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Data Watch

The Health Insurance Picture In 1993: Some Rare Good News

by Jon Gabel, Derek Liston, Gail Jensen, and Jill Marsteller

Abstract: Based on a national survey conducted in spring 1993 of 1,953 private and public employers, this DataWatch examines the design of employer-sponsored health benefits and how they have changed during the past five years. We contrast cost of coverage, employee cost sharing, and premium increases among small, mid-size, and large firms. Premiums increased 8.5 percent from 1992 to 1993, the lowest rate of increase since 1986–1987. Future premium increases should be modest by historical standards. Small firms and conventional plans experienced larger premium increases last year. Managed care plans now constitute 51 percent of enrollment, up from 29 percent in 1988. If current trends continue, even without health care reform legislation, the health care system of the future will contrast strikingly with the system most Americans remember from past decades.

The difference between truth and fiction,” observed Mark Twain, “is that fiction is obliged to stick to possibility and truth is not.” As the health care reform debate proceeds, and advocates and critics overstate their cases, fiction and truth become blurred. In the effort to reorganize one-seventh of the U.S. economy, policymakers and the American public need to understand how employer-sponsored health benefits currently are designed and how they have changed during the past five years. This understanding is essential, not only to know what type of system we may inherit under health care reform, but also what kind of health care system will endure if Congress does not pass a comprehensive reform package.

This DataWatch presents findings from the KPMG Peat Marwick/Wayne State University survey of 1,953 public and private employers that was conducted in the spring of 1993. To provide a basis for historical comparison, we contrast the study findings to those of the 1988 Health Insurance Association of America (HIAA) survey of 1,665 employers. An inescapable conclusion from an analysis of the data is that even if no reform legislation passes but current trends continue, the health care system of the future will be in striking contrast to the health care system most Americans remember from prior decades.

Methods. KPMG Peat Marwick retained National Research, Inc., a

Washington, D.C.-based survey firm to conduct telephone interviews with human resources directors from March 1993 to June 1993. There were three surveys according to firm size, with similar questionnaires. KPMG Peat Marwick surveyed 1,003 firms with 200 or more workers. KPMG Peat Marwick together with Wayne State University surveyed 750 firms with forty-nine or fewer workers; and KPMG Peat Marwick additionally surveyed 200 firms with 50–199 workers.

For all three surveys, we selected firms from a listing of the nation's employers compiled by Dun and Bradstreet.¹ To increase precision, we stratified each sample by firm size, region, and industry. Our combined response rate for the three surveys was 51 percent, ranging from 44 percent of firms with fewer than fifty workers to 61 percent of firms with 50–199 workers. In general, we found it more difficult to complete interviews in 1993 than in previous years, presumably because of the downsizing of human resources departments.

To derive national estimates, we have calculated statistical weights that are based on the probability of each firm's selection in the sample and the number of employees enrolled in each plan. These weights allow us to calculate statistics based on the number of employees enrolled in each type of health plan. In some cases, we present employer-based statistics—features of health plans offered by a typical employer. However, most statistics are presented at the employee level.

In presenting findings, we highlight differences in health insurance coverage by firm size, rather than by industry or region. We do so to focus on the small-employer market—a market whose problems have spurred much of the current interest in health care reform. We then compare the study findings with those of the 1988 HIAA survey.² Many of the questions in the two surveys are identical; the sample designs for the surveys are similar also.

Study Findings

Premium increases. Health insurance premiums increased by 8.5 percent between spring 1992 and spring 1993. This was the lowest rate of increase in health insurance premiums and the first year of single-digit increases since 1986–1987. The average premium increase for firms with fewer than fifty workers was greater than 10 percent, whereas for firms with 1,000 or more workers the average increase was 7.9 percent (Exhibit 1).

Managed care plans experienced lower increases than conventional plans. The average increase for conventional plans was 9.1 percent, while point-of-service plans had the lowest average increase at 5.2 percent. Differences in the rate of increase between managed care and conventional plans were greatest among employers with fewer than 200 workers.

