

GAO

Report to the Ranking Minority Member,
Subcommittee on Children and Families,
Committee on Labor and Human
Resources, U.S. Senate

February 1997

EMPLOYMENT-BASED HEALTH INSURANCE

Costs Increase and Family Coverage Decreases





United States
General Accounting Office
Washington, D.C. 20548

**Health, Education, and
Human Services Division**

B-271082

February 24, 1997

The Honorable Christopher J. Dodd
Ranking Minority Member
Subcommittee on Children and Families
Committee on Labor and Human Resources
United States Senate

Dear Senator Dodd:

Nearly two-thirds of Americans under 65 years old—some 150 million people—have employment-based private health insurance. Although many employers remain committed to providing employee and family coverage, the percentage of people with private coverage is declining. At the same time, the percentage of Americans who are uninsured or rely on Medicaid—particularly children—continues to increase. The effect of being uninsured on the health of families can be significant. For example, uninsured children are less likely than insured children to receive primary care, immunizations, and treatment for injuries. The lack of such care can lead to health conditions and disabilities that require more costly and long-term care.

Concerned about the decline in employment-based health insurance coverage, you asked us to (1) identify any recent trends in employment-based private health insurance, particularly for family coverage; (2) determine any corresponding changes in the number of adults and children with private insurance coverage as dependents; and (3) identify the potential effect of these changes, if any, on public costs for health care coverage. To answer these questions, we analyzed surveys of health insurance coverage conducted by the Department of Labor (DOL) and by private benefits consultants, such as KPMG Peat Marwick and Hewitt Associates. We also analyzed the Bureau of the Census' Current Population Surveys (CPS) on health insurance coverage for 1989, 1991, 1993, and 1995. In addition, we discussed trends with experts, insurance company executives, and benefits consultants to determine how employer practices may have changed in the past several years. We also reviewed research reports on private insurance and the health insurance marketplace.

Because more limited information is available on benefit practices at small firms (fewer than 100 employees), our report primarily focuses on large firms (100 or more employees) and major firms (over 1,000 employees).

For this report, family generally refers to a group of people whom insurers would consider a family for the purposes of health insurance coverage—typically adults related by marriage, parents, and their children under 18 years old.¹ (See app. I for more details of our methodology.)

Results in Brief

Eroding employer financial support for providing health insurance to employees' families has contributed to the overall decline in private health insurance coverage.² Each year between the late 1980s and 1994, increases in employers' costs to provide health insurance to their employees and their employees' families outpaced inflation—with cost growth of 18 percent one year. As health insurance reached 10 percent of employees' payroll costs, many employers began to reconsider the amount of support they would provide to employees, particularly for family coverage.

Acquiring or maintaining health insurance has become more difficult for some families because of changes that some employers made to their firms' health coverage. Some employers—particularly smaller employers—dropped coverage altogether. In 1993, over 29 million employees—almost one-fourth of the workforce—were employed by firms that did not offer group health insurance for employees' families. Most employers continued to offer coverage, but many raised employees' premium contributions significantly—especially for family coverage. In 1993, 16 percent of employees in large private firms paid \$150 or more per month for family health insurance premiums; 36 percent of state and local government employees paid as much in 1992. Some employers have used other mechanisms, such as financial incentives, that could discourage employees from two-worker families from purchasing family coverage from them.

As these changes occurred, the percentage of Americans under 65 years old with private health insurance coverage decreased from 75 percent in 1989 to about 71 percent in 1995. Of this general decline, about 70 to 90

¹Other adults who could be included as adult dependents in our CPS analysis include young unmarried adults under 19 years old or in college who are covered through their parents' health insurance policies and married spouses who have separated from the primary family policyholder. In addition, some employers extend health insurance coverage and other benefits to unmarried partners of employees as dependents—either gays or unmarried heterosexuals—and they could also be included as adult dependents.

²Most people under 65 years old with private coverage obtain their health insurance through employment-based plans. Private insurance purchased directly by individuals covers about 5 percent of the population under 65 years old as their only source of health insurance coverage. For more information on the structure of the private market for individual coverage, see *Private Health Insurance: Millions Relying on the Individual Market Face Cost and Coverage Trade-Offs* (GAO/HEHS-97-8, Nov. 25, 1996).

percent was due to fewer working-age adults and children being covered as dependents. Between 1989 and 1995, the percentage of working-age adults (18 to 64 years old) with private insurance coverage decreased from 76 percent to 73 percent. If the same percentage of working-age adults had been covered in 1995 as in 1989, about 5 million more adults would have had private insurance. However, children experienced the greatest loss of private coverage. Over these 6 years, the percentage of children under 18 years old with private health insurance decreased from more than 73 percent to 66 percent. If private coverage levels had not decreased, about 5 million more children would have private insurance.

Declines in employment-based dependent coverage can increase the number of uninsured Americans and shift a greater burden for health care onto public payers. Between 1994 and 1996, health insurance premium costs have been relatively stable, which may help slow the erosion of private coverage. However, unless the decline in employment-based insurance coverage abates, public payers could face increased costs for health care—either for uncompensated care or for public insurance.

Background

Support for employment-based health insurance by employers contributes to the health and financial security of employees and their families. U.S. employers traditionally have provided private group health insurance as an employment benefit for their employees and their employees' spouses and children. Beginning with World War II—when wages were frozen and employers wanted to attract good employees—employment-based insurance became a more common fringe benefit. Today, private health insurance offered through employment is the main source of health insurance coverage in the United States—in 1995, more than 90 percent of people under 65 years old with private insurance—150 million people—were insured through their employment. The majority of working adults 18 to 64 years old with private insurance (74 percent) work for private companies, but 17 percent work for the federal, state, or local governments. Most of the remainder are self-employed.

Employment-based insurance—where employers pay part or all of the costs—can be advantageous for employees and many employers.³ For employees, such health insurance is generally more affordable because they receive group rates for coverage, which are typically lower than those

³For employers of low-wage or part-time employees, the advantage for the employer is not as great. When employers consider salary and benefit costs together as an employee's total compensation, benefits represent a much larger share of a low-wage employee's total compensation than a high-wage employee's total compensation.

for individual coverage. In addition, employees do not pay taxes on contributions that their employers make toward their employment-based coverage—an advantage employees would lose if they were to receive additional cash income and to purchase individual coverage. For employers, offering affordable health insurance is an attractive benefit that helps them promote the health and productivity of their work force and remain competitive in recruiting new employees. Employers' contributions to employee benefits are deductible from their companies' gross income and thus reduce their companies' tax liability.⁴ In the United States, the system of private health insurance based on employment is entirely voluntary. Employers are not required to provide insurance, nor are employees required to purchase it.

In addition to private insurance, the federal, state, and some local governments provide public funding for health insurance, primarily through Medicaid, Medicare, state health insurance plans, and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). Medicaid is the largest public source of health insurance coverage for children and working-age adults, covering 29 million people under 65 years old in 1995. Enacted in 1965, Medicaid was designed to provide health care coverage for populations whose incomes and resources were insufficient to meet the costs of needed medical care, including adults and children receiving Aid to Families With Dependent Children (AFDC) and aged, blind, or permanently and totally disabled individuals. Although Medicaid has expanded eligibility beyond these groups, it still limits eligibility to specific populations of lower-income adults and children. Medicare provides health care coverage for over 37 million people—most of them people 65 years old or older. Medicare also covers people entitled to disability benefits for 24 months or more, people with end-stage renal disease requiring dialysis or kidney transplant, and certain others who elect to buy into the program through premium payments. CHAMPUS provides medical care for active-duty or retired military families, as well as to the immediate families of deceased active-duty or retired military personnel.

Although these private and public health insurance systems provide coverage for many Americans, many remain uninsured. In 1995, more than 40 million people under 65 years old had no health insurance for the entire year, including many employees and their families.

⁴However, employers would get the same deduction if they paid any other legitimate business expense, such as cash wages.

