

# Trends in Health Insurance Costs

BY ALBERT E. SCHWENK

One of the distinguishing features of the Employment Cost Index (ECI) is that it provides information on trends in employer costs for benefits as well as wages and salaries. Since 1979, when benefit data first became available from the ECI, benefit costs in private industry typically have risen faster than wages and salaries, but movements in these two components of compensation have roughly paralleled each other. (See chart 1.) The major exceptions to this pattern were in 1981-82, 1985-87, and 1992-96. The latter two exceptions can generally be explained by unusually small increases in employer costs for health insurance.

This article concentrates on one component of the insurance category—health insurance—which accounts for about 90 percent of the total cost of insurance. It examines fluctuations in the rate of increase in health insurance costs,

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evaluates their effect on total benefit costs, and attempts to explain them.

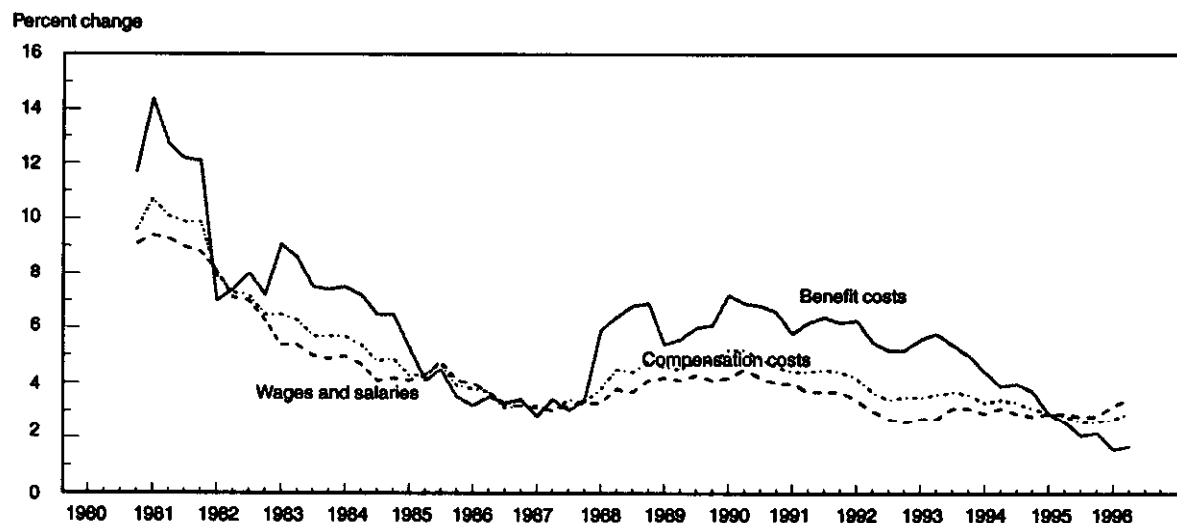
## Benefits covered by the ECI

The ECI covers wages and salaries and five major categories of benefits. Table 1 shows the cost per hour worked and percent of total compensation for those components of compensation for private industry. Legally required benefits is the most important benefit category, accounting for nearly one-third of all benefit costs; insurance and paid leave account for about one-quarter each, and retirement and savings and supplemental pay about 10 percent each.

## Trends in health insurance costs

From 1980 to 1983, health insurance costs as measured by the ECI accelerated steadily, reaching an annual increase of 23.5 percent in the 12 months ended March 1983. From that point, the rate of increase declined steadily, to 3.5 per-

Chart 1. Percent changes in wages and salaries, benefit costs, and total compensation, private industry workers, 1980-96



**Table 1. Cost per hour worked for components of compensation, and costs as a percent of compensation, private industry workers, March 1996**

Compensation component	Cost per hour worked	Percent of compensation <sup>1</sup>
Total compensation .....	\$17.49	100.0
Wages and salaries .....	12.58	71.9
Total benefits .....	4.91	28.1
Legally required .....	1.59	9.1
Insurance .....	1.14	6.5
Paid leave .....	1.12	6.4
Retirement and savings .....	.55	3.1
Supplemental pay .....	.49	2.8
Other benefits .....	.03	2

<sup>1</sup> Due to rounding, percentages may not equal total.

cent in the 12 months ended June 1986. It again accelerated to 14.7 percent in the year ended December 1988, but then slowed, reaching a low of -0.3 percent in the year ended in March 1996.