Exhibit 1

Health Insurance Premium Increases For All Plan Types, By Firm Size, 1993

Type of plan	Number of employees					All firms
	1-24	25-49	50-199	200-999	1,000 or more	
Conventional	12.0%	12.5%	10.0%	10.8%	7.8%	9.1%
PPO	6.2	7.3	5.5	8.4	8.3	7.7
HMO	-1.5	7.3	5.5	8.4	8.3	7.7
Point-of-service	9.6	9.4	2.6	4.4	5.0	5.2
All plans	10.1	10.6	8.4	8.9	7.9	8.5

Source: KPMG Peat Marwick/Wayne State University Survey of 1,953 firms, 1993.

Note: HMO is health maintenance organization; PPO is preferred provider organization.

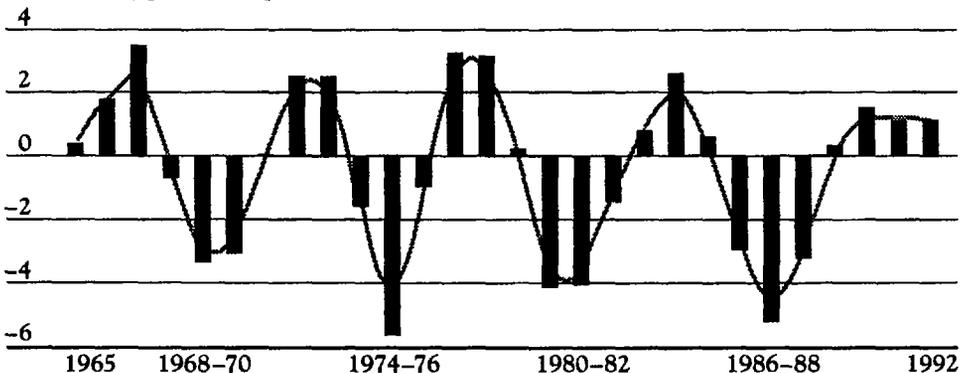
Indications are that premium increases in the next few years are likely to be modest. Health insurance historically follows a six-year cycle of profitability.³ Three years of underwriting gains (profits before investment income) are followed by three years of underwriting losses. What is critical for employers and policymakers to know is that a price cycle lags the profitability cycle by two years. When insurers experience underwriting gains, premium increases are modest two years later. When insurers suffer losses, premium increases two years later are in double figures.

Because 1991 was a profitable year for the insurance industry, modest increases in premiums were predictable for 1993. If the underwriting cycle had continued on its historical path, 1992 and 1993 would have been years of underwriting losses for insurers. However, Exhibit 2 shows that the Blue Cross/Blue Shield plans were able to maintain profitability in 1992. Reports from the first half of 1993 also indicate that profitability was on the rise.⁴ Thus, it appears that the industry has broken the underwriting cycle and

Exhibit 2

Blue Cross/Blue Shield Underwrite Results, 1965-1992

Underwriting gain/loss as percent of net revenue



Sources: Downloaded from content.healthaffairs.org by Health Affairs on December 14, 2012. Inc. by guest

that premium increases for 1994 and 1995 are likely to be in single digits.

Cost of coverage. In 1993 the average monthly cost of single coverage for all plans was \$170, and the cost of family coverage averaged \$436 (Exhibit 3). These figures are the sum of both the employer and employee contribution. Point-of-service plans were the most expensive, while health maintenance organization (HMO) plans were least expensive. With the exception of single coverage for conventional insurance, the cost of coverage showed little difference by size of employer. These comparisons do not account for differences in patient cost sharing, covered benefits, geographic mix, or the health status of covered employees.