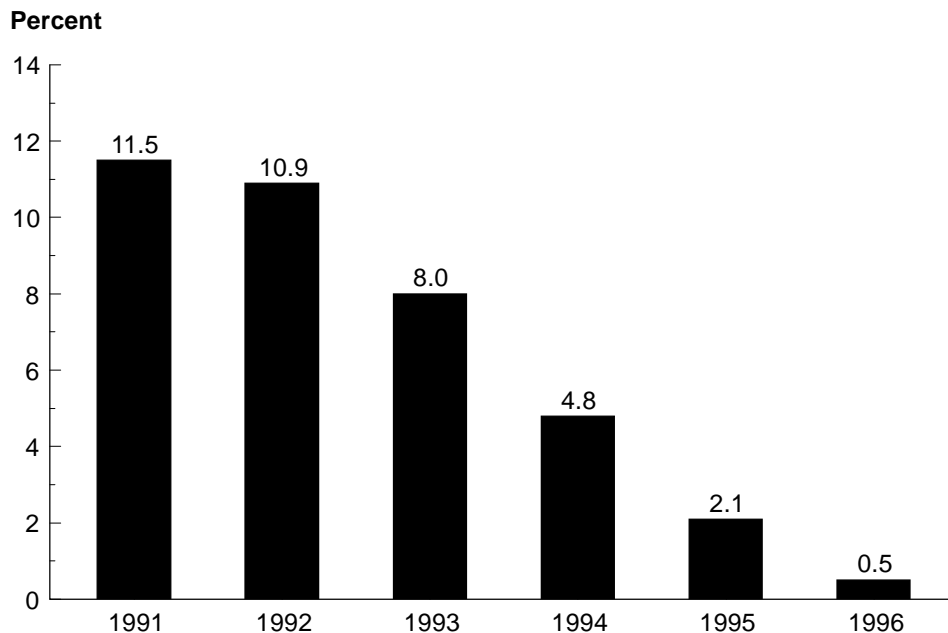
Employers Reexamined Their Role as Premium Costs Increased

From the late 1980s to the early 1994, the cost of health insurance premiums⁵ rose rapidly, especially for family coverage. With these increases in costs, many employers began to reexamine their role and the benefits they offered to employees, and some employers began to question the extent of their responsibility to finance coverage for families.

In the late 1980s, the cost of employment-based health insurance premiums significantly outpaced inflation. Between 1988 and 1989, employer costs for health insurance rose 18 percent in one year. By contrast, general inflation was under 5 percent. Health insurance premium costs began to stabilize recently. (See fig. 1.) However, health insurance continues to be a major portion of employers' total compensation to employees—7.3 percent of payroll costs in 1993, compared with 4.4 percent in 1980.

⁵Many large companies self-insure, so that while their employees generally contribute to the cost of their health coverage, they are not paying an insurance premium. However, for simplicity, we will refer to all employee contributions for their health coverage that function similar to a premium payment as premiums.

Figure 1: Increases in Health Insurance Premiums, 1991 to 1996

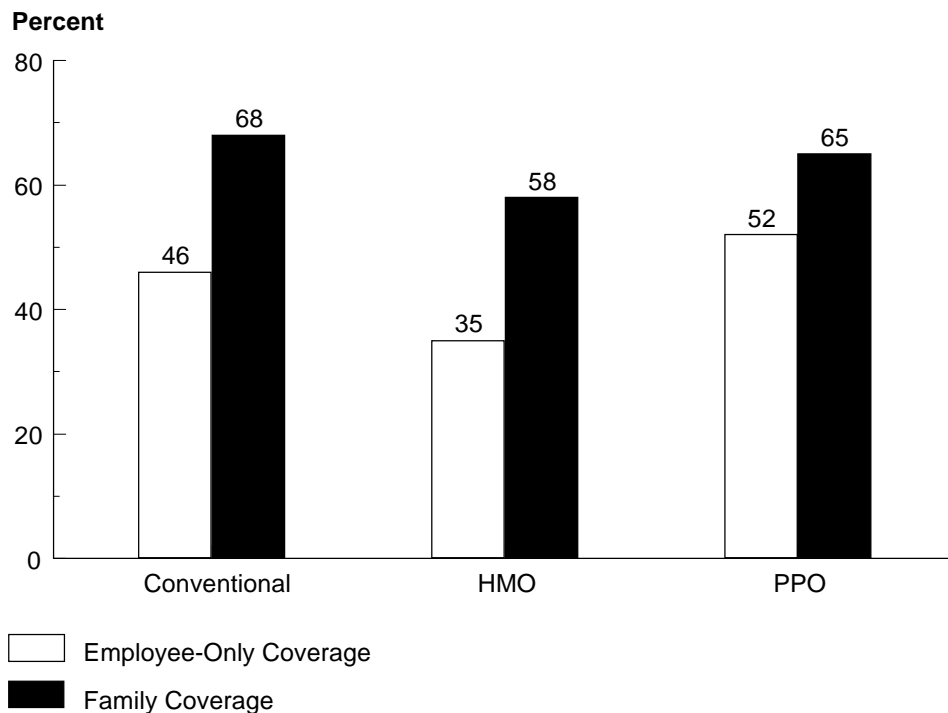


Source: KPMG Peat Marwick, *Health Benefits in 1996*. This was a survey of about 1,000 randomly selected public and private employers with 200 or more employees.

Between 1989 and 1996, cost increases for family premiums were 13 to 23 percent higher than cost increases for employee-only premiums, depending on the type of health plan. For example, since 1989, premium costs for health maintenance organization (HMO)⁶ coverage for families increased 59 percent, while premium costs for employee-only HMO coverage increased only 36 percent. (See fig. 2 and table II.1)

⁶HMOs are organized health care systems that are responsible for both the financing and delivery of a broad range of comprehensive health services to an enrolled population.

Figure 2: Percent Increases in Health Insurance Premiums for Employee-Only and Family Coverage, 1989-96



Source: Health Insurance Association of America and KPMG Peat Marwick. The Health Insurance Association of America survey was of about 2,600 public and private employers with at least 2 employees (for 1989) and the KPMG Peat Marwick surveys were of about 1,000 randomly selected public and private employers with 200 or more employees (all subsequent years).

Some Employers Question Their Role in Providing Family Coverage

With the surge in health insurance premium costs, some companies began to reevaluate their obligation to provide coverage to employees and especially their dependents. A recent survey of 601 businesses found that 40 percent would prefer to pay 50 percent or less of employee insurance premiums and only a minority believed that they should continue to pay the full cost of employee-only premiums. Of those who thought businesses should be required or encouraged to provide insurance to employees' families, nearly half agreed that employers should contribute an even smaller share for family coverage than employee coverage. According to the study, employers viewed their role in providing coverage to employees and their dependents as diminishing.⁷

⁷Jack A. Meyer, Diane H. Naughton, and Michael J. Perry, *Assessing Business Attitudes on Health Care* (Washington, D.C.: Economic and Social Research Institute, 1996).

Some firms—particularly those with fewer than 25 employees or that primarily employ low-wage employees—do not offer health insurance. In a 1994 survey of over 22,000 establishments in 10 states, 42 percent did not offer health insurance benefits; most were establishments with 1 to 4 employees or with a higher-than-average percentage of low-wage or part-time employees.⁸

Historically, large employers and certain types of businesses—such as manufacturing and other highly unionized industries—have provided insurance packages with generous benefits for employees and their families. Yet by doing so, these large employers in essence subsidize other employers who do not cover their employees or offer a less comprehensive package.⁹ Offering an attractive and costly benefits package can put the firm at a competitive disadvantage with firms who do not pay as much for benefits, and do not attract their employees' families to enroll.

According to several benefits consultants, some employers no longer want to subsidize families to the extent that they have because they prefer to more closely link total employee compensation to work contribution. Employers that provide generous family health insurance packages, in effect, pay employees with family coverage more than they pay employees without family coverage—considering the value of benefits. Some employers are concerned that this is not equitable. For example, a company that pays 100 percent of the cost of employee health insurance premiums could provide a benefit that is worth, on average, more than twice as much to the employee who chooses family coverage over employee-only coverage—\$5,000 versus \$2,000.

⁸Joel Cantor, Stephen Long, and M. Susan Marquis, "Private Employment-Based Health Insurance in Ten States," *Health Affairs*, Vol. 14, No. 2 (1995), pp. 199-211.

