[COMMITTEE PRINT]

# HEALTH INSURANCE AND THE UNINSURED: BACKGROUND DATA AND ANALYSIS

PREPARED FOR THE

SUBCOMMITTEE ON LABOR-MANAGEMENT RELATIONS

AND THE

SUBCOMMITTEE ON LABOR STANDARDS

OF THE

COMMITTEE ON EDUCATION AND LABOR

AND THE

SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT

OF THE

COMMITTEE ON ENERGY AND COMMERCE
HOUSE OF REPRESENTATIVES

AND THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

BY THE

Congressional Research Service
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MAY 1988

Education and Labor Serial No. 100-Z
Energy and Commerce Serial No. 100-X
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October 14, 1987

Mr. Joseph E. Ross, Director
Congressional Research Service
Library of Congress
Washington, D. C. 20540

Dear Mr. Ross:

Public and private institutions now provide health insurance to the majority of the nation's population. In general, most employed working-age persons and their dependents are covered through employer-provided insurance. The elderly and disabled are covered by the Federal government's Medicare program and about two-fifths of the poor receive insurance through the Federal/State Medicaid program. However, a sizeable minority (estimates run as high as 37 million) have no health insurance even though most of these are employed. Furthermore, some 10 million people in poverty are not covered by Medicaid and have no health insurance.

Various means to extend health insurance coverage to those who do not have it have been proposed in the past, and although some improvements have been made, the largest part of the problem still remains. This Committee is interested in further efforts to extend coverage to those who do not now have it, and we are writing to you to solicit the assistance of the Congressional Research Service in analyzing options for doing so.

In particular, the Committee is interested in options for extending minimum health benefits to those who do not have health insurance as part of compensation for employment. This might be by providing incentives to employers, by mandating coverage, or some other means. In addition, the Committee is interested in options for providing insurance to those who are either unemployed, are uninsurable through current practices, or who are poor and yet do not qualify for Medicaid.

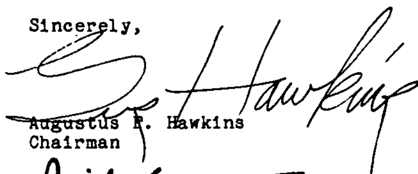
Mr. Joseph E. Ross                                                    October 14, 1987

We recognize this to be a difficult task and are in need of high quality analysis to assist us. Accordingly, we are requesting the CRS to provide the Congress with analysis on the costs of the various options for mandating health insurance, on individuals, on businesses, and on other public and private institutions. In addition, we request that the analysis include consideration of some of the administrative issues associated with options for extending health insurance to those who do not have it.

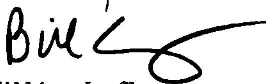
We thank you for your support.

Sincerely,

Austin Murphy
Chairman
Subcommittee on Labor Standards



Augustus F. Hawkins
Chairman



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SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT

2415 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515
PHONE (202) 225-4952

March 30, 1988

Mr. Joseph Ross, Director
Congressional Research Service
Library of Congress
Washington, D.C. 20540

Dear Mr. Ross:

I understand the Congressional Research Service is prepared to undertake a major study related to health insurance and the uninsured population in the U.S.: Who is Uncovered, what role private health insurance can play in providing coverage to the uninsured, options for extending that health insurance coverage, and the effects of a program to achieve this end.

I am aware that the Committee on Education and Labor has worked with you on the design and plan for the study. With their agreement, I would like to request that you also consider the Committee on Energy and Commerce as a requester of the study, include us in the study development, and provide us with your results.

My staff has already discussed the study plan in some detail with Royal Shipp and Janet Kline. We look forward to continuing to work with them as the study progresses. I believe it will provide great assistance to the Committee in its consideration of the Minimum Health Benefits bill, and will make an important contribution to our long-term understanding of and solution to the problem of the uninsured.

With every good wish, I am,

Sincerely,

HENRY A. Waxman
Chairman, Subcommittee on
Health and the Environment

HAW:kna

# VIII

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**United States Senate**

SPECIAL COMMITTEE ON AGING
WASHINGTON, DC 20510-6400

October 21, 1987

Joseph E. Ross
Director
Congressional Research Service
Library of Congress
Washington, DC 20540

Dear Mr. Ross:

Public and private institutions now provide health insurance to the majority of the Nation's population. Most employed persons and their dependents are covered through employer-sponsored insurance plans. Persons age 65 and older and disabled persons are covered by the Federal Government's Medicare program, and about two-fifths of the poor receive insurance through the Federal/State Medicaid program. Unfortunately, a sizeable minority (estimates run as high as 37 million) have no health insurance. While most of these are connected to the workforce, many are retirees under age 65 or others who have no current workforce connection. Ten million of those not covered live in poverty, but are ineligible for Medicaid.

Various means to extend health insurance coverage to those who do not have it have been proposed in the past, and although some improvements have been made, the largest part of the problem still remains. This Committee is interested in further efforts to extend coverage to those who do not now have it, and we are writing to you to solicit the assistance of the Congressional Research Service in analyzing options for doing so.

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Joseph E. Ross
October 21, 1987
Page 2

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We thank you for your support.

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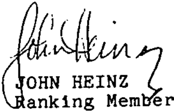

JOHN HEINZ
Ranking Member

JOHN MELCHER
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Washington, D.C. 20540

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LETTER OF SUBMITTAL

May 24, 1988

Mr. Augustus F. Hawkins, Chairman
Committee on Education and Labor
U. S. House of Representatives
Washington, D. C. 20515

Dear Mr. Chairman:

This report, submitted today, constitutes partial response to your request for analysis of issues in providing health insurance to the uninsured population, requested by your letter of October 14, 1987. The House Committee on Energy and Commerce and the Senate Special Committee on Aging joined in requesting the study.

Upon receipt of your letters, a team of CRS analysts began meeting, and in consultation with members of committee staffs, developed a plan for a comprehensive study. The foremost priority was to produce a study that would help the requesting committees, and the entire Congress, understand the benefits and disadvantages of the various approaches for extending health insurance to those who do not have it, if the Congress decides to take such action.

This first report presents background data and analysis on health insurance and the uninsured population. A second report, completing the study, will develop methodologies for measuring and assessing the effects of extending various health insurance packages to the uninsured, and will develop specific illustrative plans for doing so. We intend this second report to be completed later this year.

We hope this report will be of use to your Committee and to the Congress as you consider options for the extension of health insurance.

Sincerely,

Joseph E. Ross
Director

Enclosure

# PREFACE

This report, the first of a two-part study by the Congressional Research Service (CRS) on the issues of extending health insurance to the currently uninsured, was initially requested by the House Committee on Education and Labor and the Senate Special Committee on Aging. Subsequently, the Subcommittee on Health and the Environment of the House Committee on Energy and Commerce wrote to CRS expressing interest in the study and asked to be included as a sponsor.

After discussions with committee staffs, a CRS team began meeting and planning the study. An early decision was made to produce two separate study reports. This first report provides background information, data, and analysis on: (1) the health insurance business, (2) government regulation of health insurance, (3) the number and characteristics of the uninsured, (4) exposure to health care costs by people who have insurance, and (5) a comparison of the utilization and financing of health care services by the insured and uninsured.

The second report, completing the study, will be available later this year. This second report will develop tools for use in analyzing options for extending health insurance should Congress decide to pursue such options. The report will analyze the cost of health insurance and provide more detail about how insurance companies rate and underwrite health insurance. An actuarial model will be developed to examine these issues and to analyze the concept of actuarial equivalence. The report will review and analyze possible approaches for extending health insurance, emphasizing problems of implementation and effects on health insurance markets. Final sections of the report will study the effects of extending health insurance on individuals, businesses, health providers and insurers, and governments.

A CRS team was formed to carry out the health insurance study. This team consisted of the following analysts from the Education and Public Welfare Division:

Health Section: Janet Kline, Section Head; Beth Fuchs; Janet Lundy; and Mark Merlis.

Income Maintenance Section: Vee Burke, Section Head; Ray Schmitt; Dennis Snook; and Jim Storey.

Methodology Section: Ken Cahill, Section Head; Gene Falk; and Michael O'Grady.

The Project Manager was P. Royal Shipp. Vicki Freedman was research assistant to the study. Under contract with CRS, Edwin Hustead, Michael Carter, Larry Bobbitt, and J. Alan Lauer of Hay/Huggins Company, Inc. worked with the team to provide actuarial and other technical assistance.

The team worked together, agreeing on a study concept and structure. Then the entire team participated intensively in reviewing drafts of chapters in the first report, each analyst making major additions and changes to the text of the chapters. In the fullest sense, the report is a team product. Initial drafts were written by: Mark Merlis (Summary), Vicki Freedman (chapters 2, 5, and 6),

Beth Fuchs (part of chapter 2), Edwin Hustead (part of chapter 2), Ray Schmitt (chapter 3), and Gene Falk and Michael O'Grady (chapter 4).

The following outside experts reviewed the report and offered helpful comments:

Deborah Chollet, Employee Benefit Research Institute

Pamela Farley Short, National Center for Health Services Research

Gail Wilensky, Project Hope

In addition, chapter 2 of the report benefited from extensive, careful and expert review by the following:

Michael Schiffer, CIGNA

Mary Nell Lehnhard and Diana Jost, Blue Cross/Blue Shield Association

Judy Cahill, Group Health Association of America

Julian Pettengill, a CRS analyst in the Education and Public Welfare (EPW) Division, reviewed and gave helpful comments on chapter 6. Joseph Cislowski, also an EPW analyst, reviewed chapter 5.

To help the CRS team and congressional staffs understand the issues of health insurance, the following met formally with the team and invited guests to discuss their views on the issues.

Stuart Altman, Brandeis University and the Prospective Payment Assessment Commission

Judy Cahill, Group Health Association of America

Deborah Chollett and Frank McArdle, Employee Benefit Research Institute

Karen Davis, Johns Hopkins University

Willis Goldbeck, Washington Business Group on Health

Edwin Hustead and Mike Carter, Hay/Huggins Company, Inc.

Stanley B. Jones, Consolidated Consulting Group

Mary Nell Lehnhard and Diana Jost, Blue Cross/Blue Shield Association

Earl Pomeroy, Commissioner of Insurance, State of North Dakota

Michael Schiffer, CIGNA

Katherine Swartz, The Urban Institute

Gail Wilensky, Project Hope

Karen Williams, Health Insurance Association of America

## SUMMARY

The United States provides health insurance through a combination of private initiatives and public programs. The U.S. health insurance "system" evolved gradually beginning in the late 19th century. Health insurance plans offered by direct providers of health care, such as physicians and hospitals, grew into the Blue Cross/Blue Shield systems in the 1930s. Commercial insurers began offering health insurance policies around the same time. By the end of World War II, increasing numbers of employers were offering health insurance as a fringe benefit, while individuals with the means could buy coverage on their own. Concern that health insurance was still unavailable to many Americans led to a series of Federal attempts to fill the gaps in private coverage, culminating in the 1965 enactment of the Medicare program for the aged (and later the disabled and persons with end-stage renal disease) and the Medicaid program for certain categories of the poor. Still, private insurance, chiefly employment-based, remains the primary source of health coverage for most Americans.

The nature of private coverage has changed as the insurance industry has grown. At one time, the plans offered by Blue Cross/Blue Shield programs differed from those offered by commercial insurers in at least three key respects. First, the Blues offered "service benefits," paying in full for covered services; commercial insurers offered "indemnity" coverage, paying a fixed amount for each service and leaving the enrollee to pay any uncovered balance. Second, the Blues used "community rating," under which premium amounts were based on expected costs for all policyholders; low-cost individuals or groups helped to pay for the participants requiring more expensive services. Commercial insurers used "experience rating," under which the rate for each employer group was based on historic costs for that specific group. Third, most of the Blues practiced a policy of "open enrollment," permitting any individual or group to purchase coverage. Commercial insurers adopted underwriting practices comparable to those traditionally used in their other lines of insurance business, such as life insurance. That is, applicants perceived to be high risk might be charged higher rates, or be denied coverage (temporarily or permanently) for problems already diagnosed at the time the policy took effect. Applicants with costly chronic conditions might be denied coverage altogether.

The differences between the practices of the Blues and commercial insurers have diminished over time. Indemnity coverage is increasingly rare, especially in employment-based plans. Most of the Blues now use experience rating for large employer groups, and many—though not all—have modified their enrollment policies, using underwriting to limit their risks.

Meanwhile, new forms of competition have entered the insurance market. These include health maintenance organizations (HMOs),

that directly provide or arrange the services used by their enrollees and seek to reduce unnecessary care, and preferred provider organizations (PPOs), that give their enrollees financial incentives to use the least expensive hospitals and physicians. Traditional insurers are also taking steps to control the use of services and reduce costs; for example, they may require prior authorization or second opinions before certain services are furnished. Finally, many large and medium-sized employers have sought further cost-savings by "self-insuring," covering the costs of their employees' health care directly instead of purchasing insurance from an outside firm.

These changes all have had a potential impact on the ability of individuals and small employer groups to obtain and pay for health insurance.

## Extent and Adequacy of Health Insurance Coverage

As of 1986, 85 percent of all Americans had some form of health insurance coverage during at least part of the year. Of those aged 65 and over, 99 percent were covered, chiefly through Medicare. Of those under 65, 83 percent were covered: and among these nonaged insured persons, over three-quarters were covered through their own employment or that of another family member. The rest were covered by a mix of Medicaid, Medicare, CHAMPUS (the health program for armed services personnel and their dependents), individually purchased private policies, and other health insurance sources.

However, an estimated 37.1 million persons had no coverage at any time during 1986; all but 300,000 were under age 65. More than half of the uninsured were employed during at least part of the year. Younger and lower-paid employees, and those who worked part-time or for only part of the year, were more likely to be without coverage from their own employment. Employer-based coverage was least common for employees in certain sectors of the economy, such as agriculture, personal/household services, and retail trade, and most common for those in manufacturing, mining, or public administration. Small firms were much less likely than larger ones to provide coverage.

The share of the nonaged population lacking health insurance has grown from 14.6% in 1979 to 17.5% in 1986. The most significant change appears to have been in dependent coverage. Fewer people are obtaining insurance through another family member's employment. Two factors appear to have contributed about equally to this change. First, coverage rates for spouses and children have declined. Second, demographic shifts have occurred. For example, children under 18 made up a smaller part of the population in 1986 than in 1979; older children in the household may not be eligible for coverage under their parents' policies. (These findings contradict much "conventional wisdom" about the reasons for the continued large numbers of people without health insurance. Other analysts have speculated that this growth in the uninsured was due to increases in service sector jobs, with relatively low rates of employer-sponsored health insurance, at the expense of manufacturing industries with higher rates. The empirical evidence analyzed here,

however, demonstrates that the rise in the uninsured is mainly due to demographic shifts and to lower rates of dependent coverage.)

Those who lack health insurance may face significant financial barriers in obtaining needed health services. According to the 1986 Health Interview Survey, the uninsured see a physician two-thirds as often as the insured, and spend three-fourths as many days in the hospital. They are less likely to obtain care for certain kinds of health problems and are more likely to rely on emergency rooms for routine services. Differences in the use of health services by the insured and uninsured exist even after taking age and income into account.

When the uninsured do obtain services, they must pay for their own care or rely on some form of subsidy. The subsidy may be direct, as when a local government supports the operations of a public hospital, or indirect, as when a provider increases charges for insured patients to help cover the costs of care for patients who cannot pay. There is concern that as the number of uninsured persons grows the ability of providers to spread the costs for their care to other payers declines. Both public and private insurers have become increasingly price-conscious. New forms of insurers, such as HMOs and PPOs, restrict their members to less costly providers or negotiate discounts from the providers' usual charges. The resulting financial pressures may further reduce access to care for the uninsured.

Many persons' health insurance plans leave them at risk for having to pay much of the cost of their own care. Virtually all private health insurance plans require enrollees to make some contribution, in the form of deductibles and coinsurance payments, to the cost of their own care. Most plans have some limit on the cost-sharing amounts an enrollee could be required to pay in the course of a year, but 17 percent of the plans offered by large and medium employers in 1987 had no such limit, and an additional 24 percent had limits in excess of $1,000 for an individual enrollee. Insurance purchased on an individual basis was more likely to have no limitation on an enrollee's potential expenditures for covered services. Enrollees also may be liable for services excluded from a plan (most often prescription drugs or mental health care) or for costs in excess of a lifetime benefit limit imposed by the plan. Fourteen percent of plans offered by medium and large employers had lifetime limits of $250,000 or lower, possibly less than the cost of some kinds of catastrophic episodes. As a result of these coverage limits and enrollee cost-sharing requirements, an estimated 15.3 percent of all insured families had 1987 health expenses (not counting insurance premiums) greater than 5 percent of their family income; 3.7 percent had expenses greater than 25 percent of their family income.

## Current Regulation of Health Insurance and Health Benefits

Responsibility for regulation of health benefits and health insurance is divided between the States and the Federal Government. Regulation of all forms of insurance has traditionally been the province of the States; State primacy in this area was confirmed by the McCarran-Ferguson Act of 1945. However, the right to regulate

employee benefits, including health benefits, was reserved by the Federal Government in the Employee Retirement Income Security Act of 1974 (ERISA). ERISA established uniform national standards for employee benefit plans and preempted State regulation of these plans. States can still regulate the companies selling health insurance and the content of the policies they sell. However, States cannot directly regulate the benefit plans offered by employers. An employer that "self-insures" (covers employees' health expenses directly instead of buying insurance from an outside company) is exempt from any State regulation. In part, large employers increasingly choose to self-insure to avoid State regulations, such as mandated coverages in health insurance policies or taxes on insurance premiums.

In comparison to the regulation of pensions and other retirement benefit plans, direct Federal regulation of employee health benefits has been minimal. No employer has been required to furnish health coverage, but employers who do choose to provide coverage have been subjected to certain requirements. The Health Maintenance Organization Act of 1973 requires most employers who provide health benefits to offer employees the option of joining an HMO as an alternative to the employer's basic plan. The Consolidated Omnibus Reconciliation Act of 1985 (COBRA) requires an employer to allow employees and dependents to continue to participate in the employer's health plan, at their own expense, for up to 18 months (or in some cases, 36 months) after an event that would otherwise cause them to be dropped from the plan, such as loss of a job or a change in marital status. Finally, the Tax Reform Act of 1986 requires employers to ensure that their health plans do not discriminate in favor of highly compensated employees. Plans that continue to discriminate will lose the favorable tax treatment given to employee health benefits.

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# CHAPTER 1.—INTRODUCTION

## I. Issue Background

This report presents background data and analysis on the issue of providing access to medical care for persons who lack health insurance. In the United States, most people gain this financial access through health insurance, and the issue of expanding health insurance to those most likely to be uninsured has faced the Nation for most of this century.

Proposals to expand health insurance force health care policymakers to confront a tension between those who view health care as services that are bought and sold in a marketplace, and those who see it as an entitlement or a right that ought to be available to all. Some medical care providers and experts have argued that, at the point of need, decisions about medical care treatments should not be constrained by their cost or the ability of patients to pay for them. United States policymakers approach the issue of expanding health insurance in a way that reflects this tension.

Recent debates over medical ethics have included consideration of financial access to health care. For example, a Presidential Commission reported in 1983 that health care in the United States should be provided to all people in an equitable fashion and at a cost that does not constitute an excessive economic burden.[1] This conclusion leaves much room for debate over definitions of "equitable" and "economic burden," but nonetheless, acceptance of this view of medical care would place it in a unique category of consumer services.

Access to medical care has several dimensions, including geographic location, supply of providers, and ability to pay. Access to medical care depends importantly upon ability to pay, and, in the United States, ability to pay has been assured through health insurance for most people. In general, ability to pay is defined as financial access, which is the focus of this study.

Ensuring access to medical care through expansion of health insurance has been debated in the United States throughout much of this century. Most western European countries began enactment of national health insurance systems late in the 19th or early in the 20th centuries. During this period, proposals for national health insurance, as part of social insurance schemes, were debated but not enacted in the United States. A proposal for national health insurance received serious consideration in the 1920s, and again in the mid-1930s as part of the work of the Committee on Economic Security that produced the Social Security system. In both instances,

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[1] Securing Access to Health Care. Report of the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, Mar. 1983. pp. 4–5.

the medical community opposed national health insurance legislation, and a national program was not enacted.

After World War II, President Truman recommended health insurance for the elderly, but Congress did not act, nor was action taken during the 1950s. At hearings in 1958, Secretary Marion B. Folsom of the U.S. Department of Health, Education and Welfare, testifying on behalf of the Eisenhower Administration, opposed national health insurance on the grounds that rapid growth of employer-sponsored private insurance had made it unnecessary.

However, by the mid-1960s the Congress determined that, despite the growth of private health insurance during the post-war period, certain groups of people, particularly the elderly and cash welfare recipients, were unable to purchase health insurance at affordable rates. After extensive debate and negotiations, Congress enacted the Medicare and Medicaid programs in 1965.

Today, the approach to providing access to medical care in the United States, in contrast to that of other developed countries, reflects the Nation's unique tradition of combining private and public means for delivering most important social services. Financial access to health care is (largely) met through a combination of employer-sponsored health insurance for workers and dependents, Medicare for the elderly and long-term disabled, and Medicaid for certain categories of the poor (those potentially eligible for cash welfare).

Yet, this patchwork arrangement, however broad, leaves millions of people without any health insurance. These people are unemployed or poor but not eligible for Medicaid or are working part-time, or they work for employers who do not offer health insurance to employees. Proposals to close coverage gaps and to provide financial access to health care through expanded health insurance coverage were considered and debated, but not enacted, under the Nixon, Ford, and Carter Administrations throughout the 1970s.

By the mid-1980s, as a result of a confluence of events, political forces, and personalities, various proposals to expand health insurance coverage continued to the considered by Congress. Major initiatives to expand the number of persons covered by health insurance enacted so far in the 1980s have focused on amending existing programs to provide additional insurance to the temporarily unemployed and to uninsured low-income people who are not eligible for Medicaid (able-bodied, nonaged, childless persons, and two-parent working families with children). After reductions in Federal Medicaid funding for fiscal year 1982–1984, incremental expansions in the program to extend coverage to older children and pregnant women were enacted in 1984, 1986 and 1987. In 1983 the House passed, but the Senate rejected, a bill that would have mandated continued employer-sponsored coverage for the temporarily unemployed. In 1986, legislation was enacted that required employers to offer (but not necessarily pay for) continued coverage under group rates to employees or dependents who lose coverage as a result of loss of employment to changes in family status. In addition, as part of the 1986 Tax Reform Act, nondiscrimination rules were extended to insured employer health insurance plans.

Broad-based concern about the adequacy of health insurance for the already covered was evidenced by the Reagan Administration's

proposal to add "catastrophic" insurance features for age 65 and older people and the disabled as part of the Medicare program. Both Houses of Congress have passed legislation that would add catastrophic features to Medicare, and a Conference Committee is metting to resolve differences.

On February 17, 1988, the U.S. Senate Committee on Labor and Human Resources voted for an amended version of S. 1265, a bill that would require most employers to provide health insurance to their employees and their employees' dependents. Companion legislation (H.R. 2508) has been introduced in the U.S. House of Represenatives.

Data are not yet available to measure the effect of these recently enacted laws on the insurance status of Americans. But even if these laws met their objectives, large numbers of people would remain uninsured. In fact, the estimated number under age 65 without health insurance increased sharply during the early part of the decade, from 28.4 million in 1979 to 36.8 million in 1984, and it stayed at that high level through 1986. This increase occurred as the economy fell into serious recession (1981-82) and unemployment reached 9.7 percent of the workforce.[2]

One common hypothesis is that the increase in the uninsured in the early 1980s was due to increased unemployment. However, the economic recovery beginning in 1982 was not matched by a decline in the percent of uninsured. An alternative view emerged that this increase was caused by shifts in the economy toward service sector employment or increases in part-time or part-year jobs, which are less likely to provide health insurance coverage. However, analysis reveals that between 1979 and 1986, the percent of workers earning health insurance through their jobs remained fairly constant. During the same period the number of individuals covered through another family member's employer-based plan decreased substantially. This may be attributed to changes in family structure, with fewer young adults having spouses through whom they can gain coverage. Furthermore, many uncovered "dependents" now commonly include single, young adults over the age of 22 who live at home but usually cannot be insured as dependents.

The growth in the uninsured, and their large numbers, have raised concerns about access to medical care for this group. In addition, increasing cost consciousness has changed the way health care is provided to people without health insurance. The ultimate payers of most medical care bills—employers, governments, and insurers—have become increasingly concerned about the rapidly rising cost of health care. Public and private payers alike have undertaken comprehensive programs to become more prudent buyers of health care. They have emphasized cost management and techniques to control use; they have abandoned reimbursement meth-

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[2] Different surveys estimate different numbers of uninsured. Appendix A of this report discusses these surveys and presents some possible explanations for the differences among them. A new survey, conducted by the National Center for Health Services Research, is currently in the field. When its results are available, sometime in 1989, they should help to resolve differences among the current data sources. In the meantime, this Congressional Research Service (CRS) study does not attempt to resolve differences among estimates. Instead, the study presents estimated numbers of the uninsured, their characteristics, and trends over time, relying, as do many other analysts and organizations, principally on the Current Population Survey (CPS). The CPS estimate for 1986 is 36.8 million nonelderly uninsured.

ods in which health care providers (mainly hospitals and doctors) were paid on the basis of their actual costs or charges for treatment. Businesses and governments increasingly negotiate discounts from hospitals and other providers. They also favor other methods to restrain costs. In addition, employers are increasingly asking that employees pay part of the premium costs for insurance, particularly for dependent coverage.

In summary, emphasis on cost consciousness has created incentives for the principle purchasers of health care to manage costs more carefully. As medical care payers increasingly negotiate discounts and otherwise contract for medical care with the least costly providers, these hospitals and doctors have had a more difficult time absorbing the costs of caring for people without health insurance, and there is some evidence that doctors and hospitals will be less inclined to accept uninsured patients.

## II. Summary of Chapters

Chapters 2 through 6 of this report provide a context and an analytical framework for understanding the issue of financial access to medical care, particularly by extending health insurance to those who do not have it.

While substantial agreement might exist about the desirability of providing equitable financial access to health care, available options for expanding health insurance coverage must be viewed in the context of the large Federal budget deficit, the competitive position of the United States in the world economy, and the political traditions of this Nation that favor public/private cooperative responses to many issues.

In addition to this introduction, this report contains five chapters, summarized briefly below.

Chapter 2, "A Primer on Health Insurance," defines and explores basic concepts of health insurance, presents information on the historical development in the United States during the past 60 years, and describes the existing health insurance system with emphasis on typical employer-sponsored plans. For purposes of this study, health insurance is defined broadly to encompass all types of employer-sponsored plans—including Blue Cross/Blue Shield plans, commercial insurance plans, health maintenance organizations (HMOs), preferred provider organizations (PPOs), and self-insured employer plans. While less information exists regarding health insurance plans that individuals purchase outside of the employment setting, a discussion of these plans is included where appropriate. In addition, the chapter briefly describes publicly financed health insurance programs.

The chapter concludes by describing employer-sponsored health insurance plans. Employers, facing large health insurance cost increases over the past decade, have implemented aggressive "cost management" programs designed to reduce their health insurance costs. In general, current health insurance plans require employees to pay: (1) significant portions of the premium, especially for their dependents; (2) a certain amount of out-of-pocket payments before health insurance benefits begin (called deductibles); and (3) a share in the cost of some covered services (called coinsurance, usually re-

quiring employees to pay 20 percent of the bill). At the same time, most of these plans include certain "catastrophic" coverage features that limit employees' potential out-of-pocket payments for covered services.

An important conclusion from chapter 2 is that Blue Cross/Blue Shield, commercial insurance, HMOs, PPOs, and self-insured plans have developed similar benefit features and built-in "cost management" provisions. In general, the plans differ less in the employer's cost of providing the plan (the premium per employee) than in the amount of out-of-pocket expenses to be paid by the employees.

Chapter 3, "Government Regulation of Health Insurance," discusses issues raised by Federal and State government regulation of health insurance. Although the United States has no national health insurance system, both Federal and State governments directly finance or regulate health insurance.

In the first place, Federal and State governments directly fund health benefits for the elderly, the disabled, and some of the poor. Moreover, governments provide direct tax incentives for employers and (to a lesser degree) individuals to purchase health insurance. For example, employer-provided health insurance is not counted as taxable income to employees, and its costs are tax-deductible for employers. These deductions encourage employers to sponsor health insurance; from the employees' perspective, health insurance has advantages over taxable forms of compensation. The deductions constitute "tax expenditures" from the perspective of Federal and State governments.

In addition to making expenditures for health insurance, Federal and State governments have enacted laws to ensure that privately sponsored health insurance meets publicly determined standards. State governments have traditionally regulated insurance—including health insurance—sold within their State. Current State laws require insurers who offer health insurance plans to meet certain standards for reserves and for the types of benefits provided. According to one count, State laws and regulations include some 645 separate State-mandated benefits.

The Federal Government has passed laws affecting health insurance plans through its authority to regulate overall relationships between employers and employees, rather than through regulation of the sale of insurance. For example, the Federal Government has, in recent years, passed legislation requiring employer-sponsored plans to permit employees to choose insurance from an HMO. Furthermore, under various circumstances an employer must offer continued coverage at group rates to certain employees (and dependents), who cease to qualify for the employer's plan through active employment.

The distinction between the Federal and State roles is reinforced by a provision of the Employee Retirement Income Security Act (ERISA). Although ERISA's principal function is Federal regulation of funding and other minimum requirements for pension plans, one section of the law preempts State laws that regulate so-called "welfare benefit" plans (including health insurance). This provision has been interpreted by the courts to mean that if employers "self-insure" by setting aside funds or paying medical care costs directly for their employees, they fall under the ERISA pre-

emption provision and must conform to Federal regulations, which are minimal, rather than State-imposed mandates. However, if employers contract with commercial insurers, Blue Cross/Blue Shield plans, or HMOs to provide health insurance, the policies sold by the insurers must conform to State requirements. This is because State laws governing insurers are "saved" from Federal preemption. During the past 10 years, the percentage of large employers who self-insure for medical care has risen from 19 percent to 40 percent, and some estimates place the current percentage even higher. Larger employers enjoy several advantages if they self-insure, and thus fall under the ERISA preemption. For example, they are exempt from State-mandated benefit laws, State taxes on insurance premiums, and required participation in assigned-risk pools. The recent trend to self-insurance may be attributed, in part, to such advantages gained by employers who fall under the ERISA preemption.

Chapter 4, "The Insured and the Uninsured: Numbers and Characteristics," presents data on the number of people under age 65 without health insurance. In this chapter, the characteristics of the uninsured are described with special emphasis on their income levels, ages, work histories, and family types.

Lack of health insurance is correlated with low income. In 1986, about 30 percent of the uninsured had incomes below the poverty level ($11,200 for a 4-person family in 1986), and another 30 percent had incomes between the poverty level and twice that amount. The remaining 40 percent of people without health insurance had family incomes at least twice as high as the poverty level.

Children and young adults (two groups with substantially different health care needs) constituted the bulk of the uninsured population. About one-third of the uninsured were under age 18, with another two-fifths ages 18–34. Only one-fourth of the uninsured were age 35 and over.

Only one-eighth of uninsured people were in families where neither the family head nor spouse worked during 1986. Over two-fifths, however, were in families where either the family head or spouse worked fulltime during that year. (The remainder were in families where at least one of the adult members worked less than full time or for only part of the year.)

The extent of insurance coverage varies significantly by type of employer. For example, only 18 percent of agricultural workers and 21 percent of workers in personal services businesses have employer-sponsored health insurance. On the other hand, over 80 percent of workers in the durable goods manufacturing and the mining industries have employment-based health insurance coverage. Size of the firm also is important in understanding the issue because employees of smaller firms are much less likely to be covered than those in larger firms. In 1986, of all workers employed by a firm that did not offer health insurance, 84 percent worked in firms with less than 25 employees while only 2 percent worked in firms with 500 or more employees.

While the number of uninsured under age 65 stayed virtually constant at 37 million from 1984 to 1986, shifts occurred in the demographic makeup of this group. The number of low-income children without health insurance actually declined, possibly because

Congress expanded coverage under Medicaid during that period. However, the fastest growing uninsured group consist of young adults between the ages of 18 and 24 who live at home with their family heads.

Chapter 5, "The Insured Population and Exposure to Out-of-Pocket Expenses," examines how much people have to pay out of their own pockets for medical care even though they are covered by health insurance. As noted, most people with health insurance have to pay out-of-pocket for at least some medical care expenses. These expenditures occur because: (1) many health insurance plans do not cover all medical services, and (2) nearly all health insurance plans require insured people to pay out-of-pocket for covered services up to a limit (called a deductible) and to pay a share of expenses called coinsurance (usually 20 percent). In addition, some health insurance plans cover expenditures only up to a ceiling amount, requiring the enrollee to pay any excess expenses.

Businesses, governments, and insurers have two reasons for including deductibles and coinsurance features in their plans. In the first place, insurance costs less to the employer if the insured worker pays part of the cost. In addition, employers have come to rely increasingly on deductibles and coinsurance to reduce utilization of medical services, which in turn reduces their costs for providing health insurance.

There is little agreement on the level of out-of-pocket costs that people can reasonably bear. Chapter 5 presents data that show generally the proportion of families that pay large amounts out-of-pocket for health care. According to a study by the U.S. Department of Health and Human Services, 5.9 percent of families spend at least 15 percent of their income for health care. The level of out-of-pocket spending is a serious concern because the percentage varies so much by income class. For example, over 20 percent of poor families spend at least 15 percent of their income for health care compared to 0.4 percent of high-income families.

Definitions of catastrophic medical expenses most often are related to family income. An expenditure of $2,000 for a typical hospitalization, although affordable for many families, might well be "catastrophic" to lower income families. On the other hand, very large hospital or doctor bills could be financially catastrophic to virtually all families.

Exposure to medical care expenses is a problem for both the insured and uninsured populations. Chapter 5 explores the extent to which the insured population is at risk for out-of-pocket expenses due to provisions in their employer-provided health insurance plans. It presents data showing the proportion of health insurance plans that exclude certain benefits. In addition, the chapter indicates the amount and frequency of deductibles and coinsurance in a broad sample of health insurance plans. For example, 85 percent of plans require a deductible payment for physician services. Fewer plans—about half—have a deductible for hospitalization, a proportion that has been increasing. Two-thirds of plans require the insured to pay coinsurance of 20 percent for hospital expenses; five-sixths of plans require such payments for physician expenses. On the other hand, virtually all health insurance plans in this sample have a limit on out-of-pocket expenditures. Ninety-six percent of

these plans have a limit of $2,000 or less. Fifty-seven percent have a limit of $1,000 or less.

Health plan requirements that employees pay a portion of their medical expenses also affect the financial status of medical care providers (hospitals and doctors). While most unpaid hospital bills, for example, are incurred on behalf of uninsured patients, a significant amount results from the failure of insured patients to pay the required deductible and coinsurance.

Chapter 6, "Access to Health Care by the Uninsured," discusses possible effects of the lack of health insurance, mainly on the 37 million uninsured people themselves, but also on health care providers and payers.

This chapter reports on newly available data from the 1986 Health Interview Survey (HIS) conducted by the National Center for Health Statistics. These data, consistent with earlier studies, show that people without health insurance use fewer health services than insured persons with similar characteristics. The new HIS data indicate that, for every type of medical care except emergency room care, people with insurance use such care more than people without insurance. For example, people without health insurance contact the doctor only 64 percent as frequently as people who have insurance. The difference is even greater for people with annual incomes below $15,000. The uninsured in this income group contact a doctor 53 percent as frequently as people with insurance. In comparison, the uninsured with annual family incomes over $50,000 report 83 percent as many doctor contacts as the insured in this income group. As noted, the exception is emergency room services. The uninsured report using emergency room services at a slightly higher rate than the insured; consequently, a higher percentage of the uninsured's contacts with physicians take place in emergency room facilities.

Chapter 6 also reviews data on how health care of the uninsured is provided and financed. (While the uninsured receive fewer health care services than the insured, they still obtain substantial amounts of care, for which someone has to pay.) Historically, health care providers have covered the cost of treatment of the uninsured by charging them directly, by relying on public and private philanthropic subsidies, by relying on non-patient revenues, or by charging insured people more than the actual cost of their service and diverting the excess to finance care for those without means to pay. Although data showing actual effects are scanty, it is clear that changes in reimbursement practices and cost management measures have reduced financial incentives for providers to care for the uninsured. These changes in financing practices heighten the concern that the 37 million people without health insurance will experience increasing difficulties in gaining access to medical care.

# CHAPTER 2.—A PRIMER ON HEALTH INSURANCE

## I. DESCRIPTION OF HEALTH INSURANCE

### A. WHAT IS HEALTH INSURANCE?

Health insurance is provided by a vast and highly complex assortment of insuring entities, including commercial insurance companies, Blue Cross and Blue Shield plans, health maintenance organizations (HMOs), and preferred provider organizations (PPOs). Each insuring entity is in some way distinct, and the nature and practices of the insurance industry are continually evolving. Increasingly, large companies are self-insuring; they assume the risk of health care costs for their employees and use insurance companies only to cover catastrophic expenses and to provide administrative services, if at all. Such variation and constant change make it difficult to characterize the health insurance industry, and generalizations are likely to gloss over important differences in the way individual health insurers operate.

Yet, it is important to establish certain basics about how health insurers evaluate and select risks and price their products in order to understand why private insurance does not cover all Americans. In what follows, some basic generalizations and definitions set the stage for examining health insurance, primarily as it is provided through the workplace, which is the major source of health insurance in this country.

Insurance is broadly defined as protection against "risk"—the uncertainty associated with the occurrence of a loss. Health insurance is, therefore, protection against the risk of the financial loss that is associated with the use of health care services. In practice, health insurance plans limit their protection to losses arising from the use of a defined set of health care services, which are generally called "covered" services.

The principle of insurance is to spread risk—to minimize the losses of one person by spreading the losses of a few among the many. In health insurance, this principle is achieved when a group of people contribute to a common pool an amount of money at least equal to the expected average loss resulting from the use of covered services by the group. In this way, the actual cost of losses experienced by a few members of the group is spread over the entire group of insured people. Members who do not use covered services do not draw any financial benefits from the pool, although they may derive "peace of mind" as a result of having bought insurance coverage. Members who incur medical expenses draw benefits equal to all or some portion of their expenses, depending on the benefit provisions of their insurance policy.

Costs for medical services used by members of the group will be paid by the insurer so long as they meet the specific requirements

of the insurance plan. To finance this coverage, the insurer will determine a rate (or premium) that will generally reflect several factors, including the expected claims cost, administrative expenses, and a risk or "profit" charge. Generally, losses above those expected and reflected in the rate are covered by the insurer. In some plans, however, losses may be allocated differently. For example, physicians participating in an HMO will often share in the risk of any losses above and beyond those covered by the enrollees' premiums.

Estimating rates is the job of insurance actuaries. Actuaries will estimate the likelihood and cost of the losses for the group to be insured using the laws of probability and other information about the group, such as its health and financial status. The larger the number of insureds, the more predictable are the losses.

Health insurance can be provided to groups of individuals that are drawn together by an employer or other sponsoring organization (such as a professional association or trade union). Such groups are generally formed for some purpose other than obtaining insurance. When insurance is provided to a group, it is referred to as "group coverage" or "group insurance."

Individuals who are not associated with a group can also obtain health insurance by purchasing "individual" coverage directly from an insurer. Even in the case of individual policies, the person to be insured is evaluated as a member of a "group" of individuals (the group of persons purchasing individual coverage). As noted above, the insurer, also known as a "carrier," will typically evaluate the risk or expected loss resulting from the use of covered services by that individual by comparing certain of that person's characteristics (e.g., his/her age, sex and health status) to the loss experience of groups with similar characteristics.

In theory, there is no risk—no probability of loss—that cannot be insured. At some premium level, insurance could cover any risk. Ultimately, however, extreme risks would drive the premium so high that it would, in effect, equal the probable financial loss. (In such cases health insurance more resembles a useful budgeting technique for future health care expenses than an insurance against risk.)

The following is a discussion of techniques used by insurers to set rates, to limit their exposure to risk, and to limit the costs of insurance plans.[3]

*1. Ratesetting*

Various terms are used in the health insurance industry to describe how insurers determine rates. There are two basic methods of calculation: community-rating and experience-rating.

Under community-rating, insurers aggregate into one "community" individuals or a number of groups, such as employers, for the purpose of providing insurance. Generally speaking, a community-rated plan charges the same rate to all members or classes of members (e.g., single versus family enrollees) in the community, spreading the costs for the entire group evenly over its members. Commu-

[3] In this report the term "insurer" is used in its most general sense to include commercial insurance companies, Blue Cross/Blue Shield plans, PPOs, HMOs and self-insured plans.

nity-rating with adjustments based on such demographic factors as age and sex is common. Such a rating system has the advantage of allowing an insurer to apply a single rate to a large number of people, thus simplifying the process of determining premiums and, more importantly, averaging the costs of poor health risks.

Depending on the type of insurance arrangement, community-rating can be based on the insurer's expected operating expenses for the coming year or on the expected claims experience of the group. Arrangements which both insure and deliver health care services, such as HMOs, typically base community rates on budget projections for service delivery. Such arrangements are commonly called "prepaid" plans, although all forms of health insurance are in some sense prepaid. Other insurers not involved in the direct delivery of services to enrollees base community rates on expected claims experience.

Under experience-rating, the past claims experience of a particular group, such as the members of an employer plan, is used to determine the premium rate for that group. Experience-rating is used for groups that meet certain size requirements and is not used where groups are so small that experience is likely to be unreliable. This procedure can allow rates to be set closer to the expected claims experience of a particular group than under community-rating.

Experience-rating and community-rating spread costs differently. Experience-rating, in its purest form, charges a unique rate to a group of enrollees. Community-rating is similar in concept, but rates are based on the experience of all individuals and groups in the community. As a result, groups of enrollees with lower-than-average costs will be paying for part of the insurance for groups of enrollees with higher-than-average costs.

Many rates have elements of both community- and experience-rating. Individuals or groups within a community may be charged the community rate with adjustments to reflect specific age or sex characteristics. Conversely, an insurer may community-rate catastrophic claims among a community of otherwise experience-rated groups.

An insurer who had a monopoly would have no problem charging a community rate to employers. However, in a competitive environment, insurers try to provide the most attractive rates to increase their market share. Experience-rated plans can offer employers with lower-than-average costs the same benefits as a community-rated plan for a lower rate. In this manner, experience-rating can draw the low-risk groups out of the community-rated plans.

This process can leave a community-rated plan with fewer low-cost enrollees, thereby pushing up the average cost for groups left in the community. As the average premium for community-rated groups increases, experience-rated plans can attract increasing numbers of groups with lower-than-average risks. The ultimate effect is to leave the community-rated plan with higher-cost enrollees and upwardly spiraling rates. In order to remain competitive, insurers that once used only community-rating now use experience-rating for large groups (such as large employers) and have modified their community-rating practices to set rates far closer to the

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actual experience of the groups they are insuring. Though there are still major components of the insurance industry that community-rate, insurers generally use experience-rating to attract and retain low-risk groups.

### *2. Criteria for participation in the insured plan*

The successful operation of an insurance arrangement requires that insured people not be able to predict or influence the occurrence of the risk or the amount of the financial loss. The possibility of an individual's being able to determine the loss is particularly strong in health insurance because individuals expecting large health care expenses in a given year may seek out insurance to help pay for those expenses. For example, an individual with a newly diagnosed heart ailment may seek to buy health insurance for the first time or change to a plan that has more comprehensive coverage of the medical services required to treat that illness. The election of insurance by those who are in poor health or expect to use health services is termed "adverse selection" by the insurer.

With some exceptions, insurers seek to limit the losses associated with high-risk applicants by identifying such applicants and determining whether to offer them insurance and, if so, whether to modify the rates and/or terms of the insurance contract. When a health insurer agrees to insure a relatively large group of enrollees, such as a large employer group, the presence of high-risk individuals in the group is not necessarily a difficulty for the insurer. If the group is sufficiently large, there will be enough individuals with below-average health care costs to compensate for the high users of services who elect coverage. However, small groups may have only a few enrollees electing coverage. Those most likely to elect coverage are those who are most likely to be most in need of insurance. Similarly, individuals seeking nongroup (individual policies) coverage can be high risks for a health insurer because they, too, are more likely to use health services. To minimize losses due to adverse selection, health insurers have developed mechanisms to reduce the above-average risks associated with individual and small group policies.

Underwriting is generally defined as the process by which an insurer determines whether or not, and under what conditions, to accept an applicant for insurance.[4] The outcome of underwriting is an evaluation of whether the proposed insured will be accepted, rejected, or accepted under a "substandard" plan. An applicant accepted under a substandard plan could be charged an above-average rate or have specific benefits excluded from coverage on a permanent or temporary basis. Benefits typically excluded from plans may be for services associated with any "pre-existing condition" an enrollee has at the time coverage is obtained. Almost without exception, insurance policies that are not employment-related provide that new enrollees are subject to a "waiting period" before coverage is effective for conditions that existed prior to enrollment. All services related to an illness or injury, other than the pre-existing condition, are covered during this waiting period. This waiting

[4] It is important to emphasize that underwriting is generally used to classify and rate risks for individual and small group policies. It is not generally used in the large group market.

period is meant to encourage enrollment before medical problems develop and to reduce any losses due to adverse selection.

Health plans (except federally qualified HMOs) may decide to reject an individual or small group if the risk is judged to be too great, either because of the health status of the prospective enrollee or because of such factors as the probability that the group will not pay the premiums. Federal law precludes federally qualified HMOs that offer small group coverage from rejecting group members based on their pre-existing conditions. (For this reason, some HMOs will not offer coverage to small groups.)

Other insurers periodically or continuously hold "open enrollment" periods during which applicants are accepted regardless of health risks. During these open enrollments or "open seasons," insurers have little protection from adverse selection, although some insurers limit their loss exposure from policies sold during open enrollments by including pre-existing condition waivers or by offering limited benefits. Rather than avoid costs associated with high-risk applicants, these insurers provide high-risk individuals and small groups with insurance and spread the costs over as large a group as possible.

*3. Limiting plan costs*

Health insurers sometimes incorporate mechanisms in their insurance arrangements designed to discourage what they determine to be inappropriate utilization, potentially limiting the total cost of health services for the insured group. Insurers can set controls through mechanisms designed to limit both the enrollee's use of services and the health care providers' volume, type of treatment, and payment.

*(a) Establishing financial incentives to discourage utilization.*—Provisions which seek to discourage individuals' use of health care services generally take the form of financial incentives—really disincentives—which require the enrollee to share directly in the cost of covered services. Two of the most common disincentives are deductibles and coinsurance. In the case of a deductible, the enrollee is required to pay an initial amount for covered services before the plan begins to pay. In the case of coinsurance, the enrollee is required to pay a portion of the cost of those covered services received. These provisions limit use in different ways. Deductibles discourage the initial use of health services and the filing of small claims. Coinsurance can encourage enrollees to choose the least expensive form of treatment or to limit the use of health care services.

*(b) Restricting the provisions of health care services.*—A second set of provisions is designed to limit the volume and nature of health care services given an enrollee by a health care provider. Most provisions are specifically designed to limit relatively expensive treatments. In some health insurance arrangements, such as HMOs, the insurers can directly limit services because the insurer provides or arranges services directly for enrollees; other arrangements incorporate requirements that health care providers must fulfill in order to receive reimbursement for services.

Insurance arrangements that have direct control over the insured's volume and nature of services often require the insured to

obtain services from, or with the authorization of, a single primary physician. This doctor acts as a "gatekeeper" for more expensive treatments, particularly hospital treatments.

Other measures to limit the provision of expensive treatments when a less expensive alternative is available are introduced into health plan designs. Requirements specifically designed to limit hospital care treatments to those that are medically necessary are sometimes referred to as utilization controls. Examples include a mandatory second opinion for certain elective surgical procedures and precertification requirements for admission to the hospital for a nonemergency.

Some plan designs encourage the patient to use less expensive treatments by offering more generous payments for those treatments. For example, most plans require smaller coinsurance payments by the enrollee if surgery is performed on an outpatient basis or in a facility other than a hospital. Finally, some plans cover preventive care (in contrast to treatment only for illness or injury) that may possibly result in long-term cost savings.

*(c) Controlling reimbursement costs.*—The cost of a health plan is not only a function of the volume of services used but also of the costs of those services. The escalation of health care costs at rates above general inflation over the past few decades has led health insurers to attempt to limit not only utilization but payments as well. In arrangements where health care providers are reimbursed a specific amount for each health care service delivered, insurers can limit the payment for these services by negotiating "discount rates" with hospitals and doctors. These rates are lower than the providers' average charges for these services and are set specifically for the insurer's enrollees. (Other insurers may select providers on the basis of their current prices, contracting with providers with lower-than-average charges.) Under some arrangements discount rates are negotiated in exchange for a guarantee that enrollees will use the provider's services. Other arrangements preserve the enrollees' choice of health care providers but offer lower deductibles and coinsurance amounts to patients who use the services of specified providers.