Enrollment in managed care. Fifty-one percent of employees were enrolled in a managed care plan in 1993—defined as either an HMO, a preferred provider organization (PPO), or a point-of-service plan (Exhibit 4). In 1988 only 29 percent of employees were enrolled in a managed care plan (Exhibit 5). Larger firms have higher percentages of their employees enrolled in managed care plans than smaller firms do. For example, in 1993 managed care plans accounted for only 22 percent of enrollment for firms with one to twenty-four workers, whereas enrollment jumped to 59 percent for firms with 1,000 or more workers.

One reason that managed care enrollment is growing at the expense of

Exhibit 3
Total Monthly Health Insurance Premium Cost For All Plan Types,
By Firm Size, 1993

Type of plan	Number of employees					All firms
	1-24	25-49	50-199	200-999	1,000 or more	
Conventional						
Single	\$188	\$178	\$184	\$166	\$172	\$175
Family	430	422	438	424	446	439
HMO						
Single	165	143	143	161	160	157
Family	408	361	387	429	426	415
PPO						
Single	176	161	156	174	183	176
Family	347	417	380	419	468	435
Point-of-service						
Single	^a	^a	^a	162	189	184
Family	349	418	396	417	543	482
All plans						
Single	184	170	171	165	172	170
Family	417	414	417	417	448	436

Source: KPMG Peat Marwick/Wayne State University Survey of 1,953 firms, 1993.

Note: HMO is health maintenance organization; PPO is preferred provider organization.

a Insufficient sample size.

Exhibit 4
Market Shares Of Plan Types. Bv Firm Size, 1993

Type of plan	Number of employees					All firms
	1-24	25-49	50-199	200-999	1,000 or more	
Conventional	78.3%	65.2%	62.4%	44.6%	40.7%	48.9%
HMO	8.2	10.9	17.5	22.4	26.7	22.4
PPO	9.9	11.8	16.4	27.6	20.8	19.6
Point-of-service	2	12.1	3.7	5.4	11.8	9.1

Source: KPMG Peat Marwick/Wayne State University Survey of 1,953 firms, 1993.

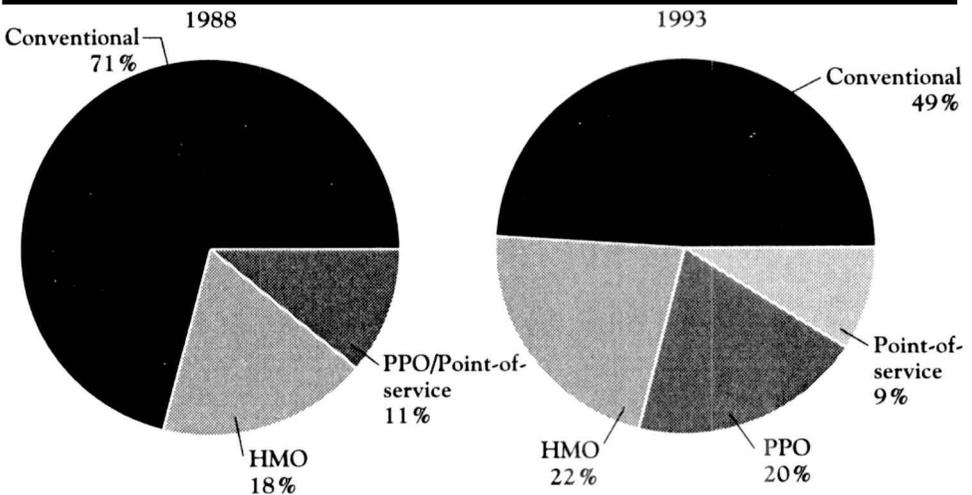
Note: HMO is health maintenance organization; PPO is preferred provider organization.

enrollment in conventional plans is that fewer employees have the option of enrolling in a conventional plan. In 1988, 90 percent of Americans who received coverage through the workplace could choose a conventional plan. In 1993 that figure had fallen to 65 percent.

cost of premiums in 1993 than in 1988. For example, employees contributed 18.5 percent of the total cost for single conventional health coverage and 29 percent of the cost for family coverage in 1993—up from the 1988 averages of about 10 percent and 25 percent for individual and family coverage, respectively. Similarly, employee contributions for HMO family and individual coverage increased from 1988 to 1993.

