

The Economic Costs of the Uninsured: Implications for Business and Government

**EDITED BY
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Established in 1978, the Employee Benefit Research Institute (EBRI) is the only nonprofit, nonpartisan organization in the United States totally committed to original public policy research and education on economic security and employee benefits.

EBRI's overall mission is to encourage, to contribute to, and to enhance the development of sound employee benefit programs and sound public policy through objective research and education.

EBRI does not lobby or endorse specific approaches. Rather, it provides balanced and unbiased analysis of alternatives based on the facts. Through its activities, EBRI advances knowledge and understanding among the public, the news media, and government policymakers of how employee benefits function and why they are critically important to our nation's economy.

Since its inception two decades ago, EBRI has grown to include a cross section of the public and private sectors with an interest in economic security programs. EBRI is funded by membership dues, grants, and contributions from foundations; businesses; labor unions; trade associations; health care providers and insurers; government organizations; and service firms, including actuarial firms, employee benefit consulting firms, law firms, accounting firms, and investment management firms. International members look to EBRI's work to gain understanding of the U.S. economic and employee benefit systems.

Today, EBRI is recognized as one of the nation's most authoritative, objective, and reliable resources on the rapidly changing employee benefits sector—health, savings, investment, retirement, work/family issues, demographics, and economic security.

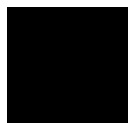


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About EBRI-ERF Policy Forums

The Employee Benefit Research Institute-Education and Research Fund (EBRI-ERF) holds two policy forums per year. The goal of the policy forums is to bring together a cross section of EBRI sponsors, congressional and executive branch staff, benefit experts, and representatives from academia, interest groups, and labor to examine public policy issues. It is a roundtable discussion featuring verbal and written exchange among speakers and participants. The roundtable format is designed to encourage discussion.

Past EBRI-ERF policy forums include:

- 12/1/99 “The Future of Private Retirement Plans”
- 5/5/99 “Severing the Link Between Health Insurance and Employment”
- 12/2/98 “Beyond Ideology: Are Individual Social Security Accounts Feasible?”
- 5/6/98 “The Future of Medical Benefits”
- 12/3/97 “Do Employers/Employees Still Need Employee Benefits?”
- 4/30/97 “Retirement Prospects in a Defined Contribution World”
- 12/4/96 “Assessing Social Security Reform Alternatives”
- 4/30/96 “Comprehensive Tax Reform: Implications for Economic Security and Employee Benefits”
- 12/7/95 “The Changing World of Work and Employee Benefits”
- 5/11/95 “When Workers Call the Shots: Can They Achieve Retirement Security?”
- 10/26/94 “The Future of Employment-Based Health Benefits”
- 5/4/94 “Retirement in the 21st Century: Ready or Not?”
- 10/6/93 “The Changing Health Care Delivery System”
- 5/5/93 “Pension Funding and Taxation: Achieving Benefit Security”
- 12/1/92 “Rationing: Making Choices and Allocating Resources in the Health Care Delivery System—Implications for Access, Quality, and Costs”
- 4/29/92 “Paternalism vs. Empowerment: What Benefits Should/Will Employers Provide?”
- 9/25/91 “Retirement Security in a Post-FASB Environment”



Foreword

The most popular work-place benefit among workers is health insurance, according to the 1999 WorldatWork/EBRI *Value of Benefits Survey* and earlier EBRI surveys as well. More than three-quarters of workers say that they would take health insurance if they could only have one benefit, and one-quarter say that their second priority would be more health insurance. These same surveys find that health insurance is a common reason why many workers select one job over another and remain in a job they might prefer to leave.

Think about this against the repeated annual finding in surveys of the Society for Human Resources Management that the number-one issue for business today is finding people to hire and the second is retaining them once hired. And consider it against the backdrop of results of the 2000 EBRI/CHEC/BCBSA *Small Employer Health Benefits Survey*, which found that employers which provide health insurance believe it does help them attract, retain, and motivate employees.

Finally, think about all of this against the facts that most small employers in the nation do not provide health insurance; that 43.9 million Americans under age 65 do not have health insurance; that 24.7 million workers do not have health insurance; and that 30 percent of uninsured workers have access to employment-based health insurance but do not sign up for it. Why?

EBRI was founded in 1978 to undertake the research necessary to document such facts, and to seek answers to such questions. The May 2000 policy forum on which this volume is based was the 48th held by the Education and Research Fund of EBRI. The policy forum, and this volume, explore the social and economic impact of 18.4 percent of the under-65 population being without health insurance, what is being done to extend health

insurance to more of these individuals, and what more can be done in the future.

The table of contents identifies those who contributed as part of the program, and the executive summary provides a review of the core conclusions resulting from the sessions. This volume presents papers; it does not present a record or transcript of the session. An appendix identifies those who participated in the policy forum, added richness to the discussion, and aided the others in refining their papers in the process. I thank both the authors and the discussion participants for their contributions.

I thank the EBRI-Education and Research Fund, the Commonwealth Fund, the Ford Foundation, and the Robert Wood Johnson Foundation for the funding that made the policy forum and this volume possible. Paul Fronstin, senior research associate at EBRI, developed the program and worked with all of the authors on topics and content, and co-moderated the forum with me; Pam Ostuw, Alicia Willis, Janice Ervin, and Patsy D'Amelio assured that the policy forum was an administrative success; Steve Blakely, Deborah Holmes, and Cindy O'Connor assured that the participants had access to materials ahead of the forum, and then took the steps to shepherd this volume to publication.

Any views expressed are those of the authors and should not be attributed to the officers, trustees, members, or staff of EBRI or its Education and Research Fund. In publishing this work, EBRI-ERF is making no effort to influence any specific legislation; rather, it is seeking to provide decision makers with information that may help them to evaluate proposals.

Dallas L. Salisbury
EBRI and EBRI-ERF
September 2000



About the Authors

Stephen Adams is the Vice President for Research and Strategy at the Initiative for a Competitive Inner City (ICIC). He joined ICIC in 1999. He brings nearly 20 years of experience in economic analysis and policy, strategy development, and public finance. Most recently he served as Assistant State Treasurer for the Commonwealth of Massachusetts, where he helped direct the Commonwealth's \$900 million annual bond program and managed the \$2.5 billion Massachusetts Deferred Compensation Plan. From 1995 to 1997, Adams was a senior associate with the Massachusetts Taxpayers Foundation, where he specialized in state capital finance. His expertise regarding the Central Artery/Tunnel project allowed MTF to play an influential role in shaping state policy in highway finance. From 1985 to 1995, Adams was with the Maine State Planning Office (SPO)—the state's strategic planning office. He was a senior economic policy advisor to the Governor and Legislature on issues ranging from defense cutbacks to utility regulatory reform. During his 11 year tenure at SPO he served as State Economist/Director of Economic and Energy Policy and then as Director of State Planning, a cabinet-level position. His duties included conducting economic and industry studies and managing teams of analysts, to designing major economic policy initiatives and representing the Governor in complex negotiations with legislative leaders and private-sector senior executives. He is on the Board of the Northeast/Midwest Institute, and is past president of the Council of Governors Policy Advisors. Adams attended Queen's University in Kingston, Ontario, where he received a bachelors Degree in International Politics. He earned a masters in Public Administration from Pennsylvania State University's Institute for Public Administration.

Stephen Blakely is managing editor and director of communications for the Employee Benefit Research Institute (EBRI), with responsibility for

production of EBRI publications and EBRI communications initiatives. Prior to joining EBRI in June 1998, Blakely was senior associate director at *Nation's Business* magazine, covering pension and insurance issues. His previous editorial experience includes news coverage of Congress as a reporter for the *Congressional Quarterly Weekly Report*, and daily newspaper coverage of national, state, and local issues for Ottaway Newspapers, a division of Dow Jones.

Phyllis C. Borzi, J.D., M.A., is a Research Professor of Health Services Management and Policy at the Center for Health Services Research and Policy (CHSRP), The George Washington University School of Public Health and Health Services, The George Washington University Medical Center. She is also the co-director of the School's Hirsh Health Law and Policy Program. Ms. Borzi specializes in legal and policy analysis relating to managed care and access to health care for workers, retirees, and their families. Her current research includes work analyzing the health benefits contracting practices of the states and the federal government as large group purchasers for Medicaid and Medicare beneficiaries and for their own employees. In addition, she is part of the CHSRP team working with the Centers for Disease Control and Prevention to develop model purchasing specifications for use by state Medicaid programs and other purchasers on a variety of public health issues. Presently, the two main areas of her concentration are asthma and smoking cessation. Borzi is also a practicing lawyer at the Washington, DC, firm of O'Donoghue & O'Donoghue, where she specializes in employee benefit plan issues, including health and pension benefits and discrimination based on age and disability. She is known nationally for her expertise in issues arising under the Employee Retirement Income Security Act of 1974 (ERISA), a federal law covering private-sector employee benefit plans. Previously, Borzi served for 16 years as the Pension and Employee Benefit Counsel for the Subcommit-

tee on Labor-Management Relations of U.S. House of Representatives' Committee on Education and Labor (now called the Committee on Education and the Workforce). For many years, Ms. Borzi has worked with state and federal officials and other health policymakers on issues relating to the impact of ERISA on access to affordable health care, insurance market reform, consumer protections, and broader health care reform efforts. In 1993, she provided technical advice on insurance reform, health care coverage for working families, and workers' compensation to the President's Task Force on Health Care Reform. She frequently chairs and/or participates on the faculty of educational training programs for lawyers, health professionals, and others involved in employer-sponsored employee benefit plans. She is also a member of the Advisory Board of the Bureau of National Affairs' weekly publication Pension and Benefits Reporter, serves on the Subcommittee on Creating an Environment for Quality in Health Care of the Institute of Medicine's Committee on Quality of Health Care in America, is the Secretary-Treasurer and a member of the Board of Trustees of the Women's Institute for a Secure Retirement (WISER), and is a member of the Advisory Committee of the Pension Benefit Guaranty Corporation, a government agency designed to safeguard the private pensions of American workers.

John Colmers has played a major role in Maryland's efforts to provide its citizens with access to quality health care at an affordable price. Effective October 1, 1999, Mr. Colmers was appointed Executive Director of the Maryland Health Care Commission (MHCC), which was created as a result of a merger of two existing health regulatory commissions. The MHCC is charged with the combined responsibilities of the former Health Care Access and Cost Commission and the Health Resources Planning Commission. In addition to the health care reform activities performed by the HCACC, the MHCC will also be responsible for the development and adoption of the State Health Plan, administration of the Certificate of Need Program, and the compilation and analysis of health care data sets. From July 1993 to September, 1999 Colmers was Executive Director of the Health Care Access and Cost Commission (HCACC), one of the preceding organizations. The

HCACC has developed the Comprehensive Standard Health Benefit Plan for the small group insurance market; developed a medical care database of nonhospital services, created "report cards" providing information on the quality and performance of health maintenance organizations; established standards for the operation of electronic health networks; implemented a payment system for all health care providers; and developed an Advisory Committee on Practice Parameters to develop recommendations on the use of statewide practice parameters. From 1987 through 1993, Mr. Colmers was the Executive Director of the Health Services Cost Review Commission—the agency that oversees Maryland's unique all payor hospital rate setting system. He is currently the Chairman of the Steering Committee of the Reforming States Group, a bipartisan group of senior state health leaders from the legislative and executive branches of over 40 states. He is also currently serving on two Institute of Medicine Committees. Mr. Colmers completed his undergraduate work at the Johns Hopkins University and received his Masters of Public Health degree from the University of North Carolina in 1977. He has completed course requirements for a Doctor of Science degree in health services research at the Johns Hopkins University School of Public Health.

Lisa Duchon is Deputy Director of Research and Evaluation for The Commonwealth Fund, a national philanthropy engaged in independent research on health and social policy issues. She serves as a policy and research advisor on initiatives to expand health insurance coverage and as program officer for the Task Force on the Future of Health Insurance for Working Americans. She is an author of several recent reports released by The Fund's Task Force, including *Can't Afford to Get Sick: A Reality for Millions of Working Americans* and *Listening to Workers: The Commonwealth Fund 1999 National Survey of Workers' Health*. Prior to joining The Commonwealth Fund in February 1999, Ms. Duchon was Executive Director of Healios Health Network, a managed long-term care company organized as an independent practice association of skilled nursing facilities in the New York City metropolitan area. Before coming to New York, she was Director of Public Affairs for the Denver Department of Health and Hospitals, one of the most comprehensive urban public health

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systems in the United States. She began her career in health care as a management engineer for Kaiser Permanente in Denver, Colorado. Duchon holds a B.S. in industrial engineering from the University of Oklahoma, an M.P.A. from the University of Colorado, and a Ph.D. in Public Administration from New York University, where she conducted research for a five-year longitudinal study of poor homeless and housed families in New York City. An article from her research, which examined differences in health care use between formerly homeless and never homeless poor mothers and children, was recently published in *Medical Care*.

D.W. Edington, is a Professor in the Division of Kinesiology at the University of Michigan, Director of the Health Management Research Center, a Research Scientist in the School of Public Health and a frequent faculty member of the Michigan Business School's Executive Education Program. In addition to his research and teaching, he spent 25 years in academic administration. Trained in mathematics, kinesiology, and biochemistry, Edington received his B.S. and Ph.D. degrees from Michigan State University and completed his M.S. at Florida State University. He did post doctoral work at the University of Toronto and taught at the University of Massachusetts before coming to Michigan in 1976. Edington's research focuses on the precursors of disease and vitality. His interest is in the relationships between healthy lifestyles, vitality and quality of life, as they benefit both individuals and organizations. He is specifically interested in how individual health promotion, work site wellness activities and programs within managed care organizations impact health care cost containment, productivity, and human resource development. He is the author or co-author of more than 300 articles, presentations, and several books, including *Biology of Physical Activity*, *Biological Awareness*, *Frontiers of Exercise Biology*, and *The One Minute Manager Gets Fit*. The Health Management Research Center's (HMRC) Health Risk Appraisal has been completed by over 1.5 million individuals. The concepts and materials from the Center have influenced health promotion and wellness programs in over 1,000 corporate worksites. Current research is concentrated on eight organizations and nearly 2 million persons who have been in the HMRC database for seven to

15 years. These longitudinal studies continue to provide leading-edge research learning opportunities.

Paul Fronstin is a senior research associate with the Employee Benefit Research Institute, a private, nonprofit, nonpartisan organization committed to original public policy research and education on economic security and employee benefits. He is also Director of the Institute's Health Security and Quality Research Program. Fronstin's research interests include trends in health insurance coverage and the uninsured, the effectiveness of managed care, retiree health benefits, retirement transitions, employee benefits and taxation, the role of nonprofit organizations in providing employee benefits, children's health insurance coverage, and public opinion about health care. His most recent publications include papers in *The Gerontologist*, *Journal of Health Politics, Policy and Law*, and *Health Affairs*. In 1995, Fronstin testified twice before the U.S. House of Representatives' Ways and Means Committee, Subcommittee on Health, to discuss health insurance portability and how employers have responded to rising health care costs. In 1998, he testified before the U.S. House of Representatives' Committee on Government Reform and Oversight, Subcommittee on Civil Service, to discuss long-term care insurance. He also testified before the U.S. House of Representatives' Ways and Means Committee, Subcommittee on Oversight, to discuss COBRA and small employers offering health insurance, and before the Senate Labor and Human Resources Committee to discuss health insurance of the near elderly population. In 1999, he testified on the uninsured in front of the U.S. House of Representatives' Ways and Means Committee, Subcommittee on Health. Fronstin has appeared before many groups to share his expertise on employee benefits. He has spoken before the Alliance for Health Reform, American Economic Association, American Public Health Association, Association for Behavior Analysis, Dade County Economic Forum, Gerontological Society of America, Harvard School of Public Health, Healthcare Leadership Council, National Association for Business Economics, National Conference of State Legislators, National Education Association, National Health Policy Forum, National Press Foundation, Orange County Employee Benefit Council, Population Association of

America, and the Southern Economic Association. He has also made numerous presentations for congressional staff and the media. Fronstin has been quoted in numerous newspapers, including the *New York Times*, the *Wall Street Journal*, the *Washington Post*, the *Miami Herald*, and the *Philadelphia Inquirer*. In addition, he has appeared on CNN, CNBC, C-Span, ABC News, Fox Morning News, Money Watch, and America's Talking and has been repeatedly interviewed on National Public Radio. Fronstin earned his Bachelor of Science degree from SUNY Binghamton and his Ph.D. from the University of Miami.

Mark Gibson is the Governor's Policy Advisor for Healthcare, Human Services and Labor in the Oregon Governor's Office. He began his work in public policy as an assistant fire chief and chief medical officer. He left the fire service in 1985 to serve as Executive Assistant to then Senate President John Kitzhaber. In this capacity he was intimately involved in the creation of the Oregon Health Plan and subsequently has lectured on this ground-breaking legislation throughout the United States and overseas. He has since worked as a consultant to state governments on health policy issues, and currently serves as Policy Advisor to the Governor of Oregon for Health Care and Human Resources issues.

Sherry Glied is Associate Professor and Head of the Division of Health Policy and Management of Columbia University's Joseph L. Mailman School of Public Health. In 1992–1993, she served as a senior economist for health care and labor market policy to the President's Council of Economic Advisers, under both President Bush and President Clinton. In the latter part of her term, she was a participant in President Clinton's Health Care Task Force and headed working groups on global budgets and on the economic impacts of the health plan. In 1996–1997, she was a Visiting Assistant Professor in the Department of Health Care Policy at Harvard Medical School. Professor Glied's principal areas of research are in health policy reform and mental health care policy. Her research on health policy has focused on the financing of health care services in the United States. She is an author of recently published articles and reports on managed care, women's health, child health, and Medicaid managed care. Her book on health care reform, *Chronic*

Condition, was published by Harvard University Press in January 1998. She is a recipient of a Robert Wood Johnson Investigator Award through which she has been studying the U.S. employer-based health insurance system. She is currently conducting research on the characteristics of uninsured Americans and on strategies to expand health insurance coverage among them. Glied's work in mental health policy has focused on the problems of women and children. She is an author of two reports to the Commonwealth Commission on Women's Health on the changing pattern of mental health service use by women, and has published several studies in this field. She has also written extensively on the economic determinants of children's mental health service utilization. She holds a B.A. in economics from Yale University, an M.A. in economics from the University of Toronto, and a Ph.D. in economics from Harvard University.

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David Hirschland is Assistant Director of the UAW Social Security Department. He has major responsibility for the Union's position on employee benefits both in the public policy and collective bargaining arenas. He has over 22 years of negotiating and program administration experience within the automobile, aerospace, and agricultural implement industries, and with numerous other companies across the United States and in Canada. Mr. Hirschland serves as a Trustee of Plans that provide benefits to the retirees of White Motor Corporation, Allis Chalmers Corporation, and Navistar International Corporation. He is a member of the Board of Trustees of the Henry Ford Health System, a member of the Board of Directors of Co-op Optical of Michigan, a member of the Steering Committee of the Michigan Consortium for Quality Improvement in Health Care (formerly the Michigan project), and is a former member of the State of Michigan Health Planning Council and the U.S. Department of Labor's ERISA Advisory Council.