⁹Deborah Chollet, "Employer-based Health Insurance in a Changing Work Force," *Health Affairs*, Vol. 13, No. 1 (1994), pp. 315-26.

Employers Raise Employees' Contributions to Premiums, Especially for Families, and Discourage Family Coverage in Other Ways

Employers have responded to the increases in health insurance costs in several ways. Some employers stopped offering health insurance coverage altogether. Many who retained coverage have switched to managed care plans in an attempt to control premium costs. Many employers also increased the amounts employees had to pay toward their premiums, with growth in premium contributions by employees for family coverage outstripping growth in premium contributions for employee-only coverage. Some employers used other strategies to encourage employees not to choose family health insurance coverage, including paying incentives to those who choose employee-only coverage.

These changes can provide significant savings for companies. A benefits consultant reported to us that certain companies have saved 15 to 20 percent in costs associated with their health plans by increasing family health insurance premium costs or by otherwise discouraging employees from choosing family coverage.

To Offset Increases, Some Employers Dropped Coverage—Others Switched to Managed Care Plans

A small percentage of employees may have lost coverage because their employer dropped health insurance or because they began working for a firm that did not offer coverage. Overall, 78.4 percent of employees reported that their employers sponsored health insurance plans in 1993, compared with 79.3 percent in 1988.¹⁰ Smaller firms were more likely to stop offering health insurance—13 percent fewer people working in firms with under 10 employees reported that their employers' offered coverage in 1993, compared to 1988. Larger firms—under 250 employees—also dropped coverage, but at much lower rates.

By 1993, more than 29 million employees—almost one-fourth of the workforce—could not get employment-based health insurance for their families. Eighteen percent of these employees worked for firms that did not offer health insurance; about 5 percent worked for firms that offered employee-only health insurance but no coverage for other family members.¹¹

Other employers reacted to health insurance premium increases by encouraging their employees to enroll in managed care. From 1984 to

¹⁰The question asked if employers' had a plan, whether or not the employee was eligible to participate. See *Employment-Based Health Benefits: Analysis of the April 1993 Current Population Survey*, Employee Benefit Research Institute Special Report SR-24 and Issue Brief No. 152 (Washington, D.C.: Employee Benefit Research Institute, 1994).

¹¹*Employment-Based Health Benefits: Analysis of the April 1993 Current Population Survey*.

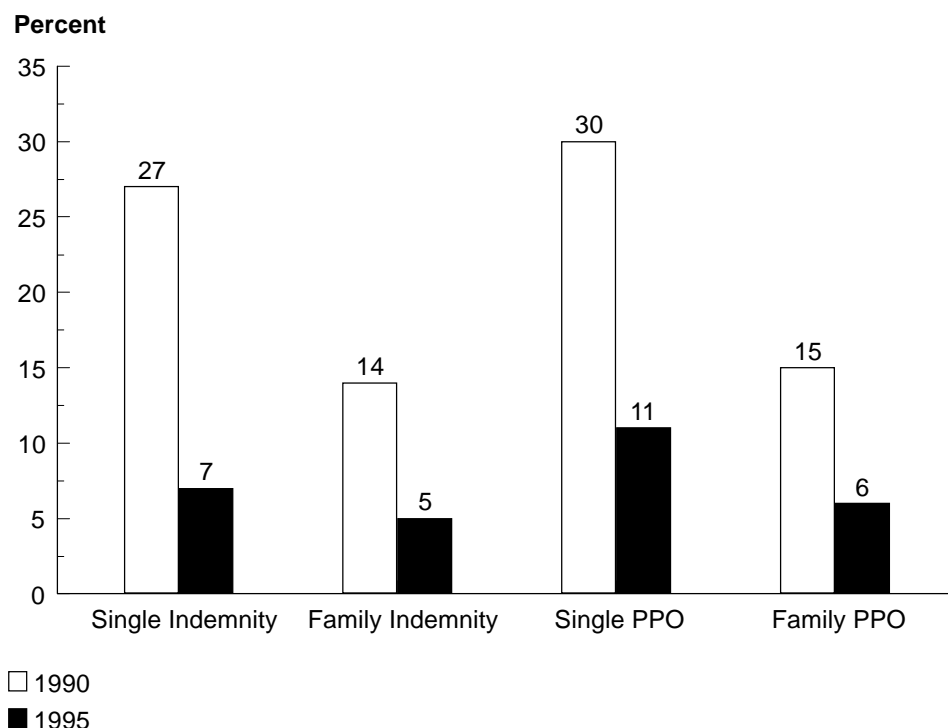
1993, the number of employees in large firms who were enrolled in managed care plans, such as HMOs, increased from 5 percent to 50 percent. HMO premiums were generally lower than premiums for fee-for-service plans, so employers could lower premium costs by switching the types of plans they offered. This is coupled with fewer employers offering indemnity plans. KPMG Peat Marwick reported that 89 percent of employees with employment-based coverage could choose a conventional indemnity plan in 1989; that percentage dropped to 57 percent by 1996.

Employers Increased Employees' Contributions for Health Insurance, Particularly for Family Coverage

To offset increases in health insurance costs, some employers opted to have employees share in the costs of their insurance premium or increased their share of these costs. According to DOL, less than one-half the employees in large firms contributed to employee-only health insurance premiums in 1988. By 1993, more than 60 percent did.¹² In addition, more than 75 percent of employers required employees to share in the costs of family premiums in 1993. Employees' share of premium costs are higher for family coverage—30 percent for family coverage in 1996, compared to 22 percent for employee-only coverage, according to Peat Marwick. Since 1989, employees' share of premiums increased more rapidly for employee-only coverage, as fewer firms offered coverage at no cost—which is more common for employee-only coverage. Hewitt Associates also found that fewer major employers provided health insurance plans at no cost to their employees or employees' families in 1995 than the same companies did in 1990. (See fig. 3.)

¹²DOL surveys medium and large establishments (with 100 or more employees) and small establishments (fewer than 100 employees) separately every other year. References in this report to DOL's information on large firms includes DOL's surveys of medium and large establishments only.

Figure 3: Percent of Major Firms Offering Health Insurance With No Employee Premium Contribution, 1990 and 1995



Notes: Major firms have 1,000 or more employees. Preferred provider organization (PPO) plans provide financial incentives for patients to get care from a selected network of doctors and hospitals by charging additional fees if patients go to providers outside the preferred network. Indemnity plans refer to traditional insurance plans, which reimburse providers and patients on a fee-for-service basis. HMOs require patients to have services delivered by providers affiliated with them, except for emergency treatment. HMOs also typically require patients to select a primary care physician to coordinate the patient's care, especially for services involving referrals to specialists and hospital care. Point-of-service (POS) plans are similar to PPO plans, in that they encourage enrollees to use a selected network of doctors and hospitals, but allow patients to see providers out of the network if the patient pays additional fees for that care. Like HMOs, POS plans have enrollees select a primary care physician who coordinates care for the patient, including care requiring referrals to specialists. The Hewitt Associates report did not provide comparative information about HMOs and POS-type plans for 1990—only information for 1995.

Source: Hewitt Associates, *Salaried Employee Benefits Provided by Major U.S. Employers in 1990 and 1995: A Comparison Study*, 1996.

Employees' average monthly contribution also increased significantly between 1988 and 1993. Increases generally were greater for employees with family coverage than for those with employee-only coverage. According to DOL, in large firms average monthly contributions for family coverage increased 79 percent, compared to 64 percent for employee-only coverage between 1988 and 1993. (See table 1.)

Table 1: Average Monthly Premium Contributions Paid by Employees in Large Firms, 1988, 1989, 1991, and 1993^a

Average monthly contribution^b	1988	1989	1991	1993	Percent increase 1988-93
Employee-only coverage	\$19	\$25	\$27	\$32	64
Family coverage	60	72	97	107	79

Note: Large firms have 100 or more employees. Percent increase may not calculate exactly from the premium costs in this table due to rounding.

^aFull-time employees only in medium and large establishments (100 or more employees). DOL also surveys small establishments (fewer than 100 employees).