Fluctuations in health insurance costs are a major reason for deviations between benefit cost changes and wage and salary changes. Chart 2 shows that when health insurance is excluded, benefit cost gains are closer to wage and salary increases.

Fluctuations in the rate of increase in health insurance costs reflect a number of factors, the most important of which are changes in the cost of medical care and cost containment efforts by employers.

Changes in the cost of medical care are provided by the medical care segment of the Consumer Price Index (CPI).<sup>1</sup> Chart 3 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.<sup>2</sup> That is to be expected, because the ECI reflects not only the cost of medical care but also employer/employee choices regarding plan types, employee contributions, and other factors.

The steady declines in the rate of increase in employer health insurance costs during 1983-86 were due to slow-downs in the rate of gain in the cost of medical care. Apparently, more important were employer efforts at health

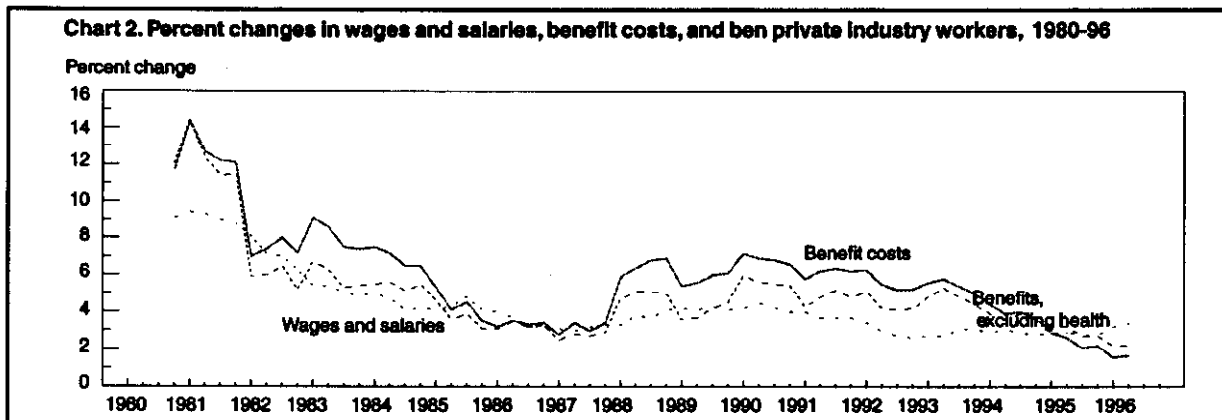
care cost containment. While it is not possible to quantify the effects of each type of cost containment, a review of cost containment efforts does shed light on what employers did to control their health insurance costs.

To contain health insurance costs, employers have used a variety of approaches, including shifting some or all of the burden to employees. As a consequence, the percentage of employees whose health insurance premiums are wholly paid by employers has declined sharply since 1980. Thirty-eight percent of full-time workers in medium and large private establishments had individual coverage wholly financed by their employer in 1993, down from 54 percent in 1986 and 72 percent in 1980. Twenty-two percent were eligible to receive fully employer-paid coverage for their families, down from 35 percent in 1986 and 51 percent in 1980.<sup>3</sup>

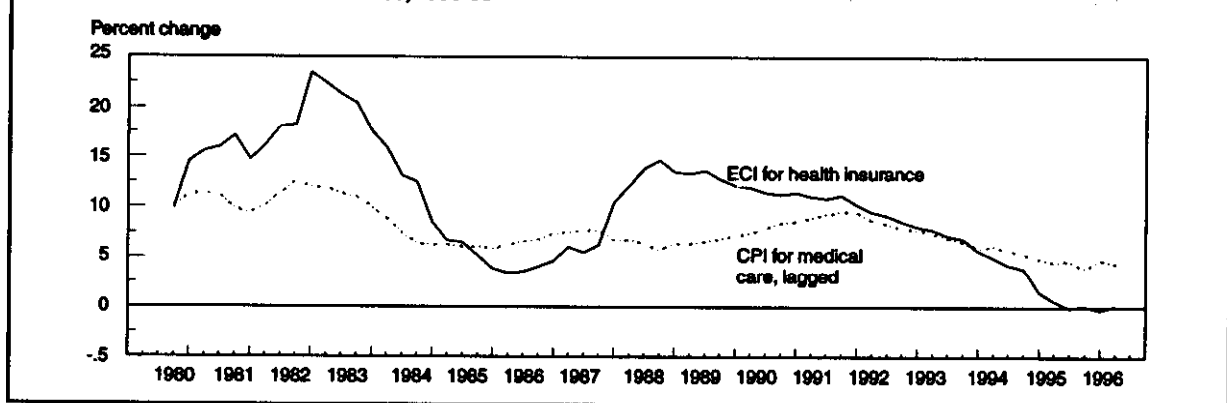
These changes in employee contributions for health insurance coincided with a number of changes in health plan design expected to curb costs. For example, some health care plans were redesigned to eliminate basic coverage for certain types of care, and placed payment arrangements under a major medical plan. Under a major medical plan, the employees were required to pay a deductible (a minimum initial payment for medical costs made by the insured individual before plan benefits can be used). The deductible requirement was an attempt to discourage unnecessary use of plan benefits, thus reducing the cost of insurance. These major medical deductibles have increased over time to keep pace with the rising cost of medical services.