Alphonse G. Holtmann is a professor of economics at the University of Miami, Coral Gables, FL, where he has taught since 1981. He was chairman of the Department of Economics from 1981 to 1988. Previously, he served as chairman of the Department of Economics at the State University of New York at Binghamton, NY, from 1978 to 1981. He has been a Fellow of the Employee Benefit Research Institute since 1994. He was associate editor of *The American Economist* from 1991 to 1997, was on the Board of Editors of the SUNY Press in Albany, NY, from 1980 to 1981, and was co-director of the Metropolitan Consolidation Study at Binghamton during 1972–1974. Holtmann is the author of *Vocational Rehabilitation for the Disadvantaged: An Economic and Sociological Evaluation* (with others); *The Economics of Local Public Service Consolidation* (with T.G. Cowing), and *The Economics of the Private Demand for Out-Patient Health Care* (with E.O. Olsen), as well as many articles on human resources, education, and economics. Holtmann holds B.S. and M.S. degrees from the University of Illinois, and a Ph.D. degree from Washington University

Mark Merlis is Senior Fellow at the Institute for Health Policy Solutions, an independent organization in Washington, DC, that studies health coverage and access issues. His recent work has included research on long-term care financing in the United States and internationally, studies of options for restructuring Medicare, and assessment of incremental options for extending coverage to the uninsured. Previously, Merlis was a senior health policy analyst at the Congressional Research Service, Library of Congress, and an administrator in the Maryland Medicaid Program.

Jack Meyer is the founder and president of the Economic and Social Research Institute (ESRI), a nonprofit research organization pursuing a broad range of studies evaluating health and social welfare programs. ESRI specializes in studies aimed at enhancing the effectiveness of social programs, improving the way health care services are delivered and financed, and making quality health care accessible and affordable. General areas of his recent and current work include: examinations of new models to improve access to health care, analysis of safety net health care

providers, evaluation of innovative health purchasing strategies developed by coalitions of private employers and by government purchasers, studies of the nature and extent of disability and of states' efforts to enroll people with disabilities on Medicaid in managed care, assessments of the strengths and limitations of managed care, and evaluation of welfare reform initiatives. Dr. Meyer's recent publications include an evaluation of health care purchasing strategies and an assessment of the Children's Health Insurance Program (CHIP), both prepared under grants from the Robert Wood Johnson Foundation; studies of Medicaid managed care for persons with disabilities and a study of public hospital conversions prepared for the Kaiser Family Foundation; and a study of employers' attitudes toward hiring people on welfare, prepared for the Urban Institute. Meyer is also founder and President of New Directions for Policy, a Washington, DC, research and policy organization that develops, analyzes, and evaluates health care issues and other social policies for business and government.

Gary N. Pheley was appointed general director of GM's Health Care Initiatives in February of 1997. As general director, Pheley is responsible for health care plans, managed care strategies, wellness promotion, and community-based initiatives. He also is responsible for development of collaborative efforts with the unions that represent certain GM employees. Pheley joined GM in 1973 and since that time has held a number of positions in labor relations and human resources in various GM facilities, divisions and staffs. He also was a member of the original GM-UAW Saturn Project Study Team. Prior to joining the Health Care Initiatives team, he was director of Labor Relations for GM's North American Operations. Currently, he is a member of the Board of Directors of the Physician Review Organization of Michigan and the Cigna Healthcare Client Advisory Council. He was also recently appointed to the Blue Cross Blue Shield of Michigan Large and Medium Groups Director Selection Council. A native of Detroit, Michigan, Pheley earned a bachelor's degree from Wayne State University and a master's degree in management from the Massachusetts Institute of Technology.

Chris Queram assumed his position as Chief Executive Officer of the Employer Health Care Alliance Cooperative (The Alliance), in Madison, WI, in June 1993. The Alliance, a nonprofit cooperative formed by Dane County employers in 1990, partners employers and providers in an effort to improve the cost and quality of the health care system. The Alliance currently serves more than 700 corporations of all sizes in Dane County and southern Wisconsin, representing over 110,000 individual subscribers. Prior to joining The Alliance, Queram was employed as a hospital administrator in Madison and Milwaukee, WI. Mr. Queram graduated from the University of Wisconsin with a bachelor's degree in political science and history and a master's degree in health management (hospital administration). In addition to his role at The Alliance, Queram is Chairman of the Board of the National Business Coalition on Health, a member of the State of Wisconsin's Board on Health Care Information, and a board member (and past president) of the Wisconsin Business Coalition on Health. Mr. Queram is a fellow of the American College of Health Care Executives and a clinical instructor for Programs in Health Management at the University of Wisconsin. Queram served as a member of President Clinton's Advisory Commission on Consumer Protection and Quality in the Health Care Industry.

Sara Rosenbaum, J.D. is the Harold and Jane Hirsh Professor of Health Law and Policy at the George Washington University School of Public Health and Health Services. She also directs the Center for Health Services Research and Policy. Prior to joining the faculty, she worked for the Children's Defense Fund, where she directed its health work and later directed the Fund's Department of Programs and Policies. For 25 years, Ms. Rosenbaum has played a major role in the design and enactment of a wide range of federal health legislation in the areas of public and private health insurance coverage and programs affecting health care access and quality for low-income and medically underserved persons. During the 1993–1994 time period, she worked for the White House Domestic Policy Council, where she directed the drafting of the Health Security Act for the President. Ms. Rosenbaum is known nationally for her work in health law and policy. She serves as co-

author of *Law and the American Health Care System*, published by Foundation Press, has testified before Congress on several dozen occasions, and has served on numerous national and public advisory boards. She has been named one of America's 500 most influential health policymakers and is a recipient of the Health Care Financing Administration's Beneficiary Services Award for distinguished national service on behalf of Medicaid beneficiaries.

Dallas Salisbury is president and CEO of the Employee Benefit Research Institute (EBRI), Washington, DC. EBRI was founded in 1978 to provide objective, unbiased information regarding the employee benefit system and related economic security issues. The objective: that decisions be made based on verifiable facts. Salisbury joined EBRI at its founding in 1978. EBRI has earned widespread regard as an organization that "tells it like it is." The Institute does not lobby and does not advocate or oppose any policy position. Its mission: "to contribute to, to encourage, and to enhance the development of sound employee benefit programs and sound public policy through objective research and education." The Institute provides information that is central to financial and human resources planning and to public policy analysis. Salisbury is also chairman and CEO of the American Savings Education Council (ASEC), and the Consumer Health Education Council (CHEC). Both are partnerships of public- and private-sector institutions that undertake initiatives to raise public awareness about what is needed to ensure long-term economic and health security. ASEC and CHEC are part of the EBRI Education and Research Fund. Salisbury is currently a member of a number of commissions and study panels, and he serves on many editorial advisory boards. He is a Fellow of the National Academy of Human Resources, the recipient of the 1997 Award for Professional Excellence from the Society for Human Resources Management and the 1998 Keystone Award of the American Compensation Association. He has served on the Secretary of Labor's ERISA Advisory Council and the Presidential PBGC Advisory Committee, has been an advisor to numerous government agencies and private organizations, and is on the committees of many professional organizations. He has written and

lectured extensively on economic security topics. Salisbury was one of 39 statutory delegates to the 1998 National Summit on Retirement Savings, hosted by the President and congressional leaders, and he moderated one of two general session panels. The EBRI/ASEC Choose to Save education campaign was featured in the other general session panel. Prior to joining EBRI, he held full-time positions with the Washington State Legislature, the U.S. Department of Justice, the Pension Benefit Guaranty Corporation (PBGC), and the Pension and Welfare Benefits Administration of the U.S. Department of Labor. He holds a B.A. degree in finance from the University of Washington and an M.A. in public policy and administration from the Maxwell School at Syracuse University.

Vernon Smith is a principal with Health Management Associates (HMA). His expertise is in state and federal health policy, with an emphasis on Medicaid and Medicare reforms. He has extensive experience analyzing and developing health reform proposals, implementing programs, and representing state agencies with federal and national organizations. At HMA, Dr. Smith assists state agencies in managed care, long-term care and understanding the impact of welfare reform on Medicaid enrollment. Prior to joining HMA, Smith was Michigan Medicaid Director and Senior Advisor for Federal Policy for the Michigan Department of Community Health. He also served as budget director for the human services agency, and began his career 30 years ago handling the welfare and Medicaid budgets for the Governor's budget office. Throughout his 30-year public service career, Smith has taken pride in policy initiatives; cost containment strategies; reimbursement and coverage changes; and new large-scale systems, including managed care, that improved access to quality care and saved millions of public dollars. In recent years, Smith has held academic appointments in health care and public administration, including Adjunct Professor in Health Services Administration for Michigan State University and Adjunct Associate Professor in Public Administration for Western Michigan University.

Laura Trupin holds a Masters in Public Health degree from the University of California, Berkeley in Epidemiology and Biostatistics. She is currently

Senior Research Associate with the Arthritis Research Group at the University of California, San Francisco and co-Principal Investigator of the California Work and Health Survey. Her research focuses on the relationships between employment, health status, and access to health care. Prior research includes studies of the labor market for persons with disabilities, and analyses of health care utilization and expenditures among persons with disabilities or chronic illness.

Ray Werntz was named President of the Consumer Health Education Council (CHEC) in May 1999. CHEC's mission is to build a diverse coalition of private- and public-sector organizations committed to raising public awareness and knowledge of the importance of health insurance coverage to health care access, quality, and personal health. Previously, Wernz was Vice President of Compensation and Benefits for Whitman Corporation in Rolling Meadows, IL, where he was a strong proponent of health and financial education for employees and their families. In addition to his more than 30 years' experience as a human resources executive, Wrentz has been active on many Boards and in other private- and public-sector organizations established to address health care delivery, quality, education, and access. Wrentz, a native of Chicago, has a B.A. and M.A. in history and philosophy from De Paul University and a J.D. from John Marshall Law School.

Dr. Edward Yelin, a social scientist, is a Professor of Medicine and Health Policy at the University of California, San Francisco. He has been involved in studies of the social and economic impact of chronic disease and disability for two decades and has over 90 publications in this area. He has published widely on the role of changes in the nature of work on the employment of persons with disabilities; included among these publications is his book, *Disability and the Displaced Worker* (Rutgers University Press, 1992). For the past two years, he has been the principal investigator of the California Work and Health Survey, a project designed to assess how the health of Californians is affected by changes in employment and, conversely, how poor health affects employment among Californians.



Executive Summary

by Stephen Blakely, EBRI

Most Americans have health insurance protection, but for more than a decade the proportion of nonelderly Americans without health insurance has been steadily creeping up. Today, some 44 million people in the United States—18.4 percent of those under 65—do not have insurance coverage to pay for their health care (see chapter 1, *Workers and Access to Health Care*).

But it is widely recognized that people without health *insurance* still receive health *care*. The uninsured are not staying out of the health care system; rather, they are receiving higher-cost medical care (through emergency room visits), and they are forcing others to pay for their health care.

“People who do not have health insurance are not dying in the street,” noted John Colmers of the Maryland Health Care Commission. “They are getting *late* care. They’re getting *more expensive* care. And the cost of that care is being shifted to the private sector and to the government sector.” Economists say these costs are picked up in various ways: by businesses and their employees, in the form of higher premiums for their insurance; by workers, in the form of taxes; and by all Americans, in the form of an opportunity cost in lost value to the U.S. economy.

Overwhelmingly, most Americans get their health insurance through their jobs. Employers in both the private and public sectors are the dominant source of health insurance for nonelderly individuals in the United States, providing coverage for nearly two-thirds of this under-age-65 population in 1998. But increasingly, the uninsured are being viewed as a challenge to and criticism of the employment-based health care system in this country—not just because the ranks of the uninsured are growing, but also because roughly 85 percent of the 44 million uninsured Americans are in a family with a working adult. As a result, many

critics see the employment-based health insurance system as a failure, and are calling for it to be replaced with an individual-based system.

However, even an individual-based system would not change the reality that health insurance in the United States is voluntary: Employers are not legally required to provide coverage to their workers, and individuals are not legally required to maintain coverage. In this kind of system, some segments of the working population will have coverage, while others will not. In addition, it is often overlooked that there are effectively two employment-based health insurance systems—one for small employers (where coverage rates are low) and one for large employers (where coverage rates are high). And, mandated solutions are not as simple as they might seem, as indicated by experience in the states concerning noncompliance with income tax, driver’s license registration, or automobile insurance.

Should employers be concerned about the uninsured population? Are there adverse consequences to driving employers out of the health care delivery system? Is there a link between health insurance and the health of the population, productivity, and economic output? What are the private and public sectors doing to increase access to health insurance coverage?

Policymakers, leading thinkers on benefits, employers, and labor representatives examined these questions during the May 3, 2000, policy forum on “The Economic Costs of the Uninsured: Implications for Business and Government,” sponsored by Employee Benefit Research Institute Education and Research Fund (EBRI-ERF). Attended by about a hundred invited experts, the policy forum examined the research that has been done connecting health insurance status to the performance of the economy, and the implications

for consumers, business, and government. While this is hard to quantify, economic research is beginning to show there may be real business costs connected to the uninsured.

“Ultimately,” said Paul Fronstin, EBRI senior research associate, “the question is whether employers view health as a cost or as an investment.”

■ Workers and Access to Health Care

It has been well documented that employment-based health insurance offers benefits to both workers and employers. For workers, it provides financial protection against unexpected events; it gives them access to a product at a discounted group rate (especially compared with individual rates), and it gives them a benefit on a pre-tax basis. For employers, health benefits are a powerful tool to attract and retain skilled workers, and the costs of any subsidized health insurance premiums that they pay are tax-deductible. For both employers and workers, health insurance allows workers to maintain their productivity.

A recent survey by EBRI, the Consumer Health Education Council, and the Blue Cross Blue Shield Association found that 80 percent of the 579 small employers surveyed reported that they offered health benefits to recruit and retain workers (see chapter 17). Furthermore, 70 percent reported that doing so increases productivity by keeping employees healthy. In addition, Hewitt Associates, which polled 600 large employers about why they offered health benefits, got a 95 percent response for “recruitment and retention,” and a 49 percent response for “maintaining and increasing productivity,” as dominant reasons. Other surveys, including one published in June by EBRI and WorldatWork, confirm that most workers consider health insurance to be the single most valuable employment-based benefit they receive (*EBRI Notes*, June 2000).

EBRI research has found that about 58 percent of workers currently have health insurance through their employer in their own name, and about 17 percent have it through a family member’s employer (typically a spouse or parent). About 9 percent have coverage either through an individual policy or public program,

leaving about 18 percent uninsured.

Who are the uninsured? Fronstin noted that research has found they tend to have certain characteristics: They are more likely to be part time, low-income, in blue-collar and “service-collar” jobs concentrated in certain industries (such as agriculture), young (the average uninsured worker is 31 years old, compared with 37 for all workers), single, less educated, minority, a noncitizen, and employed by a small firm. For instance, 27 percent of workers in firms with fewer than 100 employees were uninsured in 1998—more than twice the rate (12 percent) for workers in firms with 100 or more employees.

Although the uninsured do get health care, EBRI research has shown that health insurance clearly affects access to this care. For instance, uninsured workers are less likely to have had a complete physical in the past year than those who have insurance; they are less likely to have had a flu shot or their cholesterol checked in the past year; and they are less likely to have had preventive gender-based examinations, such as mammograms or prostate exams.

Significantly, even though uninsured workers are younger than the average worker, they are not necessarily healthier. EBRI research also found that those without health insurance were more likely to smoke, less likely to get regular exercise, less likely to eat fruits and vegetables on a daily basis, and less likely to use seat belts than those who have health coverage.

“While the uninsured may think they are more healthy, they are behaving differently from the insured population. This suggests that insurance may have a component to it that we are overlooking: education,” said Fronstin.

For instance, doctors—if you visit them—provide advice about improving health, and insurance programs provide health newsletters, access to wellness programs, and other features that can change behavior. “If you can change behavior through education, will that change productivity and health status?” asked Fronstin. “If it does, what happens to health care costs in the future?”

■ The Economic Costs of the Uninsured

Alphonse Holtmann, of the University of Miami,

noted that health care differs from other types of services that people buy because it can increase current and future productivity. For instance, flu shots are likely to reduce the number of workdays lost due to illness, and health checkups are more likely to detect illnesses at an early stage, also increasing productivity in the long run. He suggested that employers get a substantial benefit from this because wages are offset to cover the cost of health insurance and because the costs of health insurance are tax deductible.

While health insurance leads to higher consumption of health care, Holtmann argues that it also results in both higher productivity and higher wages as workers become more productive. For instance, healthy workers may be more mentally alert and more physically able than less healthy workers, leading to higher wages for a given number of hours worked. In addition, healthy workers may work more hours per year than their less healthy counterparts, because they use fewer sick days and because their higher wage encourages them to work more.

Using data from the Census Bureau's 1999 Current Population Survey, Holtmann measured the insurance status, wage levels, and self-reported health status of 54,000 wage and salary workers. He found that in general, healthy men working full time, full year earn between \$3,500 and \$4,900 more per year than less healthy men, and that healthy women working full time, full year earn between \$1,700 and \$4,200 more than less healthy women. Based on economic modeling, Holtmann estimated that in mid-sized firms (with 100–499 employees), expected gains in earnings attributable to health insurance account for 18 percent of the cost of insurance for males and for 9 percent of the cost of insurance for females.

While quantifying these issues is difficult, Holtmann acknowledged, his results clearly indicate a beneficial link between health insurance, productivity, and higher wages. "The returns to health in general and to insurance in particular, at least what came out of our study, are really quite encouraging: There are productivity gains," Holtmann said.

Research by the California Work and Health Survey found that "people without health insurance are less healthy than those who have it," according to Edward Yelin of the University of

California at San Francisco. The survey determined that people without insurance are more likely to report fair or poor health, a high level of depressive symptoms, and limitation in activities, than those with health coverage.

Yelin added that these findings do not result from demographic characteristics of the individual or employment status, which suggests that "there is something inherent in insurance" that contributed to better health. But even though people with employment-based coverage are healthier than those who are uninsured, he noted, "whether this is due to the insurance is not clear."

Yelin also added that the issue of uninsured workers has clear economic implications for the currently tight labor market, since the preponderance of people who retire early do so for health reasons.

Another study, conducted by Dee Edington of the University of Michigan, looks at ways to control health care costs using data from the university's Health Management Research Center (UMHMRC) Corporate Consortium, based on the experience of seven major corporations studied over a seven-to-18 year period and including nearly two million covered lives. The study measures health in terms of health care costs; workers' compensation; and workers' disability, absenteeism, or productivity.

Edington stressed the difference between health *risk* management and health *care* management, noting that employers must ultimately focus on managing their workers' health risks in order to control health costs. In the experience of the UMHMRC companies, health risk management programs costs between \$10 and \$100 per year per employee, while health care insurance per contract is approximately \$6,000.

Based on various risk factors, Edington noted that workers fall into one of three health-cost categories: low, medium, and high. Of the 55- to 64-year-old males in the study in 1997, 13 percent were high-risk (five or more risk factors). Twenty-six percent of this cohort had three or four risk factors, and 60 percent had zero to two risk factors. Employers' health care costs tend to be determined by what Edington termed the "natural flow" between these groups, as at-risk workers became sick (and more expensive) and as sick workers became healthier.