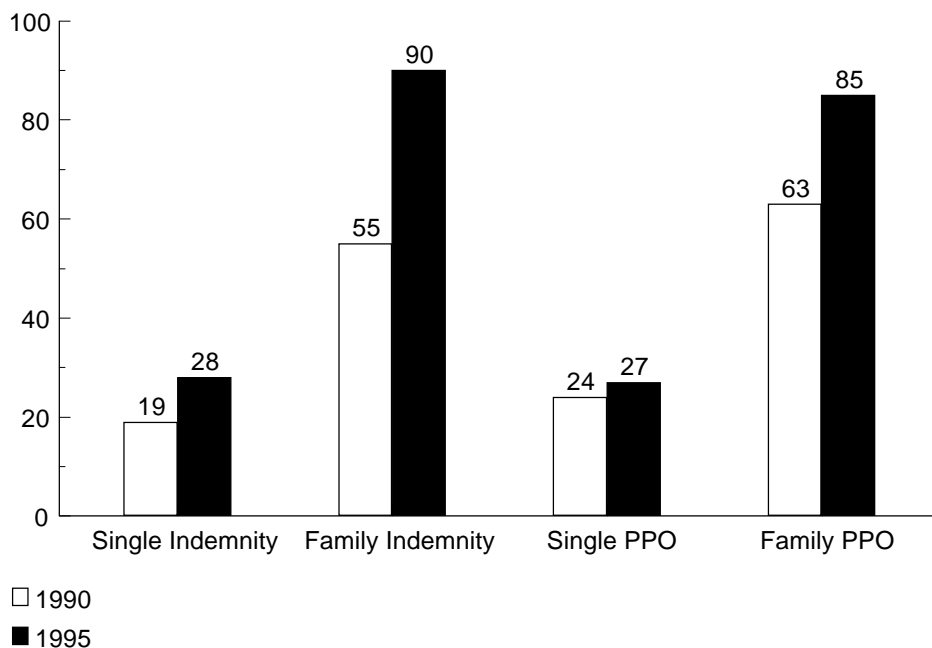
^bBased only on those employees who contribute to the cost of their employment-based premium.

Source: Bureau of Labor Statistics.

Similarly, a Hewitt Associates study comparing benefits offered by the same set of major U.S. firms in 1990 and 1995 showed that for given types of health insurance plans, employees' median monthly premium contributions increased more for family than for employee-only coverage. (See fig. 4.)

Figure 4: Median Monthly Premium Contributions by Employees for Indemnity and PPO Plans in Major Firms 1990 and 1995

Median Monthly Premium Contributions (in Dollars)



Source: Hewitt Associates, *Salaried Employee Benefits Provided by Major U.S. Employers in 1990 and 1995: A Comparison Study*, 1996.

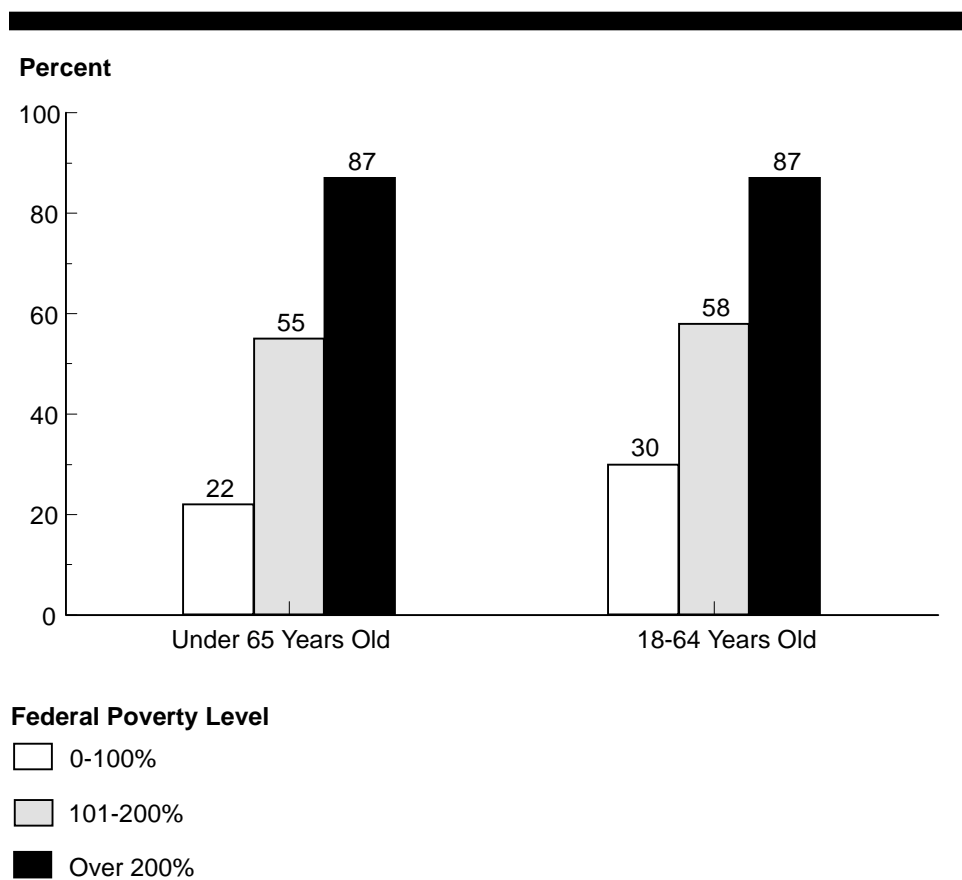
Health Insurance Is Expensive for Some Families

For some families, the overall rise in health insurance costs has made the current price of employment-based health insurance difficult to afford. DOL reported that in 1993, 16 percent of employees paid \$150 or more per month for family health insurance premiums. The percentage of employees in state and local governments who spend \$150 or more per month for family health insurance is even greater than in private industry. In 1992, 36 percent of state and local employees paid \$150 or more per month for family health insurance. In addition, state and local employees' average monthly premium contribution for families was \$139.23—almost five times the \$28.97 average premium contribution for employee-only coverage.

For low-income families, high premiums may make health insurance unaffordable. For example, premiums of \$150 per month represent 9 percent of gross income for a family with annual income of \$20,000. Lower-income and part-time employees are less likely than higher-income

and full-time employees to have employment-based insurance, in part because it is less affordable for them. (See fig. 5.)

Figure 5: Percentage of People Under 65 Years Old and Employees 18 to 64 Years Old With Private Health Insurance Coverage, by Federal Poverty Level, 1995



Note: The federal poverty level shows the relation of family size and income to the Federal Poverty Income Guidelines. In 1996, a family of three with income at or below \$12,980 would be considered poor—or with income under 100 percent of the federal poverty level. A family of three with income between 101 and 200 percent of the federal poverty level would have income between \$12,980 and \$25,960.

Source: Analysis of March 1996 Current Population Survey.

A recent study found that 64 percent of the uninsured people interviewed did not have insurance because they felt that they could not afford to purchase it, while only 8 percent did not have insurance because they did

not want or need it.¹³ In the same study, 36 percent of uninsured people reported problems paying prior medical bills. Of both insured and uninsured people having problems paying their medical bills, 49 percent paid more than \$1,000 in out-of-pocket medical expenses in the previous year and 8 percent paid more than \$5,000.

Employers Use Other Strategies to Reduce Costs, Especially Those Associated With Family Coverage

Some changes that employers have made to their benefits packages may discourage employees from choosing family coverage. These benefit changes include introducing flexible benefit plans and establishing premium rates based on family size.

Some firms have designed their benefit plans in ways that encourage employees in dual-income families to purchase health insurance coverage from their spouses' employers. This, coupled with increases in cost, can eliminate duplicate coverage for dual-income families, which provides savings for employers. It may also result in some employees dropping coverage for their spouses or other family members.