## B. THE HISTORICAL DEVELOPMENT OF HEALTH INSURANCE IN THE UNITED STATES

The first health insurance arrangements were relatively simple, but the industry today is characterized by a variety of complex arrangements. In order to understand why existing arrangements have prevailed over alternatives, the following section describes the historical development of the health insurance industry.[5]

### *1. Earliest plans*

Before the 1930s, few health insurance plans existed; Americans paid over 90 percent of their medical expenses out-of-pocket. The earliest private health insurance plans in the United States were

[5] The historical account presented here draws heavily on: Starr, Paul. The Social Transformation of American Medicine. Basic Books, New York, 1982. p. 198–234, 290–378; and Fein, Rashi. Medical Care, Medical Costs: The Search for a Health Insurance Policy. Harvard University Press, Cambridge, Mass., 1986. p. 10–32.

sponsored through employers, unions, or fraternal groups. The railroad, mining, textile, and lumber industries developed the first employee medical care programs. Employers deducted funds from the salaries of workers and contracted with physicians who would treat work-related injuries. In some cases (e.g., the United Mine Workers), workers contributed funds to hire a physician to care for them.

### 2. *Hospital plans*

During the Great Depression, increasing numbers of patients were unable to afford medical services. Physicians and hospitals had difficulty remaining solvent because they had too few paying patients. Within this context, hospital-sponsored health insurance arrangements developed to help ensure a more predictable flow of revenue to health care providers. In general, hospital services were made available to those who paid a pre-determined amount directly to the hospital. Initially, these plans involved single hospitals. Later, groups of hospitals banded together to form multiple hospital plans.

*(a) Single hospital plans.*—The first effective hospital plan was introduced in 1929, at the Baylor University Hospital in Dallas, Texas. Schoolteachers who paid $6 a year were provided up to 21 days of hospital care. The Baylor plan operated on the principle that many individuals at risk could contribute small amounts to pre-pay hospital care expenses against the likelihood they would eventually need care. This innovative financing approach was adopted by several Dallas hospitals facing severe revenue shortages during the Great Depression years. Single hospital plans were required by State law to maintain reserve levels—specified amounts of money set aside as a reserve for unexpected benefit payments.

*(b) Multiple hospital plans.*—At the same time, non-profit multiple hospital arrangements were organized in several cities. Under these arrangements, participating hospitals throughout an area agreed to provide specified services to subscribers, thus giving enrollees a choice in medical care provider at the point services were needed. These multiple hospital plans were not required by State law to maintain reserve levels.

*(c) Blue Cross plans.*—The non-profit multiple hospital plan served as a model for Blue Cross plans. In 1932, the first Blue Cross plan was established in Sacramento, California. The plan negotiated payment rates with participating hospitals, charged a single community-wide premium rate to subscribers, and guaranteed agreed-upon payments to participating hospitals for the provision of selected services to subscribers.

In the mid-1930s, some State insurance regulators tried to subject multiple hospital plans to their State's insurance regulations, including the reserve requirements. The American Medical Association, along with local hospitals and physicians, promoted State legislative initiatives to exempt Blue Cross plans from certain State insurance regulations. Blue Cross plans were incorporated under separate enabling legislation with their own sets of rules and regulations (e.g., regarding rate-setting and Blue Cross Board composition). In exchange for State tax-exempt status and relief from reserve requirements, States generally charged the plans with the re-

sponsibility to serve the entire community and to provide insurance for low- and moderate-income persons. The plans also qualified for Federal tax-exemption as charitable organizations. The combination of negotiated rates with providers and the exemption from taxes gave Blue plans certain financial advantages over other insurers, and by 1945 the plans had expanded to cover 19 million subscribers nationally.

The plans' benefit programs were known as "service benefits" because they provided full coverage for services rather than for a schedule of fixed-dollar payments that might or might not have covered a provider's full charges. Coverage provided by Blue Cross paid for inpatient care in full, and was referred to as "basic coverage."

*3. Commercial health insurance*

At the same time that Blue Cross plans were developing, commercial insurers began offering health insurance. In 1934, commercial insurers first offered groups "indemnity coverage" against hospital expenses. Unlike service benefit plans, these plans typically paid the amount specified in the policy directly to the enrollee. The enrollee paid the provider and was responsible if the provider's charges exceeded the insurance payment. By the late 1930s, many commercial insurers had expanded their policies to cover surgery and other physician services. This type of coverage was commonly called "comprehensive" and generally covered a variety of services with part of the cost paid by the enrollee. Many commercial insurers also offered "major medical" coverage. This type of plan was established to cover expenses, such as prescription drugs and physician office visits, that were not covered as a basic service through Blue Cross plans.

*4. Blue Shield plans*

In response to the expansion of commercial health insurance and to the lack of coverage by Blue Cross of physician services, Blue Shield plans were established, often with the assistance of Blue Cross plans. The first Blue Shield physician insurance program, called the California Physician's Service, was developed in 1939. Blue Shield plans reimbursed physicians, initially for the full cost of each service, based on a negotiated payment schedule.

*5. Health maintenance organizations*

Health maintenance organizations (HMOs) evolved from a variety of arrangements under which physicians contracted to furnish medical care to employers or groups of individuals for a pre-arranged fee. During the 1930s and 1940s, group practice associations were set up to serve specific employers. Among the most successful arrangements of that period were the Group Health Association of Washington, D.C. (GHA), the Kaiser Permanente medical care program of California and the Health Insurance Plan of Greater New York (HIP).[6] GHA was set up in 1937 as a member-owned con-

[6] For more information on the history of health maintenance organizations, see Brown, Lawrence. Politics and Health Care Organization: Health Maintenance Organizations as Federal Policy. The Brookings Institution, 1983.

sumer cooperative to finance and deliver medical care services to employees of the Home Owners Loan Corporation (and later to employees of other Federal agencies).

The Kaiser program was established before the beginning of World War II by Henry Kaiser, an industrialist with construction projects in isolated areas of California and Oregon where medical services were limited. Kaiser arranged for the insurance company that provided workers' compensation insurance to pay in advance a per-day amount per worker to Dr. Sidney Garfield, who agreed to provide care to Kaiser workers in exchange for fixed payments. In 1942, the Kaiser Permanente program opened membership to other employees in the community. The general public paid premiums to the program in exchange for a guarantee of hospital and medical care from the Kaiser Foundation Hospitals and Permanente Medical Groups located in various communities.

The HIP of Greater New York was designed to provide services to municipal employees of New York City. Established by Mayor LaGuardia in 1947, the plan contracted with 22 medical groups—over 400 physicians in all—to work at medical centers throughout the city. HIP paid the medical groups a "capitation rate" or an annual price per person enrolled. Hospital services for the enrollees were covered by a separate plan.

These early HMO-like organizations encountered three basic barriers that prevented wide-spread growth of this type of insurance arrangement. First, HMOs had difficulty obtaining access to start-up capital. Second, the medical community discouraged physician participation in the organizations. HMO physicians were often denied hospital admitting privileges and were sometimes excluded from local medical societies. Finally, State laws were restrictive. Some States had prohibitions against the "corporate practice of medicine," while other States had requirements that HMOs establish reserves comparable to those maintained by commercial insurance companies.

The Federal Health Maintenance Organization Act of 1973 provided capital for HMO development and preempted certain restrictive State laws. This legislation was specifically designed to encourage the establishment of HMOs by providing operating subsidies to organizations in the form of start-up grants and loans. The Act also required employers with 25 or more employees to offer an HMO plan if a federally qualified one was in the area and requested by employees. This assistance, along with employer interest in potential cost savings, helped HMOs grow from about 50 organizations serving 7 million people in the 1970s to nearly 700 HMOs serving more than 28 million enrollees in 1987.[7]

### *6. Employer-based health insurance*

Before World War II, Blue Cross/Blue Shield arrangements dominated the health insurance industry. However, new economic policies and conditions during the war facilitated the rapid expan-

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[7] Group Health Association of America. Health Maintenance Organization Fact Sheet, Dec. 1987.

sion of employer-based health insurance and brought new actors, labor unions and employers, into the health insurance arena.[8]

*(a) Health insurance as a benefit.*—In the 1940s, wartime price stabilization policies capped wages and thus encouraged employer-worker bargaining over noncash benefits. Employers could not increase wages but often were willing to increase compensation by providing more generous benefit packages in order to attract and retain employees. Health insurance was an attractive benefit for employees because it paid their medical bills. Furthermore, unlike cash compensation, it was a tax-free benefit.

*(b) Bargaining for health insurance.*—Health insurance benefits were established as an item for legitimate labor negotiation in 1949 when the Supreme Court denied review of a circuit court ruling in the case of *Inland Steel* v. *National Labor Relations Board.* Under collective bargaining agreements, bargaining over "welfare" benefits (including health insurance) became part of the definition of negotiable "wages and conditions of employment." [9] The ruling enabled labor unions to become influential in the development of medical care insurance. Specifically, the unions bargained for (1) extended benefit packages to cover the full range of hospital and physician services, mental illness, denial and optical care; (2) coverage of spouses and dependents; and (3) reduced employee contributions. By 1954, unions negotiated health insurance benefits for over one-quarter of insured Americans.

*(c) The growth of employer-based insurance.*—Once terms of the benefit package and contributions were agreed upon with the union, the employer generally retained the right to select an insurance carrier. Commercial insurance was especially appealing because it could often offer premiums at rates lower than Blue Cross/ Blue Shield plans. Because commercial insurers provided indemnity coverage (reimbursing enrollees for a specified amount or percentage of charges), they offered lower premiums than service-benefit plans which reimbursed providers often for the full value of a service. Premiums were also lower for some employers because commercial insurers used experience-rating. That is, instead of computing one premium on the basis of the experience of the entire community, they offered lower premiums to relatively healthy, low-risk groups of employees. In addition, commercial carriers could offer employers an active role in plan administration and benefit design.

Through the 1940s and 1950s, commercial insurance grew rapidly. By 1953, commercial insurers had captured half of the health insurance market. In response, many Blue Cross and Blue Shield plans changed their rating procedures and the design options of their coverage. Rating procedures were altered in two ways. First, some plans began to experience-rate large employers. Second, some Blues modified their community-rating practices by redefining the "community" for which a rate was determined and by making additional adjustments to rates for characteristics such as sex and

[8] This section draws from Munts, Raymond. Bargaining and Health: Labor Unions, Health Insurance and Medical Care. University of Wisconsin Press, Wisconsin, 1967.

[9] Inland Steel, 77 NLRB 1 (1948), affirmed *Inland Steel Co.* v. *NLRB* 170 F2d 7th Cir. (1949), certiorari denied 336 U.S. 960 (1949).

age. In this way, the plans could offer selected employers premiums that were more competitive with those of commercial insurers. Plan designs were also changed in order to remain competitive with commercial insurers. The Blues moved away from strict service-benefit plans to a combination of indemnity and service benefit arrangements. However, even now the vast majority of Blue benefits are paid as service benefits. The Blues also introduced deductibles and coinsurance into their plans in order to promote more prudent utilization of health care services by enrollees.

*(d) The growth of benefit packages.*—In the 1960s, labor unions, employers, and health insurers continued to expand health insurance coverage. Unions began to negotiate for increased benefits beyond hospital care. These were comprehensive policies covering a broad range of incurred health care expenses with no employee deductibles or copayments. Plans that start payment with the first dollar of incurred costs for covered services and that do not require the enrollee to pay a deductible or coinsurance are known as "first dollar" coverage plans. The United Steel Workers negotiated a first dollar coverage plan in 1959; the United Auto Workers negotiated a similar plan in 1961. Throughout the decade, first dollar coverage increased in popularity among workers, in part because improved tax-exempt health benefit packages continued to be attractive as rapid wage growth pushed workers into higher income tax brackets. Management also favored richer plans because managers themselves benefited from more extensive coverage. Throughout the 1960s, health insurance benefits were generally improved, with more attention being given to the scope of benefits than to the ultimate effects of such benefits on the cost of the plan and, more generally, on medical care costs.

*7. Public health insurance: Proposals and programs*

*(a) Proposals.*—The issue of publicly financed health insurance has been debated since the early 1900s. National health insurance initiatives were promoted in the United States at a time of a worldwide consideration of social insurance from 1900 to the beginning of World War I. Similar initiatives were considered again but dropped by President Franklin Roosevelt when Social Security was enacted in 1935. Ten years later, President Harry Truman unsuccessfully supported a national health insurance program that emphasized the expansion of health care facilities, and again in 1965, after President Lyndon Johnson declared "War on Poverty," the national health insurance debate was on the public agenda. Some of the neediest people were unable to pay for health care, and medical costs were rising. Blue Cross and Blue Shield plans had supplied insurance for middle- and high-income families, but low-income persons were often unable to afford even relatively low community-rated premiums. Linking health insurance coverage to employment had greatly expanded the base of the covered population but had left many unemployed, self-employed and elderly persons without health insurance. Finally, high administrative costs made individual and small group health insurance coverage expensive; in addition, medical underwriting of individuals and small groups resulted in higher cost policies, or exclusions for high-risk or disabled individuals.

In 1965, Medicare and Medicaid were enacted, establishing for the first time a major Federal commitment to financing health care for a significant portion of the population.

*(b). Programs.*—(1) Medicare: As a social insurance program, Medicare provides a base of protection for groups that were believed to be highly vulnerable to financial hardship in the face of illness. The program was designed as a national, federally administered program with uniform eligibility and benefit protection to protect the elderly against health expenses. In 1966, 19.1 million enrollees age 65 and over had hospital insurance under Medicare. By 1987, the number of elderly covered by Medicare reached 30 million.[10] In 1972, Medicare coverage was extended to two additional high-risk groups, disabled persons receiving cash benefits for at least 2 years under Social Security, and persons suffering from end-stage renal disease (ESRD). By 1987 close to 3 million disabled persons and about 120,000 ESRD beneficiaries had Medicare coverage.

(2) Medicaid: In 1965, Medicaid was enacted as a Federal-State program for the so-called "categorically" needy. These were persons eligible to receive cash assistance under welfare programs—Aid to Families With Dependent Children (AFDC) and Old Age Assistance, Aid to the Blind, and Aid to the Permanently and Totally Disabled, replaced later by Supplemental Security Income (SSI) for aged, blind and disabled adults. States were also permitted to provide Medicaid to the "medically needy"—those in the welfare categories who do not receive cash assistance but whose net income falls below State standards, usually due to high medical expenses. In 1987, the total number of Medicaid beneficiaries was approximately 23.3 million.[11]

C. THE EXISTING PRIVATE HEALTH INSURANCE STRUCTURE

Recent changes in the delivery of health care have been accompanied by changes in health insurance arrangements and a blurring of many of the historical distinctions detailed above. Specifically, the escalating cost of health care in the United States at rates far above inflation has heightened the incentives for all participants—employers, governments, and insurers—to reduce the cost of medical care. (The medical care portion of the Consumer Price Index increased 127 percent between 1977 and 1987.) Changes in plan design and payment practices have made the health insurance industry less neatly compartmentalized.

Competition and cost increases have led to plan design changes, the net effect of which has been to remove many of the differences in plan structure. Deductibles and coinsurance have been added in many cases to the basic coverage of most plans. There is increasing use of mandatory second surgical opinion programs and hospital admission precertification. Most health insurance arrangements cover alternatives to hospital care, such as hospice care, ambulato-

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[10] Gornick, Marian, et al. Twenty Years of Medicare and Medicaid: Covered Populations, Use of Benefits and Program Expenditures. Health Care Financing Review, 1985 Annual Supplement.

[11] U.S. Congress. House. Committee on Ways and Means. Background Material and Data on Programs Within the Juisdiction of the Committee on Ways and Means. Committee Print 100-29, 1988 edition. p. 810.

ry surgery, and skilled nursing facility care. Many plans encourage the use of preventive serivces by covering them in full.

As insurers compete to attract enrollees who will need the least amount of health care, rating practices have been altered. In general, commerical insurers continue to experience-rate, basing the cost per person on the experience of one group of employees. By experience-rating, commerical insurers have been able to attract many low-risk employer groups. Likewise, commerical insurers set commensurate rates for, or decline to cover, high-risk individuals and groups.

In order to attract employers through competitive rates, the Blues have modified their community-rating and underwriting practices. Today, the Blues experience-rate larger groups and are applying this practice to smaller and smaller groups. Some individual Blue Cross/Blue Shield organizations are extending underwriting rules to properly rate (or reject) the worst risks among the smaller employers.

Under existing Federal law, federally qualified HMOs have to be community-rated and cannot alter rates for high-risk individuals and groups. (No such restriction applies to HMOs licensed solely at the State level.)[12]

However, in order to guard against adverse selection, many HMOs use allowable demographic adjustments that permit some recognition of risk. While HMOs cannot adjust rates for high-risk individuals and groups, they retain the right to reject individual, non-group applicants altogether and do so more often than do the Blues or commercial insurers.[13]

A distinction that has become important in health insurance arrangements is the extent to which an individual's choice of health care provider is limited. The commercial insurers and Blues traditionally have offered plans that allow an individual an unlimited selection among health care providers. In contrast, many insurers today use newer forms of arrangements that cover only services provided by selected hospitals and doctors. The most common of this type of arrangement is an HMO, an organization that offers comprehensive benefits through affiliated providers to enrollees for a fixed monthly fee. In exchange for this monthly fee, enrollees receive hospital, primary care and preventive care services, as needed, with little or no additional charge. Except in emergencies, the enrollees are generally limited to using the providers affiliated with the HMO. Still other arrangements provide incentives to enrollees to use a limited number of selected providers who offer their services at a reduced rate. These increasingly popular arrangements are referred to as preferred provider organizations (PPOs). The term PPO is applied to a variety of arrangements under which patients who choose to obtain medical care from a specified group of participating "preferred providers" receive certain advantages under their health insurance plan. Typically, the

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[12] Legislation passed by the House of Representatives on Nov. 3, 1987, and reported with amendments on Mar. 22, 1988 by the Senate Committee on Labor and Human Resources (Report No. 100-304), would allow federally qualified HMO's to use "adjusted community rating" which, in effect, is similar to experience-rating.

[13] U.S. Congress. Office of Technology Assessment. AIDS and Health Insurance. Staff Report. Washington, U.S. Govt. Print. Off., 1988.

incentives in PPO contracts are the avoidance of higher deductibles in return for the use of a preferred provider, rather than lower co-insurance or reduced deductibles. HMOs and PPOs may be affiliated with a commercial insurer or a Blue plan or may be independent.

These recent changes in the health insurance industry and the development of new insurance arrangements prevent easy categorization of current health insurance arrangements. The health insurance arrangements for enrollees in employer-provided plans are particularly numerous. The following section briefly outlines the most common health insurance arrangements available to employers. Insurance options for individuals and for selected groups under Federal and State programs are also described.

*1. Employer-provided arrangements*

Employer-provided health insurance arrangements continue to change, and various health insurance hybrids have emerged in recent years. For example, self-insured plans are increasingly using the administrative services of commercial insurers, Blues and other administrators; similarly, commercial insurers and Blues are offering HMOs and PPOs to their enrollees. This section describes major trends within the employer-provided market and the predominant sources of employer-provided health insurance.

Two noteworthy trends have recently affected the health insurance market. First, the percent of employers that self-insure—that is, assume the risk of paying the medical care bills of their employees instead of purchasing insurance coverage—has more than doubled over the past decade. According to Hay/Huggins, the percentage of medium and large employers that self-insure increased from 19 percent in 1979 to 40 percent in 1987.[14] Second, employers are increasingly turning to cost management techniques to help reduce the total cost of the medical care provided to their employees. A 1987 survey of 771 small, medium and large firms conducted by the Health Insurance Association of America (HIAA) indicates that a majority of employees are enrolled in HMOs, PPOs or "managed care" plans which they define as plans that require some type of precertification review for hospitalization.[15] (See table 2.1.)

TABLE 2.1.—Enrollment in Managed and Unmanaged Care Plans, 1987

| *Type of plan* | *Percent of Enrollees* |
|---|---|
| HMO | 16 |
| PPO | 11 |
| Managed care | 32 |
| Unmanaged care | 41 |
| Total | 100 |

Source: Gable, et al, The Changing World of Group Health Insurance.

(a) *Self-insured plans.*—Rising health care costs and the growth in State-mandated benefits and other State insurance regulation have encouraged most large-sized employers, and many medium-

[14] Hay/Huggins Benefits Report (HHBR) selected years. The HHBR is a report on the benefits provided by 896 medium and large employers in the United States. (See appendix B for a list of survey participants.)

[15] Gable, Jon, et al. The Changing World of Group Health Insurance. Health Affairs, summer 1988.

sized employers, to turn to one of several forms of self-insurance. The preemption provision in the Employee Retirement Income Security Act (ERISA) which has been interpreted as exempting self-insured employee benefit plans from State mandates, has created a strong incentive for companies to self-insure.[16] The incentive increases as State-mandated benefits proliferate. Employers with as few as 200 employees will often consider self-insurance, and some considerably smaller employers have turned to this type of arrangement as well.

Self-insured employers have a variety of funding and administrative options. Some employers operate completely self-insured and self-administered health plans. A few employers even run their own health care facilities. Most employers who self-insure, however, retain some of the advantages of the insurance arrangement by using a commercial insurer or the Blues to process claims. Others simply contract with "third-party administrators" to review and process the claims. Employers frequently self-insure for routine health care costs but avoid extreme risks by purchasing "stop-loss" insurance, under which in return for a risk premium an insurer will cover any losses that exceed a certain level, such as 125 percent of expected claims.

A hybrid between the self-insured and fully insured plan is a "minimum premium" plan. Under this funding approach, the employer pays the insurer on a monthly basis for administrative costs and sets aside funds in an account for expected claims. The carrier handles the administration of the plan, pays the claims, and is then reimbursed from the employer's account. (In doing so, the carrier is financially liable for claims in excess of the account funds.) For the purposes of ERISA, minimum premium plans are not considered self-insured, and thus are subject to State regulations. However, because the employer retains the expected claims funds, only a minimal portion of the premium is subjected to State taxation (for most States, generally a rate of 2 percent) and, more importantly, the funds accrue interest for the employer. Thus, under a minimum premium plan arrangement, employers retain the advantages of the limited liability of a fully insured plan as well as some of the advantages of a self-insured plan.

According to the 1987 Hay/Huggins Benefits Report (HHBR, a survey of large and medium-sized firms), 40 percent of medium and large employers self-insured and 20 percent had minimum premium plans. (See table 2.2.)

TABLE 2.2.—Funding Approaches for HHBR Medical Plans, 1987

| *Approach* | *Percent of plans* |
|---|---|
| Self-insured | 40 |
| Minimum premium | 20 |
| Fully insured | 34 |
| Combination | 5 |
| Other | 1 |
| Total | 100 |

Source: Hay/Huggins Benefits Report, 1987.

[16] For further discussion of this point, see Chapter 3, Government Regulation of Health Insurance, page 83.

*(b) HMOs.*—A second category of insurance arrangements available to employers is the health maintenance organization (HMOs). HMOs typically provide comprehensive services in exchange for a prepaid (monthly) per capita fee as specified in a contract. Since HMOs not only pay for care but also arrange for or deliver it, they may be able to exert more direct control over costs.

HMOs are ordinarily classified into one of four organizational models. These vary in the degree of control the HMO organization has over the affiliated providers' activity. The "staff model" allows the HMO the most control over providers. Under this arrangement, physicians are salaried employees of the HMO. Under a "group model," the HMO contracts with a group of physicians, most of whose practice is HMO-related, but who remain separate legal entities. Less control is maintained over physicians organized in the "networked model," under which several multispecialty groups contract with one or more HMOs, usually while maintaining their fee-for-service practice. Finally, the "individual practice association" (IPA) lends the most independence to participating providers. Under this model, individual physicians contract with an organization but continue to practice separately and see patients in their own offices.

*(c) PPOs.*—Preferred provider organizations (PPOs) have grown rapidly in recent years. This term applies to a variety of arrangements in which health providers contract directly with groups of employers or through an intermediary to offer reduced rates for services. It is common for providers to join forces and offer a PPO, or for insurers and third-party administrators to negotiate preferred providers arrangements with groups of providers and then offer them to employees. Enrollees avoid higher deductibles (generally $50–100 higher) if a preferred provider is used.

*(d) Commercial plans.*—Commercial insurers still offer employers traditional indemnity plans that reimburse subscribers a set amount for services received, but they now offer a variety of new health insurance arrangements as well. Most plans offered by commercial insurers require deductibles and coinsurance payments by the enrollee. In an effort to limit the extent of unnecessary services delivered by health care providers, commercial insurers (and Blue Cross/Blue Shield plans) have introduced precertification and second surgical opinion provisions and have begun to cover treatments that serve as alternatives to hospital care.

Commercial insurers also offer arrangements that limit or influence the enrollees' choice of health care providers, for example HMOs and PPOs. In addition, insurers are entering into limited partnerships with hospitals to offer discount rates to employers.

*(e) Blue Cross/Blue Shield plans.*—Of the 78 million Blue Cross/Blue Shield subscribers nationally, 85 percent are non-elderly group enrollees covered by service benefit plans. The array of benefit packages offered to employers by the 77 Blue Cross and Blue Shield plans varies widely. Likewise, the specific financing mechanisms and reimbursement practices vary.

In general, the Blues contract with providers and pay them an agreed rate for each service delivered. These agreements generally have "hold harmless" clauses in which the providers agree to be paid according to specific contract provisions and to ignore any re-

maining charges that the plan may leave unpaid, except for non-covered services, deductibles, and copayments. This arrangement protects subscribers from unexpected out-of-pocket payments.

The Blues are also sponsoring non-traditional insurance arrangements. Surveys of the Blue Cross/Blue Shield plans reveal that over 15 percent of Blue Cross/Blue Shield enrollees participate in PPOs and HMOs owned or operated by a Blue Cross/Blue Shield plan.[17] As of January 1988, 55 plans has established PPOs; it has been estimated that more than 30 percent of PPO services are provided through Blue Cross/Blue Shield plans.[18] The plans also own or operate 96 HMOs.

*2. Small employer arrangements*

Surveys show that small employers are less likely to offer health insurance than large employers. According to the Employee Benefit Research Institute, almost half of all uninsured workers are found in firms with fewer than 25 employees.[19]

A Small Business Administration (SBA) survey in 1987 found that small employers do not offer coverage for a variety of reasons.[20] (See table 2.3.) Cost is the most prevalent self-reported reason. Over 60 percent of small employers reported that either profits were insufficient to cover the cost of insurance or insurance premiums were too high. Only 17 percent of very small employers (1-9 employees), 3 percent of small employers (10-24 employees), and 22 percent of employers with 25-50 employees reported unavailability of group coverage as a reason for not offering coverage, which suggests that lack of availability is not the major problem for most small employers. In fact, the SBA survey reported that two-thirds of small employers have not sought insurance.

Many small employers cited less generous tax treatment of health insurance premiums for unincorporated firms as an important reason for not offering coverage. While corporations can deduct 100 percent of premium costs for employees as a business expense for purposes of calculating Federal tax liability, self-employed individuals, partnerships and other unincorporated firms are eligible for only a 25 percent deduction.[21]

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[17] Blue Cross/Blue Shield Association. Office of Government Relations. Personal communication with Diana Jost, Executive Director of Private Market Programs.

[18] PPO data are from Rice, Thomas, Greg de Lissovoy, Jon Gabel, and Dan Ermann. The State of PPOs: A National Survey. Health Affairs, winter 1985. p. 30.

[19] Tabulations are from the May 1985 Current Population Survey. See Employee Benefit Research Institute. A Profile of the Nonelderly Population Without Health Insurance. Issue Brief no. 66, May 1987. Table 4. p.5.

[20] This survey included 846 small, medium and large firms and had a response rate of approximately 20 percent. The low response rate may have biased the survey results, since it is likely that nonrespondents were even less sensitized to health insurance issues. Small Business Administration. Health Care Coverage and Costs in Small and Large Firms, Apr. 1987. p. III-15.

[21] This deduction is scheduled to expire on Dec. 31, 1989.

TABLE 2.3.—Percent of Small Firms Not Offering Health Insurance Coverage By Reason and Firm Size, 1986

| Reason for not offering coverage | Number of employees (Percent of firms) | | | | |
|---|---|---|---|---|---|
| | 1 to 9 | 10 to 24 | 25 to 29 | 100 + | all firms |
| Insufficient profits | 68 | 62 | 54 | 36 | 61 |
| Insurance costs | 61 | 70 | 41 | 68 | 62 |
| Turnover | 17 | 31 | 36 | 83 | 19 |
| Group coverage not available | 17 | 3 | 22 | 0 | 16 |
| Lack of interest | 13 | 6 | 5 | 0 | 13 |
| Administrative costs | 10 | 2 | 0 | 51 | 9 |
| State regulation | 1 | 0 | 0 | 0 | 1 |
| Other | 8 | 21 | 5 | 54 | 9 |

Note.—More than one answer was permitted in response to this question.

Source: Small Business Administration, Health Care Coverage and Costs, table III-9, p. III-15.

From the insurer's point of view, small employers are costly groups, primarily because of the very high turnover and higher administrative costs of small groups. In addition, in small groups the risk is spread over fewer people. Turnover can lead to adverse selection if employees who leave small groups are younger, healthier individuals. In addition, small groups are not large enough to absorb the costs of an employee or family member with extremely high medical expenses. In some cases, small employers have decided to purchase insurance because there is an immediate or predicted need for medical care by the employer, an employee, or family members.

To reduce adverse selection, some health insurers insist that all employees of a small employer enroll in the plan. Full enrollment is often achieved by having the employer pay the entire premium. Other insurers adjust premium rates or benefit packages for small employers to take into account high-risk employees in the group. However, the Health Maintenance Organization Act prohibits federally qualified HMOs from adjusting rates based on health conditions; thus, HMOs are more inclined to reject small employers altogether.

Only 5 percent of firms with fewer than 100 employees self-insure, compared to rates between 40 and 50 percent for firms over 100.[22] Small firms are less likely to self-insure because of the high risk associated with paying claims out of their own revenues and the administrative burdens associated with self-insurance. Without the benefit of a large number of employees over whom to spread the risk, small firms that do provide health insurance generally elect to purchase insurance from commercial insurers or the Blues.

The SBA survey showed that small employers are about half as likely as large employers to offer HMO arrangements.[23] This difference may be due in part to the exclusion of employers with fewer than 25 employees from the Federal Health Maintenance Organization Act provision that requires employers to offer an HMO if they are requested to do so. In addition, small employers are less

[22] Small Business Administration, Health Care Coverage and Costs, table IV-3, p. IV-5.
[23] Ibid.

likely to have personnel or other resources to assess the complete range of health insurance options. Although HMOs and other insurers that limit enrollees' choice of providers are starting to market to smaller employers, historically they have stayed away from those smaller groups because of concern about adverse selection and the high turnover in the small-employer groups.

Thus, the most common health insurance options for small employers continue to be commercial insurance and Blue Cross/Blue Shield plans. In addition, pooling arrangements such as Multiple Employer Trusts (METs) have been established in some areas through which small employers can obtain health insurance. These arrangements are described below.

*(a) Commercial plans for small employers.*—Small commercial insurers who operate in a restricted market often offer either more expensive plans or less comprehensive benefit packages to smaller employers than they do to larger employers. However, larger insurers who operate nationally tend to have benefit packages for small employers that are at least as comprehensive as those for larger employers. Large insurers try to develop a uniform benefit package that will comply with the major State mandates throughout the nation. This tends to make the plans very comprehensive and therefore more expensive. According to the HIAA, the premium differential between large and small employers for commercial plans is between 20 and 30 percent.[24]

*(b) Blue Cross/Blue Shield plans for small employers.*—Recent initiatives by Blue Cross/Blue Shield plans have targeted the small-employer market. Nearly half the plans will insure employee groups as small as two; approximately 70 percent of plans insure groups as small as three, and 98 percent offer plans to groups of five or more. In an attempt to capture more of the small employer market, some marketing and design changes are being made in these plans. For example, benefits have been scaled down to provide less costly coverage.

Cost remains a restrictive factor for access to these plans for small employers. In general, Blue Cross/Blue Shield plans develop a community rate for small employers. For employers with relatively healthy employees, rates offered by commercial insurers may be lower because they can be experience-rated.

*(c) Pools for small employers.*—Various pooling mechanisms have been designed to simplify plan administration and spread risk over larger groups of individuals in order to reduce the cost of purchasing insurance for smaller employers. METs and Association Plans are two of the more common arrangements. METs, perhaps the most widely recognized arrangements, provide health benefits on a group basis to employees of small business or to individuals. Some METS are formed by an association of employers in the same industry; others are formed by membership associations (such as the American Bar Association). In the past, METs have attempted to self-insure, but many have run into substantial financial difficul-

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[24] Williams, Karen. Director of Policy and Planning Department. Health Insurance Association of America. Testimony before the U.S. House of Representatives, Committee on Small Business, May 6, 1987. See U.S. House of Representatives. Committee on Small Business. The Health Insurance Problem. Serial No. 100–7. p. 17.

ties because they have set unrealistically low rates in order to attract customers. METs that fully insure (pay premiums to an insurer in exchange for the insurer's assumption of claims payments and processing) have fared better. These are trusts that contract with an insurance company to assist with plan administration. One of the largest operating trusts is sponsored by the Council for Smaller Enterprises' (COSE) Group Health Insurance Program, which serves 4,500 of COSE's members through 9 insurance carriers in the Cleveland area. Other commercially insured METs have not been successful in recruiting large numbers of small employers because they do not offer insurance at competitive rates.

Alternative pooling arrangements have been proposed or set up in some States in an effort to provide coverage to small employers. Pilot programs have been launched in a few areas. For example, the Robert Wood Johnson Foundation has funded the Health Choice Small Business Program which is designed to improve access to health insurance for self-employed people and small businesses.[25] States have addressed the issue through legislation. While differences in strategies exist, most legislative options would create State-administered pools of small employers. Administrative costs would be financed by tax revenues, while benefits would be funded through premium rates. Regardless of the design, States have begun to recognize the unique problems of the small employer in providing health insurance and have proposed a variety of legislative remedies.

*3. The individual market*

Individuals who do not have access to employer-based coverage may obtain health insurance coverage by purchasing it directly from commercial insurers, the Blues, or HMOs. About 14.5 million non-Medicare individuals are enrolled as individuals in "non-group" policies.[26] (See table 2.4) Commercial insurers cover the majority of these individuals, Blue Cross/Blue Shield plans insure over 4 million, and HMOs enroll about 1 million.

TABLE 2.4.—Non-Group Enrollees by Insurance Arrangement, 1987

| Insurer | Enrollees (in millions) | Percent |
|---|---|---|
| Commercial insurers | 9.3 | 64 |
| Blue Cross/Blue Shield plans | 4.2 | 29 |
| HMOs | 1.0 | 7 |
| Total | 14.5 | 100 |

Source: Office of Technology Assessment, AIDS and Health Insurance, Staff Report, p. 1.

Insurers have found that individual health insurance is purchased by three distinct types of people. Some need extensive and permanent coverage, perhaps because their jobs do not provide coverage. Other individuals may need extensive coverage temporarily,

[25] The Robert Wood Johnson Foundation. Health Care for the Uninsured Program, Quarterly Report. July 1987.

[26] U.S. Congress. Office of Technology Assessment. AIDS and Health Insurance. Staff Report. Washington, U.S. Govt. Print. Off., 1988.

perhaps because they are students no longer covered by their parents' policies, are between jobs, or are "early" retirees not yet eligible for Medicare. In addition, some individuals purchase supplemental coverage outside group insurance schemes to cover medical expenses beyond the scope of their primary coverage.[27]

Individuals face many of the same restrictions as small employers in their search for health insurance. In order to guard against adverse selection, many insurers underwrite individuals. Some simply do not accept individual enrollees. Other insurers reserve the right to reject individual applicants on the basis of existing health conditions. Commercial insurers and the Blues can offer an individual applicant coverage with an above-average rate or with specific services excluded from coverage. Such coverage is problematic for persons with serious or chronic health problems, who may find it impossible to get insurance because of "pre-existing condition" clauses which exclude treatment for any illness or condition contracted prior to enrollment. The following discussion describes the most common choices available to persons seeking individual health insurance coverage.

*(a) HMOs.*—Federally qualified HMOs are prohibited from varying rates based on the health status of applicants. Instead, HMOs must reject the applicant outright or offer insurance to individuals at the established community rate, with an allowable add-on for the extra administrative costs of individual contracts. Accordingly, HMOs have a much higher denial rate for individual applicants than do commercial insurers or the Blues. According to an Office of Technology Assessment (OTA) survey, approximately one-quarter of nongroup applicants are turned down by HMOs, compared to less than one tenth rejected by commercial plans and the Blues.[28] Some HMOs do not offer nongroup coverage except as conversion coverage for members who leave a group.

*(b) Commercial plans.*—Commercial insurers typically subject individual applicants to underwriting. According to the OTA, 73 percent of applicants are accepted under the same conditions as group enrollees, but nearly 8 percent of applicants are denied policies.[29] In general, individuals may be denied coverage on the basis of having a chronic, life-threating disease such as AIDS, leukemia or diabetes. The remaining 19 percent of individual policyholders are covered under modified policies. Common conditions requiring a higher premium include chronic but mild conditions such as allergies, obesity, and arthritis. Commercial policies may exclude from coverage conditions that are more severe on a temporary or permanent basis. Examples include migraine headaches, knee impairments, and spine or back disorders.

(c) *Blue Cross/Blue Shield plans.*—Blue Cross/Blue Shield plans currently insure over 4 million non-group enrollees under age 65. The majority of these individuals are age 55 to 64.

Open enrollment periods are held on a yearly basis by nearly one-third of the plans, generally the larger ones (16 of which have

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[27] Health Insurance Association of America. A Course in Individual Health Insurance, Part A. Washington, D.C., 1983. p. xvii.

[28] U.S. Congress. Office of Technology Assessment. AIDS and Health Insurance. Washington, U.S. Govt. Print Off., 1988.

[29] Ibid., p. 14.

continuous open enrollment). During open seasons, individuals are accepted without regard to health conditions.[30] Policies written during an open enrollment period sometimes include less comprehensive benefits than those offered to medically underwritten applicants. Benefits for pre-existing conditions commonly are payable only after a waiting period. The remaining two-thirds of Blues plans underwrite individuals in a manner comparable to commercial insurers. Plans usually community-rate policies for all individual applicants. Rates for these policies are generally more expensive than community rates for group enrollees.

*(d) Pooling arrangements for individuals.*—In some States, pools have been established as a means of providing health coverage for uninsured individuals, and in particular for the "uninsurable" (i.e., those who have been refused health insurance because of a preexisting health condition). Fifteen States currently have programs implemented or planned that offer health insurance coverage to all individuals regardless of health status.[31] At the end of 1986, six pools covered 21,573 high-risk individuals.[32] Under these programs, State-formed associations of all health insurance companies provide coverage, and one insurer is chosen to administer the plan under guidelines prescribed by State law. In general, these pools offer fairly comprehensive benefits with rates that vary inversely with the range of available deductibles that can be as low as $150 to as high as $2,000 a year. Eligibility is typically based upon two or more rejected applications for insurance, although some States automatically qualify anyone with a medical condition such as cancer or AIDS. Premium levels are set as a percentage of a "standardized risk rate" and generally range from 100–200 percent of the individual rate as determined by the State insurance commissioners. In general, risk pools are designed to make insurance available to high-risk individuals, but they do not necessarily make insurance affordable.

## D. CURRENT GOVERNMENT PROGRAMS FOR SELECTED GROUPS

A wide assortment of government health care financing programs exist alongside the private health insurance industry. Public programs are designed to provide access to health care for particularly needy or entitled population groups. Groups covered by these programs include, but are not limited to, certain poor families, the elderly, the disabled, and veterans. In addition, the Federal Government provides health insurance coverage to its employees, both civilian and military.

### *1. Government employee health insurance*

The Federal Government, and State and local governments, provide health insurance for their employees by contracting with private-sector health insurance companies. Two of the largest public programs for government employees are the Federal Employees

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[30] Personal communication with Diana Jost, Executive Director of Private Market Programs, Blue Cross/Blue Shield Association.

[31] See Comprehensive Health Insurance for High Risk Individuals: A State by State Analysis. Minneapolis, Communicating for Agriculture, 1986.

[32] Intergovernmental Health Policy Project: Focus On the Risk Pool Strategy. Comprehensive Health Insurance Associations, Feb. 1988.

Health Benefits Program (FEHB) and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) for military employees and their dependents. These employee benefit plans resemble large private-sector plans and have incorporated many of the same cost-control techniques as the private-sector arrangements, including cost-sharing with the employee, managed care provisions, and coverage of hospital care alternatives.

*(a) Military programs.*—Active duty members of the armed forces are entitled to receive health care at military health care facilities. Active duty dependents, military retirees and their dependents, and survivors of deceased members may receive health care at these facilities, subject to availability.

CHAMPUS finances health care that is received outside of military facilities. Active duty dependents, military retirees and their dependents, and survivors of deceased members are eligible to receive coverage. In 1986, approximately 10 million military retirees, dependents, and survivors were eligible to receive CHAMPUS benefits. No premiums are paid, but enrollees not in military service pay a portion of the cost of allowable medical care. Cost-sharing amounts depend on the enrollee's status, services received, and type of facility (military or non-military).

CHAMPUS Prime is a reform initiative currently being phased in over several years and is designed to restrain cost growth and improve health care services. The program is modelled after private sector PPOs and offers reduced rates to military dependents, retirees, and survivors who use specified provider services. In the two States currently involved in the initiative, Blue Cross/Blue Shield handles the administrative claims for the Department of Defense.

*(b) The Federal Employees Health Benefits Program (FEHB).*—The FEHB provides voluntary health insurance coverage for Federal employees, annuitants, and their dependents. Administered by the Office of Personnel Management (OPM), this insurance program is the largest employer—sponsored health plan in the world, covering approximately 10 million employed and retired workers and dependents. Employees and retirees choose among a large number of health plans that have varying levels of benefits and premiums. Insurance arrangements include several commercial carriers, Blue Cross/Blue Shield plans, employee organization plans, HMOs, and PPOs. The Federal Government pays between 60 and 75 percent of the premium costs (depending on which plan the employee joins), while the remainder is withheld from employee paychecks or annuitant pension checks. Open seasons are held annually, during which time employees may change plans.

*2. Government-financed programs for special groups*

In FY 1986, Federal, State, and local expenditures for health care programs totaled over $180 billion, approximately 40 percent of total national health care expenditures.[33] The following section briefly describes the major Federal and State health insurance programs currently available to eligible individuals in the United States.

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[33] Health Care Financing Administration: National Health Care Expenditures: 1986–2000. Health Care Financing Review, summer 1987, v. 8, no. 4. p. 24.

*(a) Medicare.*—Medicare is a two-part Federal health insurance program serving 30 million aged and 3 million disabled persons. Virtually all people over the age of 65 qualify for coverage under the Hospital Insurance (HI) program (Part A), and those who do not meet eligibility requirements for coverage may qualify by paying a monthly premium. The HI program is financed primarily through a payroll tax on employers and employees.

Part B of Medicare (Supplemental Medical Insurance or SMI) provides coverage to the elderly and some disabled for physician and related health services. All persons age 65 or older may elect to enroll by paying a monthly premium. The program is financed by a combination of enrollee premiums (about 25 percent) and general revenues (about 75 percent).

Both parts of Medicare incorporate cost-sharing provisions (deductibles and coinsurance). Despite these measures, Medicare costs (in current dollars) have risen rapidly in the past decade from approximately $35 billion in 1979 to an estimated $85 billion in FY 1989. The growth in Medicare expenditures has resulted from an increase in the eligible population, changes in technology, general inflation in the economy, and other factors.[34]

*(b) Medicaid.*—Medicaid is a medical assistance program serving 24 million low-income persons in families with children and low-income aged, blind, and disabled people. Matching Federal funds are provided to States, which operate and administer the program within Federal guidelines. Eligibility requirements, benefit levels, and provider reimbursement policies vary greatly from State to State. Overall, about 41 percent of the people below the Federal poverty level are eligible to participate in Medicaid.

All States provide coverage to the categorically needy, generally those eligible for cash assistance from Aid to Families with Dependent Children (AFDC) or Supplemental Security Income (SSI) programs. In addition, States may cover (and receive Federal matching funds for) medically needy people who meet the non-income criteria for cash assistance and who meet an income standard established by the State. Often the medically needy meet this standard because they have high medical expenses. States may also establish special, higher income standards for pregnant women and young children, and for the aged and blind. In FY 1989, Federal funds used for Medicaid program reimbursement are estimated to reach $59.3 billion—or about 56 percent of total Medicaid outlays.

*(c) Veterans programs.*—Veterans with a service-connected disability are provided free care in Veterans Administration (VA) hospitals, nursing homes, and outpatient clinics. The VA owns a network of 172 hospitals, 225 outpatient clinics, and 106 nursing home care units. The VA also contracts with private facilities for emergency care or under other special circumstances. Poor veterans without a service-related disability generally can receive care at these facilities without charge, while nonpoor, nondisabled veterans can receive care but are expected to pay some or all of the costs.

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[34] See Arnett, Ross, David McKusick, Sally Sonnefeld and Carol Cowell. Projections of Health Care Spending to 1990. Health Care Financing Review, spring 1986, v. 7, no. 3.

Hospital and outpatient care is provided for certain dependents and survivors of veterans under the Civilian Health and Medical Program of the VA (CHAMPVA). Under this program, the VA subsidizes the cost to veterans for the medical care of their dependents, who typically receive care in non-VA facilities.

*(d) Other Federal and State programs.*—Though not ordinarily considered "insurance" programs, a host of small health care initiatives provide uninsured, mostly low-income, Americans with access to care. Federal programs make grants to States and health care providers to establish programs for pregnant mothers and children, migrant workers, and people living in medically underserved areas. Other Federal grants to States fund specific health services such as immunizations for children, family planning clinics, and alcohol and drug abuse treatment programs. In addition, the Federal Government funds and administers the Indian Health Service, which provides health care to urban American Indians and to American Indians and Alaska natives living on or near Federal Indian reservations. These programs serve needy but relatively small segments of the uninsured population.

State-sponsored programs also provide free health services, generally targeting either the poor outside the federally funded categories or the medically indigent population. In 1985, 34 States had indigent care programs to supplement existing Federal-State Medicaid programs.[35] In 16 of the 34 States, State-county programs cover hospital and ambulatory services for the medically indigent with standards similar to Medicaid. Other initiatives include catastrophic health care programs, State-run risk pools, hospital reimbursement and rate-setting systems which spread the costs for uninsured patients across all payers, and State and county general assistance programs. Many States also fund health care for particularly needy subpopulations. Some programs are disease-specific (for example, for people suffering from renal disease, cancer, or tuberculosis) while others target specific population subgroups such as pregnant women, native Americans, or the disabled.

## II. Description of Existing Employer-Provided Plans [36]

As described above, a wide assortment of arrangements exist through which persons in the United States can obtain health insurance. The majority of Americans receive coverage through an employer-provided plan. This section describes the characteristics

[35] Desonia, Randolph, and Kathleen King. Intergovernmental Health Policy Project. State Programs of Assistance for the Medically Indigent. George Washington University, Nov. 1985.

[36] Data for this section were drawn primarily from the "Hay/Huggins Benefits Report" (HHBR) for 1987. The HHBR is a report on the benefits provided by 896 medium and large employers in the United States. (See appendix B for a list of survey participants). The data on these employers are supplemented by information from: Employee Benefits in Medium and Large Firms, 1986 published by the Bureau of Labor Statistics (BLS). BLS reports on the fringe benefits of 21,800,000 employees. (In some cases BLS data will vary from HHBR data due to differences in reporting—BLS presents percent of the employees while HHBR presents percent of plans.) The source for the information on plans of small employers was Health Care Coverage and Costs in Small and Large Businesses prepared by ICF Incorporated for the Small Business Administration (SBA) in April 1987. The SBA report was based on responses from 846 employers—a response rate of approximately 20 percent. Percentages from the BLS survey are weighted by the number of employees. Percentages from the other surveys are weighted by the number of plans. Unless otherwise indicated, the data are drawn from the HHBR. Small employers are defined to be those with less than 100 employees, and large employers are those with 100 or more employees.

of employer-provided health insurance plans. First, important health insurance terms are defined. Next, trends in coverage and cost management measures implemented in the last decade are described. The section also presents typical health insurance plans and shows how they vary by region, industry, and size of employer. Finally, the chapter discusses the cost of health insurance plans for 1987 and trends in costs over the last 10 years.

While employers have an array of options for providing health insurance to employees and their dependents, the plans that are offered through these various arrangements are generally similar. Important exceptions are HMO plans, which provide more comprehensive coverage with lower payments required of employees at the point of service. In this discussion, typical HMO plans are described separately from the analysis of employer-provided plans. Individual plans, usually less comprehensive than typical group policies, are also briefly described at the end of this section.

