Comparing Employee Health Benefits In The Public And Private Sectors, 1997

The benefits of government workers stack up well against those in the private sector, and government workers are more likely to be offered health insurance at work.

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ABSTRACT: Data from the 1997 Robert Wood Johnson Foundation Employer Health Insurance Survey provide new information comparing public- and private-sector employee health benefits. The federal government is ahead of other employers in adopting managed competition principles using financial incentives and consumer information to promote choosing efficient plans. Federal employees experience a $200 annual compensation gap relative to those in the private sector, but it is partly explained by advantage in purchasing power. In contrast, state and local governments make higher payments toward health insurance than private-sector employers do. Their premiums are equivalent, but they pay a greater share of the total cost.

POLICYMAKERS HAVE A LONG-STANDING INTEREST in comparisons of the health benefit plans sponsored by public and private employers. These comparisons can inform them about "best practices" under managed competition, parity of compensation between public- and private-sector workers, and the possible costs of permitting legal action against private employers and their health plans over delayed or wrongfully denied benefits.

The Federal Employees Health Benefits Program (FEHBP) has long been touted as a model for health system reform based on managed competition, as have some state employee plans (such as those of California, Minnesota, and Wisconsin).[1] More recently, major corporations and universities have jumped on the managed competition bandwagon.[2] Although the public sector took the lead originally, how do the two sectors compare today, in view of the private sector's more recent efforts?

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It is commonplace for journalists, legislators, and taxpayers to express concern that public employees are overpaid relative to their private-sector counterparts.[3] The evidence on this topic is mixed, however, and subject to concerns about methodological flaws.[4] Moreover, there is considerably more and better evidence on pay and pensions than there is on health insurance benefits.[5] The two empirical studies we found that compared health benefits suggest that federal employees' health benefits are not as generous as those in the private sector.[6] For example, the Congressional Budget Office (CBO) estimates that the value of employer-paid federal health insurance ranges from 77 percent to 89 percent of that in large private companies, a shortfall of $445–$629 annually across the five hypothetical federal employees of different ages for whom they produced illustrative calculations.[7] Information on the health benefits of state and local public employees relative to private employees is scant.[8]

The Employee Retirement Income Security Act (ERISA) now protects private employers and their health insurers and health maintenance organizations (HMOs) from lawsuits related to wrongful denial or delay of health benefits. This litigation, which otherwise would be permitted under many state laws, also is prohibited under the law governing the FEHBP. However, it is permitted for state and local government employees, whose employers and health plans are exempt from ERISA.[9] Proposed legislation for a patients' bill of rights would amend the ERISA preemption of state law to extend the right of litigation to private employees. Opponents argue that this would cause health insurance premiums to rise. Current law provides a natural experiment whereby, in principle, comparisons of premiums for state and local government employees versus those of private employees provide a measure of the costs. Evidence on these magnitudes is scant, and estimates cover a wide range.[10]

The purpose of this DataWatch is to provide new descriptive statistics comparing the health benefits provided to public- and private-sector employees. We also provide some new evidence on the issues of pay comparability and liability costs. The estimates are based on a large national survey of private and public employers in 1997.

Methods

Our data are from the 1997 Robert Wood Johnson Foundation (RWJF) Employer Health Insurance Survey, which collected information from a sample of private business establishments and local government units, from each state government in the forty-eight contiguous states and the District of Columbia, and from the federal government. Details about the data collection from private employ-

"The health plans available to private-sector workers are more likely to be restricted to one type of managed care plan."

ers are described elsewhere in this volume.[11] Here we briefly describe the methods to collect public-sector information.[12]

The 1992 Census of Governments was the sampling frame for local government employers. The frame was stratified by geography and by employer size, with simple random samples selected from within each stratum. Interviews were completed with 713 local government units, following the procedures for interviewing private employers. Sampled public and private employers are weighted to account for different sampling probabilities and for nonresponse. We use employee or health plan enrollee weights throughout this DataWatch because our interest is in comparing the coverage of workers in different employment settings.[13]

We collected information about all state government employees in each state and the District of Columbia using data-collection procedures similar to those for private businesses and local governments. Interviewers contacted a person in each state government knowledgeable about health insurance benefits and attempted to complete the computer-assisted telephone interview. However, procedures were adapted to reduce the reporting burden. Special worksheets were developed for state representatives to fill out in lieu of reporting the information over the telephone. Some states elected to send plan booklets, which were then abstracted by interview staff into the interview format.