While the traditional management approach has been to concentrate on ways to reduce the number of high-cost (and unhealthy) workers, Edington said his research indicates the greater cost-saving opportunity is to keep the low-cost employees low cost—by keeping them healthy. “The primary opportunity is to ensure that the low-cost people stay low-cost,” Edington said. “You can ‘pull’ as many as you want from the high-cost down to the low-cost, but as long as there’s a continuous supply of high-cost people, you never win.”

Edington said his research has led to three major suggestions for how employers can control their health-care costs: focus on a disease management program to take care of people with existing disease; focus on preventive services and screenings; and focus on risk-reduction programs and low-risk maintenance, such as smoking cessation and fitness programs.

“This is where the opportunity is: managing risks within a population,” Edington said. “By doing so, you manage the health and eventually costs.”

Ray Werntz, president and COO of the Consumer Health Education Council (CHEC), cited research started a decade ago by the Medstat group that focused on the costs to employers of workers with health problems, and how illness and injury can cause a multitude of other costs related to disability insurance, life insurance, workers’ compensation, and other worker program expenses. The lesson, he noted, is that impaired health affects turnover, waste, absenteeism, and other direct business costs besides health insurance.

“An overly narrow focus on containing or reducing the cost of health care services may negatively affect other employee-related business costs,” Werntz said. “If you consider the ‘ripple effects’ of compromised health, then you have to realize the value of improved health care access and quality to entire communities, and maybe even the nation.”

■ Private- and Public-Sector Initiatives

Even as the number of uninsured continues to climb, both the private and public sectors are working on initiatives to increase health insurance coverage. Both sectors recognize that the lack of

coverage for a significant percentage of the population may affect population health and the well-being of the community and the economy.

One company that voluntarily extended its health insurance to “nontraditional” members of their workers’ households is American Century Investments (ACI), a mutual fund brokerage and investment service firm in Kansas City, KS. After lengthy planning and negotiations with its insurance carrier, ACI implemented its “Plus One” coverage, for which a worker’s adult child, aging parent, nanny, or domestic partner is eligible.

According to Deena Robben of AGI, the plan resulted from a benefits evaluation survey of the company’s rapidly growing work force, stemming from corporate mergers. She said the benefit was “a good cultural fit” with the company’s 3,000-person work force, because “we have goals to be innovative and market leaders, not only in our industry but in the communities in which we work.”

Eligibility is limited to a nonspousal household member, and the person being covered must have lived with the employee for at least 12 months prior to receiving coverage and must not have any other health coverage. “We are truly trying to get to an uninsured population,” she said.

However, Robben noted that the company’s medical carrier had significant concerns about creating the benefit, which delayed the program’s implementation until Jan. 1, 2000. So far, relatively few people have signed up for it: one father, one mother, three siblings, and 34 domestic partners. Robben said that the added benefit is not expected to create a significant additional cost.

Another local initiative is Institute for a Competitive Inner City (ICIC), which attempts to spur economic development around the country by working with fast-growing, successful inner-city companies. ICIC has joint program with *Inc.* magazine, called the Inner City 100 Program, designed to identify and publicize 100 of the fastest-growing companies in the United States each year. The goal of the program is to highlight “success stories in places people don’t expect to see them,” according to Stephen Adams of ICIC, in order to get private investors to realize that “inner-city areas are places where money can be made.” Not only is this designed to attract private capital, he added, but “to get public-sector decision-makers to

start focusing on their winners” and keep them from relocating out of their inner-city neighborhoods.

The average-size firm in the ICIC program has about 70 employees and pays slightly above the national average wage. About half are in the service sector. Their competitive edge, Adams said, lies in their location (being close the highways and to their customers), in having a ready labor pool, and by being nimble and rapidly customizing their goods and services as needed.

Adams noted that these firms, despite being mostly small, also provide benefits: About 96 percent of the companies sponsor health care coverage for their workers, 72 percent provide retirement plans, and 77 percent provide bonus plans. While Adams said no conclusions can be drawn about the connection between health insurance and successful inner-city businesses, he did note that attracting, promoting, and retaining workers is increasingly critical to all businesses, and further ICIC research of the Inner City 100 companies will help identify how to do that. He described the work of ICIC as “somewhat of an indirect initiative to increase access to health insurance for low-income families” by increasing inner-city jobs.

One of the most well-known and closely watched efforts at expanding small-business insurance coverage is the Alliance Chamber Health Insurance Program (A-CHIP), which was initiated by the Greater Madison (Wisconsin) Chamber of Commerce in 1990, and currently serves a three-county region of south-central Wisconsin, and involves 27 local Chambers of Commerce. It is an employer-owned and -directed health care cooperative, and has grown from just seven companies initially to about 170 self-funded firms and 1,000 fully insured small employers.

According to Chris Queram of A-CHIP’s Employer Health Care Alliance Cooperative, the initiative stemmed from several unique circumstances, including Madison’s extremely low unemployment rate, the failure of President Clinton’s national health care plan and the subsequent focus on state and local initiatives, and strong health care resources in the Madison area. Small employers were added after the coalition realized it did not want to exacerbate cost-shifting to local business. The initial concept was to create a “managed

competition” health plan model, incorporating annual premium ceilings, community rating, and a “common pool” approach that would include self-employed workers.

While A-CHIP enjoyed initial success, and this year celebrates its 10th anniversary, Queram said the program has encountered some serious challenges that are threatening its profitability. Among the problems have been a lack of governmental sponsorship or support, competition from local health plans, lack of support from local insurance agents, and a disproportionate share of self-employed workers. Currently, the program is losing money in two of the three counties where it operates.

“While we remain committed to the small-group market,” Queram said, “our attempt to do innovative programming on a voluntary basis has thus far been a very challenging proposition with mixed results, and with a potentially guarded future.”

Because insurance is generally regulated on the state level (except for self-insured plans), most of the innovative public-sector initiatives have involved insurance reform at the state level. Two of the more active states have been Maryland and Oregon.

According to John Colmers of the Maryland Health Care Commission, most new initiatives on health insurance coverage issues are occurring at the state level, for a variety of reasons: Due to the prosperous national economy, many states have budget surpluses, in addition to revenue from tobacco-related settlements that have a number of states focusing on ways to improve health care access and services. He also argued that both state governments and the business sector have a common interest in expanding employment-based health insurance coverage, because it spurs economic development and is more efficient.

States can help increase health insurance coverage within their borders by using innovative state programs that utilize federal funds (such as through Medicare or the State Children’s Health Initiative Program, or S-CHIP), and by providing state-level tax incentives and special purchasing arrangements for the small-group market, Colmers said. But he added that “it’s a very tricky business” to impose new state health laws and regulations on employers without causing negative or unintended

consequences, and that federal pre-emption of certain state laws under the Employee Retirement Income Security Act of 1974 (ERISA) complicates state initiatives.

Colmers noted that Maryland has been particularly active in encouraging health care coverage for small groups (two to 50 eligible workers), with the state law requiring guaranteed issue and renewal, elimination of pre-existing condition restrictions, and modified community rating. The program had almost half a million covered lives in 1998, which represents a 22 percent increase since 1995.

One of the state's unique features is that health insurance carriers are also required to offer a standard benefit plan, which Colmers said helps offset adverse selection by providing a basic set of benefits to everyone. Because the state legislature recognized that "the single most important barrier to insurance coverage is cost," he added, the law also requires that the cost of the standard benefit plan cannot exceed 12 percent of the state's average wage, and state regulators are authorized to waive any of the state's many health mandates.

In recent years, as health insurance premiums have begun to shoot up again, the cost of the small-group standard benefit plan is approaching the 12 percent average wage cap—which means the state is now facing the likelihood of having to reduce the minimum benefit requirements in order to control costs.

"In Maryland, because of the increase in premiums, we are going to have to make the difficult choices associated with eliminating or reducing benefits," Colmers said. "The cost of health insurance is the Number One determinant of whether or not people purchase it, and you have to make those tradeoffs in order to keep it affordable."

Mark Gibson, of the Oregon governor's office, outlined the four initiatives that his state has undertaken to expand commercial health insurance coverage: a high-risk pool for individuals who are otherwise uninsurable; reforms to state insurance laws governing the small-group market (two to 50 lives); a state subsidy for low-income people to purchase health coverage; and assistance with small-firm health purchasers' coalitions, similar to A-CHIP.

But Gibson added "one of the key elements"

that allows Oregon's private insurance market to operate as well as it does is the fact that the federal Medicare and Medicaid programs provide coverage to the elderly, the disabled, and the poor. "They [Medicare and Medicaid] take some of the worst risks going," Gibson said. "If we were relying on the private sector to compete for the infirm elderly, the costs would be entirely different in our system."

The Influence of Business and Labor

Another innovative approach to health coverage, beyond cooperation between the public and private sectors, is cooperation between labor and management. One of the more remarkable initiatives in that realm is the joint effort by General Motors and the United Auto Workers to encourage the development of community health care delivery systems in areas where they have large populations of employees and retirees.

As Gary Pheley of GM put it, this project brings a lot of people and money to the table: 1.2 million covered lives and about \$3.5 billion spent on health care each year. Pheley said the thrust was to focus on the health status of their communities and to make sure that both the workers and the company got what they were paying for by sharing information on the quality of care they received from their health insurance. The result has been to force health care providers and insurers to quickly improve their services where lapses or problems have been identified.

"It's our philosophy that by focusing on quality and by eliminating waste in the system, your costs will eventually be reduced as well," Pheley said. "Cost is certainly an issue, but the driving force here is quality." The overall goal, he added is to encourage disease prevention and accident prevention, and expand health education, and thereby improving community health status.

The project has expanded in some auto-manufacturing communities to include the other major domestic automakers. Given the size of the auto industry's work force, Pheley said, both management and labor agreed that "you can't just address our little corner of the world—we have to address the whole community, and we need to improve the efficiency and effectiveness of the health care delivery system."

David Hirschland of the UAW reviewed several specific projects, such as a hospital "report

card” initiative, an information program to help provide standardized consumer information on health maintenance organizations (HMOs), and a project in Michigan designed to reduce overuse of antibiotics.

In each case, he said, the initiative involved coalitions of local and national groups, and in all cases the biggest challenge was collecting objective information on health care services in a standardized format that could be easily compared. Because of regional and institutional differences in the ways medical data are reported, Hirschland said, coming up with consistent reporting formats and uniform measurements has proved difficult.

■ Options for Enhancing the Employment-Based System

Given the complexities and dilemmas relating to the uninsured, how could the existing health coverage system be enhanced? And given the known benefits of having health insurance, how can coverage be increased? In 1999, the Commonwealth Fund, a philanthropic foundation in New York, set up a Task Force on the Future of Health Insurance for Working Americans to address that question.

The task force recently issued four reports designed to help policymakers grapple with incremental strategies to make health insurance more accessible and affordable. The reports address the issues of:

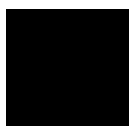
- Health insurance and low-income workers.

- The insurance crisis facing the U.S. Hispanic population.
- Risks for mid-life Americans (ages 45–64) who become sick, disabled, unemployed, and uninsured.
- Younger adults (ages 19–29), who have the highest uninsured rate.

Among the approaches outlined in the reports are federal subsidies to encourage individual-based coverage, through tax credits; expansions of existing federal programs, such as Medicaid and S-CHIP; new types of purchasing arrangements, such as opening the Federal Employee Health Benefit Plan to allow individuals and small firms to purchase coverage through FEHBP, or trying to expand purchasing groups/coalitions to allow individuals and small employers to buy coverage; or some combination of all these approaches.

According to Lisa Duchon of the Commonwealth Fund, the Task Force was designed to serve as an “honest broker” in assessing incremental and workable options to expand employment-based health coverage, to provide the incoming Congress and president—as well as state officials—with some practical strategies that can be adapted as needed. But being realistic, she said, also means having limited expectations.

“Even incremental approaches are complex and costly, and there’s a limit to what we can do,” Duchon said. “There are only so many things to try.”



Overview

Workers and Access to Health Care: Consequences of Being Uninsured

by Paul Fronstin, EBRI

Introduction

Employment-based health insurance is the most common form of health insurance coverage in the United States. Nearly 100 million workers, or 72.8 percent of the adult working population, are covered by an employment-based health plan. Employers offer employment-based health benefits to provide workers and their families with protection from financial losses that can accompany unexpected serious illness or injury. They also offer the benefits to promote health, to increase worker productivity, and as a form of compensation to recruit and retain qualified workers. Health insurance is the benefit most valued by workers and their families. Sixty-five percent of workers responding to a recent survey rated employment-based health insurance benefits as the most important employee benefit (Salisbury et al., 2000).

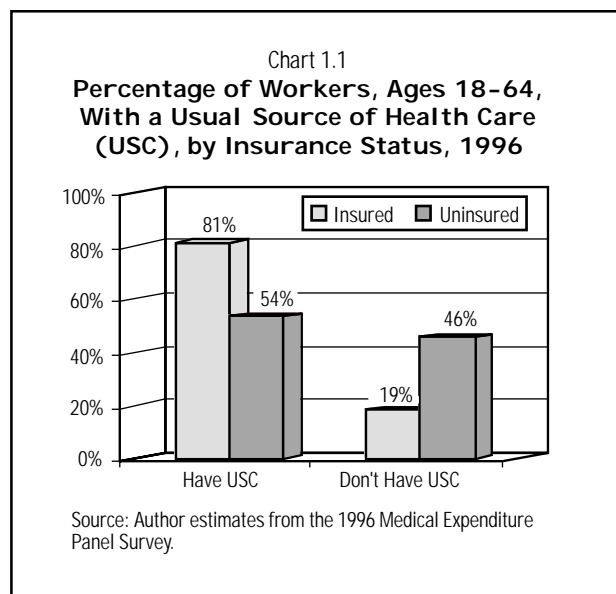
Employers offer health insurance on a voluntary basis. Because employers are not legally required to provide health insurance to workers and individuals are not required to maintain coverage, some segments of the working population will have coverage while others will not. While 72.8 percent of workers were covered by an employment-based health plan in 1998, most of the remainder, 18.2 percent, were uninsured. Some of these workers had the option to purchase health insurance on their own, get it through a second job or previous job, or even through a family member, but chose not to (Fronstin, 1999). As long as the employment-based system is a voluntary system, some workers will not have the protection and benefits afforded by insurance.

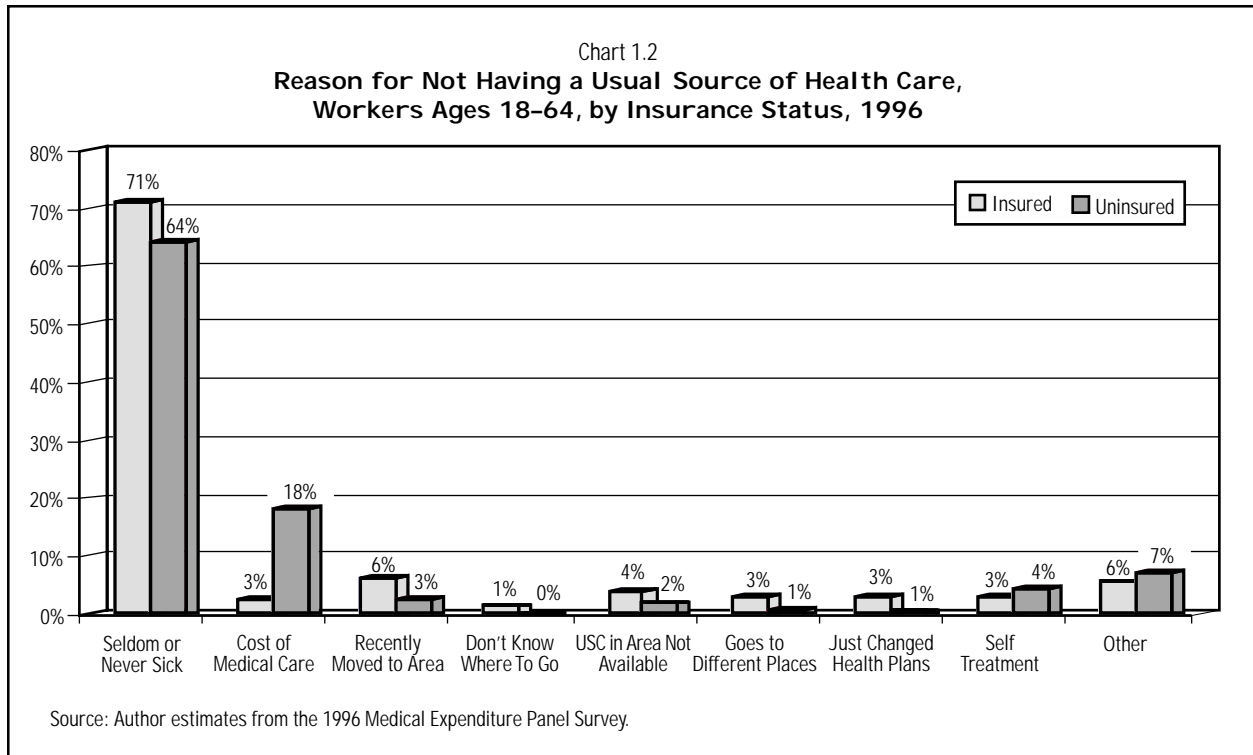
There is a large and growing literature examining the link between insurance coverage and access to health care. For example, Brown et al. (1998) reviewed the literature that appeared in the MEDLINE database between 1966 and August

1996 regarding the consequences of being uninsured on health and the intermediate processes likely to affect health. The research generally finds that there are adverse health consequences for individuals who become uninsured or lose access to care. However, with one exception (Monheit et al., 1985), none of the studies reviewed examined the implications specifically for workers.

While workers tend to be healthier than the general population, suggesting that lack of access to health care may be less important to workers, we find that insurance status of workers does have an impact on access to health care. Specifically, 46 percent of uninsured workers reported that they did not have a usual source of health care, compared with 19 percent among workers with insurance coverage (chart 1.1).¹

¹ Usual source of health care was defined as a particular doctor's office, clinic, health center, or other place that the person usually went to if he or she were sick or needed advice about health.





While the main reason for not having a usual source of health care was that workers were either seldom or never sick, insured workers were more likely than uninsured workers to report that they were seldom or never sick. This reason was given by more than 70 percent of insured workers who reported that they did not have a usual source of health care, compared with 64 percent of uninsured workers (chart 1.2). In contrast, 18 percent of uninsured workers reported that the cost of health care was the main reason for not having a usual source of health care, compared with 3 percent among insured workers.

The purpose of this analysis is to examine workers' health insurance. The next section examines workers' likelihood of being uninsured in terms of various characteristics. The third section discusses the consequences of being uninsured and behavioral differences between insured and uninsured workers. The final section presents conclusions.

■ Uninsured Workers

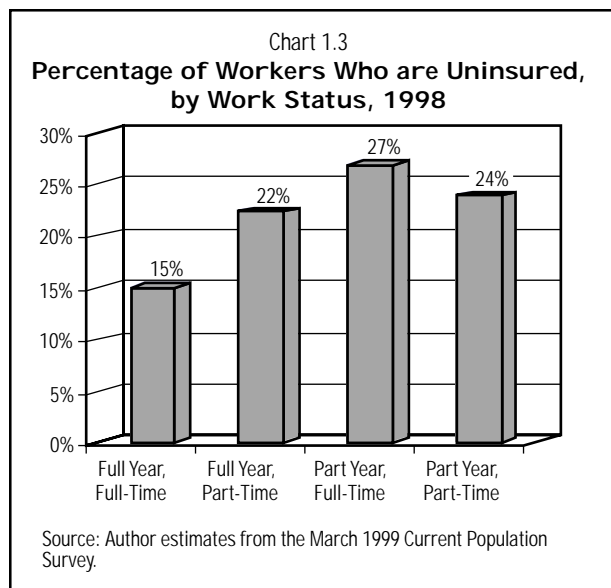
As mentioned above, there is a strong link between health insurance coverage and access to health care. In this section, we show workers' likelihood of

being uninsured by job characteristics and demographics. While we could have shown the relationship between insurance coverage through a job and related characteristics, workers often get insurance coverage through their spouse, making the uninsured data a better indicator of potential access, or lack of access, to health care.