In 1993 larger firms tended to pay a greater share of the total health

Exhibit 5
Growth In Managed Care Enrollment, 1988-1993



Sources: KPMG Peat Marwick/Wayne State University Survey of 1,953 Firms, 1993; and Health Insurance Association of America Survey of 1,665 Employers, 1988.

Note: HMO is health maintenance organization; PPO is preferred provider organization.

premium cost than did smaller firms for all plan types (Exhibit 6). For example, the smallest firms paid 61 percent of the cost of conventional single coverage, whereas firms with 1,000 or more workers contributed 86 percent of the cost. Data displayed in Exhibit 6 clearly indicate that by making larger absolute contributions, employers are subsidizing their fee-for-service plans over their managed care plans. In fact, firms that offer both HMO and conventional plans contributed on average 15 percent more

Exhibit 6
Employee Cost Sharing, By Firm Size And Type Of Plan, 1993

	Number of employees					
	1-24	25-49	50-199	200-999	1,000 or more	All firms
Employer contributions as percent of total premium cost						
Conventional						
Single	61%	61%	77%	88%	86%	81.5%
Family	55	50	63	77	76	71.1
HMO						
Single	64	66	68	82	83	78.2
Family	63	40	54	74	76	69.6
PPO						
Single	54	74	13	82	79	76.0
Family	37	59	55	75	73	66.7
Point-of-service						
Single	-	-	-	63	88	83.4
Family	50	62	52	63	78	69.0
Average annual deductibles						
Conventional						
Single	\$347	\$249	\$263	\$191	\$222	\$236.5
Family	740	610	580	475	498	534.2
PPO						
In-plan	273	254	242	146	161	185.4
Out-of-plan	865	1,443	362	262	286	404.8
Point-of-service						
In-plan	-	-	-	61	34	38.9
out-of-plan	302	171	272	259	304	286.6
HMO copayments						
None	17%	22%	4%	30%	23%	20.6%
\$2	-	-	-	7	10	9.5
\$5	43	21	-	7	10	29.2
\$10	17	38	4	4	27	29.7
\$15	3	4	8	6	6	5.9
\$20	-	-	-	0.3	0.3	0.3
Other	17	5	14	5	3	6.2
Don't know	3	10	3	1	1	1.9

Exhibit 6**Employee Cost Sharing, By Firm Size And Type Of Plan, 1993 (cont.)**

	Number of employees					All firms
	1-24	25-49	50-199	200-999	1,000 or more	
Lifetime maximum benefit, conventional plans						
Under \$250,000	8.4%	5.4%	1.8%	2.6%	6.4%	5.4%
\$250,000-\$1 million	15.5	22.5	27.9	26.8	31.3	28.3
More than \$1 million	32.0	26.9	23.7	39.1	42.9	37.9
Unlimited	16.9	13.3	17.8	14.4	15.4	15.6
Don't know	27.2	31.9	28.8	17.0	4.1	12.8
Lifetime maximum benefit, PPO plans						
Under \$250,000	13.6%	4.2%	1.6%	2.2%	0.9%	2.5%
\$250,000-\$1 million	7.8	21.1	38.4	16.2	16.3	18.9
More than \$1 million	30.7	22.3	26.2	50.4	61.6	50.3
Unlimited	5.9	15.7	18.9	20.9	18.1	17.4
Don't know	41.9	36.7	14.9	10.3	30.1	10.9

Source: KPMG Peat Marwick/Wayne State University Survey of 1,953 firms, 1993.

Note: HMO is health maintenance organization; PPO is preferred provider organization.

dollars to the conventional plans. Since one of the tenets of managed competition is to improve the efficiency of the health care system, there must be no subsidization of more expensive plans.

