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Report to the Chairman, Committee on Labor and Human Resources, U.S. Senate

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PRIVATE HEALTH INSURANCE

Continued Erosion of Coverage Linked to Cost Pressures

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GAO

United States
General Accounting Office
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Health, Education, and
Human Services Division

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July 24, 1997

The Honorable James M. Jeffords
Chairman, Committee on Labor
and Human Resources
United States Senate

Dear Mr. Chairman:

In response to your request, this report provides information on major trends in the private health insurance market during the 1980s and 1990s. Specifically, the report discusses the decline in private health insurance coverage and factors contributing to this decline, trends in health insurance premiums and reasons for these trends, and employers' efforts to control health benefits costs.

We are sending copies of the report to interested congressional committees and are making copies available to others on request.

This report was prepared under the direction of Michael Gutowski, Assistant Director, who may be reached at (202) 512-7128 if you or your staff have any questions. Other major contributors to this report are listed in appendix III.

Sincerely yours,

Jonathan Ratner
Associate Director, Health Financing
and Systems Issues

Executive Summary

Purpose

Spending on private health insurance represents one-third of all U.S. health expenditures—or nearly 5 cents of every dollar spent in the United States. This significant share of the U.S. economy provides health coverage for 7 of every 10 Americans. During the past decade, private health insurance has undergone fundamental changes in who is covered, how much coverage costs, and the type of coverage Americans receive. To better understand the major trends in private health insurance during the 1980s and 1990s, the Chairman of the Senate Committee on Labor and Human Resources asked GAO to report on

- trends in the number of people covered by private health insurance and factors affecting health coverage rates and
- changes in health insurance premiums, including reasons for these changes and efforts to control the costs of providing health benefits.

Background

Most Americans rely on private health insurance to help pay for medical expenses. More than 90 percent of people with private health insurance coverage have access to group insurance through employment. However, some people, particularly those unable to get employment-based health benefits, purchase health insurance directly in the individual insurance market. While the premium cost of employment-based coverage is generally shared by the employer and the employee, participants in the individual market must absorb the entire premium costs out of pocket.

Results in Brief

Private health insurance coverage has slowly but steadily declined. Between 1980 and 1995, the population under age 65 covered by private health insurance decreased from 79.5 percent to 70.5 percent. (In 1995, about 164 million persons under age 65 were covered by private health insurance.) This trend has continued even though the U.S. economy has been strong and employment has grown. Coverage for children, early retirees, and near-poor families has declined faster than that for the overall population. For example, just from 1989 to 1995 the level of private health coverage for children declined by 7 percentage points compared to a decline of 4.5 percentage points in the overall population under 65. Declining private health coverage has been accompanied by growth in the uninsured population and Medicaid enrollment, which in turn increased government health expenditures. The proportions of the population under age 65 that are uninsured or are Medicaid recipients increased by 5.5 and 4.3 percentage points, respectively, between 1980 and 1995. A major reason for declining private health coverage is the rising cost of health

insurance. This has absorbed a growing share of business and family incomes and has influenced employers and employees' health insurance decisions. Other factors that contribute to declining coverage include shifts in employment patterns, low growth in real family income, and the indirect effects of expanded Medicaid coverage.

Health insurance premiums, in contrast, have alternated between rapid growth and relative stability over the past two decades. During the late 1980s, employers faced sharply rising health insurance premiums. In contrast, premium growth rates have decelerated in the 1990s and remained relatively stable in recent years. It is unclear whether this stability in premiums is likely to continue. Several reasons cited as contributing to the recent near-zero growth in health plan premiums include the cyclical nature of health insurance premiums, the expansion of managed care, the increasingly competitive market for health insurance, and low overall inflation. Nonetheless, the high level of health insurance costs and uncertainty about future increases remain a concern of employers and individuals purchasing coverage. For example, in 1996, average annual premiums for family coverage ranged from $5,071 for a health maintenance organization (HMO) plan to $5,388 for an indemnity plan. Average premiums for family coverage have more than doubled since 1988.

As employers have adopted various strategies to control the costs of health benefits, the costs consumers bear have increased and the types of health insurance products they receive has evolved. Since 1980, employees are more likely to be required to pay a share of their health plans' premiums—typically 20 to 30 percent. In addition, most Americans are now enrolled in a network-based plan. A network-based plan requires or encourages enrollees to use physicians and hospitals affiliated with the plan. However, network-based plans often have lower deductibles, and most of these plans allow enrollees to use nonaffiliated providers at a higher cost. Finally, nearly 40 percent of persons with private employer-based health insurance participate in a self-funded plan. In such plans, unlike conventional health insurance, the employer assumes the risk for health claims and the plan is exempt from state insurance regulation.

If at some point health insurance costs start rising again, employers and insurers will face heightened pressure to control costs. This may lead to increased cost shifting from employers to employees, reduced benefits in

employer-based health plans, and faster declines in the number of employers offering health benefits.

Principal Findings

Private Health Coverage Decreasing Across All Segments of the Population but at Higher Rates Among Children, Early Retirees, and the Near Poor

Private health coverage gradually declined for many Americans between 1980 and 1995. During this period, the population under 65 with private health insurance fell by 9 percentage points (from 79.5 percent to 70.5 percent). This decline was accompanied by an increase in the numbers of nonelderly Americans who are uninsured or covered by Medicaid. The uninsured as a percentage of Americans under age 65 increased from 11.8 percent in 1980 to 17.3 percent in 1995—over 40 million Americans in 1995. Similarly, Medicaid enrollment among the population under 65 grew from about 8.2 percent to 12.5 in the same period.

The erosion of private health insurance has affected people in nearly all demographic and employment categories, but children, early retirees, and near-poor families experienced the greatest decline in coverage. Health coverage for children decreased by 7 percentage points, from about 73 percent to 66 percent between 1989 and 1995, compared to a 4.5 percentage point decline for the overall nonelderly population during this period. If children's private health insurance coverage had remained at the 1989 level, nearly 5 million more children would have been covered by private health insurance in 1995. Similarly, private health coverage rates for retirees under age 65 dropped from nearly 76 percent in 1989 to 69 percent in 1995. While private coverage also decreased for families between 100 and 200 percent of the federal poverty level, some children and pregnant women in this income range gained Medicaid coverage.

Rising Health Care Costs a Key Factor in the Decline in Health Coverage

A number of factors have contributed to the decline in private health coverage for specific time periods. Among the reasons researchers cite are rising health care costs, shifts in employment patterns, low rates of growth in real family incomes, and the indirect effects of expanded Medicaid coverage. Health care cost increases have affected employers' decisions to limit or drop coverage for employees and to increase employees' share of health insurance costs, as well as employees' decisions to purchase health coverage. No single study has measured the effect these factors had throughout the 1980s and 1990s. The extent to which Medicaid expansions

have caused private health coverage to decline as opposed to covering people who otherwise would have been uninsured is still in dispute.

Rapid Growth in Health Insurance Premiums During the Late 1980s Followed by Recent Near-Zero Growth

Private health insurance premiums have exhibited a cyclical growth pattern over the past two decades. Premium growth rates increased sharply during the late 1980s, but growth rates decelerated throughout the 1990s. For example, real premium growth rates of indemnity, preferred provider organization (PPO), and HMO plans peaked at 15.2, 13.2, and 11.2 percent, respectively, in 1989. Real premium growth rates slowed to an average of about 5 percent across all health plan types in 1993. Over the past 2 years, health insurance premiums have grown at lower rates than the overall price and medical price indexes.

Health experts attribute the declining growth in health insurance premiums to several factors, including cyclical trends in the health insurance industry. Since 1970, premiums have declined to near zero growth in real terms in at least three periods. Periods of very low growth in private health insurance premiums—similar to the current situation—occurred around 1980 and 1986. Other factors often cited as contributing to the slowdown in premium growth rates include the low overall inflation rate of the past several years, the effects of managed care, and the increasingly competitive market for health insurance from purchasers' seeking lower prices and insurers' and HMOs attempting to gain market share.

Some health analysts maintain that recent declines show that health cost growth has been tamed, but other analysts are beginning to discuss early signs of potential premium increases. For example, Foster Higgins reported that many HMOs have raised premiums because of sagging profits and that most of the savings from managed care have already been achieved. Thus, whether premium growth will rise or remain low is unclear.

Employers' Responses to Rising Health Benefit Costs Are Changing the Nature of Private Health Insurance

Employers have adopted a variety of methods to address their high health benefits costs, such as requiring employees to assume a greater share of health plan costs, encouraging use of managed care plans, and self-funding employee coverage. Some of these methods are changing the cost and nature of private health insurance coverage for employees. For example, the average share of premiums paid by employees for single coverage more than doubled from 10 percent in 1988 to 22 percent in 1996.

Three-quarters of people with employment-based health coverage are enrolled in a network-based health plan. Most of this growth has occurred in newer, hybrid types of managed care plans, such as PPOs and point-of-service (POS) plans, which are less restrictive than traditional HMOs.

In addition, many employers have self-funded their health plans, assuming much of the risk for health claims directly rather than purchasing insurance from a third party. In this way, the employer gains greater control over the health plan, avoids costs associated with state taxes and regulation, and can provide uniform benefits across states. However, the plan is not subject to state oversight.

Concluding Observations

Rising health care costs and the erosion of private employment-based health insurance coverage have contributed to the rapid transformation of America's health insurance system. People who receive coverage through private sector employment are paying a growing share of their health plan's premiums, but their out-of-pocket expenses have only increased moderately. In addition, many people with employer-based coverage are more likely to have some limitation in their choice of health plan or health provider. Further, more people depend on Medicaid coverage or are uninsured.

The erosion of private health insurance coverage has continued even during years of national economic growth. Although health policy experts are not anticipating the rapid increases in health costs of the late 1980s, the extent of future changes in premium costs remain uncertain. Many of the underlying pressures for rising health care costs, including an aging society and new medical technologies, remain. If private health coverage continues to erode, federal and state policy decisionmakers will be called upon to tackle issues of access, affordability, and quality of health insurance, particularly for children, early retirees, and near-poor families.

Recommendations

GAO is making no recommendations in this report.

Comments From Outside Reviewers

GAO obtained comments on a draft of this report from experts on private health insurance. The reviewers agreed with the report and also provided suggestions that GAO included where appropriate.

Contents

Figures

Abbreviations

AAHP	American Association of Health Plans
BLS	Bureau of Labor Statistics
CPS	Current Population Survey
ERISA	Employee Retirement Income Security Act of 1974
HCFA	Health Care Financing Administration
HIAA	Health Insurance Association of America
HIPAA	Health Insurance Portability and Accountability Act
HMO	health maintenance organization
IPA	independent practice association
POS	point of service
PPO	preferred provider organization

Introduction

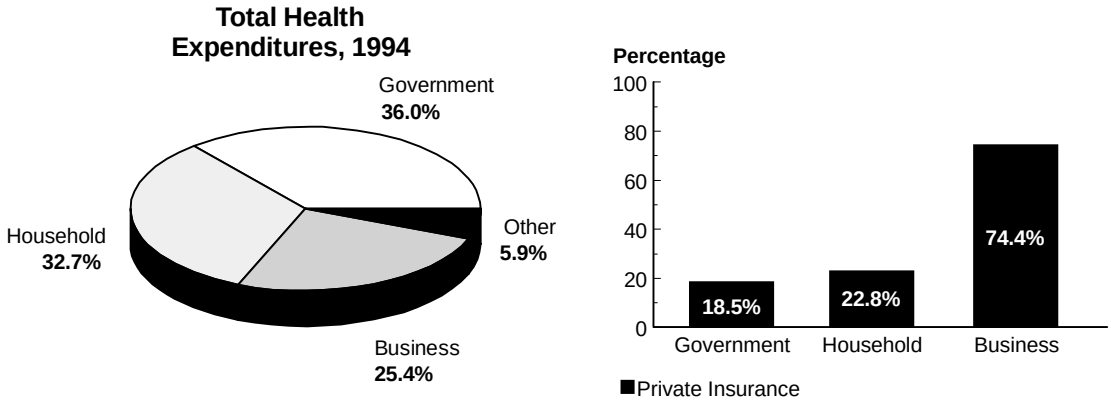
The U.S. health insurance market is often characterized as a private, employer-based system. Most Americans under age 65 participate in the health insurance market through employer-based health plans, and contributions to private health insurance represent the bulk of employer spending on health care. Federal and state policy initiatives such as the Employee Retirement Income Security Act of 1974 (ERISA) and state legislation regulating the small employer health insurance market have had major implications in the development of the private health insurance market.

Private Health Insurance: A Significant Share of U.S. Health Spending, Particularly for Private Businesses

Of the $950 billion spent on health care in the United States in 1994, private health insurance accounts for about one-third ($313 billion). Businesses paid for the majority of these private health insurance costs, but individuals and federal, state, and local governments paid for over 40 percent of total spending on private health insurance.[1] (See fig. 1.1 for distributions of total health spending by businesses, households, and government and the share spent by each for private health insurance.) Moreover, about one-third of what businesses paid for private health insurance—an estimated $65 billion in 1996—is returned in the form of tax subsidies resulting from the tax deductibility of employer health insurance expenses.