The data for this section are from the March 1999 supplement to the Current Population Survey (CPS). The CPS is the primary source of data on labor force characteristics for the U.S. civilian noninstitutionalized population. It is also the official source of data on unemployment rates, poverty, and income in the United States. Approximately 50,000 households, representing over 130,000 individuals, are interviewed each month. The analysis is based on a sample of over 65,000 workers in the CPS.

Work Status

There is a strong connection between hours of work and a worker's likelihood of being uninsured. Workers employed on a full-year, full-time basis had a below average chance of being uninsured (15 percent), while all workers employed less than full, full year had an above average chance of being uninsured (chart 1.3). Specifically, 22 percent of



workers employed on a full-year, part-time basis were uninsured, and between 24 percent and 27 percent of workers employed on a part-year basis, whether full-time or part-time, were uninsured.

Wages

Workers with higher wages are less likely than those with lower wages to be uninsured. It appears that \$10 per hour is the break point between whether the chance of being uninsured is above or below average. For example, 35 percent of workers earning less than \$7 per hour and 24 percent of workers earning at least \$7 per hour and less than \$10 per hour were uninsured (chart 1.4). In contrast, 15 percent of workers earning at least \$10 per hour and less than \$15 per hour were uninsured, and between 7 percent and 9 percent of workers earning \$15 per hour or higher were uninsured.

Occupation

The likelihood of being uninsured varies substantially with occupation. In general, white-collar workers are least likely and blue-collar workers are most likely to be uninsured, with service-collar workers falling in between, although there are exceptions. For example, less than 10 percent of professional service workers (executive, administrative, managerial, professional specialty, technician and related support) were uninsured (chart 1.5). In contrast, 47 percent of private household service

occupations and 31 percent of other service occupations were uninsured. In comparison, about 20 percent of blue-collar workers were uninsured.

Industry

Workers employed in the goods-producing sector are generally less likely to be uninsured than workers employed in the service sector, although, again, there are exceptions to this general observation. Public-sector workers were the least likely to be uninsured (8 percent), followed by workers in the durable manufacturing sector (10 percent), and workers in the finance, insurance, and real estate industry (11 percent) (chart 1.6). In contrast, 38 percent of workers employed in the agriculture, forestry, and fishing industry were uninsured, along with 34 percent of workers employed in construction, and 32 percent of workers employed in the personal service sector.

Firm Size—Firm size is one of the most important determinants of health insurance coverage and whether a worker is uninsured. Workers in small firms are generally more likely than those in large firms to be uninsured. More than 30 percent of workers employed in firms with fewer than 10 employees were uninsured (chart 1.7). In contrast, 11 percent of workers in firms that employ 1,000 or more workers were uninsured.

Sector

As mentioned above, public-sector workers are less likely than private sector workers to be uninsured.

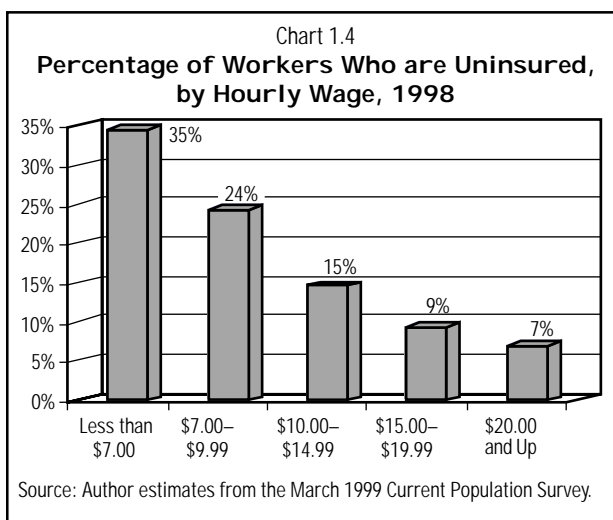
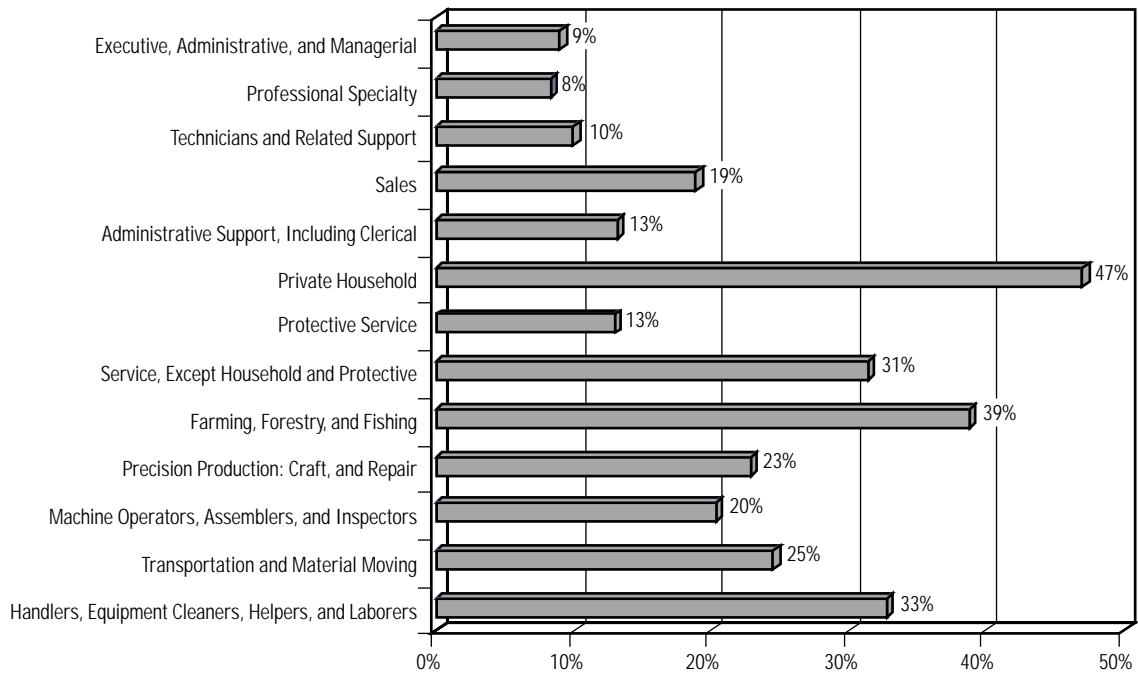
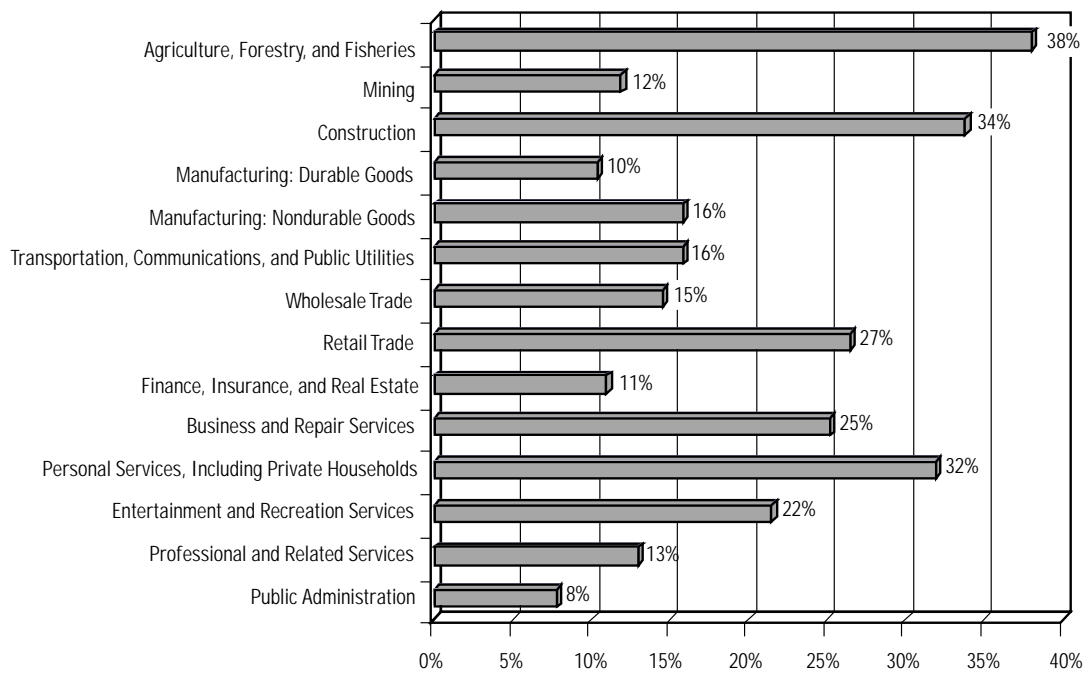


Chart 1.5
Percentage of Workers Who are Uninsured, by Occupation, 1998

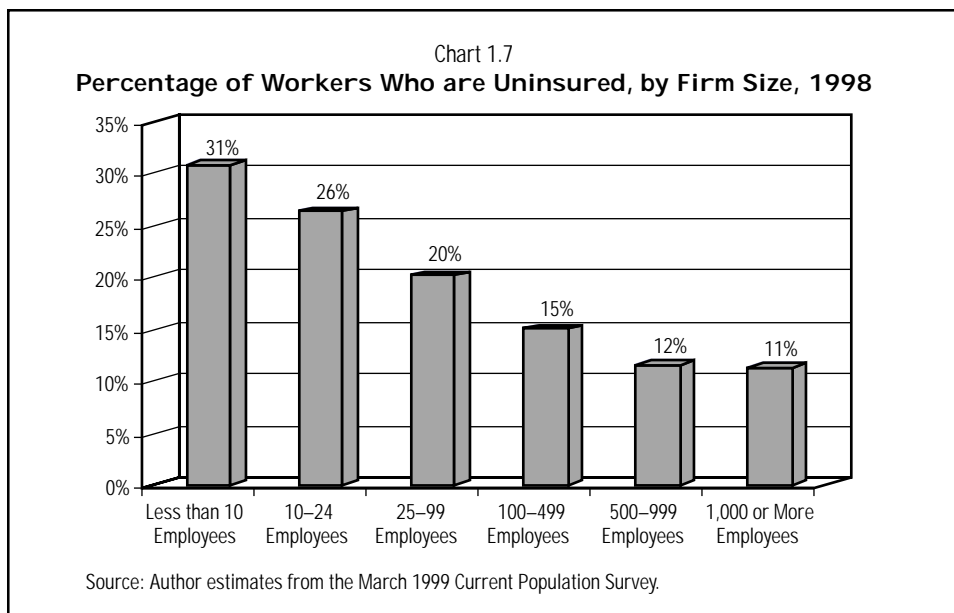


Source: Author estimates from the March 1999 Current Population Survey.

Chart 1.6
Percentage of Workers Who are Uninsured, by Industry, 1998



Source: Author estimates from the March 1999 Current Population



This is true for public-sector workers at all levels of government. Specifically, 8 percent of public-sector workers, whether employed by the federal, state, or local governments, were uninsured (chart 1.8). In comparison, unincorporated self-employed workers were the most likely of any sector to be uninsured, at 29 percent.

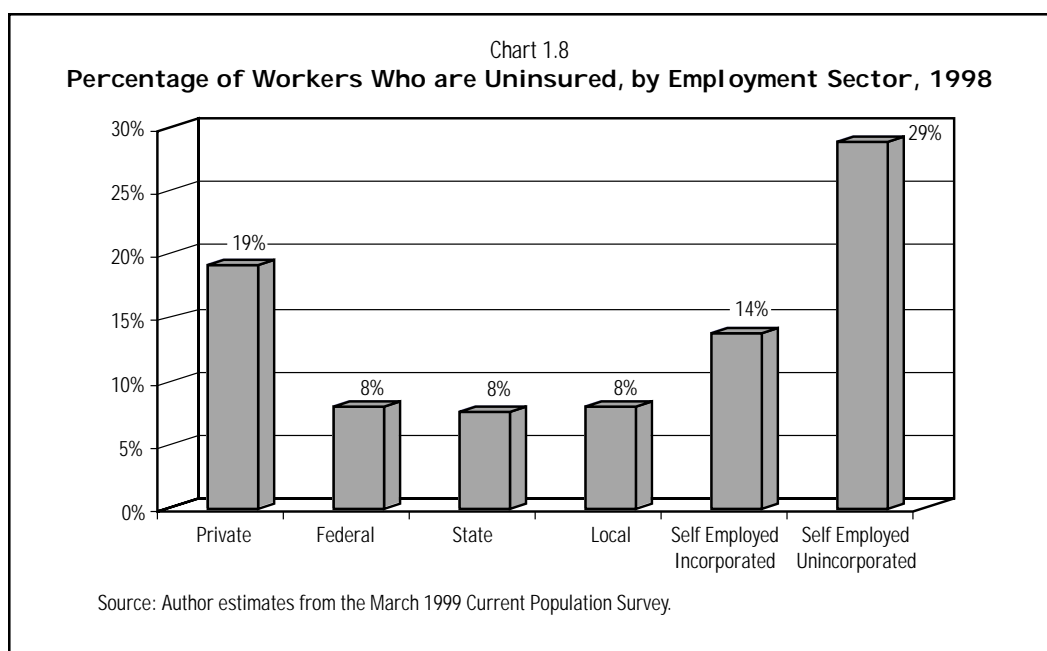
Education

Highly educated workers are less likely to be uninsured than workers with less education. For

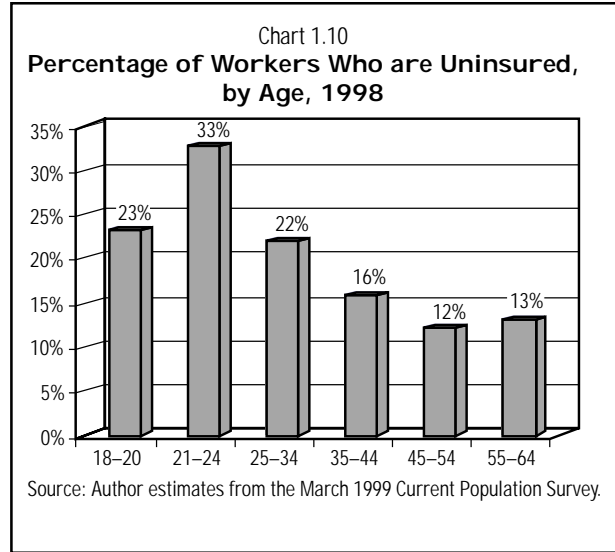
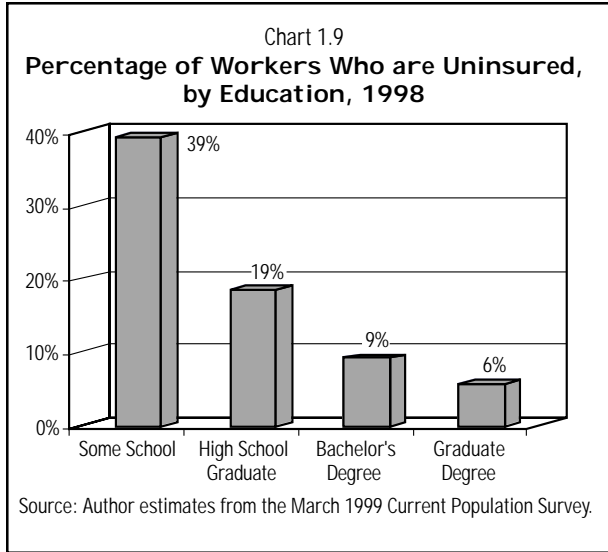
example, 39 percent of workers with less than a high school education were uninsured (chart 1.9). In contrast, 19 percent of workers with only a high school education were uninsured, while 9 percent of workers with a college education and 6 percent of workers with a graduate degree were uninsured.

Age

Younger workers are more likely than older workers to be uninsured. More than 20 percent of workers ages 18-20 and 25-34 were uninsured



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(chart 1.10). In addition, 33 percent of workers ages 21–24 were uninsured. In comparison, 16 percent of workers ages 35–44 were uninsured, as well as 12–13 percent of workers ages 45–64. It is likely that workers ages 18–20 are still covered by insurance through their parents, leading to a higher percentage with coverage in this age group versus the workers ages 21–24. Workers ages 55–64 were one of the least likely age groups to be uninsured, although they are often targeted by public policy.

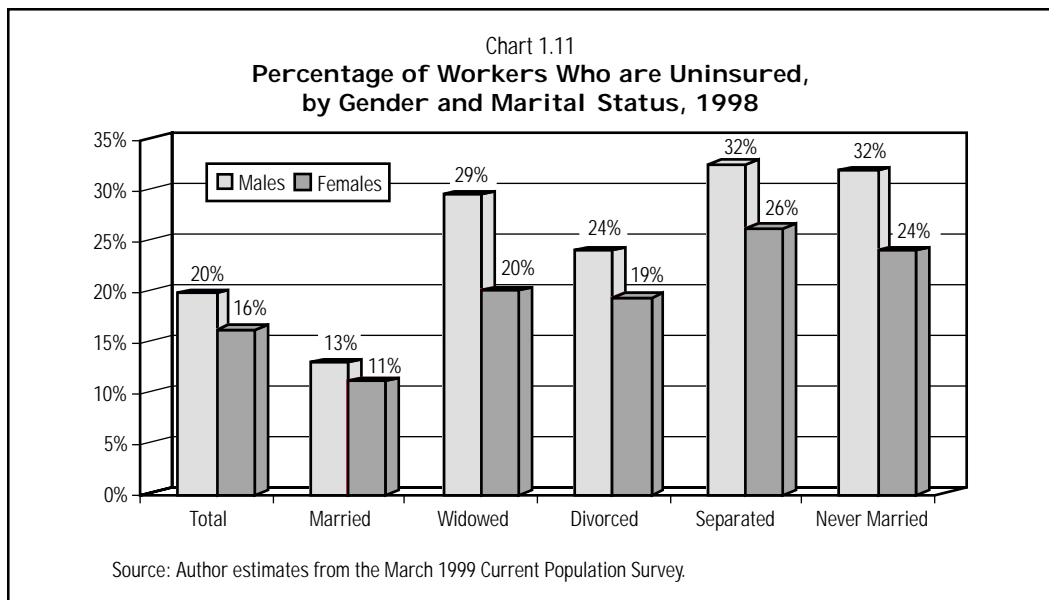
to be uninsured. Twenty percent of male workers and 16 percent of female workers were uninsured (chart 1.11). Across all types of marital status, men were more likely than women to be uninsured.