### A. DEFINITION OF TERMS USED TO DESCRIBE HEALTH INSURANCE PLANS

Health insurance plans in the United States use a confusing array of terms that often complicate the comparison of different plans. In many cases, the same term can have different meanings in different plans. Therefore, it is useful to assign a consistent definition to each of the terms for the purposes of this report.

One set of terms identifies the people who are covered by the provisions of the health insurance plan. The person who has obtained the insurance, through his own or his employer's efforts, is the "enrollee." In an employer insurance plan, this person can be a current or former employee. A plan might cover only the enrollee or it might also cover members of the enrollee's family. Any person whose expenses could be reimbursed under the insurance policy will be called an "insured" for purposes of this report.

#### *1. Enrollee share of expenses*

There are three ways that enrollees can pay part of the cost for an insured's health care expenses. First, the enrollee may be required to pay part of the premium. Second, the enrollee may be required to pay for some health care services under the health plan. Third, the enrollee may be required to pay part of the covered health care expense.

*(a) Enrollee's share of premiums.*—If an enrollee purchases an individual policy (in contrast to a policy provided through employment), the enrollee will pay the entire premium, representing the average cost of the health care and related expenses for all individual policyholders covered by the insurer. If the health insurance is provided as part of the employment contract, the enrollee may be required to pay part of the premium. The premium is the average cost of the health care and related expenses of all enrollees in the employer group.

*(b) Uncovered services.*—The plan defines the type and extent of care to be "covered" and the part, if any, to be paid by the enrollee. The plan will describe the benefit categories that are covered as well as the type of providers that are acceptable. For instance, a plan may pay for mental health services only if provided by a psy-

chiatrist or a psychologist. Services provided by other professionals, such as family counselors, would then be "not covered."

Plans also require that a service be "medically necessary." Services that are not medically necessary generally include services for educational research or vocational training purposes, experimental treatments, and services that do not meet generally accepted standards of medical practice. Some plans may also exclude as unnecessary such services as admission to a hospital on a Saturday for surgery to be done the next Monday or tests not needed for a particular condition.

*(c) Enrollee's share of covered expenses.*—Finally, the insurance plan defines the portion of each covered health care expense that will be paid by the insurer. The remainder of the expense will be paid by the enrollee. Most plans will cover only expenses defined by the plan as usual, customary and reasonable for the type of treatment. This provision is called the "usual, customary and reasonable" (UCR) or "reasonable and customary" (R&C) limit. Typically, the insurer will use a schedule of allowable charges or base the payment on a combination of the physician's actual charge and charges of other physicians in the community.

In determining the UCR amounts, large insurers maintain records on all relevant claims. Provider charges are classified by type of visit and geographic area. Within each category, claims are then ranked from highest to lowest cost. The insurer then picks a percentile as the usual and customary charge. Typically, between 75 and 90 percent of the claims are less than or equal to the designated UCR amount. Some Blue Cross/Blue Shield plans use a substantially lower UCR percentage as a cost containment measure. Many PPOs also use a lower UCR percentage. Usual and customary charge amounts are updated frequently to reflect inflationary trends.

If an expense is covered, the enrollee may be responsible for the first part of the expense before the plan will pay anything. This is the "general deductible" that must be paid by the enrollee. For instance, a plan may require that an enrollee pay the first $200 of covered expenses in a year. (Separate deductibles may be required for certain expenses such as mental health care.)

The enrollee may have to pay a portion of the covered expenses after the deductible has been met. For instance, the enrollee may have to pay 20 percent of the cost of all covered expenses after a deductible of $200. In this report, the portion paid by the enrollee will be referred to as the "coinsurance." [37]

Most plans limit the total coinsurance that must be paid by the enrollee in a year. Some plans also count the general deductible in determining this "out-of-pocket maximum." After the maximum out-of-pocket threshold has been reached, all covered expenses are paid for by the insurer. For instance, an out-of-pocket maximum of $2,000 would mean that, after the coinsurance paid by the enrollee totals $2,000, all additional covered expenses would be paid by the

[37] Insurance plans define "coinsurance" as the portion paid by the insurer. For instance, "80 percent coinsurance" means that the insurer will pay 80 percent of the expense and the insured will pay the other 20 percent. This report will use the more familiar concept of coinsurance as that portion paid by the insured. Thus, "20 percent coinsurance" will mean 20 percent of the expense will be paid by the insured.

insurer, typically for both the current and the succeeding year. This maximum out-of-pocket is sometimes referred to as a protection against catastrophic expenditures.

Additionally, some plans have annual or lifetime "maximums" on the payments by the insurer. The insurer will not pay for any health care after the total annual or lifetime payments by the insurer reach this maximum. In many cases there are separate maximums on specific parts of the coverage. For instance, a plan may pay up to $25,000 for psychiatric expenses and $250,000 for all other expenses.

### *2. General plan design*

Most health insurance plans are categorized as either "comprehensive" or "basic plus major medical." This distinction has become more confusing than helpful over the years and will not be used in this report. However, it is useful to define these terms since they often arise in the description of health insurance plans.

Basic coverage originally meant the type of expense that was fully paid for by the insurer without any coinsurance or deductible. The most common type of basic coverage was for hospital expenses and physician services provided in a hospital setting. Expenses covered as basic were often reimbursed by direct payment to the provider.

Major medical insurance was established to cover expenses, such as prescription drugs and doctor's office visits, that were not covered as basic expenses. Since basic and major medical insurance plans were usually combined as one package, although often offered by two different insurers, the package became known as "basic plus major medical."

Comprehensive insurance originally subjected all covered expenses, including hospital-related expenses, to a common deductible and coinsurance. A typical design would have been for the enrollee to pay 20 percent of all covered expenses after a $100 deductible.

Basic insurance was traditionally provided by the Blue Cross/Blue Shield organizations with the major medical part provided by a commercial insurance company, but major medical policies are now offered by the Blues as well. Comprehensive insurance was originally provided by commercial insurance companies. Deductibles and coinsurance have been added to the basic coverage of many plans, and hospital and surgery are now covered in full by many comprehensive plans. Therefore, while the terms are still used, the distinction has become more apparent than real.

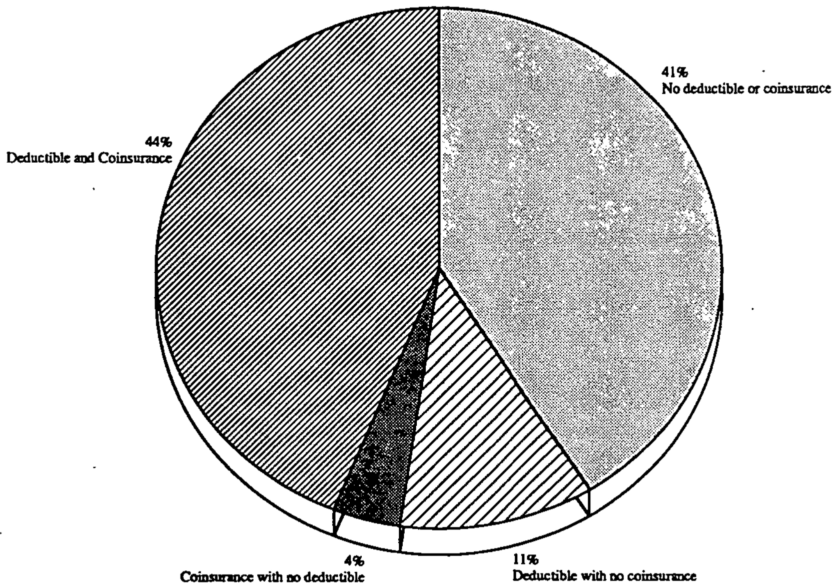
## B. DESIGN OF PLAN BY TYPE OF COVERAGE

### *1. Hospital expenses*

In the last decade, many insurers and employers have ceased the historic approach of paying all expenses related to a hospitalization. As shown in chart 2.1, only 41 percent of plans pay the full

cost of all hospital expenses. The most prevalent practice is to charge the insured both a coinsurance and a deductible. In most plans with a hospital deductible, the hospital bills are combined with other bills subject to the general deductible. In one-fifth of the cases, there is a separate hospital deductible, most commonly $100. After the deductible, the enrollee will usually be required to pay 20 percent of the bill.

# Chart 2.1
## Hospital Coinsurance and Deductible




Source: Hay/Huggins Benefits Report, 1987

The traditional approach to hospital coverage, still followed by almost all plans, is to base the accommodations portion of reimbursement on the full cost of semi-private room and board accommodations. Sixty percent of the plans have no maximum, and another 18 percent cover 365 or more days per stay. For those that do have a limit on the number of days, the most common limit is 120 days, and a few, less than 2 percent, have limits of less than 70 days per stay. Only 6 percent of plans have a limit on the total dollar amount of hospital expenses.

The requirement for enrollee coinsurance on hospital bills is generally capped by a maximum out-of-pocket limit (used by 83 percent of the HHBR plans). Under a typical plan with a maximum out-of-pocket cap of $1,000, if an insured is in the hospital for 6 days (with a total charge of $4,000 and has other medical expenses of $1,100), the insured would be required to pay $1,000 out-of-pocket. Therefore, all days after the sixth day would be paid in full. There is often a separate limit for hospital stays that are related to psychiatric care. One-third of the plans apply a separate maximum to these stays, the most typical maximum being 30 days per stay.

Treatment in an emergency room of a hospital is covered in full if the treatment results from an accident, sudden illness, or is life-threatening. Plans also usually cover, in full, treatment in outpatient medical facilities to encourage the use of less expensive alternatives to hospitalization. Most plans apply the inhospital coinsurance and deductible, if any, to X-ray and laboratory tests (performed on an outpatient basis) to remove the incentive for a physician to admit a patient to a hospital simply to obtain full reimbursement for these tests.

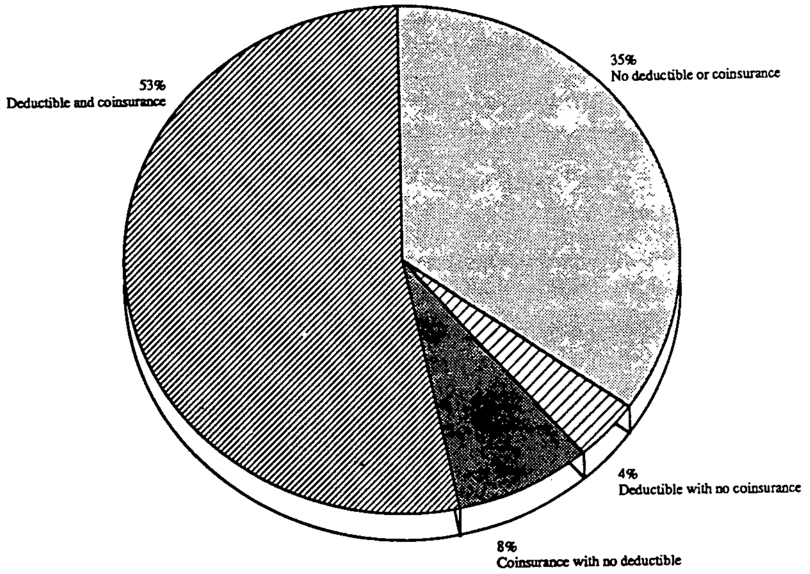
There has been a trend toward coverage of health care provided in institutions other than hospitals. Ninety percent of employers now provide coverage for care in a skilled nursing or an extended care facility.

*2. Surgical expenses*

As with hospital expenses, the most common plan provision is to require the insured to pay both a deductible and coinsurance. As shown in chart 2.2, only 35 percent of plans will pay in full for all surgery expenses. Almost all plans (94 percent) cover the full reasonable and customary charges for surgery, and the others reimburse a scheduled amount depending on the type of surgery.

## Chart 2.2

## Surgery Coinsurance and Deductible




Source: Hay/Huggins Benefits Report, 1987

Typically, surgery is covered at the same rate, no matter where it is performed. If the inpatient surgery is paid in full, surgery in a physician's office or other non-hospital facility is paid in full. Otherwise, the in-patient surgery deductible and coinsurance are applied to the outpatient treatment. However, 35 percent of plans pay a larger portion of the outpatient surgery than of inpatient surgery to encourage enrollees to seek outpatient treatment and avoid the additional inpatient hospital charges.

*3. Other professional expenses*

Almost all expenses for medically necessary treatment by a physician are covered under health insurance plans. The amount of the expense that is reimbursed will typically be subject to the general deductible and coinsurance, but there are significant exceptions. Most plans will reimburse the physician's fees for visits in a hospital on the same basis as surgery. As with the inpatient hospital and surgery expenses, however, most plans now apply coinsurance and deductibles to all physician's visits in or out of the hospital.

Almost all plans cover the UCR charges for physician's office visits; 85 percent apply the general coinsurance and deductible. Eleven percent do not apply a deductible, and 4 percent have a specific deductible for these visits.

Most carriers will cover the services of other medical professionals if the service is delivered under the supervision of a physician. Treatment by a psychologist is usually covered with the same coinsurance as for treatment by a psychiatrist. Coverage of non-physician practitioners, such as podiatrists, chiropractors, and nurse midwives, is frequently based on whether the practitioner has hospital admitting privileges in that State. In many States, direct payment to certain non-physician practitioners is mandated by State law.

Coverage is usually limited for expenses related to treatment for psychiatric care outside a hospital. Seventy percent of plans pay only 50 percent of costs compared to a typical 80 percent for treatment of physical illness. The most common limits used by plans are shown in table 2.5. Most plans combine two or more of the limits. The result is that total reimbursement for outpatient psychiatric care is limited to $1,000 to $1,500 a year in most plans.

TABLE 2.5.—Limits on Reimbursement of Outpatient Psychiatric Expenses

| | *Percent of HHBR plans* |
|---|---|
| Coinsurance of 50 percent | 70 |
| Dollar maximum per year or lifetime | 68 |
| Maximum payment per visit | 36 |
| Maximum visits per year | 29 |

Note.—Since some plans use more than one limit the total is greater than 100 percent.

Source: Hay/Huggins Benefits Report, 1987.

*4. Other benefits*

The percent of employers in the HHBR who offer specific coverage is shown in table 2.6. Eight percent of medical plans also cover dental expenses. However, 79 percent of employers provide a separate dental plan.

TABLE 2.6.—Type of Plan Offered by Employers

| | Percent of HHBR plans |
|---|---|
| Hospital and medical care | 100 |
| Dental care | 87 |
| Physical examinations | 71 |
| Vision care | 21 |
| Separate prescription drug plan | 12 |

Source: Hay/Huggins Benefits Report, 1987.

Most medical plans cover prescription drugs under the general deductible and coinsurance, but 12 percent of plans have a separate prescription drug benefit. Only 21 percent of employers provide coverage of vision care expenses through either a separate vision care program or under the medical plan.

Seventy-one percent of employers provide coverage for some physical examinations. In most plans, coverage of physical examinations is limited to employees in certain categories, but non-discrimination rules in the tax code, to be implemented in 1989, may cause employers to either extend the coverage to all employees or eliminate the benefit.[38]

### 5. *Enrollee share of health care expenses* [39]

Every plan in the HHBR requires the enrollee to share in the payment of some or all of the covered expenses through deductibles and coinsurance. Even if expenses related to a hospitalization or surgery are covered in full, deductibles and coinsurance apply to other covered medical expenses.

Deductibles are included in health insurance plans for three reasons. First, the deductible reduces the expense that is insured. Second, the use of a deductible avoids the processing of small claims. If an individual has only a minor illness in a year, involving one or two doctor's visits and prescriptions, the deductible avoids the expense of processing these relatively small claims. Finally, if the deductible is high enough, it may discourage an insured from seeking unnecessary (or even necessary) treatment.

Chart 2.3 shows the amount of the general deductibles for HHBR plans. The few deductibles that are not multiples of $50 are grouped with the nearest $50 deductilbe in the chart. A few plans (6 percent) have a deductible of $50 or less, but the most common deductible is $100 (47 percent of plans). Seven percent of plans have deductibles that are greater than $200. BLS reports that 46 percent of employees are covered by plans that have a $100 deductible and 3 percent are in plans with deductible of $300 or more.

Coinsurance is included in health care plans to keep the cost of the plan as low as possible and to encourage the enrollee to avoid unnecessary or overly expensive treatment. The traditional coinsurance percentage has been 20 percent; however, higher coinsurance amounts have been used where insurers have wanted to increase enrollee participation in the cost of certain types of care.

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[38] See Chapter 3, Government Regulation of Health Insurance, p. 145, for a description of the nondiscrimination provisions of the Internal Revenue Code.

[39] For a discussion of the extent to which persons insured by employer-provided plans are at risk for out-of-pocket expenses due to provisions in their health insurance plans, see Chapter 5, The Insured Population and Exposure to Out-of-Pocket Expenses, p. 205.

For instance, enrollees are often required to pay more than 20 percent for expenses of outpatient mental health coverage or orthodontia. Lower coinsurance rates are sometimes used to encourage less expensive alternatives to hospitalization. Eighty-eight percent of commercial plans use the traditional coinsurance of 20 percent after the deductible has been met. Most of the remaining plans use a coinsurance of 15 or 10 percent.

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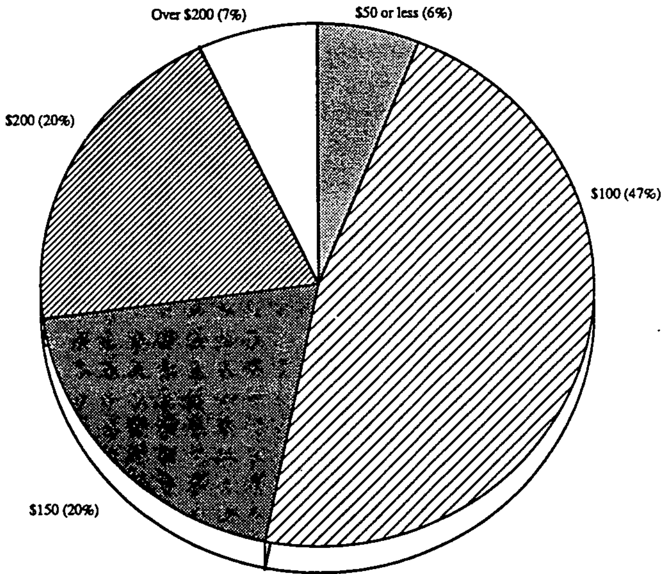
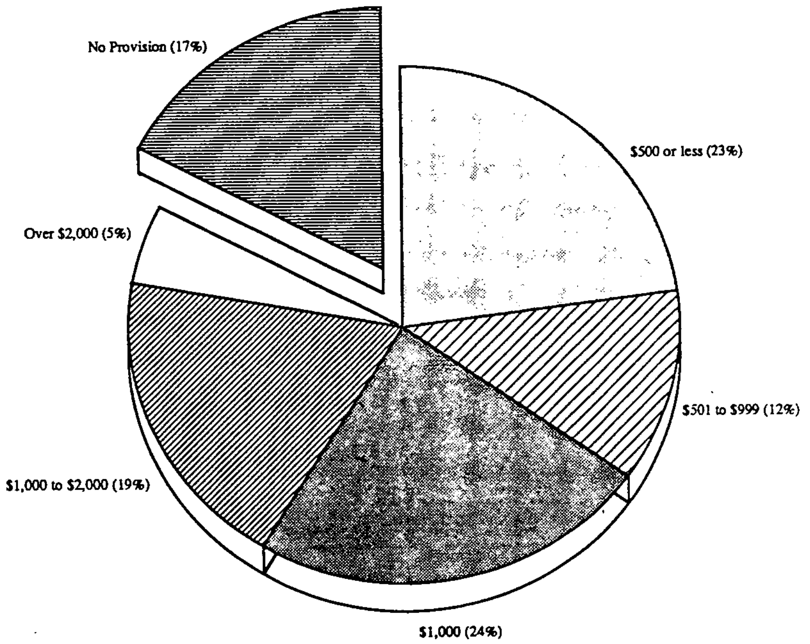
# Chart 2.3
## General Deductible




Source: Hay/Huggins Benefits Report, 1987

## Chart 2.4
## Limit on Annual Enrollee Out-of-Pocket Expenses



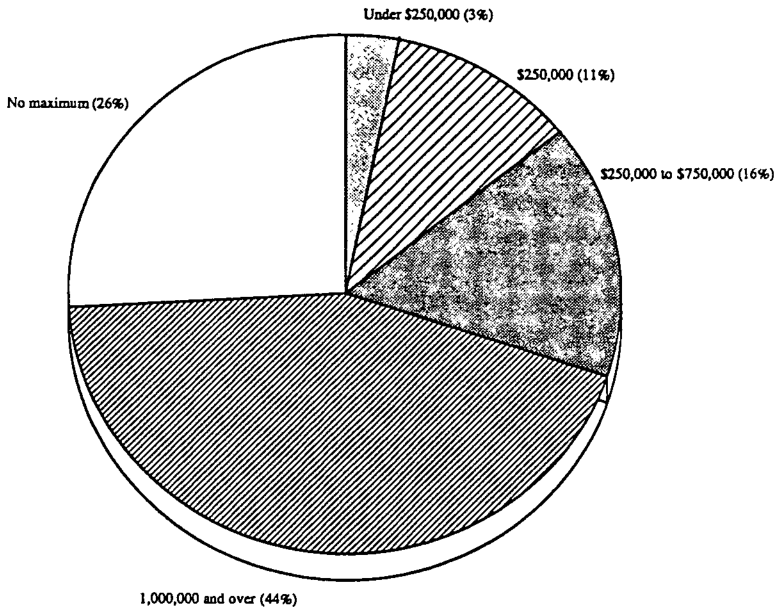

Source: Hay/Huggins Benefits Report, 1987

As chart 2.4 indicates, 83 percent of plans place a maximum on out-of-pocket payments by the enrollees. Employers use coinsurance and deductibles to encourage enrollees to participate in the decision to receive treatment and to share the cost of health care. However, most employers also believe that patients with major bills need full relief after they have paid substantial out-ot-pocket costs as a result of the deductible and coinsurance. The most common out-of-pocket limit (24 percent of plans) is $1,000. Most limits are in the $500 to $2,000 range, but a few are as high as $5,000. Some plans count the deductible in determining the limit, while others consider only coinsurance payments.

Few plans limit the total lifetime benefits that will be paid by the plan. As shown in chart 2.5, a fourth of the plans have no maximum, and 44 percent have limits of at least $1,000,000. Some insurers believe that a $1,000,000 maximum sells better than no maximum, although in effect they are the same.

Fourteen percent of plans have a maximum of $250,000 or less. The maximum usually applies to all expenses over the lifetime of an insured. Since costs for major illnesses, such as severe burn cases, can exceed $100,000 a year, enrollees in plans with $250,000 or lower lifetime limits do run a risk of incurring major expenses that will exceed plan limits.

## Chart 2.5
## Limit on Lifetime Benefits Paid by Plan




Source: Hay/Huggins Benefits Report, 1987

*6. Measures to reduce plan cost*

While some insurers had utilization review programs in the 1960s, they were joined in the 1970s by many employers and insurers who began to take measures to reduce the cost of health care plans in the 1970s. Use of these measures was increased as a result of the sharp escalation in health care costs in the early 1980s. One method of cost reduction, used in all HHBR plans, involves the enrollee more in the choice and cost of care through the use of deductibles and coinsurance, as discussed above. Table 2.7 shows the prevalence of the most common types of measures other than deductibles and coinsurance.

TABLE 2.7.—Illustrative Measures to Reduce Plan Cost

| | Employers with provision | Employers considering provision |
|---|---|---|
| Drug and alcohol assistance program | 60 | 7 |
| Precertification of hospital admissions | 57 | 15 |
| Second surgery opinion requirement | 54 | N/A |
| Claims review for accuracy | 51 | 11 |
| Smoking cessation program | 50 | 9 |
| Concurrent review of hospital stays | 43 | 20 |
| Higher reimbursement on outpatient than on inpatient surgery | 35 | N/A |
| Member of employer coalition | 31 | 6 |
| Full reimbursement of care in skilled nursing facility | 28 | N/A |

N/A—Data not available.

Source: Hay/Huggins Benefits Report, 1987.

Several of the most effective measures are introduced directly into the design of the health plan. One approach is to encourage treatment outside the hospital. Two-thirds of plans reimburse all expenses for surgery performed outside the hospital. For 35 percent of plans, outpatient surgery is reimbursed at a higher rate than inpatient surgery. A small but increasing number will pay in full for home health care or for care in an alternative facility such as a skilled nursing facility.

Another common cost-reduction procedure is to require a second opinion for voluntary surgical procedures. Over half (54 percent) of plans in the HHBR require a second opinion for selected surgical procedures before they are performed. If the second opinion is that surgery should not be performed, a third opinion can be sought to break the tie. If the insured does not get a second opinion before surgery, 83 percent of plans will cover the surgery expenses but at a lower rate. For instance, if surgery is covered in full with a second opinion, the plan might pay 80 percent for surgery where no second opinion was obtained.

Procedures to control hospital admissions are of particular interest since expenses associated with hospital admissions account for over half the benefits paid under typical plans. Most plans (57 percent) require a certification by a professional review organization before a non-emergency admission to the hospital. Many plans (43 percent) review the treatment while the patient is in the hospital to make sure that the stay is as short as is medically necessary.

Twenty-seven percent of plans review the claim after the patient has been discharged from the hospital. This post-discharge review is used primarily to identify providers who may exceed the norms for duration of hospitalization.

Many insurers and employers have introduced special controls for potentially high-cost cases. A relatively new approach is case management of large claims. When an insurer identifies a new case that will probably involve $25,000 or more in expenses, a case manager will be assigned to follow the treatment plan and make sure that the most efficient treatment is used. In some cases, this can involve payment of expenses that are usually not covered by a health plan, including even nonmedical costs. For instance, it may be desirable for an insurer to pay for a wheelchair ramp in a patient's home if that is the only way that the patient can be treated at home instead of in a hospital.

When employers and insurers find that they are not large enough to influence the amounts that health care providers charge for their services, they sometimes join together in a coalition. A typical coalition will negotiate directly with one or more hospitals to receive a discount or introduce an effective review program.

Most larger employers have introduced health promotion programs. The most popular are smoking cessation and assistance with drug and alcohol problems.

Larger employers are more likely to have taken steps to control costs. The SBA study shows that 53 percent of large employers have recently introduced the requirement of a second surgery opinion compared to 30 percent of small employers. Half of large employers have established treatment of outpatient surgery at the same level of coverage as inpatient, but only a fourth of small employers follow this practice. Around 20 percent of large employers, but only 5 percent of small employers (with less than 100 employees), use a utilization review or health promotion program. Some of the HHBR and SBA data on cost-control show substantially different results for larger employers. The SBA and HHBR cost-control results are not comparable. SBA asked if the cost-control feature had been introduced in the last 2 or 3 years, while the HHBR survey asked if the employer currently had such a provision.

*7. Extent of coverage*

According to the SBA survey, most employers (73 percent) exclude some employees from coverage. The most common exclusion, used by 68 percent of the firms, was for part-time employment. Half of the employers exclude employees who are only seasonal or temporary. Eight percent of plans exclude hourly workers; 3 percent have an upper age limit; and 2 percent have a lower age limit.

According to the SBA survey, only 9 percent of employers permit employees to join the health plan immediately. Most employers admit employees after a month (36 percent) or 2 to 3 months (38 percent) of service. Eleven percent require the employee to wait 4 to 6 months, and 7 percent have a waiting period longer than 6 months. The practice differs by size of employer. Seventy-five percent of employers with 500 or more employees have a waiting

period, compared to 92 percent of employers with fewer than 10 employees.[40]

Eighty-six percent of plans reporting in the HHBR continue coverage for some or all retirees. Six percent of employers cover only early retirees under age 65 on the theory that they are responsible for the insurance of a former enrollee only until Medicare coverage begins. Seventeen percent of the employers cover only retirees aged at least 62 (or 65) on the opposite theory that their responsibility for retirees' insurance extends only to persons who worked long enough to receive full retirement benefits. The other 63 percent provide insurance for any retiree.

Most employers (79 percent) who provide retiree coverage after age 65 continue the employee plan with an offset for Medicare benefits. Fifteen percent have lower lifetime benefit limits for retirees than the lifetime limit for employees. Plans continuing coverage for annuitants who are over age 65 coordinate their benefits with Medicare in three ways. First, plans may specify that the employer plan, when combined with Medicare's benefits, will equal the benefits for enrollees who are under age 65. The second type of plan will pay up to the amount specified for actively employed enrollees, so long as the sum of the health plan payment and the Medicare payment does not exceed 100 percent of the bill for the covered expense. The third type of plan is designed specifically to supplement Medicare benefits.

All of the plans in the HHBR permit the enrollee to elect dependent coverage. However, as will be discussed later, only a third of employers surveyed in the HHBR pay the full cost of dependent coverage.

*8. Trends in the enrollee share of health care expenses*[41]

Most of the changes in plan provisions in the last decade have been designed to help control the cost of health care coverage. Employers have increasingly looked to alternative types of health insurance, such as those provided by HMOs and PPOs, and to alternative providers, such as surgical care centers, in response to the sharp increases in the cost of insuring traditional hospital-based health care.

Plan provisions have also been modified to shift more of the cost to the enrollees. In particular, current plans do not pay full costs for all inpatient hospital and surgical services. Rather, insurers pay only part of the cost, requiring more coinsurance and deductible payments from enrolless. In 1977, 80 percent of all plans paid in full for inpatient room and board costs. In 1987, most plans required some coinsurance and/or a deductible, even on hospital

[40] Many employers will have to liberalize their pay exclusions when the discrimination rules under the 1986 Tax Reform Act become effective in 1989. Under these rules, if higher-paid employees receive more generous benefits than lower-paid employees, the value of the added benefits must be treated by the employer as income for tax purposes. Some employers who have restrictions that affect lower-paid employees may prefer to keep the restrictions and pay the penalty (i.e., taxes on imputed income of the higher-paid employees). In any event, the practice today indicates that many employers will try to exclude as many employees as are permitted by the law.

[41] Data from 1977 and 1987 HHBR surveys are used in this section to show changes in health insurance plans over the past decade.

room and board expenses. Only 41 percent of plans now pay hospital expenses in full.

As shown in table 2.8, general deductibles have increased. In 1977, 30 percent of the plans had a deductible of $50 or less compared to 6 percent of the plans in 1987. The most common deductible in both 1977 and 1987 was $100. Only 2 percent of the plans had a deductible of at least $200 in 1977 compared to 27 percent in 1987.

TABLE 2.8.—Changes in the Amount of General Deductibles, 1977 and 1987

| Amount of deductibles | Percent of HHBR plans | |
|---|---|---|
| | 1977 | 1987 |
| $50 or less | 30 | 6 |
| $75 | 5 | 1 |
| $100 | 62 | 46 |
| $150 | 1 | 20 |
| $200 or more | 2 | 27 |

Source: Hay/Huggins Benefits Report, 1977 and 1987.

Although the size of deductibles has increased in the last decade, the increase has not kept pace with growth in the health care costs. The health care component of the Consumer Price Index (CPI) has increased by 127 percent in the last decade, while the average deductible has increased by 65 percent, from $85 in 1977 to $140 in 1987.

As shown in table 2.9, the proportion of plans lacking an out-of-pocket limit has decreased from 81 percent in 1977 to 17 percent in 1987. In 1977 only 2 percent of plans had out-of-pocket limits under $2,000. By 1987, despite inflation in health care costs, over 70 percent of plans had limits of less than $2,000. In 1987, more enrollees were required to share in the cost of minor treatment and the early part of major treatment through the use of coinsurance and deductibles. However, the enrollee is usually protected in full against major or long-term expenses through the out-of-pocket limit.

TABLE 2.9.—Changes in Maximum Limits on Annual Out-of-Pocket Expenditures, 1977 and 1987

| Out-of-pocket limit | Percent of HHBR plans | |
|---|---|---|
| | 1977 | 1987 |
| $500 or under | [1] | 23 |
| $500 to $900 | [1] | 12 |
| $1,000 to $1,900 | 2 | 36 |
| $2,000 | 8 | 7 |
| Over $2,000 | 8 | 4 |
| No maximum | 81 | 17 |

[1] Less than 1 percent.

Source: Hay/Huggins Benefits Report, 1987.

Especially when health care inflation is taken into account, plans have vastly improved with respect to protecting enrollees from high out-of-pocket expense, although the tradeoff has been a higher percentage of premium costs born by the enrollee.

Table 2.10 compares the maximum lifetime benefits in 1977 and 1987. In 1987, only 14 percent of plans had a maximum benefit of $250,000 or less. However, in 1977, 49 percent of plans had a limit of $100,000 or less and a total of 84 percent had a maximum benefit of $250,000 or less. Thus, the risk that enrollees will exceed lifetime benefit limits and therefore face large financial burdens has decreased considerably since 1977.

The medical portion of the CPI increased by 127 percent between 1977 and 1987. Thus, the 49 percent of plans with maximums of $100,000 or less in 1977 would be roughly comparable to the 14 percent with maximums of $250,000 or less in 1987, (still substantially greater in 1977 even if these are expressed in 1987 dollars).

TABLE 2.10.—Changes in Maximum Lifetime Benefit Payments, 1977 and 1987

| Amount of Maximum | Percent of HHBR plans | |
|---|---|---|
| | 1977 | 1987 |
| $25,000 or less | 7 | |
| $30,000 to $75,000 | 20 | |
| $100,000 | 22 | |
| $110,000 to $240,000 | 2 | [1] 3 |
| $250,000 | 35 | 11 |
| $250,000 to $999,999 | 3 | 16 |
| $1,000,000 and over | 4 | 44 |
| No maximum | 7 | 26 |

[1] Total under $250,000.

Source: Hay/Huggins Benefits Report, 1987.

## C. TYPICAL PLANS [42]

This subsection first presents a typical plan offered by large employers in the HHBR and a description of how plans included in collective bargaining agreements differ from the typical plan. The next two parts explain how plan features might differ for a more expensive or less expensive type of plan offered by large employers. Other subsections show the differences in typical plan provisions by size of employer, industry, and region. A typical HMO plan is presented, followed by a discussion of the plans available for direct purchase by individuals.

[42] Three composite plans for large employers have been selected by reviewing the provisions reported in the HHBR: a typical plan, a more expensive plan and a less expensive plan. "Typical" plan provisions have been selected from the average or most prevalent provisions. A more expensive plan is representative of plans among the highest 10 percent in cost. A less expensive plan is representative of plans among the lowest 10 percent in cost. Provisions of a small employer plan have been derived from the SBA survey. The provisions for collective bargaining plans are from a Hay/Huggins survey of such plans. The provisions for HMOs are from the HHBR. Information on individual plans is from the 1987 Disability Insurance Time Saver, published by the National Underwriter Company.

*1. Typical plan offered by large employers*

A typical large-employer plan covers all employees who work more than 30 hours a week starting in the month following employment. The premium for the enrollee is paid by the employer, but the enrollee must pay 25 to 50 percent of the additional premium required to cover dependents.

Costs related to a stay in a hospital are covered in full with no deductible or coinsurance. To encourage the use of less expensive alternatives to hospital care, costs of care in facilities such as skilled nursing care facilities are also covered in full.

All other covered costs are paid at 80 percent after the enrollee pays a deductible of $100 per individual ($300 for all family members). The other covered costs include services of a physician, services of other medical professionals, prescription drugs, and laboratory tests.

Inpatient charges for mental health services are covered in full for up to thirty days in the hospital. Half of outpatient mental health charges are paid up to an annual maximum of $1,500 per person.

The 20 percent payment by the enrollee for costs in excess of the deductible stops when the enrollee's share reaches $1,000 in a year. There is no maximum on allowable benefits paid by the plan.

The enrollee is covered by a separate dental plan but not by a vision care plan. After a $50 deductible, the dental plan covers all expenses for preventive care, 50 percent of expenses for restorative treatment, and 80 percent of other covered dental expenses.

A typical plan resulting from collective bargaining places less of the cost on the enrollee. There is no enrollee contribution for enrollee or dependent coverage. The plan fully reimburses the cost of all services related to a stay in a hospital, including physician's inpatient and outpatient charges. All other expenses are covered at 80 percent after a $100 or $150 deductible. The out-of-pocket maximum is $750 or less, and there is a separate dental program.

*2. More expensive large employer plans*

The more expensive employer health plans do not require any enrollee contribution for the premium. All employees are covered from the first day of employment. All major expenses including inpatient care, surgery, and tests are reimbursed in full. All other expenses are paid at 90 percent after a $100 deductible per person. The maximum deductible is $200 for a family.

Expenses for inpatient mental health care are paid in full. Expenses for outpatient mental health care are reimbursed at 80 percent of the reasonable and customary charge.

The plan pays all costs after an enrollee's out-of-pocket expenses equal $500. All deductibles and enrollee coinsurance payments are included in the determination of the $500.

The insured is covered by a separate prescription drug plan with a one dollar copayment per prescription. The insured is also covered by separate dental and vision plans.

*3. Less expensive large employer plans*

A plan that would be typical of the lowest level of benefits offered by large employer plans only covers full-time employees who have at least 3 months of employment. The enrollee is required to pay 25 percent of the cost of the enrollee's insurance and 50 percent of the additional cost of dependents' insurance.

All expenses are reimbursed at 80 percent of reasonable and customary charges after a deductible of $200 per person, with a maximum deductible of $600 for the family. There is a separate deductible of $300 for each hospital admission.

Inpatient mental health care is reimbursed under the 80-percent formula, but the coverage stops after 30 days. Outpatient mental health treatment is reimbursed at 50 percent up to a maximum of $500 per person per year.

There is no maximum on the out-of-pocket payments by the enrollee. There is a lifetime maximum benefit of $250,000.

The enrollee is not covered by a dental or vision plan.

*4. Plan variations by number of employees in firm*

All of the employers in the HHBR provide a health care plan for their employees, and 95 percent of the employees in the BLS survey are covered by a plan. However, a significant number of smaller firms do not offer health care plans. The SBA survey shows that 98 percent of employers with 100 or more employees have a health care plan compared to 55 percent of firms with fewer than 100 employees.

The plan provisions for the small employers who have health plans are similar in many respects to those of large employers. All plans cover major hospital and surgery costs. However, small employers are less likely to cover alternatives to hospital care or to install cost-control features. For instance, the SBA study shows that 76 percent of small employers cover home health or extended care, compared to 86 percent of large employers. Only a third of small employers have a dental plan, compared to 42 percent of large employers.

According to the SBA survey, 94 percent of employers of all sizes have a maximum on out-of-pocket expenses. However, smaller employers are likely to have a higher maximum. One-third of small employers have a maximum of less than $1,000, compared to 44 percent of larger employers; 18 percent of small employers have limits of $2,000 or more, compared to 9 percent of large employers.

*5. Variations by region and industry*

The HHBR data were segregated into six regions for the purposes of this analysis—New England, Mid-Atlantic, South, Central, Plains, and Mountain/West Coast.[43] The regional analysis suggests

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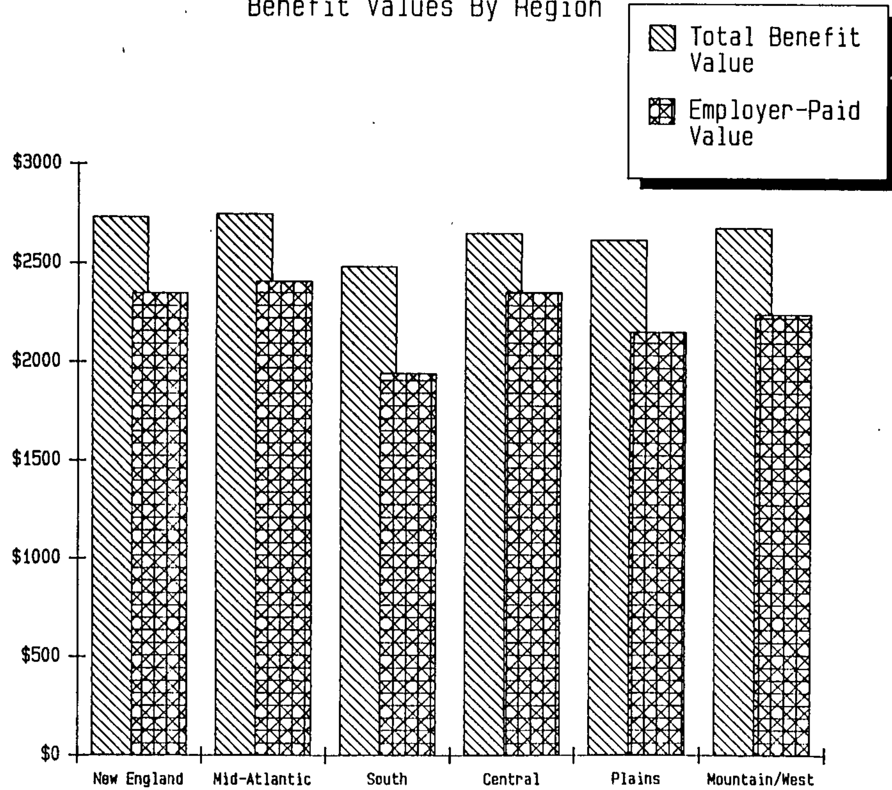
[43] States included in these regions are as follows: *New England:* Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont. *Mid Atlantic:* Delaware, District of Columbia, Maryland, New York, New Jersey, Pennsylvania, Virginia, West Virginia. *South:* Alabama, Arkansas, Florida, Georgia, Louisiana, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas. *Central:* Iowa, Kansas, Minnesota, Nebraska, North Dakota, South Dakota. *Plains:* Illinois, Indiana, Kentucky, Michigan, Ohio, Wisconsin. *Mountain and West Coast:* Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, Wyoming. There are no HHBR participants from the State of Hawaii.

that the general design of employer health care plans is consistent across the United States. Typically, all of the inpatient hospital expenses are paid and other medical expenses are covered at 80 percent after a $100 to $200 deductible. The employer pays most of the premium cost, and the plan reimburses all expenses after the total paid by the enrollee hits $1,000 to $1,500. The large majority of employers in any region offer a dental plan.

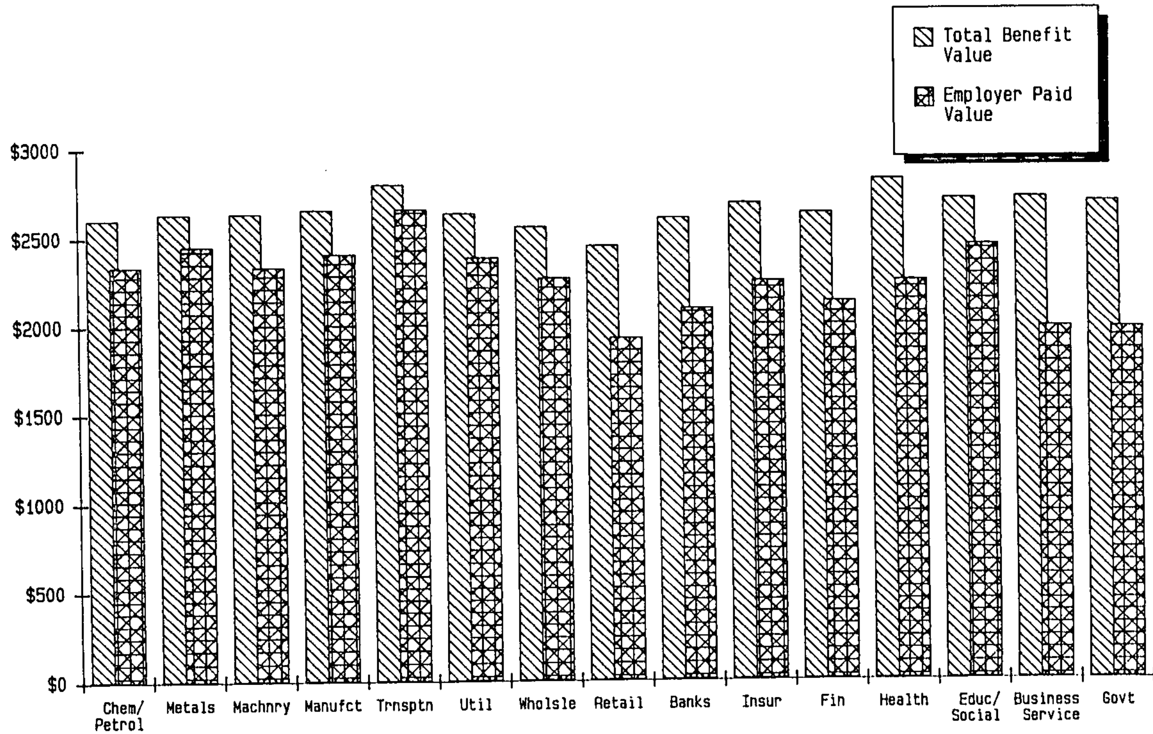
Although the general benefit designs are consistent across regions, there are variations in some benefit details and more significant variations in the proportion of the premium paid by the employer. The variations are shown in chart 2.6. The values were calculated by measuring the value of each plan provision using the Hay-Huggins' method of Benefit Value Comparison (BVC).[44] The employer-paid value is the total value less the enrollee contributions, if any. The chart shows that there is less variation in total benefit design (total benefit value) than in the level of enrollee contribution.

Chart 2.6
Benefit Values By Region




Source: Hay/Huggins Benefits Report, 1987.

## Chart 2.7
## Benefit Values By Industry




Source: Hay/Huggins Benefits Report, 1987.

The total value of the average health plan by region was in a fairly narrow range from $2483 for plans in the South to $2735 for plans in the New England and the Mid-Atlantic regions.

Plans in the New England and Mid-Atlantic regions are more likely to pay all major expenses, including inpatient surgery, at 100 percent than plans in the other regions. Employers on the West Coast are more likely to offer separate prescription drug and vision plans and options to participate in HMOs or PPOs.

The most significant regional difference is in the level of enrollee contribution. Less than half (46 percent) of employers in New England pay for the full enrollee coverage, but almost two-thirds of employers in the Mid-Atlantic (63 percent) and West Coast (64 percent) regions pay for the full coverage.

The percentage of employers who pay the full family coverage ranges from 23 percent in the South and Plains regions to 40 percent in the Mid-Atlantic region. This difference in contribution is shown by the wider variation for the employer-paid value, from $1943 in the South to $2408 in the Mid-Atlantic States.

The range of values is wider by industry than by region. Chart 2.7 shows the benefit values for plans in the HHBR by industry. As with the geographic breakdown, the variation in values is much greater for the employer-paid portion of the plan than for the total benefit value. The total benefit values range from $2450 for retail firms to $2820 for health service firms. However, the employer-paid values range from $1930 for retail to $2658 for transportation firms.

Plan provisions are relatively constant by industry, but a few benefits show wide variation. The percentage of plans that pay hospital expenses in full ranges from 40 percent for retail firms to 64 percent for transportation firms. The proportion of plans with a $100 deductible ranges form 34 percent for transportation to 62 percent for the chemical/petroleum industry. Only 58 percent of government plans have dental care compared to 90 percent for transportation plans. The most significant variation is in the share of premium paid by the enrollee. Ninety percent of transportation firms pay the full cost of enrollee coverage, and 68 percent pay the full cost for dependent coverage. This compares to 24 percent of retail firms paying the full cost of enrollee coverage and 8 percent paying in full for dependent coverage.

The number of small businesses offering health insurance differs significantly among industry groups. On average, 46 percent of employers with fewer than 10 employees offer a health insurance program. Sixty percent or more of employers with fewer than 10 employees in wholesale, finance, and manufacturing industries offer health plans. On the other hand, only a third of small transportation firms and only 21 percent of small retail firms have a health plan.

*6. Health maintenance organizations*

There are major differences between HMOs and traditional plans offered by employers. First, HMOs generally cover all preventive care (e.g., routine physicals, immunizations, eye exams) in full. Second, non-psychiatric services are usually paid in full or with a small coinsurance payment. Finally, HMOs typically have more

limited psychiatric coverage. The usual HMO plan limits inpatient psychiatric services to 30 days and limits outpatient services to 20 visits. However, the HMO required coinsurance payment for outpatient psychiatric services is usually lower than in traditional plans, at $10–$15 per visit rather than 50 percent (which averages around $40 per visit).

The typical HMO plan provides 100 percent coverage for hospitalization, skilled nursing facility care, home health care, surgery and inhospital physician services. There is usually a small coinsurance payment ($2–$5) for an office visit.

Prescription drugs are frequently covered with a $1–$3 per prescription coinsurance payment. Eye exams, but not lenses or frames, are covered. Dental care is not covered but is frequently made available to employees as a separate plan.

*7. Individual (non-group) health insurance plans*

*(a) Commercial insurance plans.*[45]—There are two basic types of individual commercial policies. The first is often called "hospital-surgical." As the name implies, this type of plan provides coverage for hospital bills and for doctors' bills related to surgery. The typical policy will pay for hospital room and board, up to stated daily limits elected by the insured, for a stated maximum number of days. Daily room and board limits range from $100 to $400, and the maximum number of days of inpatient confinement might be 365. Intensive care would be covered at twice the regular daily limit for up to 14 days. Other hospital bills associated with an inpatient stay are paid by the plan at 80 percent with a maximum payment of $8,000.