Employees face higher cost sharing in the form of increased deductibles than they did five years ago. In 1993 the average annual deductibles for single and family conventional coverage were \$237 and \$534, respectively, compared to \$150 and \$348 in 1988. Deductibles in PPO plans also have increased substantially during the past five years, from \$101 to \$185 for the average in-network deductible, and from \$191 to \$405 for the out-of-plan deductible.

In general, both PPO and point-of-service plans have strengthened incentives to use network providers. Point-of-service plans have low deductibles for using in-plan providers because many are structured like an HMO and thus have no deductible. The average deductible, however, for using out-of-network providers in a point-of-service plan hovers around \$300.

Employees in small firms face higher deductibles than do those in large firms. For example, the average deductible for firms with one to twenty-four workers in a conventional single plan was \$347 in 1993, whereas the average deductible for a conventional single plan in firms with 1,000 or more workers was \$222.

Coinsurance rates in conventional plans in 1993 look much like they did in 1988: The vast majority of employees face an "80/20" coinsurance rate (Exhibit 7). To increase the use of network providers, PPO plans, on the

Exhibit 7
Coinsurance Rates For Firms With 200 Or More Employees, 1993

	Type of plan				
	Conventional	PPO		Point-of-service	
		In-network	Out-of-network	G-network	Out-of-network
No coinsurance	5%	12%	2%	44%	0.5%
10%-90%	5	39	3	26	0
15%-85%	2	8	1	2	0.5
20%-80%	77	27	41	10	42
25%-75%	0.6	2	2	0	3
30%-70%	1	0.4	32	0	40
Varies	5	4	1	5	7
Other	3	4	1	13	7
Don't know	2	0	0.2	0	1

Source: KPMG Peat Marwick/Wayne State University Survey of 1,953 firms, 1993.
 Note: PPO is preferred provider organization.

other hand, have raised the coinsurance rates faced by workers, imposing greater financial costs on workers for using out-of-network providers. In 1993 a majority of employees had to pay more than 20 percent coinsurance when using out-of-plan providers, compared with fewer than 24 percent of workers who did so in 1988. Point-of-service plans in 1993 showed even stronger incentives to use in-plan providers.

HMOs continued to use predominantly \$5 and \$10 copayment rates in 1993 (Exhibit 6). More than one-fifth of HMO enrollees still faced no copayment for an office visit, while nearly 10 percent had a \$2 copayment.

Lifetime maximum benefits failed to keep pace with the rising cost of care in conventional plans. The percentage of conventional enrollees with unlimited lifetime benefits fell from more than 20 percent in 1988 to about 15.6 percent in 1993. Surprisingly, small firms are more likely to have unlimited lifetime maximum benefits than are larger firms (Exhibit 6).⁵ In PPO plans, larger firms tend to provide greater lifetime maximum benefits.

Preexisting condition clauses. Preexisting condition limitations are a major battleground in the provision of health services: Insurers and employers may require them as a cost-saving technique, while consumers and government generally view them as restricting access to health care. Nearly three-quarters of employees in PPO plans face preexisting condition limitations, followed by 63 percent of conventional enrollees and 52 percent of point-of-service enrollees (Exhibit 8). Surprisingly, there is no apparent pattern of preexisting condition limitations across firm sizes. The average wait before such limitations expire is nine months for conventional plans and ten months for PPO plans.

Exhibit 8**Preexisting Condition Limitations In Coverage, By Firm Size, 1993**

	Number of employees					All firms
	1-24	25-49	50-199	200-999	1,000 or more	
Percent of firms with limitations						
Conventional	59%	60%	59%	66%	64%	62.9%
PPO	72	57	82	6 8	71	71.6
Point-of-service	86	66	64	6 7	40	52.4
Average wait for coverage (months)						
Conventional	8.3	9.5 ^a	9.2 ^a	8.4 ^a	9.3 ^a	9.1 ^a
HMO	- ^a	- ^a	- ^a	- ^a	- ^a	- ^a
PPO	11.1	7.2	11.3	10.3	10.0	10.2
Point-of-service	- ^b	- ^b	- ^b	8.9	7.4	7.7

Source: KPMG Peat Marwick/Wayne State University Survey of 1,953 firms, 1993.