[1]Individuals pay for the employee share of employment-based private health insurance and the entire cost of individually purchased coverage. Federal, state, and local governments contribute to the premium costs of their employees' health benefits. For more details on health spending by sector, see Cathy A. Cowan and others, "Business, Households, and Government: Health Spending, 1994," Health Care Financing Review, Vol. 17, No. 4 (summer 1996), pp. 157-78.

Figure 1.1: Businesses, Households, and Government All Pay for Private Health Insurance



Note: "Other" includes nonpatient revenues and research and construction.

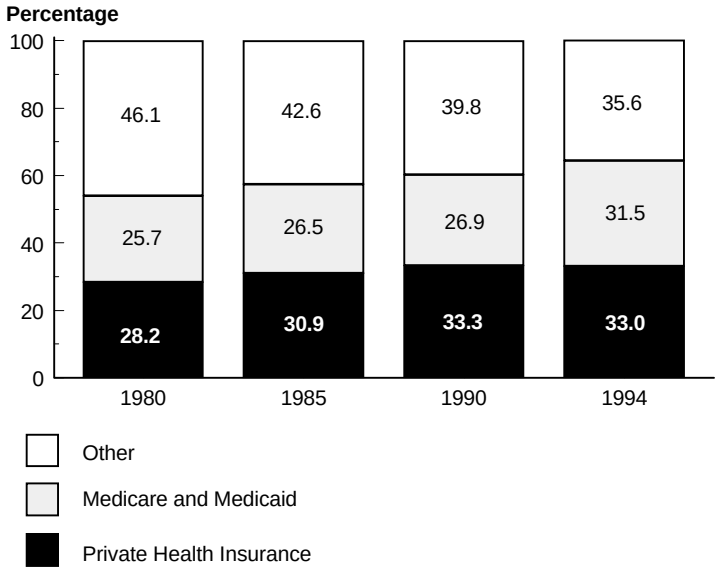
Source: HCFA, Office of the Actuary.

Public health insurance, including Medicare and Medicaid, also represents about one-third of total U.S. health spending. The remaining 36 percent of health spending is not financed through health insurance but represents out-of-pocket spending by consumers for copayments, deductibles, and medical services not covered by insurance.[2]

Figure 1.2 shows the changes in health expenditures from 1980 to 1994 for different categories of spending. Increases in health care expenditures during this period stemmed from numerous factors, including changes in medical technology, general price inflation, rising health care prices, the aging of the population, and an increase in the overall population.

[2]The remainder also includes research and construction costs and nonpatient revenues (such as charitable donations).

Figure 1.2: Private Health Insurance and National Health Expenditures, 1980-94



Note: "Other" includes out-of-pocket spending; other federal, state, and local programs; nonpatient revenues; and research and construction.

Source: HCFA, Office of the Actuary.

Public Policy Has Shaped Private Health Insurance

Both federal and state government policies have shaped the development of private health insurance. Two major federal laws have influenced the employer provision of health benefits. Since 1954, the tax code has encouraged employment-based health coverage by making employer health benefit payments tax-deductible and by excluding employee-provided benefits from employees' taxable income. ERISA allows employers to offer uniform national health benefits by preempting states from directly regulating employer benefit plans. As a result, states are unable to directly regulate self-funded health plans but can regulate health insurers.[3] Between 1990 and 1994, 45 states enacted legislation to increase access and affordability of health insurance for small employers; by 1995,

[3]For information on the implications of ERISA for private health insurance, see Employer-Based Health Plans: Issues, Trends, and Challenges Posed by ERISA (GAO/HEHS-95-167, July 25, 1995).

25 states had also enacted reforms in the individual market.[4] States also have required insurers to provide coverage for specific benefits, such as mental health care, mammography screening, and services provided by chiropractors and optometrists.[5] Recent federal legislation, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), has expanded the federal role in regulating private health insurance and may set precedents for further amendments to ERISA and the tax deductibility of health insurance.

Scope and Methodology

This report focuses on key trends in the number of people covered by private health insurance and the cost of health coverage since 1980. We also examined how efforts to control costs have resulted in changes to the health coverage Americans receive. To examine overall changes in the number of people covered, we analyzed data reported by the Bureau of the Census's Current Population Survey (CPS) from 1980 to 1995. Because of changes in the CPS during this time, we adjusted the data for some years to make them more comparable. While these adjustments enhance the comparability of data on health coverage for the population under age 65, we did not attempt to adjust data to make comparisons among regional, employment, and demographic population groups. Instead, to examine trends in coverage among these segments of the population, we analyzed data from the CPS for 1989 and 1995—a period for which the data are comparable without further adjustments.

To develop trend data on costs of coverage and changes in employer-sponsored health benefits, we used data from a variety of sources. We reviewed several employer surveys, including those conducted by the Bureau of Labor Statistics (BLS), Foster Higgins, and KPMG Peat Marwick to gain information on employment-based health plans, including premiums and types of plans offered. Data on national health spending are from the Health Care Financing Administration (HCFA).

In addition, we reviewed literature on reasons for declining health coverage, changes in health costs, and private sector initiatives to control costs. We also built on information from earlier GAO reports on private health insurance. A list of related GAO reports is included at the end of this

[4]For more information on state reforms in the small employer and individual health insurance markets, see Health Insurance Regulation: Variation in Recent State Small Employer Health Insurance Reforms (GAO/HEHS-95-161FS, June 12, 1995) and Private Health Insurance: Millions Relying on Individual Market Face Cost and Coverage Trade-Offs (GAO/HEHS-97-8, Nov. 25, 1996).

[5]For information on mandated benefits and other state requirements on health insurers, see Health Insurance Regulation: Varying State Requirements Affect Cost of Insurance (GAO/HEHS-96-161, Aug. 19, 1996).

report. Appendix I provides a more detailed discussion of the data sources we used and our methodology for making estimates. We conducted our review from December 1996 to May 1997 in accordance with generally accepted government auditing standards.

The Share of the Population Under 65 With Private Health Insurance Coverage Has Slowly but Steadily Declined

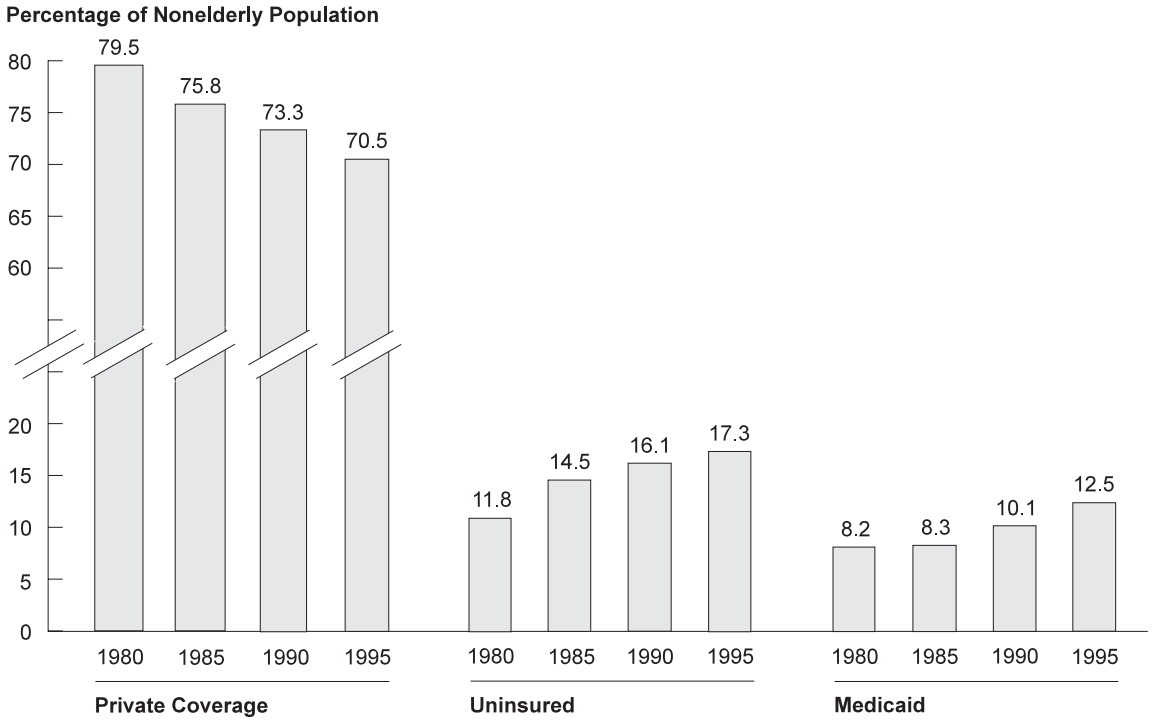
During the 1980s and 1990s, private health insurance has covered a declining share of the population under age 65. The gradual decline in private health coverage has been nearly universal, although children, early retirees, and near-poor families have experienced somewhat greater declines in coverage. Changes in employment patterns, low real growth in family incomes, and expanded Medicaid coverage may have contributed to the decline in private coverage, but the rapid increase in health insurance premiums during much of this time period has made coverage less affordable for many families and employers.

Declining Private Health Insurance Has Been Accompanied by Growth in the Uninsured Population and in Medicaid Enrollment

The slow but steady erosion of private coverage has resulted in significant long-term increases in the uninsured population and increases in publicly provided insurance. We estimate that between 1980 and 1995, the share of the nonelderly population covered by private health insurance fell from 79.5 percent to 70.5 percent.[6] (See fig. 2.1.) While most Americans under 65 continue to have private health insurance—164 million people in 1995—nearly 21 million more would have had private health insurance if coverage had remained at the 1980 level.

[6]Our estimates of health insurance coverage rates are based on data from the Bureau of the Census's CPS for the period 1979 to 1996. However, changes in the survey methodology make comparisons of coverage rates over time difficult. Appendix I discusses how we adjusted the CPS data prior to 1992 to make them more comparable with the recent CPS data on health insurance coverage.

Figure 2.1: Estimates of Private Health Coverage and Uninsured Rates, 1980-95



Note: Data were adjusted to account for changes in survey methodology. See app. I.

Source: GAO estimate based on Bureau of the Census data.

An increase in the share of the population under 65 that is uninsured or covered by Medicaid has accompanied this decline in private coverage. In 1995, 17.3 percent of the population under 65—more than 40 million Americans—lacked any health insurance coverage, compared to 11.8 percent in 1980. Similarly, the share of the population under 65 covered by Medicaid grew from an estimated 8.2 percent in 1980 to 12.5 percent in 1995.[7]

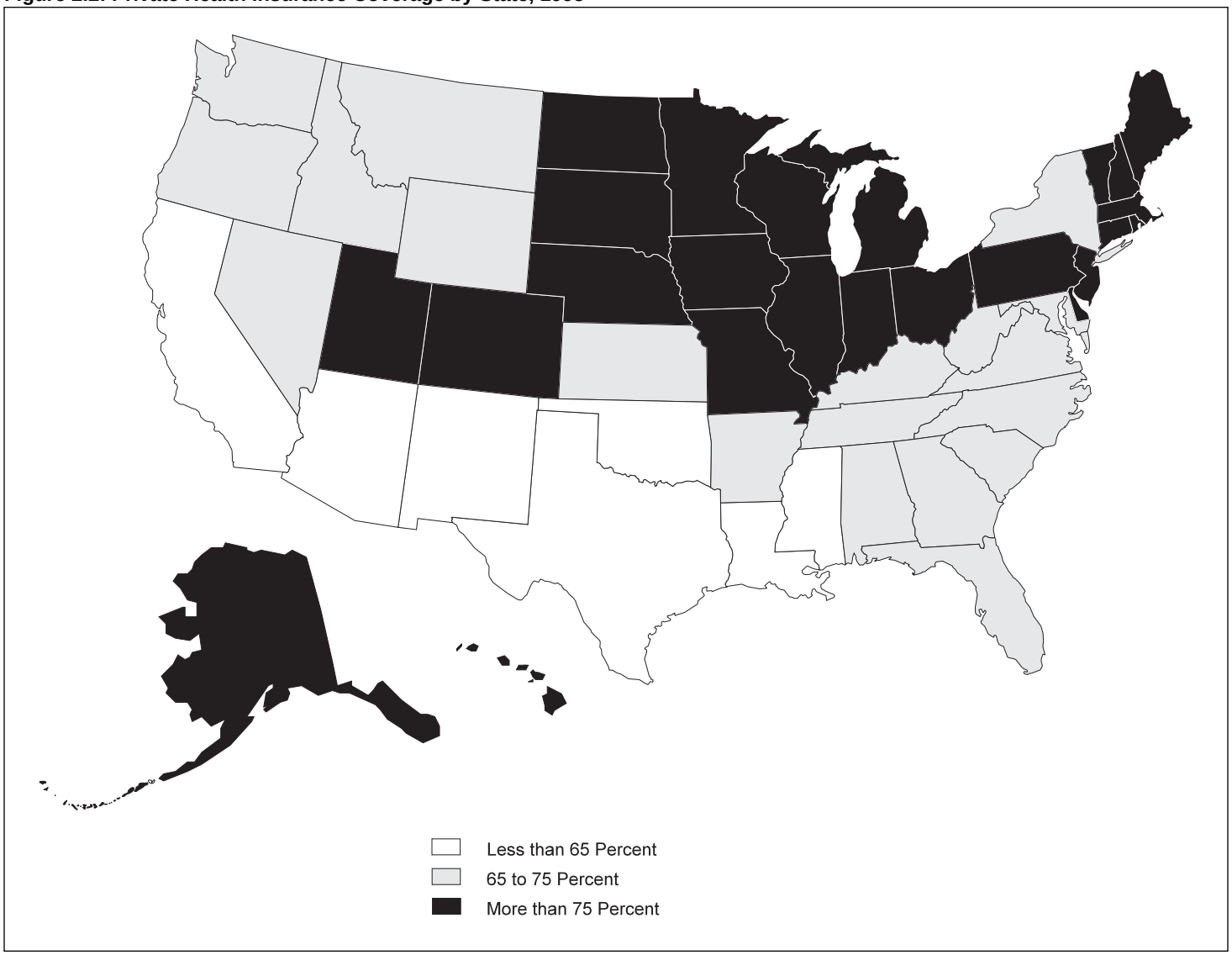
[7]The remainder of the nonelderly population was covered by military health care programs (3.5 percent) or Medicare (1.8 percent). The total of these categories exceeds 100 percent because some people maintain more than one type of health coverage during a year.