Employers also explored ways to reduce their expenses, such as creating self-funded plans instead of using commercial health care insurance plans. Self-funded plans were viewed as a way to save money by allowing companies to retain funds which would otherwise be used to pay insurance premiums, and to eliminate taxes on insurance premiums, as well as giving the companies more control over plan design and expenditures. In 1979, 11 percent of all medical plan participants were covered by self-insured plans in medium and large firms; by 1988, the proportion had tripled to 34 percent; by 1993, nearly half of medical plan participants (46 percent) were in self-funded plans.

**Chart 2. Percent changes in wages and salaries, benefit costs, and ben private industry workers, 1980-96**



**Chart 3. Percent changes in the Consumer Price Index for medical care (lagged 1 year), and Employment Cost Index for health insurance, 1980-96**



In addition to self-funding, there was a greater reliance on managed care programs, such as health maintenance organizations (HMO's) and preferred provider organizations (PPO's). HMO's are prepaid health care plans that deliver comprehensive medical services to members for a fixed periodic fee. According to the Bureau's Employee Benefits Survey (EBS), 5 percent of employees in medium and large firms were covered by HMO's in 1984, 13 percent in 1986, and 23 percent in 1993.

PPO's provide coverage for individuals on a fee-for-service basis and offer a choice of providers. According to the EBS, 1 percent of employees in private medium and large firms were covered by PPO's in 1986 (the first year the data were tabulated); by 1993, 26 percent were.

Some cost savings were realized through changes in plan design that increased the employer's control over the type of health care services employees were able to use. Examples of these changes include requiring second opinions for surgical procedures and prehospitalization testing, as well as creating incentives to use outpatient facilities, to buy generic prescription drugs, and to audit hospital bills.<sup>4</sup>

### 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 cost 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); or
- 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.<sup>5</sup> This is in contrast to other types of employee benefit plans, such as paid holidays and vacations, that are tied directly to wages.

### —Endnotes—

<sup>1</sup> The CPI for medical care prices a fixed market basket of medical commodities and services.

<sup>2</sup> The change in ECI health insurance costs showed a closer relationship to the CPI for medical care lagged 1 year than to the concurrent change in the CPI for medical care. For example, the March 1993-March 1994 change in ECI health insurance costs were more closely related to the March 1992-March 1993 change in the CPI for medical care than to the March 1993-March 1994 change.

<sup>3</sup> See, for example, Ann C. Foster, "Employee Contributions for Medical Care Coverage," *Compensation and Working Conditions*, September 1996, pp. 51-53.

<sup>4</sup> For more information on employer containment of health insurance costs,

see Stephanie Hyland, "Health Benefits Show Cost Containment Strategies," *Monthly Labor Review*, February 1992, pp. 42-43; Thomas P. Burke, "Alternatives to Hospital Care Under Employee Benefit Plans," *Monthly Labor Review*, December 1991, pp. 9-15; and Robert B. Grant, "Outpatient Surgery: Helping to Contain Health Care Costs," *Monthly Labor Review*, November 1992, pp. 33-36. These articles are all reprinted in *Employee Benefits Survey: A BLS Reader*, Bulletin 2459, Bureau of Labor Statistics, February 1995.

<sup>5</sup> Of course, the likelihood of a plan being offered by an employer is directly related to an employee's earnings. See, for example, Albert E. Schwenk and William R. Bailey, "Employer Expenditures for Private Retirement and Insurance Plans," *Monthly Labor Review*, July 1972, pp. 15-19.