Information about federal employees was obtained primarily from administrative records. Employee data came from the Central Personnel Data file provided by the U.S. Office of Personnel Management (OPM). Health plan enrollments were obtained from the Health Benefits Data file, also provided by the OPM. Details about the coverage provisions of all federal health plans were abstracted from the OPM Internet site.

Our analysis examines differences in health plan participation among private and public workers, in the extent and nature of plan choice available to them, in the types of financial incentives and comparative plan information provided, and in total premiums and employer contributions to premiums. The questions used to determine health plan choice, to classify plans by type, and to establish the kinds of financial incentives and information available to employees are described elsewhere in this volume.[14]

Health insurance premiums and employer contributions for both

single and family coverage were reported for each health insurance plan offered. Some employers offer coverage for special services, such as dental care or prescription drugs, in plans that are separate from the general medical plan. We constructed premiums and employer contributions for the package of benefits held by enrollees by adding together the premiums and contributions paid for both the general medical plan and for any plans covering special services. Because we collected information on the enrollments in the special-service plans as well as the general medical plans, we can determine how many enrollees hold the expanded package of benefits, including these special-service plans, and how many hold just the general medical plan benefits.

We report premiums that are adjusted for differences in the actuarial value of plan benefits and for differences in the characteristics of employees in different groups. The actuarial value of plan benefits is measured by estimating average plan benefit payments for a standardized distribution of expenditures. The adjusted premiums also control for differences between the sectors in the distribution of workers by age, sex, and hours worked.[15]

Study Results

Likelihood of coverage. Employees in the public sector are more likely than employees in the private sector are to receive health insurance as part of their compensation (Exhibit 1). Overall, 60 percent of private-sector workers are enrolled in their employer's health insurance plan, compared with 79 percent of public-sector workers. Most of the difference is attributable to fewer private-sector than public-sector employees working for an employer that offers health insurance (83 percent versus 99 percent). The lower rates of offering insurance to private-sector employees can be traced to smaller firms' decisions not to offer insurance.[16] The offer of insurance to employees in large private firms (those with 500 or more employees) is the same as for public-sector employees. As a result,

EXHIBIT 1
Employees' Health Plan Participation, By Type Of Employer, 1997

	Private			Public		
		Firm size				
	All	Fewer than 500	500 or more	All	Federal	State/local
Employees enrolled in their own employer's plan[a]	60%	50%	76%	79%	71%	81%
Employees in firms offering insurance	83	72	99	99	100	99
Eligible employees among those in firms offering insurance	84	81	86	89	93	88
Enrolled employees among those eligible	87	85	89	90	77	93

SOURCE: 1997 Robert Wood Johnson Foundation Employer Health Insurance Survey.
[a] This overall enrollment rate is the product of the offer, eligibility, and participation rates shown in the next three rows.

participation in health insurance for employees in large private firms also is similar to the overall rate for those in the public sector (76 percent versus 79 percent).

The results for all public-sector employees mask some differences between federal and state or local government workers. Eligibility for insurance is higher among federal employees than among other public- or private-sector employees. Participation rates among workers who are eligible to enroll are lowest for federal workers and highest for workers in state and local governments. As we show below, this pattern mirrors differences in the amount of the health insurance premium contributed by the employer.

Choice of plans. There are substantial differences in the extent and nature of the choice of health plans available to workers in the private and public sectors. Only 43 percent of private-sector health plan enrollees had a choice of plans in 1997, in contrast to 100 percent of federal employees and 70 percent of state and local government workers (Exhibit 2). This difference is only partly explained by the limited choice offered by small private employers.[17] Only 59 percent of plan enrollees in large firms had a choice of health plans—still far less choice than what is available to those in the public sector.

The health plans available to private-sector workers are more likely to be restricted to one type of managed care plan—that is, HMOs, preferred provider organizations (PPOs), or point-of-service (POS) plans—whereas government workers are more likely to have a choice of plan types as well. Among all private-sector plan enrollees, 53 percent are offered a single type of managed care plan, while only 35 percent are offered a choice of type of plan—either multiple types of managed care products or a choice that includes an indemnity product (Exhibit 2). Even among health plan enrollees in large private firms, only 49 percent have a choice of plan types. In contrast, all federal plan enrollees and 64 percent of state and local

EXHIBIT 2
Health Plan Choices Offered To Enrollees, By Type Of Employer, 1997

	Private			Public		
		Firm size				
	All	Fewer than 500	500 or more	All	Federal	State/local
Enrollees offered a choice of plans	43%	25%	59%	74%	100%	70%
Enrollees by type of plan offered						
One type of managed care plan only	53	68	39	25	0	28
Indemnity only	12	14	12	7	0	8
Multiple types of managed care plans, no indemnity plan	20	11	27	38	99	29
Managed care and indemnity plans	15	7	22	30	1	35

SOURCE: 1997 Robert Wood Johnson Foundation Employer Health Insurance Survey.

plan enrollees have a choice of plan types.