Private Health Insurance Coverage Varies Among States and Demographic, Income, and Employment Groups

The prevalence of private health insurance coverage varies among segments of the population. For example, people living in southern states, low-income families, and young adults are less likely to have private health coverage than the national average. In addition, persons employed by small firms, part time, and in industries such as construction or agriculture are less likely to have private health coverage. (App. II presents private health insurance rates in 1989 and 1995 by state and for several demographic, employment, and income categories.)

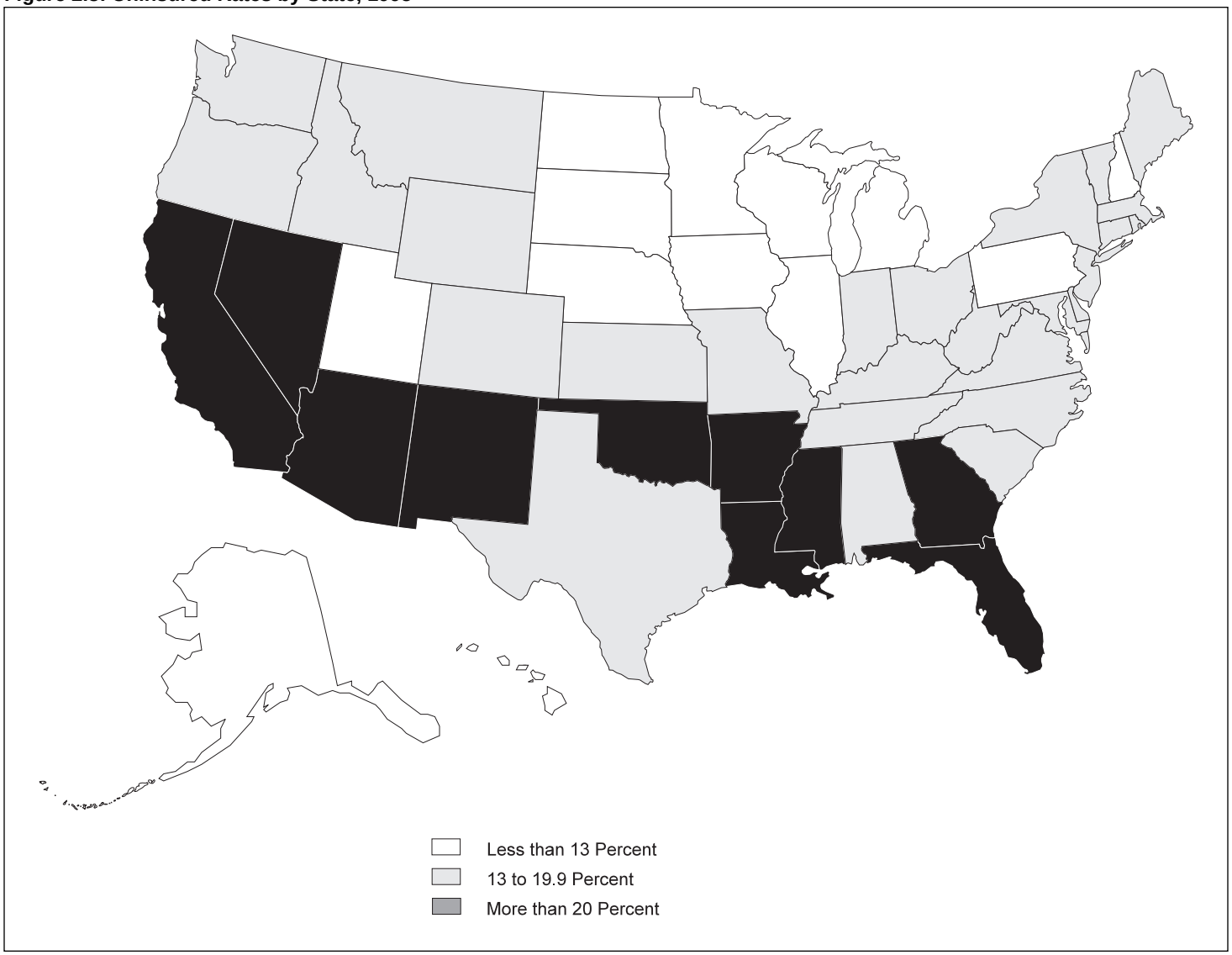
Private health insurance coverage is most common among people living in the midwestern and northeastern United States and least common among those in the southwestern and south central United States. (See fig. 2.2.) For example, only half of the population under 65 in New Mexico had private health insurance in 1995 compared to 82 percent of the population under 65 in Connecticut and Minnesota. As shown in figure 2.3, states with low rates of private health insurance coverage tend to have high uninsured rates.

Figure 2.2: Private Health Insurance Coverage by State, 1995



Source: Bureau of the Census, March 1996 Current Population Survey.

Figure 2.3: Uninsured Rates by State, 1995



Source: Bureau of the Census, March 1996 Current Population Survey.

Private health insurance coverage is particularly low among young adults aged 18 to 24 (60 percent), blacks (51 percent), and Americans of Hispanic origin (43 percent). These low levels are reflected in high uninsured rates among these groups (28 percent, 22 percent, and 35 percent, respectively.)

In addition, low-income families are much less likely to have private health insurance than high-income families. Whereas less than one-third of families with incomes of less than $20,000 had private health insurance in 1995, over 90 percent of families with incomes of at least $60,000 had private insurance coverage.

Several employment characteristics are important in private health insurance coverage levels. In 1995, most Americans (64.6 percent) received private health insurance through employment—either as workers or as dependents of workers. Workers in small firms are less likely to have employment-based health insurance than are workers in large firms. For example, 50 percent of workers in firms with fewer than 10 employees had private employment-based health insurance in 1995 compared to 82 percent of workers in firms with at least 1,000 employees.[8] Recent research based on KPMG Peat Marwick and HIAA data for 1989 to 1996 indicates that while more small firms are offering coverage now compared to the past, a smaller percentage of employees are covered now compared to 1989.[9]

Contingent workers, including part-time and temporary workers, are also less likely to have employer-sponsored coverage. While 79 percent of full-time, full-year employees had employment-based health insurance in 1995, only 59 percent of employees working part-time or part-year had employment-based health insurance. Employment-based health insurance covers less than 60 percent of workers in the agricultural, personal services, business and repair services, and construction industries but at least 82 percent of workers in the finance and insurance, mining, and public administration industries.

Some people who are unable to get health benefits through their employment purchase private health insurance directly. In a previous report, we estimated that more than 10 million Americans—4.5 percent of the nonelderly U.S. population—had individual health insurance as their only source of health coverage in 1994.[10] Individual health insurance is most common in some Mountain and Plains states and among the

[8]For all firm sizes, 72 percent of workers had employment-based health insurance.

[9]Analysis completed by Jon Gabel, KPMG Peat Marwick, and Paul Ginsburg, Center for Studying Health System Change.

[10]For information on the characteristics of individual insurance enrollees, the structure of the individual insurance market, and insurance reforms undertaken by states, see Private Health Insurance: Millions Relying on Individual Market Face Cost and Coverage Trade-offs (GAO/HEHS-97-8, Nov. 25, 1996).

self-employed and agricultural workers. Other people who do not have employment-based coverage and do not qualify for Medicaid may be unable to purchase individual health insurance because of its cost or a preexisting medical condition. Some of these people may be able to get private coverage through a state high-risk pool or other programs, but others remain uninsured.[11]

Private Health Coverage Has Declined Among Almost All Segments of the Population

The decline in private health insurance coverage has been nearly universal in nearly all demographic, income, and employment groups. Between 1989 and 1995, private coverage declined in 43 of 50 states (representing 93 percent of the U.S. nonelderly population) and 10 of 12 industrial categories (representing 93 percent of all U.S. workers).[12] Similarly, between 1989 and 1995 private health coverage also declined among firms of all size categories, among both full-time and part-time workers, and among all income categories.

While declining health insurance has been widespread, coverage has declined more quickly for some population groups. For children under 18 years old, private health insurance declined by 7 percentage points between 1989 and 1995 (from 73.1 percent to 66.1 percent) compared to a 4.5 percentage point decline for the nonelderly population overall. If children's level of private health insurance coverage had remained at the 1989 level, nearly 5 million more children would have been covered by private health insurance in 1995.[13]

The level of private health insurance coverage has also declined more rapidly among people younger than 65 who are retired (69.0 percent in 1995 compared to 75.9 percent in 1989). This trend reflects the decline in employers offering retiree health coverage. Foster Higgins reported that only 40 percent of large employers offered medical coverage to retirees younger than 65 in 1996 compared to 46 percent in 1993.[14]

[11]About 25 states have high-risk pools, covering about 100,000 persons nationwide.

[12]We are using 1989 as a base for comparison because of difficulties in comparing CPS data for earlier years, particularly when examining subgroups of the population. For 1989, the Bureau of the Census released revised estimates (weighted to the 1990 decennial census) that are comparable to the 1995 CPS data on private health insurance coverage. See app. I.

[13]For information on children's health insurance coverage, see Health Insurance for Children: Private Insurance Coverage Continues to Deteriorate (GAO/HEHS-96-129, June 17, 1996) and an update in Children's Health Insurance, 1995 (GAO/HEHS-97-68R, Feb. 19, 1997).

[14]Foster Higgins, National Survey of Employer-Sponsored Health Plans, 1996.

Private health insurance coverage has also declined more quickly among near-poor families. While Medicaid is the primary source of insurance coverage for persons at or below the federal poverty level, private health insurance covered 55 percent of families between 100 and 200 percent of the federal poverty level in 1995. This represents a 6 percentage point decline since 1989. Many of these near-poor families losing private health coverage gained Medicaid coverage. For some children and pregnant women in families with incomes between 100 and 200 percent of the federal poverty level, Medicaid coverage grew from 6.5 percent in 1989 to 11.2 percent in 1995.

Cost Pressures Are One of Many Factors Linked to Declining Employer-Based Coverage

The decline in private health insurance coverage during the 1980s and the 1990s reflects decisions made by both employers who offer health insurance and their employees. The long-term growth of health insurance premiums has made health insurance a more prominent component of both employer and household budgets. These cost increases contributed to employer decisions to limit or drop coverage for workers and to increase the share of insurance costs paid by the worker.

A decline in the number of employers offering health insurance is prominently cited as a key contributor to declining coverage.[15] Particularly for small employers, costs are cited as a key factor in their decision to drop coverage for their workers or to consider offering it.[16] For those employing lower-wage workers, health premiums represent a significant share of total compensation. Even firms that provide coverage for their workers often exclude part-time or temporary workers—a rapidly growing component of the labor force.

Not surprisingly, key indicators of the structure of the labor force have been prominently cited in research that attempts to explain declines in health coverage. For example, coverage is higher in the Midwest and in industries with higher wage rates. But recent employment growth has been concentrated in industries and areas of the country where insurance coverage has not been as prominent. Several studies suggest that this change in employment composition was an important factor in recent declines in coverage.

[15]Paul Fronstin and Sarah C. Snyder, "An Examination of the Decline in Employment-Based Health Insurance Between 1988 and 1993," Inquiry, Vol. 33 (winter 1996-97), pp. 317-25.

[16]See Access to Health Insurance: State Efforts to Assist Small Business (GAO/HRD-92-90 May 14, 1992), pp. 12-15.

Table 2.1 summarizes some of the key factors that these studies have identified as contributing to the decline in private health coverage. While these studies embrace many of the same variables, their effect is not always consistent because of differences in modeling, data sources, the specific population covered, and time periods. There is clearly a complex interaction among a number of variables affecting costs over time. However, these studies acknowledge that much of the decline in coverage remains unexplained by these factors.