Flexible Benefit Plans Encourage Substitution of Other Benefits for Family Coverage

To control benefit-related cost increases and to broaden employees' choice of benefits, large firms increasingly are offering flexible or cafeteria-type benefit plans and flexible spending accounts. In 1995, Hewitt Associates reported that 88 percent of the major firms in its database offered at least one of these options. Flexible plans and accounts allow employees to select the benefits they want from a menu of benefits, thus allowing them to maximize the value of their benefits by selecting the ones they need most. Generally, firms designate a portion of employee salaries as per-year credits; employees then allocate these credits among available benefits, including health insurance. The amount of employer-provided flexible benefit credits is typically set each year with reference to some target—such as the change in current cost of one health insurance option—plus enough to cover certain other benefits. However, the increased flexible benefit credits may not cover employees' increased costs. If employees choose health insurance whose cost, along with other benefits, exceeds the employer-provided credits, employees must pay the difference. Some firms allow employees to designate an additional portion of their salary to increase their flexible benefits plan or set up a flexible spending account.

¹³Karen Donelan, and others, "Whatever Happened to the Health Insurance Crisis in the United States? Voices From a National Survey," *The Journal of the American Medical Association*, Vol. 276, No. 16 (1996), pp. 1346-50. An earlier study also showed cost was a major issue for the uninsured: See David U. Himmelstein, and Steffie Woolhandler, "Care Denied: U.S. Residents Who Are Unable to Obtain Needed Medical Services," *American Journal of Public Health*, Vol. 85, No. 3 (1995), pp. 341-44.

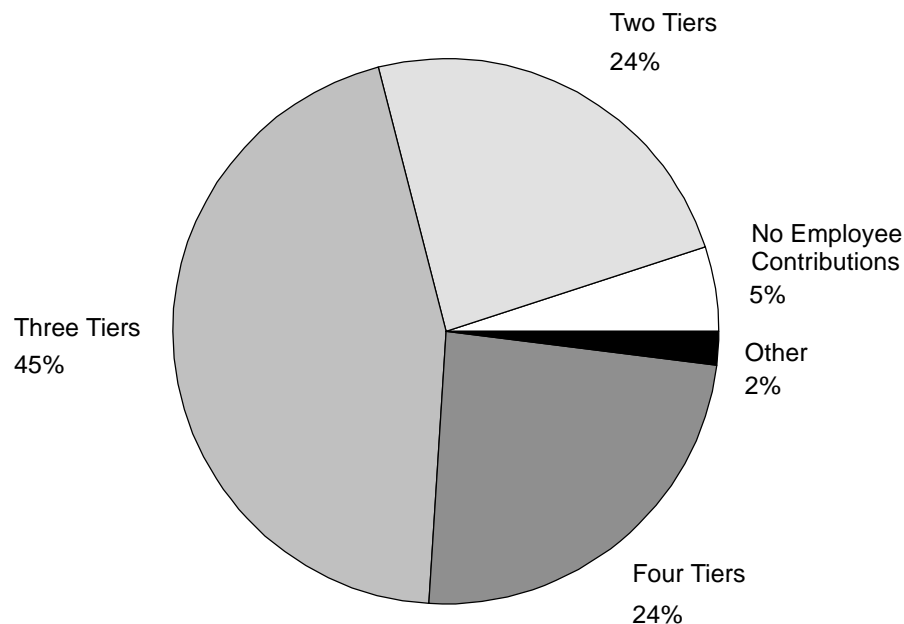
By eliminating the direct link between their contributions and the cost of health insurance, firms can use flexible benefit plans to control their benefit costs. Over time, they can make other changes to shift more cost to employees with families, such as expanding the benefits for employees using employee-only coverage and restraining benefits for families. For example, one major high-technology manufacturing firm gives a \$1,000 credit to an employee's flexible benefits account if the employee chooses to get health insurance coverage through his or her spouse. The employee can use this \$1,000 credit for other benefits. Even with the credit, the firm saves over \$2,000 per year, per employee, when the employee chooses not to elect family coverage.

Tier Rating Offers Greater Differentiation of Premium Rates

Some employers restructured employee premium payments to base them on the number of dependents covered. This tier structure can reduce health insurance costs for smaller families but raise them for larger families. Without these changes, smaller families are subsidizing larger ones. Lower premiums for a family composed of a single parent with one child could encourage such families to purchase coverage for dependents. But a higher premium for the larger family could discourage such families from purchasing coverage for their dependents.

A simple two-tier structure would include one price for employee-only coverage and another price for employee and dependent coverage. According to some of the benefit consultants we spoke with, increasing the number of tiers beyond the two-tier structure is becoming more common for large firms. The majority of major firms have three or more tiers. (See fig. 6.) An example of a three-tiered plan would be one that has separate premium prices for employee-only coverage, for employee plus one dependent, and for employee with two or more dependents.

Figure 6: Coverage Tiers for Major Firms in 1995



Source: Hewitt Associates, Salaried Employee Benefits Provided by Major U.S. Employers in 1995, 1996.

Employers Implement Strategies to Shift Burden of Coverage Onto Working Spouses

According to benefits consultants, some firms design their benefit plans to encourage employees with working spouses to get their insurance from their spouses' company. These strategies include

- refusing to cover a spouse if the spouse has other health insurance coverage,
- providing incentive payments to employees who refuse family coverage,
- imposing a surcharge for working spouses covered as dependents, and
- refusing to provide dependent coverage unless the employee is the family's primary wage-earner.

For example, one major manufacturing firm offers a policy that supplements major medical for employees' families—covering costs that other policies do not—if the employees use their spouses' health insurance as the primary coverage. This policy covers 100 percent of the first \$1,000 of eligible expenses for the employee—thus allowing the employee to avoid any deductible on the primary policy—and then pays an additional 25 percent of covered expenses, with an out-of-pocket maximum of \$1,500.

How often these strategies are used is not known. In addition, some of these strategies are difficult to implement without the cooperation of employees because they depend on self-reporting of other coverage by working spouses.

Whether or not such strategies lead to a loss of coverage may depend on family circumstances. Where dual-income families have more than one source of coverage and can absorb any increase in costs, the effect on coverage might be minimal. A 1992 survey showed that only 30 percent of major companies allowed their employees to opt out of health insurance coverage without at least a sworn statement that the employees had other coverage. However, even firms that require that the employees have coverage may not require their employees' dependents to have coverage.

Loss of Dependent Coverage Accounts for Most of the Recent Loss in Private Coverage

As employers dropped coverage or raised the cost of coverage for employees and families, the percentage of people with private health insurance coverage declined. In 1989, 75 percent of people under 65 years old had private health insurance; by 1995, this number dropped to just under 71 percent. Most of this decline was among dependents.¹⁴ Changing or losing jobs leads to breaks in coverage, but even when working steadily on the same job, employees and their families can lose their insurance.

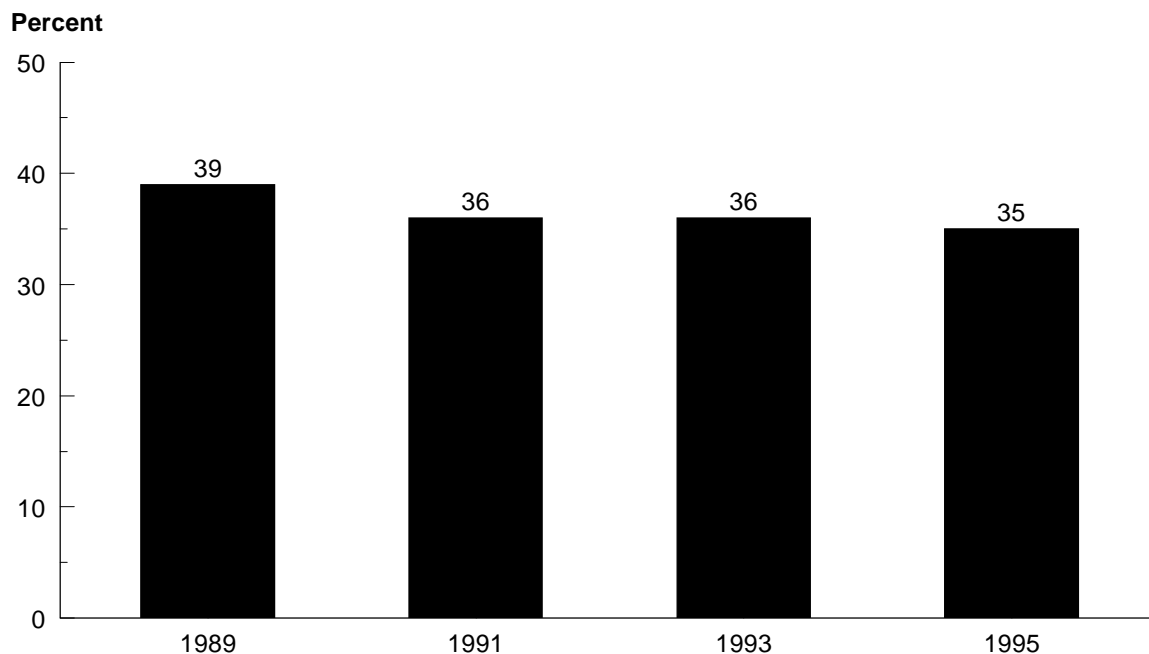
Children and working-age adults both lost health insurance coverage and losses were greatest among lower-income people. In 1989, 76 percent of working-age adults and almost 74 percent of children under 18 years old had private insurance. In 1995, almost 73 percent of working-age adults had private health insurance compared with almost 66 percent of children. If the same percentage of children and working-age adults had been privately covered in 1995 as had been covered in 1989, about 5 million more children and about 5 million more adults would have had private insurance.