The policy typically provides a schedule of benefits for surgical services. The highest amount payable for any operation may be selected by the insured and would range from $2,000 to $6,000. Benefits are also provided, with limits, for services of an anesthesiologist and for physician hospital visits.

Hospital and surgical benefits are also provided for outpatient surgery, and coverage is provided for freestanding surgical centers. Convalescent care is usually not covered, but limited benefits may be provided. Well-baby care is not covered. Mental conditions, alcoholism and drug abuse usually are not covered, but limited benefits may be available.

The other general type of coverage is often called "major medical." This type typically provides coverage for a broad range of health care expenses, including physician bills for inpatient care, surgery and other services, and prescription drugs. Dental and vision care are not covered. Various types of medical tests and medical equipment are covered. Limited benefits are provided for mental conditions, alcoholism and drug abuse.

The major medical policy provides for a deductible, that may be selected by the insured. Deductibles are typically $100 to $1,000 but can be as high as $20,000. Once the deductible is satisfied, benefits

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[45] This discussion is concerned with policies that provide for reimbursement of a broad range of health care expenses. No description is given of policies that (a) provide for stated amounts of income in the event of disability arising from accident or sickness, (b) provide a stated daily or monthly benefit in the event of confinement in a hospital or in a nursing home, or (c) cover a broad range of health care expenses only for specified diseases, such as cancer.

are payable by the plan at 80 percent until the insured has paid $1,000 to $2,500 out-of-pocket in addition to the deductible. Benefits are then payable at 100 percent to a maximum benefit of $250,000 to $2,000,000.

In addition to variation in benefits, policies differ according to whether the enrollee has an automatic right to renew. A few policies guarantee renewability to age 65 or for life. Premiums for those policies can be changed only if premiums for all policies in a class are changed uniformly. Most policies provide that the insurer may refuse to renew at any time. In some States the insurer may not be able to deny renewal to an individual, but may have the right to terminate all such policies in the State.

*(b) Blue Cross/Blue Shield plans.*—In general, the description of plans offered to individuals by commercial insurance companies is also applicable to the Blues. The Blues are more likely than the commercials to cover hospital bills in full or with only a specific deductible (e.g., $500 or less per stay). They are also more likely to provide full coverage of doctors' bills for surgery in the hospital or in the doctor's office. Such full coverage is contingent on the hospital's or doctor's having a contractual relationship with the Blues.

Some of the Blues have a program under which payments to doctors are based on a fee schedule significantly lower than customary charges. Under this program, participating doctors agree to accept payment from the Blue plan as payment in full if the patient is below a specified income level. For patients over the specified income level, the doctor may charge the patient more than the amount covered by the insurance.

Some of the Blues underwrite each applicant for nongroup coverage the same way that the commercials do and refuse to insure people who do not meet their underwriting standards. Other Blue plans, mostly larger plans in the northeastern United States, have periodic or continuous open enrollments in which anyone in the service area may purchase coverage. In most cases the Blues guarantee that coverage can be renewed, although premiums may be changed and policy provisions may be revised with approval of the State insurance department.[46]

Finally, a number of the Blues follow the practice of the commercials in varying premiums by the age of the insured. Others still follow the traditional practice of charging the same premium regardless of age.

### D. COST OF PLANS

The most common unit of measurement of health insurance cost is the monthly premium per enrollee or per family unit (the total cost for the enrollee and dependents). The premium cost refers to the total cost of the coverage for the enrollee or the family unit, no matter whether the employer or employee (or both) pays the cost.

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[46] While guaranteed renewal is not necessarily written into contract agreements, such guarantee may be required by State regulation.

### *1. Cost of large employer plans*

Tables 2.11 and 2.12 show the range of monthly premiums for the medical care plans (for enrollee and family coverage) reported in the 1987 HHBR. The premiums do not include the cost of separate plans such as dental and vision or the cost of retiree coverage. The average monthly premium in 1987 was $77 for enrollee coverage and $201 for family coverage. Forty-two percent of the enrollee coverage rates were between $60 and $79 a month. Forty-four percent of the family coverage rates were between $160 and $219 a month.

The premiums for any particular plan can be significantly higher or lower than the premiums for another plan with identical benefits because of factors unique to the employer. One important factor is location, with substantial variation between high-cost and low-cost geographic areas. Differences also arise from the demographics of the insured group. For instance, an employer whose workforce is younger than average will probably have lower costs than average.

Premiums will also fluctuate with the financial experience of the group for larger employers. The true long-term cost of a plan is the premium needed to cover the claims and the administrative costs, less investment income earned on premiums. If expenses are greater than premium income in a given year, the insurer may recover deficits through future rate increases. Conversely, excess reserves built from unexpectedly favorable experience will be used to reduce future rates.

TABLE 2.11.—Monthly Premium for Medical Plan: Individual Enrollee Coverage

| *Premium* | *Percent of HHBR plans* |
|---|---|
| Under $40 | 1 |
| $40 to $49 | 6 |
| $50 to $59 | 13 |
| $60 to $69 | 22 |
| $70 to $79 | 20 |
| $80 to $89 | 14 |
| $90 to $99 | 11 |
| $100 to $119 | 8 |
| $120 to $139 | 3 |
| $140 and over | 2 |

Source: Hay/Huggins Benefits Report, 1987.

### *2. Portion of premium paid by enrollee*

Charts 2.8 and 2.9 show the employer share of the enrollee and dependent premium. Most employers in the HHBR (57 percent) pay the entire cost of the enrollee coverage. Employers who require the enrollees to pay part of the cost of their coverage typically require that less than one-fourth of the cost be paid by the enrollee. Only 3 percent of plans require a contribution of more than 35 percent of total cost.

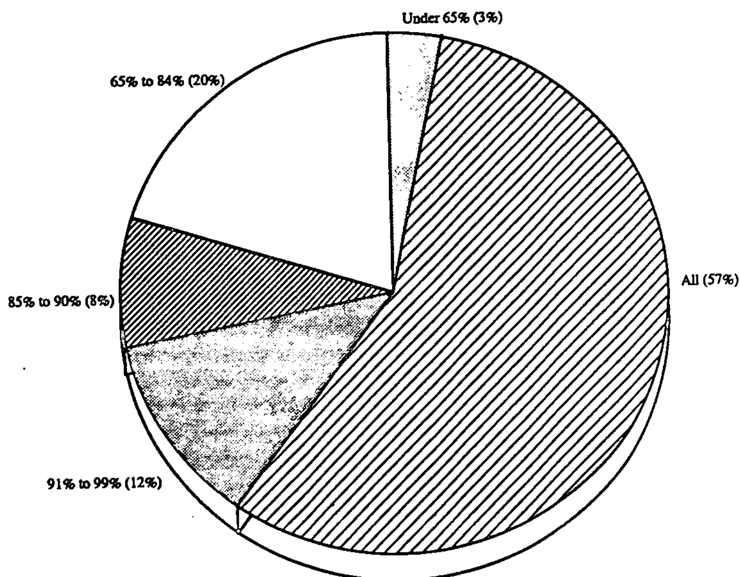
About a third of employers pay the total premium for dependents. Plans that require the enrollee to pay a share of the additional dependent cost typically require payment of a fourth of the cost. Four percent of the plans require the enrollee to pay the entire cost of dependent coverage.

TABLE 2.12.—Monthly Premium for Medical Plan: Family Coverage, Including Individual Enrollee Cost

| *Premium* | *Percent of HHBR plans* |
|---|---|
| Under $100 | 1 |
| $100 to $129 | 5 |
| $130 to $159 | 15 |
| $160 to $189 | 25 |
| $190 to $219 | 19 |
| $220 to $249 | 18 |
| $250 to $280 | 9 |
| $281 to $300 | 4 |
| $301 and over | 4 |

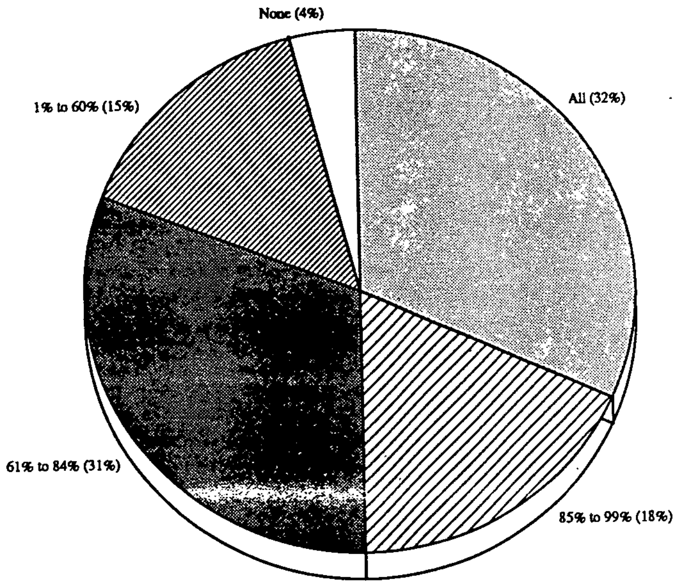
Source: Hay/Huggins Benefits Report, 1987.

## Chart 2.8
## Employer Share of Enrollee Cost




Source: Hay/Huggins Benefits Report, 1987

## Chart 2.9
## Employer Share of Dependent Cost




Source: Hay/Huggins Benefits Report, 1987

*3. Variations by number of employees in firm*

The SBA study reports that the premium rates of a health insurance plan are inversely related to the number of employees in the firm. The comparison of costs is affected by the fact that plans have different designs. However, small employers' plan provisions are typically less valuable than those of larger employers. Small employers pay higher rates for the same level of benefits for several reasons. First, the administrative expenses are greater per enrollee for a small plan. Second, small plans are greater risks because of the greater opportunity for adverse selection. Finally, the likelihood that a small employer will remain with an insurer for a sufficient "profit-making" time period is relatively low.

Enrollee coverage costs an average of $77 (in 1986 dollars) a month for large employers (100 or more employees) compared to $85 for small employers (fewer than 100 employees). The highest cost is for the smallest employers (with 1–9 employees), who pay an average of $88 a month.

The family premium in the SBA survey averages $181 for large employers compared to $206 for smaller employers. The highest cost is $209 for firms with 10 to 24 employees, but the premium for firms with fewer than 10 employees is almost the same at $208.

The SBA report shows that 61 percent of large employers and 70 percent of small employers pay the full cost of the health plan for enrollee coverage. Only 35 percent of large employers pay the full cost of family coverage, compared to 60 percent of small employers and 70 percent of small employers who have fewer than ten employees.

Small employers are more likely to pay the full cost of the health care plan because of insurance company requirements. Insurers often want to make sure that most healthy employees participate in a plan to balance the high cost of higher-risk employees. In a small plan, this balance can be disturbed if a few employees opt out of the plan. Therefore, the insurer may require that the employer pay the entire cost of the plan so that all employees will be covered. Insurers do not have the same requirement for larger employers because opting out by a few potential enrollees will not have a major effect on average cost.

The average premium rate for enrollee coverage for large employers reporting in the SBA survey was the same $77 as in the HHBR. The family rate of $181 was 10 percent lower than the HHBR rate of $201. The SBA survey reports that 61 percent of large employers pay the full enrollee cost and 35 percent pay the full dependent cost compared to 57 percent and 32 percent, respectively, reported by HHBR. Even though the SBA survey was conducted in 1986 and the HHBR in 1987, using different questions and samples of employers, the two surveys found quite similar cost data.

*4. Trends in plan costs*

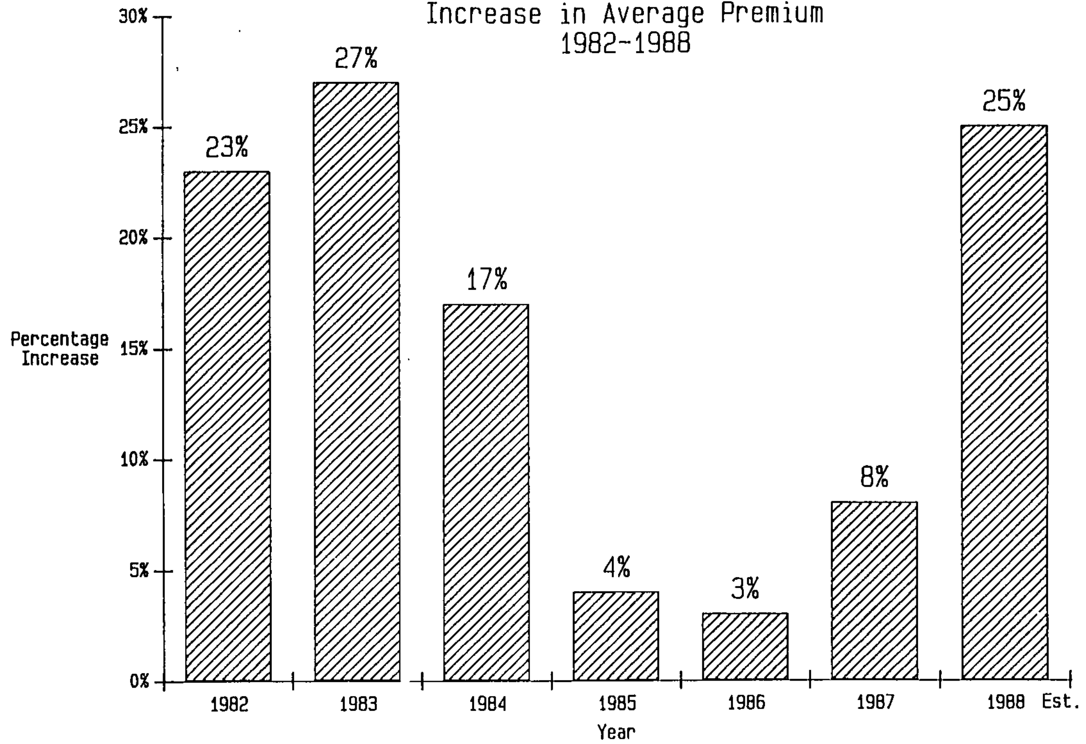
Chart 2.10 shows the trend in average premium increases from 1982 to 1987. During the early 1980s, premium rates increased rapidly, but the increase slowed between 1984 and 1987. However, in-

creases for 1988 and 1989 are expected to resume the high growth rate of the early 1980s.

In 1977, the average monthly premium for enrollee coverage was $25 and the average for family coverage was $65. Taking into account medical care inflation as indicated by the medical care portion of the CPI, these premiums would have been equal to $57 for individuals and $148 for family in 1987. By 1987, the average enrollee premiums had risen by 35 percent in real terms to $77 and family premiums has risen to $201.

As total premiums have risen, employees have had to pay a larger share. In 1977 through 1983, two-thirds of employers paid the full cost of enrollee coverage and 40 percent paid the full cost of dependent coverage. By 1987, however, employers were paying the full cost for substantially fewer enrollees—57 percent for enrollees and about one-third for dependents.

Chart 2.10
Increase in Average Premium
1982-1988




Source: Hay/Huggins Benefits Report, 1987

# CHAPTER 3.—GOVERNMENT REGULATION OF HEALTH INSURANCE

## I. INTRODUCTION

Proposals to increase the number of Americans with health insurance must take into consideration the regulatory framework in which benefit plans exist. The Federal role in the regulation of health benefits focuses on employers as providers of health benefits, attempting to insure "fairness and equity" in benefit delivery and to protect the tax base. The role of State governments focuses on the sellers of insurance, with emphasis on "consumer protection."

Employer health care plans are subject to many Federal requirements. For instance, a number of features in the Federal tax code affect such plans. Provisions in the Employee Retirement Income Security Act (ERISA) of 1974, the Health Maintenance Organization (HMO) Act, and Title XVIII of the Social Security Act (Medicare) affect health care plans. Congress also has prohibited certain discriminatory practices relating to age and sex in the provision of health benefits, and most recently imposed a requirement that certain employers who provide health plans offer continued coverage to former workers and their dependents.

The regulation of the business of insurance—including health insurance—has by statute and long tradition been primarily a State, rather than a Federal, function. Accordingly, there is no Federal agency with the mandate or the requisite flow of information to perform any broad supervisory or oversight function. In certain circumstances, insurance companies, like other corporate entities, may be subject to a measure of "functional oversight" by various Federal bodies with general corporate monitoring responsibilities. An example would be stock issue supervision by the Securities and Exchange Commission.[47] In addition, the Federal Government exercises more direct oversight of Federally qualified HMOs, and to some extent regulates the participation of HMOs or other insurers in Federally funded insurance programs.

All States have laws that regulate companies selling health benefit plans. States have also enacted statutes governing the organization and operations of hospital service (Blue Cross) and medical service (Blue Shield) organizations. In addition, 46 States and the District of Columbia have passed laws pertaining to the formation of HMOs.[48]

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[47] U.S. Library of Congress. Congressional Research Service. Insurance Industry Regulation and Supervision: A Reexamination of the McCarran-Ferguson Act of 1945. Issue Brief No. IB86149, by David Whiteman. (Regularly updated). Washington, 1986.

[48] The four States that have not passed specific enabling legislation are Alaska, Wisconsin, Hawaii, and Oregon. HMOs may still operate in these States.

ERISA has had a profound and far reaching effect on the health care system. ERISA's greatest impact on health benefit plans results from its preemption of State laws affecting employer-provided plans. The effects of the preemption are significant and complex, and raise a number of public policy questions in the health field. Since plans that self-insure (i.e., assume the risk of paying health claims directly, instead of buying insurance) fall under the auspices of ERISA, they are exempt from State-mandated benefit laws, State taxes on insurance premiums, and required participation in insurance pooling arrangements known as assigned risk pools. Exemption from these requirements, together with economic incentives and minimal ERISA regulation and standards for self-insured plans, have led to a trend among major employers to self-insure their health benefit plans. This trend has thwarted attempts by State legislatures to ensure that certain health benefits are offered or made available to all the residents of their States or to require that health benefits be provided in the workplace.

The two-tiered regulation of health benefits (that is, Federal versus State), coupled with the ERISA preemption provision, has raised a number of regulatory issues: Should State health insurance laws be preempted only where ERISA regulates? Should additional ERISA standards be established for self-insured plans? Should ERISA preemption be retracted, or should it be expanded to include all health benefit plans?

This chapter will discuss the effect of the current regulatory framework on health benefit plans, examine the ERISA preemption provision, and outline the effect of ERISA on State-mandated benefit laws, risk pools, and the ability of States to mandate health insurance in the workplace. It also will examine the trend among major employers to self-insure their health benefits as a way of escaping State regulation and will summarize other Federal laws affecting employer-provided benefits.

## II. State Regulation of Private Health Insurance

The United States is unique among major industrial nations in not supervising its insurance industry at the national level. Historically, the regulation of health insurance, like that of the insurance industry in general, has been a State responsibility. For many years insurance was not considered to be "commerce" in the consitutional meaning of the word. It was, therefore, not subject to Federal regulation under the Interstate Commerce Clause. However, in 1944 the U.S. Supreme Court reversed its traditional position by finding that insurance was "commerce" and therefore subject to a number of Federal statutes (particularly antitrust laws).

In *U.S.* v. *South-Eastern Underwriters Association* (322 U.S. 533), the Court ruled that the business of insurance was interstate commerce and, therefore, subject to Federal antitrust laws. This decision caused considerable confusion and concern on the part of the insurance industry and State regulatory officials. Some insurers cited the new ruling in legal challenges to State premium tax obligations. These actions greatly alarmed those States that considered

premium taxes an important source of revenue. Considerable pressure was brought to bear for a quick solution.[49]

### A. MC CARRAN-FERGUSON ACT

Congress passed the McCarran-Ferguson Act within one year of the *South-Eastern Underwriters* decision. In effect, the McCarran-Ferguson Act reaffirmed and continued the traditional power of the States to be the primary regulators of insurance by authorizing the States to preempt the application to the business of insurance of Federal laws that do not deal specifically with insurance. The McCarran-Ferguson Act also gave the business of insurance an exemption from antitrust laws, except for agreements that "boycott, coerce or intimidate," areas which McCarran-Ferguson left subject to coverage under the Sherman Antitrust Act.[50]

### B. REGULATION OF COMMERCIAL INSURERS

State insurance laws require commercial insurance companies to meet a variety of capitalization and other requirements in order to obtain a license to do business in each State. The exact requirements vary widely from one jurisdiction to the next, but ordinarily they specify the minimum amount of financial resources needed to establish solvency as an insurer. Other financial standards vary according to such factors as the type of corporate organization involved (e.g., a stock versus a mutual company), how the firm is licensed to operate (e.g., whether as a domestic or out-of-State company), the number and/or combination of insurance lines (e.g., life, casualty, accident and health) a company intends to market, and the insurance experience of a firm prior to the licensing request.[51]

State regulations usually identify specific categories of "allowable" investments and prescribe limits on the extent to which companies may hold certain investments such as equity and real estate. In addition, every State insurance commissioner is empowered in some way to conduct examinations or audits of the operations and financial condition of commercial insurers. However, unlike the property-casualty side of the insurance business, regulation of the rates or premiums established by commercial health insurers for group plans is virtually non-existent.

Several reasons have been advanced why health insurance premiums set by commercial insurers are not regulated. First, there is intense competition among insurers, which tends to hold premiums down. Second, there is a multiplicity of policies, coverages and benefits in health insurance, which makes premium regulation difficult. Third, employers, unions, and associations that are parties to the insurance contract are presumed to have staff personnel or expertise to determine whether the premiums are reasonable. Be-

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[49] U.S. Library of Congress. Congressional Research Service. Insurance Industry Regulation and Supervision: A Reexamination of the Mc Carran-Ferguson Act of 1945. Issue Brief No. IB86149, by David Whiteman, (regularly updated). Washington, 1986.

[50] For a complete discussion of the history of the McCarran-Ferguson Act, see U.S. Library of Congress. Congressional Research Service. The McCarran-Ferguson Act's Exemption of the Business of Insurance from Federal Antitrust Law. Report No. 79–81 A, by Henry Cohen. Washington, Mar. 22, 1979.

[51] U.S. Library of Congress. Congressional Research Service. Private Health Care Plans—A Brief Summary of Federal and State Requirements. Report No. 80–113 EPW, by Glenn R. Markus. Washington, June 12, 1980.

cause individual buyers of health insurance may not have this knowledge or expertise, some States have what is known as a "relationship of benefits to premium" requirement. This rule basically permits a State insurance commissioner to disapprove a policy submission if he finds the benefits are unreasonable in relation to the premium charged. Generally speaking, States that have such a requirement limit its application to policies purchased by individuals and exclude those covering groups. While most States do not actually regulate the premiums established by commercial companies, most require (or have the authority to require) the filing of rates and rate information as part of their policy form filing and approval procedures.

### C. REGULATION OF BLUE CROSS/BLUE SHIELD

As shown in chapter 2, much of the health insurance sold in the United States is written by non-profit hospital and medical service corporations, popularly known as Blue Cross and Blue Shield plans.[52] State regulation of the Blues is characterized by a unique feature—the use of special enabling State legislation. Such legislation generally exempts non-profit hospital and medical service plans from the provisions of State law applicable to commercial insurers. While varying from State to State, the enabling legislation spells out the standards and procedures to which these organizations are subject, including specific requirements for the Blues that are either identical, or very similar, to comparable requirements imposed on commercial insurers. These requirements include regulation of investments, reports and examination requirements and procedures for approving policy forms. While the States have established various solvency standards for commercial insurers, the Blues are generally exempt from these requirements.

Another distinction between commercial insurers and the Blues is their treatment by State taxation. While commercial plans are generally subject to premium taxes, only 18 States apply premium taxes to Blue Cross/Blue Shield plans. Several other States assess a nominal fee on the Blues, usually to offset expenses of the State insurance department.

Although a State's regulation of the Blues is often quite similar to that of commercial insurers, there is an important exception in the area of rate regulation. While most States require commercial health insurers to file rate information along with their policy forms to determine if the premium charged for the benefits is reasonable, the rates are not actually subject to approval. In contrast, many States subject the Blues to some sort of rate approval process.[53]

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[52] Eleven Blue Cross/Blue Shield organizations have elected to organize as non-profit mutual insurance companies. They are as follows: BC/BS of Arkansas; BC/BS of Connecticut; BC/BS of Florida; BC/BS of Illinois; BC/BS of Indiana; BC/BS of Kentucky; BC/BS of Louisiana; BC/BS of Northern Ohio (Cleveland, Ohio); BC/BS of South Carolina; Central Benefits Mutual Insurance Company (Columbus, Ohio); and Community Mutual Insurance Company (Cincinnati, Ohio). Like mutual commercial carriers, they are owned by their subscribers and are subject to less intensive State insurance regulation than are traditional Blues.

[53] Ibid. In addition, in some States open enrollment is required.

### D. REGULATION OF HEALTH BENEFIT CONTRACTS

All States require that policy forms for health insurance sold to individuals be filed with the appropriate regulatory authority before being used. Most States also require similar filings of group health insurance contracts issued in their jurisdiction. Insurance laws generally authorize an insurance commissioner to disapprove policies that contain unjust, unfair, inequitable, misleading, or deceptive provisions.[54]

### E. MANDATED BENEFITS

All 50 States have passed laws requiring insurers to provide or make available particular benefits in their health insurance policies. These requirements are known as "mandated benefit" laws. As will be explained later, these mandated benefit laws do not fall on employers who self-insure their health benefit plans. The most common mandates (those occurring in 30 or more States) are coverage of psychologists, optometrists, chiropractors, alcoholism treatment, newborn coverage, and coverage for the mentally and physically handicapped.

#### *1. Types of mandated benefits*

Mandated benefit laws can be classified into four categories that are roughly equivalent to the questions "who, what, when, and where." [55] These categories are as follows:

—Dependents (who)—these mandates specify the kind of persons to be covered under a contract, such as adopted children;

—Benefits (what)—these mandates specify the kind of services covered under a health insurance contract, such as alcoholism treatment or in vitro fertilization;

—Continuation/Conversion (when)—these mandates specify the length of time that coverage must be in effect (for example, a requirement that a worker may continue participating in a group contract for a prescribed amount of time after the job ends;

—Provider (where)—these mandates specify the numbers and types of providers eligible to perform and be reimbursed for covered services (for example, a requirement that birthing centers be covered as hospital maternity units, or that social workers be reimbursed for covered services within the scope of their license).

#### *2. Prevalence and trends*

From 1965 through the end of 1986, 645 mandated health benefit laws were enacted. As shown in chart 3.1, the decade since 1975 saw a sharp increase in State-mandated benefit laws. However, there has been a slowing down in recent years. This deceleration may be due in part to the general saturation of mandated benefits and the controversy surrounding them. While providers of certain

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[54] U.S. Library of Congress. Congressional Research Service. Private Health Care Plans—A Brief Summary of Federal and State Requirements. Report No. 80-113 EPW, Glenn R. Markus. Washington, June 12, 1980.

[55] Scandlen, Greg. The Changing Environment of Mandated Benefits. Employee Benefit Notes, June 1987.

services and advocates for certain disease victims argue that the costs of mandated benefits are not high (and may even result in savings, for example, if less expensive services or less costly providers are used), insurance companies and employer groups generally maintain that the costs of mandates are high and rising. This trend has led several States to develop health benefit-cost criteria for evaluating proposed mandates. These criteria were inspired by model criteria developed by the National Association of Insurance Commissioners (NAIC) and amount to a social and financial impact statement.[56]

The policies offered by commercial insurance companies and Blue Cross/Blue Shield plans must include State mandated benefits, but self-insured plans are not subject to State mandates because of the ERISA preemption clause. The private insurers argue that the ERISA preemption clause puts them at a competitive disadvantage, forcing them to pass on to their customers the costs that they say mandated benefits add to the price of a policy.[57] Since plans that self-insure are exempt from State mandated benefit laws, State legislatures are unable to ensure that certain health benefits are offered or made available to all residents. In addition, since self-insured plans do not have to offer all benefits or cover all providers, the market for certain medical services is reduced, a cause of concern for some health care providers. This is discussed in greater detail later in this chapter.

### F. NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

While the regulation of commercial insurance companies and the Blues is, with minor exceptions, under the jurisdiction of the various State insurance commissioners, the National Association of Insurance Commissioners (NAIC) plays a significant part in determining the degree, direction, and scope of efforts by States to regulate private insurance sold in the United States. The NAIC is a tax-exempt, unincorporated, voluntary association of State insurance regulatory officials that was established in 1871. A primary objective of this organization has been to promote uniformity in State legislation affecting insurance. To this end, the NAIC develops and promulgates model State statutes and regulations. It is up to each State whether it will adopt any of these NAIC models.

In the health benefits area, for example, the NAIC has developed minimum standards for Medicare supplement policies. Certain provisions in these standards were recently revised, including filing requirements for out-of-State group policies, loss ratio standards, and enforcement authority. The NAIC also designed and implemented a model statute and accompanying regulation for long-term care insurance. The regulation sets forth minimum standards to be observed for all policies marketed as long-term care insurance.

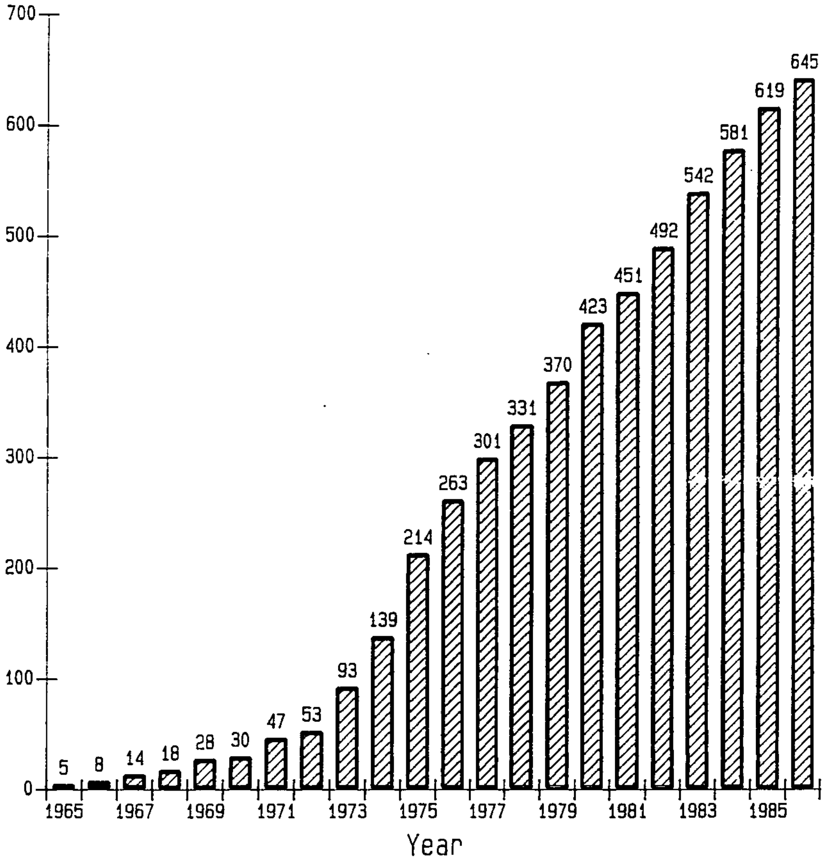
Other significant pieces of NAIC model legislation and regulation include coordination of benefits guidelines, a Health Insurance Pooling Act, a Preferred Provider Arrangements Act, an HMO Act, and AIDS guidelines. The coordination of benefits guidelines estab-

[56] Ibid.
[57] ERISA and the States. Focus On . . . Intergovernmental Health Policy Project. Washington, D.C., Mar. 1986.

lish which insurance company pays in cases where two policies cover an individual. The Health Insurance Pooling Act is designed to provide model standards for mechanisms that provide pooled coverage to the "medically uninsurable" or those who are unable to obtain coverage because of pre-existing medical conditions. The Preferred Provider Arrangements Act provides model authorization for health care insurers to enter into preferred provider arrangements and sets forth minimum standards for the arrangements. The HMO Model Act, which is currently undergoing revision, provides a model for the establishment and operation of HMOs and provides regulatory safeguards designed to assure the viability of these organizations. Finally, the AIDS guidelines were developed as a prototype of questions which insurers are allowed to ask applicants for individual health insurance coverage.

85-568 88 - 4

Chart 3.1.
Cumulative Number of Health Mandates
Enacted by 50 States
1965-1986




Source: Blue Cross/Blue Shield Association.

## III. Federal Regulation of Employer-Provided Health Benefits

The Federal Government plays a broad role in regulating health benefit arrangements offered by employers. Federal requirements range from ERISA provisions affecting employer-provided health benefits to tax code rules designed to ensure that benefits are provided in a nondiscriminatory manner. This section will discuss the Federal laws and requirements affecting employer-provided health benefits.

### A. EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

The ERISA of 1974 (P.L. 93-406) was enacted in response to private pension problems experienced by workers. These problems included excessive requirements for benefit eligibility, inadequate funding by employers, diversion of plan assets for private purposes, and the ending of plans with insufficient assets to pay benefits. Although ERISA was developed primarily with pension plans in mind, several of its requirements apply to both pension and "welfare benefit plans". These are defined in ERISA to include plans that provide health benefits. ERISA requirements for welfare benefit plans deal mainly with reporting and disclosure requirements and fiduciary standards. These requirements are enforced by the Secretary of Labor.

#### *1. Reporting and disclosure*

ERISA imposes the following reporting and disclosure requirements upon employee welfare benefit plans:

—A summary plan description must be furnished to all plan participants and filed with the Department of Labor. It must be written so that it can be understood by the average plan participant;

—Summaries of changes in the plan description and material modifications to the plan must be furnished to each plan participant and filed with the Department of Labor;

—An annual financial report must be filed with the Department of Labor. This report must include information on plan participation and finances and schedules on payments to insurance carriers, service providers, or health maintenance organizations;

—Plan participants must be provided with specified statements and schedules from the annual report and other information necessary to summarize fairly the annual report;

—Plan participants must be notified in cases of plan termination, merger, consolidation, or a transfer of plan assets.

Employee welfare benefits plans that cover fewer than 100 participants, and pay benefits either through an insurance policy or from the general assets of the employer or employee organization maintaining the plan, are partially exempted from ERISA's reporting and disclosure requirements. For example, such plans need not furnish plan participants and beneficiaries with a summary of the annual financial report.

*2. Fiduciary and other ERISA provisions*

ERISA requires that plan fiduciaries (those who are responsible for managing and overseeing plan assets) and all those who handle funds or property be bonded, usually in an amount of at least 10 percent of the value of funds handled. Fiduciaries must discharge their duties solely in the interest of the participants and beneficiaries and can be held liable for any breach of their responsibilities.

Plan participants and beneficiaries have the right to file suit in State and Federal courts to recover benefits due them, to enforce their rights under the terms of the plan, and to clarify their rights to future benefits.

*3. Lack of standards and incentives for funding health benefits*

ERISA does not require prefunding of self-insured health benefit plans and surveys show that most employers finance their health benefit plans on a pay-as-you-go basis. This has been a source of concern, particularly with regard to retiree health benefits. This fact has led some to question whether employers who self-insure should be required to set funds aside to pay for retiree health benefits in advance.[58]

However, many analysts feel that there is little advantage to advance funding under current law because income earned by the fund is subject to taxation, and medical cost inflation may not be taken into consideration in determining funding levels. These funding issues will become sharpened if, as now anticipated, the Financial Accounting Standards Board (FASB), requires companies to disclose on their financial statements the amount of unfunded liabilities for health benefits. This body, which sets standards for the accounting profession, already has prescribed rules for reporting pension plan liabilities on corporate financial statements, and now is drafting comprehensive accounting rules for retiree health benefits. Final rules are expected in 1989, but implementation is likely to be later.

Concern also has been expressed over the lack of benefit protection for retirees under existing Federal laws and regulations. There are no Federal standards for vesting (the earning of a nonforfeitable right to a benefit), and there are few safeguards to protect retirees from losing their benefits in the event of plan termination. Moreover, unlike private pensions, there is no insurance mechanism to guarantee the payment of health benefits if the employer goes bankrupt.

The legal status of retiree health benefits is analogous to the status of pension benefits before the passage of ERISA. Whether retirees receive the health benefit depends on the goodwill and financial ability of the employer. Differing court rulings on the employ-

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[58] Employers may prefund their retiree health benefits in accordance with rules established by the Deficit Reduction Act (DEFRA) of 1984 (P.L. 98-369). DEFRA set limits on employer deductions for contributions to welfare benefit plans and established nondiscrimination standards to ensure that the plan benefits rank-and-file employees. These changes were made because of congressional concern over excessive employer contributions for prefunding some employee benefit plans. There was also some question whether such plans were broadly based. DERFA also served as a means of reducing the Federal deficit and generating increased revenue.

er's option to reduce or terminate a retiree health plan have added to the uncertainty.[59]

### B. ERISA PREEMPTION

ERISA's greatest impact on health and other employee welfare benefit plans results from its preemption of State laws affecting employer-provided plans. Section 514 preempts all State laws relating to employee benefit plans. Under ERISA, an employee benefits plan can be either an employee *pension* plan or an employee *welfare benfit* plan. The definition of a welfare benefit plan is broad and extends beyond employer-provided health benefits. Specifically, it is defined as any plan, fund, or program that is established or maintained by an employer or employee organization for the purpose of providing any of the following:

—Medical, surgical, or hospital care or benefits;
—Sickness, accident, disability, death, unemployment, or vacation benefits;
—Apprenticeship or other training programs;
—Day-care centers;
—Prepaid legal services; or
—Severance pay.

To understand ERISA preemption, it is necessary to understand the three clauses that compose it.[60] The first part—called the "preemption" clause—holds that ERISA provisions supersede "any and all State laws" that relate to employee benefit plans. The second series of clauses, referred to as the "saving" clause, exempt various State laws from preemption. Among these are laws regulating insurance, banking and securities. The saving clauses are in turn qualified by a third clause known as the "deemer" clause. This clause holds that no employee benefit plan, or any trust established under such a plan, "shall be *deemed* to be an insurance company or other insurer, bank, trust company, investment company, or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, including insurance contracts, banks, trust companies, or investment companies." (emphasis added)

To summarize with regard to an employer-provided health benefit plan, the preemption provision first provides that ERISA supersedes all State laws affecting these plans, then "saves" State insurance laws from preemption, and then finally prohibits a health benefit plan from being deemed an insurance company. What preemption means is that, if an employer self-insures its own health benefit plan, it is regulated by ERISA, rather than by State insurance law.

Employer-provided health benefit plans purchased through an insurer remain subject to State insurance laws.

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[59] U.S. Library of Congress. Congressional Research Service. Health Benefits for Retirees: An uncertain Future. Issue Brief No. IB88004, by Beth C. Fuchs, (Updated regularly). Washington, 1988.

[60] For a complete legal discussion of preemption, see U.S. Library of Congress. Congressional Research Service. Federal Preemption of State Law Under ERISA, by Vincent E. Treacy. Washington, Dec. 1985.

*1. Legislative history and rationale*

The sweeping ERISA preemption provision represented a last minute legislative compromise. Both the House and Senate versions of ERISA contained more limited preemption provisions than that which eventually became law. The House provision listed the specific areas in which State law would be preempted (i.e., reporting and disclosure requirements, fiduciary standards, and the nonforfeitability of pension benefits). The broader Senate provision would have preempted those State laws related to the subject matters regulated by ERISA. The Conference Committee substituted the present preemption provision, which is broader than either the House or Senate version.

ERISA was regarded as a pension reform law. The congressional hearings and studies leading up to passage dealt with problems and inequities in private pension plans, not with health or other benefits. Although not articulated in the legislative history of ERISA, reasons advanced for broad preemption were generally understood to include organized labor's concern over State regulation of prepaid legal service plans and the desire of some business and labor representatives to halt an increase in State regulation of interstate employee benefit plans.[61]

The switch to a broader preemption provision was praised by some as consistent with the congressional desire to replace inadequate and conflicting State standards with Federal standards.[62] Adoption of a broad preemption provision was also thought to be a way to avoid the legal controversies that might ensue from narrower, more specific provisions.

One of ERISA's principal sponsors was Senator Jacob Javits. In explaining why Congress rejected a narrower and more specific approach to preemption, he noted the desire to avoid "the possibility of endless litigation over the validity of State action that might impinge on Federal regulation, as well as opening the door to multiple and potentially conflicting State laws. . . ." He also said ". . . although the desirability of further regulation—at either the State or Federal level—undoubtedly warrants further attention, on balance, the emergence of a comprehensive and pervasive Federal interest and the interests of uniformity with respect to interstate plans required—but for certain exceptions—the displacement of State action in the field of private employee benefit programs." [63]

Accordingly, ERISA called for a report from a newly constituted Joint Pension Task Force that would address the "effects and desirability of the Federal preemption of State and local laws with respect to pension and similar plans." The Joint Pension Task Force never issued a report, but the House Committee on Education and Labor did. The Committee report concluded:

> . . . the legislative scheme of ERISA is sufficiently broad to leave no room for effective State regulation within the field preempted. Similarly, it is our finding that

[61] Turza, Peter H., and Lorraine Halloway. Preemption of State Laws Under the Employee Retirement Income Security Act of 1974. Catholic University Law Review, v. 28, 1979.
[62] Ibid.
[63] Javits, Jacob. Remarks in the Senate. Congressional Record, v. 120. p. 29942. 1974.

> the Federal interest and the need for national uniformity are so great that the enforcement of State regulation should be precluded.[64]

*2. Preemption in the courts*

Contrary to the expectations of some of its framers, the passage of ERISA led to a substantial amount of litigation concerning the meaning and scope of section 514's preemption provision, particularly for health benefits. Subsequent court decisions supported both a broad and a narrow view. Key preemption issues emerged in three areas:

—Regulation of multiple employer trusts;
—State-mandated accident and health benefits; and
—State-required comprehensive health insurance.

*(a) Multiple employer trusts.*—Multiple employer trusts (METs) are arrangements usually among small employers that provide employee health benefits on a group basis. These arrangements have existed for many years as a way of providing group purchasing power for individuals or small entities. METs fall into three major groupings:

—Those formed by an association of employers in the same industry to provide health benefits to the employees of member companies;
—Those formed by members of an association (such as the American Bar Association) to provide health coverage to members; and
—Those established by independent administrators to market health insurance coverage to various firms.

METs falling into the first two groups have been considered under ERISA to be welfare benefit plans that are exempt from most State regulations. However, METs falling into the third group were the subject of much controversy over regulation.

The number of METs increased in the years following enactment of ERISA in 1974. These arrangements tended to be self-insured. They offered small employers, who usually could not bear the risk of self-insurance on their own, some of the advantages associated with self-insurance—avoidance of State taxes on insurance premiums, freedom from the minimum reserve requirements applicable to commercially insured plans, and lack of mandated benefit requirements.

Since ERISA did not establish minimum funding standards for welfare benefit plans or set up an insuring agency to guarantee payment of benefits as it did for pension plans, some METs with unexpectedly high claims costs found themselves with insufficient assets to pay claims. The resulting MET insolvencies reportedly resulted in millions of dollars in unpaid claims. In reaction, State insurance departments began to challenge MET operators' claims that they were immune from State regulation because of ERISA's preemption of such State laws. Even when favorable court rulings upheld the legal authority of States to regulate METs, there was the practical problem of discovering the existence of a self-insured

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[64] U.S. Congress. House. Committee on Education and Labor. House Report No. 94-1785, 94th Cong., 2d Sess.

MET before it became insolvent. This problem was one reason for Congress' decision to amend ERISA in 1982.

The Multiple Employer Welfare Arrangement Act of 1982 (P.L. 97-473) redefined a MET as a multiple employer welfare arrangement (MEWA). There are two types of MEWAs. The first type consists of arrangements that are fully insured, or are not fully insured but have been certified by the U.S. Department of Labor as "employee welfare benefit plans." State regulation of this type of MEWA is limited to State insurance laws that require the maintenance of adequate reserve levels in order that promised benefits can be paid.

The second type of MEWA consists of those arrangements which are not fully insured and have not been certified by the U.S. Department of Labor as employee welfare benefit plans. This latter group of MEWAs is subject to the full range of State laws regulating insurance, so long as such regulations do not conflict with the specific ERISA provisions dealing with welfare benefit plans. MEWAs of both types are subject to ERISA's reporting, disclosure, and fiduciary standards.

*(b) Impact of ERISA preemption on State-mandated benefit laws.*—As noted earlier, many States have passed laws requiring health insurance policies issued within their jurisdiction to provide or make available specific health benefits. Because these mandated benefit laws affect the content of health benefit plans purchased by employers, courts have had to rule on whether such laws were preempted by ERISA.

In 1985, the U.S. Supreme Court said in *Metropolitan Life* that "nearly every court that has addressed the question [of mandated benefits] has concluded that laws regulating the substantive content of insurance contracts are laws that regulate insurance and thus are within the scope of the insurance saving clause." [65] The Court ruled that a Massachusetts law requiring health insurance policies to provide mental health benefits was not preempted by ERISA, even though the mandated benefit law would have an indirect effect on employer health benefit plans. The Court first observed that the mandated benefit law did affect employee benefit plans and was therefore potentially subject to the preemption clause. However, the Court then noted that, because the mandated benefit law is a State law that "regulates insurance," it was preserved by the insurance saving clause. The Court pointed out that ERISA specifies that an employee benefit plan should not be deemed an insurance company or to be engaged in the insurance business for purposes of any law purporting to regulate insurance companies, insurance contracts, and the like. The Court stated:

> In short, the plain language of the saving clause, its relationship to the other ERISA preemption provisions, and the traditional understanding of insurance regulation, all lead us to the conclusion that mandated benefit laws . . . are saved from preemption by the operation of the saving clause.[66]

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[65] *Metropolitan Life Insurance Company* v. *Massachusetts*. 471 U.S. 224 at 242, 85 LE2d 728, 105 S.Ct. 2380, June 3, 1985, footnote 18.

[66] (Ibid., p. 18).

The Court noted further that the legislative history of ERISA supports such a view and that there was little indication that Congress was aware of the conflict between the saving clause and the preemption clause, or that Congress intended a narrow reading of the saving clause. The Court therefore held that "if a State law 'regulates insurance,' as mandated benefit laws do, it is not preempted."

The Court was aware that the decision resulted "in a distinction between insured [i.e., purchased from Blue Cross/Blue Shield or from a commercial insurance company] and uninsured [i.e., self-funded by employer] plans, leaving the former open to indirect regulation while the latter are not." However, the Court stated that "by so doing we merely give life to a distinction created by Congress in the 'deemer clause,' a distinction Congress is aware of and one it has chosen not to alter." While the Court acknowledged the insurance company's view that broad preemption would have eliminated some of the "disuniformities currently facing national plans that enter into local markets to purchase insurance," the Court noted that such disuniformities were "the inevitable result of the congressional decision to 'save' local insurance regulation." [67]

*(c) Impact of ERISA on State-required health insurance plans.*—State laws that required both insured and self-insured plans to offer various types of benefit coverage and to participate in some form of insurance pool for the uninsurable both have been struck down by the courts as falling under the ERISA preemption provision. For example, in *Hewlett-Packard* v. *Barnes*, a U.S. district court ruled that the California Knox-Keene Health Care Service Plan Act of 1975 was not a law regulating insurance.[68] The Act was challenged by employers with self-funded (i.e., self-insured) plans. The Knox-Keene Act would have required all health insurance plans, including self-insured plans, to observe funding, disclosure, sales practice, service quality, and licensing regulations. As a result of the ruling, the Act as it applied to self-insured plans was preempted by ERISA. The U.S. Circuit Court of Appeals for the Ninth Circuit upheld this decision, stating that the self-insured plans operated by Hewlett-Packard and other employers were to be considered welfare benefit plans and that the employers, therefore, could not be considered to be in the insurance business.

Similarly, in *Standard Oil Company of California* v. *Agsalud*, the Ninth Circuit held that the Hawaii Prepaid Health Care Act, which required employers to provide specific health benefits, was preempted by ERISA.[69] However, Congress later amended ERISA to exempt the Hawaii Act from ERISA preemption.[70] This exemption was limited to the original provisions of the Hawaii Act, which had been passed in 1974, shortly before the enactment of ERISA. In addition, it was made clear that any future amendments to the Hawaii Prepaid Health Care Act would be preempted and that the exemption was not to serve as a precedent for other States.

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[67] Ibid., p. 21.

[68] 425 F.Supp 1294 (N.D. Cal. 1977), aff'd, 571 F.2d 502 (9th Cir. 1978).

[69] *Standard Oil Company of California* v. *Agsalud*, 442 F. Supp. 695 (N.D. Calif. 1977), affirmed, 633 F.2d 760 (9th Cir. 1980).

[70] Public Law 97-473, Periodic Payment Settlement Tax Act of 1982.