Types of plans selected. Despite the very large differences in the extent of choice offered, there is much less difference in the types of plans elected by public- and private-sector health plan enrollees. Overall, POS plans are slightly more common among private employees than among public employees, while PPO plans have slightly lower enrollment among those in the private sector (Exhibit 3). These differences are somewhat more pronounced in comparisons of public employees with private employees in large firms. Among the latter, 21 percent are enrolled in POS plans and 33 percent in PPO plans; the corresponding numbers for public-sector plan enrollees are 9 percent and 38 percent. HMOs receive a greater share of enrollment among private-sector employees in small firms than among other private or public employees, because many small employers limit choice to a single HMO.[18]

Managed competition. The federal government has led the way in adopting managed competition principles. In general, the federal government's contribution policy is to pay a fixed-dollar contribution to any plan to which the enrollee subscribes, thus leaving the employee with the full cost of choosing a more expensive plan (Exhibit 4).[19] Among state and local government health plan enrollees, 42 percent receive an equal employer contribution regardless of the plan selected. In contrast, only 25 percent of private-sector health plan enrollees offered a choice of plans pay the full cost of choosing a more expensive plan.

Information on quality. All federal workers have access to comparative information on the quality of their health plan choices (Exhibit 4). However, provision of this information is not prevalent for other workers. Only about one-third of plan enrollees in large private firms or in state and local government receive information to help them evaluate the quality of their health plan options.[20]

Premiums. Average total monthly premiums paid for enrollees covered by the FEHBP are lower than premiums paid by private

EXHIBIT 3
Enrollment In Different Types Of Plans, By Type Of Employer, 1997

	Private			Public		
		Firm size				
Type of plan	All	Fewer than 500	500 or more	All	Federal	State/local
HMO	33%	40%	26%	33%	36%	33%
POS	15	8	21	9	4	10
PPO	34	36	33	38	60	34
Indemnity	18	16	20	20	1	23

SOURCE: 1997 Robert Wood Johnson Foundation Employer Health Insurance Survey.
NOTES: HMO is health maintenance organization. POS is point-of-service. PPO is preferred provider organization.

EXHIBIT 4
Use Of Financial Incentives And Provision Of Comparative Quality Information, By Type Of Employer, 1997

	Private			Public		
		Firm size				
	All	Fewer than 500	500 or more	All	Federal	State/local
Enrollees with a fixed-dollar contribution	25%	28%	23%	52%	100%	42%
Enrollees provided with comparative quality information	–[a]	–[a]	30	51	100	36

SOURCE: 1997 Robert Wood Johnson Foundation Employer Health Insurance Survey.
NOTE: Data are limited to employers offering a choice of plans.
[a] Not asked of private employers with fewer than 500 employees.

employers overall (Exhibit 5). These comparisons are adjusted for differences in the scope and breadth of benefits, as well as differences in the composition and, therefore, health risk of the populations. On the other hand, premiums for private-sector employees do not differ greatly from those for state and local government employees. These conclusions apply both overall and to workers in large firms.

Contribution share. Private employers contribute a higher share of the premium for single coverage than does the federal government, but they contribute a smaller share than state and local governments do. As noted earlier, these patterns mirror differences in participation rates among eligible workers, which are lowest for federal employees and highest for state and local employees. This suggests that workers' decisions to enroll are related to the amount the employer contributes to the coverage.

The picture differs when we look at contribution rates for family coverage. Private employers and state and local governments con-

EXHIBIT 5
Premiums, Employer Contributions, And Benefits For Health Plan Enrollees, By Type Of Employer, 1997

	Private			Public		
		Firm size				
	All	Fewer than 500	500 or more	All	Federal	State/local
Adjusted total monthly premium[a]						
Single coverage	$184	$176	$192	$187	$160	$191
Family coverage	464	435	488	450	384	460
Employer contribution share						
Single coverage	85%	86%	84%	93%	81%	95%
Family coverage	70	67	72	78	78	78
Employer contribution level						
Single coverage	$158	$149	$165	$182	$140	$188
Family coverage	325	291	355	362	310	370

SOURCE: 1997 Robert Wood Johnson Foundation Employer Health Insurance Survey.
[a] Adjusted total monthly premium is the monthly premium adjusted for the actuarial value of plan benefits and the distribution of workers by age, sex, and hours worked.

