Job-Based Health Insurance In 2000: Premiums Rise Sharply While Coverage Grows

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America enjoyed an unprecedented period of low inflation in the health care sector from 1994 to 1998. Over this four-year stretch the cost of job-based insurance increased more slowly than the overall rate of inflation.\(^1\) Virtually no expert forecast the slowdown in premiums or overall health care spending. For example, in 1992 the Congressional Budget Office (CBO) projected that national health care spending would reach 18 percent of gross domestic product (GDP) by 2000.\(^2\) Assisted by strong economic growth, health care spending in 1998 constituted only 13.5 percent of GDP, two-tenths of a percentage point lower than in 1993.\(^3\) The difference between projected and actual health spending was approximately $250 billion, roughly equivalent to what the nation spends on kindergarten-grade twelve education.\(^4\) Thus, prolonged periods of health care inflation or price stability can profoundly affect a nation’s spending priorities.

Low inflation and the best economy in three decades did not deliver a robust expansion in health coverage. True, these two factors have reversed the decline in employer-based coverage that occurred between 1988 and 1993, when the percentage of the population under age sixty-five with job-based coverage fell from 69.5 percent to 63.5 percent. Yet the percentage of workers with coverage rose only to 64.9 percent by 1998.\(^5\)

Relying on anecdotes, many major magazines and newspapers prematurely reported the return of inflation in job-based health insurance, beginning in January 1997.\(^6\) Data from the Bureau of Labor Statistics (BLS) and the survey on which we report here indicate that the rate of inflation did rise every year from 1996 to 1999 yet remained below 5 percent in 1999.\(^7\) In contrast, by exposing that the number of uninsured persons was rising in the midst of falling unemployment, the media helped to position health care as a major issue for the 2000 presidential contest.\(^8\)

This paper examines the state of employer-based health insurance in the spring of 2000, and how it has changed over the past year and since 1988. Among the facets of health insurance of interest are the cost of health insurance to employers and employees; enrollment in different types of health plans; cost sharing and covered benefits; and coverage and eligibility of the workforce.
Study Methods

The Kaiser Family Foundation/Health Research and Educational Trust (Kaiser/HRET) Survey of Employer-Sponsored Health Benefits is an annual survey of employer-based health plans. Core elements of the survey are a continuation of the benefit survey conducted by KPMG Peat Marwick from 1991 to 1998 and the Health Insurance Association of America (HIAA) from 1987 to 1991. From January to May 2000, National Research LLC, a Washington-based survey firm, completed interviews with employee benefit managers from 1,887 public and private employers. The survey asks more than 400 questions about its largest conventional or indemnity, health maintenance organization (HMO), preferred provider organization (PPO), and point-of-service (POS) health plans. Employers range in size from three to hundreds of thousands of employees.

Kaiser/HRET drew its sample from a Dun and Bradstreet list of the nation’s private and public employers with three or more workers. To increase precision, Kaiser/HRET stratified the sample by the number of workers in the firm and industry. This year’s total sample of 1,887 firms included 982 firms that participated in both the 1999 and 2000 surveys. The overall response rate was 45 percent, down from 60 percent in 1999 largely as a result of the decision not to reinterview any of the firms with three to nine workers that participated in the 1999 survey. Our response rate for firms with three to nine workers was 30 percent.

Previous years’ experiences show that firms that decline to participate in the study are more likely not to offer health coverage. We therefore asked one question to all sample firms with which we made contact but that declined to participate: “Does your company offer or contribute to a health insurance program as a benefit to your employees?” A total of 3,402 firms responded to this question (including 1,887 that responded to the full survey and 1,515 that responded to this one question). Our estimates of the percentage of firms offering health coverage are thus based on the broader sample of 3,402 firms, including firms declining to participate in the full survey.

Because this is a random sample of firms, it is possible to use statistical weights to extrapolate the results to national (as well as regional, industry, and firm-size) averages. We calculated weights by determining the basic weight, applying a non-response adjustment, and then applying a post-stratification adjustment.