Attempts by other States to mandate health insurance have generally been frustrated by ERISA preemption. While an exception was granted in the case of Hawaii, the courts have struck down other State attempts to require employers to provide health benefit coverage or offer a certain benefit package. For example, a Minnesota law, which did not require employers to provide health insurance to their employees, but required those who did to adhere to certain quality standards, was successfully challenged in the courts. The law, as originally written, covered both fully insured and self-insured plans. However, as a result of a lawsuit brought under ERISA's preemption provisions, the State was enjoined from forcing the self-insured plans to comply.[71]

On April 21, 1988, Massachusetts Governor Dukakis signed into law a universal health care plan that requires each Massachusetts employer with over five employees to choose between providing employees and their dependents with health insurance of a specified value or paying a new tax on a specified portion of each employee's wages. Funds from the new tax will be used, with revenues derived from other sources, to finance health insurance for State residents who do not otherwise have it. Although the new law uses the State's taxing power in order to avoid ERISA preemption, it is expected that the law may be challenged in the courts. The legislation is scheduled to be fully implemented by 1992.

### *3. Trends towards self-insurance*

ERISA's preemption of State regulation has increased the attractiveness of self-insurance to many employers because it means that self-insured health benefit plans can avoid State regulation. Table 3.1 shows that the percentage of plans in medium and large firms using a self-insured funding approach for medical benefits increased from 19 percent in 1979 to 40 percent in 1987.

While the purchase of commercial insurance or a Blue Cross/Blue Shield plan is administratively the simplest way an employer can provide health benefits to employees, it has several disadvantages related to the differing impact of ERISA on insured plans versus self-insured plans. As noted earlier, the Supreme Court ruled in the *Metropolitan Life* case that insured plans are subject to mandated benefit laws. Commercially insured plans and some Blues may also be subject to State taxes on insurance premiums, which often amount to 2 percent of claims costs.[72] In addition, 12 States require insurers to participate in assigned risk pools.[73] These pools spread among many insurers the cost of insuring individuals who would otherwise be uninsurable. To the extent these insurers are not given a premium tax offset (i.e., a dollar-for-dollar credit on their State premium taxes), participation in such pools tends to drive up the average premium cost in insured plans. This is because insurers spread their costs of participating in pools to their enrollees. Self-insured plans, in contrast, are not subject to

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[71] *St. Paul Electrical Workers Welfare Fund* v. *MacKenan.* U.S. Dist. Ct. D. Minn. Third Div., May 21, 1980. (490 F. Supp. 931 (1980)).

[72] Self-Funding of the Health Plan: Why Employers Assume Risk. EBPR Research Reports, Mar. 1985.

[73] Intergovernmental Health Policy Project. Focus On . . . the Risk Pool Strategy: Comprehensive Health Insurance Associations. p. 6. 1988.

pool participation, only to ERISA's fiduciary, reporting, and disclosure requirements.

TABLE 3.1.—Funding Approaches for Medical Benefit Plans of Medium and Large Employers, 1979-87

[In percent]

| | 1979 | 1980 | 1981 | 1982 | 1983 | 1984 | 1987 [1] |
|---|---|---|---|---|---|---|---|
| Self-insured | 19 | 34 | 35 | 37 | 38 | 38 | 40 |
| Minimum premium [2] | 9 | 11 | 17 | 21 | 22 | 22 | 20 |
| Fully insured | 71 | 50 | 43 | 37 | 35 | 35 | 34 |
| Combination | 0 | 5 | 5 | 5 | 4 | 4 | 5 |
| Other | 0 | 0 | 0 | 0 | 1 | 1 | 1 |
| Total | 100 | 100 | 100 | 100 | 100 | 100 | 100 |
| Total (plans) | 643 | 552 | 611 | 666 | 773 | 770 | 694 |

[1] Information not available for 1985 and 1986.
[2] A funding approach halfway between self-insurance and conventional insurance. The employer has limited liability as under an insured approach, but also has many of the same advantages as a self-insured plan (e.g., greater cash flow and avoidance of premium taxes).

Source: Hay/Huggins Benefits Reports, selected years.

There are also other financial advantages to self-insuring. First, the employer does not pay a fee (usually embedded in the premium) to an outside insurance company to cover the insurance company's profit margin. Second, by self-insuring, an employer has greater control over a plan and any underlying assets. For example, a switch from commercial insurance to self-insurance allows the employer to recapture the use of funds that would otherwise be held in insurance company reserves. Third, there has been a growth in the variety and scope of support services for self-insured plans such as administrative-services-only contracts under which an insurer handles the claims processing and other administrative aspects of the health insurance plan while the employer retains the risk involved with paying the claims.

The Hay/Huggins Benefits Reports from 1979 to 1987 show the increased popularity of self-insurance among medium and large employers. (See table 3.1.) It is not clear whether ERISA rules or economic factors have played a greater role in encouraging the growth in self-insured plans. However, ERISA's preemption of State regulation has been influential.

*4. Concerns of insurers and small employers*

Representatives of commercial insurance companies and Blue Cross/Blue Shield plans have argued that ERISA's preemption of State regulation for self-insured plans places the Blues and commercial plans at a competitive disadvantage. As noted earlier, commercial insurers are subject to State taxes on premiums, and commercial insurers and Blues may be required to participate in a State-assigned risk pool. These insured plans may also be required to provide certain types of benefits, whether or not they are desired by the policyholder. All other things being equal, these instances of State regulation may raise the cost of insured plans relative to self-insured plans since insurers generally pass any added costs on to their customers. ERISA preemption, according to the insurance in-

dustry, creates an "unlevel playing field" and may shrink their market.

While larger employers have the option of switching to self-insurance (and minimal Federal requirements), small employers often have no choice but to remain insured. Small employers thereby cannot obtain the cost reductions of using self-insurance. The relative difference in cost may be even higher in States that require insurers to participate in an assigned risk pool. In locations in which a large proportion of employers are self-insured, the insurance costs for high risk individuals may be spread among relatively few policyholders, yielding still higher insured policy costs.

### C. CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985

Title X of the Consolidated Omnibus Reconciliation Act (COBRA) of 1985 (Public Law 99-272) and its amendments revised the tax code to require that continuation provisions be included in a health benefit plan offered by an employer. This requirement was enacted in response to concerns over access to affordable health care for individuals who would otherwise lose it because of events such as loss of job or change in marital status.[74]

The health plan continuation requirement applies both to those plans that employers purchase from insurance companies (i.e., insured plans) and plans that are self-funded (i.e., self-insured). For a person to be eligible for continued coverage, a "qualifying event" must occur. In the case of an *employee*, a qualifying event would be:

—Termination of employment other than for gross misconduct (including voluntary quits and retirement), or
—A reduction of hours.

In the case of a *dependent*, a qualifying event would be:

—Employee's termination of employment or reduction in hours;
—Death of the employee;
—Divorce or legal separation from the covered employee;
—Entitlement of covered employee to Medicare benefits; or
—Dependent child ceases to meet the plan's definition of dependent.

For either an employee or a dependent, a qualifying event would also include a bankruptcy proceeding resulting in loss of health insurance coverage. In addition, if the plan offers the privilege of conversion to individual coverage, then this conversion option must be offered at the end of the continuation period.

The benefit continuation provision must continue for 18 months in the case of loss of coverage due to termination of employment or reduction in hours, and for 36 months for the other qualifying events. However, in the case of a company undergoing a proceeding under Chapter 11 of the Bankruptcy Act, the continuation requirement extends for the life of the retiree or the surviving spouse.

The employer is permitted to charge the covered individual the full cost of the coverage plus 2 percent for administrative costs. The cost of this coverage is the cost for the employer's active employees and their dependents; the cost *cannot* be determined on the

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[74] U.S. Library of Congress. Congressional Research Service. Private Health Insurance Continuation Coverage. Issue Brief no. 87182, by Beth Fuchs (regularly updated). Washington, 1988.

basis of COBRA individuals only. Employees must be given written notice of the availability of the health insurance continuation provision.

Failure to provide continued health coverage could result in IRS penalties, including loss of tax deductibility for employer health insurance payments and loss of tax exclusion for benefits provided to highly compensated employees, and ERISA penalties. Moreover, the Labor Department may sue for injunctive relief, and the individual participant or beneficiary may sue under the ERISA enforcement provisions. In addition to the requirements imposed on private-sector employers, similar requirements are imposed on group health plans maintained by any State that receives funds under the Public Health Service Act or by any local government (except the District of Columbia or any territory or possession of the United States) or instrumentality of that State.

As a result of the COBRA continuation provisions, almost all employees and dependents who lose employer-provided coverage and do not have new coverage will at least have the option of purchasing health care coverage at group rates. However, many of these individuals may not be able to afford the coverage. With an average annual employer-offered plan cost of $940 annually for an individual and $2,460 for a family, many unemployed and low-wage earners will not choose continued coverage.[75] Those availing themselves of COBRA benefits may be limited to people with sufficient family income or for whom the costs are outweighed by extraordinary medical care needs.

Employees experiencing a "qualifying event" have up to 60 days from the date they receive notice of eligibility to notify their employer that continued coverage is desired. In addition, if the individual elects to continue coverage, the initial payment is not due until 45 days following the election. As a result, if health care needs arise very shortly after the qualifying event, individuals can retroactively elect coverage. These provisions may mean that some individuals who initially decline coverage will acquire it later if faced with high medical bills.

### D. HEALTH MAINTENANCE ORGANIZATIONS

Congress enacted legislation in 1973 to promote the development of health maintenance organizations (HMOs). As was discussed in chapter 2, HMOs are organizations that directly provide or arrange for a comprehensive array of health services to an enrolled population for a fixed prepaid per capita fee. The Federal HMO Act stipulates that, if an HMO plan meets certain standards and is deemed to be a federally qualified HMO, certain employers may be required, under what is known as the "dual choice" option, to offer their employees an opportunity to become members of the HMO.

Employers who meet four criteria are required (under Federal law) to make an HMO offering if an HMO so requests:

—The employer must be one who is subject to the Fair Labor Standards Act (minimum wage law);

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[75] Estimates furnished by Hay/Huggins.

—The employer must have at least 25 workers, and at least 25 workers must live in the area serviced by the HMO;
—The employer must have a health benefit plan in force toward which financial contributions are being made;
—The employer must receive a request from a qualified HMO for inclusion in the employer's health benefits program.

The employer is not obligated to contribute more for HMO coverage than otherwise would be paid for another traditional employer-sponsored health benefit plan. In collective bargaining situations, the HMO offer is subject to the bargaining process and may be accepted or rejected.

Both States and the Federal Government regulate HMOs. To operate in most States, an HMO must receive a license from the State. Licensure requirements usually include providing a minimum range of health services, demonstrating financial soundness and an adequate quality assurance system, and assuring that health services are available and accessible to the HMO's enrollees. States also review and approve rates, marketing literature, and agreements between the HMO and its enrollee.

The Federal Government regulates HMOs through the Federal qualification process, which is voluntary for the HMO. About 80 percent of all HMO enrollees are members of a federally qualified plan. Federal qualification means that an HMO has met strict standards that assure the plan is fiscally sound, has a quality assurance system in place, and provides a comprehensive benefit package for a fixed monthly fee. Other plans have chosen not to seek Federal qualification or are subject to conflicting Federal and State requirements.

The requirements for Federal qualification are similar to those for State licensure. A minimum level of benefits is required. HMOs are required to demonstrate fiscal soundness and meet a variety of requirements, as mentioned above, related to the delivery of health services. Under the current Federal HMO Act, the advantage of Federal qualification is that it gives the HMO a "seal of approval," and the HMO can require employers with more than 25 employees to offer the HMO.

In general, States are not precluded from imposing licensure requirements that are stricter than the requirements for Federal qualification. The exception to this rule is that Federal law expressly precludes a State from imposing certain requirements related to requiring physician participation in HMO management, requiring an HMO to accept all physicians as providers, applying the State's financial requirements for insurance companies to HMOs, or limiting HMO advertising.

While ERISA exempts self-insured plans from certain State laws, that exemption is generally thought not to apply to the offering of an HMO alternative by a self-insured employer. Therefore, the HMO would be required to satisfy a State's mandated benefit law and to pay taxes applicable to HMO premiums if it were offered by a self-insured employer.

However, HMOs until now have been able to avoid most mandates and traditionally have been exempt from premium taxes. It has been suggested that so long as there is legislative and regulatory resistance to applying mandates to HMOs, they increasingly

will become a way for insured plans who offer HMOs to enjoy the same advantages as self-insured plans.[76]

### E. NONDISCRIMINATION PROVISIONS OF THE INTERNAL REVENUE CODE

Individual taxpayers may exclude the value of certain employer-provided benefits from their gross income. Employers are entitled to a business deduction for the expense of providing employee benefits. Similar deductions apply for payroll-based taxes imposed on employers (i.e., the employer share of social security and unemployment insurance). This tax-favored treatment of employee benefit plans—including employer-provided health benefits—reduces both the Federal income tax base and budget receipts. According to the General Explanation of the Tax Reform Act of 1986 prepared by the staff of the Joint Committee on Taxation, "Congress believed these costs justifiable if such benefits fulfill important social policy objectives, such as increasing health insurance coverage among taxpayers who are not highly compensated and who otherwise would not purchase or could not afford such coverage." [77] The tax code includes nondiscrimination provisions, designed to ensure that rank-and-file workers participate in, and receive benefits from, these tax-favored plans.

The Tax Reform Act of 1986 revised the nondiscrimination rules that had applied to self-insured health benefit plans and extended them to insured plans effective for plan years beginning on or after January 1, 1989. The new law requires group health plans to apply a series of complex tests to the eligibility and benefit provisions. Employers have the option of using one of two tests: a two-part eligibility and benefits test, or the special alternative test.

Under the *eligibility* test, the plan must satisfy three requirements:

—Non-highly compensated employees (generally those earning less than $50,000) must constitute at least 50 percent of the group of employees eligible to participate in the plan; [78]

—At least 90 percent of the employer's nonhighly compensated employees must be eligible for a benefit that is at least 50 percent as valuable as the benefit made available to the highly compensated employee with the most valuable benefits;

—A plan must not contain any provision relating to eligibility to participate that suggests discrimination in favor of highly compensated employees.[79]

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[76] Feezor, Allen. No Future Guarantees for Self-Insured Plans. Business and Health, Apr. 1987.

[77] U.S. Congress. Joint Committee on Taxation. The General Explanation of the Tax Reform Act of 1986 (H.R. 3838, 99th Congress, P.L. 99-514). Prepared by the staff of the Joint Committee on Taxation. May 4, 1987. pp. 780-781.

[78] According to the General Explanation of the 1986 Tax Reform Act prepared by the staff of the Joint Committee on Taxation, this requirement will be deemed satisfied if the percentage of highly compensated employees who are eligible to participate is not greater than the percentage of nonhighly compensated employees who are eligible. For example, assume a small employer has 20 employees, 15 of whom are highly compensated. Because more than 50 percent of its workforce is highly compensated, the employer could make all employees eligible but still not satisfy the 50-percent test. However, if all employees are eligible, the employer would be deemed to satisfy the 50-percent test because the percentage of highly compensated employees and nonhighly compensated employees who are eligible is the same (i.e., 100 percent).

[79] This third nonquantifiable test is intended to disqualify arrangements on the basis of discrimination alone.

Under the *benefits* test, the average employer-provided benefit received by nonhighly compensated employees must be at least 75 percent of the average employer-provided benefit received by highly compensated employees.[80]

A *special alternative* test may be applied in lieu of the eligibility and benefits tests described above. If a plan benefits at least 80 percent of an employer's nonhighly compensated employees, it is considered to satisfy the new nondiscrimination rules. However, this alternative test will not apply unless the plan satisfies the third eligibility test requirement described above.

Each benefit plan will be tested separately, including the dependents' portion if the premium contribution for the dependent is different. Plans can be combined if they are within 5 percent of equivalent "value" (to be determined by Internal Revenue Service regulations). A plan may exclude employees who have less than 6-months' service, those who work less than 17½ hours per week, or those who are covered by a collective bargaining agreement under which health benefits were the subject of good-faith bargaining.

One element of the test is that all nonbargaining employees with 6 months' service, working more than 17½ hours per week, must be included in the test calculation. Most employers do not provide medical coverage to part-time workers (part-time is frequently defined as less than 30 hours per week). As a result, it is expected that most employers with a significant number of part-timers will fail the nondiscrimination tests.

If a plan fails to comply with these rules, all highly compensated employees in the plan will be taxed on the value of the discriminatory portion of the benefit. Moreover, employers who fail to report in a timely manner that a plan is discriminatory are liable for an excise tax.

Employers who fail the tests have several options. Those with a large number of uninsured part-timers (such as in the retail trade) may choose to fail the tests and impute income to highly compensated employees because cost of compliance may be too high. The increased taxes to the employee could be offset by a pay increase. Employers are also likely to reduce the number of insurance options, thereby reducing the likelihood of failing the tests because of employee elections and the administrative costs associated with tests.

Employers with relatively small numbers of part-timers are likely to take one or more actions. One approach would be to cut the hours of part-timers to below 17½ hours per week. Another option would be to consolidate part-time jobs into fewer full-time jobs and provide benefits. Another approach would be to extend coverage to part-timers.

The approaches of consolidating jobs and extending coverage would mean that some employees currently not covered would receive coverage due to the nondiscrimination rules. However, this may be a small percentage of the part-time uninsured.

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[80] The term "average employer-provided benefit" means, with respect to highly compensated employees, an amount equal to the aggregate employer-provided benefits received by highly compensated employees under all plans of the employer of the type being tested divided by the number of highly compensated employees of the employer (whether or not covered by any such plans).

### F. AGE DISCRIMINATION AND THE WORKING AGED

The Age Discrimination in Employment Act (ADEA), P.L. 90-202, prohibits employment discrimination on the basis of age for most workers age 40 and over. The law deals with fringe benefits provided by employers to older workers, including health benefits. In general, benefits may not be curtailed on account of age, but the level of benefits may be reduced for older employees if differences in cost on account of age can be demonstrated.

Before 1982, employers were permitted to use Medicare coverage as the basic health insurance for their Medicare-eligible employees, supplemented by an employer-provided policy that filled gaps iin Medicare. This arrangement tended to ensure that health care costs paid by the employer-provided plan for older workers were confined to supplemental, as opposed to basic, health benefits. However, this arrangement was changed by the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 (Public Law 97-248).

TEFRA required private employers with 20 or more employees to give their employees between age 65 and 69 a choice between primary coverage under either the employer's plan or Medicare. This provision was adopted to reduce Medicare expenditures by shifting part of the health care costs of older workers to employers. If an employee chooses the employer plan, it becomes the primary payer for all claims (i.e., the plan that first pays the health care claims), and Medicare becomes secondary (i.e., it pays any remaining costs according to its coverage rules).

The "working aged" or "secondary payer" requirement was expanded through subsequent laws. DEFRA (P. L. 98-369) expanded coverage to include spouses age 65-69 when the worker was under 65. COBRA of 1985 (Public Law 99-272) extended the provisions to workers and spouses age 70 and over. In addition, the Omnibus Budget Reconciliation Act (OBRA) of 1986 (Public Law 99-509) required firms with 100 or more employees that offer group health insurance to offer disabled workers and their spouses the option of coverage under their employer's health plan, making it the primary payer.[81]

### G. CIVIL RIGHTS LAW

It is an unlawful employment practice under Federal law for an employer to discriminate between men and women with regard to fringe benefits. Fringe benefits include health benefits. That benefits may be more costly for one sex than the other is not a valid reason for discrimination.

In 1978, Congress amended the Civil Rights Act of 1964 to extend the prohibition against sex discrimination in employment to the treatment of pregnancy, childbirth and related conditions. This law had a direct impact on the design of employer health benefit plans since discrimination on the basis of these conditions was no longer permitted under employer fringe benefit programs, including health insurance benefits. Since the Pregnancy Discrimination Act

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[81] U.S. Library of Congress. Congressional Research Service. Mandated Employer-Provided Health Insurance. Issue Brief No. IB87168, by Beth Fuchs (regularly updated). Washington, 1987.

(Public Law 95-555) applies to employers who provide health benefits to their employees, it applies to self-insured employers as well as employers who purchase insurance for their employees from either commercial insurance companies or Blue Cross/Blue Shield plans. Full-plan benefits must be available to the employee or the employee's spouse for maternity care.

The effect of the pregnancy discrimination amendments has been dramatic. A study conducted by the Health Insurance Association of America (HIAA) of new group plans written in 1986 found that 99 percent of employees in such plans (with from 25 to 499 members) had maternity coverage for themselves or their spouses, compared to 57 percent in 1977. Among those with maternity coverage, 85 percent were covered for a full range of plan benefits in 1986, compared to 43 percent in 1977.[82] However, there are still gaps in the law that exempt large categories of insurance policies and insured women from the pregnancy discrimination protections. First, the law applies only to insurance policies that are offered as employment-related benefits by employers to their employees. This limitation leaves out about 5.6 million women of reproductive age who are covered by nongroup policies that are not related to employment. Second, the plan can exclude pregnancy-related conditions of teenage dependents provided it excludes the dependents of male and female employees equally. Third, the protections are not extended to employees of firms with 15 or fewer employees.[83]

### H. BANKRUPTCY LAW AMENDMENTS

In May 1988, the Congress passed amendments to the bankruptcy laws to protect retired workers' health and life insurance benefits while their employer is undergoing reorganization under chapter 11 of the Bankruptcy Code. The measure (H.R. 2969), which is awaiting approval by the President, would protect retirees from unilateral termination of benefits by a debtor company filing a chapter 11 bankruptcy petition. Health and life insurance benefits would be continued throughout the reorganization proceedings unless the court found it necessary to modify them to the extent necessary to keep the company operating. Before seeking a court reduction in retiree benefits, a company would have to propose a reduction to retirees after negotiating in good faith with a retiree representative. The measure would also clarify that retiree health and life insurance claims are to be treated as high priority administrative expenses when they are paid during the company's reorganization and before the court's confirmation of the plan.

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[82] New Group Health Insurance. Health Insurance Association of America. Washington, D.C., various publications.

[83] The Financing of Maternity Care in the United States. The Alan Guttmacher Institute. New York, 1987.

# CHAPTER 4—THE INSURED AND THE UNINSURED: NUMBERS AND CHARACTERISTICS

Most people have some form of health insurance. In 1986, an estimated 84.4 percent of the total population and 82.5 percent of the nonaged (under age 65) population had coverage. (See table 4.1.)

TABLE 4.1.—The Uninsured Population, 1986

| | Total population | Number insured (in millions) | Number uninsured (in millions) | Percent uninsured |
|---|---|---|---|---|
| Total population | 238.6 | 201.5 | 37.1 | 15.6 |
| Nonaged population | 210.6 | 173.8 | 36.8 | 17.5 |

Source: Table prepared by the Congressional Research Service (CRS) based on data from March 1987 Current Population Survey (CPS).

Though most people do have health insurance, concern remains about that part of the population lacking this protection. Moreover, the recent growth in the number and percent of the nonaged population who are uninsured has heightened this concern.

The first part of this chapter examines health insurance status in 1986. Major findings in this part of the chapter include:

—In 1986, an estimated 36.8 million persons (17.5 percent of the nonaged population) lacked health insurance.

—Only 57 percent of the persons who reported some work experience in 1986 (or a total of 72 million), were enrolled in a health insurance plan on their own job. Workers whose jobs did not provide health insurance tended to be part-time rather than full-time workers, young rather than older workers, lower-paid rather than higher-paid workers, in small firms rather than in large firms. These workers also tended to be employed in the service-producing sector of the economy. Most of them were covered by health insurance through a spouse's or parent's policy.

—Persons enrolled in employer-based plans often cover both themselves and eligible dependents under their plans.[84] In 1986, 136.5 million people had coverage through employment-based plans, representing 64.8 percent of the nonaged population.

—Half of those not insured through employment-based plans had coverage from other sources, either private purchases of health insurance or government-provided health insurance (Medicare, Medicaid, and military programs).

[84] Employment-based plans, as used in this chapter, are defined as insurance provided on workers' current jobs. The insurance cost may be paid by employers, unions, or workers themselves, or it may be shared by these parties.

—About one-third of the uninsured are single people over age 22, people living with nonrelatives, or people living in extended family arrangements. Since health insurance plans typically cover only "immediate families" of enrollees, this one-third of the uninsured would likely have to obtain health insurance themselves.

—Family income and family type help determine health insurance status. For nonaged persons without private insurance coverage, Medicaid is the most important source of health coverage. However, Medicaid for the nonaged is restricted to poor (usually single-parent) families or poor and disabled or blind adults.

—About 30 percent of the uninsured in 1986 had cash incomes below the poverty threshold. Another 30 percent had incomes between one and two times the poverty threshold.

The second part of this chapter briefly examines trends in health insurance coverage over the 1979 to 1986 period. From 1979 to 1986, the percent of the nonelderly population who lacked health insurance grew from 14.6 percent to 17.5 percent. A somewhat more detailed look at the trend in the percent of the population who were uninsured reveals:

—The proportion of the population covered by employment-based health insurance fell from 67.4 percent to 64.8 percent.

—The drop in health insurance coverage occurred among those who were covered under other family members' plans. This drop in "dependent" coverage occurred because:

  —fewer dependents (spouses and dependent children under the age of 22) were covered by plans.

  —as the baby boom generation continued to age, a large group of people who had been in categories with fairly high coverage rates, i.e., children under age 18, moved into categories with much lower coverage rates, i.e., young adults age 18 and older.

The third part of this chapter briefly discusses the "dynamics" of health insurance coverage: that is, how health insurance status changes over time for individuals. Studies that have examined the dynamics of health insurance coverage show that a substantial proportion of the population undergoes a change in health insurance status (gaining coverage, losing coverage) during a relatively short period of time (one to two years). People generally lose health insurance because of changes in work or family status or because they are no longer eligible for public assistance.

## I. Health Insurance Status in 1986

The information on health insurance status for 1986 is based on an analysis of the March 1987 Current Population Survey (CPS), a household survey conducted by the Census Bureau. The March 1987 CPS collected information on health insurance coverage for 1986; it asked whether persons had coverage from selected sources of health insurance at any time during 1986.[85]

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[85] Household surveys are subject to reporting errors by survey respondents. The March CPS requires respondents to recall information from January of the previous year. The lengthy

Continued

A. SOURCES OF HEALTH INSURANCE COVERAGE AMONG THE NONAGED

For the nonaged population, health insurance offered on a job is the single most important source of health insurance coverage. In 1986, employment-based plans covered about two-thirds of the nonaged population, including both workers and their eligible dependents. Table 4.2 shows the source of health insurance coverage among the nonaged population. Some individuals had coverage from more than one source during 1986, so the total coverage rate is lower than the sum of the coverage rates from individual sources.

TABLE 4.2.—Sources of Health Insurance Coverage for the Nonaged Population: 1986

| Source of coverage | Number covered (millions) | Percent covered |
|---|---|---|
| Total (all health insurance plans) | 173.7 | 82.5 |
| Employment-based health insurance [1] | 136.5 | 64.8 |
| Medicare | 2.7 | 1.3 |
| Medicaid | 17.0 | 8.1 |
| CHAMPUS | 8.9 | 4.2 |
| Other health insurance | 23.9 | 11.4 |

[1] Employment-based health insurance is insurance coverage of workers and their dependents obtained by workers on a job in 1986. It does not include employer-provided retiree health insurance, which is included as "other" health insurance.

Note.—Coverage rates from individual sources do not add to the total covered rate because some people were covered by more than one type of health insurance plan during 1986.

Source: Table prepared by the CRS based on data from the Mar. 1987 CPS.

About half of those who lacked employment-based health insurance had coverage from other sources. In addition to employer-based coverage, health insurance coverage was obtained from Government programs (Medicare, Medicaid, and military plans) and from private purchases of insurance.

Employment-based health insurance coverage comes from one's own work or that of a family member. These plans commonly cover workers' dependents in addition to workers themselves. Of course, a family without at least one worker cannot obtain employment-based health insurance. Moreover, people who do not live in families, and those who cannot obtain health insurance because they are not members of an enrollee's immediate family, must obtain health insurance on their own. This chapter first examines the portion of the workforce who do not obtain health insurance coverage through their own employment. These people either obtain coverage in some other way or remain uninsured.

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recall period is likely to introduce some reporting errors. Some analysts have suggested that answers to the health insurance questions could represent coverage at the time of the survey rather than coverage during the previous year. This conclusion is based on a comparison of different surveys that address health insurance coverage. Appendix A discusses this issue and notes that such comparisons are inconclusive. This chapter assumes that the CPS question was answered correctly; i.e., the answers represent the survey respondents' best (albeit imperfect) attempts to respond to questions about health insurance coverage in the prior year.

## B. WORKERS AND EMPLOYMENT-BASED HEALTH INSURANCE

Of the 126.7 million who worked in 1986,[86] an estimated 57 percent were included in an employment-based health insurance plan on their job.[87] This percentage does not include workers who were covered by a plan through another family member—that is, spouses or dependents. It represents only coverage earned by workers through their own employment. Thus, 55 million people (or 43 percent of those who had at least some work experience in 1986) did not obtain employment-based health insurance through their own work. This section focuses on the characteristics of these 55 million workers.

Among the important factors associated with exclusion from a health plan on their job is a worker's:

—Degree of attachment to the labor force. The weaker the attachment to the labor force (fewer hours or weeks of work) the less likely a worker will be included in a health insurance plan on the job;

—Age. Generally, the younger the worker, the less likely that the worker will be included in a health plan on the job;

—Earnings. Workers with low earnings were much less likely to be included in a health plan on their job than those with higher earnings.

These three factors are interrelated. For example, young workers tend to have both a weaker attachment to the labor force and lower earnings than older workers and thus are less likely than older workers to obtain health insurance on the job.

In addition, workers in the goods-producing sector of the economy are more likely than workers in the service-producing sector to obtain health insurance on a job, though coverage rates vary significantly among industries within the service-producing sector. Firm size also helps determine whether workers obtain health insurance: large companies are much more likely to provide coverage than small ones.[88]

### *1. Attachment to the labor force*

Among the strongest predictors of obtaining health insurance on the job is degree of attachment to the labor force. Part-time workers are far less likely than full-time workers to earn health insurance from their own jobs. Those who worked for only part of 1986 were also less likely than full-year workers to obtain health insurance through their employment. Table 4.3 shows the proportion of workers who did not obtain health insurance by their work in 1986.

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[86] This figure represents all those who reported some work in 1986, including aged workers and teenagers.

[87] The CPS data do not differentiate between workers who were in jobs where employers did not offer health insurance and workers who refused health insurance offered to them by employers.

[88] Regional differences in health insurance coverage rates are not examined in this study. Regional analyses by the Employee Benefit Research Institute (EBRI) reveal that persons in the South, Southwest, and Pacific States are less likely to have employer-based health insurance. See EBRI. A Profile of the Nonelderly Population Without Health Insurance. EBRI Issue Brief No. 66, May 1987, table 9, p. 14–15.

TABLE 4.3.—Percent of Workers Not Obtaining Health Insurance From Their Own Jobs: Full- and Part-Time and Full- and Part-Year Workers, 1986

| | Percent |
|---|---|
| Full-year, full-time workers | 24.4 |
| Full-year, part-time workers | 75.1 |
| Part-year, full-time workers | 55.1 |
| Part-year, part-time workers | 88.7 |

Note.—Full-time workers represent those who worked 35 hours per week or more during the majority of weeks they worked during the year. Full-year workers are those who worked in civilian jobs for 50 weeks or more during the year.

Source: Table prepared by CRS based on data from the Mar. 1987 CPS.

### *2. Age of Workers*

A worker's age strongly affects the likelihood of obtaining health insurance on the job. The very youngest workers, those from age 15 to 17, almost never obtain health insurance on the job. The proportion of workers in jobs without health insurance declines as workers' ages increase until age 55. Workers aged 55 to 64 are less likely to obtain health insurance on the job than other workers over 30. Chart 4.1 shows the proportion of workers not obtaining health insurance on the job by age of the worker.

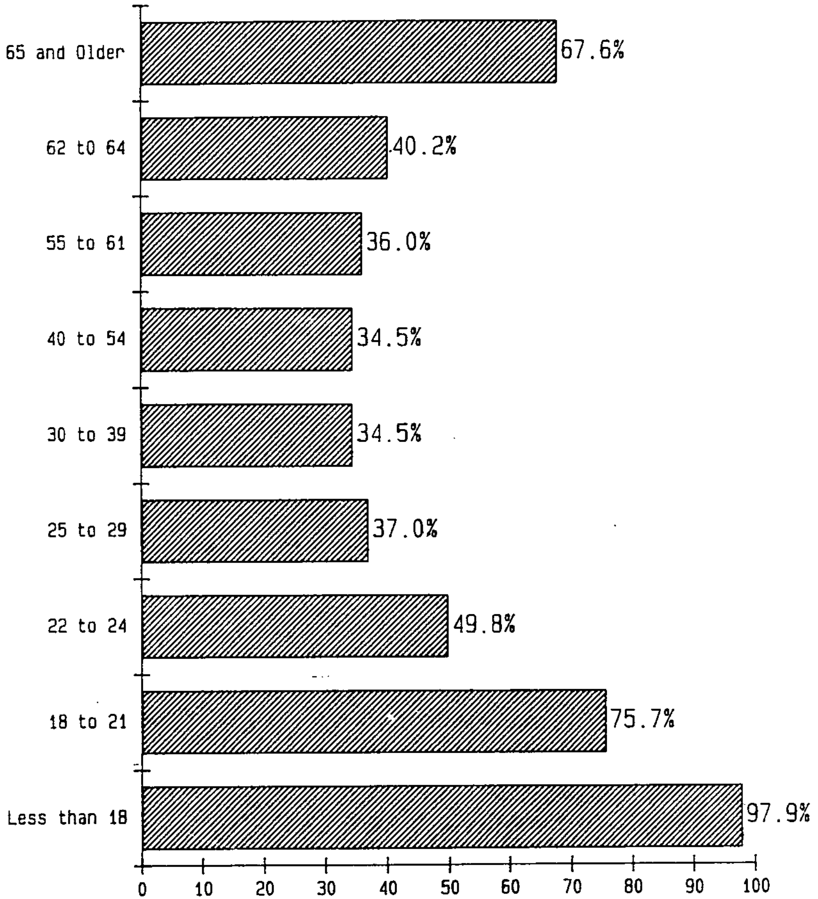
### *3. Worker's Earnings*

Workers who had low earnings in 1986 were very likely to lack health insurance protection from their jobs. Almost 9 out of 10 workers earning less than $5,000 did not obtain health insurance on their jobs. As previously mentioned, low earnings often reflect less than full-time or full-year work. Those who work part-time have a much smaller chance of obtaining health insurance on the job than do full-time workers. In higher earnings groups, the proportion of workers not obtaining health insurance on the job drops considerably. Chart 4.2 shows the proportion of workers in jobs without health insurance, by workers' earnings.

### *4. Industry and Firm Size*

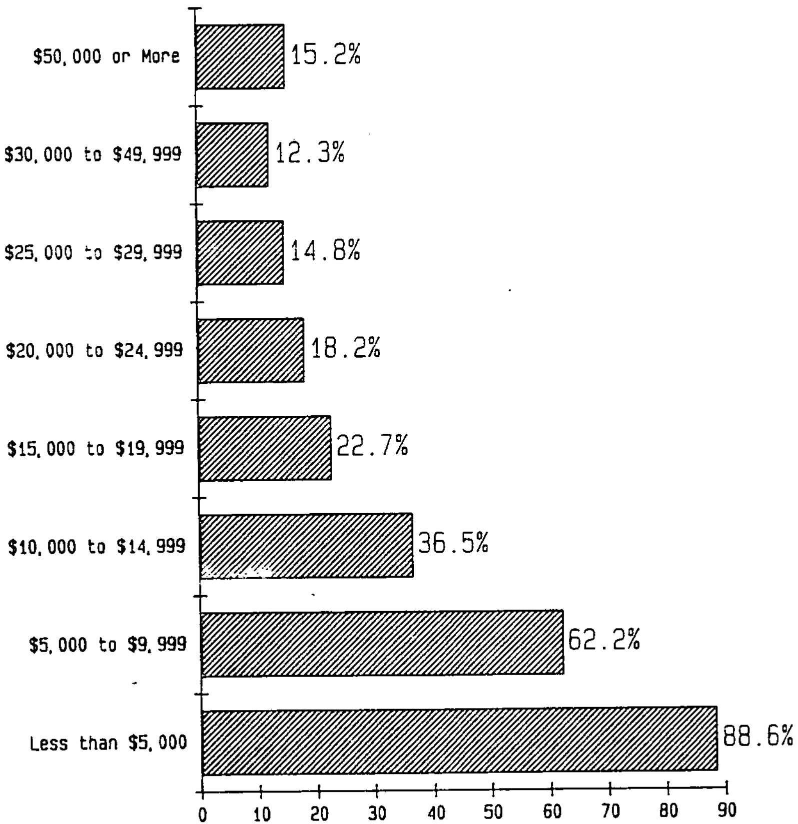
The type of industry and size of firm are factors influencing whether fringe benefits such as health insurance are offered to employees. Table 4.4 shows the variation among industries of workers without employment-based health insurance.

Chart 4.1
Percent of Workers Not Obtaining Health Insurance
From Their Own Jobs By Age
1986




Source: Figure prepared by the Congressional Research Service based on data from the March 1987 CPS.

Chart 4.2
Percent of Workers Not Obtaining Health Insurance
From Their Own Jobs by Workers' Earnings
1986




Source: Figure prepared by the Congressional Research Service based on data from the March 1987 Current Population Survey.

TABLE 4.4.—Percent of Workers Not Obtaining Health Insurance from Their Own Jobs by Major Industry: 1986

| Major industry | Percent |
|---|---|
| Agriculture, forestry, and fisheries | 82.0 |
| Personal services, including households | 78.7 |
| Entertainment and recreation services | 68.5 |
| Retail trade | 63.8 |
| Business and repair services | 56.1 |
| Construction | 52.4 |
| Professional and related services | 39.8 |
| Finance, insurance, and real estate | 33.2 |
| Wholesale trade | 31.5 |
| Manufacturing, nondurable goods | 27.0 |
| Transportation, communications, and public utilities | 23.8 |
| Public administration | 22.9 |
| Mining | 20.0 |
| Manufacturing, durable goods | 17.4 |

Source: Table prepared by CRS based on data from the Mar. 1987 CPS.

As shown in the table, there are considerable variations within the service-producing sector in the proportion of workers not obtaining health insurance coverage on the job. High proportions of workers not obtaining health insurance on the job were reported in the service-producing industries such as entertainment, personal services, and retail trade industries. Yet, other service-producing industries such as wholesale trade, finance, professional services, and public administration had fairly high coverage rates. In the goods-producing sectors, most industries had high coverage rates, though more than half of all workers in construction were in jobs without health insurance.

The annual March CPS does not contain information on workers' firm size. Therefore, no direct estimates of health insurance coverage and noncoverage by firm size are possible from it. A special supplement to the May 1983 CPS did collect information on health insurance coverage and firm size for that month. These data are shown in table 4.5.

TABLE 4.5.—Workers Not Obtaining Health Insurance from Their Own Jobs by Firm Size, May 1983

| Firm size | Percent |
|---|---|
| Under 25 employees | 62.7 |
| 25 to 99 | 34.0 |
| 100 to 499 | 25.2 |
| 500 to 999 | 20.5 |
| 1,000 or more | 14.6 |

Source: Employee Benefit Research Institute. A Profile of the Nonelderly Population Without Health Insurance. EBRI Issue Brief No. 66. May 1987. p. 5.

## C. EMPLOYMENT-BASED HEALTH INSURANCE AND FAMILY RELATIONSHIPS

Employer-provided health insurance usually includes an option for dependent coverage. Table 4.6 shows coverage for family heads, spouses, and children when either the family head or spouse is enrolled in an employer-provided plan. In 1986, 136 million people had coverage through employer-based plans. As shown in the table, coverage rates exceed 90 percent for family heads, spouses, and children, under age 18; coverage rates fall for older children. Some children, of course, may pick up employment-based health insurance by enrolling in a plan through their own work. Thus, some of

the coverage reported in the table for children, especially the older children, may represent their own coverage rather than dependent coverage.

TABLE 4.6.—Employment-Based Health Insurance Coverage for Dependents of Family Heads and Spouses When Either the Husband or Wife is Enrolled in an Employment-Based Plan: Nonaged Workers and Dependents, 1986

| | Percent covered |
|---|---|
| Family heads [1] | 97.4 |
| Spouses | 97.0 |
| Children of the family head: | |
| Under age 18 | 92.0 |
| Age 18 to 21 | 86.4 |
| Age 22 to 24 | 41.7 |
| Age 25 and older | 52.0 |

[1] Family heads represent heads of households who were in families. Does not include heads of households who are single or living only with unrelated people.

Source: Table prepared by CRS based on data from the Mar. 1987 CPS.

Of particular interest are workers who do not obtain health insurance on their own job but receive employment-based coverage from another family member. Of the 55 million workers who did not obtain coverage from their own jobs, 21 million, almost 4 out of 10 such workers, had employment-based coverage through another family member.

### D. THE NONAGED UNINSURED

In 1986, an estimated 36.8 million nonaged persons lacked health insurance, representing 17.5 percent of the nonaged population. Persons who do not privately obtain health insurance, either through their jobs or by purchasing insurance, sometimes receive coverage from Government programs such as Medicaid. However, coverage from Government programs is contingent upon meeting program eligibility requirements. For the nonaged without private insurance, Medicaid is the most important source of coverage. Eligibility for this program is generally restricted by requiring that recipients meet a test of financial need *and* have a certain physical status (blind or disabled) or be in a certain family type (in a family with children, often a single-parent family with children).

Those who do not have private coverage, and either do not meet the eligibility requirements of Government programs or choose not to participate in them, represent the 36.8 million who are uninsured. This section profiles these people. Since family relationships are very important in looking at private health insurance status, and family income and type are important in terms of government health insurance, the uninsured will be examined by these family characteristics.

#### *1. Poverty status*

Most of the uninsured are not poor.[89] In 1986, about 7 out of 10 uninsured persons lived in families with incomes exceeding the Federal poverty threshold for their family size.

[89] Persons in families with family incomes below poverty thresholds established by the Census Bureau are counted as poor. The 1986 Federal poverty thresholds are as follows: $5,572 for a single person, 15 to 64 years old; $7,372 for a family of two (householder age 15 to 64); $8,737 for

Continued

In interpreting health insurance coverage by poverty status, it is important to note that the Federal Government measures poverty by family rather than individual income. An uninsured individual may have a low personal income but live in a family with a relatively high income. Poverty thresholds are also higher for larger families. For example, a 1986 income of $10,000 does not represent poverty for a single person, since the poverty threshold for a nonaged single person is $5,572. A family of four that also had an income of $10,000, however, would be counted as poor, since its 1986 poverty threshold was $11,203.

Chart 4.3 shows the uninsured by poverty ratio. A person's poverty ratio represents their total family income divided by their family's poverty threshold. Therefore, a poverty ratio of one represents income at the poverty line; the uninsured with a poverty ratio of less than 1.0 are poor, while those with a poverty ratio of 1.0 or more represent the uninsured who are not poor. In 1986, about 30 percent of the uninsured were poor, another 30 percent had poverty ratios between 1.0 and 1.99, and the remaining 40 percent uninsured had poverty ratios of 2.0 or higher.

*2. Family relationship*

The CPS is a household survey, and therefore a great deal of its information refers to relationships within a household, for example, the relationship of individuals to the head of the household. This information indicates more about household living arrangements and relationships than it does about family relationships.

Family relationships are key to examining health insurance status, since insurers typically cover units that consist of the enrollee, his or her spouse, and dependent children below a certain age (18 or 25, depending on the insurer and generally with some extension of coverage for full-time students). However, living arrangements are very diverse: single people, for example, may live alone or with nonrelatives; some children over the maximum dependent coverage age still live in their parents' household; and many "extended family" living arrangements show up on the CPS, such as the sharing of a household by aunts, uncles, nieces, and nephews, grandparents and grandchildren of the household head. Health insurance policies normally do not cover such persons in extended families. Moreover, some insurance "units" may span more than one household (dependent children living on their own may still be covered under their parents' policies).

The CPS does not provide information that would permit examining insurance units that are split among two or more households. It is possible, however, to examine the uninsured who could potentially be in a "family" insurance unit and those who would be unlikely to be in such a unit. Chart 4.4 shows the uninsured according to their family relationships. Family heads are household heads who are in families, in contrast to single and childless household heads. The "other persons" category consists of single people who

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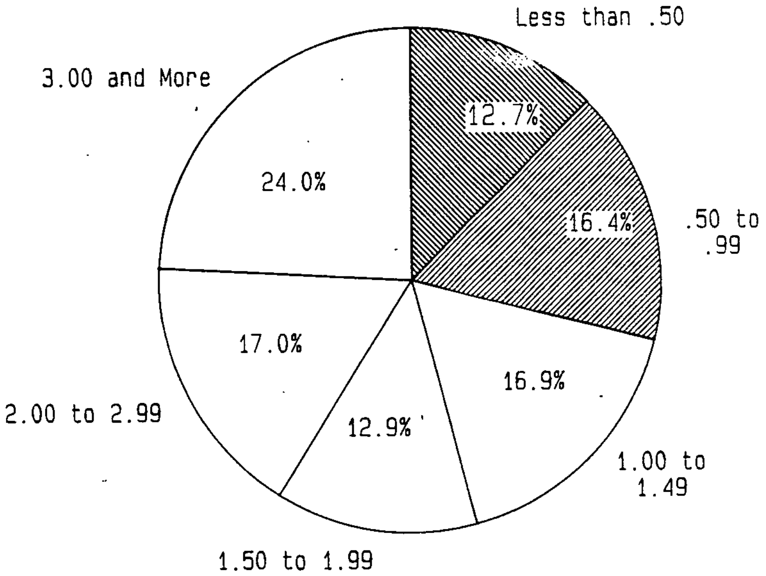
a family of three; $11,203 for a family of four; $13,259 for a family of five; and higher levels for larger families. Source: U.S. Bureau of the Census. Money Income and Poverty Status of Families and Persons in the United States: 1986. Current Population Reports, Series P-60, no. 157. Wash., 1987. p. 38.

live alone, with nonrelatives, or are otherwise unrelated to the household head, and members of "extended" families.

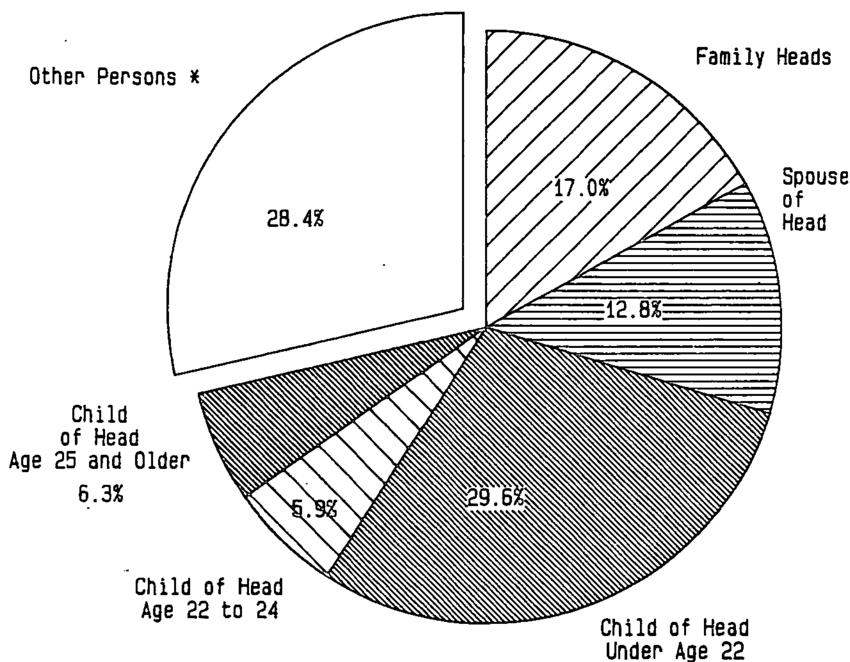
The chart shows that more than two-fifths of the uninsured fall into a category where they are not likely to be covered by the household head's or spouse's family plan. About 28 percent of the uninsured represent single people, members of an extended family or nonrelatives of the household head. An additional 12.2 percent of the uninsured represent children (of the household head) over age 21.

Chart 4.3
Nonaged Population Not Covered by Health Insurance
by Poverty Ratio
1986




Source: Figure prepared by the Congressional Research Service based on data from the March 1987 CPS.

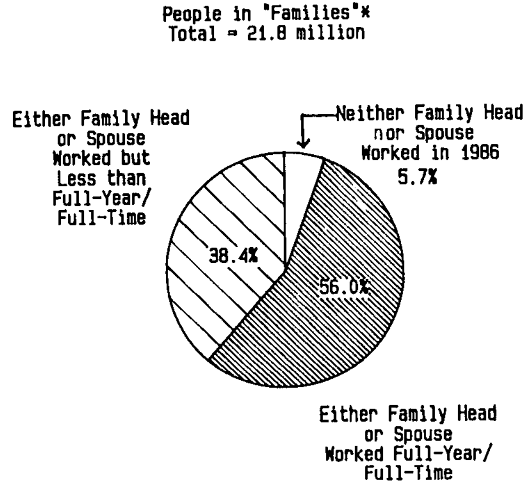
Chart 4.4
Nonaged Population Not Covered by Health Insurance
by Relationship to Family Head
1986

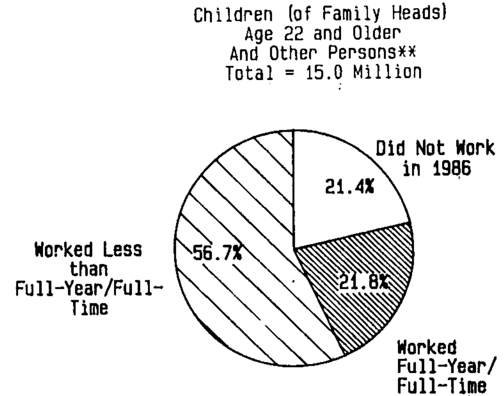



* Other persons include single people who live alone, with non-relatives, or are otherwise unrelated to the household head, and members of "extended" families.