Table 2.1: Summary of Studies Identifying Factors Contributing to Declining Coverage

Author: period, population analyzed	Factor contributing to declining coverage (percentage accounted for by factor)	Factor not contributing to declining coverage
Gregory Acs: 1988-91, nonelderly population	Family income (67%), unemployment (15%)	Industry shifts, location, firm size, demographics
Gregory Acs: 1988-91, workers	Family income (38%), industry shifts (17%)	Location, firm size
Kronick: 1979-89, low-income workers	Industry shifts (not available)	
Fronstin and Snider: 1988-93, workers	Wage rate (23%), industry shifts (10%), part-time work (7%), unionization (6%)	Demographics, firm size, occupation, region
Long and Rodgers: 1980-87; workers	Industry shifts (<15%)	Part-time work

Sources: Gregory Acs, "Explaining Trends in Health Insurance Coverage Between 1988 and 1991," Inquiry, Vol. 32 (spring 1995), pp. 102-10; Richard Kronick, "Health Insurance, 1979-1989: The Frayed Connection Between Employment and Insurance," Inquiry, Vol. 28 (winter 1991), pp. 318-32; Paul Fronstin and Sarah C. Snyder, "An Examination of the Decline in Employment-Based Health Insurance Between 1988 and 1993," Inquiry, Vol. 33 (winter 1996-97), pp. 317-25; Stephen H. Long and Jack Rodgers, "Do Shifts Toward Service Industries, Part-time Work, and Self-Employment Explain the Rising Uninsured Rate?" Inquiry, Vol. 32 (spring 1995), pp. 111-16.

Moreover, the relative importance of each variable may change over time. For example, declines in real wages and family income contributed to the declines in coverage in the 1980s, but whether recent increases in real wages may have the opposite effect in the next few years is unclear. The analysis of most of the studies covers a fairly short time period, which may not reflect many of the potential interactions among these variables. A key variable like industry mix may have played a more prominent role in the 1980s as service sector employment increased relative to manufacturing, government, and transportation—industries in which health coverage has traditionally been more prevalent. But the service industry now represents a more prominent share of total employment, and some of its recent growth has been channeled into particular segments like health care or

computer services, where wage rates are higher and coverage is more common.

Factors affecting an employer's decision to offer coverage are important determinants of the level of coverage. But the growing cost of health insurance has also affected decisions individuals make. Employees of firms that offer coverage are being asked to pay a higher share of premiums. Data from the National Health Interview Survey indicate that over 62 percent of employed, uninsured family heads report that the main reason for not being covered is that health insurance is too expensive.[17] For those without employer-based coverage, the rise in premiums for policies purchased in the individual insurance market has been borne exclusively by those individuals.

Some analysts have also indicated that the expansion in Medicaid enrollment during the late 1980s and 1990s has "crowded out" private health insurance coverage—that is, some low-income families who previously received private coverage are now replacing it with publicly funded Medicaid. One study concluded that as much as 15 percent of the decline in private health insurance between 1987 and 1992 could be attributed to the substitution of Medicaid enrollment.[18] However, the extent to which the Medicaid expansions have caused a decline in private health insurance coverage rather than absorbed coverage that otherwise would have been lost remains in dispute.

The erosion of private health insurance coverage for many Americans has continued through the mid-1990s, a time when health insurance premiums have been relatively stable and the U.S. economy has been strong, with low unemployment and steady growth. However, many of the studies attempting to quantify the reasons for declining private health coverage use data only through the early 1990s. Researchers have yet to examine the causes of the decline in coverage over these past few years, taking into account the more recent economic trends.

[17]See statement of Patrick J. Purcell, Congressional Research Service, before the U.S. House of Representatives, Committee on Ways and Means, Subcommitee on Health, April 8, 1997.

[18]See David M. Cutler and Jonathan Gruber, "Medicaid and Private Insurance: Evidence and Implications," Health Affairs, Vol. 16, No. 1 (Jan.-Feb. 1997), pp. 194-200; Lisa Dubay and Genevieve Kenney, "Did Medicaid Expansions for Pregnant Women Crowd Out Private Coverage?" Health Affairs, Vol. 16, No. 1 (Jan.-Feb. 1997), pp. 185-93.

Sharp Increases in Private Health Insurance Premiums Have Subsided, but the Future Remains Uncertain

Health insurance premiums for employer-sponsored plans increased sharply during the late 1980s, but their growth rates have decelerated substantially in the 1990s, with premium changes reaching record lows in 1996. Studies have attributed the downturn in premium growth to various factors, including the effects of managed care and cyclical patterns in the health insurance industry. While some health insurance experts are identifying signs of future premium increases, it is too early to tell how much longer premium increases will remain low and how much higher future growth rates will be. Furthermore, although trend data are not available for purchasers of individual health insurance, premiums in this market are very sensitive to the age, gender, and health of enrollees as well as to state regulation.

Trends in Health Insurance Premium Growth Rates During the 1980s and 1990s

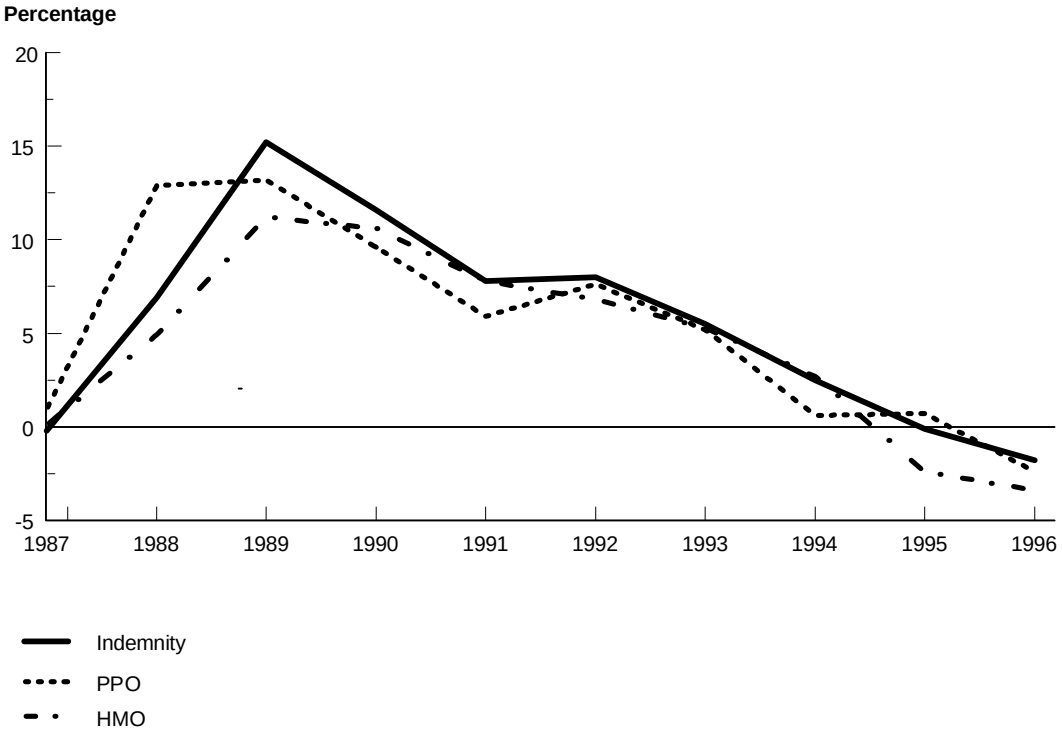
Increases in employer-based health insurance premiums far exceeded the general price inflation rate in the late 1980s but premium growth rates have declined in the 1990s. For example, the average annual premium for employer-based family health insurance coverage increased by 111 percent, from $2,530 to $5,349 between 1988 and 1996, while general prices rose by 33 percent during this period. Similarly, the average annual premium for employer-based single coverage increased by 79 percent, from $1,153 to $2,059 between 1988 and 1996.[19]

However, the real annual rate of increase in health insurance premiums has slowed across all employer-based health plan types in the past 7 years.[20] As figure 3.1 shows, real premium growth rates of indemnity, preferred provider organization (PPO), and health maintenance organization (HMO) plans peaked in 1989 at rates of 15, 13, and 11 percent, respectively. Real premium growth rates slowed to an average of about 5 percent across all plan types in 1993; over the past 2 years, premiums experienced near-zero growth. In 1996, premiums increased at lower rates than the consumer price index and the medical cost index. As figure 3.1 also shows, the differences in premium growth rates among various types of health plans narrow after 1990. See also table 3.1.

[19]These average premiums are based on surveys from KPMG Peat Marwick, Survey of Employer Sponsored Health Benefits, 1996, and Health Insurance Association of America (HIAA), Employee Survey, 1988.

[20]"Real premium growth rate" refers to a growth rate that has been adjusted to take into account the effect of general price inflation.

Figure 3.1: Real Growth in Premiums by Health Plan Type, 1987-96



Sources: GAO calculations using data from KPMG Peat Marwick (1991-96); HIAA (1987-90), and the BLS consumer price index. Includes employer and employee shares of premiums for workers in private firms with at least 200 employees.

Table 3.1: Real Annual Growth in Premiums Per Health Plan, 1987-96

Plan	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996
Indemnity	–0.2	6.9	15.2	11.6	7.8	8.0	5.5	2.5	–0.1	–1.8
PPO	0.9	12.9	13.2	9.6	5.9	7.6	5.2	0.6	0.7	–2.4
HMO	0.1	4.9	11.2	10.6	7.8	6.8	5.3	2.7	–2.4	–3.4

Sources: GAO calculations based on data from KPMG Peat Marwick (1991-96); HIAA (1987-90), and BLS consumer price index. Includes employer and employee shares of premiums for workers in private firms with at least 200 employees.

Managed Care and Cyclical Factors in the Health Insurance Industry Among Major Causes of Slowdown in Premium Growth Rates

Health insurance researchers attribute the slowdown in annual premium growth to several causes, including the increased use of managed care and a downward trend in the health insurance underwriting cycle in which premiums tend to decline when health insurers' profits are high. However, no studies have comprehensively examined the reasons for the recent 7-year decline in premium increases. While the precise effect of managed care on premiums continues to be debated, some studies contend that managed care has contributed to the slowdown in premium increases because HMO plans generally cost less than other health plans and many managed care organizations control health care use. Hence, the savings occur from moving consumers from indemnity plans to HMO plans. In contrast, other research attributes the savings from managed care to changes in the operation of the health insurance market when managed care penetration rates reach a critical threshold.

The increased HMO enrollment has contributed to a one-time reduction in premium levels. KPMG Peat Marwick's survey found that in 1996 HMO premiums for employer-sponsored health insurance premiums averaged 6 to 10 percent less than indemnity plan premiums, whereas PPO and point-of-service (POS) plan premiums were similar to or higher than indemnity plan premiums. (See table 3.2.) As noted above, however, all employer-sponsored plan types have had similar growth patterns since 1987, with HMO premium growth rates tending to be slightly lower than indemnity plan premiums.

Table 3.2: Average Annual Health Insurance Premiums by Employer-Sponsored Plan Type, 1996

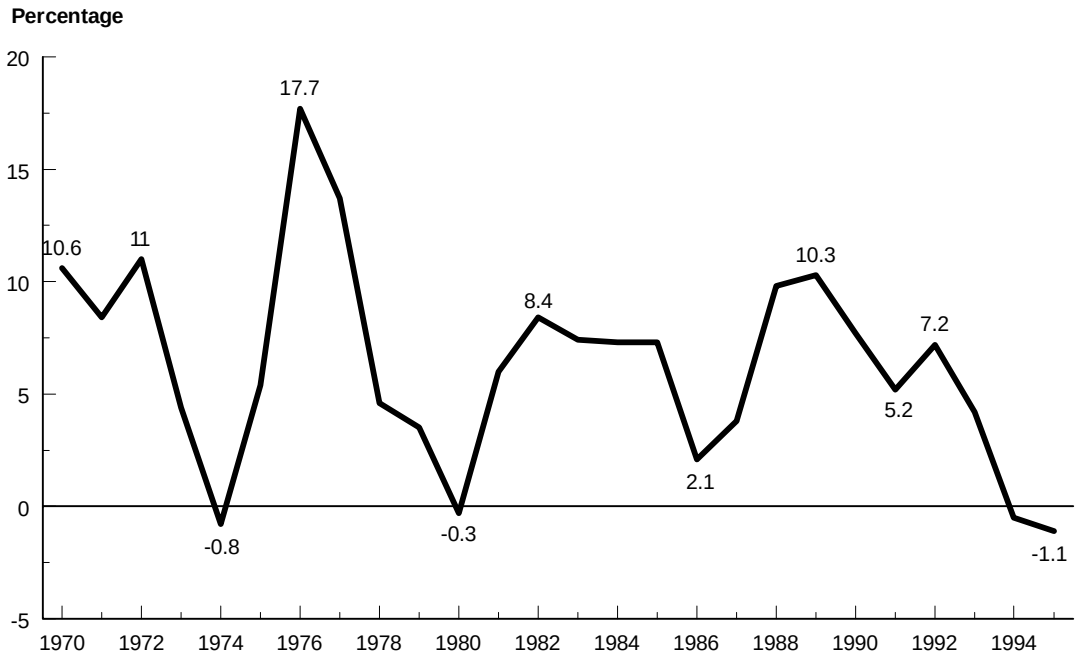
	Single coverage		Family coverage	
Plan	Average annual premium	Percent different from indemnity	Average annual premium	Percent different from indemnity
Indemnity	$2,090		$5,388	
PPO	$2,173	+4.0%	$5,377	–0.2%
POS	$2,058	–1.5	$5,477	+1.7
HMO	$1,883	–9.9	$5,071	–5.9

Source: KPMG Peat Marwick Survey of Employer-Sponsored Health Benefits, 1996. This survey includes employers with at least 200 employees.