Between 1989 and 1995, a larger percentage of people under 65 years old whose incomes were at or below 200 percent of the federal poverty level lost private insurance than those whose incomes were above the 200 percent level. For the poorer group, coverage dropped from about 45 percent in 1989 to less than 40 percent in 1995. Private coverage for those with incomes above 200 percent of the federal poverty level also dropped but by less—from about 89 percent to 87 percent.

¹⁴Employment-based coverage is over 90 percent of all private coverage. We discuss trends in private coverage in this section because changes in the CPS have made data on employment-based coverage in 1994 incompatible with previous years' data on employment-based coverage. (See app. I.)

Most of the overall decline in private coverage is due to the loss of coverage for dependents—between 69 and 91 percent, depending on which years are compared.¹⁵ Both children and adults lost coverage as dependents. (See fig. 7.) In addition to the loss of children's dependent coverage cited above, 24 percent of adults had private dependent coverage in 1989, which dropped to 21 percent by 1995—almost all of the drop in adult coverage in those years. In contrast to the loss of adult dependent coverage, the percentage of working-age adults as the primary holder of private health insurance was similar in 1989 and 1995—51.6 percent compared with 51.4 percent.

¹⁵Sixty-nine percent of the decline was due to loss of dependent insurance comparing 1989 with 1993. Comparing 1989 and 1995, dependent coverage becomes an even greater percentage of the loss in private coverage—over 90 percent. However, changes in the CPS for March 1995 may have affected our analysis for 1995, so we are reporting a range of estimates. (See app. I.) For a different analysis of the CPS, which came to a similar conclusion, see John Sheils, and Lisa Alecxih, Recent Trends in Employer Health Insurance Coverage and Benefits, prepared by The Lewin Group, Inc., for the American Hospital Association (Washington, D.C.: American Hospital Association, 1996). These researchers chose to adjust earlier years' CPS data so that they could compare employment-based coverage in 1994 with earlier years.

Figure 7: Percentage of People Under 65 Years Old With Private Dependent Health Insurance Coverage, 1989-95

Source: GAO analysis of the March 1990, 1992, 1994, and 1996 Current Population Survey.

Job change is not the only reason for loss of coverage. One study showed that between February 1991 and September 1993, 36 percent of adults and children who lost insurance for at least 1 month were dependents of a employee who remained on the same job.¹⁶ Another 25 percent of adults and children experienced breaks in their insurance coverage when a family member changed jobs or occupations and 21 percent lost insurance at the same time an employed family member lost his or her job. Some children lost insurance because they became too old to be covered under their parent's policy, while other adults and children lost insurance because of the death of or divorce from an employed family member.

Some of the loss of adult dependent coverage probably represents shifting among adults in their coverage status. It is likely that some dual-income families found it less costly to have each earner covered under his or her own employer's policy—these families may now have two policyholders. However, other families might have an employee who dropped or lost

¹⁶Sheils and Alecxih, Recent Trends in Employer Health Insurance Coverage and Benefits.

coverage entirely. For example, women were and continue to be more likely to be covered as dependents on others' health insurance policies than men, but the percentage of women as policyholders has increased. In 1989, almost 55 percent of women 18 to 64 years old with private health insurance were policyholders; by 1994, this number was almost 60 percent. Similarly, comparing 1989 with 1995, the percentage of people who were married without children increased as policy holders, which helped offset their decrease in dependent coverage.

Reductions in Private Coverage May Shift More Burden for Health Care to Public Payers

Families that do not have individual or employment-based private health insurance basically have one of two options: they can remain uninsured or they can seek health insurance through public assistance. Part of the burden to pay for health care for individuals without private insurance then falls onto taxpayers through directly subsidized health providers, such as public hospitals or community clinics, or through publicly subsidized insurance. Medicaid, the main public health insurance program for children and working-age adults, has greatly expanded its enrollment in recent years. Evidence is mixed on the extent to which Medicaid expansion served to dampen the effects of deteriorating private coverage or exacerbated losses in private coverage by encouraging some low-income people to drop private insurance.

Welfare reform efforts may decrease Medicaid enrollment and increase the percentage of uninsured Americans. Eligibility rules have changed for some groups, and states will be moving welfare recipients into the workforce. However, low-income adults moving into the workforce may not gain access to private insurance, while losing Medicaid coverage.

Being Uninsured Has Serious Health and Financial Consequences

Being uninsured can have serious health and financial consequences. According to a recent survey funded by the Kaiser Family Foundation, 45 percent of uninsured adults had problems getting health care and most reported having serious financial and health consequences as a result. Thirty-six percent of uninsured adults reported having trouble paying health care bills.¹⁷ Moreover, people without health insurance tend to forego health care more than those with health insurance. Therefore, when the uninsured seek care, their condition often is more advanced and,

¹⁷Twenty-eight percent had problems with getting care and paying bills, 17 percent only had problems getting care, 8 percent only had problems paying bills, and 47 percent reported neither problem.

thus, more expensive to treat.¹⁸ Compared with all adults, uninsured adults who had trouble getting care or paying their health care bills were more likely to be in fair or poor health (34 percent compared with 19 percent), to be disabled (38 percent compared with 14 percent), or to have been hospitalized in the previous year (21 percent compared with 12 percent).¹⁹

People without health insurance are more likely to seek care in public clinics and hospital emergency rooms—increasing the burden on these facilities. Covering the expenses of treating the uninsured has become increasingly difficult for hospitals. Due to more aggressive contracting by insurers and managed care companies, these payers are less likely to pay full hospital charges. Public payments to hospitals through Medicaid and Medicare have helped hospitals cover the cost of caring for the uninsured, although Medicare and Medicaid traditionally paid less than full charges for hospital costs. But in the past, private payers helped to subsidize the difference. Increased use of managed care in the public sector in some areas of the country may also be shifting patients away from the hospitals that primarily serve the uninsured.

As Private Coverage Eroded, Medicaid Expanded—but So Did the Uninsured

While the percentage of people with private insurance declined, the percentage of people with Medicaid coverage increased. In 1987, about 18 million people under 65 years old had public insurance through Medicaid; by 1995, this number escalated to almost 29 million. More families sought assistance through AFDC and Supplemental Security Income (SSI)—which entitled them to Medicaid coverage as well—and Medicaid eligibility was expanded to include pregnant women and children. In addition, several states, through federal waivers of Social Security law, expanded Medicaid coverage to low-income populations not previously eligible. While expanding Medicaid helped to stabilize the percentage of insured people in families with incomes below 200 percent of the federal poverty level between 1989 and 1994, a greater percentage of people with family incomes above 200 percent of the federal poverty level were uninsured in 1994.

According to two studies, expanded government insurance programs may have encouraged some families to drop private health insurance coverage

¹⁸See David U. Himmelstein, and Steffie Woolhandler, "Care Denied: U.S. Residents Who Are Unable to Obtain Needed Medical Services."