Source: Figure Prepared by the Congressional Research Service based on data from the March 1987 CPS.

## Chart 4.5. The NonAged Population Without Health Insurance by Labor Force Ties and Family Status, 1986




*Families include family heads, spouses, and children of family heads under age 22.

** Other persons include single people who live alone, with non-relatives, or are otherwise unrelated to the household head, and members of "extended" families.

Source: Figure prepared by the Congressional Research Service based on data from the March 1987 CPS.

*3. Labor force ties*

Chart 4.5 shows how many of the uninsured have ties to the labor force. Given that the uninsured can be divided into two groups, those likely to be covered by a family plan and those who generally must earn health insurance on their own, two pies are shown representing each group. The left pie represents the proportion of the uninsured who are family heads, spouses, and children (of family heads) under age 22. The labor force status of the family head and spouse is shown for this group (whether *either* the head or spouse was in the labor force or worked full-time). The right pie represents the uninsured who are single, unrelated to the household head, children (of the family head) age 22 and older, or members of the household head's extended family. For this group, their own labor force participation is shown.

The pie on the left shows the group that could presumably be covered by a family health insurance plan if either the family head or spouse were enrolled in such a plan. This group numbered 21.8 million of the uninsured. Most of these persons were in families with at least some labor force connection. Of this group, 56 percent were in families where either the family head or spouse worked full-time/full-year; another 38 percent were in families where either the head or spouse worked less than full-time/full-year.

The pie on the right shows the labor force connection for the uninsured who are in groups not likely to be covered by a family plan. This group numbered 15.0 million of the uninsured. Not only are these persons unlikely to be covered by a family plan, but the nature of their labor force attachment makes many of these persons unlikely to be enrolled in health insurance through their own employment. About 21 percent of these persons reported that they did not work at all during 1986; another 57 percent reported that they worked less than full-time/full-year and 22 percent worked full-time/full-year.

*4. Family type*

For persons without private health insurance, government programs provide coverage to some persons based on either their past work, past or current military service, or membership in certain types of needy families. For the non-aged, Medicare is restricted to persons who receive social security disability benefits (and is available only after a 24-month waiting period) and persons with end-stage renal disease. Veterans Administration medical care is provided only to certain veterans and their dependents. Medicaid, the major needs-tested program, is available only to needy adults who are aged, blind, and disabled or to persons who are in (mainly) poor families with children.

Medicaid's categorical eligibility rules affect the composition of the uninsured. For families with children, Medicaid is available to single-parent families with children who meet State-determined tests of financial need, and sometimes (at State option) to married-couple families with children who have an unemployed parent and meet a needs test. States also may cover children in poor families, even when both parents are present and working, but may not cover the adults in these families. For families with children, how-

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ever, the bulk of the beneficiaries are persons in single-parent families with children, usually female-headed families.

Chart 4.6 shows the uninsured by family type. The chart is broken into two wedges. The wedge on the right represents the uninsured in families with related children under age 18, by type of family head. Included in these "families" are only family heads, spouses, and related children under age 18.[90] Other persons—unrelated children, older children, and members of extended families—are generally considered to be outside the family for Medicaid purposes and are included in the wedge on the left. In addition to these persons, the left-side wedge includes single people and people in families without children.

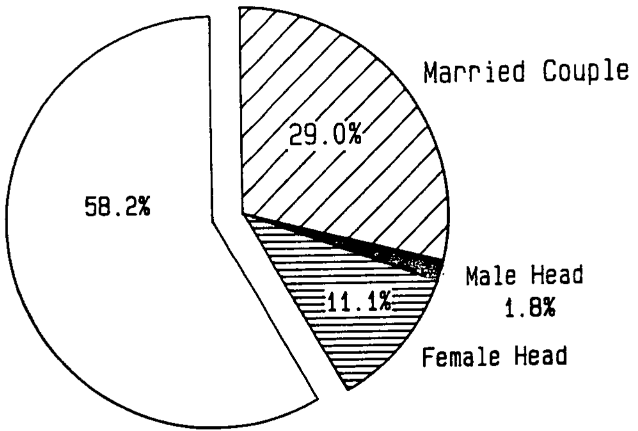
The chart shows that the largest proportion of the uninsured are in families without related children (or with children who are outside the family for Medicaid purposes). Among the uninsured who were in families with related children, the largest group is families headed by a married couple, a group not eligible for Medicaid in many States.

[90] A child turning 18 (or up to 21 in some States) will lose Medicaid even though the rest of the family remains covered.

Chart 4.6
Nonaged Population Not Covered by Health Insurance
by Family Type: 1986

People In Families Without Children Under Age 18

Families with Children Under Age 18




Source: Figure prepared by the Congressional Research Service based on data from the March 1987 CPS

## II. Trends in Health Insurance Coverage: 1979–1986 [91]

Between 1979 and 1986, the percent of the nonaged population who were uninsured increased from 14.6 to 17.5 percent. The number of uninsured would have been expected to grow from 28.4 to 30.8 million simply because the overall nonaged population grew. However, the number of the nonaged uninsured actually grew from 28.4 million to 36.8 million. That is, the number of uninsured increased by 8.4 million people, yet only 2.4 million of the growth was due to an expanding nonaged population. This section analyzes the reasons for this additional 8.4 million uninsured people, with emphasis on the 6 million not explained by population growth.

### A. CHANGES IN COVERAGE

Table 4.7 shows trends in the nonaged uninsured for selected years from 1979 to 1986.[92] Most of the change in health insurance coverage occurred between 1979 and 1984; after 1984, coverage rates remained fairly constant.

Table 4.7.—Number and Percent of the Nonaged Population Without Health Insurance, 1979 and 1983 to 1986

| | 1979 | 1983 | 1984 | 1985 | 1986 |
|---|---|---|---|---|---|
| Number uninsured (millions) | 28.4 | 34.8 | 36.8 | 36.7 | 36.8 |
| Percent uninsured (percent) | 14.6 | 16.9 | 17.7 | 17.6 | 17.5 |

Source: Table prepared by CRS based on data from the Mar. 1980, Mar. 1984, Mar. 1985, Mar. 1986, and Mar. 1987 CPS. Information from 1980 to 1982 is not presented due to errors on the CPS computer tapes for those years.

To examine why the uninsured have increased since 1979, table 4.8 displays insurance coverage by source and year. People receive health insurance through:

—Employment-based health insurance at their own jobs;

—Employment-based health insurance as dependents of workers—people who do not obtain health insurance on their own job but receive coverage from another family member's employment-based plan;

—Other plans—people who are not covered by employment-based plans, but receive coverage from Medicaid, Medicare, CHAMPUS, and other health insurance. Retirees who receive coverage through plans provided from previous employment are included in this category.

Table 4.8.—Sources of Health Insurance Coverage by Year for Nonaged Population, 1979–86

| | Percent of nonelderly population | | | | |
|---|---|---|---|---|---|
| | 1979 | 1983 | 1984 | 1985 | 1986 |
| Employment-based plans: | | | | | |
| Covered on own job | 33.1 | 32.5 | 32.6 | 33.1 | 33.4 |

[91] Support tables for figures in this section can be found in appendix A.

[92] The years 1980 to 1982 are not shown on the table due to an error in the CPS coding of coverage under "other health insurance" plans for those years.

TABLE 4.8.—Sources of Health Insurance Coverage by Year for Nonaged Population, 1979-86—Continued

| | Percent of nonelderly population | | | | |
|---|---|---|---|---|---|
| | 1979 | 1983 | 1984 | 1985 | 1986 |
| Covered through someone else | 34.3 | 32.1 | 31.4 | 31.2 | 31.4 |
| Total employment-based | 67.4 | 64.6 | 64.0 | 64.3 | 64.8 |
| Other plans [1] | 17.9 | 18.5 | 18.3 | 18.1 | 17.7 |
| Uninsured | 14.6 | 16.9 | 17.7 | 17.6 | 17.5 |
| Total | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |

[1] Excludes persons covered by employment-based plans.

Source: Table prepared by CRS based on data from the Mar. 1980, Mar. 1984, Mar. 1985, Mar. 1986, and Mar. 1987 CPS. Information from 1980 to 1982 is not presented due to errors on the CPS computer tapes for those years.

The most dramatic trend shown in the table is the decline in the percent of the nonelderly population covered by employment-based plans through another family member from 34.3 to 31.4 percent. This proportion declined consistently between 1979 and 1984, and then leveled off. On the other hand, the percent of the nonelderly population covered by health insurance from their own work actually increased between 1979 and 1986 from 33.1 to 33.4 percent. This percent declined during the early 1980s but increased by nearly a full percentage point between 1983 and 1986.

Several factors contributed to these changes in health insurance coverage over the 1979 to 1986 period:

—Changes in the work force. From 1979 to 1986, the percent of the nonaged in the work force grew as the last of the "baby boomers" entered the work force. Moreover, the percent of workers in service-producing industries grew over the 8-year period.

—Demographic changes and changes in family structure. The percent of the population under 18 (traditionally covered as dependents under parents' plans) has declined. Moreover, family structure has changed, with a greater proportion of the nonaged population living outside of "traditional" family arrangements.

—Economic incentives. Noncash compensation grew rapidly during the 1970s, as high inflation and high tax rates made nontaxable, inflation-resistent noncash compensation such as health insurance more valuable relative to cash wages. The low inflation of the mid-1980s and the changed tax structure may have reduced the incentive for employees to favor compensation in noncash forms relative to cash forms. Also, the cost of family premiums has increased 66 percent in real terms over the past ten years and the required enrollee share of premiums for family coverage has risen.[93]

Data from the Census Bureau's Current Population Survey (CPS) can be used to examine the effect of the first two factors on health insurance coverage trends. However, census data are insufficient to measure the effect of economic incentives upon coverage rates.

[93] See Chapter 2, A Primer on Health Insurance, p. 65, for further discussion of this point.

## B. CHANGES IN THE WORK FORCE

This section analyzes changes in health insurance coverage of the nonaged according to their attachment to the workforce. Workers are classified as being in: (1) the service-producing sector, (2) the goods-producing sector, or (3) the public sector. From 1979 to 1986, the percent of the nonaged population in the service-producing sector grew, while the percentages of people out of the work force, in the goods-producing sector, and the public sector declined.[94]

Between 1979 and 1986, the share of the nonaged population without health insurance increased by 2.9 percentage points, from 14.6 to 17.5 percent. Examining the three types of health insurance coverage in both 1979 and 1986 gives some indication of where decreases in coverage have occurred. The largest decrease, −2.9 percentage points, occurred in coverage obtained through another family member's employment, usually termed "dependent coverage." Non-employment based health coverage also decreased by .2 percentage points. Coverage obtained through one's own employment increased slightly from 33.1 to 33.4 percent. (See table 4.9).

People out of the labor force, usually children and adults not looking for work, are highly dependent on obtaining coverage through another family member's employment. A 4.4 percentage point decline in coverage through another family member, somewhat offset by a 1.8 percentage point increase in coverage not tied to employment, explains the overall 2.6 percentage point decline in coverage.

TABLE 4.9.—Percentage Point Changes in Health Insurance Coverage by Type of Coverage, 1979 to 1986

| Health insurance coverage | Total nonaged population | In the labor force | Not in the labor force |
|---|---|---|---|
| Health Insurance from: | | | |
| Own job | +0.3 | −1.1 | 0.0 |
| Other's job | −2.9 | −0.8 | −4.4 |
| Other health insurance | −0.2 | −1.3 | +1.8 |
| Overall change in coverage | −2.9 | −3.2 | −2.6 |

Source: Table prepared by CRS based on data from the Mar. 1980 and Mar. 1987 CPS.

For people in the labor force, the decreases are much more evenly distributed. It should be noted that for people in the labor force the coverage rate for insurance obtained through their own employment has declined (by 1.1 percentage points). However, the first column in table 4.9 shows a slight increase in coverage obtained through one's own employment. The trend is different for the overall population than for those in the labor force because a higher percentage of the overall population was in the labor force

[94] As a percent of the population under age 65, the private service-producing sector grew from 31.5 to 34.8 percent from 1979 to 1986; people out of the work force declined from 43.4 to 41.8 percent; people in the private goods-producing sector declined from 22.2 to 20.7 percent; and people in the public sector declined from 2.9 to 2.7 percent.

in 1986 than in 1979. Even though coverage rates from a person's own job declined somewhat for those in the labor force, rates were still higher than those for persons outside the labor force. Thus, with more people in the labor force, the net effect was slightly more insurance coverage from a person's own job.

Chart 4.7 further divides the labor force into goods-producing and service-producing sectors,[95] and shows changes in coverage rates for these two sectors. In the service-producing sector (1) most of the drop in coverage has taken place in employment-based health insurance from other family members, (2) the proportion of persons who had health insurance from their own jobs actually increased but not enough to offset the drop in dependent coverage. Finally, while the decrease in coverage for people working in the goods-producing sector came from all sources, a significant proportion can be attributed predominantly to a drop in coverage based on their own employment.

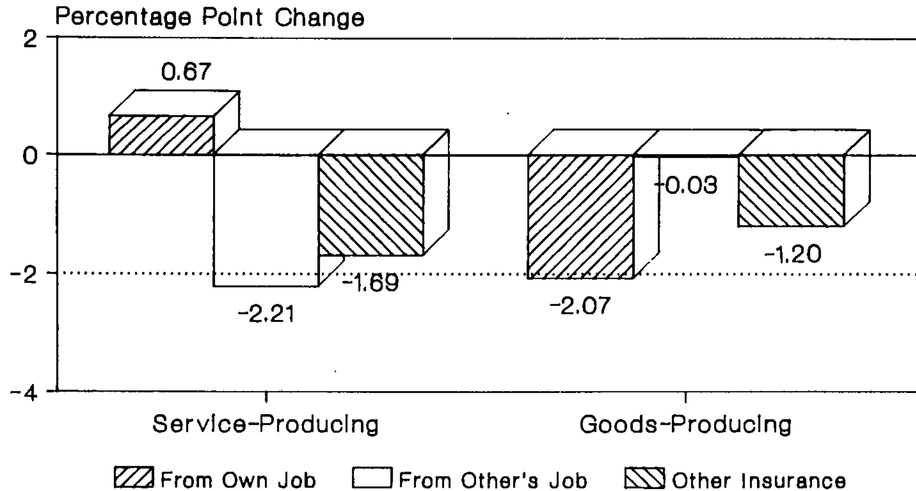
The results presented above indicate that something other than a shift of jobs into the service-producing sector is associated with the decrease in coverage. It is true that the service-producing sector has lower coverage rates than the goods-producing sector or the public sector, but the new service-producing workers are not necessarily workers who had been employed in goods-producing or public sector jobs. Employment in the service-producing sector grew from 31.5 to 34.8 percent of the nonaged population between 1979 and 1986. The data show that people not previously in the workforce (with lower coverage rates than workers) made up close to 50 percent of the shift towards the service-producing sector. Accordingly, it is clear that the growth in the service-producing sector by itself did not reduce coverage.

Using the 1986 increases in the service-producing sector and the 1979 coverage rates generates a 1986 uninsured nonaged population of 14.61 percent. This is very close to the 1979 rate of 14.64 percent. If there had been only shifts between the different sectors of the economy the change in coverage would not have been as severe, but the rates of coverage within the sectors would have dropped as well. By far most of the change has been due to decreases in the rates of coverage, and, in turn, these chiefly represent decreases in coverage through another family member.

[95] Also in the labor force are Federal, State and local government workers. Their trends are different enough from the rest of the labor force that they have been separated out in this analysis. The data for government workers can be found in appendix A.

## Chart 4.7

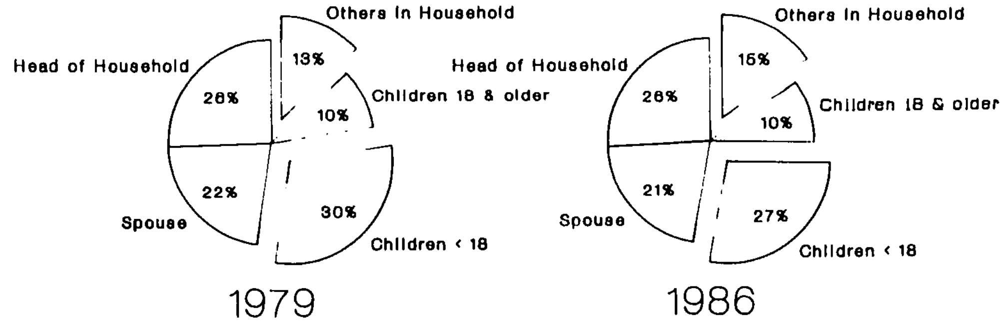
# Changes in Health Insurance Coverage By Sector of the Economy and Source of Coverage, 1979 to 1986.




Source: CRS, March 1980 & 1987 CPS.

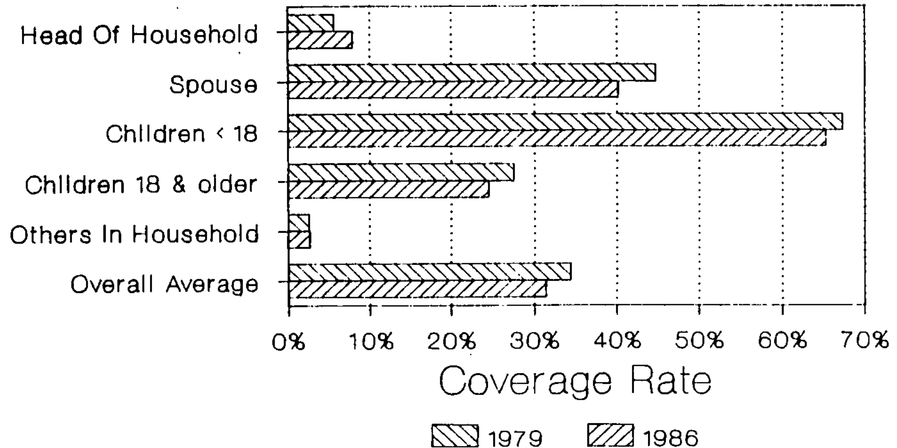
## Chart 4.8

# Percentage of the Nonaged Population By Family Relationship, 1979 & 1986




Source: CRS - March 1980 & 1987 CPS.

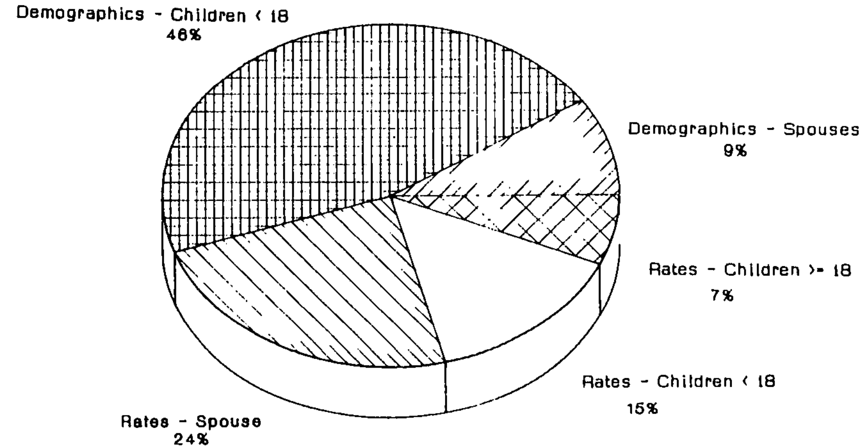
## Chart 4.9
## Health Insurance Through Another Family Member's Employment, 1979 & 1986.
## ** Coverage Rates **




Source: CRS, March 1980 & 1987 CPS.

# Chart 4.10

# Decrease in Health Insurance Coverage Through Another Family Member Due to Demographic & Rate Changes 1979 and 1986




Source: CRS, March 1980 & 1987 CPS.

### C. DEMOGRAPHIC CHANGES AND CHANGES IN FAMILY STRUCTURE

The 1979–1986 decrease in health insurance coverage is closely related to changes in the population that received coverage through another family member's employment. Overall, the percent of the population receiving coverage through another family member's employment-based health insurance dropped from 34.3 percent in 1979 to 31.4 percent in 1986. Two hypotheses can be examined to explain the drop in coverage through another family member. First, there may have been a shift in the population into categories that have always had lower dependent coverage rates. Second, there could have been an actual change in the rates for the different types of family members.

Chart 4.8 illustrates changes that have occurred in family relationships. The percent of children under age 18 has dropped 3 percentage points between 1979 and 1986. The percentage of people in the category "others in household," a category that includes single adults, grew by 2 percentage points during the same period. Chart 4.9 also indicates that these two groups that have shown the most change in population, children under 18 years old and others in the household, have had very different coverage rates under another family member's employment-based health insurance. Children under 18 have the highest coverage rates and "others in household" have the lowest. Chart 4.8 indicates that there have been shifts in the population toward groups with lower coverage rates. Chart 4.9 goes further and indicates that, even had there been no population shifts, there still would have been a drop in overall coverage because of declines in coverage rates for the different categories of family members.

One simple way to distinguish the changes associated with population shifts from those associated with coverage rates is to hold population shifts constant while allowing coverage rates to change. Overall coverage of the nonaged population dropped 2.9 percentage points between 1979 and 1986. If coverage rates had not changed between 1979 and 1986, demographic changes alone would have caused a decline of 1.6 percentage points, or 55 percent of the total decline. Reversing the process, if the demographics had not changed between 1979 and 1986, changes in the coverage rates would have caused a 1.3 percent decline, or 45 percent of the total decline.

Chart 4.10 indicates the relative share of the decline in health coverage through another family member's employment. It can be said that the 55 percent of the decrease associated with demographic factors, i.e., population shifts, is split between drops in the percentage of the population found in two categories with high rates of dependent coverage. There simply are smaller percentages of children under age 18 and spouses. Compounding these demographic shifts, the rates of coverage for these two groups, as well as for older children living in the household, have declined as well. These demographic shifts are beyond the normal control of policymakers. These two groups, spouses and children under 18, have become a smaller percentage of the nonaged population. At the same time, between 1979 and 1986 the rates of coverage through another worker for these groups declined. That is, spouses and children

under 18 were less likely to have health insurance through another worker's employment in 1986 than was true in 1979.

Overall two patterns emerge:

—A significant percentage of the change associated with demographic shifts is due to a movement out of the children under age 18 into the "others living in household" group. The first group has relatively high coverage rates. The second group has relatively low coverage rates. This shift may have been unavoidable given the aging of the baby boom population;

—Another significant percentage of the overall change is associated with a decrease in the coverage rates for spouses and children under age 18. There is no clear explanation for this decrease. Possibilities include the movement away from employer-provided noncash benefits and the increase in the required employee share of premiums for dependent coverage.[96] The data provided here cannot provide a definitive answer.

In conclusion, the notion that the drop in coverage is mostly due to the movement of jobs to the service-producing sector is not supported by this analysis. Decreases in coverage are found most significantly in coverage obtained through another family member's employment-based plan. The cause of the decrease in this type of coverage seems almost evenly attributable to demographic shifts and to a decline in coverage rates for spouses and children under age 18.

## III. Loss of Coverage

Individuals with private health insurance can lose coverage as a result of unemployment, job change, a change in family status, or retirement before Medicare eligibility. Medicaid beneficiaries also face problems of insurance loss. Categorically eligible individuals (i.e., those receiving Medicaid in conjunction with cash assistance benefits) can lose Medicaid coverage because of a change in family status or increased income. Persons under age 65 who qualify for Medicaid because of high medical bills may be eligible only during an acute illness of limited duration.

### A. LOSS OF PRIVATE HEALTH INSURANCE

A recent study by researchers from the National Center for Health Services Research (NCHSR) explores the loss of health insurance coverage over a 32-month period using the 1984 panel of the Survey of Income and Program Participation (SIPP).[97] The study found that 22 percent of the privately insured population changed insurance status at least once during the time period examined. Further, the uninsured population was found to be "heterogeneous, consisting of many persons who lose coverage for relatively short periods of time, others who experience periodic spells without insurance coverage, and many who are persistently uninsured."[98]

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[96] See also chapter 2, A Primer on Health Insurance, p. 65, for a discussion of increases in premiums for dependent coverage.

[97] See appendix A for description of SIPP.

[98] Monheit, Alan, and Claudia Schur. Examining the Dynamics of Health Insurance Loss. Unpublished paper presented at the annual meetings of the American Public Health Association, Oct. 20, 1987.

*1. Reasons for loss of coverage*

Unemployment contributes significantly to loss of private health insurance. Based on the 1977 National Medical Care Expenditure Survey (NMCES) and characteristics of unemployed persons in mid-March 1982, approximately 1.4 million workers, lost private health insurance.[99]

An analysis by the Bureau of Labor Statistics of the 1984 CPS's supplement on displaced workers concluded that "upon termination, most displaced workers lose employer-financed health insurance along with their jobs . . . [D]ata for 1983–84 suggest that such workers ran a high risk of remaining uninsured for extended periods, even after new employment was secured." [100]

Employees can also lose coverage because of a change in family status, including death, divorce, or a change in dependent status. For example, if a couple and their children are covered under the household head's health insurance policy and the policyholder dies, the spouse and children can in turn lose coverage. The health insurance continuation provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) were designed to deal with some of the problems of losing employer-based coverage.

*2. Legislation to continue coverage*

In April 1986, the health insurance continuation provision was enacted as Title X of COBRA (P.L. 99-272).[101] The option to continue coverage must be provided by the employer for 18 or 36 months, depending on the qualifying event.[102]

This law provides most employees experiencing a change in job or family status with access to group health insurance, but it requires them to pay for it. Data are not yet available to evaluate of the effects of Title X on coverage. There are reasons to think that some eligible people may not purchase the offered insurance. Employers can charge employees and other qualified beneficiaries up to 102 percent of the group premium rate, and employees who have lost their job (or had their work hours cut) may be unable to pay the premium. In addition, widows or widowers and divorcees may lack the funds to pay the costs of continued coverage. Furthermore, Title X offers early retirees assistance for only 18 months, a period which may end before they reach age 65 when they may become eligible for Medicare. Similar problems may be faced by disabled retirees, whose COBRA coverage would expire before they completed the required waiting period for Medicare disability coverage.

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[99] Monheit, Alan, Michael Hagan, Marc Berk and Gail Wilensky Health Insurance for the Unemployed: Is Federal Legislation Needed? Health Affairs, spring 1984. p. 101–111.

[100] Podgursky, M.P. Swaim, Health Insurance Loss: The Case of the Displaced Worker. Monthly Labor Review, Apr. 1987. p. 30–33.

[101] For additional discussion of this legislation see chapter 3, Government Regulation of Health Insurance, p. 86.

[102] An amendment to Title X provides that retirees of companies that have filed for bankruptcy under Chapter XI of the U.S. Bankruptcy Code are eligible for lifetime continued coverage. See U.S. Library of Congress. Congressional Research Service. Private Health Insurance Continuation Coverages. Issue Brief No. 1B87182, by Beth Fuchs (regularly updated).

## B. LOSS OF PUBLIC HEALTH INSURANCE

Individuals covered by public health insurance programs, such as Medicaid, are also at risk for loss of coverage, but for different reasons than the privately insured. For some people, the events triggering loss are closely tied to their eligibility for cash benefits. Other individuals obtain Medicaid coverage only briefly, during a period of very high medical expenses.

### *1. Reasons for loss of coverage*

A study based on SIPP data collected from interviews between fall 1983 and summer 1986 analyzed the extent to which persons lose Medicaid coverage and the reasons for loss.[103] About 38 percent of the population covered by Medicaid at the time of the first interview lost coverage over the 34-month period. About 45 percent of the losses of Medicaid coverage could be attributed to a gain or change in employment status. (See table 4.10.) Nearly half of those losing Medicaid coverage were subsequently covered by private insurance, but about 55 percent remained uninsured.

Of Medicaid beneficiaries who retained eligibility over the entire period, 88 percent received either AFDC or SSI benefits. Of those who were eligible for Medicaid for only part of the 34 months, only 28 percent received AFDC or SSI. Many of the short-term Medicaid beneficiaries were probably "medically needy"—persons whose income is too high to qualify for cash assistance benefits but who need help with their medical bills. These beneficiaries face possible loss of Medicaid benefits if their income increases or their medical costs decrease.

TABLE 4.10.—Events Associated with Loss of Medicaid for the Under 65 Population, 1984 SIPP Panel

| *Event* [1] | | *Percent* |
|---|---|---|
| Marriage | | 4.2 |
| Improved employment | | 45.0 |
| Newly employed | 14.6 | |
| Increased hours | 13.9 | |
| Increased wage | 16.5 | |
| Other increase in family income | | 13.9 |
| Decrease in family size | | 5.3 |
| Other | | 31.7 |
| Total | | 100.1 |

[1] Person or spouse experienced event during the 8 months preceding the first interview without Medicaid. Events associated with Medicaid loss for children under 18 are classified according to the events experienced by their parents, or by the householder if not living with a parent. Persons who dropped out of SIPP (died or were institutionalized) are excluded from this table. Persons with more than one event associated with a transition off Medicaid are classified according to the first applicable category shown.

Source: Short, et al., The Dynamics of Medicaid Enrollment, table 9.

### *2. Legislation to continue Medicaid coverage*

States are required to continue Medicaid coverage for a limited period for select groups after the loss of AFDC or SSI benefits.

[103] Short, Pamela Farley, Joel Cantor and Alan Monheit. The Dynamics of Medicaid Enrollment. Unpublished paper presented at the annual meetings of the American Public Health Association in New Orleans, Oct. 1987 (updated Mar. 1988).

Families losing AFDC benefits as a result of increased employment income or working hours or increased child or spousal support payments must receive continued Medicaid coverage for 4 months. Eligibility must be continued for 9 months when the family loses AFDC benefits because it has ceased to be entitled to certain income "disregards"—subtractions from earned income used in determining eligibility. For this group States may extend coverage an additional 6 months beyond the mandatory 9-month extension. In addition, some SSI beneficiaries who qualify on the basis of disability and low-income may continue to receive Medicaid after an income increase that disqualifies them for SSI benefits.[104]

[104] A proposal to provide prolonged transitional coverage has been included in Senate welfare reform legislation (S. 1511). This bill would require States to continue coverage for a period of 12 months, charging an income-related premium the last 6 months unless the family's income is below the Federal poverty level.

# CHAPTER 5.—THE INSURED POPULATION AND EXPOSURE TO OUT-OF-POCKET EXPENSES

Eighty-three percent of the nonaged (under 65) population has some protection against health care expenses, yet even the most generous health insurance plans do not pay for 100 percent of expenses. Enrollees always pay some share of the cost of health care services, with the amount of those out-of-pocket expenses depending on the plan's specific provisions.

This chapter examines the cost-sharing provisions of employer-provided and individual plans and discusses the extent of out-of-pocket expenses for which enrollees are at risk.[105] First, a general framework for defining the extent of risk for out-of-pocket expenses is presented. Next, the chapter describes provisions of employer-provided health insurance plans that affect an enrollee's risk for out-of-pocket expenditures and presents data on the prevalence of these provisions. When available, information on individual plans is used to supplement this discussion. Finally, hypothetical health care bills are presented to illustrate the proportion of the insured population that would be at risk for different amount of out-of-pocket expenses under plans surveyed in the 1987 Hay/Huggins Benefits Report (HHBR).[106]

## I. EXTENT OF RISK FOR OUT-OF-POCKET EXPENSES

The extent of out-of-pocket expenses for health care can be measured in absolute dollars or as a percent of family income.[107] Expressing out-of-pocket expenditures as a percentage of income indicates that large health care expenses are a particular problem for poor and low-income families. A recent study by the Department of Health and Human Services (DHHS) reports that, as income increases, the incidence of catastrophic expenses decreases.[108] According to a recent DHHS study, about 35 percent of poor families (both insured and uninsured), compared to about 3 percent of high-income families, had out-of-pocket expenses exceeding 5 percent of income in 1986. (See table 5.1.) As the threshold is increased, the incidence of catastrophic expenses becomes more heavily concentrated among poor and low-income families.

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[105] Out-of-pocket medical care expenditures as defined in this chapter do not include premium amounts paid by enrollees.

[106] For a description of the survey and plans, see Chapter 2: A Primer on Health Insurance, p. 33.

[107] Discussions of "catastrophic" medical expenses (or high out-of-pocket expenses) commonly refer to both high-cost illnesses and conditions and those which are extraordinarily expensive in relation to income. See Wyszewianski, Leon. Families with Catastrophic Health Care Expenditures. Health Services Research, Dec. 1986. p. 617–620.

[108] U.S. Department of Health and Human Services. Office of Health Policy. Insuring Catastrophic Illness for the General Population. Technical Report, 187.

TABLE 5.1.—Percent of Families Experiencing Out-of-Pocket Expenditures above Income-Related Thresholds by Threshold and Income Status, 1987 [1]

| | Out-of-pocket expenditures for family in excess of | | |
|---|---|---|---|
| | 5 percent of income | 15 percent of income | 25 percent of income |
| Percent of all families | 15.3 | 5.9 | 3.7 |
| Percent of families by income status: | | | |
| Poor | 35.1 | 20.9 | 15.9 |
| Low | 26.1 | 9.1 | 4.1 |
| Middle | 11.2 | 2.4 | 1.1 |
| High | 2.9 | .4 | .1 |

[1] Income class is assigned according to family income relative to the Federal poverty level, adjusted for family size. Poor are below poverty; low are 100–200 percent of poverty; middle are 200–400 percent; and high are above 400 percent of poverty. .

Note.—Out-of-pocket expenditures do not include health insurance premium costs.

Source: DHHS, Office of Health Policy, Insuring Catastrophic Illness, table 2-10, p. 2-39. Derived from 1980 NMCUES, modified to reflect changes in population and health insurance coverage between 1980 and 1987.

High out-of-pocket expenses, as a percent of income, are not always the result of an expensive illness or condition. For poor and low-income families, payment for even routine health care expenses may represent a substantial share of family income. For families with more moderate incomes, however, out-of-pocket expenses that are a high percent of income are less common and usually result from inadequate insurance coverage. Specifically, plans with no cap on out-of-pocket expenditures or with a relatively low plan maximum could expose insured enrollees to costly out-of-pocket expenses.[109] In order to identify the extent to which the insured population is at risk for out-of-pocket expenses, the following section focuses on the provisions in existing plans that require enrollees to pay a portion of health care costs.[110]

## II. PLAN PROVISIONS AFFECTING EXPOSURE TO OUT-OF-POCKET EXPENDITURES

### A. PLANS EXAMINED

This discussion of the extent of risk for out-of-pocket expenses is mostly limited to employer-sponsored plans. The plan profiles presented in this chapter are from the 1987 Hay/Huggins Benefits Report (HHBR), as supplemented by information from the Small

[109] See Chapter 2, A Primer on Health Insurance, page 33, for definitions of out-of-pocket cap and plan maximum.

[110] Pamela Farley Short, Senior Economist at the National Center for Health Services Research, has suggested a further refinement in defining and measuring the "underinsured" population. Based on personal characteristics and health care expenditure data from the 1977 National Medical Care Expenditures Survey, she estimated the probability distribution of expected health care expenses for the insured population, against which she measured the adequacy of existing health insurance plans. Using this methodology, she estimated that 7.9 percent of the insured population had a 1-percent expectation of total health care expenses that would leave them with out-of-pocket expenses greater than or equal to 10 percent of family income. See Farley, Pamela. Who Are the Underinsured? Milbank Memorial Fund Quarterly/Health and Society, v. 63, no. 3, 1985. p. 476–503.

Business Administration (SBA) survey of small and large businesses.[111]

This analysis does not include health maintenance organizations (HMOs). As discussed in chapter 2, A Primer on Health Insurance, (see page 58) the typical HMO plan leaves an enrollee with out-of-pocket expenses only for services not provided by the HMO along with nominal copayments for some covered services. Typically an HMO will provide preventive care and non-psychiatric services in full, or with a nominal copayment (usually $2–$5 per service). However, inpatient and outpatient services for mental health care may require substantial enrollee payments, and outpatient mental health care visits generally require comparatively higher copayments as well ($10–15 per visit). Still, by design (i.e., nominal copayments and few limits on services) HMOs usually do not expose enrollees to risk for high out-of-pocket expenses.

Most plans offered by medium and large firms place limits on enrollees' out-of-pocket expenses. However, 17 percent of such plans have no out-of-pocket cap, and 14 percent of plans have a maximum lifetime benefit payment of $250,000 or less. The deductible and coinsurance payments determine the out-of-pocket expenses for an enrollee without costly medical conditions, but the out-of-pocket cap and the plan maximum are the primary provisions that determine the extent of an enrollee's out-of-pocket expenses for a costly illness.[112] In addition, about 5 percent of plans exclude mental health coverage; one-third of plans limit payment for inpatient and outpatient mental health coverage, and almost all plans limit payment for outpatient care. As a result, most enrollees with need for mental health care are left at risk for a large share of the total cost.

## B. PLAN PROVISIONS

Several features of health insurance plans determine the extent of out-of-pocket expenses for which an enrollee is at risk. First, if a specific service is excluded from a policy, an enrollee must pay the full cost of such services. Second, even for medical care expenses included in the insurance plan, enrollees are generally responsible for an initial payment for covered services, or a "deductible." After the deductible is paid, enrollees may be required by a plan to pay a percentage of costs incurred for covered services, usually 20 percent. Some plans have no annual limits on these "coinsurance payments," but about 83 percent of plans offered by medium and large

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[111] See Chapter 2, A Primer on Health Insurance, p. 33, for further details of plans provided by employers. The Hay/Huggins Benefits Report (HHBR) is a report on the benefits provided by 896 medium and large employers in the United States. (See appendix B for a list of survey participants). The source for the information on plans of small employers was Health Care Coverage and Costs in Small and Large Businesses prepared by ICF Incorporated for the Small Business Administration (SBA) in Apr. 1987. The SBA report was based on responses from 846 employers—a response rate of approximately 20 percent.

[112] For example, compare the out-of-pocket expenses under two plans that are identical except for the out-of-pocket cap provision. Both plans pay, after a $100 deductible, 80 percent of hospital and surgical care. The first plan has no out-of-pocket cap while the second plan has an out-of-pocket cap of $1,000. If presented with a hospital bill for $10,000, the enrollee under the first plan would be responsible for $100 (the deductible) plus $1,980 (20 percent of the remaining $9,900), or for a total of $2080. Under the second plan, however, (assuming that the deductible is applied to the out-of-pocket cap), the enrollee would be responsible for the deductible and copayments up to $1,000—an amount equivalent to the out-of-pocket cap.

firms have an "out-of-pocket cap" that places a ceiling on the annual liability of the enrollee for covered services. If a health insurance plan has a "plan maximum" provision (e.g., a lifetime maximum), the enrollee may be held accountable for all expenses beyond the stated maximum. For example, plans sometimes have maximum lifetime plan payments of $250,000; under such plans, enrollees would be required to pay expenses once the plan had made benefit payments in excess of $250,000.

*1. Services not covered*

When a benefit is excluded by a plan, an enrollee must pay out-of-pocket all of the costs of services related to that benefit.[113] Likewise, if a plan limits the number of units of service that may be covered, an enrollee will sometimes have to pay for services in excess of the limit. (With the exception of mental health care, to be discussed below, the payments for excess services often may be applied to a plan's out-of-pocket limit.)

(a) *Services excluded from employer-provided plans.*—Virtually all employer-provided health plans cover hospital room and board, surgical care, X-ray and laboratory tests, physician care in hospitals, and some amount of outpatient care. Large firms usually offer a health plan that includes benefits covering payment for physician office visits, medical supplies, prescription drugs, ambulance services, and mental health care. Many plans provided by smaller firms do not cover some basic services. According to the SBA survey, 18 percent of firms with fewer than 25 employees exclude physician office visits from their health plans. (See table 5.2.)[114] Thirteen percent of all surveyed firms exclude outpatient prescription drugs and 18 percent exclude mental health care.[115]

TABLE 5.2.—Firms Excluding Different Types of Services by Firm Size, 1986

| Service | Percent of firms by size | | | | |
|---|---|---|---|---|---|
| | All firms [1] | 1 to 24 | 25 to 99 | 100 to 499 | 500+ |
| Physician office visits | 17 | 18 | 5 | 5 | 3 |
| Outpatient prescriptions | 13 | 15 | 18 | 15 | 6 |
| Mental health care | 18 | 23 | 8 | 7 | 12 |

[1] The percent of employees with a plan excluding selected services would be considerably less than the percent of firms excluding such services because nearly 90 percent of firms have 1-24 employees. For example, 17 percent of plans exclude physician office visits; yet only 6 percent of employees in firms included in the SBA study have physician office visits excluded from their plans.

Source: SBA, Health Care Coverage and Costs.

[113] Some enrollees may have additional coverage under another health plan. In this case, benefit payments are generally coordinated between the two health plans so that the secondary plan may pay for benefits excluded under the primary coverage.

[114] SBA, Health Care Coverage and Costs, table IV-4, p. IV-6. The firms included in this discussion offered only one health plan.

[115] According to a 1987 study by the Alan Guttmacher institute, about 9 percent of women of reproductive age are covered by private insurance plans that do not include maternity care. While the 1978 Pregnancy Discrimination Act requires employers to offer employees and their spouses policies that cover maternity care in the same manner that they cover other medical care, several groups are excluded from the Act. Specifically, the law does not apply to plans offered by firms with 15 or fewer employees or to nongroup policyholders. See, Alan Guttmacher Institute. Blessed Events and the Bottom Line: Financing Maternity Care in the United States, 1987.

(b) *Services for conditions excluded from a particular enrollee's plan.*—Some employer-provided plans include "pre-existing condition" clauses that preclude payment for specified conditions or diseases for a new enrollee, either permanently or for a specified period of time (typically one year).

A similar provision for individual subscribers, called "exclusion waivers," may permanently or temporarily exclude a medical condition from coverage. Permanent waivers for individuals generally exclude chronic conditions that are moderately costly such as asthma or allergies. (More serious conditions may lead to denial of individual coverage.) Temporary exclusions are generally applied to acute conditions such as fractures or pregnancy. Time periods for temporary exclusions generally range from 12 to 24 months for commercial plans and from 6 to 11 months for Blue Cross/Blue Shield plans.[116] A recent study by the Office of Technology Assessment (OTA) estimates that 13 percent of individual applicants for commercial insurance policies and 5 percent of Blue Cross/Blue Shield plan applicants are insured by health plans that include such exclusion waivers.[117]

(c) *Services not covered after a designated number of times.*—Some plans limit the number of days or visits for which a service is eligible for payment. For example, a plan may cover a limited number of hospital days or doctor visits per year.

However, plans with a limited number of hospital days seldom require an enrollee to pay the full cost of hospital services after the day limit is reached. Instead, the enrollee is typically required to pay only the coinsurance portion of the cost of hospital care beyond the stated limited number of days. Once the enrollee has reached the out-of-pocket cap, the plan pays 100 percent of covered expenses for hospital care (until a plan maximum is reached). Since hospital care is relatively expensive, the out-of-pocket cap (and thus the 100-percent payment of covered services by the plan) is reached quickly in most cases.

In contrast, the limit on allowable days for inpatient hospital care for mental health often increases an enrollee's overall out-of-pocket expenses because costs for subsequent days generally cannot be applied to a plan's out-of-pocket cap. Approximately 30 percent of HHBR plans limit the number of days for room and board coverage during psychiatric inpatient treatment; over half of these plans have a limit of 30 or fewer days.

### 2. *Deductibles and coinsurance* [118]

As discussed in detail in chapter 2, all employer plans in the HHBR survey require deductible and/or coinsurance payments by

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[116] Commercial insurance information from a 1984 Health Insurance Association of America (HIAA) survey of individual subscribers. Blue Cross/Blue Shield information from personal communications with Mary Nell Lehnhard, Vice President of Government Affairs, and Diana Jost, Executive Director of Private Market Programs, of the Blue Cross/Blue Shield Association.

[117] U.S. Office of Technology Assessment. AIDS and Health Insurance: An OTA Survey, Feb. 1988. The survey sample consisted of 2 million commercial insurance applicants and 400,000 Blue Cross/Blue Shield plan applicants.

[118] Although the HHBR data do not provide the number of employees covered by each plan, there is evidence to suggest that variation in plan generosity correlates with employer size to some extent. Nevertheless, the data also indicate that this variation is relatively insignificant

Continued

the enrollee. Some employer plans have a general deductible (which applies to all covered benefits), while others have separate deductibles for specific benefits. (See table 5.3.) For example, 11 percent of plans include a separate deductible for hospitalization. About two-fifths of plans with separate deductibles require an enrollee to pay a deductible of over $100 out-of-pocket for hospital expenses; one-fifth require enrollee payment of over $200. (See table 5.4.)

TABLE 5.3.—Percent of HHBR Plans with Deductible by Type of Benefit and Deductible

| Benefit | Percent of plans with | | |
|---|---|---|---|
| | General deductible applied | Separate deductible applied | No deductible |
| Hospitalization | 44 | 11 | 45 |
| Surgical | 57 | 0 | 43 |
| Inpatient physician | 67 | 0 | 33 |
| Physician office visits | 85 | 4 | 11 |
| X-rays/lab tests | 55 | 2 | 43 |

Source: Hay/Huggins Benefits Report, 1987.

TABLE 5.4.—Percent of HHBR Plans with Hospitalization Subject to Separate Deductible by Amount of Deductible

| Separate hospitalization deductible: | *Percent of plans* |
|---|---|
| <$100 | 23 |
| 100 | 38 |
| 101 to 199 | 12 |
| 200 | 8 |
| >200 | 19 |

Source: Hay/Huggins Benefits Report, 1987.

As presented in table 5.5, nearly two-fifths of plans require coinsurance payments of 20 percent to be made by the enrollee for hospital care, but 53 percent require no coinsurance at all. For surgical care, inpatient and outpatient physician visits and tests, the most common coinsurance requirement is 20 percent. For each type of benefit, a mere 1 percent of plans require the enrollee to make coinsurance payments of more than 20 percent.

TABLE 5.5.—Percent of HHBR Plans with Enrollee Coinsurance Requirements for Expenses by Type of Benefit and Percent of Coinsurance

| *Enrollee coinsurance* | *Percent of plans* |
|---|---|
| Hospital expenses: | |
| >20 | 1 |
| 20 | 38 |
| 1 to 19 | 9 |
| None | 53 |
| Total | 100 |
| Surgical expenses: | |
| >20 | 1 |
| 20 | 53 |
| 1 to 19 | 10 |

for these large and medium size firms. Thus, the estimated percent of plans offering different levels of deductibles, coinsurance, and out-of-pocket limits and plan maximum payment amounts and the percent of employees in plans with such provisions can be assumed to be similar.

| Enrollee coinsurance | Percent of plans |
|---|---|
| None | 36 |
| Total | 100 |
| Inpatient doctor visits: | |
| >20% | 1 |
| 20 | 59 |
| 1 to 19 | 9 |
| None | 31 |
| Total | 100 |
| Doctor office visits: | |
| >20 | 1 |
| 20 | 78 |
| 1 to 19 | 9 |
| None | 11 |
| Total | 100 |
| X-rays and lab tests: | |
| >20 | 1 |
| 20 | 47 |
| 1 to 19 | 8 |
| None | 44 |
| Total | 100 |

Source: Hay/Huggins Benefits Report, 1987.

Under plans that pay on a usual, customary and reasonable (UCR) basis for services, if providers do not have to agree to accept such payment as payment in full, patients could be liable for any balance left unpaid by the insurer.

In a relatively few plans, enrollees are not required to pay a specific percentage of costs for some types of care. Instead, the plan pays for services according to a fixed payment schedule, and the enrollee may be required to pay remaining charges in excess of the allowed amount. Approximately 6 percent of plans use a fee schedule for surgical procedures, 8 percent have a schedule for inhospital doctor visits, and 2 percent do so for office visits.

### *3. Out-of-pocket caps*

In 17 percent of HHBR plans, enrollees are responsible for an unlimited amount of coinsurance payments. The remaining 83 percent of HHBR plans have "out-of-pocket caps," or explicit limits on the dollar amount of expenses enrollees pay for covered health care services. About 79 percent of plans have caps applied to an individual's expenses; 35 percent have caps applied to the combined expenses for a family.