Survey Findings

**Premium increases.** Premiums rose 8.3 percent from spring 1999 to spring 2000, a sharp upsurge from the 4.8 percent figure for 1998–1999 and 3.7 percent for 1997–1998 (Exhibit 1). Premium increases were more than 2.5 times the overall rate of inflation. All plan types and regions of the nation experienced sharply higher premiums. Conventional plans had the highest rate of increase (10.5 percent), followed by PPO plans (8.6 percent), HMO plans (8.1 percent), and POS plans (7.8 percent). Premiums for firms located in the Northeast grew most rapidly (8.9 percent), while those in the West grew more slowly (7.6 percent).

Higher premiums in 2000 reflect two forces at work: the health insurance underwriting cycle and surging claims expenses.
catch-up phase of the underwriting cycle.\textsuperscript{11} The second force was a surge in underlying medical claims expenses. Premium equivalents for self-insured health plans rose 7.1 percent in 2000, up from 3.8 percent in 1998–1999. The rate of increase in premium equivalents corresponds to the expected increase in medical claims expenses in self-insured plans. Although less than the 9.4 percent premium increase that occurred in fully insured plans, this 7.1 percent growth indicates that claims expenses rose sharply over the past two years. Prescription drug expenses constitute 40 percent of this increase, by some estimates.\textsuperscript{12}

In the 2000 Kaiser/HRET survey, respondents were asked, “How much do you think each of the following factors is contributing to increases in health insurance premiums?” Employers identified prescription drug costs (75 percent) most often as contributing “a lot” to the rising cost of premiums. Other factors and the percentage saying “a lot” were hospital expenses (49 percent); medical technology (42 percent); physician expenses (37 percent); insurer profits (18 percent); and richer benefit packages (10 percent).

\textbf{Cost of coverage.} The average monthly cost for single coverage, including both the employer and employee contribution, was $202, while the average cost for family coverage was $529 (Exhibit 2). Employers spent the most on conventional coverage—on average, $238 a month for single coverage and $624 for family coverage. They spent the least on HMO coverage—24 percent less than conventional coverage for single and 22 percent less for family coverage. The cost of health insurance is highest in the Northeast and lowest in the West. All of the above comparisons do not control for the breadth of covered benefits, differences in patient cost sharing, or the health status or geographic location of the covered population.

\textbf{Employee contributions and patient cost sharing.} Despite the rise in the cost of health insurance, American workers contributed no more for monthly premiums for single and family coverage in 2000 than they did in 1999—whether measured in absolute dollars or as a percentage of the total bill (Exhibit 3).
Comparing 1996 with 2000, employees with single coverage have enjoyed a statistically significant decline (testing results are not shown) in both absolute dollars and the percentage of the monthly premium for their contribution. Employees contributed $37 per month in 1996 on average for single coverage and $28 in 2000. These contributions constituted 21 percent of the monthly cost of coverage in 1996 and 14 percent in 2000.

Employers made modest changes in cost-sharing requirements during the past year. For example, the average deductible for using non-network providers increased 15 percent in PPO plans, and the average deductible in POS plans when using network providers grew from $41 to $79. Copayments rose in both HMO and POS plans. For example, in HMO plans $15 copays are more commonplace today than $5 copays, whereas in 1999 $5 copays were 2.5 times more commonplace.

### Prescription drug coverage

With prescription drug expenses rising at double-digit rates, the survey included new questions...
about the nature of drug coverage. Virtually every employer-based plan covers prescription drugs. Only 3 percent of employees are subject to a drug benefit cap. Fewer than 10 percent of workers face a separate annual deductible for prescription drug benefits.

Copays varied greatly among classes of drugs (generic versus brand-name). About one-third of managed care plan members are in a plan with three tiers of cost sharing, and about 45 percent are in a plan with a two-tier formula. About one-fifth of members face the same copayment or coinsurance level regardless of whether the drug is generic or brand name. Under a two-tier formula, employees face one payment level for generic drugs and another for all brand-name drugs. Under a three-tier formula, one payment level exists for use of generic drugs, another payment level for use of brand-name drugs that have no generic substitute, and a third payment level for use of brand-name drugs that have a generic substitute.