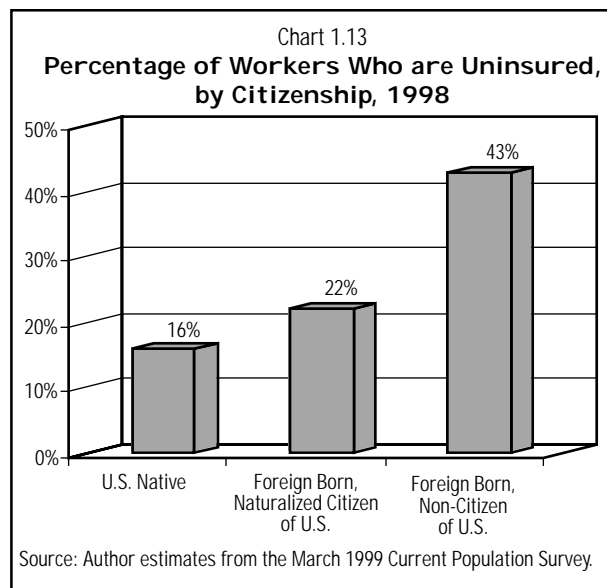
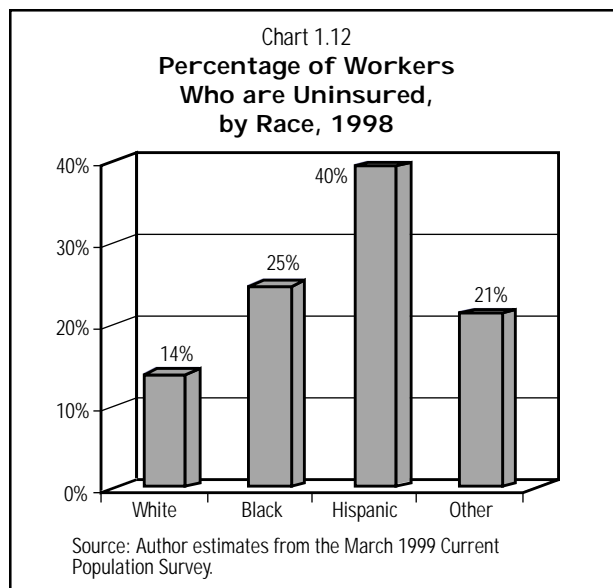
Race

Minority workers are more likely to be uninsured than white workers. Specifically, 14 percent of white workers were uninsured, compared with 25 percent of African-American workers, 40 percent of Hispanic-American workers, and 21 percent of workers of other races (chart 1.12).

Gender and Marital Status

Male workers are more likely than female workers





Citizenship

Working U.S. citizens are much less likely to be uninsured than noncitizen workers. For example, 16 percent of working citizens were uninsured, compared with 22 percent of foreign-born workers who have become citizens and 43 percent of workers who have not become citizens (chart 1.13).

■ Consequences of Being Uninsured

Uninsured workers are less likely than insured workers to have a usual source of health care (chart 1.1). As a result, uninsured workers are less likely to receive preventive health care than insured workers, as shown in this section. Uninsured also behave differently than insured workers. Specifically, uninsured workers are more likely than insured workers to put themselves at risk. These findings are also shown in this section.

The data used in this section are from two surveys. The first is the Medical Expenditure Panel Survey (MEPS), conducted by the Agency for Healthcare Research and Quality (AHRQ). The purpose of MEPS is to provide nationally representative estimates of health care utilization, expenditures, sources of payment, and insurance coverage for the U.S. civilian noninstitutionalized population. Over 10,000 households were sampled, representing over 20,000 individuals in panel 1 of the survey in 1996. MEPS is used in this section to show that uninsured workers were less likely than

insured workers to receive preventive health care. The second is the Behavioral Risk Factor Surveillance Survey (BRFSS), conducted by the Center for Disease Control and Prevention (CDC) in collaboration with the states. The objective of the BRFSS is to gather data on health risk behaviors at the state level in order to promote healthy personal behaviors. BRFSS is used to examine differences in behavioral patterns between insured and uninsured workers.

Below is a summary of our findings.

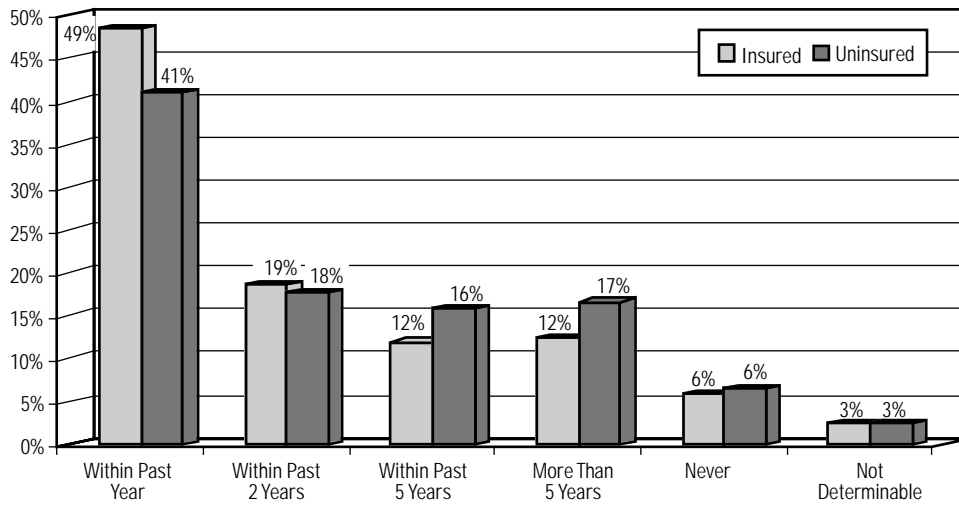
Physical Exams (charts 1.14 and 1.15)

- Uninsured females are less likely than insured females to have had a physical exam within the past year (41 percent vs. 49 percent, respectively).
- Uninsured males are much less likely than insured males to have had a physical exam within the past year (23 percent and 39 percent, respectively).
- Uninsured males are more likely than insured males to have never had a physical exam (15 percent and 6 percent, respectively).

Flu Shot (charts 1.16 and 1.17)

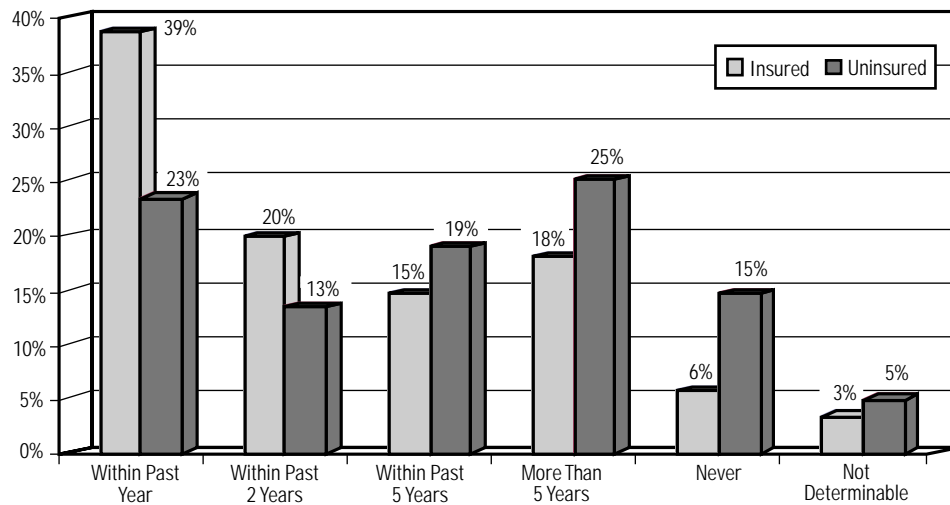
- Uninsured females are less likely than insured females to have had a flu shot within the past year (13 percent vs. 23 percent, respectively).
- Uninsured males are less likely than insured males to have had a flu shot within the past year (10 percent vs. 17 percent, respectively).

Chart 1.14
**Time Since Last Complete Physical ,
 Female Workers Ages 18-64, by Insurance Status, 1996**



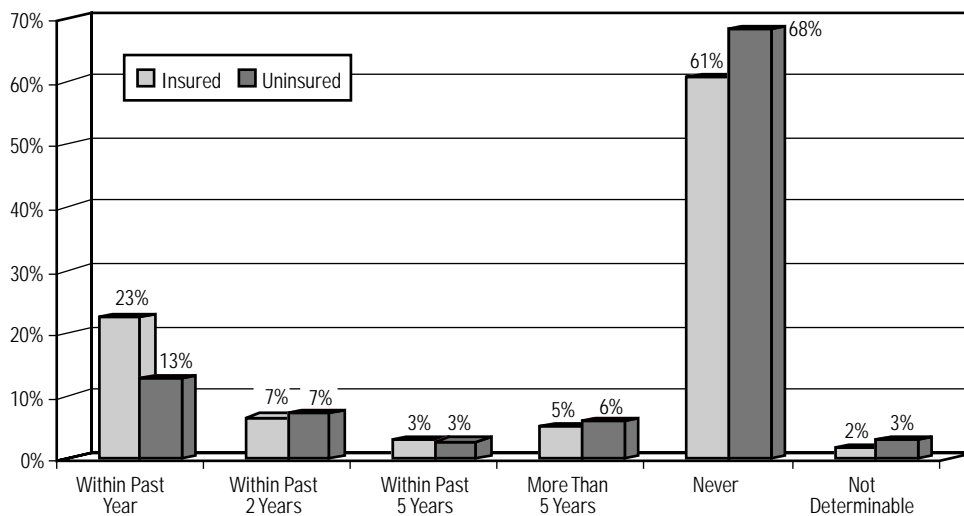
Source: Author estimates from the 1996 Medical Expenditure Panel Survey.

Chart 1.15
**Time Since Last Complete Physical ,
 Male Workers Ages 18-64, by Insurance Status, 1996**



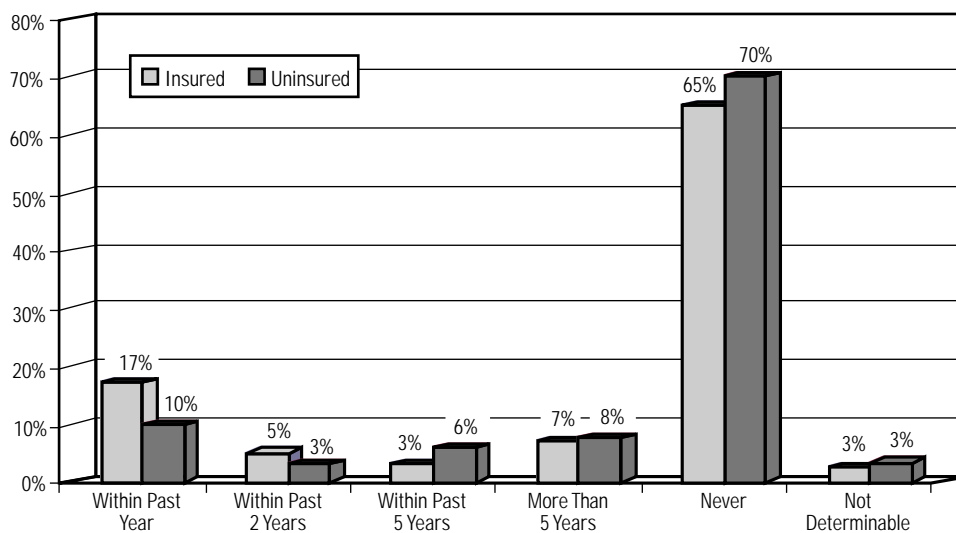
Source: Author estimates from the 1996 Medical Expenditure Panel Survey.

Chart 1.16
**Time Since Last Flu Shot,
 Female Workers Ages 18-64, by Insurance Status, 1996**



Source: Author estimates from the 1996 Medical Expenditure Panel Survey.

Chart 1.17
**Time Since Last Flu Shot,
 Male Workers Ages 18-64, by Insurance Status, 1996**

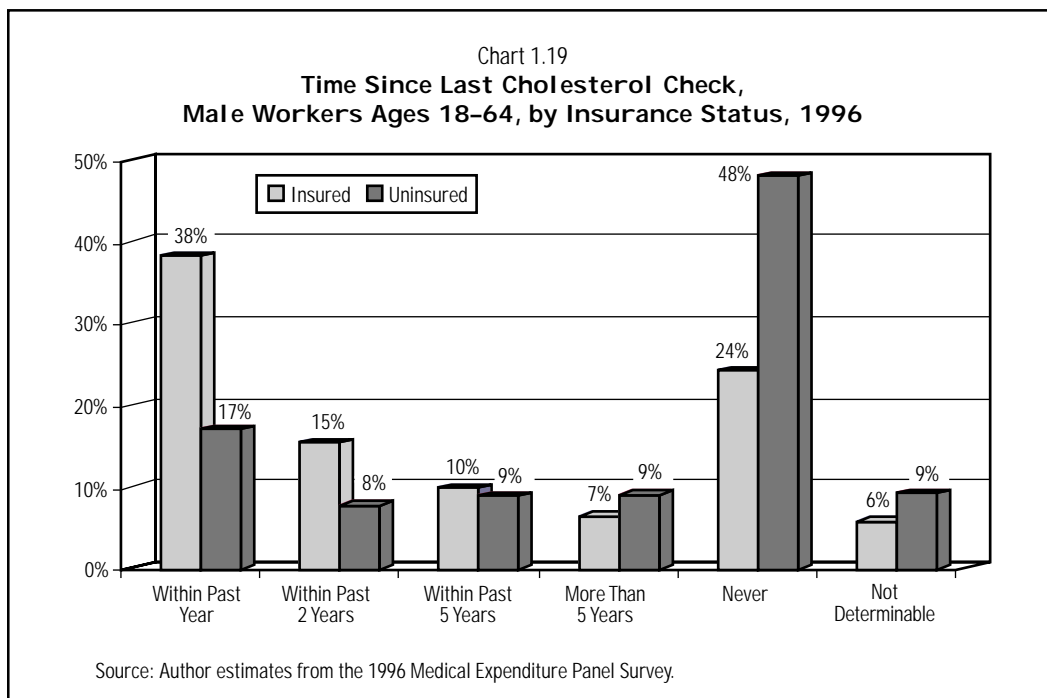
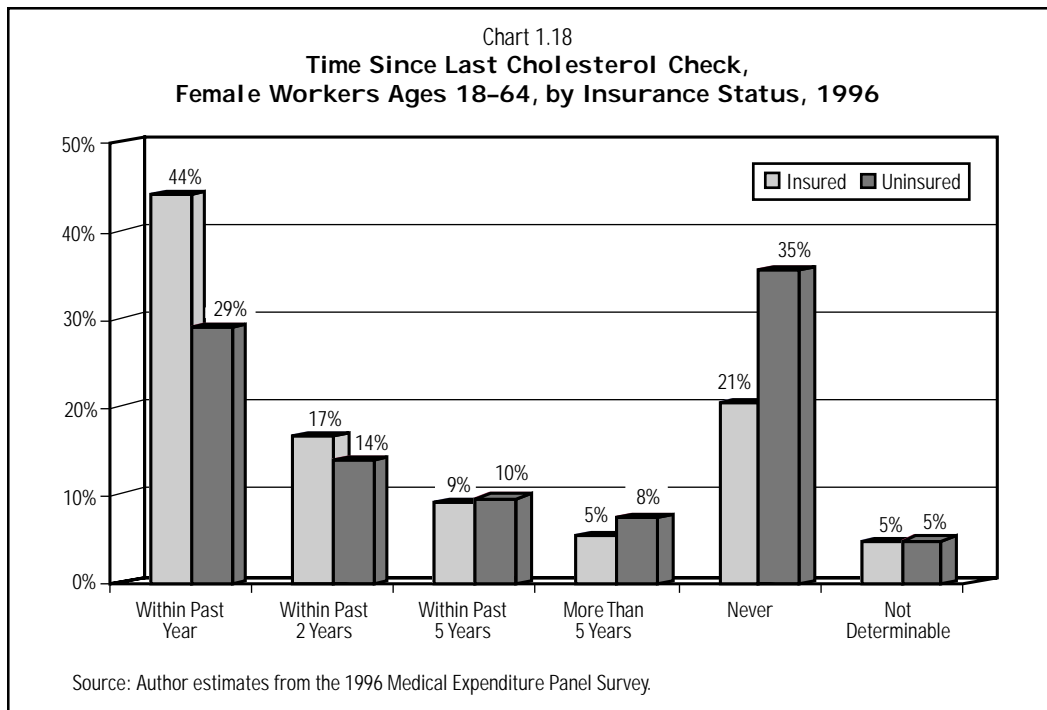


Source: Author estimates from the 1996 Medical Expenditure Panel Survey.

The Economic Costs of the Uninsured

Cholesterol Check (charts 1.18 and 1.19)

- Uninsured females are less likely than insured females to have had their cholesterol checked within the past year (29 percent vs. 44 percent, respectively).
- Uninsured females are more likely than insured females to have never had their cholesterol checked (35 percent vs. 21 percent, respectively).
- Uninsured males are less likely than insured males to have had their cholesterol checked within the past year (17 percent vs. 38 percent, respectively).
- Uninsured males are more likely than insured males to have never had their cholesterol checked (48 percent vs. 24 percent, respectively).