Some studies indicate that a fundamental cause of the downturn in premium increases lies in the nature of the health insurance underwriting

cycle.[21] Health insurer's profits and premiums are inversely related. Health insurance researchers have found that historically health insurance premiums have increased about 2 years after health insurers' profits declined and vice versa. Industry profits were high from 1993 to 1995, which suggests that low premium increases for 1996 were predictable. As shown in figure 3.2, 1974 and 1980 were other periods of near-zero real premium growth. Our review showed that the 7-year downward trend in premium growth rates since 1989 is the longest period of declining rates of growth in private health insurance premiums over the past two decades. (Fig. 3.2 shows changes in enrollee spending in private health insurance from 1970 to 1995.)

Figure 3.2: Change in Private Health Insurance Real Spending Per Enrollee, 1970-95



Source: HCFA Office of Actuary and BLS, Consumer Price Index.

[21]See Gail A. Jensen and others, "The New Dominance of Managed Care: Insurance Trends in the 1990s," Health Affairs, Vol. 16, No. 1 (Jan.-Feb. 1997), and Jon Gabel and others, "Tracing the Cycle of Health Insurance," Health Affairs (winter 1991).

Some analysts also attribute part of the duration of this downward trend to market responses to the comprehensive federal health care reforms proposed during the early 1990s and to increased competition among health plans trying to build market share through favorable pricing. In addition, the private health insurance industry has been undergoing consolidation and mergers.[22] However, there is limited research on the effects of these mergers, and it is too early to determine their effect on health insurance premiums.

It is difficult to tell whether the low premium growth rates of the past 2 years are temporary or a signal of price stability in the private health insurance market. Nonetheless, some health researchers are beginning to identify signs of possible premium increases in the next few years. For example, according to Foster Higgins' 1996 National Survey of Employer-Sponsored Health Plans, premiums may increase because (1) many HMOs have raised their rates for 1997 following sagging profits in 1996, (2) health care providers are consolidating and gaining more bargaining clout with managed care plans, (3) state and federal laws are requiring health insurance plans to expand the benefits covered, and (4) there is little room for additional savings in costs from shifting employees to managed care plans, since more than three-fourths of active employees are already in managed care plans. In addition, with low unemployment, the prospects of a tight labor market could reverse the low, overall inflation rate of the past years.

Premiums for Individual Health Insurance Vary With Demographic Traits, Health Status, and State Regulation

In most states, premiums for health coverage purchased in the individual health insurance market primarily reflect the demographic characteristics and health status of each applicant, unlike employer-based health insurance premiums, which reflect the average risk characteristics of the entire insured group. Premium rates in the individual market vary substantially among states and carriers, affecting individual consumers differently, depending on their particular circumstances.[23] The demographic characteristics that carriers often considered in setting premium prices in the individual insurance market include age, gender, geographic area, and family composition. For example, a plan in Arizona

[22]See Roger Feldman, Douglas Wholey, and Jon Christianson, "Economic and Organizational Determinants of HMO Mergers and Failures," Inquiry, Vol. 23 (summer 1996), pp. 118-32. This study discusses the implications of HMO mergers on premiums and the effects of mergers, depending on the competitive nature of the HMO markets.

[23]For details on premium price variation stemming from demographic characteristics and health status, see Private Health Insurance: Millions Relying on Individual Market Face Cost and Coverage Trade-Offs (GAO/HEHS-97-8, Nov. 25, 1996).

charges a healthy 55-year-old man more than three times the rate for a healthy 25-year-old man for the same coverage ($191 versus $57 per month). In addition, people with a preexisting condition, such as knee injuries or diabetes, would not be able to purchase this plan or would have an exclusion for that condition.[24]

State regulation has also affected premium prices in the individual market. Some states, including New Jersey, New York, and Vermont, have enacted legislation requiring community rating. Under pure community rating, the cost of insurance is spread equally among all community members, regardless of demographic characteristics and health status.[25] Although prices range widely depending on the plan, all applicants are eligible for and may select from among any of the plans that carriers provide. For example, in New Jersey, the monthly premium price for a fee-for-service plan ranges from $155 to $565.

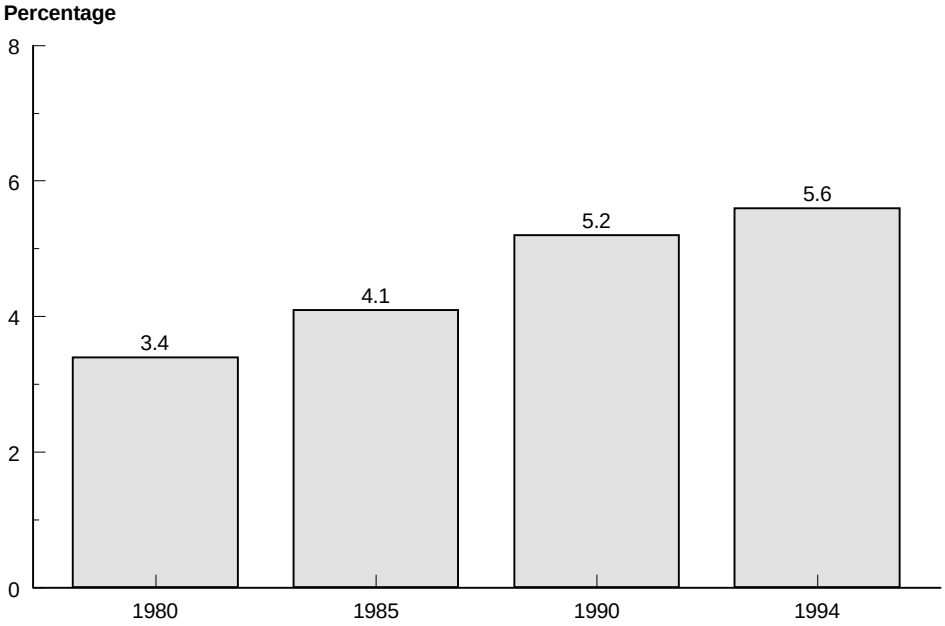
[24]Effective July 1, 1997, HIPAA allows people with continuous group coverage to purchase individual coverage without meeting preexisting condition exclusions. Some states have indicated that they may develop alternative mechanisms to provide access to coverage for people with preexisting conditions when they lose coverage, such as high-risk pools.

[25]Some states that have enacted community rating, such as New York, allow for limited adjustments by geographic regions; some also allow adjustments for age or gender.

Employers' Efforts to Control Costs Have Changed the Nature of Private Health Insurance

The increasing costs of providing health benefits to employees during the 1980s and 1990s have stimulated employers to become increasingly aggressive in attempting to control their costs. Between 1980 and 1996, the costs of providing private health coverage to employees increased from 3.4 percent of total compensation to 5.6 percent.[26] (See fig. 4.1.) Many of the changes in employment-based health coverage over the past two decades—notably requiring employees to pay a greater share of premium costs, encouraging enrollment in network-based managed care plans, and self-funding health benefits—have fundamentally changed the nature of private health insurance coverage for employees.

Figure 4.1: Employer Private Health Insurance Spending as a Percentage of Total Compensation, 1980-94



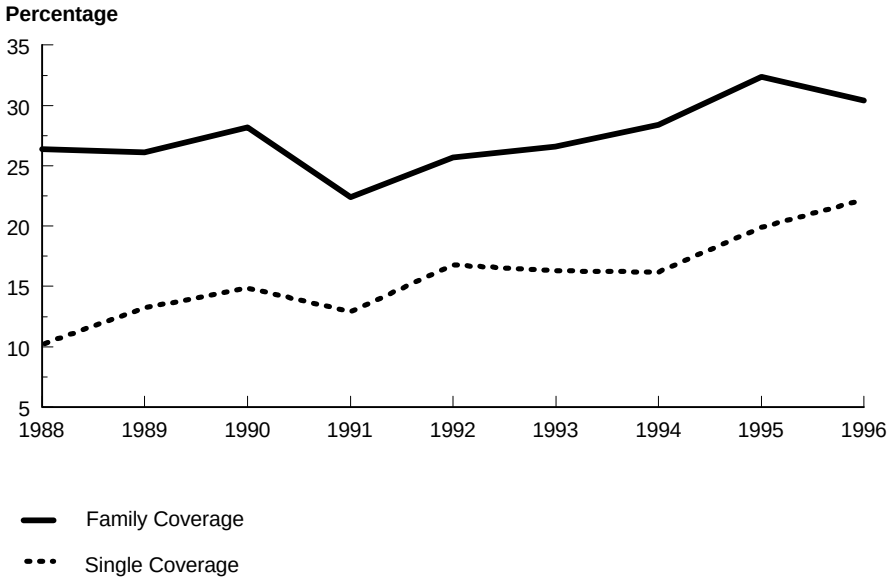
Source: HCFA, Office of the Actuary.

[26]Total business health costs, including private health insurance premiums as well as workers compensation costs, payments to the Medicare Hospital Insurance Trust Fund, and on-site health services rose, from 4.7 percent of total compensation in 1980 to 7.5 percent of total compensation in 1994.

Employees Are Required to Pay an Increasing Share of Premiums for Their Coverage

As private health insurance costs increased rapidly during the late 1980s and early 1990s, employers required their employees to pay an increasing share of the premiums for employment-based health insurance. On the average, employees paid about 30 percent of the premium for family coverage and 22 percent of the premium for single coverage in 1996. In comparison, in 1988 employees paid 26 percent of family plan premiums and 10 percent of single plan premiums. (See fig. 4.2.)

Figure 4.2: Employee Share of Premiums, 1988-96



Sources: KPMG Peat Marwick, 1991-96; HIAA, 1988-90.

The increasing share of premiums paid by employees represents a trend away from employers paying the entire premium for employees' coverage. BLS reports that health benefits paid entirely by the employer for single coverage were available to 72 percent of employees in 1980. By 1993, only half as many employees (37 percent) had single coverage available at no cost from their employer. For family coverage, employees with health

benefits paid entirely by the employer fell from 51 percent in 1980 to 21 percent in 1993.[27]

While the share of premiums paid by the employee has grown more for single coverage than for family coverage, family plan premiums have grown more quickly than single plan premiums. As noted in chapter 3, premiums for family coverage increased 111 percent compared to 79 percent for single coverage between 1988 and 1996. In addition, employers have increasingly adopted tier-rating practices that charge employees different rates, depending on the number of people covered in their family. As a result, employees have had to pay more for dependent coverage, particularly if they are covering several dependents.[28] To some extent, this higher cost for dependent coverage has contributed to the more rapid decline in private health insurance coverage for children.

While employees have paid an increasing share of premiums, their out-of-pocket costs for coinsurance and deductibles have not changed much. According to the BLS survey, the median deductible for single coverage in non-HMO plans offered by medium and large employers was $200 in 1993.[29] Deductibles for family coverage are generally two or three times deductibles for single coverage. Most health plan participants in medium and large firms had a $100 deductible in 1980, which would have been $175 in real 1993 dollars.[30] Similarly, the most common coinsurance rate has remained at 80 percent.

Cost sharing arrangements vary by plan type. HMOs generally do not require a deductible or coinsurance, instead charging a copayment such as $10 per visit. PPOs and POS plans typically vary the coinsurance rates, depending on whether the patient visits a provider within or outside their network. For example, KPMG Peat Marwick reports that in 1996 most PPOs

[27]See Bureau of Labor Statistics, Employee Benefits in Medium and Large Private Establishments, 1993 (Washington, D.C.: Nov. 1994), and Employee Benefits in Medium and Large Firms, 1988 (Washington, D.C.: Aug. 1989).

[28]For a detailed discussion of changes in dependent coverage, see Employment-Based Health Insurance: Costs Increase and Family Coverage Declines (GAO/HEHS-97-35, Feb. 24, 1997).

[29]In contrast, in the individual insurance market there tends to be a wider range of deductible levels, with deductibles commonly between $250 and $2,500. In a previous report, we found that for one insurer an individual health plan with a $2,000 deductible was nearly half the cost of a similar plan with a $250 deductible ($565 versus $1,073) for a healthy 30-year-old man.

[30]Smaller firms tend to have higher deductibles. The 1993 Robert Wood Johnson Foundation Employer Health Insurance Survey found that the average annual deductible was $408 for firms with 1 to 4 employees compared to $202 for firms with 50 or more employees.

paid 80 or 90 percent for preferred providers, whereas they paid 70 or 80 percent for nonpreferred providers.

Network-Based Health Plans Have Become Prevalent, but Wide Variation in Plan Types Remain

Health plans available in the private market continue to evolve, with greater reliance on management of care and medical services provided through a defined network of physicians and hospitals. Most insured Americans under 65—over 100 million people—are enrolled in a network-based health plan that requires or encourages them to use hospitals and physicians affiliated with the plan. This is a fundamental change from 1980, when nearly all privately insured Americans were enrolled in traditional indemnity plans without restrictions or incentives to use particular providers. However, even with the rapid growth of network-based health plans, most people have enrolled in plans that retain their ability to receive medical care from physicians not affiliated with the plan at a higher cost to the patient.