As table 5.6 shows, caps for individuals are concentrated in the range of $500 to $4,000. (For families, caps generally range from $1,000 to $4,000.) About half the plans include the general plan deductible when figuring total out-of-pocket expenses. Surveys indicate that non-group enrollees are more than twice as likely as group enrollees to be at risk for unlimited health care expenses due to the absence of an out-of-pocket cap.[119]

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[119] Pamela Farley Short, Senior Economist at the National Center for Health Services Research, estimated that in 1984, approximately 90 percent of private nongroup enrollees (13 million persons) and 35 percent of group enrollees (47 million persons) were at risk for such unlimited expenses. Though a greater percentage of plans have incorporated out-of-pocket caps since 1984, there is little reason to expect that the difference between nongroup and group plans has changed much since 1984. See Farley, Pamela. Who Are the Underinsured? Milbank Memorial Fund Quarterly/Halth and Society, v. 63, no. 3, 1985. p. 476-503.

TABLE 5.6.—Out-Of-Pocket Limit for Individuals in Employer-Provided HHBR Plans

| Maximum amount: | Percent of plans |
|---|---|
| <=$ 500 | 23 |
| $501–999 | 12 |
| $1,000 | 24 |
| $1001–2000 | 19 |
| $2001–3999 | 3 |
| >= $4000 | 2 |
| Total with individual limit | 83 |
| No provision | 17 |
| Total | 100 |

Source: Hay/Huggins Benefits Report, 1987.

### 4. *Lifetime maximum payment provisions*

Nearly one-quarter of plans offered to group enrollees have no annual or lifetime maximum payment provision, leaving open-ended the payments that could be made by the insurer for covered services.

Of the plans that do have a lifetime maximum provision, 75 percent cap payments at $1,000,000 or greater. Almost all of remaining plans establish maximum levels between $250,000 and $1,000,000, beyond which the enrollee is responsible for 100 percent of expenses. Three percent have a maximum payment level below $250,000. (See table 5.7.)

A low plan maximum ($250,000 or below) is still sufficiently high that an expensive illness will usually not reach the maximum amount of expenses paid for the majority of persons. However, a low maximum may present a problem for some insured, particularly for persons who experience hospital stays of a year or more or for persons with long-term illnesses using expensive treatments.[120] In addition, approximately 1 percent of plans have a maximum amount per illness and another 1 percent set maximum amounts per year.

TABLE 5.7.—Limit on Lifetime Benefits Paid by HHBR Plans

| Lifetime plan maximum: | Percent of plans with maximum |
|---|---|
| < $250,000 | 3 |
| $250,000 | 11 |
| $250,001 to 750,000 | 16 |
| $1,000,000 and over | 44 |
| No maximum | 26 |
| Total | 100 |

Source: Hay/Huggins Benefits Report, 1987.

Very expensive illnesses (such as certain cancers or serious automobile accidents) could require high out-of-pocket expenses for a plan enrollee if the plan has no out-of-pocket cap or has a low plan maximum. The next section illustrates the level of out-of-pocket expenses that would be paid by enrollees who are admitted to a hospital under three hypothetical situations.

[120] See, for example, U.S. Office of Technology Assessment. Technology-Dependent Children: Hospital v. Home Care. A Technical Memorandum. Wash., D.C., May 1987. p. 53.

## III. Extent of Risk for Out-of-Pocket Expenses: Illustrations

Enrollees in the HHBR health insurance plans are at risk for out-of-pocket expenses because all plans require payment of coinsurance and deductibles, exclude some types of care, and/or base payments on a usual, customary, and reasonable schedule that leave enrollees responsible for bills in excess of allowable charges. The extent of out-of-pocket costs is a function of a health insurance plan's provisions and the extent and cost of the medical care services used by an enrollee and/or family. This section illustrates three hypothetical illnesses or conditions, each resulting in a mix of hospital, surgical, physician and other expenses. The section estimates the percent of HHBR plans under each hypothetical illness that would leave enrollees at risk for different levels of out-of-pocket expenses.[121] The thresholds used for the illustrations are dollar amounts.[122]

In general, the typical individual enrollee plan as described in chapter 2, "A Primer on Health Insurance" (page 59), is less generous than the typical plan provided by medium and large size firms. Similarly, according to the SBA study, small firms typically offer less generous plans to their enrollees. Thus, it can be assumed that the data presented below represent relatively low estimates of the percent of plans that expose enrollees to high or unlimited out-of-pocket expenses.

*Case 1.*—Consider a hypothetical mix of bills in one year for a relatively healthy individual. Assume that the individual has an annual checkup ($75) and additional visits to the doctor for treatment of a case of bronchitis ($75), for which several chest x-rays are taken ($50). The bronchitis worsens and the enrollee contracts pneumonia. The illness requires a 5-day hospital stay totaling $3,200, and other services such as tests and x-rays costing $200. The total bill for this individual is $3,600.

As table 5.8 indicates, approximately 36 percent of HHBR plans would require enrollee out-of-pocket payments greater than $600. The extent of the out-of-pocket expenses for this case is driven mainly by the deductible and coinsurance features of the insurance plans. Under most plans, these expenses are not large enough to exceed the out-of-pocket cap. Even a plan that had a $200 deductible and required 20 percent enrollee coinsurance payments would not trigger a $1,000 out-of-pocket cap in this example. No enrollee covered under an HHBR plan would be at risk for more than $1,050 (29 percent of the total bill) for this type of illness.

Table 5.8.—Level of Out-of-Pocket Expenditures Under HHBR Plans, 1987

*Case 1.—Pneumonia, total cost $3,600*

| Out-of-pocket expenditures: | *Percent of plans* |
|---|---|
| $80 to 150 | 28 |
| 151 to 350 | 25 |

[121] The estimated percent of plans leaving enrollees at risk for a specified amount of out-of-pocket expenses and the percent of employees at risk for those expenses can be assumed to be similar. See footnote 118 for explanation.

[122] These dollar thresholds serve for illustrative purposes only and should not be interpreted as standards for determining a "catastrophic" level of medical expenses. Though preferable, income-related thresholds are not used here because income data are not available on enrollees covered by HHBR plans.

| | |
|---|---|
| 351 to 600 | 11 |
| 601 to 875 | 22 |
| 876 to 1,050 | 14 |
| Total | 100 |

Note.—Out-of-pocket expenditures include deductibles, coinsurance payments and services not covered by the plans, but do not include premiums.

Source: Hay/Huggins special analysis for CRS based on data from the Hay/Huggins 1987 survey of medium and large firms (from which the Hay/Huggins Benefits Report 1987 is drawn).

*Case 2.*—Case 2 is a serious car accident involving three members of a family.[123] The three are taken to the emergency room by ambulance for initial treatment. The head of the family is given several x-rays and found to have a mild case of whiplash, for which several additional doctor visits are needed. One dependent is found to have multiple rib and hip fractures, needs an operation to stop internal bleeding, and spends 6 days in the hospital. Rehabilitation visits are required over the next 6 months. The other dependent has several x-rays in the emergency room and needs reconstructive jaw surgery and orthodontia work. The total family cost for this accident is $7,700. (This amount does not include any routine health care obtained by any of the family members that year.)

Table 5.9 indicates that approximately 36 percent of HHBR plans under this scenario would leave enrollees with out-of-pocket expenses of $1,000 or more. The extent of out-of-pocket expenses is driven mainly by the deductible but also by the coinsurance provisions. Enrollees who pay 20 percent for coinsurance on hospital as well as physician and outpatient care would have out-of-pocket expenses as high as $1,500 from coinsurance payments alone. In about two-thirds of the plans, enrollee payments are not extensive enough to exceed the out-of-pocket limits. Under this hypothetical example, all HHBR enrollees would have to pay at least $250, but none would be subject to more than $1,900 (25 percent of the total bill) out-of-pocket expenditures.

TABLE 5.9.—Level of Out-of-Pocket Expenditures Under HHBR Plans, 1987

*Case 2.—Family auto accident, total cost $7,700*

| Out-of-pocket expenditures: | *Percent of plans* |
|---|---|
| $250 to 349 | 26 |
| 350 to 499 | 27 |
| 500 to 999 | 11 |
| 1,000 to 1,249 | 15 |
| 1,250 to 1,900 | 21 |
| Total | 100 |

Note.—Out-of-pocket expenditures include deductibles, coinsurance payments and services not covered by the plans, but do not include premiums.

Source: Hay/Huggins special analysis for CRS based on data from the Hay/Huggins in 1987 survey of medium and large firms (from which the Hay/Huggins Benefits Report 1987 is drawn).

*Case 3.*—Finally, consider a 7-month pregnant woman who is taken by ambulance to the hospital, where she delivers a low-weight baby by a caesarean section. The mother remains in the

[123] This analysis assumes that the family head and two dependents are covered under the family head's insurance policy. Although coverage for health care expenses resulting from an automobile accident can in some cases be obtained as a provision of automobile insurance coverage, this example assumes the family has no medical coverage from their automobile insurance plan; nor was another driver's policy liable for the family's medical costs.

hospital 4 days; the infant remains in a neonatal intensive care unit for 45 days. Over the next 2 months, the infant has three outpatient hospital visits and monthly physician office visits for the following four months. The total cost of care for the mother and child for the first six months of the child's life is $54,000.

As table 5.10 indicates, 36 percent of HHBR plans leave enrollees at risk for expenses of $1,000 or greater. Out-of-pocket expenses would total between $2,000 and $5,000 for 6 percent of plans and over $5,000 for enrollees in 8 percent of plans. However, no HHBR plan would require enrollees at risk for more than $11,500 (21 percent of the total bill) under this illustration.

TABLE 5.10.—Level of Out-of-Pocket Expenditures Under HHBR Plans, 1987

*Case 3.—Delivery and Neonatal Intensive Care, total cost $54,000*

| Out-of-pocket expenditures: | *Percent of plans* |
|---|---|
| $100 to 199 | 33 |
| 200 to 499 | 20 |
| 500 to 999 | 11 |
| 1,000 to 1,999 | 22 |
| 2,000 to 4,999 | 6 |
| 5,000 to 11,500 | 8 |
| Total | 100 |

Note.—Out-of-pocket expenditures include deductibles, coinsurance payments and services not covered by the plans, but do not include premiums.

Source: Hay/Huggins special analysis for CRS based on data from the Hay/Huggins 1987 survey of medium and large firms (from which the Hay/Huggins Benefits Report 1987 is drawn).

Thus, although most plans provided by employers of medium and large firms limit the extent to which enrollees are at risk for high out-of-pocket expenditures, about 15 percent of these plans would require enrollees to pay between 5 and 20 percent of the cost of a very expensive condition or illness. Persons with relatively low family incomes who are enrolled in these plans and in less generous individual (non-group) plans may not have the means to pay such out-of-pocket expenses and in this sense can be considered "underinsured."

# CHAPTER 6.—THE UNINSURED'S ACCESS TO HEALTH CARE

In the United States, people without health insurance receive fewer health care services than do comparable persons covered by health insurance. Health care utilization and access surveys have consistently revealed differences in the amount and type of health care services used by the uninsured as compared to the insured. Some uninsured people receive fewer services because they have limited resources to pay for care; others may need less care. Furthermore, the uninsured are more likely than the insured to delay seeking care and to be denied health care because they do not have a guaranteed source of payment for health care services. This chapter examines the extent to which health insurance status influences access to health care, compares the use of health care services by the uninsured and the insured, and describes the issues hospitals face in financing care for the uninsured.[124]

## I. THE UNINSURED AND ACCESS TO CARE

The amount of services used by the uninsured is determined not only by their need and ability to pay for services but also by providers' willingness to furnish care. Lack of insurance coupled with low incomes may cause individuals to delay care or to avoid seeking care altogether and may provide physicians and hospitals with incentives to avoid furnishing care to the uninsured. The following section summarizes the limited evidence regarding the effects of insurance status on access to health care services. As discussed below, it is difficult to distinguish the effects of insurance status from the effects of other factors such as income, age and health status.

### A. SOME UNINSURED DO NOT RECEIVE CARE

An important barrier to health care for uninsured individuals is the lack of ability to pay for services. According to the 1986 National Access Survey by the Robert Wood Johnson Foundation, close to 14 million persons reported that they did not seek health care because they could not afford it.[125]

Findings from controlled experiments conducted in the 1970s by the Rand Corporation suggest that people who are required to pay part of the cost of health care (the uninsured may be liable for the total charges) are less likely to receive care for a particular condi-

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[124] This chapter addresses only financial access to health care through insurance. It does not deal with how the supply and distribution of health care providers' resources affect the uninsured's access to health care. The effect of provider supply and geographic distribution on the access to health care is discussed in May, Joel. Utilization of Health Services and the Availability of Resources. Chapter 8. Equity in Health Services: Empirical Analyses in Social Policy. Cambridge, Ballinger Publishing Company, 1975. pp. 131-150.

[125] Robert Wood Johnson, National Access Survey, 1986.

tion than persons with the same condition who are not required to pay part of the cost.[126]

B. SOME UNINSURED RECEIVE DELAYED CARE

A recent study on prenatal care by the General Accounting Office (GAO) suggests that the uninsured (and those insured through Medicaid) delay care. The study concluded that uninsured women and Medicaid recipients began care later in their pregnancies and saw a health care provider less frequently than privately insured women. Women beginning care in the third trimester or having four or fewer visits for pregnancy cited lack of money as the main barrier to earlier and more frequent care. (Although those eligible for Medicaid are considered to have health insurance, relatively lower payment levels by the States under this program may lead some providers to deny care to Medicaid patients.) [127]

Other studies support the theory that the uninsured delay care until they acquire the means to pay for such care (i.e., obtain insurance). Data from the 1977 National Medical Care Expenditures Survey on doctor visits for persons who were uninsured for part of the year indicate that such persons, when insured, use more services than persons who have coverage throughout the year.[128]

C. SOME UNINSURED RECEIVE DIFFERENT TYPES OF CARE

Finally some evidence suggests that the uninsured and insured receive different types of care for similar conditions. A recent study concludes that insurance status is a significant factor in determining whether a cancer patient receives surgery, is given a different anticancer treatment (such as chemotherapy without surgery), or receives no treatment at all. Based on the treatment records of nearly 1,400 lung cancer patients diagnosed for the disease between 1973 and 1976 in New Hampshire and Vermont, the study found that over 20 percent of patients with private insurance had surgery while only 13 percent of patients with public or no insurance did so. Among the patients who did not have surgery, over 75 percent of the privately insured received radiation, chemotherapy or both treatments while only 60 percent of cancer patients with public or no insurance received treatment. The study concluded that socioeconomic features such as insurance status and marital status, as well as medical factors, determine treatment. However, the study was ambiguous with regard to whether the patients elected less aggressive treatments, providers prescribed less aggressive (and less costly) treatment for those without insurance, or providers pre-

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[126] Though the Rand study was specifically designed to measure the effect of changes in cost-sharing on demand for health care services, the results are relevant to a discussion of the uninsured's demand for care since a lack of insurance constitutes cost-sharing in its most extreme form. See Lohr, et al., Chapter 8—Executive Summary: Results, Conclusions and Discussion, Medical Care, Sept. 1986, v. 24, no. 9, supplement.

[127] U.S. General Accounting Office. House. Committee on Government Operations. Report to the Chairman, Subcommittee on Human Resources and Intergovernmental Relations. Prenatal Care: Medicaid Recipients and Uninsured Women Obtain Insufficient Care. #HRD-87-137, Sept. 1987. Washington, 1987.

[128] The result of these behavioral patterns is sometimes referred to as pent-up demand. See Wilensky, Gail, Daniel Walden and Judith Kasper. The Uninsured and Their Use of Health Services. Paper Presented at the Annual Meeting of the American Statistical Association, Aug. 1981.

scribed more aggressive treatments for those patients who were insured and therefore could guarantee payment.[129]

## II. Health Insurance and the Use of Health Services

Data from the Health Interview Survey (HIS) for 1986 confirm that the health care behavior of the uninsured differs from that of the insured population in several ways.[130] The uninsured use fewer health care services than the insured population and obtain care from different sources. As discussed below, these differences may not be due only to health insurance status. Rather, many factors interact with health insurance status to affect utilization, including income, age, and health status.

### A. AMOUNT AND TYPE OF HEALTH SERVICES USED

Surveys of the health utilization rates of the uninsured consistently show that the population without health insurance uses fewer physician and hospital services than the insured population. The National Medical Expenditure Survey of 1977 (NMCES) and the National Medical Care Utilization and Expenditure Survey of 1980 (NMCUES) both indicate that the insured population has a higher average number of doctor visits and hospital stays per year than the uninsured. The 1986 National Access Survey conducted by the Robert Wood Johnson Foundation reports similar findings. Data from that survey also indicate that, compared to the insured, the uninsured are twice as likely to be without a regular source of care and have a slightly higher rate of medical emergencies than the insured.

Additional evidence is contained in the 1986 HIS. The National Center for Health Statistics conducts the HIS annually and in 1986 interviewed approximately 60,000 people in a nationwide sample of 24,000 households on doctor visits, hospitalization, and medical conditions. The 1986 survey included a special health insurance supplement that provides detailed information on insurance status and type of coverage. The following sections draw primarily from the 1986 HIS data; these data, in general, are consistent with findings from earlier studies.[131]

#### *1. Physician Contacts*

On average, the uninsured contacted a physician only two-thirds as frequently as the insured (3.32 contacts compared to 5.17 contacts) in 1986. (Contacts include telephone calls to physicians and house calls as well as visits to the doctor's office, a company-based clinic, a hospital emergency room, or a hospital outpatient facility.)

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[129] Interestingly, researchers also found that despite the fact that privately insured patients were more aggressively treated, they did not survive any longer than the uninsured after diagnosis. Greenberg, E.R., C.G. Chute, T. Stukel, J.A. Baron, D.H. Freeman, J. Yates, and R. Korson. Social and Economic Factors in the Choice of Lung Cancer Treatment: A Population Based Study in Two Rural States. The New England Journal of Medicine, Mar. 10, 1988. p. 612-617.

[130] See appendix C for a description of the Health Interview Survey, its uses and limitations, and support tables for the charts presented in this chapter.

[131] The discussion in this section is based on estimates of utilization and health status for the population under age 65.

*(a) Factors affecting average number of physician contacts.*[132] *(1) Income:* As would be expected, a lack of insurance has the greatest effect on persons with lowest incomes.[133] Chart 6.1 shows the average number of physician contacts during 1986 for individuals by family income and health insurance status; patterns are consistent with past findings.

The uninsured consistently reported fewer contacts per person with physicians than the insured; however, the difference in contact rates per person between the insured and uninsured tends to decrease as family income increases. Low-income persons without insurance reported only about half as many physician contacts during 1986 as did the low-income insured (3.47 contacts for the uninsured compared to 6.57 for the insured). In contrast, uninsured persons with family incomes of $50,000 or more reported 85 percent as many contacts as their insured counterparts.

*(2) Age.*—As shown in chart 6.2, the average number of reported physician contacts during 1986 generally increases with age for both insured and uninsured persons. For example, uninsured 25–45 year-olds reported on average 3.38 physician contacts annually, while uninsured 46–64 year-olds averaged 4.95 visits. Similarly, insured 25–45 year-olds reported 4.95 contacts annually, while 46–64 year-olds reported 6.72 contacts.

The uninsured 18–24 year-olds appear to be an exception to the trend that shows utilization rising with age. Instead, this group reported fewer physician contacts than any other age group. As a result, 18–24 year-olds show the widest gap in utilization between the insured and the uninsured. Uninsured 18–24 year-olds reported using only 57 percent as many physician services as their insured counterparts.[134]

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[132] The complex interaction between health status and the use of health care services is not easily untangled. The use of health care services is often used as a proxy for health status. However, many other sociological, cultural and economic factors interplay with health status to influence the actual amount of health care services used by any individual. Additionally, researchers have tried to identify a causal relationship between the use of services and a person's status. To some extent the use of preventive health care services may actually improve health status; however, researchers do not agree whether health status is improved, unchanged or adversely affected by the use of curative and custodial health care services. For a discussion of this point see, Pope, Gregory. Medical Conditions, Health Status, and Health Services Utilization. Health Services Research, v. 22, no. 6, Feb. 1988. p. 854-877. This report does not attempt to untangle the relationship between use of health services and health status. A later section does, however, examine the relationship between health insurance status and health status using the 1986 Health Interview Survey data. See p. 148 of this chapter.

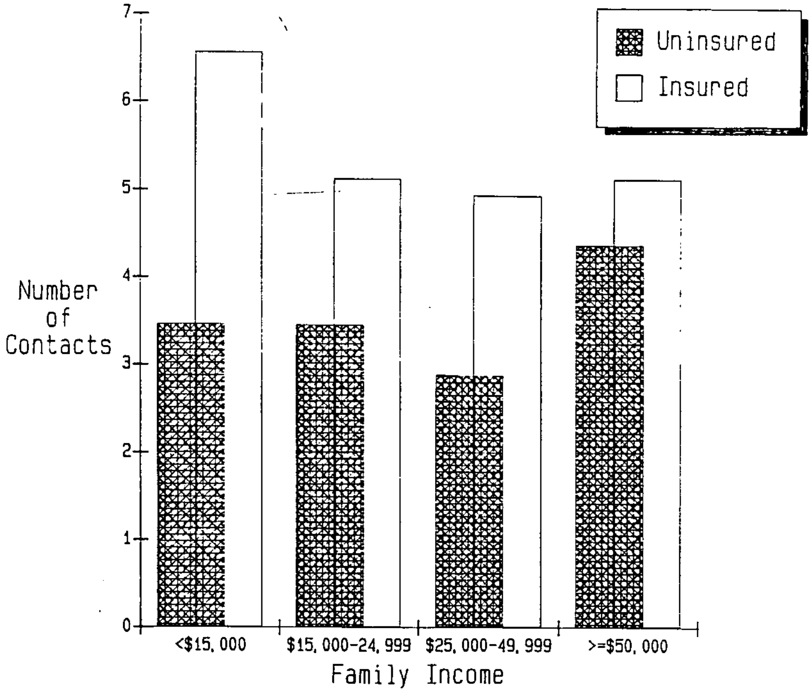
[133] Karen Davis and Diane Rowland find that, after correcting for health status, ability to pay is the most important factor affecting the use of health care services. They also identify location (region and urban/rural residency) and race as barriers to physician care. See Davis, Karen, and Diane Rowland. Uninsured and Underserved: Inequities in Health Care in the United States. Milbank Memorial Fund Quarterly, v. 61, no. 2, 1983. p. 149-15.

[134] Care should be exercised in interpreting some of the HIS data presented here. It is often difficult to accurately characterize the health care utilization and insurance status of this particular age group because many of these young adults are in college. Many college students may have access to health care through their school, though this coverage may not be particularly comprehensive. There is no way to determine how students with such coverage are reporting their health insurance status.

It is important to note that 18-24 year-olds make up over 21 percent of the uninsured population but only 11 percent of the insured population.[135]

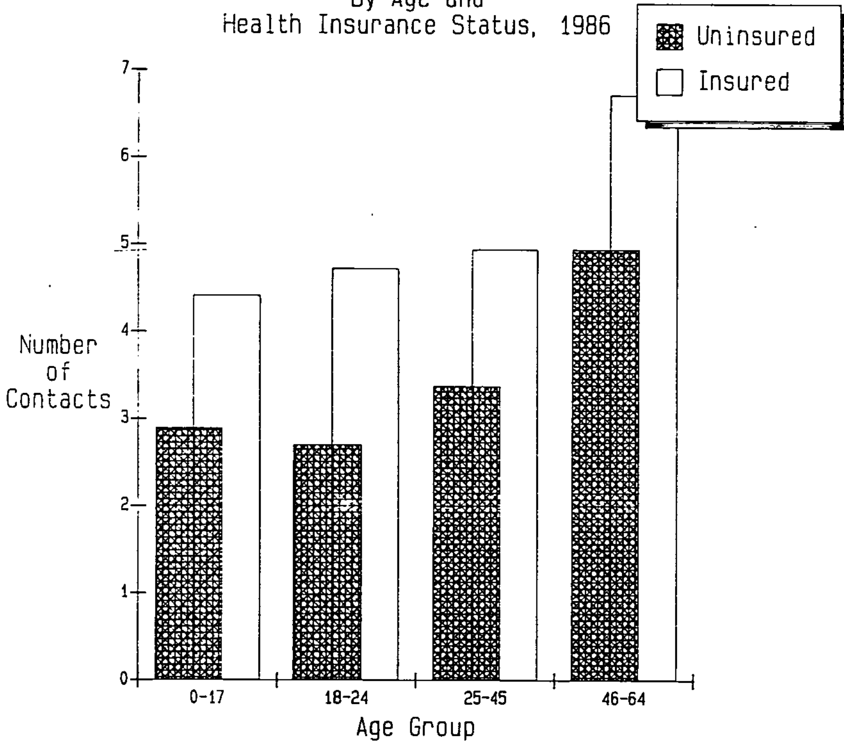
The wide utilization gap for this age group disproportionately affects the overall average rates of the insured and uninsured populations; if 18-24 year-olds are omitted, the reported contacts for the uninsured increase slightly from .64 to .67 of the reported rate of the insured.

[135] These figures from the 1986 HIS are consistent with the 1987 CPS data used in chapter 4, The Insured and the Uninsured: Numbers and Characteristics.




Source: CRS analysis of 1986 HIS public use tapes.

Chart 6.2
Average Physician Contacts
By Age and
Health Insurance Status, 1986




Source: CRS analysis of 1986 HIS public use tapes.

*(b) Place of contact.*—When physician contacts are examined by place of contact, the uninsured reported fewer physician contacts in a physician's office and reported somewhat higher use of hospital emergency rooms.[136] Table 6.1 presents the average number of contacts during 1986 reported by the insured and uninsured by place of visit and also presents the frequency of contact for each category as a percent of total contacts. The table indicates that, compared to the insured, persons without insurance reported that a greater percentage of their contacts with physicians took place in emergency rooms and hospital outpatient departments. Additionally, the uninsured reported less than half as many inpatient doctor visits as the insured.

Though additional research is necessary to identify reasons for a higher percentage of emergency room and hospital outpatient visits by the uninsured, this pattern is consistent with the conclusion reached by the Robert Wood Johnson Foundation in its 1986 National Access Survey. That is, the uninsured may be more likely to use emergency room services for routine care. The National Access Survey reports that the uninsured are twice as likely as the insured to be without a regular source of care. Other surveys reach similar conclusions, reporting that the uninsured use emergency room and outpatient services more than the insured.[137]

TABLE 6.1.—Average Number of Reported Physician Contacts Per Person and Percent of Contacts by Place of Contact and Health Insurance Status, 1986

| | Uninsured | | Insured | | Ratio uninsured/insured (number of contacts) |
|---|---|---|---|---|---|
| | Number of contacts | Percent | Number of contacts | Percent | |
| Total physician contacts | 3.32 | 100.0 | 5.17 | 100.0 | 0.64 |
| By place of contact: | | | | | |
| Doctor's office | 1.68 | 50.6 | 2.91 | 56.3 | .58 |
| Hospital: | | | | | |
| Emergency room | .23 | 6.9 | .21 | 4.1 | 1.10 |
| Outpatient | .33 | 9.9 | .44 | 8.5 | .75 |
| Inpatient | .07 | 2.1 | .15 | 2.9 | .47 |
| Phone calls | .40 | 12.0 | .66 | 12.8 | .61 |
| Company clinic | .06 | 1.8 | .06 | 1.2 | 1.00 |
| House calls | [1].05 | 1.5 | .06 | 1.2 | .83 |
| Other | .50 | 15.0 | .68 | 13.2 | .74 |

[1] Care should be exercised in interpreting some of the HIS data presented in this table. Like any sample, eventually cell sizes become too small to make reliable estimates. Some items, like house calls to the uninsured, are fairly rare events. The estimate above is that there are .05 house calls per year to the uninsured, or one in twenty uninsured individuals received a house call during the year. The sampling error for this item is such that there is a 95 percent confidence level that the estimate is between .01 and .09. In other words, there is 95 percent certainty that the actual number should be no lower than one house call per 100 uninsured individuals, and no higher than one house call per 11 uninsured individuals.

Source: Congressional Research Service analysis of 1986 Health Interview Survey public use tapes.

[136] Respondents were asked to report the number of physician contacts in the past 2 weeks and the place of visit. These days were then weighted to represent the average number of contacts in a year. Averages include persons reporting no contacts and therefore in some cases appear as fractions less than one.

[137] Both hypotheses are consistent with findings from a 1982 Louis Harris Associates survey of 6,000 individuals which indicates that 18 percent of the uninsured (compared to 16 percent of the insured) reported using emergency rooms as a regular source of care. See Aday, LuAnn, and Ronald M. Anderson. The National Profile of Access to Medical Care: Where Do We Stand? American Journal of Public Health, v. 74, no. 12, 1984. p. 1331-1339.

*2. Hospital Days*

*(a) Number of days.*—Just as the uninsured reported fewer physician visits than the insured in 1986, and they also reported spending fewer days in the hospital. Overall, the uninsured reported on average three-fourths as many hospital days—.42 per person per year versus .55 days for the insured.[138]

*(b) Factors affecting average number of hospital days.*—*(1) Income:* For both the insured and uninsured, reported hospital days were generally fewer for those with higher family incomes than for those with lower income levels. However, the difference between the insured's and uninsured's reported use of hospital services tends to increase with income. The low-income uninsured reported 62 percent as many days in the hospital as the low-income insured during 1986. Although people in families with incomes greater than $50,000 reported fewer inpatient days than those at lower income levels, the difference between the insured and uninsured in this income group was greater than for any other group; the uninsured in this case reported one-third as many hospital days as the insured.[139]

Chart 6.3 shows the effects of the interaction of two trends. For a variety of reasons, the poor (whether insured or not) report more days of hospital care than do persons with higher incomes. In addition, at all income levels use of hospital care is lower by those without health insurance than by those with health insurance. Thus, the comparatively high rates of hospital days reported by poor uninsured persons seems to be related not only to their lower income levels but also to their lack of insurance coverage.

*(2) Age.*—A second significant factor affecting use of hospital services is age. For most age groups, average hospital days increase with age regardless of insurance status. (See chart 6.4.)

An important exception to this trend are uninsured children under age 18; this group reported on average slightly more days in the hospital than did uninsured 18–24 years-olds and nearly one-and-one-half times as many days as insured children under age 18.

Research findings to date do not fully explain the phenomenon of uninsured children spending more days in the hospital than insured children. The data in chart 6.4 show a consistent trend with previous studies, and a reasonable explanation would be that uninsured children face comparatively greater barriers to access to physician care outside the hospital setting. (As discussed above, uninsured children report only two-thirds as many physician contacts as insured children.) It is also possible that the uninsured under

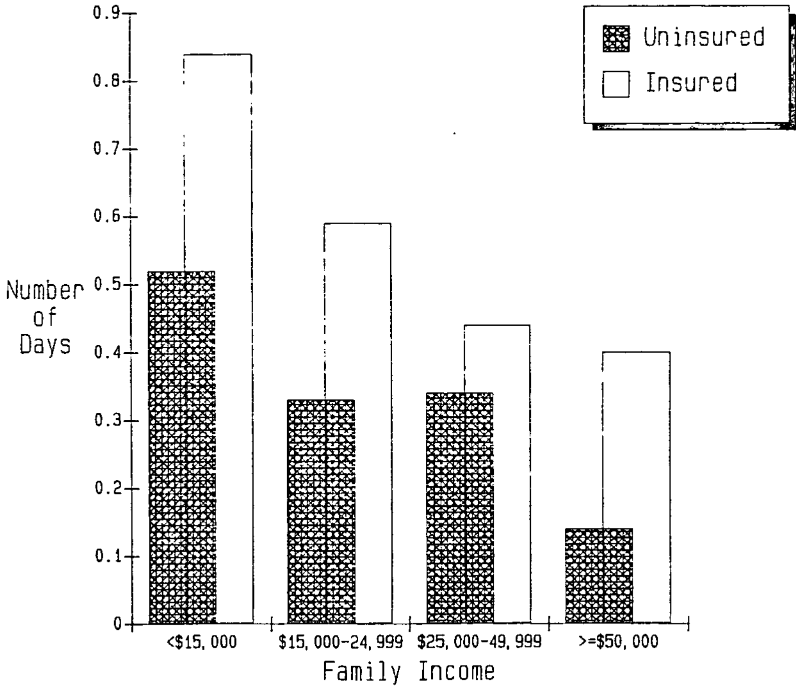
[138] Survey respondents were asked how many days they spent in the hospital over the past year. Calculations of the average number of hospital days for the insured and uninsured include persons reporting no days in the hospital and therefore appear as fractions less than one.

[139] Some caution should be exercised in interpreting these results. The variation around the estimate for the uninsured with family incomes over $50,000 is fairly large. Though the estimate for this group is .14 hospital visits per year, there is 95 percent certainty that hospital visits were no higher than .39 per year. Although this is still lower than insured persons with high family incomes, it is not clear that this income group is much different from uninsured persons in the next income category ($25,000–$49,999).

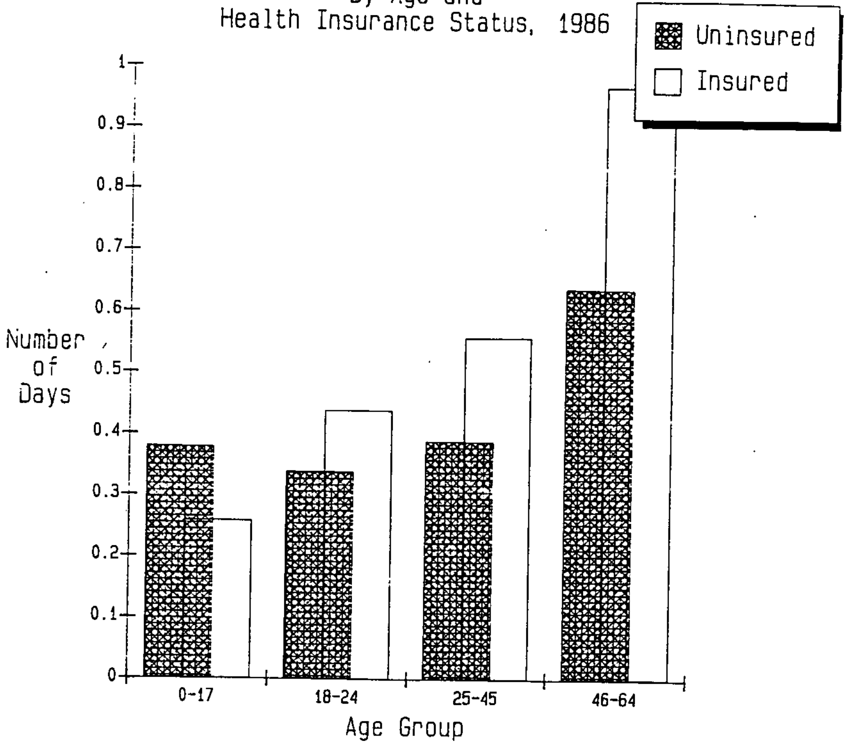
age 18 are more likely to delay seeking care until conditions are more severe. Moreover, because uninsured children are in the aggregate poorer than both older uninsured persons and their insured counterparts, and income levels are closely related to health status, higher hospitalization may be related to both the income and health status factors as well.[140]

[140] This finding is consistent with findings from the Rand Corporation that cost sharing decreases poor children's utilization of physician services while increasing their use of hospital services. See Helms, Jay, Joseph Newhouse and Charles Phelps. Copayments and Demand for Medical Care: The California Medicaid Experience. Rand Corporation, 1978.

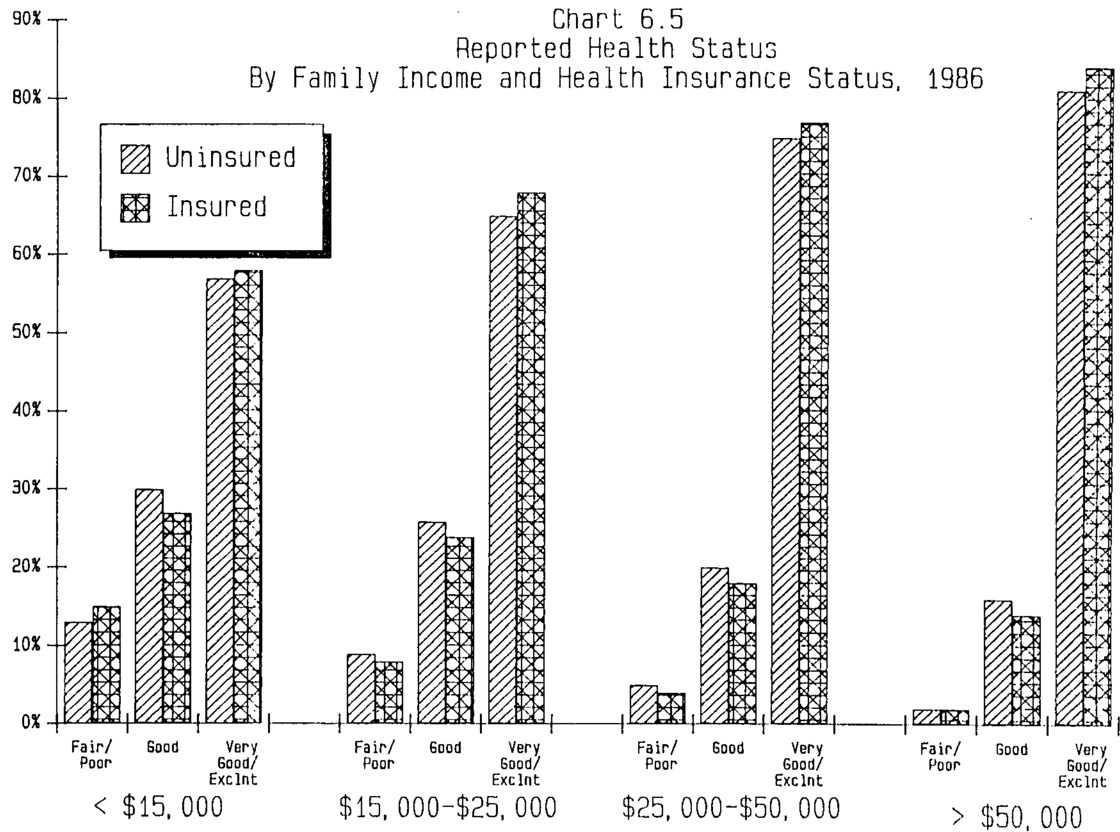
Chart 6.3
Average Hospital Days
By Family Income and
Health Insurance Status, 1986




Source; CRS analysis of 1986 HIS public use tapes.




Source: CRS analysis of 1986 HIS public use tapes.




Source: CRS analysis of 1986 HIS public use tapes.

### B. HEALTH INSURANCE AND HEALTH STATUS

Survey results indicate that the self-reported health status of the uninsured is poorer than average. However, when analysis takes income into account, the differences in health status between the insured and uninsured decrease substantially. In general, lower income people report poorer health status than higher income groups, whether they are insured or not, and a disproportionate share of the uninsured have low income.

The 1986 HIS survey provides information on self-reported health status. As seen in chart 6.5, for families with income below $15,000, 13 percent of uninsured people report having poor or fair health status compared to 15 percent of the insured. Across income groups, there is at most a difference of three percentage points between the insured and uninsured in their reporting of health status.

The chart indicates that the relationship between health insurance status and health status may actually be related to income. Low-income persons (in families earning less than $15,000/year) are more likely than any other income group to report poor or fair health status (and least likely to report very good/excellent health status), whether they have health insurance or not.[141]

## III. Financing Health Care for the Uninsured

The uninsured use fewer services than the insured, but nevertheless they receive substantial hospital and physician care that must be paid for by someone. Public hospitals and clinics generally budget a certain amount of free or subsidized care to pay for services provided to persons who are unable to pay. These funds may be partly or fully subsidized by State or local governments through government appropriations. Hospitals that received Federal funds from the Hill-Burton Program must provide specified levels of charity care for 20 years, and they are forbidden to deny emergency room services for economic reasons to any person who resides or works in the facility's service area.[142] Teaching hospitals often provide care for the uninsured for instructional as well as benevolent reasons. Finally, providers may treat some uninsured patients with the expectation of payment; however, when the patient is unable to pay for the care, the provider must absorb the costs of that care.

Patients without insurance do not have a guaranteed source of payment for health care services, and providers' incentives award priority attention to insured patients. However, existing sources of information regarding access barriers for the uninsured are limited, and most of the data are restricted to the uninsured's use of hospital services.[143]

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[141] This analysis suggests that cross tabulations intended to isolate the relationship between health insurance status and health utilization rates should control for income rather than, or in addition to, health status.

[142] "Charity care" in this case can be distinguished from "bad debt" in that it is provided without the expectation of eventual payment. In practice, however, hospitals do not uniformly distinguish between these types of care.

[143] No consensus has been reached regarding the extent of uncompensated physician care. Some estimate that about 10 percent of private physician services are provided without charge or reimbursement by a third party. One researcher found that, in 1982, physicians rendered $2.9

Continued

The sections below review the extent and nature of uncompensated hospital care. In addition, attention is given to the question of whether the changing financial conditions of hospitals are encouraging them to reduce their provision of uncompensated care.

### A. THE UNINSURED AND UNCOMPENSATED CARE

In recent years the number of people without health insurance increased, thereby expanding the potential volume of hospital uncompensated care. At the same time, hospitals faced pressures to cut costs for insured patients, making more difficult the absorption of costs for patients unable to pay.

Uncompensated care is a hospital accounting term used to describe care given to patients unable (or unwilling) to pay. In general, the term refers to the value of services rendered for which the hospital does not receive payment or receives only partial payment. Uncompensated care can include the cost of services for which no payment is expected (charity care) and for which payment is expected but not received (bad debt). Bad debts consist of charges not paid for by uninsured individuals and partial charges left unpaid by insured patients who decline to pay the out-of-pocket portion of their bills that arise from deductibles, coinsurance, expenses above a maximum plan payment, and services not covered by the plan.

An alternative measure of uncompensated care is "unsponsored care"—that is, charity care plus bad debt, less any State and local government tax appropriation received by the hospital. Unsponsored care can be expressed in dollars or as a percentage of costs. The result is the amount that the hospital has to either absorb or pass on to private-pay patients. Estimates by the American Hospital Association (AHA) for 1986 indicate that unsponsored care reached 5 percent of hospital expenses, or $6.96 billion.[144]

Though not the same, the issues of uncompensated care and care for the uninsured are closely related. According to a study conducted at the University of Florida on hospital care for the poor, patients classified as "self-pay" or "no-charge" accounted for approximately 70 percent of Florida hospitals' unpaid charges in 1985.[145] One analyst estimated, based on a national survey of hospitals, that 68 percent of hospitals' bad debts in 1982 were due to uninsured patients.[146]

### B. INCREASES IN UNCOMPENSATED CARE

Cost data from the AHA's annual surveys of community hospitals (including private, not-for-profit, investor-owned and State and

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billion in free or reduced care for the unemployed and those who lost Medicaid coverage. See, Lewin, Marion Ein. Uncompensated Care Overview. Chapter 4, A Primer on Uncompensated Care. Department of Health and Human Services, p. 36, and Bizolli, Gloria. Health Care for the Indigent. Overview of Critical Issues. Health Services Research, v. 21, no. 3, Aug. 1986. p. 379.

[144] Throughout this section, estimates for uncompensated and unsponsored care costs come from the American Hospital Association. See Cost and Compassion: Recommendations for Avoiding a Crisis in Care for the Medically Indigent. Chicago, American Hospital Association, 1986. This information was updated using the testimony of Jack Owen, Executive Vice President of the American Hospital Association, at a hearing before the Subcommittee on Health of the Committee on Ways and Means. Uncompensated Hospital Care: In Memoriam: William Trumball, Mar. 12, 1987. Data for 1986 were provided by the AHA, personal communication, Apr. 1988.

[145] Center for Health Policy Research. State University of Florida Study of Indigent Care. Analytic Report, v. 2, 1986. p. 2.71.

[146] Bizolli, p. 379.

local government hospitals) indicate that the amount of unsponsored care provided by hospitals has been increasing. In 1980, hospitals provided $2.8 billion in unsponsored care, representing 3.6 percent of total costs. Between 1980 and 1986 unsponsored care costs more than doubled, amounting to $6.96 billion (or 5 percent of total costs) in 1986.[147] These amounts increased at a rate approximately 40 percent faster than the rate of health care inflation during the same period.

The burden of uncompensated care has been distributed unevenly across hospital types, with public hospitals providing a larger portion of uncompensated care in relation to total patient charges. Hospitals in the South and in urban areas and teaching hospitals have had disproportionate shares of uncompensated care.[148]

### C. COST-SHIFTING

The increase in the use of negotiated rates and Federal and State government restraints in reimbursement have limited hospitals' ability to offset uncompensated care increases. Given insufficient revenues from payers and from non-patient sources, hospital administrators can attempt to economize or reduce operating margins (the difference between revenues and costs) and, in doing so, may cut into "profits." Government hospitals can seek additional public subsidies. Hospitals can try to "shift" costs to privately insured patients and patients who pay for their own care. Finally, they can try to reduce their volume of and expenditures on uncompensated care.

Hospitals may attempt to shift the expense of uncompensated care to those who pay for hospital care by including that expense in the determination of the rates that are charged to paying patients. If the patient is insured, the expense of uncompensated care is then shifted to the insurer and, ultimately, to the employer or insured who pays the insurance premium.

Controversy exists over the amount of cost-shifting that actually occurs in hospitals. The AHA estimated in 1986 that private payers were charged at least a 10-percent surcharge, or "hidden tax," on hospital services.[149] The "tax" is implicit because charges for services are set higher than costs in order to cover the direct cost of providing health care services not only to paying patients but also to patients who do not reimburse the hospital for care.

Researchers at the Urban Institute have studied the extent to which hospitals respond to increases in uncompensated care by increasing charges for privately insured patients. Results of one survey indicate that hospitals with the highest proportions of un-

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[147] Unsponsored care amounts are in current dollars. See footnote 144 for sources.

[148] A recent study by Lewin Associates on the amount of uncompensated care provided by hospitals found that non-profit hospitals frequently provide a greater share of uncompensated care than for-profit hospitals. However, these findings remain controversial since there are many intervening factors affecting the amount of uncompensated care provided by hospitals (such as the fact that for-profit hospitals tend to be located in areas where there is less demand for charity care.) For further information on the distribution of uncompensated care costs by hospital type, see Sulvetta, Margaret, and Katherine Swartz. The Uninsured and Uncompensated Care. National Health Policy Forum, June 1986. p. 25–41.

[149] This tax rate is the ratio of unsponsored care costs to the costs associated with private paying patients. See Cost and Compassion: Recommendations for Avoiding a Crisis in Care for the Medically Indigent. American Hospital Association. p. 6 and 52.

compensated care also were the most limited in their ability to shift costs to privately insured patients because these hospitals also had the highest proportions of Medicaid-funded patients and the lowest proportion of privately paying patients. (In some States, Medicaid reimbursement rates may be below actual cost.) [150]

Another study suggests that hospital rates charged to private patients did not rise systematically with increased unsponsored care needs from 1980 to 1982, nor did they rise enough to compensate for overall revenue declines.[151]

Representatives of the hospital industry have expressed concern that they will find it increasingly difficult to shift costs in an attempt to pay for larger amounts of uncompensated care. This uneasiness stems from several changes in the health care industry, particularly the increased negotiating of rates with private insurers and changes in government payment methods.

*1. Negotiated rates*

Hospitals increasingly are providing "discounted" rates, below standard charges, in order to remain price-competitive. Under these arrangements, hospitals negotiate rates with insurers in exchange for a guaranteed patient flow. Today's market has an expanded number of insurers with whom hospitals negotiate charges, including very large self-insuring employers, HMOs, and PPOs. If a hospital's volume does not increase enough to compensate for the discounted rates, these arrangements may lower total revenues.

*2. Medicare's prospective payment system (PPS)*

Hospital reimbursement under the Medicare program was changed five years ago. Under the old system, hospitals were reimbursed for "reasonable" costs incurred in providing care to Medicare patients. In 1983 Medicare initiated a new hospital payment system, the Prospective Payment System (PPS). Under this system, hospitals are paid a fixed, predetermined amount for each Medicare case. The rate is based on the average cost of services, with a few adjustments for hospital characteristics.[152] Federal law explicitly states (under both the old and new payment systems) that Medicare will pay only for the care of Medicare patients; thus, the program does not include the costs of uncompensated care for non-Medicare patients in its payment rates. Under the new system, however, average Medicare revenue margins (the excess of Medicare payments over Medicare costs) were about 14 percent in 1984 and 1985. These margins occurred in some hospitals because the PPS pays a fixed amount even if the cost of caring for patients is lower than the predetermined payment. Presumably the hospital could use these excess revenues as it sees fit, including the funding of uncompensated care. Conversely, if Medicare patients' costs exceed the total fixed payment amounts, the hospital must somehow absorb these extra costs, possibly leaving little or no excess

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[150] Hadley, Jack, et al. Care to the Poor and Hospitals' Financial Status: Results of a 1980 Survey of Hospitals in Large Cities. Working Paper no. 1444-02, May 1983.