Note: HMO is health maintenance organization; PPO is preferred provider organization.

^a HMOs generally have no preexisting condition limitations or waiting periods.

^b Insufficient data on waiting periods for point-of-service plans in small firms.

Outlook For The Future

The good news is not just that premium increases are at their lowest level since 1986–1987. With the insurance industry breaking the six-year cycle of profitability evident since 1965, indicators suggest that premium increases will be modest by historical standards for the next few years. Premiums are increasing at single-digit rates for the first time since 1986–1987, yet the insurance industry has maintained profitability. The implication is that increases in medical claims expenses per family have moderated.

Why the decreased growth rate in premiums and medical claims expenses? First, the experience of the underwriting cycle would predict modest increases in premiums in 1992–1993. Second, some of the moderation in inflation in medical claims expenses is a spillover from the decline in overall inflation in the economy—inflation in the health sector tends to lag that in the overall economy by about a year. A third possible explanation is that managed care and utilization management collectively have altered the mindset and practice patterns of physicians and hospitals. Finally, a fourth possible explanation is the so-called Hillary effect. Like the Voluntary Effort of the hospital industry in the late 1970s, the provider community is showing restraint in raising charges for fear that higher inflation will encourage more draconian measures in health care reform. If the experience of the Voluntary Effort is repeated, rapid inflation will ensue once the threat of national health care reform is removed.

A further cause for optimism can be found in the statistics on the small-employer market. These statistics suggest that purchasing coopera-

tives could realize significant savings by bringing managed care to small firms. Managed care enrollments among small firms lag behind those in the mid-size and large markets.⁶ Most small firms offer just one plan, and in most cases that plan is a conventional plan. Yet in the small-employer market conventional plans not only have higher premium costs but require higher employee cost sharing; in addition, they have experienced considerably higher rates of increase in premiums than managed care plans have.

Optimism on the health care front has its limits. Premium increases remain more than double the overall rate of inflation. Since 1986 premiums have increased more than 3.5 times the overall rate of inflation and nearly five times as much as wages for nonsupervisory workers.⁷

In comparing 1988 data with 1993 data, we note some trends. Managed care enrollment has grown to 51 percent of the market—60 percent among larger employers. Employers have increased cost sharing in all types of plans. Employees pay a larger share of the monthly cost of premiums, deductibles are up, and lifetime maximum benefits have been reduced. Managed care plans have enhanced their incentives to use network providers by increasing employees' out-of-pocket expenses when employees use nonnetwork providers. If current trends continue, even without any health care reform legislation, 1970s-style health insurance—where employees received free health insurance, faced low deductibles, and could choose any provider without financial penalty—will become a statistical outlier.

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NOTES

1. In the KPMG Peat Marwick survey of 1,003 employers, 662 were from a panel of firms from the 1992 KPMG Peat Marwick survey of firms with 200 or more workers.
2. For more on the HIAA study, see J. Gabel et al., "Employer-Sponsored Health Insurance in America," *Health Affairs* (Summer 1989): 116-128.
3. See J. Gabel et al., "Tracing the Cycle of Health Insurance," *Health Affairs* (Winter 1991): 48-61.
4. M. Schahner, "Health Insurers Post Strong Results but Won't Cut Rates," *Business Insurance* (31 August 1993): 1; and T. Musco, unpublished data from the Health Insurance Association of America.
5. Employee turnover is greater in small firms, which may make unlimited benefits less risky in small than in large firms.
6. One reason that managed care enrollments lag in the small-employer sector is that insurers have more to gain from risk selection than from efficient management of costs.
7. KPMG Peat Marwick, *Health Benefits in 1993* (Montvale, N.J.: KPMG Peat Marwick, 1993), 9. Data on overall inflation and wages are from the Bureau of Labor Statistics.