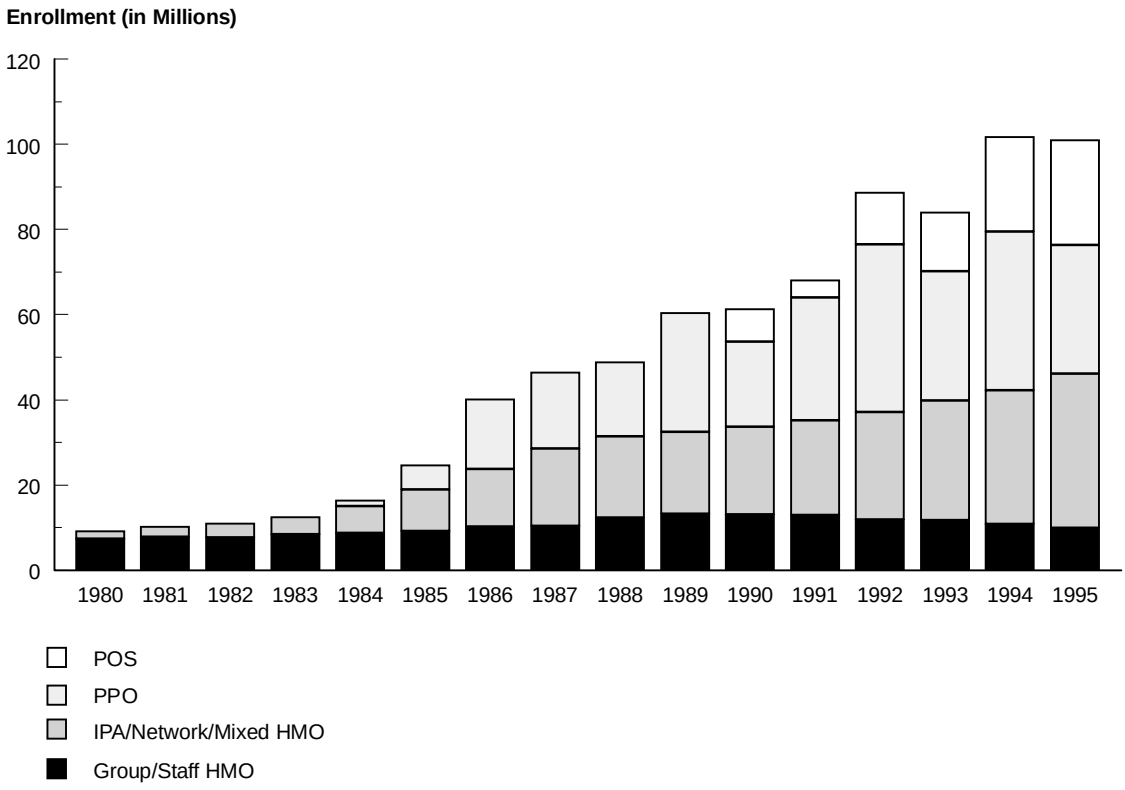
Network-based health plans have often been categorized as "managed care," but the methods they use vary widely and so does the extent to which they manage enrollees' use of health care services. Examples of these plans include group and staff model HMOs, independent practice association (IPA) HMOs, PPOs, and POS plans. These plans vary as to whether enrollees can use health care providers other than those affiliated with the plans' network of providers, the breadth of the network relative to the number of enrollees, and how physicians and hospitals are reimbursed for serving the plans' enrollees. Table 4.1 summarizes variation among the different types of network-based health plans according to these characteristics.

Table 4.1: Characteristics of Health Insurance Plans

Plan	Choice of provider	Size of network	Provider payments
Traditional indemnity	Unlimited	No network	Fee-for-service
PPO	Financial incentives to use preferred providers	Narrow to broad network	In-network physicians, discounted fee-for-service; out-of-network physicians, fee-for-service
POS	Financial incentives to use preferred providers; may have primary care gatekeeper	Narrow to broad network	In-network physicians, discounted fee-for-service or capitation; out-of-network physicians, fee-for-service
IPA HMO	Restricted to network providers; generally includes primary care gatekeeper	Narrow to broad network	Capitation or fee-for-service, may include withholds or bonuses
Group and staff HMO	Restricted to network providers; primary care gatekeeper	Narrow network	Capitation or salary

The most tightly managed plans are traditional group and staff HMOs; enrollment in these types of plans has fallen since 1989. (See fig. 4.3 and table 4.2.) These HMOs contract with physicians who generally serve the plan's enrollees exclusively and are paid either a per member, per month payment (capitation) or salary. Enrollees are restricted to the providers affiliated with the plan and pay only a small copayment, such as $10, per visit. Generally enrollees are assigned a primary care physician, sometimes called a "gatekeeper," who coordinates their care and approves the use of specialist services.

Figure 4.3: Enrollment in Network-Based Health Plans by Type, 1980-95



Sources: HMO enrollment from Interstudy and includes Medicare and Medicaid. PPO and POS enrollment GAO estimate based on data from KPMG Peat Marwick.

Table 4.2: Enrollment in Network-Based Health Plans by Type, 1980-95

	Group/Staff HMO	IPA/network/ mixed HMO	PPO	POS
1980	7.4	1.7	0.0	0.0
1981	7.8	2.4	0.0	0.0
1982	7.6	3.3	0.0	0.0
1983	8.4	4.1	0.0	0.0
1984	8.7	6.4	1.3	0.0
1985	9.2	9.7	5.8	0.0
1986	10.2	13.5	16.5	0.0
1987	10.4	18.2	17.9	0.0
1988	12.3	19.1	17.5	0.0
1989	13.2	19.3	28.0	0.0
1990	13.1	20.6	20.0	7.7
1991	12.9	22.2	28.9	4.1
1992	11.9	25.3	39.4	12.1
1993	11.7	28.1	30.4	13.8
1994	10.8	31.5	37.2	22.3
1995	9.9	36.3	30.2	24.7

Sources: HMO enrollment data are from Interstudy and includes Medicare and Medicaid. PPO and POS enrollment numbers are GAO estimates based on data from KPMG Peat Marwick.

Most Americans with private health insurance are enrolled in one of a variety of newer network-based health plans that incorporate some of the elements of both the traditional group and staff HMOs as well as unrestricted fee-for-service plans. These plans, including IPA HMOs, PPOs, and POS plans, were nearly nonexistent in 1980. Nearly all the growth in HMO enrollment since 1980 has occurred in IPA and similar HMOs rather than group and staff HMOs. As with group and staff model HMOs, IPA HMO enrollees receive coverage only for medical services provided by providers affiliated with the HMO. However, the plan contracts with physicians in different practice settings who generally serve patients from other health plans as well as the contracting HMO. Furthermore, physicians contracting with IPA HMOs are less likely to be reimbursed through capitation or salary; often, these physicians receive a fee-for-service payment with financial incentives to control use.[31]

[31]Some former staff and group model HMOs have expanded by incorporating IPA contracts with physicians. These are generally categorized as mixed-model HMOs.

The most common types of network-based health plans, enrolling at least 55 million Americans, are PPOs and POS plans.[32] These plans encourage enrollees to seek care from physicians affiliated with the plan but allow enrollees to receive care from physicians outside the plan's network at a higher out-of-pocket cost to the patient. Thus, they provide enrollees with more options in choosing a provider but are less able to manage the enrollees' use of health services. PPOs generally resemble traditional indemnity plans, except that they give financial incentives for enrollees to use physicians who have agreed to accept discounted fee-for-service payments and other standards established by the plan. Often, POS plans developed from HMOs but allow enrollees to choose a physician outside the panel of HMO physicians at greater expense to the enrollee. Increasingly, however, the distinction between plan types has become blurred. Thus, some PPOs may have greater use controls than some IPA HMOs.[33]

Employers Have Increasingly Self-Funded Their Health Benefits

Increasingly, employers have assumed greater direct control over their health benefits by self-funding their plans, paying the cost of health claims directly from their revenues rather than contracting with an insurer to assume the risk. Many employers moderate the level of the risk that they are self-funding by purchasing stop-loss coverage to insure against health costs that exceed a set threshold. In addition, many contract with a third-party administrator to handle claims payments, benefit design, and other administrative tasks traditionally performed by an insurance company.

Employers decide to self-fund their health plans for several reasons, but a significant advantage to employers results from the fact that states cannot apply their insurance requirements to self-funded health plans. ERISA preempts states from directly regulating employer pension and welfare benefit plans, including health benefit plans. However, ERISA allows states to continue their traditional role in regulating the terms and conditions of insurance.[34] Thus, states require insurers to pay premium taxes, offer specific benefits, meet solvency standards, and use specific practices for

[32]This may underestimate PPO and POS plan enrollment. The American Association of Health Plans (AAHP) reports that by year-end 1995 HMOs enrolled 58.2 million people (including 10.8 million in HMOs with POS options) and PPOs enrolled 91 million people. However, the AAHP survey may double count some PPO enrollees. See app. I for a discussion of our methods in estimating enrollment in the different network-based health plans.

[33]For information on how managed care attempts to control the use of health services, see Managed Health Care: Effect on Employers' Costs Difficult to Measure (GAO/HRD-94-3, Oct. 19, 1993).

[34]For information on ERISA and its implications for health plans, see Employer-Based Health Plans: Issues, Trends, and Challenges Posed by ERISA (GAO/HEHS-95-167, July 25, 1995).

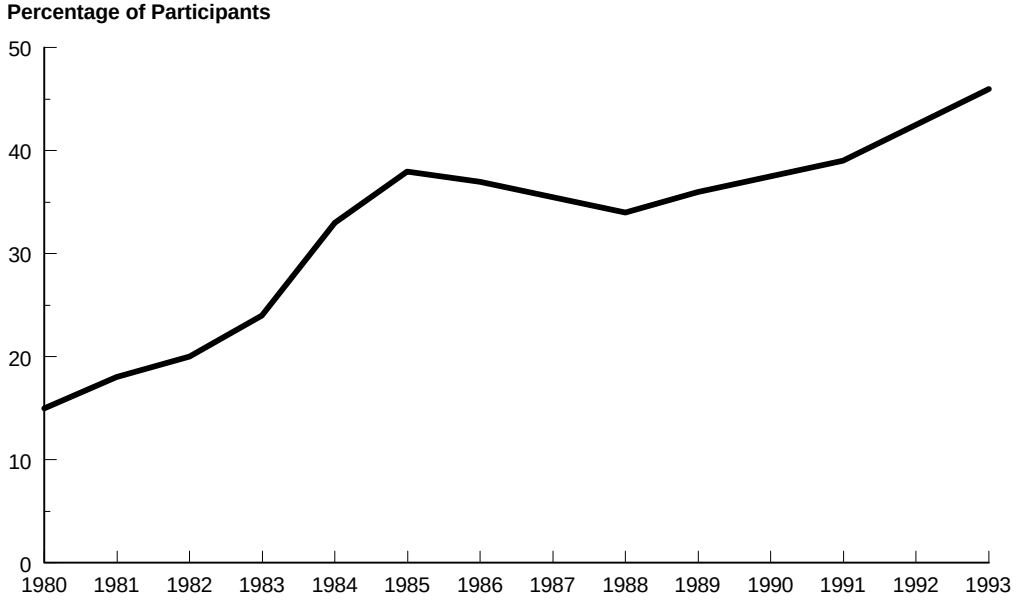
setting premium prices, but self-funded health plans are preempted from these state requirements.

This exemption from state regulation allows employers who self-fund their health plans to save costs associated with state regulation and to offer a uniform, interstate health plan. In an earlier report, we examined the cost differences to self-funded and fully insured health plans resulting from these state requirements.[35] We found that the extent to which these requirements increased the costs of insured health plans compared with self-funded health plans varies by state. On the average, premium taxes increased costs to commercial health insurers by about 2 percent. Although studies of the claims costs associated with state-mandated benefits range from 5 to 22 percent, most self-funded plans offer many of the benefits that are mandated by states. As a result, the additional costs to most self-funded plans, if they were required to comply with state-mandated benefits, would not be as high as these studies estimate. In addition, most insurers voluntarily exceed states' minimum financial solvency standards, indicating that these standards have a limited potential effect on their costs.

The share of insured workers who get their health coverage through self-funded plans has grown. As shown in figure 4.4, this share has tripled since 1980 for workers and dependents in medium and large private establishments (from 15 percent in 1980 to 46 percent in 1993). Data on self-funding among smaller firms are more limited. BLS reports that 31 percent of participants in establishments with fewer than 100 employees self-funded their health plans in 1992. However, this overstates the extent of self-funding among small employers because some self-funded larger employers may have multiple establishments that are included in the survey. Another 1993 survey, by the Robert Wood Johnson Foundation in 10 states, found that only 6 to 10 percent of establishments with fewer than 50 employees self-funded their health plans.

[35]For a detailed discussion of the costs associated with these and other state insurance requirements, see Health Insurance Regulation: Varying State Requirements Affect Cost of Insurance (GAO/HEHS-96-161, Aug. 19, 1996.)