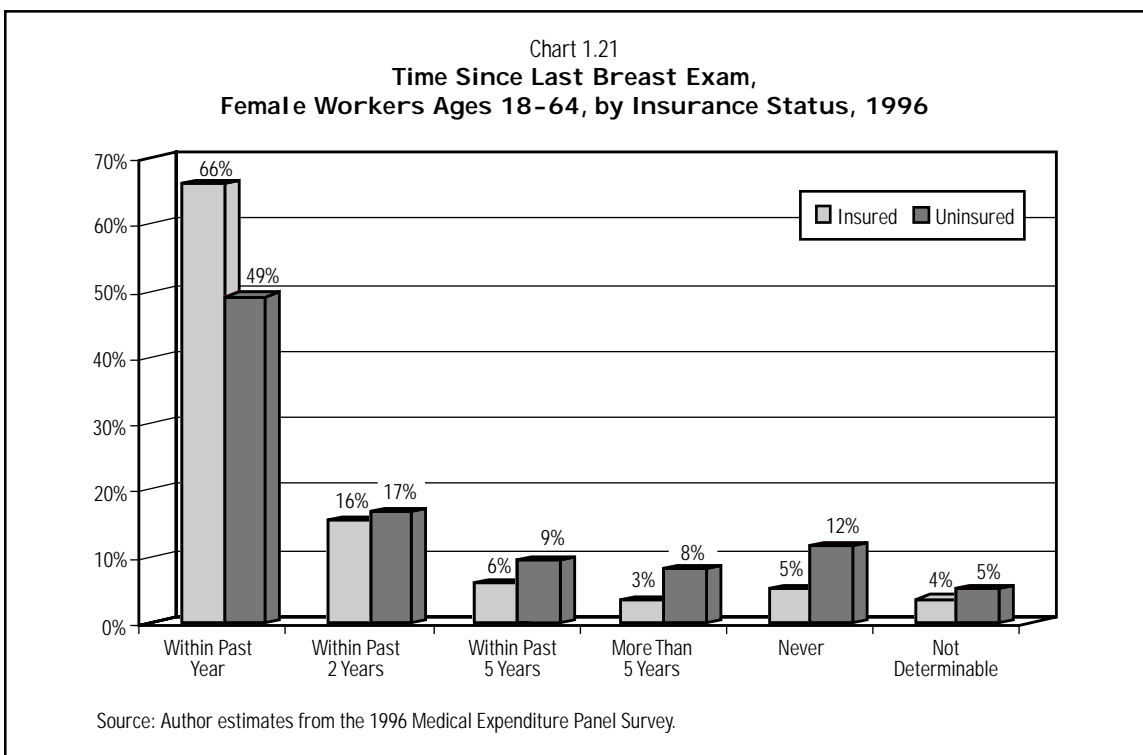
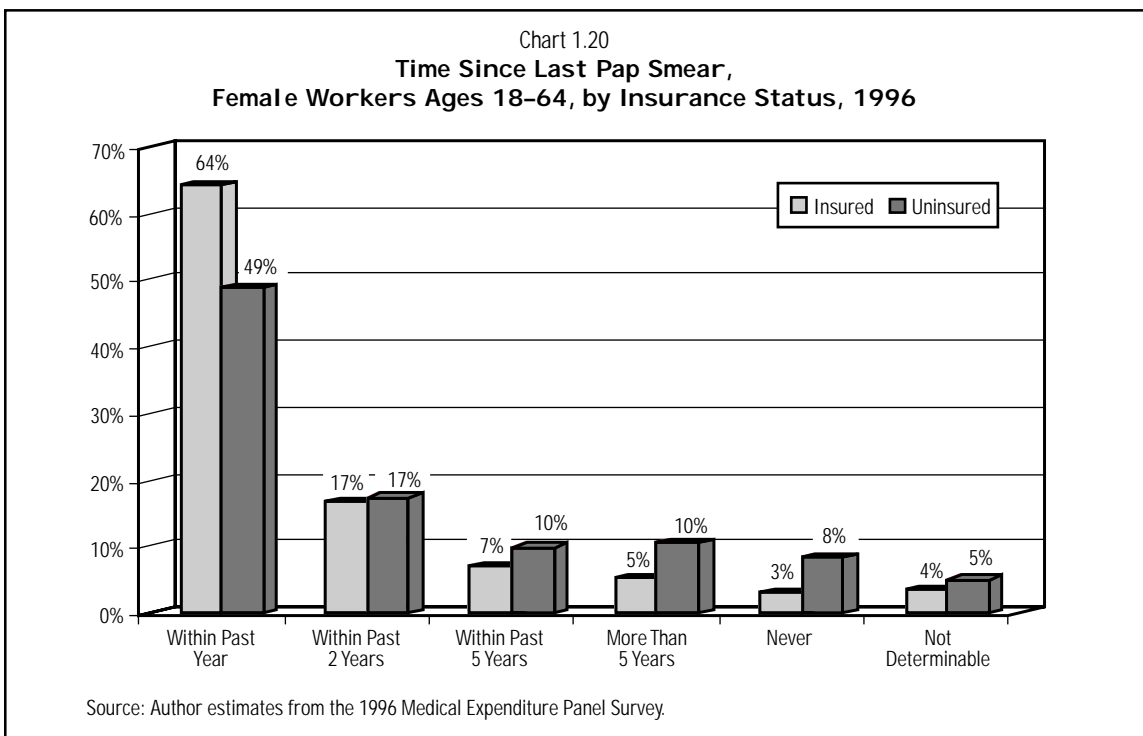


Pap Smear (chart 1.20)

- Uninsured females are less likely than insured females to have had a pap smear within the past year (49 percent vs. 64 percent, respectively).

Breast Exam (chart 1.21)

- Uninsured females are less likely than insured females to have had a breast exam within the past year (49 percent vs. 66 percent, respectively).



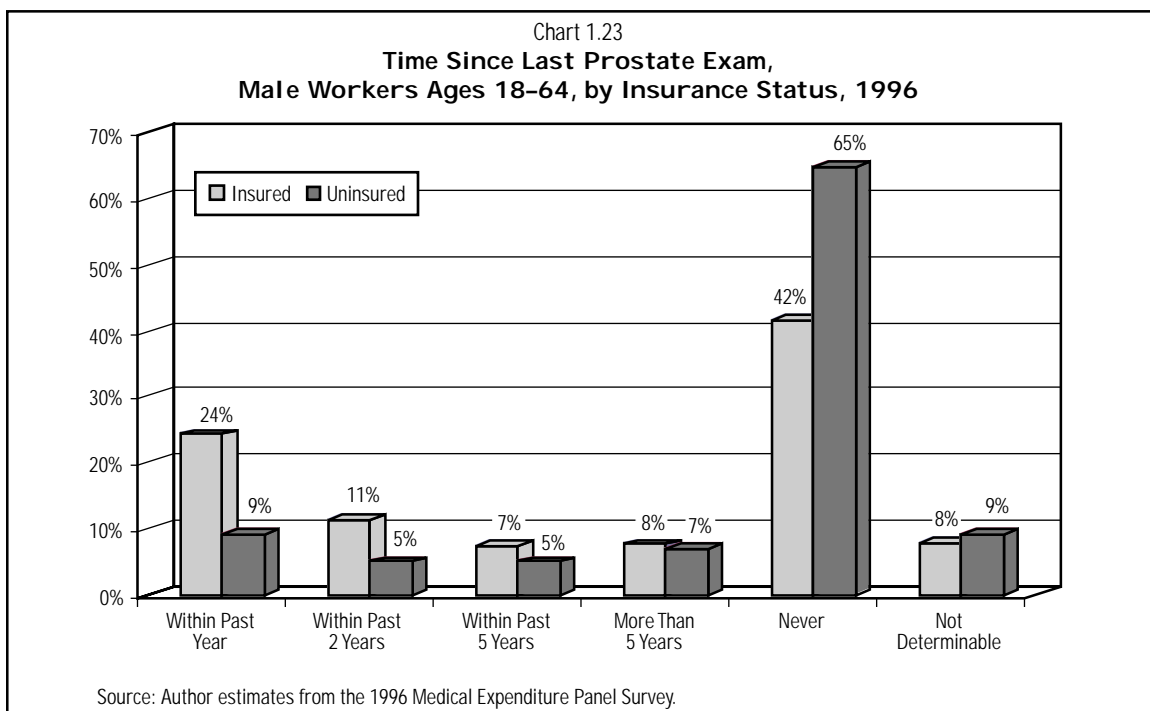
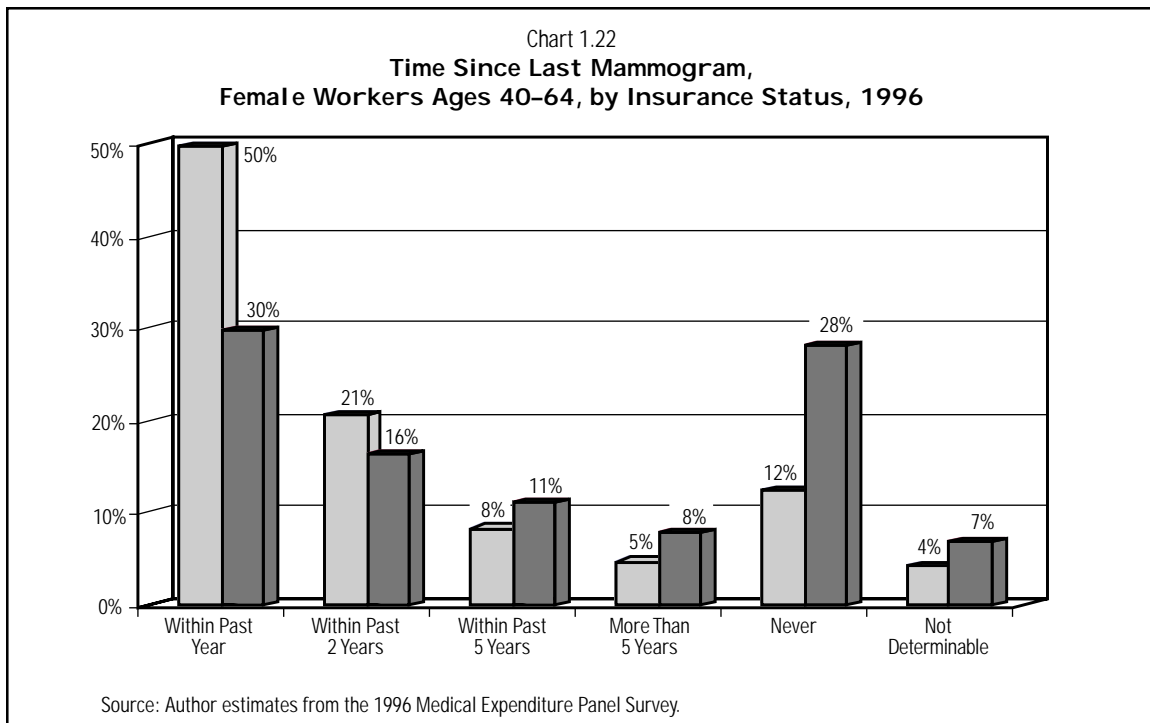
The Economic Costs of the Uninsured

Mammogram (chart 1.22)

- Uninsured females over age 40 are less likely than insured females over age 40 to have had a mammogram within the past year (30 percent vs. 50 percent, respectively).
- Uninsured females are more likely than insured females to have never had a mammogram (28 percent vs. 12 percent, respectively).

Prostate Exam (chart 1.23)

- Uninsured males are less likely than insured males to have had a prostate exam within the past year (9 percent vs. 24 percent, respectively).
- Uninsured males are more likely than insured males to have never had a prostate exam (65 percent vs. 42 percent, respectively).



To our knowledge, this analysis and the paper by Monheit et al. (1985) are the only studies that focus exclusively on access to health care for the insured and uninsured working population. While it is clear that being uninsured causes adverse consequences in the general population, it is important to make a distinction between workers and nonworkers to determine what effect, if any, the lack of worker coverage is having on the work place.

In addition to lacking access to health care and being less likely to receive basic preventive health services, there are other consequences of being uninsured. While there are no studies that focus on workers for these other consequences, a large literature exists that examines these other consequences for the population in general and for children specifically. Since these findings likely apply to the working population as well, some of the findings are discussed below.

The studies on the consequences of being uninsured generally fall into two broad categories: access to health care and outcomes from treatment. While many studies have examined access to health care, few have made comparisons between the insured and uninsured populations regarding outcomes from the care that was received. As mentioned above, it appears that Monheit et al. (1985) is the only study to focus on the consequences of being uninsured for workers. It is also one of the earliest studies on the consequences of being uninsured. The study found that insured workers were more likely to visit physicians, to have a prescription drug, and to have been hospitalized. The study also found that among workers who had visited a physician, the insured made more visits than the uninsured. For workers with a prescription drug, the insured had more prescriptions than the uninsured. Given these differences, the study found that insured workers had substantially higher medical expenses than uninsured workers, but uninsured workers paid more out-of-pocket than insured workers. In general, the other studies on access to health care show that the uninsured are less likely than the insured to visit a physician, be admitted to a hospital, have proper immunizations, and receive preventive care.² While few studies have examined the health outcomes of uninsured individuals, the studies all find adverse outcomes. A number of studies have

found higher mortality and death rates among the uninsured than among the insured.³ They have also found that the uninsured with appendicitis were more likely than the insured to have a ruptured appendix, and generally have worse control of their blood pressure.⁴

According to data from the March 1999 CPS, uninsured workers were, on average, 31 years old and insured workers were, on average, 38 years old. Because they are younger, uninsured workers may be less likely to seek preventive health services like physical examinations, screening, etc., because they are more likely to perceive themselves as healthy. Even if uninsured workers are healthier than insured workers, insured and uninsured workers exhibit different health behaviors, which may indicate that uninsured workers are putting their health at risk. For example, uninsured workers are more likely than insured workers to smoke. Specifically, 24 percent of insured workers currently smoke, compared with 38 percent among uninsured workers (chart 1.24). Also insured workers are more likely to be former smokers than uninsured workers. This may suggest that the education and assistance provided by health plans can have an effect on behavior, although other reasons are certainly possible.

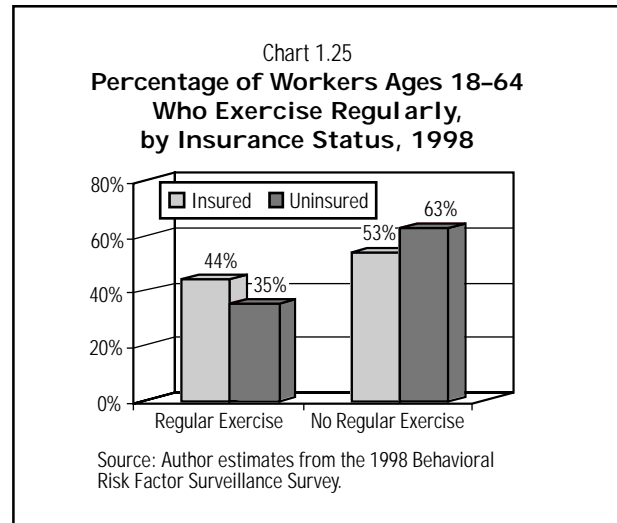
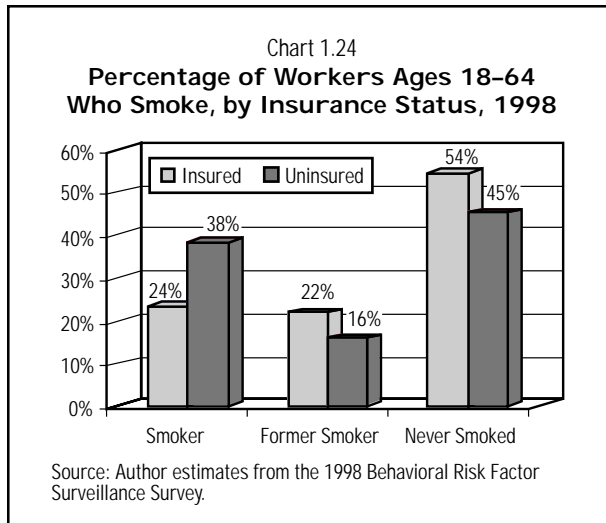
Other findings include the following:

- Insured workers are more likely than uninsured workers to get regular exercise (44 percent and

² See the following studies that were summarized in Brown et al. (1998): Arnold and Schlenker (1992); Burstin, Lipsitz, and Brennan (1992); Fleishman and Mor (1993); Freeman et al. (1987, 1990); Freeman and Corey (1993); Greenberg et al. (1988); Haas et al. (1994); Kerr and Siu (1993); Kuykendall, Johnson, and Geraci (1995); Moy, Bartman, and Weir (1995); Spillman (1992); Thomas et al. (1996); Weissman, Gatsonis, and Epstein (1992); Weissman et al. (1991); and Yelin, Kramer, and Epstein (1983).

³ See the following studies that were summarized in Brown et al. (1998): Ayanian et al. (1993); Braveman et al. (1991); Berg, Ross, and Latourette (1977); Foster, Guzick, and Pulliam (1992); Franks, Clancy, and Gold (1993); Haas and Goldman (1994); and Hadley, Steinberg, and Feder (1991).

⁴ See the following studies that were summarized in Brown et al. (1998); Braveman et al. (1994); and Lurie, et al. (1984 and 1986).



35 percent, respectively) (chart 1.25).

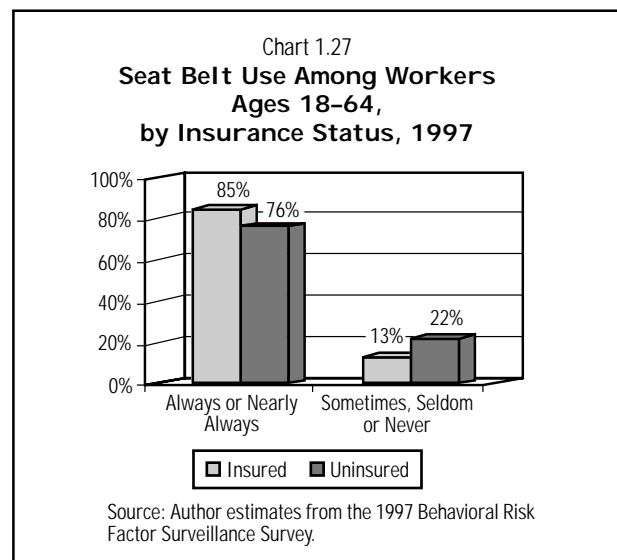
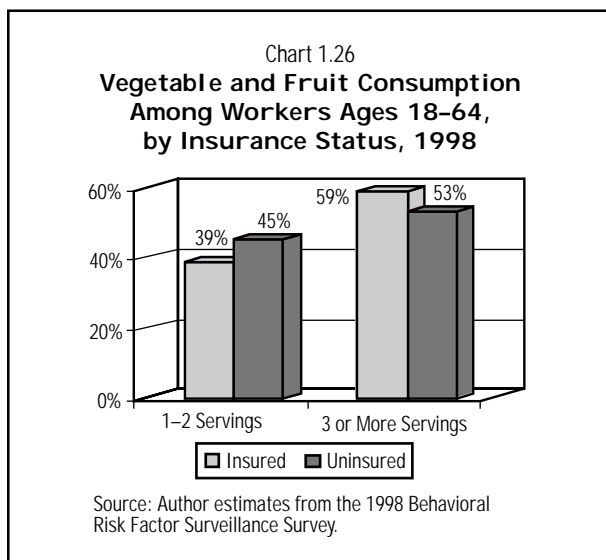
- Insured workers are more likely than uninsured workers to consume three or more daily servings of fruits and vegetables (59 percent and 53 percent, respectively) (chart 1.26).
- Insured workers are more likely than uninsured workers to always or nearly always wear their seat belt while in an automobile (85 percent and 76 percent, respectively) (chart 1.27).

events. For example, health plans offer a variety of educational materials, programs, and services to help members modify personal behaviors like smoking, nutrition, and exercise that may affect their future health status. If health plans are having a positive effect on personal behavior that mitigates future health problems, then we need to examine the economic benefits—as well as the costs—of extending health care coverage that educates as well as pays for care to the uninsured.

The purpose of insurance had traditionally been to provide financial protection against unexpected events. Health insurance still serves that purpose. However, with the advent of health promotion programs and managed care in the past 20 years, insurers have taken a proactive role to reduce the likelihood or severity of unexpected

■ Conclusion

Most Americans get health insurance coverage through the employment-based health insurance system. Employers offer health insurance for many reasons: some as a form of compensation, some to



attract and retain workers, and some to enhance worker health and possibly productivity. Not all employers offer health insurance benefits. While virtually all large employers offer health benefits, many small employers do not. These firms either do not agree with the reasons other firms offer for providing health benefits or they agree with the reasons but find that they do not need to provide health benefits to their workers for various other reasons. In addition, many small employers report that they just cannot afford to provide health benefits.

The evidence presented in this analysis that uninsured workers are less likely than insured workers to receive preventive health care and are more likely to exhibit risky behavior may have far-reaching implications for employers that do not provide health benefits as well as for employers that do provide them. If lack of access to health care can be shown to be detrimental to health status over an individual's lifetime, then there are opportunity costs to society of having an uninsured population. In the long run, we may find that the costs of providing health benefits offset at least part of the costs of not providing health benefits.

