated in the 60 communities tracked by the RWJF Community Tracking Study and in 12 States that enacted legislation with significant regulations on premiums that can be charged to small businesses. These cases were supplemented by a sample from the remainder of the continental United States to better represent the Nation's business establishments.[6] Within geographic units, the sample was further stratified by the number of workers at each establishment. Simple random samples were then selected from within each stratum.

Data from interviewed employers in both surveys were weighted to account for different sampling probabilities and for nonresponse. Health plan enrollee weights were used throughout this study because coverage comparisons are for insured workers only. The weighted samples represent health plan enrollees in all private establishments that have at least one employee.[7] The NEHIS sample used in the study was restricted to health plan enrollees in the continental United States because this was the population covered in the RWJF survey.

The surveys used similar questions and definitions. Both collected information from employers using computer-assisted telephone interviews, which were conducted with the person or persons in each establishment most knowledgeable about health benefits and firm and worker characteristics. The databases were subjected to similar algorithms to edit data for consistency and to impute missing data. The response rate was 71 percent for the NEHIS and 60 percent for the RWJF survey.

A number of specialized concepts and definitions were used in this study. To measure whether insured workers were offered coverage for a special service, we considered the benefits in the particular general medical plan in which they were enrolled as well as those in any separate single-service plans available to them through their employer. Because the surveys collected information on the enrollments in the special-service plans as well as the general medical plans, we also were able to determine how many enrollees held the expanded package of benefits including these special-service plans and how many held just the general medical plan benefits.

Establishments were defined as having low- or high-wage workers based on the average earnings of the workers.[8] Establishments with low-earnings workers were those with average earnings in the lowest quintile of the distribution of all establishments, and establishments with high-earnings workers were those with average earnings in the highest quintile.

In the 1997 RWJF survey, employers were asked to report the amount of employee cost-sharing (above any deductible) for physician's services in the general medical plan. If mental health services or prescription drugs were included as benefits of the general medical plan, the employer was asked whether cost-sharing for these services differed from that for physician services, and the amount of cost-sharing if it differed. If mental health services or prescription drugs were covered under separate, single-service plans, employers reported the cost-sharing amounts in these plans. The cost-sharing amount for physician services in the general medical plan was compared with that for the special-services in the general medical plan or single-service plan, as applicable, to charac-

TABLE 2. Percent of insured workers participating in coverage for selected special services by firm size and average worker earnings in the establishment, 1993 and 1997

Percent of insured workers	Services in—							
	Mental health		Prescription drugs		Dental		Vision	
	1993	1997	1993	1997	1993	1997	1993	1997
Offered	92	98	94	96	71	72	45	56
Offered and enrolled [1]	97	99	97	99	83	90	75	83
Covered [2]	89	96	91	95	59	65	34	46
Firm size [3]								
Fewer than 25	77	93	79	92	33	39	21	35
25-99	86	95	90	96	47	52	25	42
100-499	91	98	94	97	59	65	33	42
500 or more	93	97	94	95	70	75	41	52
Firm size [3] and worker earnings in establishment [4]								
Fewer than 100								
Low worker earnings	74	91	80	87	33	40	20	37
High worker earnings	85	96	85	95	46	52	27	40
100 or more								
Low worker earnings	90	97	92	94	61	77	33	42
High worker earnings	94	98	93	96	71	77	47	49

[1] Percent of insured workers who were offered the benefit and participated in it.

[2] Percent of total workers who are enrolled in a benefit. For example, in 1997, if 72 percent of insured employees are offered dental benefits and 90 percent of them enroll in the benefit, 65 percent of total workers are covered by the benefit.

[3] Number of employees.

[4] Low worker earnings signifies establishments in the lowest quintile of the distribution of average worker earnings; high worker earnings signifies establishments in the highest quintile.

SOURCE: 1993 National Employer Health Insurance Survey and 1997 Robert Wood Johnson Foundation Employer Health Insurance Survey.

terize the relative generosity of benefits for these two services.

Coverage

In 1997, coverage for mental health services and prescription drugs was nearly universal—96 percent and 95 percent, respectively—among workers who were enrolled in employer-sponsored health insurance plans. (See table 2.) In contrast, dental coverage was held by about two-thirds of insured workers and vision benefits by about one-half of insured workers. The lower coverage rates for these latter services were explained mostly by whether the employer offered the coverage; when it was offered, between 83 percent (vision) and 90 percent (dental) of workers were enrolled.