Figure 4.4: Growing Share of Insured Workers and Dependents in Self-Funded Health Plans, 1980-93



Note: Includes firms with at least 100 employees 1988-93 and at least 50, 100, or 250 employees depending on industry 1980-86.

Source: BLS Employee Benefit Surveys, 1980-93.

The growth of self-funding has occurred primarily among indemnity and PPO plans, but some employers are beginning to develop arrangements in which they self-fund their HMO plans as well. In general, large employers have self-funded their indemnity plans and contracted with HMOs as fully insured products that are subject to state insurance requirements. However, KPMG Peat Marwick's survey indicates that as much as 20 percent of HMO enrollment may be in self-funded arrangements. In addition, AAHP, an association that represents HMOs, reports that more than half of HMOs offered self-insured products to employers in 1995.

Concluding Observations

Although private health insurance premiums have stabilized in recent years, the share of Americans covered by private health insurance continues to gradually decline. This trend has persisted despite growth in employment since 1992. Rising costs and declining coverage have contributed to fundamental changes in many Americans' health coverage. More people have Medicaid coverage or are uninsured. Those with private coverage often have to pay a greater share of a plan's premiums and are more likely to be in a health plan that manages their use of health services.

Although it is difficult to predict trends, at some point costs are likely to start rising again. Many of the underlying causes of rising health care costs, such as an aging society and new medical technologies, remain. Furthermore, many of the easily obtained savings from switching to managed care plans may have been achieved. If health insurance costs increase, employers and insurers will have greater pressure to continue pursuing stronger cost control methods. Thus, employees may continue to be required to pay more for health coverage, employers will likely encourage enrollment in tighter forms of managed care, and some employers may even stop offering health benefits.

Public demand for federal and state reforms to address the affordability of and access to private health coverage may increase if private health coverage continues to erode. Federal legislation, the Health Insurance Portability and Accountability Act, has expanded the federal role in regulating private health insurance. Future attention may focus on groups that have been most likely to lose private coverage—children, early retirees, and near-poor families. In addition, the public sector may be called upon to react to changes in the private sector, such as by examining managed care practices and the consequences of increased self-funding of health benefits by employers.

Major Data Sources and Methodology for GAO Estimates

There is no single, comprehensive source of data on private health insurance. Instead, a variety of surveys provide information based on samples of people receiving private health insurance, employers offering health insurance, or health plans providing health coverage. Each survey samples different populations, focuses on different questions, and uses different methodologies. In addition, few data sources have consistently used a comparable methodology over a long period of time, often requiring that long-term trends be identified from a variety of data sources or adjusting the data to make them more comparable. This appendix briefly describes the major data sources used for this report and the methodology we used when major adjustments were necessary to make estimates for trends in private health insurance.

Data on Health Insurance Coverage From the Bureau of the Census' Current Population Survey

The Current Population Survey (CPS) provides data on the source of health insurance coverage, or lack thereof, for the civilian noninstitutional population of the United States. The March 1996 CPS surveyed 48,000 households with over 136,000 individuals and asked about health insurance coverage during the previous year. Thus, the March 1996 CPS asks about health coverage in 1995.[36]

The CPS contains data on health insurance coverage for the period 1979 to 1996, but several methodological changes make it difficult to compare the data. These include changes in the questions asked, the way in which responses are weighted to be nationally representative, and the method of interviewing and processing data. While some of these changes have had only minor effects on the comparability of the data, in other cases we have adjusted the data reported by the CPS to make them more comparable with more recent years.

The most significant revisions occurred in March 1988 when the questions regarding private health insurance coverage and children's health coverage were changed. In particular, these revisions resulted in the identification of many children as having health insurance who would have previously been identified as being uninsured. Following this change in the CPS questions, the CPS reported a drop in the number of uninsured persons from 37.4 million in 1986 to 31.0 million in 1987 while private health insurance coverage went from 170.4 million to 182.2 million. Census notes that "most of the difference was a result of changes to the health insurance questions" rather than an actual decline in the number of

[36]Some experts, however, believe that most respondents provide information on their health coverage at the time of the survey—that is, March 1996.

uninsured. Therefore, we adjusted the CPS data prior to 1987 to make them more comparable with data since 1987. Specifically, we assumed that the rate of change in coverage between 1986 and 1987 was the average rate of change for the 2 years before and after 1986-87. In effect, this increases the share of the nonelderly population with private health insurance as reported by CPS prior to 1987 by about 3.6 percentage points.

Another redesign of the CPS private health insurance questions occurred in March 1995. Census representatives report that this change affects the distribution of respondents with "employment-based" coverage and "other private" coverage, but the number of people with private insurance broadly (combining both "employment-based" and "other private" coverage) is not significantly affected. For this reason, this report discusses the combined "private health coverage" rather than "employment-based" coverage when comparing trends from the CPS before and after 1994.[37]

We made a minor adjustment to the CPS data prior to 1992 to reflect changes in the data resulting from the way Census weights CPS responses to be nationally representative. As reported by Census, data prior to 1992 were weighted based on the 1980 decennial census, whereas since 1992 data have been weighted based on the 1990 decennial census. Census has reported data from the March 1990 and March 1993 CPS with both the 1990 and 1980 weights. Comparing data for 1989 and 1992 with both sets of weights, we calculate that the change in weights resulted in a shift in private health insurance coverage rates of about –0.5 percentage points.[38] To avoid having a one-time shift in coverage rates resulting from the change in weights, we adjusted the CPS data to spread the effect of the weighing change over multiple years. Specifically, we revised the data from earlier CPS years by a graduated proportion of this difference resulting from the weights. That is, the March 1989 CPS data are decreased by an amount equal to 90 percent of the effect attributed to changing the weights (90 percent of –0.5 percentage points for private health insurance coverage), whereas the March 1981 CPS is decreased only by 10 percent of the effect attributed to changing the weights. Data from the March 1991 and March 1992 CPS were adjusted for the full effect of the change in weights (–0.5 percentage points for private health insurance).

[37]Other revisions in the CPS since 1979 include changes in how responses are weighted to be nationally represented and a shift from paper and pencil to computer-assisted telephone interviews.

[38]In addition, Census has provided revised weights for the March 1990 CPS. For this reason, we use the March 1990 CPS as our base in comparing changes in health coverage among segments of the population.

Table I.1 presents the unadjusted CPS data on private health insurance as reported by Census and our estimates based on the adjustments discussed above; figure I.1 shows our estimates of health coverage resulting from these adjustments.

Table I.1: GAO Estimates of Private Health Coverage Based on the Current Population Survey, 1979-95

	Unadjusted private health coverage	Adjusted private health coverage[a]	Net effect of adjustment
1979	76.4%	80.0%	3.6
1980	n/a	79.5[b]	n/a
1981	75.5	78.9	3.5
1982	74.4	77.8	3.4
1983	73.1	76.5	3.4
1984	72.5	75.8	3.3
1985	72.5	75.8	3.3
1986	72.7	75.9	3.2
1987	76.2	75.8	–0.5
1988	75.5	75.1	–0.5
1989	75.5,[c] 75.0[d]	75.0	–0.5
1990	73.8	73.3	–0.5
1991	72.7	72.2	–0.5
1992	71.6[c] 71.0[d]	71.0	–0.5
1993	70.8	70.8	
1994	70.6	70.6	
1995	70.5	70.5	

Note: “n/a” is not available.

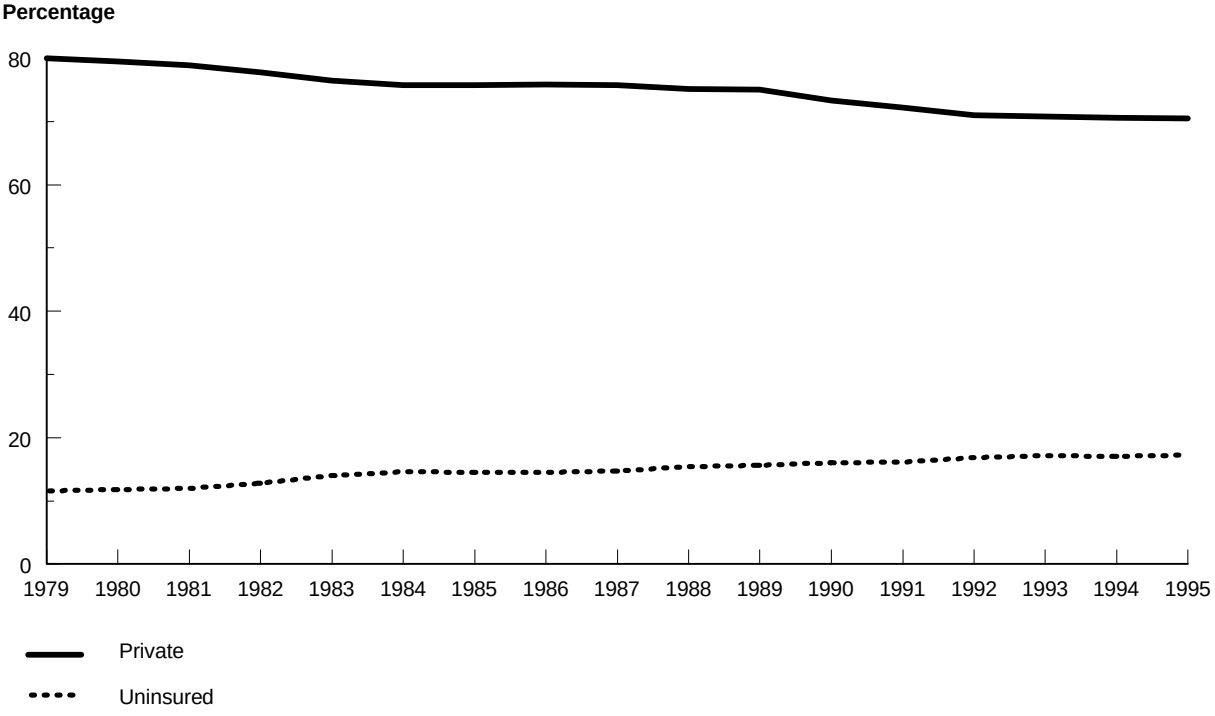
[a]CPS data adjusted to make trends in coverage more comparable as a result of (1) a change in survey questions in the March 1988 CPS and (2) changes in weights in the March 1993 survey.

[b]The 1981 CPS did not ask about nongroup private health insurance coverage for 1980. We estimated 1980 private health insurance coverage as the average for 1979 and 1981.

[c]1980 weights.

[d]1990 weights.

Figure I.1: Estimate of Private Health Coverage, Population Under Age 65, 1979-95



Source: GAO estimate based on Bureau of the Census data.

We used the March 1990 CPS (1989 data) and the March 1996 CPS (1995 data) to assess how private health insurance coverage has changed among subgroups of the U.S. population because the data from the two years are comparable without making any adjustments. In particular, Census provided revised weights for the March 1990 CPS to reflect the 1990 decennial census. This is the same weighing method used in making the March 1996 CPS nationally representative. Therefore, we were able to compare changes in private coverage between 1989 and 1995 without any artificial data distortions resulting from changes in the CPS weighing methods.

Health Spending Data From the Health Care Financing Administration

The Health Care Financing Administration (HCFA) reports data on national health care expenditures.[39] These national health expenditure accounts include data by spending type (for example, hospital, physician, and pharmaceutical), as well as funding sources such as businesses, households, and government. In this report, we report on total national health care expenditures and spending for private health insurance. National health care expenditures include all spending for personal health care services and supplies—including hospitals, physicians, home health, pharmaceuticals, nursing facilities, and other services and supplies—as well as spending associated with health research and construction. Private health insurance expenditures include payments by private insurers to health care providers as well as the net costs of administration and profits. The premiums paid to private health insurers are divided into payments by businesses, households, and governments.

Employer Health Benefit Surveys

Several organizations conduct nationally representative surveys based on random samples of employer health plans. In general, these surveys ask employers about the types of health plans provided to employees, premiums paid, and features of the benefit design. Key features of the employer surveys used in this report are summarized below.[40]

BLS Employee Benefit Surveys

The Bureau of Labor Statistics (BLS) annually surveys a nationally representative sample of employers regarding their employee benefit plans, including health benefits. Between 1979 and 1986, BLS conducted employee benefit surveys of full-time employees in medium and large establishments, defined then as having at least 100, or 250 or more, employees, depending on industry. In 1988 and in odd-numbered years since 1989, BLS has surveyed medium and large private establishments, currently defined as employing at least 100 workers. BLS has surveyed small private establishments (employing fewer than 100 workers) and state and local governments during even-numbered years since 1990.[41] The 1993 medium and large employer survey included 2,325 responding

[39]See Katharine R. Levit and others, "National Health Expenditures, 1995," Health Care Financing Review, Vol. 18, No. 1 (fall 1996), pp. 175-214, and Cathy A. Cowan and others, "Business, Households, and Government: Health Spending, 1994," Health Care Financing Review, Vol. 17, No. 4 (summer 1996), pp. 157-78.

[40]For a detailed summary of various surveys of employer health plans, see Pamela Farley Short, Data Sources for Studies of Self-Insured Health Plans (Washington, D.C.: RAND, Nov. 1995).