"The federal government leads all other employers in using best practices of health insurance purchasing."

tribute a smaller proportion of the cost of dependent coverage than for employee coverage. As a result, these employers' contribution shares for family coverage are lower than their contributions for single coverage. The federal government contribution for family coverage (78 percent), however, is similar to that for employee-only coverage (81 percent). Moreover, the share of the family premium paid by the federal government is higher than that paid by private employers or state governments.[21]

The relative contribution to dependent coverage appears to be related to employees' decisions to elect family coverage. Among federal enrollees, who receive similar contribution rates for workers and dependents, 65 percent elect family coverage (not shown). In contrast, only about half of enrollees in private employers' plans or in state and local government plans do so.

Contribution level. The dollar amount that employers contribute to the health insurance plan is the direct monetary value of the health insurance component of the worker's compensation package.[22] This dollar contribution is lowest for federal workers and highest for employees in state and local governments.

Discussion

The federal government continues to hold a leadership position among employers in adopting managed competition principles.[23] It offers a wide array of choices to its eligible employees, providing them with financial incentives to shop for low-cost plans and comparative information to assist them in their decisions. State and local government employers fall somewhere in the middle. The majority of their workers are offered a choice of both plans and plan types. On the other hand, strong financial incentives and the provision of information for informed choice are not as pervasive among these employers as in the federal program. In contrast to the public sector, most private employers—even larger ones—have not begun using best practices of health insurance purchasing.

We offer a more positive spin than others have offered in comparing the health insurance benefits of federal versus private workers. Although the federal government makes lower direct payments for health insurance on behalf of its enrollees, the gap is much smaller than previously believed. We estimate that annual federal health benefit payments fall about $200 per enrollee short of those for all

private-sector enrollees, lower than the roughly $450–$630 gap recently reported by the CBO.[24] Moreover, several other factors work in the direction of offsetting this shortfall. Eligibility for health insurance benefits is more likely to be a part of the compensation package for federal workers than for private workers.[25] Once eligible, federal workers have greater opportunity to choose a plan and a type of plan. We expect that workers value this range of choice. Finally, part of the reason for the lesser federal contribution amount apparently derives from the better purchasing power of the federal government. Overall, FEHBP premiums are lower than private-sector premiums, even after we control for differences in benefit packages and population characteristics.

Premiums paid by state and local governments (which are exempt from ERISA) are similar to those paid by private-sector employers. This appears to contrast with the hypothesis offered by opponents of extending litigation rights, who argue that it will lead to higher costs. However, we are not able to control for a number of factors that might affect these comparisons, such as differences in purchasing power or the breadth of provider panels. Our adjustments for risk also may be incomplete and mask true premium differences. Moreover, the relatively equal levels of premiums we observe may reflect the now limited right to sue employers and health plans among enrollees across all sectors. If patients' right to sue were extended to all employees in the future, costlier behavior among providers and plans might be induced.[26]

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NOTES

1. A.C. Enthoven, "Consumer-Choice Health Plan (Second of Two Parts)," *New England Journal of Medicine* (30 March 1978): 709–720; A.C. Enthoven, "The History and Principles of Managed Competition," *Health Affairs* (Supplement 1993): 24–48; W. Francis, "A Health Care Program Run by the Federal Government That Works," *American Enterprise* (July/August 1993): 50–61; E.W. Hoy, E.K. Wicks, and R.A. Forland, "A Guide to Facilitating Consumer Choice," *Health Affairs* (Winter 1996): 9–30; and M.L. Maciejewski, B.E. Dowd, and R. Feldman, "How Do States Buy Health Insurance for Their Own Employees?" *Managed Care Quarterly* (Summer 1997): 11–19.
2. T. Bodenheimer and K. Sullivan, "How Large Employers Are Shaping the Health Care Marketplace (First of Two Parts)," *New England Journal of Medicine* (2 April 1998): 1003–1007; T.C. Buchmueller, "Does a Fixed-Dollar Premium