Coverage for all four special services rose between 1993 and 1997, with increases that ranged from 4 percentage points for prescription drugs to 12 percentage points for vision. These increases can be attributed both to an increase in the likelihood of employers offering the benefits and an increase in the likelihood of employees enrolling when the benefit is offered.

There were some differences in coverage rates for special services by firm size and worker earnings. In both years, 1993 and 1997, insured workers in small firms (those with fewer than 25 employees) were less likely to be covered for each of the special benefits than were those in larger firms. (See table 2.) The extreme case is dental coverage, which in 1997 was only about half as likely among insured workers in small firms (39 percent) as it was among those in firms with 500 or more employees (75 percent). Increases in coverage between 1993 and 1997 occurred among employees in firms of all sizes; however, the largest increases in coverage for most services took place among small firms. Workers in establishments with higher earnings levels were more likely to be covered for each of the special benefits studied in both years. Overall, this effect was especially pronounced in firms with fewer than 100 employees.

Benefits

Table 3 shows how participants' cost-sharing for mental health and prescription drug benefits compared to their cost-sharing for physician services in 1997. Cost-sharing for mental health tends to be the same for about three-quarters of enrollees, while it is higher (a less generous benefit) about one-quarter of the time. Larger employers are more likely to use less generous cost-sharing as a cost containment mechanism than are smaller employers. In contrast, cost-sharing for prescription drugs is lower for about one-fifth of enrollees, while it is the same about four-fifths of the time. For prescription drugs, large employers appear to be a bit more likely to have more generous benefits, although the difference is not statistically significant.

Discussion

Special services are a significant portion of national health spending and

TABLE 3. Percent of insured workers whose participant cost-sharing for selected special services benefits is lower than, the same as, or higher than their cost-sharing for physician services by firm size, 1997

Firm size[1]	Patient cost-sharing for—					
	Mental health compared to physician services			Prescription drugs compared to physician services		
	Lower	Same	Higher	Lower	Same	Higher
Total	3	73	24	18	79	3
Fewer than 25	2	81	17	15	83	2
25-99	3	78	19	15	82	3
100-499	3	72	25	17	79	4
500 or more	3	71	26	19	78	3

[1] Number of employees.
SOURCE: 1997 Robert Wood Johnson Foundation Employer Health Insurance Survey.

are covered under employer plans for many enrollees. For the 1993-97 period, coverage of the four special services studied was expanding. However, this was a period of relatively stable prices for employer-sponsored health coverage overall. If health insurance premiums start to rise more rapidly, employers might respond either by cutting back this new coverage or by reducing the breadth of current benefits. Policy changes, such as mandated benefits and mental health parity, also could affect coverage of these services. These trends deserve monitoring over coming years. ■

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[1] For example, the Mental Health Parity Act of 1996 prohibits annual and lifetime reimbursement ceilings for mental health coverage that are more restrictive than other ceilings. Prescription drug coverage for medicare is currently under debate and if spending trends continue there will be pressure on employers to modify this benefit as well. See K. Swartz, "Be Creative in Consumer Cost-Sharing for Pharmaceutical Benefits," *Inquiry*, Winter 1998-99, pp. 365-68.

[2] G. A. Jensen and others, "Mental Health Insurance in the 1990s: Are Employers Offering Less to More?" *Health Affairs*, May/June 1998, pp. 201-08.

[3] *Employee Benefits in Medium and Large Private Establishments, 1997*, Bulletin 2517 (Bureau of Labor Statistics, September 1999).

[4] Ibid., and C. Baker and N. Kramer, "Employer-sponsored prescription drug benefits," *Monthly Labor Review*, February 1991, pp. 31-35.

[5] A. J. Moss, *Plan and Operation of the National Employer Health Insurance Survey* (Hyattsville, MD, National Center for Health Statistics, 1999).

[6] *1997 Employer Health Insurance Survey: Final Methodology Report* (Research Triangle Park, NC, Research Triangle Institute, 1998); and P. Kemper and others, "The Design of the Community Tracking Study: A Longitudinal Study of Health System Change and Its Effects on People," *Inquiry*, Summer 1996, pp. 195-208.

[7] Self-employed individuals with no employees are excluded.

[8] These measures were based on responses in the two surveys about the shares of workers with earnings in a set of categories. In NEHIS, there were 3 categories: Less than $10,000 per year, $10,000-$30,000 per year, and $30,000 per year or more. In RWJF, there were 5 categories: Less than $10,000 per year, $10,000-$14,000 per year, $14,000-$20,000 per year, $20,000-$30,000 per year, and $30,000 per year or more.