■ References

- Arnold, P.J., and T.L. Schlenker. "The Impact of Health Care Financing on Childhood Immunization Practices." *American Journal of Diseases of Children*. Vol. 146 (June 1992): 728–732.
- Ayanian, J.Z., B.A. Kohler, T. Abe, and A.M. Epstein. "The Relation between Health Insurance Coverage and Clinical Outcomes among Women with Breast Cancer." *New England Journal of Medicine*. Vol. 329 (29 July 1993): 326–331.
- Berg, J., R. Ross, and H.B. Latourette. "Economic Status and Survival of Cancer Patients." *Cancer*. Vol. 39 (February 1977): 467–477.
- Braveman, P.A., S. Egerter, T. Bennett, and J. Showstack. "Differences in Hospital Resource Allocation among Sick Newborns According to Insurance Coverage." *Journal of the American Medical Association*. Vol. 266 (18 December 1991): 3300–3308.
- Brown, M.E., A.B. Bindman, and N. Lurie. "Monitoring the Consequences of Uninsurance: A Review of Methodologies." *Medical Care Research and Review*. Vol. 55, no. 2 (June 1998): 177–210.
- Burstin, H.R., S.R. Lipsitz, and T.A. Brennan. "Socioeconomic Status and Risk for Substandard Medical Care." *Journal of the American Medical Association*. Vol. 268, no. 4 (November 1992): 2383–2387.
- Fleishman, J.A., and V. Mor. "Insurance Status among People with AIDS: Relationships with Sociodemographic Characteristics and Service Use." *Inquiry* 30 (Summer 1993): 180–188.
- Foster, D.C., D.S. Guzick, and R.P. Pulliam. "The Impact of Prenatal Care on Fetal and Neonatal Death Rates for Uninsured Patients: A 'Natural Experiment' in West Virginia." *Obstetrics & Gynecology*. Vol. 79 (January 1992): 40–45.
- Franks, P., C.M. Clancy, and M.R. Gold. "Health Insurance and Mortality: Evidence from a National Cohort." *Journal of the American Medical Association*. Vol. 270, no. 11 (August 1993): 737–741.
- Freeman, H.E., L.H. Aiken, R.J. Blendon, and C.R. Corey. "Uninsured Working-Age Adults: Characteristics and Consequences." *Health Services Research*. Vol. 24 (February 1990): 811–823.
- Freeman, H.E., R.J. Blendon, L.H. Aiken, S. Sudman, C.F. Mullinix, and C.R. Corey. "Americans Report on their Access to Health Care." *Health Affairs*. Vol. 6 (Spring 1987): 6–18.
- Freeman, H.E., and C.R. Corey. "Insurance Status and Access to Health Services among Poor Persons." *Health Services Research*. Vol. 28 (December 1993): 531–541.
- Fronstin, P. "Employment-Based Health Insurance: Who Is Offered vs. Who Takes It." *EBRI Issue Brief* no. 213 (Washington, DC: Employee Benefit Research Institute, September 1999).
- Greenberg, E.R., C.G. Chute, T. Stukel, J.A. Baron, D.H. Freeman, J. Yates, and R. Korson. "Social and Economic Factors in the Choice of Lung Cancer Treatment: A Population-Based Study in Two Rural States." *New England Journal of Medicine*. Vol. 318 (10 March 1988): 612–617.
- Haas, J.S., P.D. Cleary, E. Guadagnoli, C. Fanta, and A.M. Epstein. "The Impact of Socioeconomic Status on the Intensity of Ambulatory Treatment and Health Outcomes after Discharge for Adults with Asthma." *Journal of General Internal Medicine*. Vol. 9 (March 1994): 121–126.
- Haas, J.S., and L. Goldman. "Acutely Injured Patients with Trauma in Massachusetts: Differences in Care and Mortality, by Insurance Status." *American Journal of Public Health*. Vol.

The Economic Costs of the Uninsured

- 84 (October 1994): 1605–1608.
- Hadley, J., E.P. Steinberg, and J. Feder. “Comparison of Uninsured and Privately Insured Hospital Patients: Condition on Admission, Resource Use, and Outcome.” *Journal of the American Medical Association*. Vol. 265 (16 January 1991): 374–379.
- Kerr, E.A., and A.L. Siu. “Follow-Up after Hospital Discharge: Does Insurance Make a Difference?” *Journal of Health Care for the Poor and Underserved*. Vol. 4 (1993): 133–142.
- Kuykendall, D.H., M.L. Johnson, and J.M. Geraci. “Expected Source of Payment and Use of Hospital Services for Coronary Atherosclerosis.” *Medical Care*. Vol 33 (July 1995): 715–728.
- Lurie, N., N.B. Ward, M.F. Shapiro, and R. Brook. “Termination from Medi-Cal: Does it Affect Health?” *New England Journal of Medicine*. Vol. 311 (16 August 1984): 480–484.
- Lurie, N., N.B. Ward, M.F. Shapiro, C. Gallego, R. Vaghaiwalla, and R.H. Brook. “Termination of Medi-Cal Benefits: A Follow-Up Study One Year Later.” *New England Journal of Medicine*. Vol. 314 (8 May 1986): 1266–1268.
- Monheit, Alan C., Michael M. Hagan, Marc L. Berk, and Pamela J. Farley. “The Employed Uninsured and the Role of Public Policy.” *Inquiry* Vol. 22 (Winter 1985): 348–364.
- Moy, E., B.A. Bartman, and M.R. Weir. “Access to Hypertensive Care: Effects of Income, Insurance, and Source of Care.” *Archives of Internal Medicine* Vol 155, no. 24 (July 1995): 1497–1502.
- Spillman, B.C. “The Impact of Being Uninsured on Utilization of Basic Health Care Services.” *Inquiry*. Vol. 29 (Winter 1992): 457–466.
- Thomas, E.J., H.R. Burstin, A.C. O’Neil, E.J. Orav, and T.A. Brennan. “Patient Noncompliance with Medical Advice after the Emergency Department Visit.” *Annals of Emergency Medicine*. Vol. 27 (January 1996): 49–55.
- Weissman, J.S., C. Gatsonis, and A.M. Epstein. “Rates of Avoidable Hospitalization by Insurance Status in Massachusetts and Maryland.” *Journal of the American Medical Association*. Vol. 268, no. 4 (November 1992): 2388–2394.
- Weissman, J.S., R. Stern, S.L. Fielding, and A.M. Epstein. “Delayed Access to Health Care: Risk Factors, Reasons and Consequences.” *Annals of Internal Medicine*. Vol. 114, no. 15 (February 1991): 325–331.
- Yelin, E.H., J.S. Kramer, and W.V. Epstein. “Is Health Care Use Equivalent Across Social Groups? A Diagnosis-Based Study.” *American Journal of Public Health*. Vol. 73 (May 1983): 563–571.

The Value of Health: Is There Hope for Employer-Led Quality and Universal Access?

by Ray Werntz, Consumer Health Education Council

■ Introduction

I have wrestled with something I call the “value of health” for some time; it is a subject that gets more attention every day. In fact, given the number and diversity of authorities writing about it, it may even have a chance of becoming conventional wisdom someday.

I recently participated in a meeting with some very smart and dedicated people at the Belmont Conference Center near Baltimore, MD. The topic of this meeting was universal access. Most of the attendees were from the mental health and policy research communities. All were deeply committed to expanding coverage for uninsured Americans.

Once again, I was asked to represent employers. I have discovered during my time in Washington that not many employers participate in these kinds of discussions. So I had another opportunity to pull my old employer hat off the shelf and try to add something to the discussion. Figuring out how to develop and distribute information and educational tools to reduce the number of uninsured Americans is my first priority at the Consumer Health Education Council (CHEC). So meetings like this are enjoyable and a great learning experience. But I also get kind of lonely. My old friends, large employers, care about the uninsured, but it is not their top priority. However, for most of the others at the Baltimore meeting, universal coverage seemed to be the only priority.

My goal at the meeting was to encourage the group to explore ways to persuade employers—especially those who provide health care coverage to their employees—to support access initiatives. To

that end, I explained, we need to show them that an 18 percent—and rising—uninsured rate is a systemic problem of the American health care system that rivals and impacts their top priorities: quality, cost and patient safety.

This is why I subtitled this discussion “Is There Hope for Employer-Led Quality and Universal Access.” In my opinion, these issues are interconnected and vitally important to affordable, quality health care for all Americans.

Chart 2.1 contains a quote from Dr. Uwe Reinhardt from his article in the November/December 1999 issue of *Health Affairs* in which he concludes that the debits of the employer-based health care system outweigh the credits. It is also essentially what he said at an Alpha Center meeting in November 1999. I think it is fair to say that he would be happy to see something else take the place of employer-based health care even though he is not sure what that something else is.

Having lived in Chicago for over five decades before coming to Washington last year, I did not understand the depth of the policy community’s concern over the defects—Reinhardt’s

Chart 2.1

Is There Hope for Employer-Led Quality and Universal Access?

Conventional Wisdom?

“Although different evaluators may come up with different credits, debits, and account balances for the employer-based health insurance system, I conclude from the exercise that the debits outweigh the credits.”

Source: Uwe Reinhardt. *Health Affairs* Nov/Dec 1999.

debits—in employment-based health insurance. In my prior life, I was for several years a strong proponent of more employer involvement in access for the uninsured and in Medicaid policy. However, I was unable to convince my peers to join me. There was no urgency about either of these issues. But it is different today. The urgency is such that many of the policy options now under consideration could bring about the end of employment-based health insurance.

■ Employers and the Health Care System

With that in mind, let us consider the stake employers now have in the health care system (chart 2.2). Employers pay over 25 percent of health care costs nationally and cover two-thirds of Americans under age 65. According to the surveys I have seen, most employees like employers as middlemen. Employers have successfully stabilized their costs—if only for a few years—and since the early 1990s many have encouraged best practices, quality processes, and value from their health care suppliers.

My former employer canned and distributed soft drinks. We purchased sugar and aluminum that met exacting price and quality standards to make and distribute Pepsi Cola products profitably. We were good at purchasing what we needed to make our company profitable. Value purchasing is a core competency of most businesses, and our attempts to apply those skills to purchasing health care has exerted a powerful influence on the organization and operation of the health care system since the late 1980s.

■ The Debits

Let us return to a Reinhardt-like balance sheet analysis, starting with the debits (chart 2.3). He notes accurately the inequity of pre-tax employer payments for health insurance versus after-tax payments by individuals.

Also, it is true that job lock is an issue for some people, although with nearly full employment, this is less a problem today than it was in the past. However, one thing has not changed. Each employer continues to differentiate its expectations for the health care it purchases from those of other

Chart 2.2
Is There Hope for Employer-Led Quality and Universal Access?

- Employers Have The Leverage
- Pay 25 percent of the dollars
 - Are preferred as sponsors
 - Cover 65 percent of the nonelderly
 - Are “semi-organized”
 - Adopt best processes and practices
 - Are bottom-line oriented

employers. This results in multiple, confusing, and even contradictory instructions to health professionals and causes disconnects in the health care system.

Concern with patient privacy is justified because employers have access to a great deal of confidential information. However, based on over 30 years’ experience with employers, privacy protection is a very high priority.

My main complaint with employment-based health care coverage is employers’ exclusive use of health care costs relative to other costs to measure the effectiveness of their dealings with the health care system. Costs for small employers and low-income workers are a major reason that 85 percent or more of the uninsured are connected to the work place. Single-mindedness about relative costs as the only measure of value is the reason some employers and more than 35 million workers and their families can’t or won’t purchase coverage. This inability or unwillingness of employers and workers get coverage is why policy experts like Dr. Reinhart conclude that the employment-based system is fatally flawed.

■ The Benefits

But as chart 2.2 shows, there are some benefits of the current system. As I mentioned earlier, employers are very attuned to process engineering and quality and insist on financial accountability from their suppliers. Employers have led the charge on employee health education and health promotion. Some of them, such as Delta Airlines, are implementing sophisticated Internet tools for employee health education and are even supplying employees with home computers.

To sum up what I have discussed so far, I believe it is premature to write off employment-

Chart 2.3
**Is There Hope for Employer-Led
 Quality and Universal Access?**

The Debits

- It's inequitable
- It interferes with worker mobility
- It's complex and inflexible
- Expectations and financing are "Balkanized"
- It's perceived as a threat to worker privacy
- Costs reign as the dominant performance standard
- 85 + % of uninsured are workers or dependents

based health care as a failure simply because most of the uninsured are connected to the work place. There is much more to employer health *management* than group coverage to provide financial protection against the cost of medical services. Before we rush to judgement about employers, we ought to consider the consequences of breaking the connection between employment and coverage as well as the possible benefits.

Several of the contributors to this book discuss employer initiatives to improve quality, access, and employee and family health, often in collaboration with other employers and the public sector. They also outline options for enhancing employer-based coverage.

John Colmers¹, Chris Queram,² Mark Gibson³ and others will tell you about successes in Maryland, Wisconsin, Oregon and other communities in getting more people covered. Management and labor representatives from General Motors will explain their efforts to help community providers improve quality for all their patients. Though not discussed here, Ford and Daimler-Chrysler and other large employers are also engaged in similar initiatives across the country. Dee Eddington⁴ of the University of Michigan reports on his work with companies like Bank One that emphasize employee and family health in their programs.

Regrettably, while innovative and laudable,

these examples are not characteristic of the majority of employers. And, in spite of the great work in Maryland, Wisconsin, Oregon, California, Ohio and other states, the number of uninsured workers continues to grow.

■ The Economic Justification for Health Coverage

This brings me back to my fascination with a new economic justification for health and health care coverage that is beginning to resonate with employers. (See report by Paul Fronstin and Al Holtman on their research and the importance of these new notions to individuals.⁵)

About 10 years ago, a few employer customers of a company called Medstat began meeting informally to dig deeper into the costs of workers with health problems. They soon realized the magnitude of other costs triggered by illness and injury. Disability insurance, life insurance, workers compensation and other employee program costs were affected. Later on, better data helped us understand the influence of impaired health on turnover, waste, absenteeism, and the like.

Out of these inquiries arose a belief that an overly narrow focus on containing or reducing the cost of health care services may negatively affect other employee-related business costs. This early work led to the pioneering Health and Productivity Management collaborations led by the Washington Business Group on Health and Sean Sullivan's Institute for Health and Productivity Management.

This new way of thinking about the cost "ripple effects" of compromised health may stimulate new examinations of the benefits of population health and the value of improved access and quality to entire communities and possibly even to the nation (chart 2.5).

As chart 2.6 shows, until now, the focus of this new thinking has been on costs to support a

¹ See John Colmers, "Public- and Private-Sector Initiatives to Increase Access to Health Coverage: The Experience in Maryland," in this volume.

² See Chris Queram, "Employer Health Care Alliance Cooperative," in this volume.

³ See Mark Gibson, "Public-Sector Initiatives to Expand Private-Sector Insurance Coverage in Oregon," in this volume.

⁴ See Dee Eddington, "Health Management for the Insured and Uninsured," in this volume.

⁵ See Paul Fronstin and Alphonse Holtman, "Productivity Gains from Employment-Based Health Insurance," in this volume.

Chart 2.4
Is There Hope for Employer-Led Quality and Universal Access?

The Credits

- Greater accountability and economic discipline
- Better practices and processes
- Widespread employee education and sophisticated IT applications
- Innovative procurement
- Quality, population health and access case studies
- An emerging value paradigm for health program performance

Chart 2.5
Is There Hope for Employer-Led Quality and Universal Access?

Promising Case Studies

- Access to coverage and care
- Care system quality
- Population health

more sophisticated, systems approach to health management programs to address the drivers of such costs. However, using changes in costs at the sponsor level to assess the effect of such programs creates a barrier to more comprehensive private and public solutions to the twin problems of access and quality. As long as meaningful changes in access and quality are seen by most employers as merely too expensive, we will not likely see much progress without systemwide “reform.”

The quote in chart 2.7 puts this into perspective. Dr. Miles Shore says that all expenditures must add value and, therefore, health care cannot continue to be justified on humanitarian grounds. According to Webster, value is a fair return for money exchanged. Does it make sense that our expectations of value from over \$1.1 trillion expended last year on population health be limited to the relative size of the expenditure? On the other hand, are there lessons to be learned from that small group of employers who struggled with the possible links between health and productivity

that might lead to entirely new notions of the value of health?

■ Conclusion

When investors make investment decisions, they look at a company’s history of, and prospects for, long-term profitable growth. Cost patterns do not constitute value, they affect it. Today, investors are much more interested in a potential investment’s human or intellectual capital than ever before. Do we know how much health affects the ability and desire of workers to innovate and adapt to ever-changing global markets and economic environments? Do we want to know?

Finally, will a shift from costs to a new definition of value unify the diverse stakeholders I mentioned at the beginning of my remarks and allow us to resolve the access-quality dilemma within the boundaries of current policy? Are these possibilities even worth thinking about?

I think they are.

Chart 2.6
Is There Hope for Employer-Led Quality and Universal Access?

The Emerging Performance Paradigm

- Other health related costs affected by health care
- Other employment costs affected by health care
- Community-wide costs affected by care provide the uninsured
- Employee output maintained/enhanced by health care

Chart 2.7
Is There Hope for Employer-Led Quality and Universal Access?

One Physician’s Point of View

“However much we might wish it otherwise, in a world where all expenditures are closely scrutinized for value added, health care cannot continue to be justified solely on humanitarian grounds as an unqualified public good.”
Miles Shore M.D.-Harvard Rev Psychiatry 1999, “The Economic Costs of the Uninsured Implications for Business and Government”



The Economic Costs of the Uninsured

Productivity Gains From Employment-Based Health Insurance

by Paul Fronstin, EBRI and Alphonse G. Holtmann,
University of Miami

■ Introduction

Insurance is a common means of pooling risk, with many Americans purchasing homeowner's insurance, auto insurance, and life insurance to protect themselves from the substantial financial losses associated with largely random events. Although health insurance provides this same protection against financial loss, it also changes the insured individual's purchases of health care: insured individuals purchase more medical services than the uninsured.¹

Health care has attributes that differ from those of other services that individuals purchase. Specifically, the purchase of health care can increase current and future productivity. Flu shots, for example, are likely to reduce the number of workdays lost due to illness or to reduce the flu symptoms enough for partial productive activity. Likewise, health checkups are more likely to find illnesses at an early stage. These prevention, early detection, and treatment activities may increase productivity in the long run. The productivity gains associated with employment-based health insurance are the focus of this chapter.

The focus on gains in economic productivity associated with health insurance is not meant to detract from the numerous other benefits that accrue from spending on health care. The flu shot example above illustrates the public benefits from individual health purchases: vaccinated individuals do not communicate disease to others. This is why childhood immunizations are required before entry into school. Health insurance also leads to economic gains because it changes the manner in which people receive health care. Uninsured individuals are more likely to delay seeking care (Burstin et al., 1992; Fronstin, 2000; and Weissman et al., 1991). Delay in receiving a mammogram would be a case in point. Uninsured women are less likely than insured women to receive mammograms (Centers for Disease Control, 1998; Fronstin, 2000; and Himmelstein and Woolhandler, 1995). Such delays may lead to higher health costs to treat advanced disease and to higher mortality rates.

Nevertheless, employment-based health insurance plans are ubiquitous, suggesting that employment-based health insurance may be extended to some of the currently uninsured population. If employment-based insurance is going to be extended to many of the 44 million uninsured Americans, it is important to consider any productivity gains that might offset some of the costs of this insurance. Thus, while recognizing that there are other benefits from health insurance, such as public health, this analysis concentrates on the relationships among the labor market, employment-based health insurance, health status, and productivity.