■ Plan enrollment. In 2000, 29 percent of those with employment-based insurance are enrolled in an HMO, unchanged statistically from 31 percent in 1996 (Exhibit 4). In contrast, the share of enrollment in PPOs has grown to 41 percent, up from 38 percent in 1999 and 28 percent in 1996. Enrollment in POS plans (which combine elements of HMOs and PPOs by permitting use of nonnetwork providers yet at the same time using HMO-like management techniques) grew rapidly in the mid-1990s, but that growth appears to have ended. POS plans’ share of enrollment now stands at 22 percent. Conventional fee-for-service (FFS) insurance has all but disappeared in the employer market, with just 8 percent of enrollment this year.

Employers have altered their menu of plan choices in recent years, and this has affected
plan enrollments. Since 1996 the percentage of covered workers who can choose an HMO has declined from 64 percent to 55 percent, while the percentage who can choose a PPO has risen from 45 percent to 66 percent. Overall, about two-thirds of covered employees in 2000 continue to work for a firm that offers more than one health plan, but choice varies dramatically by firm size. While 84 percent of firms with 5,000 or more employees offer more than one health plan, just 9 percent of firms with three to 199 workers do so.

**Coverage.** The continuing economic boom and high demand for labor may finally be affecting health insurance coverage. In 2000 two-thirds (67 percent) of all small firms (those with 3–199 employees) report offering health coverage to their workers, up from 54 percent in 1998 (Exhibit 5). Coverage continues to vary by firm size: 60 percent of the smallest firms (three to nine workers) offer coverage, but that rises to 79 percent for firms with ten to twenty-four workers and 87 percent for companies with twenty-five to forty-nine employees. Nearly all firms with fifty or more employees offer coverage. Firms that employ many low-wage workers are less likely to offer coverage. For example, while just 35 percent of low-wage small firms (firms with fewer than 200 workers in which 35 percent or more earn less than $20,000 per year) offer coverage to their workers, 85 percent of high-wage small firms (where 10 percent or less of the workforce is low paid) do so.14

However, offering health insurance does not necessarily mean that workers get covered. Some employees are not eligible to enroll as a result of waiting periods or minimum-work-hour rules, and others choose not to enroll because they must pay a share of the premium or have coverage available elsewhere (for example, through a spouse). Overall, employers that offer coverage report that 79 percent of workers are eligible for the coverage, and 81 percent of those who are eligible choose to take it up (meaning that 65 percent of employees in firms that offer coverage end up being covered by their firm). When em-

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**EXHIBIT 5**

**Percentage Of Firms Offering Health Benefits, By Firm Size, Selected Years 1996–2000**

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**3–9 workers** | **10–24 workers** | **25–49 workers** | **50–99 workers** | **All small firms** | **All large firms**


**NOTES:** Tests found no statistically different estimates from the previous years. Year 2000 small-firm figure (67 percent) is statistically different from 1998 figure (60 percent) (alpha = .05).
ployers were asked their perceptions of why workers decline coverage for which they are eligible, the vast majority (72 percent) said that the main reason is because they have coverage elsewhere, followed by 11 percent who said that employees cannot afford their share of the premium.

Conclusions And Policy Implications

We may finally be seeing the positive effects of the nation’s long-running economic boom on the offering of health insurance by employers. However, the return of large annual premium increases—driven in large part by rising drug expenditures—may snuff out those improvements before they have a chance to take hold.