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3. See, for example, P. Peterson, *Facing Up: How to Rescue the Economy from Crushing Debt and Restore the American Dream* (New York: Simon and Schuster, 1993), 103–104, under the subheading referring to federal employees' "Benefits Bonanza."
4. B. Braden and S. Hyland, "Cost of Employee Compensation in Public and Private Sectors," *Monthly Labor Review* (May 1993): 14–21; and M. Miller, "The Public-Private Pay Debate: What Do the Data Show?" *Monthly Labor Review* (May 1996): 18–29.
5. Braden and Hyland, "Cost of Employee Compensation;" A.C. Foster, "Public and Private Sector Defined Benefit Pensions: A Comparison," *Compensation and Working Conditions* (Summer 1997): 37–43; Miller, "The Public-Private Pay Debate;" and W. Wiatrowski, "On the Disparity between Private and Public Pensions," *Monthly Labor Review* (April 1994): 3–9.
6. Congressional Budget Office, *Comparing Federal Employee Benefits with Those in the Private Sector* (Washington: CBO, August 1998); and Congressional Research Service, *Federal Civil Service Retirement: Comparing the Generosity of Federal and Private-Sector Retirement Systems*, CRS Report for Congress no. 95-687 EPW (Washington: CRS, 5 June 1995).
7. CBO, *Comparing Federal Employee Benefits*. Absent nationally representative data on private benefits, the values for private-sector employees were based on data characterizing large companies from an employee benefit consulting firm convenience sample.
8. Overall, cost per labor hour for health insurance is higher in these governments, but this is largely owing to a larger share of all employees' being offered and participating in health plans, as well as a somewhat higher percentage of covered state and local employees' having fully paid benefits. See Braden and Hyland, "Cost of Employee Compensation;" and A.C. Foster, "Brief: Employee Benefits in the United States, 1993–94," *Compensation and Working Conditions* (Spring 1997): 46–50. We did not find relative values of premiums for state and local enrollees in the literature.
9. California Health Policy Roundtable, *Health Plan Liability* (Berkeley, Calif.: Center for Health and Public Policy Studies, University of California, June 1999); U.S. General Accounting Office, *Employer-Based Health Plans: Issues, Trends, and Challenges Posed by ERISA*, GAO/HEHS-95-167 (Washington: GAO, July 1995); and S. Hunt, J. Saari, and K. Traw, *Impact of Potential Changes to ERISA: Litigation and Appeal Experience of CalPERS, Other Large Public Employers, and a Large California Health Plan* (Menlo Park, Calif.: Henry J. Kaiser Family Foundation, June 1998).
10. California Health Policy Roundtable, *Health Plan Liability*; and Hunt et al., *Impact of Potential Changes to ERISA*.
11. S.H. Long and M.S. Marquis, "Stability and Variation in Employment-Based Health Insurance Coverage, 1993–1997," *Health Affairs* (November/December 1999): 133–139; and M.S. Marquis and S.H. Long, "Trends in Managed Care and Managed Competition, 1993–1997," *Health Affairs* (November/December 1999): 75–88.

12. For more details of these methods, see *1997 Employer Health Insurance Survey: Final Methodology Report* (Research Triangle Park, N.C.: Research Triangle Institute, 1998).
13. The weighted samples represent employees in all private employment establishments that have at least one employee and in all substate government units. Self-employed persons with no employees are excluded.
14. Long and Marquis, "Stability and Variation;" and Marquis and Long, "Trends in Managed Care."
15. Specifically, we regressed reported premiums on the actuarial value of the plan and employee characteristics. We then measured the adjusted premium as the observed premium for a plan minus the product of the regression coefficients and the vector of differences between the quantity measures for the plan and the average value of the quantity measures for all plans. Equivalently, the adjusted premium is the predicted premium for a plan with average characteristics plus the residual from the regression equation for the specific plan in question.
16. Long and Marquis, "Stability and Variation."
17. Marquis and Long, "Trends in Managed Care."
18. Ibid.
19. In practice, the federal government pays a fixed-dollar amount not to exceed 75 percent of the plan cost; hence, there is some partial government subsidy of the difference between the lowest-price and mid-price plans. For all other employers, our measure of incentives is based on a self-reported contribution policy.
20. Federal workers are provided results of satisfaction surveys. Among both private and state and local workers provided information, about 40 percent receive satisfaction survey results, 10 percent receive outcome measures such as Health Plan Employer Data and Information Set (HEDIS) measures, and 50 percent receive both types of information.
21. The employer shares for family coverage in state and local governments are 75 percent and 79 percent, respectively (not shown).
22. However, having a choice of plans, the scope and breadth of benefits available, and the exercise of employer's purchasing power all may have value to the employee that we are unable to measure directly.
23. This is not to say that the FEHBP does not have its critics. See A.C. Enthoven, "Effective Management of Competition in the FEHBP," *Health Affairs* (Fall 1989): 33–50.
24. Much of the difference in the estimates can be explained by the fact that the CBO used information for an unrepresentative sample of very large employers. If we had restricted our comparison to all large employers, the estimated gap would be about $450.
25. The likelihood is similar if the contrast is limited to workers in large private firms only.
26. California Health Policy Roundtable, *Health Plan Liability*; and Hunt et al., *Impact of Potential Changes to ERISA*.