[41]See BLS, Employee Benefits in Medium and Large Private Establishments, 1993 (Washington, D.C.: Nov. 1994); Employee Benefits in Small Private Establishments, 1994 (April 1996); and Employee Benefits in State and Local Governments, 1994 (1996).

establishments; the 1994 small employer survey included 2,135 responding establishments.

KPMG Peat Marwick's Survey of Employer-Sponsored Health Benefits

Since 1991, KPMG Peat Marwick has annually surveyed a nationally representative sample of private and public employers with 200 or more workers regarding the health benefits provided to their employees.[42] Because the KPMG survey questions are similar to employer surveys conducted by the Health Insurance Association of America (HIAA) from 1987 to 1993, we use data from both the HIAA and KPMG surveys to report on trends in private health insurance since 1987. Although the KPMG annual survey is limited to employers with at least 200 employees, KPMG and Wayne State University conducted similar surveys of employers with fewer than 200 employees in 1993, 1995, and 1996. We combined information from these surveys to provide data for employers of all sizes.[43]

Foster Higgins

Foster Higgins also conducts an annual survey on health benefits offered by private employers.[44] Since 1993, the survey has been based on a random sample of employers with at least 10 employees. Between 1986 and 1992, the survey was not randomly selected and focused on large employers (typically with at least 500 employees).

Robert Wood Johnson Foundation

In 1993, the Robert Wood Johnson Foundation commissioned a survey of 2,000 employers regarding their health benefits in 10 states: Colorado, Florida, Minnesota, New Mexico, New York, North Dakota, Oklahoma, Oregon, Vermont, and Washington.[45] According to this study, the survey, which included firms of all sizes, generally reflected the national pattern of employers health benefits.

[42]In 1996, the KPMG survey included 1,151 firms. See KPMG Peat Marwick, Health Benefits in 1996 (Tysons Corner, Va., and San Francisco, Calif.: Oct. 1996).

[43]See Gail Jensen and others, "The New Dimension of Managed Care Insurance Trends in the 1990s," Health Affairs, Vol. 16, No. 1 (Jan.-Feb. 1997).

[44]See Foster Higgins, National Survey of Employer-sponsored Health Plans (1996).

[45]See Joel C. Cantor, Stephen H. Long, and M. Susan Marquis, "Private Employment-Based Health Insurance in Ten States," Health Affairs (summer 1995), pp. 199-211.

GAO Estimates of Managed Care Enrollment

We estimated enrollment in managed care health plans using several sources. We used data from Interstudy's annual survey of U.S. health maintenance organizations (HMO) for HMO enrollment since 1980.[46] We estimated enrollment in preferred provider organizations (PPO) and point-of-service (POS) plans since 1987 using data from the KPMG Peat Marwick and HIAA survey discussed above. The KPMG-HIAA survey provides the distribution of enrollment in the various health plan types for employees in firms with at least 200 employees. We multiply the ratio of PPO and POS enrollees to HMO enrollees to the number of private HMO enrollees (not including Medicaid and Medicare enrollment) to estimate the number of enrollees in PPO and POS plans.

Our method may underestimate PPO and POS plan enrollment if the ratio of PPO and POS enrollees to HMO enrollees is higher in smaller firms (those with fewer than 200 employees). Although smaller firms are in general less likely to use managed care, this fact does not affect our estimates of managed care enrollment. However, if smaller firms tend to have more enrollment in PPO and POS plans than in HMO plans relative to larger firms, then we may underestimate PPO and POS enrollment. According to the 1995 survey of firms of all sizes conducted by KPMG and Wayne State University, the ratio of PPO and POS to HMO enrollment is somewhat greater if small firms are included. If we had used this ratio of all firm sizes rather than the ratio for firms with more than 200 employees, our estimate of PPO and POS enrollment would have been 10.4 million higher (65.3 million rather than 54.9 million). However, comparable data on managed care enrollment among smaller firms are not available for earlier years.

The American Association of Health Plans (AAHP) reports that 58.2 million people were enrolled in HMOs by October 1, 1995, including 10.8 million in HMOs with a POS option. Thus, if HMO enrollees with a POS option are excluded, the 1995 AAHP survey reports a similar number of Americans enrolled in an HMO plan (47.4 million) as the 1995 Interstudy survey (46.2 million).

The AAHP survey finds that 1995 enrollment in PPO plans is much higher (91.0 million) than our estimate (54.9 million, including POS enrollment). However, AAHP's survey may double count some PPO enrollment. Thus, while our method may underestimate PPO and POS enrollment, the AAHP survey may overestimate PPO enrollment. In addition, AAHP reports on PPO enrollment only since 1992. In order to be able to report on managed care

[46]See Interstudy Publications, The InterStudy Competitive Edge: HMO Industry Report 6.2 (Minneapolis: 1996).

enrollment since 1980, we used a consistent method to estimate PPO enrollment since 1987. We used data from HIAA to estimate PPO enrollment between 1984 and 1986. Prior to 1984, fewer than 1 million Americans were enrolled in PPOs.

Private Health Insurance Coverage Within Population Categories, 1989 and 1995

Table II.1: Share of Population Under Age 65 With Private Health Insurance Coverage by State, 1989 and 1995

State	Private health coverage, 1989	Private health coverage, 1995	Difference in coverage, 1989-95
U.S.	**75.0%**	**70.5**%	**-4.5**
New England	**83.2**	**78.6**	**-4.6**
Connecticut	87.7	81.7	–6.0
Maine	80.5	76.2	–4.3
Massachusetts	81.9	77.7	–4.2
New Hampshire	81.3	81.2	–0.1
Rhode Island	81.5	76.0	–5.5
Vermont	83.6	75.5	–8.1
Middle Atlantic	**78.3**	**72.8**	**-5.5**
New Jersey	81.9	76.6	–5.3
New York	74.5	68.1	–6.4
Pennsylvania	82.0	77.6	–4.4
East North Central	**80.6**	**78.0**	**-2.6**
Illinois	79.1	76.3	–2.8
Indiana	78.8	79.9	1.1
Michigan	79.3	79.0	–0.3
Ohio	82.9	75.9	–7.0
Wisconsin	83.5	82.0	–1.5
West North Central	**81.5**	**78.2**	**-3.3**
Iowa	85.9	80.8	–5.1
Kansas	82.0	72.0	–10.0
Minnesota	84.5	82.1	–2.4
Missouri	77.5	75.4	–2.1
Nebraska	79.4	79.9	0.5
North Dakota	82.7	80.6	–2.1
South Dakota	76.9	78.3	1.4
South Atlantic	**74.5**	**68.7**	**-5.8**
Delaware	73.8	75.2	1.4
District of Columbia	61.8	60.7	–1.1
Florida	70.4	65.1	–5.3
Georgia	73.9	68.1	–5.8
Maryland	81.2	72.6	–8.6
North Carolina	76.1	70.5	–5.6
South Carolina	75.8	68.5	–7.3
Virginia	77.1	72.8	–4.3
West Virginia	72.9	65.9	–7.0

(continued)

State	Private health coverage, 1989	Private health coverage, 1995	Difference in coverage, 1989-95
East South Central	**72.0**	**68.1**	**-3.9**
Alabama	71.5	73.0	1.5
Kentucky	74.8	68.0	–6.8
Mississippi	64.2	61.3	–2.9
Tennessee	74.7	67.7	–7.0
West South Central	**66.6**	**62.0**	**-4.6**
Arkansas	69.9	66.5	–3.4
Louisiana	66.8	59.1	–7.7
Oklahoma	67.9	63.3	–4.6
Texas	66.0	61.9	–4.1
Mountain	**74.2**	**69.8**	**-4.4**
Arizona	72.1	63.2	–8.9
Colorado	74.2	77.7	3.5
Idaho	77.6	74.4	–3.2
Montana	73.6	69.6	–4.0
Nevada	75.7	72.5	–3.2
New Mexico	64.2	50.5	–13.7
Utah	83.6	80.8	–2.8
Wyoming	79.0	71.6	–7.4
Pacific	**68.8**	**64.4**	**-4.4**
Alaska	65.8	68.3	2.5
California	66.2	61.5	–4.7
Hawaii	78.7	72.4	–6.3
Oregon	78.3	73.9	–4.4
Washington	77.6	74.1	–3.5

Source: U.S. Bureau of the Census, Current Population Survey (Mar. 1989 and Mar. 1996).

Table II.2: Share of Population Under Age 65 Covered by Private Health Insurance, 1989 and 1995

Age	Private health coverage 1989	Private health coverage 1995	Difference in coverage, 1989-95
Under 18	73.1%	66.1%	–7.0
18 to 24	65.1	60.2	–4.9
25 to 34	73.5	68.3	–5.2
35 to 44	81.1	76.2	–4.9
45 to 54	81.4	80.0	–1.4
55 to 64	78.8	76.5	–2.3
U.S. average (0 to 64)	**75.0**%	**70.5**%	**-4.5**

Source: U.S. Bureau of the Census, Current Population Survey (Mar. 1989 and Mar. 1996).

Table II.3: Share of Population Under Age 65 Covered by Private Health Insurance by Race or Ethnic Group, 1989 and 1995

Race or ethnic group	Private health coverage 1989	Private health coverage 1995	Difference in coverage, 1989-95
White[a]	82.2%	79.1%	–3.1
Black[a]	56.4	51.3	–5.1
Hispanic origin	49.9	43.3	–6.6
Other[a]	67.5	63.7	–3.8
U.S. total (0 to 64 years)	**75.0**%	**70.5**%	**-4.5**

[a]Nonhispanic.

Source: U.S. Bureau of the Census, Current Population Survey (Mar. 1989 and Mar. 1996).

Table II.4: Share of Population Under Age 65 With Private Health Insurance Coverage by Annual Family Income, 1989 and 1995

Income	Private health coverage 1989	Private health coverage 1995	Difference in coverage, 1989-95
Under $10,000	25.6%	19.7%	–5.9
$10,000 to $19,999	56.5	42.8	–13.7
$20,000 to $29,999	77.6	64.4	–13.2
$30,000 to $39,999	87.6	77.5	–10.1
$40,000 to $49,999	90.9	85.5	–5.4
$50,000 to $59,999	92.6	88.5	–4.1
$60,000 to $74,999	93.7	90.5	–3.2
$75,000 and above	93.3	92.9	–0.4
U.S. average (0 to 64 years)	**75.0**%	**70.5**%	**-4.5**%

Source: U.S. Bureau of the Census, Current Population Survey (Mar. 1989 and Mar. 1996).

Table II.5: Share of Population Under Age 65 With Private Health Insurance Coverage by Percent of Poverty Level, 1989 and 1995

Level	Private health coverage 1989	Private health coverage 1995	Difference in coverage, 1989-95
Poverty level and below	26.5%	21.6%	–4.9
101% to 150% of poverty level	52.9	46.7	–6.2
151% to 200% of poverty level	68.7	62.9	–5.8
201% of poverty level and above	89.1	86.8	–2.3
U.S. average (0 to 64 years)	**75.0**%	**70.5**%	**-4.5**

Source: U.S. Bureau of the Census, Current Population Survey (Mar. 1989 and Mar. 1996).

Table II.6: Share of Population Under Age 65 With Private Health Insurance Coverage by Industry, 1989 and 1995

Industry	Private health coverage 1989	Private health coverage 1995	Difference in coverage, 1989-95
Finance, insurance, and real estate	88.9%	88.4%	–0.5
Professional and related services	87.8	86.2	–1.6
Mining	88.3	86.2	–2.1
Transportation, communication, and other public utilities	88.1	84.7	–3.4
Public administration	80.1	84.6	+4.5
Manufacturing	87.3	84.3	–3.0
Entertainment and recreation services	73.5	77.0	+3.5
Trade	75.3	71.1	–4.2
Business and repair services	72.9	67.7	–5.2
Construction	68.9	66.4	–2.5
Personal services, including private households	67.2	62.3	–4.9
Agriculture, forestry, and fisheries	63.8	62.2	–1.6
U.S. average for all workers	**80.7**%	**78.4**%	**-2.3**

Source: U.S. Bureau of the Census, Current Population Survey (Mar. 1989 and Mar. 1996).

Table II.7: Share of Population Under Age 65 With Private Health Insurance Coverage by Firm Size, Nonelderly Population, 1989 and 1995

Number of employees	Private health coverage 1989	Private health coverage 1995	Difference in coverage, 1989-95
Under 25	70.3%	66.9%	–3.4
25 to 99	78.7	77.0	–1.7
100 to 499	84.0	82.8	–1.2
500 to 999	88.1	84.6	–3.5
1,000 or more	87.1	85.4	–1.7
U.S. average for all workers	**80.7**%	**78.4**%	**-2.3**

Source: U.S. Bureau of the Census, Current Population Survey (Mar. 1989 and Mar. 1996).

Table II.8: Share of Population Under Age 65 With Private Health Insurance Coverage by Employment Status, 1989 and 1995

Employment status	Private health coverage 1989	Private health coverage 1995	Difference in coverage, 1989-95
Full-time	86.9%	84.2%	–2.7
Less than full-time	70.9	68.2	–2.7
Not working	56.7	50.8	–5.9
U.S. average (15 to 64)	**75.8%**	**72.4%**	**-3.4**

Source: U.S. Bureau of the Census, Current Population Survey (Mar. 1989 and Mar. 1996).

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