¹⁹See Donelan, and others, "Whatever Happened to the Health Insurance Crisis in the United States? Voices from a National Survey."

in favor of Medicaid.²⁰ The extent to which this happens is unclear, however, because three other studies found no effect.²¹ Cutler and Gruber estimate that between 1987 and 1992, 17 percent of the decrease in employment-based insurance was due to Medicaid expansions for pregnant women and children. They attribute the other 83 percent to changes in employer behavior unrelated to Medicaid generosity, changes in the demographic mix of the population, and economic conditions at the time. Dubay and Kenney, using somewhat different assumptions, estimate that 12 to 18 percent of children's increase in Medicaid coverage was linked to a reduction in employment-based health insurance coverage. They also state that children above federal poverty levels were more likely to have displaced private insurance with Medicaid than poor children.

Unless the decline in private insurance coverage abates, public payers may be facing increased costs for health care—either for uncompensated care or public insurance. If employment-based insurance continues to decline, the number of people who are uninsured will likely increase. The Lewin Group, Inc., has estimated that the number of uninsured Americans will increase from about 40.0 million Americans in 1995 to 45.6 million Americans in 2002.

Low-Income Families May Lose Coverage Through Welfare Reform

Whether Medicaid will continue to expand its enrollment and help hold down growth in the number of uninsured people over the next few years is unclear. Under welfare reform, eligibility rules have changed in ways that could affect Medicaid coverage for low-income children and adults.

Before reform, over 60 percent of the children and adults receiving assistance through Medicaid were automatically enrolled under AFDC or SSI. Under the new welfare program—Temporary Assistance for Needy Families (TANF)—families receiving cash assistance will not be automatically enrolled in Medicaid unless a state chooses to do this. Past studies of the Medicaid population have shown that automatic enrollment in Medicaid for AFDC recipients led to higher coverage levels than among

²⁰See David M. Cutler, and Jonathan Gruber, *Does Public Insurance Crowd Out Private Insurance?* National Bureau of Economic Research, working paper No. 5082 (Cambridge, Mass.: 1995), and Lisa Dubay, and Genevieve Kenney, *Revisiting the Issues: The Effects of Medicaid Expansions on Insurance Coverage of Children* (Washington, D.C.: The Urban Institute, 1995).

²¹See Lara D. Shore-Sheppard, "Stemming the Tide? The Effect of Expanding Medicaid Eligibility on Health Insurance Coverage" (unpublished draft, Nov. 1995), Lara D. Shore-Sheppard, "The Effect of Expanding Medicaid Eligibility on the Distribution of Children's Health Insurance Coverage" (unpublished draft presented at the Cornell/Princeton conference on Reforming Social Insurance Programs, May 1996), and Esel Y. Yazici, "Medicaid Expansions and the Crowding Out of Private Health Insurance" (paper presented at the 18th Annual Research Conference of the Association for Public Policy Analysis and Management, Pittsburgh, Penn., Nov. 2, 1996).

people who had to apply separately for Medicaid. If states develop separate application processes for TANF and Medicaid, such processes may raise barriers to Medicaid enrollment.

Generally, families who would have qualified for AFDC-Medicaid coverage will still qualify for Medicaid. The law extends eligibility to people who would have been eligible under AFDC rules in effect as of July 16, 1996. However, states can roll back the July 16, 1996, AFDC income standards to May 1, 1988, levels. States also can raise these levels for inflation and can use more liberal methodologies to determine countable income and resources. The new law allows states to terminate Medicaid eligibility for any adult who is terminated from TANF because of failure to work, but their minor children cannot be terminated from Medicaid on that basis. The law also extends Medicaid for up to a year for those who either become employed or have increased earnings and received Medicaid under the prewelfare reform AFDC eligibility criteria in 3 of the preceding 6 months.

There are no changes in current eligibility rules for pregnant women and children based on age and income. However, SSI eligibility for children with disabilities is tighter under the new law, which could reduce Medicaid enrollment of SSI children. Some children who lose eligibility based on SSI or because their families exhaust transitional Medicaid may be able to gain eligibility based on age and income.

The new law limits eligibility in a significant way—based on citizenship status. Before the new law, all legal immigrants and permanent residents who qualified based on other eligibility criteria were eligible for Medicaid. Under the new law, qualified aliens currently residing in the United States will be eligible for Medicaid only at the state's option, unless a qualified alien is a member of one of the excepted groups whose Medicaid eligibility is mandated by law.²² Qualified aliens who enter the country in the future will be banned from Medicaid coverage for 5 years from their date of entry, except for treatment of emergency medical conditions.

Conclusion

As the cost of health insurance escalated, many employers restructured their benefits. Some employers dropped health insurance coverage

²²A qualified alien is a person lawfully admitted for permanent residence, asylees, refugees, persons paroled into the United States for at least 1 year, persons whose deportation has been withheld, and persons granted conditional entry. The excepted groups of qualified aliens are legal permanent residents with 40 qualifying quarters of work; and for 5 years from entry to the U.S.—refugees, asylees, and persons whose deportation has been withheld; and certain veterans and active duty military and their families.

entirely—particularly small employers—shifting the burden entirely to employees. But more commonly, employers increased the amount employees had to pay to gain coverage, particularly for family coverage.

As this occurred, coverage became less available and less affordable for many Americans. The percentage of Americans under 65 years old with private health insurance decreased. Thus, many Americans who are unable to purchase health insurance for themselves and their families have trouble getting health care. In particular, some children and working adults who earn low wages are being squeezed out of the private insurance market. At the same time, many of these Americans are not eligible for public medical assistance. This slow erosion of private coverage contributed to a loss of coverage—leaving more than 40 million Americans under 65 years old uninsured.

Public pressure to increase publicly funded care may intensify if the number of Americans who lose private insurance coverage continues to rise. However, state and federal efforts to reform welfare may decrease the number of people covered through Medicaid. In addition, policymakers have become concerned that increasing public coverage will encourage employers or families to drop private coverage in favor of public coverage. If the availability of both public and private coverage continues to erode, the number of uninsured will inevitably continue to grow.

Through welfare reform, states will be trying to move families off assistance and into the private sector. Ideally, as welfare recipients begin working, they will gain access to private insurance. However, former welfare recipients tend to land low-wage jobs, which often do not offer health insurance coverage or may not offer insurance which they can afford. Even after a year in the workforce, many former welfare recipients may still not be able to access or afford private coverage for their families. This suggests that low-income working families may continue to need subsidized health insurance if they are to have health insurance coverage.

Agency Comments

We sought comments on a draft of this report from experts on private health insurance issues and from the Health Care Financing Administration on the section of the draft report that dealt with Medicaid and welfare reform. The reviewers generally agreed with our report, but provided technical suggestions that we included where appropriate.

As agreed with your office, we plan no further distribution of this report for 30 days. At that time, we will make copies available on request. Please contact me at (202) 512-7114 or Michael Gutowski at (202) 512-7128 if you or your staff have any further questions. This report was prepared by Michael Gutowski, Sheila Avruch, Paula Bonin, and Karen Sloan.

Sincerely yours,

A handwritten signature in black ink that reads "Jonathan Ratner". The signature is written in a cursive, flowing style.

Jonathan Ratner
Associate Director, Health Financing
and Systems Issues

Contents

Letter		1
Appendix I		30
Information Sources	Sources of Information for This Report	30
and Methodology	Methodological Issues in the CPS Analysis	31
Appendix II		33
Average Monthly Health Insurance Premiums for Employer-Sponsored, Employee-Only, and Family Coverage, 1989-96		
Related GAO Products		36
Table	Table 1: Average Monthly Premium Contributions Paid by Employees in Large Firms, 1988, 1989, 1991, and 1993	12
Figures	Figure 1: Increases in Health Insurance Premiums, 1991 to 1996	6
	Figure 2: Percent Increases in Health Insurance Premiums for Employee-Only and Family Coverage, 1989-96	7
	Figure 3: Percent of Major Firms Offering Health Insurance With No Employee Premium Contribution, 1990 and 1995	11
	Figure 4: Median Monthly Premium Contributions by Employees for Indemnity and PPO Plans in Major Firms 1990 and 1995	13
	Figure 5: Percentage of People Under 65 Years Old and Employees 18 to 64 Years Old With Private Health Insurance Coverage, by Federal Poverty Level, 1995	14
	Figure 6: Coverage Tiers for Major Firms in 1995	17
	Figure 7: Percentage of People Under 65 Years Old With Private Dependent Health Insurance Coverage, 1989-95	20

Abbreviations

AFDC	Aid to Families With Dependent Children
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CPS	Current Population Survey
DOL	Department of Labor
HMO	health maintenance organization
POS	point of service
PPO	preferred provider organization
SSI	Supplemental Security Income program
TANF	Temporary Assistance for Needy Families

Information Sources and Methodology

This report used several sources of information, including the Bureau of the Census' Current Population Survey. This appendix discusses the sources of information and selected information on the CPS and how we analyzed it.