[151] Hadley, Jack, and Judith Feder. Hospital Cost Shifting and Care for the Uninsured. Health Affairs, v. 4, no. 3. fall 1985. p. 67-80.

[152] For example, teaching hospitals and hospitals that provide a disproportionate share of indigent care receive larger payments.

revenue from which to fund uncompensated care. Policies to restrain increases in PPS payment rates have raised the concerns of some hospital administrators because, according to one official study, Medicare revenue margins fell to 2 percent in 1987 and could fall below zero in 1988.[153]

A recent analysis of influences on the propensity of hospitals to accept self-paying patients reveals no evidence that PPS has actually reduced hospitals' willingness to treat uninsured patients. Yet, the authors of the study concluded that, while some hospitals have fared relatively well under PPS, policies to reduce Medicare's payments may make it difficult for hospitals to continue providing high levels of care to the uninsured. Specifically, reduction of Medicare's payment for indirect teaching costs might affect the ability of teaching hospitals to provide such care.[154]

*3. Medicaid reimbursement*

Although research data are not conclusive, some analysts believe that the hospital payment methods used by States under the Medicaid program reimburse many hospitals at levels below cost.[155] Thus, Medicaid payments are unlikely to serve as a substantial source of subsidy for non-Medicaid patients. Conversely, to the extent that Medicaid payments fall short of hospitals' costs, hospitals in some States may believe cost-shifting is necessary to supplement the cost of care for Medicaid patients.

### D. ALTERNATIVES TO COST-SHIFTING: LIMITING ACCESS TO CARE

Rather than shift all costs for uncompensated care to privately insured patients, some hospitals have adopted a number of explicit strategies to avoid treating uninsured patients or those without the ability to pay for care. Case studies conducted in three major cities in 1984 by the Institute of Medicine Committee for Implications of For-Profit Enterprise in Health Care (hereinafter referred to as the IOM Committee study) suggest that hospitals, whether for-profit, not-for-profit or publicly owned, take steps to diminish their chances of providing care to those without means to pay for care.[156] Similarly, based on a national survey of hospitals by the American Hospital Association (hereinafter the AHA survey), Sloan concludes that hospitals may implement policies to avoid (or postpone) the financial problems associated with high levels of uncompensated care, though he qualifies the date as fragmentary and preliminary.[157]

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[153] Prospective Payment Assessment Commission, Report and Recommendations to the Secretary, U.S. Department of Health and Human Services, Mar. 1, 1988. p. 54.

[154] Sloan, Frank A., Michael Morrisey and Joseph Valvona, "Self-Pay" Patients, Journal of Health, Policy and Law, v. 13, no. 1, spring 1988, p. 83-102.

[155] This problem may be alleviated somewhat by the inclusion in the Omnibus Budget Reconciliation Act (OBRA) of 1987 (P.L. 100-203) of language strengthening the existing provision allowing States to adjust Medicaid payment rates to hospitals that serve a disproportionate share of indigent patients.

[156] See Townsend, Jessica. Hospitals and Their Communities: A Report on Three Case Studies. In Institute of Medicine. For-Profit Enterprise in Health Care. Washington, National Academy Press, 1986. p. 458-473.

[157] Sloan, Frank A., Joseph Valvona and Ross Mullner. Identifying the Issues: A Statistical Profile, in Sloan, et al., editors, Uncompensated Hospital Care: Rights and Responsibilities. Baltimore, Johns Hopkins University Press, 1986, p. 27-28.

Data from the American Medical Association Socioeconomic Monitoring System indicate that a hospital's propensity to discourage admission of uninsured patients varies with hospital ownership. Approximately 43 percent of doctors affiliated with independent for-profit hospitals, compared to 20 percent associated with private not-for-profits and 14 percent associated with public facilities, reported that the hospital discouraged admissions of uninsured patients.[158]

In general, hospitals have been alleged to use two basic strategies to limit uncompensated care. Providers can take action to minimize the services most often used by patients who receive uncompensated care. Alternatively, hospitals can implement strategies to avoid admitting patients identified as potential nonpayors.

*1. Hospital practices*

Some hospitals are reportedly changing operating procedures to avoid treating those patients who will leave them with uncompensated care costs. Based on case studies conducted in three major cities in 1984, the IOM Committee concluded that for-profit, not-for-profit and public hospitals have tended to locate in neighborhoods with insured populations; stopped providing trauma or obstetric services (since these cases produce a disproportionate share of bad debts); and, in one case, closed emergency rooms in order to shift uninsured patients to other facilities. The AHA survey also found that hospitals reduced staff and hours of operation for outpatient facilities and emergency rooms.

*2. Preventing admission of nonpaying patients*

Some hospitals are increasingly seeking to limit admission of charity cases as well as potential bad debt patients. Available research indicates that public hospitals may be adopting these practices at least as frequently as private hospitals.[159]

*(a) Limits on charity care.*—Based on AHA survey, Sloan concluded that nearly 15 percent of all hospitals adopted explicit limits on the amount of charity care provided in 1981 and 1982. Hospitals that traditionally provided disproportionate shares of charity care, such as public teaching and public rural hospitals, were most likely to establish these limits.

*(b) Identifying bad-debt patients.*—Hospitals have also adopted practices to identify potential bad-debt patients. For example, some hospitals require a preadmission deposit for patients who do not present a health insurance card. More commonly, however, some hospitals transfer patients from their emergency rooms to other hospitals solely on the basis of their inability to pay. Some providers stabilize emergency room patients and then transfer them to other hospitals, while other providers deny care altogether. This practice, known as "patient dumping," has been cast as an uninsured issue since a majority of dumped patients do not have health insurance. A 1983 study of Cook County Hospital in Chicago indi-

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[158] These data were based on physicians' perceptions of hospital behavior. See, Schlesinger, Mark, et al. The Privatization of Health Care and Physicians' Perceptions of Access to Hospital Services. Milbank Quarterly, v. 65, no. 1, 1987. p. 25–58.

[159] See Institute of Medicine, For-Profit Enterprise in Health Care, p. 97–126, and Sloan, et al., Uncompensated Hospital Care, p. 27–28.

cated that 87 percent of patients transferred from another hospital were moved to Cook County because they lacked adequate health insurance coverage.[160] Findings from other studies are consistent. In 1986, for example, a study at the Regional Medical Center at Memphis found that over 80 percent of transfer requests from other facilities were primarily because the patient had no insurance.[161]

While national data are not available, from single-hospital studies it has been estimated that 250,000 emergency room patients in the U.S. are transferred from one hospital to another each year for purely economic reasons.[162] This figure represents approximately 5 percent of all uninsured patients receiving emergency care.[163]

Patient dumping can have medical consequences. Patients who are transferred often receive delayed emergency care and are more likely to experience unnecessary medical risks. This situation has been documented in a few single-hospital studies. For example, researchers at Highland General Hospital in Oakland, California, found that 32 percent of transferred patients had been jeopardized by an unrequested move to the hospital from another facility.[164] Likewise, the Cook County study found that 24 percent of transferred patients were in unstable condition and that the treatment delay caused by the transfer process was over 5 hours on average.[165]

To the extent that patient dumping results in redistribution of the costs of care for the uninsured, the practice has financial implications for hospitals receiving such transfers, usually public and teaching hospitals. These hospitals typically provide the largest amount of care to the uninsured, and patient dumping exacerbates their uncompensated care problem. If this situation worsens, the hospitals will have to be even more cost conscious and may have to limit further the uninsured's access to care.

The Congress has taken steps to prevent hospital dumping, especially in the case of emergency patients. A provision of the Consolidated Omnibus Reconciliation Act (COBRA) of 1985 (P.L. 99-272, 1986) subjects any hospital that participates in the Medicare program to sanctions for transferring (for purely economic reasons) patients in labor or in an unstabilized condition.

States have also passed legislation to limit patient dumping. Half of the States have hospital licensing laws requiring facilities with emergency departments to provide life-saving care regardless of the patient's insurance status or ability to pay. Some States have less rigorous standards but have targeted specific groups of people, prohibiting the transfer of women in labor, for example.

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[160] Schiff, Robert, et al. Transfers to a Public Hospital: A Prospective Study of 467 Patients. New England Journal of Medicine, v. 314, Feb. 27, 1986. p. 552-557.

[161] Kellermann, Arthur, and Bela Hackman. Emergency Department Patient "Dumping" in Memphis, Tennessee: An Analysis of Interhospital Transfers to the Regional Medical Center at Memphis. July 22, 1987. Testimony submitted to the U.S. Congress. House. Committee on Government Operations. Subcommittee on Human Relations.

[162] Ansell, David, and Robert Schiff. Patient Dumping: Status, Implications and Policy Recommendations. Journal of American Medical Association, v. 257, vo. 11, Mar. 20, 1987. p. 1500-1502.

[163] Based on estimates of the uninsured population receiving emergency care from the 1986 National Access Survey by the Robert Wood Johnson Foundation.

[164] Ansell and Schiff, p. 1500-1502.

[165] Schiff, et al., p. 552-557.

Despite this activity, a recent congressional report concluded that most State provisions and Federal laws have limited effectiveness because they are narrowly targeted, lack specificity with regard to necessary definitions of patient condition, or lack enforcement mechanisms.[166]

In sum, while uninsured persons may need as much health care (or more) as insured persons of similar age, income and other characteristics, the uninsured have less access to health care. Though the American health care system appears to provide the uninsured with care when they seek it, the care received by the uninsured is more likely to be provided in hospital emergency rooms and, for uninsured children, in hospitals. Hospitals have traditionally provided this care (with some types of hospitals providing more than others); they have financed it through cross-subsidization from other sources of revenue including government funds, paying patients and charitable contributions. However, with increasing pressures on hospitals to hold down costs, the availability of subsidized care could be on the decline, and there are signs that the uninsured may experience increasing problems in obtaining access to hospital care.

[166] See U.S. House. Committee on Government Operations. Equal Access to Health Care: Patient Dumping. House Report 100-531, Mar. 25, 1988.

# APPENDIX A.—ESTIMATES OF THE UNINSURED

## I. Estimates in Chapter 4

The estimates reported in chapter 4 on the population's health insurance status come from the public use computer tapes of the annual March supplements to the Current Population Survey (CPS). The CPS is a Census Bureau survey on the characteristics of the noninstitutionalized population of the 50 States and the District of Columbia. It does not describe characteristics of the institutionalized population, residents of Puerto Rico and the other outlying areas of the United States, or citizens living abroad.

The CPS surveys a national representative sample of 155,000 people; therefore, its estimates are subject to sampling error. These estimates are also subject to nonsampling error, such as inaccurate reporting by survey respondents of characteristics such as income and health insurance coverage.

### A. THE MARCH SUPPLEMENT TO THE CPS

The CPS is administered each month to collect information on the labor force. In addition, in March of each year, the Census Bureau collects information on the extent of health insurance coverage in the population. This is done in conjunction with collecting information on demographic and economic characteristics. The demographic, economic, and health insurance part of the March CPS is usually referred to as in the March supplement to the CPS.

Population counts in the March CPS are for the time of the survey, but the economic data collected by the income supplement refer to the previous calendar year. For example, the March 1987 CPS surveyed respondents on 1986 health insurance coverage, income, and labor force participation; the estimates represent the 1986 health insurance status, income, and labor force participation of the March 1987 population.

The March CPS reports characteristics for the entire previous calendar year. The survey requests that respondents report whether or not household members were covered by health insurance at any time during the previous calendar year; income and earnings information are annual data for the entire previous calendar year.

The CPS is a household survey. To obtain information on characteristics of household members, a Census Bureau interviewer, attempts to identify and interview a "responsible person living in each sample unit to complete a CPS questionaire." [167] For the remainder of this appendix, this person will be referred to as the survey respondent.

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[167] U.S. Department of Commerce. Bureau of the Census. The Current Population Survey: Design and Methodology. Technical Paper 40, Washington, 1978. p. 33.

Each March, the Census Bureau asks CPS respondents to report whether or not household members had, in the previous year, health insurance coverage and the source(s) of such coverge. The survey collects information on the following sources of health insurance coverage:

Group health insurance (called in chapter 4 "employment-based health insurance coverage). Respondents are asked whether each member of the household 14 years and older who worked in the previous year was included in a health insurance plan on any job held in the previous year, and the number of other family member covered by such employer-based plans;

Medicare, Medicaid, and CHAMPUS. Respondents are asked whether each member of the household had coverage from any of these sources;

Any other health insurance. The respondent is asked whether any member of the household had coverage from sources other than those listed above and whether any other family member was also included in this plan.

### B. ADVANTAGES AND DISADVANTAGES OF USING THE MARCH CPS FOR EXAMINING HEALTH INSURANCE COVERAGE

Examining health insurance coverage by use of the CPS has several advantages. First, the CPS is the most frequently cited source of income, program participation, and yearly labor force data. Health insurance analyzed by these characteristics, then, would be consistent with the commonly cited numbers of people in poverty, median income, full- and part-time work and full- and part-year work. Second, the CPS has asked health insurance questions each year since 1980, obtaining a reasonably consistent series on health insurance coverage from 1979 to 1986. Third, the CPS has a relatively large sample size, which results in smaller sampling error compared with surveys with smaller samples.

The CPS does have some weaknesses for study of health insurance coverage. Intrayear variations in health insurance coverage cannot be determined from the CPS. It is not possible to tell whether a person was covered by insurance for one week or for all 52 week during the year. The annual data also give an incomplete account of some persons' labor force activity. A worker's occupation and industry are reported for the longest job held during the previous year. Employment and unemployment, hours worked, and wages can vary substantially within a year.

### C. CPS TREND INFORMATION AND THE INSURED AND UNINSURED

Chapter 4 includes information on the trend in the number and percent of the population with and without health insurance from 1979 to 1986, as reported by the CPS income supplements, 1980–1987. Estimates for earlier years from other surveys were not used in the chapter, since it is advisable to use a consistent measure to describe a trend.

This report does not show information on health insurance coverage for 1980, 1981, and 1982 because of a technical problem in the way data on "other health insurance" coverage was collected and coded on the public use tapes. This problem is confined to the

March 1981, 1982, and 1983 CPS tapes and does not affect other years.

## II. Health Insurance Estimates of the CPS Compared With Other Surveys

Different surveys produce different estimates of the uninsured, and the estimates vary greatly. For example, the Census Bureau's Survey of Income and Program Participation (SIPP) reported that a monthly average of 31.3 million people lacked health insurance during the fourth quarter of 1985.[168] CPS's 1985 estimate of the uninsured (those who never had coverage during the 1985) is 37.0 million people, almost one-fifth higher. (CPS estimates of the uninsured tend also to be higher than those of other surveys as well.)

There are many potential reasons for differences in estimates of the uninsured. However, first and most important, all surveys produce *estimates* based on *samples.* Surveys such as the CPS and SIPP obtain information on a sample of persons and then generalize information obtained from the sample to the total population. Larger samples generally produce more accurate estimates. The CPS sample consists of about 57,000 households; the SIPP sample consists of 20,000 households. This size difference makes the CPS estimate, based on sample size alone, somewhat more accurate than the SIPP estimate.[169]

## III. Support Tables for Trend Charts [170]

Some of the differences in estimates of the uninsured may relate to the survey design. Potential sources of error include the survey's sampling design for certain population groups, such as low-income groups; the burden the survey places on respondents in recalling information; the wording of its health insurance questions; and methods for imputing information for households that refuse interviews.

Aside from conjecture, however, it is difficult to pinpoint the source of differing estimates of the uninsured. However, additional research may help identify whether the CPS systematically overcounts the uninsured in certain population groups.

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[168] SIPP is a longitudinal household survey of a nationally representative sample of approximately 50,000 people. Households are interviewed every 4 months. The survey was designed to provide detailed information about the economic circumstances of the noninstitutionalized U.S. population. U.S. Department of Commerce. Bureau of the Census. Disability, Functional Limitation, and Health insurance Coverage: 1984-85. Data from the Survey of Income and Program Participation, Series P-70, no. 8. 1986. Table I, p. 10.

[169] However, it should not be interpreted that the Current Population Survey is three times more accurate than the Census Bureau's Survey of Income and Program Participation. Sampling error is based on an exponential formula. The marginal gains from increasing sample size diminish fairly rapidly.

[170] Analysis in chapter 4, The Insured and Uninsured: Number and Characteristics, p. 179, identified reasons for the large increase in the uninsured between 1979 and 1986. The findings of the analyses are presented in the form of charts in chapter 4. The data from which the charts were constructed are shown below.

Support Table for Chart 4.7.—Percent Change in Health Insurance Coverage by Type of Coverage, 1979 and 1986

| | Percentage point change 1979-86 | | | |
|---|---|---|---|---|
| | Producing industries | | Public workers | Not in the labor force |
| | Service | Goods | | |
| Health insurance from: | | | | |
| Own job | +0.67 | −2.07 | +2.48 | 0.00 |
| Other's job | −2.21 | −0.03 | −1.43 | −4.44 |
| Other health insurance | −1.69 | −1.20 | −0.33 | +1.82 |
| Overall change in coverage | −3.22 | −3.29 | +0.72 | −2.61 |

Source: Congressional Research Service, Education and Public Welfare Division, Methodology Section. Based upon March 1980 and 1987 Current Population Survey calculations.

Support Table for Charts 4.8 and 4.9.—Health Insurance Coverage Through a Family Member's Employment-Based Health Plan by Family Relationship, 1979 and 1986

[In percent]

| Family relationship | Population 1979 | Insured 1979 | Population 1986 | Insured 1986 |
|---|---|---|---|---|
| Head of household | 25.58 | 5.59 | 25.77 | 7.85 |
| Spouse | 22.10 | 44.71 | 21.41 | 40.10 |
| Children under 18 | 29.77 | 67.29 | 27.48 | 65.18 |
| Children 18 and older | 9.53 | 27.48 | 9.99 | 24.46 |
| Others living in household | 13.01 | 2.52 | 15.36 | 2.64 |
| Total/average | 99.99 | 34.30 | 99.99 | 31.36 |

Note.—Percents do not add to 100.00 due to rounding.

Source: Congressional Research Service, Education and Public Welfare Division, Methodology Section. Based upon March 1980 and 1987 Current Population Survey calculations.

Support Table for Chart 4.10.—Health Insurance Coverage Through a Family Member's Employment Based Health Plan by Family Relationship Percent Change Due to Demographic Shifts and Rate Changes, 1979–1986

| Family relationship | Demographic shifts | Rate changes |
|---|---|---|
| Head of household | +0.35 | +19.27 |
| Spouse | −10.27 | −33.92 |
| Children under 18 | −51.51 | −20.94 |
| Children 18 and older | +4.14 | −9.61 |
| Others living in household | +1.98 | +0.52 |
| Total | −55.31 | −44.68 |
| | | +55.31 |
| Combined total | | −99.99 |

Note.—Percents do not add to 100.00 due to rounding.

Source: Congressional Research Service, Education and Public Welfare Division, Methodology Section. Based upon March 1980 and 1987 Current Population Survey calculations.

## APPENDIX B.—HAY/HUGGINS BENEFITS REPORT 1987

The Hay/Huggins Benefits Report 1987, Prevalence of Practice, provides information on the health care plans and other employee benefits of 896 industrial, financial, and service organizations throughout the U.S. The firms are predominantly medium and large in size: 3 percent of participants are small (fewer than 100 employees), 13 percent are medium (100 to 499 employees) and 84 percent are large (500 or more employees). Table B.1 shows the distribution of participants by number of employees. Following the table is a list of participants by major category.

TABLE B.1.—Hay/Huggins Benefits Report Participants by Number of Employees, 1987

| Number of employees | Participants | |
|---|---|---|
| | Number | Percent of respondents |
| < 100 | 28 | 3 |
| 100 to 249 | 47 | 6 |
| 250 to 499 | 61 | 7 |
| 500 to 999 | 100 | 12 |
| 1,000 to 999,999 | 596 | 72 |
| Total respondents | 832 | 100 |
| No response | 64 | ............... |
| Total participants | 896 | ............... |

Source: Hay/Huggins Benefits Report, 1987.

[1987 Hay/Huggins Benefits Report]

1987 LIST OF PARTICIPANTS BY MAJOR CATEGORY

**Industrials**

Abbott Laboratories
ADC Telecommunications
AEL Industries
Aerospace Corporation
Air Products and Chemicals
Air-Shields Vickers
Alabama Power
ALCOA
Alexander & Baldwin
Allen-Bradley
Allied/Bendix Aerospace
Allied Chemical
ALM
AMAX
AMC
Amerada Hess
American Association for the Advancement of Science
American Broadcasting Companies
American Chemical Society
American Crystal Sugar
American Hospital Supply
American Society of Civil Engineers
American Standard
American Sterilizer
American Systems
Amfac Hotels
Anchor Hocking
Andersons, The
Anheuser Busch Companies
Anser
Arc America
Archer-Daniels Midland
Arco Chemical
ARINC
Aris Isotoner Gloves
Arkansas Best
Arkansas Power & Light
Armco
Armstrong World Industries
ASARCO
ASEA
Ashland Oil
Atlantic Aviation
Atlantic Richfield Company
Austin Company
Austin Industries
Baker Perkins
Baltimore Aircoil
Baltimore Sun. The
Barber Coleman
Barber-Greene
Bariven
Barry Wright

Basin Electric Power Cooperative
Battelle Memorial Institute
BATUS
BDM Corporation. The
Bean Company (L.L.)
Becor Western
Beecham
Bell Atlantic
Bell Communication Research
Bell Helicopter Textron
BellSouth Corporation
Beram & Company, George
Bergen Record
Berol
Berry & Company (L.M.)
Bessemer & Lake Erie Railroad
Best Products
Betz Laboratories
Beverage Management
Biney & Smith
Blick Company, Dick
Blount International
BMC Industries
Boston Edison
Bourns
Bristol-Meyers
British Petroleum, Alaska Exploration
British Petroleum, North America
Brooklyn Union Gas
Brown & Williamson Tobacco
Brunswick Corporation
Burger King
Burlington Northern Railroad
Burnett Company, Leo
Business and Technological Systems
Butler Manufacturing
Bytex Corporation

C.A.C.I.
California & Hawaiian Sugar
Camcar-Illinois Division
Cameron Iron Works
Campbell Soup Company
Cargill
Carson Pirie Scott & Company
Castle (A.M.) & Company
CBI Industries
Ceco Corporation. The
Centel
Central Soya
CertainTeed
CFS Continental
Chemlawn
Chenango Industries
Cherry/Textron
Chesebrough-Pond's
Chicago & Northwestern Transportation
Chipman-Union
Ciba-Geigy
Clark O'Neill
Cole National Corporation
Colgate Palmolive
Columbia Gas System
Commercial Shearing
Compuchem Laboratories
Computer Sciences Corporation
Computer Sciences Corporation Systems Divisions
Computervision
Consolidated Rail
Continental Materials
Contraves Goerz
Cook Travel, Thomas
Cookson America
Cooper Industries
Copperweld
Cornelius Company, The
Cox Cable Communications
Crane
Crompton & Knowles
Crawley Maritime
CRST
CSX
Curtis Mathes
Cyclops

Danly Machine
Day & Zimmerman
Dayton Power and Light
Dayton-Hudson
Dead River
Decision Data Computer Corporation
Delux Check Printers
Dennison Manufacturing
Dexter Corporation. The
Dick (A.B.)
DiGiorgio Corporation
Disston
Donaldson Company
Donnelly (R.R.) & Sons Company
Dow Chemical
Dow Corning
Dravo
Duke Power
Duriron
Durr Fillauer Medical
Dynamic Systems

Echo Bay Mines
Edwards Baking Company
EG & G Idaho
Elco Industries
Elkay Manufacturing
Elkem Metals
Eltech System
EMC Technologies
Empire District Electric Company
Evaluation Research
Exide

Factory Mutual Engineering and Research
Federal Express
Ferrell Gras
First Mississippi Corporation
Fischer & Porter
Fisher-Price Toys
Fisher-Stevens
Florida Power
Florida Steel
Follett
Fox-Stanley, Photo Products
Foxboro Company, The
Frantz Manufacturing
Freeport-McMoRan
Fruit Growers Express

Galileo Electro-Optics
General Electric
General Foods
General Mills
General Research
General Shale Products
Genicom Corporation
Georgia Power
Gifford Hill and Company
Glynwed
Godfather's Pizza
GoldKist
Gore & Associates, (W.L.)
Gould Inc. Computer Systems Division
Grainger (W.W.)
Grand Trunk Western Railroad
Graybar Electric
Greyhound
GTE
GTE Communication Systems Corporation
Gulf States Utilities

Hallmark Cards
Hamady Bros. Food Markets
Hanes
Hannaford Brothers
Hartmarx
Heinz Company (H.J.)
Hewlett-Packard
Hiland Potato Chip Company
Hilti
Hiram Walker
Honeywell Information Systems
Houghton Mifflin
Howe-Baker Engineering
Huber (J.M.)
Huffy
Human Resources

Research Organization
Hunt Manufacturing

IBM
ICL
Illinois Bell Telephone
Illinois Central Gulf Railroad
Illinois Power Company
Illinois Tool Works
IMS America
Info Plus
Inland Steel
Insurance Organizations pension & Group Trust
Intremedics
IPC
Itek Graphic and Composition Systems
IU International Management Corporation

Jacobs Engineering Group
Johnson (S.C.) & Son
Johnson Matthey
Joy Technologies

Kansas City Power & Light
Kawasaki Motors Corporation, USA
Kellogg
Kellogg Company, M.W.
Kelly Services
Kerr-McGee
Kimberly-Clark
Kroger

Lamb-Weston
Lanzagorta Group
Lavino Shipping
Lawrence Livemore National Laboratory
Lehigh Press
LeRoy Industries
Levi Strauss
Levy Circulating Charles
Leybold Hereaus Vacuum Products
Logistics Management Institute
London International
Long Island Lighting
Los Alamos Technical Associates
TV Energy Products
Lucas CAV Industries
Lucas Industries

MacDermid
Mack Printing
Mack Trucks
MAR
Mary Kay Cosmetics
Matsushita Industrial
Maxus Energy Corporation
May Department Stores
Mayflower
McCaffrey & McCall
McDonnell Douglas
McGraw-Hill
MCI Telecommunications System
McKee (Robert E.)
McKesson Corp
Mead
Memphis Light, Gas & Water
Merck
MetPath
Metro North Commuter Railroad
Metropolitan St. Louis Sewer District
Metropolitan Transportation Authority
MichCon
Mid-Atlantic Toyota Distributors
MidCon
Milchem
Miles Laboratories
Milwaukee Metropolitan Sewage District
Minnesota Mining & Manufacturing
Minolta
Missouri Public Service
MITRE
Mitsubishi International
Modine
Montgomery Ward
Mood
MOPAC
Morgan Corporation
Morie Company, The
Morrison
Motorola
MSBA
Murphy Oil USA

National Computer Systems
National Gypsum
National Railroad Passengers Corporation (AMTRAK)
National Railway Labor Conference
National Restaurant Association
NCR
Nebraska Public Power District
NEC Information System
NERCO
New Jersey Transit Rail Operations
New York Port Authority
New York Stock Exchange
Newport Steel
Nike
Nippondenso of Illinois
Nippondenso of Los Angeles
Nipro
Nisan Motor Manufacturing U.S.A.
Norfolk Southern
Northern Indiana Public Service
Northwestern Bell Telephone
Norton
Nynex

Occidental Chemical
Ohio Edison
OKIDATA
Oklahoma Natural Gas Company
Otis Engineering
Owatonna Tool
Owens-Corning Fiberglas
Owens-Illinois

Pacific Telesis Group
PacTel Spectrum Services
Pako
Paper Converting
Payless Cashways
Peabody Coal Company
Pendleton Woolen Mills
Pennwalt
Pentair
People Gas, Light & Coke
Peoples Natural Gas
PepsiCo
PepsiCo-Frito-Lay
Perdue
Perkin-Elmer
Piedmont Natural Gas
Pillsbury
Pinkerton Tobacco
Pitney Bowes
Pizza Hut
Plantronics
Poole Equipment, Gregory
Portland General Electric
Potters Industries
Power Authority of the State of New York
PPG Industries
PQ Corporation
Price Brothers
Primark
Prime Computer
Public Broadcasting Service
Public Service Company of New Mexico
Puritan-Bennett

Racal
Ragold
Raymond Corporation
Raymond International
Reckitt & Colman, North America

Recognition Equipment
Regional Transportation Authority
Research-Cottrell
Rexnord
Reynolds Metals
Rhone Poulenc
Richardson-Vicks
Roadway Express
Rogers
Rouse
Ryan Homes
Ryder System

Sanders Associates
Sandvik
Santa Fe Railroad
Santee Cooper
Schafer Associates (W.J.)
Schreiber Foods
Schumaker & Company (F)
Schweiber Electronics
Scott Paper
Sears Roebuck and Company Mercahndise Group
Seton Company
Sherex Chemical
Shipboard and Ground Systems
Shipley Company
Siemens Medical Systems
Sierra Pacific Power
Simplot
Sola Optical U.S.A.
Solar Energy Research Institute
Soltex Polymer
Sonoco Products
Soo Line Railroad
South Jersey Industries
Southern Company Services
Southern New England Telephone
Southern Pacific Transportation
Southwestern Bell Telephone
Staley Continental
Stanadyne
Steamboat Ski
Steelcase
Steiger Tractor
Stone Container
Storer Communications
Subaru of America
Sun Chemical Company
Sun Company
Supermarkets General
Sverdrup Technology
Syntex
Syscon Corporation
Systems & Computer Technologies
Systems Research Laboratories

Talon
TBTA
Tektronix
Tennessee Valley Authority
Terra Chemicals International
Texas Instruments
Thermo Electron
Thompson Medical Company
Time Life Books
Timet
Timex
Timken
Tonka
Topps Chewing Gum
Trailer Train
Transamerica Corporation
Travenol Laboratories
Triangle Corporation
Triangle Publications
Tricil
Uarco
UGI Corporation
Union Carbide
Union Pacific Railroad
Union Special
Unit Rig & Equipment
United Telecommunications
Upjohn Company, The
U.S. Gypsum
Utah Power and Light

Valero Energy
Vallen
Versa Technologies
Virginia Chemical
Vitro Corporation
Volvo White Truck Corporation

Warner & Swasey
Washington Post, The
Washington Public Power Supply System
Western Forge Corporation
Western Publishing
Western Union
Westin Hotels
Weyerhaeuser
Wickland Oil Company
Williams Companies, The
Wisconsin Public Service
Wool Bureau
Woolworth Company (F.W.)
Wrigley (Wm.) Jr.
Wyman Gordon

Zale
Zayre
Zenith Electric

**Financials (Banks)**

Amerifirst Federal Savings & Loan
Arizona Bank, The

Bank of New England
BankEast Corporation
Barclays Bank of California
Barclays Bank of New York
Barnett Banks of Florida
Bright Bank

Carteret Savings and Loan
Central Bancshares of the South
Central Bank
Chase Federal Savings and Loan
Chase Manhattan Bank
Chemical Bank
Citibank
Citicorp Savings
City Bank & Trust
Colonial Bank
Commercial Security Bank
Commonweath National Bank
Community Federal Savings and Loan

Deak International
Deposti Guaranty National Bank

Equibank

Federal Home Loan Banks, San Francisco
Federal Reserve Bank of Dallas
Federal Reserve Bank of San Francisco
Fidelcor
First America Corporation
First American Bancshares
First American Bank of Maryland
First Empire State Corporation
First National Bank of Chicago
First National Bank of Maryland
First Nationwide Bank
First Pennsylvania Bank
First Security Corporation
Fuji Bank & Trust

Germantown Savings Bank
Gibraltar Savings
Goldome Bank for Savings
Great American First Savings Bank

Jefferson Bancorp

Kanawha Valley Bank

Liberty National Bank & Trust
Lincoln National Bank

Marine Midland Bank
Mechanics Savings Bank
Mellon Bank East
Mellon Bank West
Merchants Bancorp
Meridian Bankcorp
Midland Bank
Morgan Guaranty Trust
Mutual Federal Savings and Loan Association

National Bank of Detroit
National Bank of Washington
NCNB Corporation
New England Savings Bank
Norwest Corporation

Old Kent Bank and Trust
Old National Bank
Old Stone Bank
Onbank

People's Bank
People's National Bank of Washington
Perpetual American Federal Savings and Loan
Pioneer Savings and Loan
Pittsburgh National Bank
Poughkeepsie Savings Bank

Royal Bank of Canada

Sea First
Security Bank
Society National Bank
Society for Savings
Southeast Bank

Texas American Bancshares
Tokai Bank

United Virginia Bank

Valley National Bank

**Financials (Insurance)**

AAL
Acacia Group, The
Alexander & Alexander
Allendale Mutual Insurance
American Family Insurance Group
American Reinsurance Company

BABB
Bankers Life and Casualty
Bankers Life of Nebraska
Banner Life Insurance
Beaven Companies
Benefit Trust Life Insurance Company
Berkshire Life Insurance
Business Mens Assurance of America Career Agents
Business Mens Assurance Company of America

Capital Holding Corporation
Central Life Assurance
Century Companies of America
Cigna
Cigna Healthplan
CNA Insurance
Colonial Life and Accident
Commercial Union Insurance
Connecticut Mutual Life Insurance
Cooperative de Seguros de Vida de Puerto Rico, La
Cotton States Insurance
Country Companies

Equitable Life of Iowa
Equitable Trust
Erie Insurance Group

Farm Family Insurance
Fidelity Mutual Life Insurance
Fidelity Union Life Insurance
Florida Employers Insurance Corp.
Foremost Corporation of America

GEICO
General American Life Insurance
Great American Insurance Company
Group Health Assoc. of America

Independent Life Insurance
Indianapolis Life Insurance
Insurance Services Office
Integon
Interstate

Jefferson-Pilot Life Insurance Company
John Hancock Mutual Life Insurance
Johnson & Higgins

Kaiser Foundation Health Plan
Kansas City Life Insurance
Keystone Organiation
KVI Group

Lincoln National Corporation
Lutheran Brotherhood

Massachusetts Mutual Life Insurance
Medical Inter-Insurance Exchange of New Jersey
Merchants Insurance Group
Metropolitan Life Insurance
Midland Mutual Life Insurance
Minnesota Mutual Life Insurance
Monarch Capital Corporation
Monumental Life Insurance
Mutual Benefit Life Insurance
Mutual Life Insurance Company of New York
Mutual of Omaha Insurance

Nationwide Insurance
New England, The
North American Life and Casualty
Northwestern Mutual Life Insurance
Northwestern National Insurance Company
Northwestern National Life Insurance

Ohio National Life Insurance
Old American Insurance

Pacific Mutual Life Insurance
Pennsylvania National Mutual Casualty Insurance
Preferred Risk Mutual Insurance
Principal Financial Group, The
Progressive Companies, The
Protective Life Insurance
Provident Life & Accident Insurance

Royal Insurance

Sentry Insurance
Shelby Insurance Company

St. Paul Fire and Marine
State Farm Insurance Companies

TIAA-CREF
Time Insurance
Tokio Marine Management Inc.
Travelers, The

Underwriters Management Insurance
Unigard Security Insurance
United Family Life Insurance
United Services Life Insurance
UNUM
U.S. Life Corporation

Washington National Insurance
Western Life Insurance
Wisconsin Physician Service

Zurich Insurance

**Other Financials**

American Express
Ameritrust
Amev Holdings
Arvida Corporation
Atlantic Financial

Bank Fund Staff Federal Credit Union
Barclays American Corporation
Borg-Warner Acceptance

California Credit Union League
Chicago Board of Trade
Chicago Title & Trust
Chrysler Credit
Chrysler First

Educational Systems Employees Federal Credit Union
Equitable Real Estate

Farm Credit Banks of Springfield
Farm Credit Services
Federal National Mortgage Association
First Bank System
First Republic Bank

IBJ Schroder Bank & Trust
IBM Endicott/Owego Employees Federal Credit Union
IDS Financial Services
Investment Centre

Mark Twain Bankshares
Merrill Lynch
Michigan Farm Bureau and Associate Companies
Midwest Stock Exchange

Nassau Educators Federal Credit Union
National Rural Utilities Cooperative Finance
Navy Federal Credit Union

Pentagon Federal Credit Union
Price Associates (T. Rowe)

Securities Industry Automation
State Department Federal Credit Union
Statesman Group
Student Loan Marketing Association

Tower Federal Credit Union

**Blue Cross/Blue Shield**

Blue Cross of Greater Philadelphia
Blue Cross of Northwest Ohio
Blue Cross/Blue Shield Associations
Blue Cross/Blue Shield of Alabama
Blue Cross/Blue Shield of Colorado
Blue Cross/Blue Shield of Connecticut
Blue Cross/Blue Shield of Delaware
Blue Cross/Blue Shield of Florida
Blue Cross/Blue Shield of Indiana
Blue Cross/Blue Shield of Iowa
Blue Cross/Blue Shield of Kansas
Blue Cross/Blue Shield of Maryland
Blue Cross/Blue Shield of Massachusetts
Blue Cross/Blue Shield of Michigan
Blue Cross/Blue Shield of Nebraska
Blue Cross/Blue Shield of North Carolina
Blue Cross/Blue Shield of Texas
Blue Cross/Blue Shield of West Central West Virginia
Blue Cross/Blue Shield of West Virginia
Community Mutual Blue Cross/Blue Shield
Consolidated Healthcare
Empire Blue Cross/Blue Shield of New York City
GHI Blue Cross/Blue Shield of New York City
GHI Blue Cross/Blue Shield of Washington, D.C.
Hospital Service Plan of New Jersey
Pennsylvania Blue Shield
St. Louis Blue Cross Plan

**Services and Not-For-Profit Organizations**

Abbott Northwestern Hospital
Allegheny Intermediate Unit
Alliance Health System
Alta Bates Corporation
American Bankers Association
American College, The
American Heart Association
American Hospital Association
American Institute of CPA's
American Institutes for Research
American MedCenters
American Medical International
American Public Transit Association
American Red Cross of New York
Anchorage School District
ASHRAE

Bank Marketing Association
Baptist Hospital
Baptist Hospital and Health System
Baptist Medical System
Baystate Health System
Bethesda Hospital and Deaconess Association
Beverly Enterprises
Bishop Clarkson Memorial Hospital
Bon Secours Health System
Brim & Associates
Baptist Medical System
Carle Foundation Hospital
Carnegie Library of Pittsburgh
Carondelet Health Services
Catholic Health Associations, The

Catholic Health Corporation
Catholic Healthcare West
Chamber of Commerce of the United States
Champaign County
Charter Medical Corporation
Chester County Intermediate Unit
Children's Aid Society
Cincinnati Association for the Blind
City of Colorado Springs
City of Hampton
City of Los Angeles
City of Los Angeles (Fire & Police)
City of Los Angeles (General)
City of Los Angeles (Water & Power)
City of Norfolk
City of Philadelphia
City of Portland
City of Rapid City
City of Rapid City (General)
City of Rapid City (Fire & Police)
City of Richmond
City of Suffolk
Columbia Hospital
Columbus-Cuneo-Cabrini Medical Center
Congressional Budget Office
County of Lake

Deseret Research Company

Episcopal Mission Society
Eskaton Health Systems
Evangelical Health Systems

Fairview Hospitals & Healthcare Services
Fargo Clinic
First Data Resources
Forbes Health System

Gallaudet College
Golden Health System
Good Samaritan Hospital
Group Health Cooperative of Puget Sound

Hahnemann University
Harris Methodist Health System
Hartford Hospital
Harvard Community Health Plan
HCA Wesley Medical Center
Health Central System
Healthcare international
Healthcare Management
HealthWest
Hillcrest Medical Center
Horton Memorial Hospital
Hospital Corporation of America
Howard University
Humana

Intermountain Health Care
Irvington General Hospital

Jeannes Hospital
Jewish Child Care Association

LHS Corporation
Life Insurance Marketing & Research (LIMRA)
Lutheran Health Systems
Lynchburg General Hospital

Manchester Memorial Hospital
Manor Care
Maricopa Community College District
Memorial Care Systems
Memorial Hospital Medical Center of Long Beach
Memorial Medical Center
Mercy Health Services
Mercy Health Systems of the Midlands
Mercy Healthcare System
Merritt Peralta Medical Center
Methodist Medical Center of Illinois
MetLife Healthcare Management
MIB
Michael Reese Hospital
Midwest Research Institute
Milton Hershey School
Montefiore Hospital and Medical Center
Moses H Cone Memorial Hospital, The

NACUBO
National Council of the Paper Industry
National Futures Association
National Healthcare
National Medical Enterprises
National Medical Hospitals
NKC
North Bay Healthcare Corporation
North Broward Hospital District
North Carolina Baptist Hospital
North Kansas City Hospital
North Mississippi Health Services

Ohio Hospital Association
Pennsylvania Medical Society
Pious XII Youth & Family Services
Presbyterian Healthcare System

Republic Health Corporation
Research Health Services
Research Triangle Institute
Riverside Methodist Hospital
Rockford Memorial Hospital
Rushmore National Health System

Safecare Health Services
Samaritan Health Services
Shands Hospital
Sioux Valley Hospital Association
Sisters of Providence Health Care Corporation
South Suburban Hospital
Southern Baptist
Southwest Community Health Services
Southwest Research Institute
St. Clair Health Corporation
St. Louis Board of Police Commissioners
St. Luke's Hospital-Meritcare
St. Mary's Medical and Health Center
St. Vincent's Hospital & Health Center
State of Arizona
State of Connecticut
State of Florida
State of Georgia
State of Maryland
State of Michigan
State of New Jersey
State of North Carolina
State of South Dakota
Stormont Vail Regional Medical Center

Sun Health Corporation
Sunday School Board of
  Southern Baptist
SunHealth
Sutter Health System

Touche Ross & Company
Town of Palm Beach
Town of Palm Beach
  (Public Safety)
Town of Palm Beach
  (General)

Travelers Health Network

United HealthCare
United Way of
  Southampton Roads
United Way of Southeast
  Pennsylvania
United Hospital of
  Cleveland
University of Alabama
  Birmingham
University of California

University of Texas

Virginia Baptist Hospital
Voluntary Hospitals of
  America

Washoe Medical Center
West Penn Motor Club
William Beaumont
  Hospital
YMCA of the United
  States of America

# APPENDIX C.—THE NATIONAL HEALTH INTERVIEW SURVEY

## I. Uses and Limitations of Data

The estimates presented in chapter 6 on the use of health care services by the insured and the uninsured come from the public use computer tapes of the 1986 National Health Interview Survey (HIS). The HIS is a survey conducted by the National Center for Health Statistics (NCHS) of the civilian noninstitutionalized population in the United States. The Census Bureau interviews a sample of the population to collect information about the health and other characteristics of each member of the household. The 1986 HIS interviewed approximately 24,000 households containing 60,000 persons.

### A. USES OF THE HIS

#### *1. Information on public use tapes*

The HIS core survey includes questions on demographics, physician visits, hospital stays and medical conditions. In addition, the 1986 survey contained supplemental questions regarding health insurance coverage. Responses from the core and supplemental tapes were merged together by CRS to allow for analysis of doctor visits and hospital stays by health insurance status.

#### *2. Coding health insurance status*

In assigning health insurance status, respondents were coded "insured" if they reported having private health insurance, Medicare, public assistance or military/veterans health insurance coverage. Respondents were also coded "insured" if they answered that the reason they had no private health insurance coverage or Medicare coverage was because they were covered by another type of health insurance. Respondents were coded as "not knowing if covered" if they did not answer "yes" to any of the coverage questions and answered "don't know" to one or all of them. The "don't knows" were not included in this analysis because their patterns of use of health care use did not resemble either the insured or the uninsured, but were in fact consistently much higher than both groups.

### B. LIMITATIONS OF THE HIS

#### *1. Survey errors*

Because the estimates are based on a sample of the population, they are subject to sampling error. Additionally, errors may result from the inability or unwillingness of household respondents to answer some of the questions about health status and use of health care services.

### *2. Two-week physician visit reference period*

Respondents are asked their number of physician visits in the past year and also in the past two weeks. More detailed questions, including place of visit and type of doctor, are asked for the two-week reference period. In chapter 6, estimates of the average annual number of doctor visits are obtained by weighting the number of reported visits in the two-week reference period by 26 and by the number of people the respondent represents. Though this procedure may underestimate the total number of visits for the population by as much as 20 percent, this method of estimation provides a better comparison than year-long estimates between average annual visits for the insured and the uninsured, for two reasons: First, recall is more precise over shorter reference periods; and second, a respondent's health insurance status (as assigned according to the point in time of the interview) is less likely to have changed over the past two weeks than over the past year.

### *3. Poverty rates*

Finally, estimates of the population below poverty from HIS were substantially lower than Census Bureau estimates. NCHS calculated poverty codes from poverty data provided by the Census Bureau and included the poverty codes on the HIS public use tapes. Differences in the poverty rates may be attributable to several sources of error including missampling, miscalculation and miscoding. Accordingly, chapter 6 presents comparisons of the insured and uninsured populations by family income (without regard for family size) instead of by poverty status.

## II. Support Tables for Charts [171]

Support Table for Chart 6.1.—Average Number of Reported Physician Contacts per Person by Family Income and Insurance Status (Nonaged Population) 1986

| Family income | Uninsured | Insured | Ratio of uninsured to insured |
|---|---|---|---|
| < $15,000 | 3.47 | 6.57 | .53 |
| $15,000 to 24,999 | 3.46 | 5.13 | .67 |
| $25,000 to 49,999 | 2.89 | 4.94 | .59 |
| > $50,000 | 4.38 | 5.13 | .85 |
| All individuals | 3.32 | 5.17 | .64 |

Source: Congressional Research Service analysis of 1986 National Health Interview Survey (HIS) public use tapes.

[171] Comparisons of health care utilization by the insured and uninsured population are shown in charts in chapter 6, The Uninsured's Access to Health Care. The tables contain the data from which the chapter 6 charts were constructed.

Support Table for Chart 6.2.—Average Number of Reported Physician Contacts per Person by Age and Insurance Status (Nonaged Population) 1986

| Age | Unin-sured | Insured | Ratio of uninsured to insured |
|---|---|---|---|
| 0 to 17 | 2.90 | 4.42 | .66 |
| 18 to 24 | 2.71 | 4.73 | .57 |
| 25 to 45 | 3.38 | 4.95 | .68 |
| 46 to 64 | 4.95 | 6.72 | .74 |
| All individuals | 3.32 | 5.17 | .64 |

Source: Congressional Research Service analysis of the 1986 HIS public use tapes.

Support Table for Chart 6.3.—Average Number of Reported Hospital Days per Person by Health Insurance Status and Family Income (Nonaged Population) 1986

| | Unin-sured | Insured | Ratio of uninsured to insured |
|---|---|---|---|
| Family income: | | | |
| <$15,000 | .52 | .84 | .62 |
| $15,000 to $24,999 | .33 | .59 | .56 |
| $25,000 to $49,999 | .34 | .44 | .77 |
| >$50,000 | .14 | .55 | .25 |
| All individuals | .42 | .55 | .24 |

Source: Congressional Research Service analysis of 1986 HIS public use tapes.

Support Table for Chart 6.4.—Average Number of Reported Hospital Days per Person by Health Insurance Status and Age, During 1986

| Age | Unin-sured | Insured | Ratio of unisured to insured |
|---|---|---|---|
| 0 to 17 | .38 | .26 | 1.46 |
| 18 to 24 | .34 | .44 | .77 |
| 25 to 45 | .39 | .56 | .70 |
| 46 to 44 | .64 | .97 | .66 |
| All individuals | .42 | .55 | .24 |

Source: Congressional Research Service analysis of 1986 HIS public use tapes.

Support Table for Chart 6.5.—Self-Reported Health Status by Family Income and by Health Status (Nonaged Population), 1986

| Family income | Unin-sured | Insured | Differences in percentage points (uninsured minus insured) |
|---|---|---|---|
| Percent reporting poor or fair: | | | |
| <$15,000 | 13 | 15 | −2 |
| $15,000 to $24,999 | 9 | 8 | 1 |
| $25,000 to $49,999 | 5 | 4 | 1 |
| >$50,000 | 2 | 2 | 0 |
| All persons | 10 | 7 | 3 |
| Percent reporting good: | | | |
| <$15,000 | 30 | 27 | 3 |
| $15,000 to $24,999 | 26 | 24 | 2 |
| $25,000 to $49,999 | 20 | 18 | 2 |
| >$50,000 | 16 | 14 | 2 |

Support Table for Chart 6.5.—Self-Reported Health Status by Family Income and by Health Status (Nonaged Population), 1986—Continued

| Family income | Unin-sured | Insured | Differ-ences in percent-age points (unin-sured minus insured) |
|---|---|---|---|
| All persons | 28 | 21 | 7 |
| Percent reporting very good/excellent: | | | |
| <$15,000 | 57 | 58 | −1 |
| $15,000 to 24,999 | 65 | 68 | −3 |
| $25,000 to $49,999 | 75 | 77 | −2 |
| >$50,000 | 81 | 84 | −3 |
| All persons | 61 | 72 | −11 |

Source: Congressional Research Service analysis of 1986 HIS Public use tapes.

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