More employers are offering coverage to their workers, and companies continued to absorb most of the increases in premiums in 2000—average employee contributions did not rise at all. This is presumably in large part because of the need to attract workers in an economy marked by low unemployment. However, if the economy suffers a recession, and workers become plentiful once again, a chain of unfavorable events could follow. Assuming that premiums continue to rise at their year 2000 level—greatly exceeding the rise in workers’ wages and general inflation—and unemployment rises, employers will likely shift costs to workers (as occurred in the late 1980s and early 1990s). This will lead to a lower takeup rate of coverage, especially among lower-wage employees for whom affordability is a significant issue. In a softer economy, large premium increases also may lead some employers to drop coverage altogether, or at least to make it less likely that new firms will offer coverage.

In recent years, as policymakers have considered how to expand coverage for the uninsured, strategies have generally focused on non-employer-based solutions (such as expanding public programs like Medicaid or providing tax benefits for individuals to buy insurance on their own). Whether the job of covering the uninsured will get easier or harder, however, will depend in large part on whether employer-sponsored coverage expands or contracts over time. And that, in turn, will depend primarily on how the economy performs and how fast health insurance premiums rise in the coming years.

By most accounts, the primary culprit behind the recent growth in underlying health care expenses is prescription drugs, another topic of great interest to policymakers as they consider ways to expand prescription drug coverage among Medicare beneficiaries and to control the growth in drug spending. This survey finds that prescription drugs are now a standard benefit in employer-sponsored insurance. Coverage also tends to be much more comprehensive than what has been considered in proposals to reform Medicare; few employers put caps on drug benefits or have a separate deductible for prescription drugs. However, employers have moved rapidly to put in place measures to control the cost of drugs, in part by shifting costs to employees. Copayment structures with two or three tiers now predominate. Most covered workers have benefits that provide incentives to choose less expensive (generic) drugs.

Legend has it that when Albert Einstein taught a graduate course in physics at Princeton, he gave a test one day, and a student approached him, saying, “Professor Einstein, the questions on the exam are the same ones as last year.” Einstein paused, scratched his chin, and replied, “That’s right. But the answers are different this year!” We are struck by how different the answers about the health care economy are from just a few years ago. Stable premiums...
have turned to rapidly rising ones. Employees are paying less, rather than more, for their health insurance. Managed care “light” rather than “heavy” is on the rise. Coverage, rather than eroding in the face of rising costs, is expanding—if only momentarily. These paradoxical trends are made possible by an economy that has put more money in the pockets of American households and businesses than ever before. Of course, next year may provide an entirely different set of answers!

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NOTES


9. Analysis of earlier years’ data revealed that panel firms are more likely to offer health insurance than nonpanel firms, and our major interest with the smallest firms is to identify the percentage of firms offering coverage. Hence, in 2000, to obtain more accurate statistics on small firms’ likelihood of offering health benefits, we did not re-interview firms with 3–9 workers from the 1999 sample. This does affect the comparability of estimates between 1999 and 2000. However, we believe that our estimates are conservative, since the observed increase in offer rate from 55 percent in 1999 to 60 percent in 2000 is not significant. Furthermore, we compared the 1999 offer rate for nonpanel firms with 3–9 workers with the 2000 offer rate for firms with 3–9 workers (all of whom were newly interviewed), and again found no significant difference. While we recognize that the response rate among firms of this size is low and may lead to biased results, for the important question of whether the firm offers coverage, 80 percent of the overall sample and 70 percent of firms with 3–9 workers responded to the question, “Do you offer health benefits to your employees?”

10. In comparison, unpublished data from the Bureau of Labor Statistics’ employment cost index (ECI) indicate that the average cost per employee increased 7.6 percent during this same period. The ECI measures the cost to the employer per worker and hence does not include workers’ contributions in the calculations.

11. InterStudy reported that in 1997 one-third of HMOs showed a profit. InterStudy Competitive Edge, Part II: HMO Industry Report, Vol. 8.2 (October 1998). HCIA reported that 44 percent of HMOs were profitable in 1996. HCIA, Guide to the Managed Care Industry (Baltimore: HCIA, 1997).


13. The change from 1999 is not statistically significant at the .05 level but is significant when compared to 1998.