Sources of Information for This Report

Several sources of information can be used to track trends in health insurance coverage. Each of the sources we used provides different information in different ways for different years. In general, less information is available on small businesses than on large and major firms. We define large firms as those with at least 100 employees and major firms as those with over 1,000 employees. Therefore, we focused on large and major firms. Consequently, we may have overstated support for employer coverage of health insurance because larger firms are more likely to provide coverage to employees and families than smaller firms.

We used the following sources of information:

DOL's Bureau of Labor Statistics. The Bureau's surveys of employee benefits provide representative data for 34 million employees in medium and large private establishments (places of work that employ 100 or more people) in 1988, 1989, 1991, and 1993 and for 49 million employees in small private establishments (places of work that employ fewer than 100 people) in 1990, 1992, and 1994. The Bureau surveys establishments of different size in alternate years. We reported information from the surveys on medium and large establishments (which fit our definition of large firms) and state and local governments.

The Health Insurance Association of America. The Association began a survey in 1987 that was continued for several years.

KPMG Peat Marwick. Since 1991, KPMG Peat Marwick has conducted a nationwide telephone survey of about 1,000 randomly selected private and public employers with 200 or more employees on the health benefits they provide. The survey instrument and sample design is similar to the Health Insurance Association of America surveys and, thus, can be compared.

Hewitt Associates. This company collects information on benefits provided by major U.S. employers (many with over 5,000 employees) and has published reports on major companies' benefits.

The Robert Wood Johnson Foundation. The Foundation studied health insurance coverage in 10 states by surveying over 22,000 establishments.

The Bureau of the Census' CPS. The CPS is a nationally representative survey that is the official source of government statistics on employment and unemployment. Every March the Bureau collects additional information on health insurance coverage. We used the CPS to measure private insurance coverage and private dependent insurance coverage in 1989, 1991, 1993, and 1995. Because of certain methodological changes implemented in March 1995 and continued in March 1996 (which affected the 1994 and 1995 data), including changes in the questionnaire, we considered it more appropriate to compare private insurance coverage, rather than make such comparisons for employment-based insurance coverage in 1995 to earlier years.

We did not independently verify data from these sources. The private surveys are proprietary, and DOL and the Bureau of the Census conduct their own validity and reliability checks of their data. We checked some of our CPS analyses against published Census data and have consulted with the Bureau of the Census to ensure accurate analyses of its data files.

Methodological Issues in the CPS Analysis

For the March 1995 CPS, the Bureau of the Census implemented a number of changes in an effort to improve the accuracy and ease of administering the survey. These changes include moving to a computer-assisted telephone interviewing system and reordering and rewording survey questions on health insurance. The earlier questionnaire asked people (1) if they had private insurance, (2) if they were the policyholder, (3) if the insurance was obtained through their employment, and (4) who else was covered as a dependent. The new questionnaire asks (1) if they have private insurance through an employer or union; (2) who is the policyholder; (3) who else is covered; and (4) if they have purchased individual health insurance and, if so, additional people who are covered by this policy.

These changes appear to affect how people answer questions about their insurance coverage, which can affect estimates of insurance coverage. These changes also can affect the comparability of 1994 and subsequent years' estimates with previous years' estimates. When the 1994 data were released, officials at Census stated that the 1994 estimate of overall private insurance agreed well with previous years' estimates. However, the number of people who report that their private insurance coverage comes

from their employer or union increased, while the number who reported that their private insurance was individually purchased decreased. Therefore, because these apparent differences may be due to the questionnaire change—rather than actual changes in the composition of private health insurance coverage—comparisons of employment-based insurance coverage in 1994 and 1995 with previous years may not be appropriate to understand trends in coverage. In particular, dependents appeared to be misclassified as not having employment-based insurance in past surveys. This is why our CPS analysis compares private insurance, rather than employment-based insurance.

Because we were concerned that changes in the questionnaire would affect estimates of private dependent health insurance coverage, we also partially analyzed the March 1994 CPS (1993 data), to compare dependent coverage in 1993. However, the change in the questionnaire did not appear to affect the estimates of dependent coverage.

Our work was conducted between February and November 1996 in accordance with generally accepted government auditing standards.

Average Monthly Health Insurance Premiums for Employer-Sponsored, Employee-Only, and Family Coverage, 1989-96

Plan type	1989 ^a	1991	1992	1993	1994	1995	1996	Percent increase 1989-96
Conventional								
Employee-only	\$119	\$145	\$154	\$170	\$181	\$166	\$174	46
Family	268	355	384	441	463	433	449	68
HMO								
Employee-only	116	139	148	158	166	160	157	35
Family	267	350	377	422	450	423	423	58
Preferred provider organization								
Employee-only	119	150	157	181	177	174	181	52
Family	271	376	412	454	453	433	448	65

^aThe 1989 survey included smaller firms. Smaller firms generally had higher premium costs. We used the average cost by type of insurance and, for HMOs, calculated a weighted average by type of HMO. This made baseline insurance costs in 1989 a little higher for indemnity plans and HMOs and lower for PPOs than if we had only reported costs for firms with 1,000 or more employees.

Source: Health Insurance Association of America and KPMG Peat Marwick. The Health Insurance Association of America survey was of about 2,600 public and private employers with at least 2 employees (for 1989) and the KPMG Peat Marwick surveys were of about 1,000 randomly selected public and private employers with 200 or more employees (all subsequent years).

Appendix II
Average Monthly Health Insurance
Premiums for Employer-Sponsored,
Employee-Only, and Family Coverage,
1989-96

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Average Monthly Health Insurance
Premiums for Employer-Sponsored,
Employee-Only, and Family Coverage,
1989-96

Related GAO Products

Private Health Insurance: Millions Relying on Individual Market Face Cost and Coverage Trade-Offs (GAO/HEHS-97-8, Nov. 25, 1996).

Medicaid and Uninsured Children, 1994 (GAO/HEHS-96-174R, July 9, 1996).

Health Insurance for Children: Private Insurance Coverage Continues to Deteriorate (GAO/HEHS-96-129, June 17, 1996).

Medicaid: Spending Pressures Spur States Toward Program Restructuring (Testimony, GAO/T-HEHS-96-75, Jan. 18, 1996).

Health Insurance for Children: State and Private Programs Create New Strategies to Insure Children (GAO/HEHS-96-35, Jan. 18, 1996).

Medicaid and Children's Insurance (GAO/HEHS-96-50R, Oct. 20, 1995).

Health Insurance for Children: Many Remain Uninsured Despite Medicaid Expansion (GAO/HEHS-95-175, July 19, 1995).

Medicaid: Spending Pressures Drive States Toward Program Reinvention (GAO/HEHS-95-122, Apr. 4, 1995).

Medicaid: Restructuring Approaches Leave Many Questions (GAO/HEHS-95-103, Apr. 4, 1995).

Medicaid: Experience With State Waivers to Promote Cost Control and Access Care (GAO/HEHS-95-115, Mar. 23, 1995).

Uninsured and Children on Medicaid (GAO/HEHS-95-83R, Feb. 14, 1995).

Employer-Based Health Insurance: High Costs, Wide Variation Threaten System (GAO/HRD-92-125, Sept. 22, 1992).

Access to Health Insurance: State Efforts to Assist Small Businesses (GAO/HRD-92-90, May 14, 1992).

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