¹ A number of researchers have reviewed the literature on insurance coverage and utilization of health care. The scope of these studies includes both the effect of the financial incentives associated with insurance on the utilization of health care and the effect of being uninsured on utilization of health care. See Brown et al. (1998), Holtmann and Olsen (1978), and Newhouse (1993).

■ Health Insurance and Labor Markets: Theoretical Considerations

Health insurance can be thought of as an investment in human capital (Grossman, 1972). Insured workers have better access to health care than uninsured workers, possibly leading to higher productivity. As a result, employers have an interest in providing workers with access to health care, even in the absence of tax incentives. Therefore, it is not surprising that employment-based access to health care predates the tax advantages associated with employment-based health insurance. For example, as early as the 1870s, railroad, mining, and other industries in the United States began providing company doctors to employees and funded it with deductions from workers' wages (Institute of Medicine, 1993). These companies had a practical interest because workers often worked in remote geographic areas without access to health care. As another example, Montgomery Ward entered into one of the earliest group insurance contracts for workers in 1910.

How might the cost of such employment-based health insurance be shared between employers and workers in a competitive labor market? The productivity gains from health insurance are likely to be spread over a worker's entire working lifetime, and they are likely to be valuable to all employers. Thus, employers do not realize all of the benefits from the investment in health insurance: insured workers are more productive, but they can command a wage equal to their productivity with any employer. Employers must pay higher future wages to keep their more productive workers from being bid away by other employers. Therefore, if employers were to pay for an employee's health insurance, they could not recover these costs by paying future wages that were below the worker's productivity. In perfect labor markets, then, insurance costs are shifted entirely to the worker. That is, workers' wages are reduced to reflect the cost of health insurance, although they are also higher as they reflect the increased productivity associated with better health. Such a model of the labor market suggests that observed wages are net of insurance costs but reflect health-related productivity gains. Of course, if health insurance produces no productivity gains and is merely a tax-subsidi-

dized wage payment, the cost of insurance will be shifted to the employee in a competitive labor market.

Recent empirical work shows that, at the group level, employers shift more than 100 percent of the cost of insurance to their workers through lower wages (Sheiner, 1999). This finding is consistent with the economic theory outlined above. More than 100 percent of the cost of insurance is shifted to workers because employment-based health benefits are not subject to the income and payroll taxes that would be paid on higher wages. In any case, it appears that employers shift much of the cost of health benefits to workers through lower wages at the group level. According to Sheiner (1999) there is still no evidence that employers are able to shift the cost of insurance to workers at the individual level (i.e., workers with high health care costs due to pre-existing conditions experience direct wage losses). These findings lead to the belief that any positive difference in wages attributable to health insurance is a pure return, which is net of investment costs.

To the extent that workers cannot easily change jobs, or to the extent that current employers have better information about workers' productivity than potential employers do, we would expect that employers and employees might share the cost of health insurance and the health-related productivity gains. These imperfections in the labor market help explain why large employers with well-developed internal labor markets provide more extensive health insurance than small employers (Holtmann and Idson, 1995). Because of the isolation of workers in geographic regions and the cost involved in finding replacements, less competitive labor markets in mining and railroads may also account for the fact that worker health care was provided at such an early date in these industries. Even when employers and employees share in the productivity gains from insurance, some of this gain could be expected to be reflected in higher wages. The employer shares the gains and costs of investments in workers to prevent the workers from quitting the firm.

Hence, our view is that health insurance increases both the quantity and quality of the health care that insured workers purchase, and that this health care increases worker productivity. The health-related increases in worker productivity

may be manifested in a number of different ways. Healthy workers may be more mentally alert and more physically able than less healthy workers, leading to higher wages for a given number of hours worked. In addition, healthy workers may work more hours per year than their less healthy counterparts, because they use fewer sick days and because their higher wage encourages them to work more. In the following empirical analysis, the benefits of good health are measured by comparing the annual earnings of “healthy” workers with their “less healthy” counterparts, holding other factors constant. This procedure should capture the total gains in productivity from improved health.

■ Empirical Methodology and Data

This empirical analysis is based on the hypothesis that health insurance increases health care consumption, which in turn increases productivity and earnings. This functional relationship can be stated symbolically as follows:

$$(1) H = H(I, n)$$

and

$$(2) E = E(H, m),$$

where H is the worker’s health status, I is insurance, n is a number of worker characteristics that influence the worker’s health status, E is the worker’s annual earnings, and m is a number of worker characteristics that influence the worker’s earnings. The change in earnings due to an increase in insurance coverage can be written as:

$$(3) \partial E / \partial I = (\partial E / \partial H)(\partial H / \partial I).$$

To implement this model, reported health status is related to a worker’s insurance coverage and to a number of economic and demographic worker characteristics that are thought to influence a person’s health. This first equation provides an estimate of the influence of insurance on health status, $\partial H / \partial I$, holding other factors constant.

In the second part of this empirical analysis, we regress earnings on worker health status and a number of other worker characteristics that influence earnings. This second equation provides an estimate of $\partial E / \partial H$, holding other factors con-

stant. Multiplying the two estimates provides an estimate of the independent impact of health insurance on earnings, as shown in equation (3).

Data for this study come from the March 1999 supplement to the Current Population Survey (CPS). The CPS is the primary source of data on labor force characteristics for the U.S. civilian noninstitutionalized population. It is also the official source of data on unemployment rates, poverty, and income in the United States. Approximately 50,000 households, representing over 130,000 individuals, are interviewed each month.

This empirical analysis is based on a sample of almost 54,000 wage and salary workers in the CPS. Besides providing detailed information on a large number of worker and family characteristics, the CPS includes a self-reported indicator of a worker’s health status.

As a means of measuring the effect of health insurance coverage on health status, a set of variables is used that reflect both the worker’s insurance status (insured or uninsured)² and the size of firm in which the worker is employed. It is known that health insurance coverage is both more prevalent and more encompassing in large firms than in small firms. Hence, one might expect large firms to offer better benefits than small firms, which is accounted for in this analysis. The combined insurance-firm size variable measures a range of workers, from those who have no insurance and are employed in firms with fewer than 10 workers to those who have insurance coverage and are employed in firms with 1,000 or more employees. As can be seen from table 3.1, insured workers are generally more likely than uninsured workers to be in excellent health. Most of this difference comes from uninsured workers being more likely than insured workers to be in good health and fair health. While health status was expected to be higher for workers in large firms compared with those in small firms because large firms typically offer better benefits than small firms, examination of health status differences by firm size does not reveal much difference, as shown in table 3.1. However, it is necessary to control for

² A small number of workers who reported coverage from either a public program or coverage that they purchased directly from an insurance company are excluded from this analysis.

Table 3.1
Self-Reported Health Status, by Firm Size and Insurance Status
Wage and Salary Workers, Ages 18-64

	Total	Excellent	Very Good	Good	Fair	Poor
Total						
Uninsured	100%	28%	34%	28%	7%	2%
Insured	100	35	38	22	4	1
Fewer than 10 Workers						
Uninsured	100	28	34	29	8	2
Insured	100	37	36	22	4	1
10-24 Workers						
Uninsured	100	29	34	29	6	2
Insured	100	37	37	21	4	1
25-99 Workers						
Uninsured	100	26	36	29	8	2
Insured	100	35	38	22	4	1
100-499 Workers						
Uninsured	100	27	34	30	7	2
Insured	100	35	38	21	5	1
500-999 Workers						
Uninsured	100	28	33	31	7	2
Insured	100	34	40	21	4	1
1,000 or More Workers						
Uninsured	100	30	34	26	7	2
Insured	100	35	38	22	5	1

Source: Authors' estimates from the March 1999 Current Population Survey.

other factors, as is done below, before the impact of the amount of health benefits on health status can be determined.

We expected that those with health insurance coverage would report better health status compared with those who are uninsured, even after controlling for other factors that affect health. In addition, we expected that those with insurance in large firms would have a greater advantage over their uninsured colleagues than the insured in small firms have over their uninsured colleagues, because large firms usually provide better health benefits. Thus, we predicted that the health status advantage of the insured over the uninsured grows as firm size increases. Of course, it was assumed that uninsured workers would report no significant difference in health status by firm size.

Other economic and demographic variables that were expected to influence health status are also included in our model. The means of these variables are reported in table 3.2. Although these variables are used as control variables in the analysis of insurance and health status, some of them merit further discussion. Note that most of the sample report superior health status, with approximately 70 percent of the individuals reporting excellent or very good health. Those with

extremely poor health are not likely to be in the labor force, so it is not surprising that our sample of workers contains a large proportion of healthy individuals. Such selectivity in the sample has the effect of downwardly biasing the estimate of the effect of insurance on health status.³ That is, the positive influence of insurance on health status is likely to be underestimated, which provides a conservative test of this hypothesis.

If self-reported health status reflects actual health status in a meaningful way, age should be expected to be negatively related to reported health status. Hence, the age variable in the analysis is not only a means of determining the influence of age on reported health status, but also a means of validating reported health status as a measure of physical health status.

Higher family income is likely to result in a greater chance that a worker has insurance, but higher income is also likely to lead to better health through other investments that people make in human capital. For example, higher income groups

³ Because we do not observe wages and other job characteristic variables for nonworkers, we are unable to correct our estimates for selectivity.

Table 3.2
Sample Means, Wage and Salary Workers, Ages 18–64, 1998

	Men		Women	
	Full time, full year	Less than full time, full year	Full time, full year	Less than full time, full year
n	22,155	5,774	16,481	9,538
Percentage in Excellent or Very Good Health	0.73	0.67	0.71	0.68
Mean Log of Annual Earnings	10.44	9.18	10.14	8.94
Firm Size and Insurance Status				
Fewer than 10 employees and uninsured	0.04	0.10	0.03	0.06
Fewer than 10 employees and insured	0.06	0.08	0.06	0.11
10–24 workers and uninsured	0.03	0.06	0.02	0.03
10–24 workers and insured	0.06	0.07	0.06	0.07
25–99 workers and uninsured	0.03	0.06	0.02	0.03
25–99 workers and insured	0.12	0.09	0.11	0.10
100–499 workers and uninsured	0.02	0.05	0.02	0.03
100–499 workers and insured	0.14	0.10	0.14	0.12
500–999 workers and uninsured	0.01	0.01	0.01	0.01
500–999 workers and insured	0.06	0.04	0.07	0.05
1,000 or more workers and uninsured	0.03	0.10	0.04	0.08
1,000 or more workers and insured	0.40	0.25	0.43	0.30
Age	39.72	33.63	40.05	36.50
Marital Status				
Married	0.67	0.41	0.57	0.60
Widowed	0.01	0.01	0.02	0.02
Divorced	0.09	0.08	0.16	0.07
Separated	0.02	0.02	0.03	0.02
Never married	0.21	0.49	0.22	0.28
Family Income as a Percentage of Poverty				
Under 100% of poverty	0.03	0.12	0.02	0.10
100%–149% of poverty	0.04	0.10	0.04	0.09
150%–199% of poverty	0.07	0.10	0.07	0.08
200%–299% of poverty	0.18	0.18	0.18	0.18
300%–399% of poverty	0.17	0.15	0.17	0.16
400% or more of poverty	0.52	0.36	0.52	0.39
Education				
Less than high school	0.12	0.22	0.08	0.13
High school	0.59	0.62	0.63	0.64
College	0.19	0.10	0.20	0.17
Graduate degree	0.09	0.06	0.09	0.06
Race/Ethnicity				
White	0.72	0.67	0.71	0.73
Black	0.07	0.09	0.11	0.08
Hispanic	0.17	0.19	0.14	0.14
Other race	0.04	0.05	0.04	0.05
Occupation				
White collar	0.48	0.34	0.77	0.65
Service collar	0.32	0.38	0.16	0.27
Blue collar	0.20	0.28	0.07	0.08

(continued)

Table 3.2 (continued)

	Men		Women	
	Full time, full year	Less than full time, full year	Full time, full year	Less than full time, full year
Firm Size and Health Status				
Fewer than 10 employees and bad health	0.03	0.07	0.03	0.06
Fewer than 10 employees and good health	0.07	0.11	0.06	0.11
10–24 workers and bad health	0.03	0.04	0.02	0.03
10–24 workers and good health	0.06	0.09	0.05	0.07
25–99 workers and bad health	0.04	0.05	0.04	0.04
25–99 workers and good health	0.11	0.11	0.09	0.09
100–499 workers and bad health	0.04	0.05	0.04	0.05
100–499 workers and good health	0.12	0.09	0.12	0.10
500–999 workers and bad health	0.02	0.02	0.02	0.02
500–999 workers and good health	0.05	0.03	0.05	0.05
1,000 or more workers and bad health	0.11	0.11	0.14	0.12
1,000 or more workers and good health	0.32	0.24	0.34	0.26
Industry				
Agriculture, forestry, fishing, mining, and construction	0.12	0.22	0.02	0.03
Manufacturing	0.34	0.22	0.19	0.11
Wholesale and retail trade	0.31	0.36	0.31	0.36
Personal service	0.16	0.18	0.41	0.48
Public administration	0.07	0.02	0.06	0.02

Source: Authors' estimates from the March 1999 Current Population Survey.

are more likely to join health clubs. To reduce the correlation of income and health insurance and to determine the impact of family income on reported health status, we constructed seven categorical variables that reflect the ratio of family income to the poverty level of income for such a family. Families at or below the poverty line form the basis of the comparison. Reported health status was expected to be positively correlated to family income.

Race and ethnicity were also expected to be good predictors of health status, independent of their association with income. This may be due to such factors as discrimination in the medical care market or diseases that are race specific. In any case, a race-ethnic group of variables is included, with white workers forming the basis of comparison.

Also included are other categorical variables that reflect workers' education, occupation, and whether they are employed full time with the firm. The relationship of some of these variables to health status seems fairly transparent. For example, more educated workers have better access

to health care information than those who are less well educated.

Other economic and demographic variables that were also expected to influence reported health status include gender and marital status. Although we have no compelling prior notion concerning the influence of gender and marital status on health status, we felt these were important control variables in this analysis. One might argue, for example, that because women live longer than men, they are more likely to report better health status, all else being equal. Conversely, women visit physicians more often than men, controlling for child bearing, which might lead one to conclude that they have more minor health problems (Sandman, Simantov, and An, 2000). Women may also visit the physicians more often than men because of certain "elective" preventive health exams, such as mammograms, breast exams, and Pap smear tests. Married individuals may live a life style that is more conducive to good health. The following sections discuss these types of detailed interpretations of the results of this analysis.

■ Health Status Findings

The correlation between health status and insurance status presented in table 3.1 and the discussion above concerning other factors that influence health status suggest that relationships exist between health status and many factors. However, the correlations may pick up some of the effects of other correlated factors. For example, while insured workers are healthier than uninsured workers, and older workers are less healthy than younger workers, older workers are more likely to have insurance, which may have an independent effect of making them healthier than younger workers. In order to consider the multitude of factors that affect health status, and understand the independent effects of each, a multivariate equation was estimated on health status. The equation can be used to understand the relationship between insurance status and health status, holding other influencing factors constant. This allows us to quantify equation 1. In addition, the estimated coefficients from the multivariate analysis allow us to calculate the probability of being healthy and how that probability changes when one of the characteristics changes.

Table 3.3 shows the explanatory variables included in the health status multivariate analysis and the change in the likelihood of being healthy associated with moving to a new category of an explanatory variable. Separate analyses are conducted for both men and women and for full-time, full-year workers and workers working less than full time full year. Considering the 12 categories that reflect the influence of insurance status and firm size on health status, it can be seen that insured workers in all size firms generally report higher health status than their uninsured counterparts, with most of the differences being significant.⁴ For men working full time, full year, the differential health advantage of the insured over the uninsured varies from about three percentage points to about eight percentage points, depending upon the firm size being considered. As an example, there is a 2.7 percentage point difference in the likelihood of being healthy between insured workers and uninsured workers in firms with 1,000 or more employees. These regression results are consistent with the hypothesis that health insurance improves the health status of workers.

The results are also consistent with other hypotheses about insurance status and health status in the employment-based system. Most prominently, the results are consistent with the hypothesis that employers screen employees to determine health risks, denying insurance to less healthy, high-risk employees, either by actuarially adjusting the premium for certain workers or by selecting workers for jobs based on certain attributes (Pauly, 1999). Although we do not completely discount the possibility that our results can be interpreted as evidence of a screening process, we think it unlikely. First, as discussed in more detail in Pauly (1999), there are legal restrictions on certain types of screening, such as reducing benefits to the disabled, women, or older workers. Second, there is little evidence that employers and insurers practice screening. Many companies provide domestic partner benefits, and insurance companies often pay for treatments that are considered experimental. Such behavior seems inconsistent with a screen for high-risk employees. Third, if these results were attributable to screening, a decline would be expected in the advantage of the insured in large firms compared with the insured in small firms, because large firms are more likely than small firms to practice community rating. To the contrary, there was no relationship between firm size and the health status gains from insurance. Finally, with unemployment at a 30-year low of 4 percent, employers may be more concerned about filling job vacancies than with trying to screen out a high-health-cost worker. Thus, the results seem more supportive of the human capital model of health insurance and health than of the screening model of health insurance and health.

Turning to the other variables in this health status model, as expected, age was found to have a significant negative influence on reported

⁴ *The effect of insurance on health status is not significant for men employed full time, full year in firms of 500–999 workers, and for full-time, full-year women employed in firms with fewer than 10 workers. Otherwise, all other differences for full-time, full-year workers were significantly different from zero. With respect to workers employed less than full time, full year, the differences were not significant in the firms with fewer than 10 employees, 25–99 employees, and 100–499 employees for men, and in firms with 10–24 employees and 1,000 or more employees for women.*

Table 3.3
Marginal Effects of Explanatory Variables on Health Status

Variable	Change in the Likelihood of Being Healthy (Percentage Point Difference Between Variable and Base Category)			
	Men		Women	
	full time, full year	less than full time, full year	full time, full year	less than full time, full year
Firm Size and Insurance Status				
Fewer than 10 employees and uninsured	–	–	–	–
Fewer than 10 employees and insured	8.0 ^a	2.4	2.0	4.4 ^c
10–24 workers and uninsured	0.7	–1.4	–0.2	5.5 ^c
10–24 workers and insured	4.2 ^b	8.3 ^a	4.3 ^c	4.8 ^c
25–99 workers and uninsured	0.5	4.6	–1.1	–1.8
25–99 workers and insured	6.3 ^a	6.8 ^b	3.8	2.7
100–499 workers and uninsured	–1.2	–3.5	–2.4	–1.3
100–499 workers and insured	6.5 ^a	–0.3	4.4 ^b	4.8 ^b
500–999 workers and uninsured	2.7	–6.5	–6.9	–3.8
500–999 workers and insured	5.8 ^a	6.7 ^c	4.0 ^c	6.6 ^b
1,000 or more workers and uninsured	3.3	–3.2	–1.4	0.7
1,000 or more workers and insured	6.0 ^a	2.0	2.2	2.1
Age (change from each additional year)	–0.8 ^a	–0.9 ^a	–0.7 ^a	–0.8 ^a
Marital Status				
Married	–	–	–	–
Widowed	–7.9 ^b	–26.3 ^a	0.8	2.7
Divorced	–4.2 ^a	–2.6	0.5	–5.0 ^a
Separated	–5.5 ^a	–2.4	1.7	–1.5
Never married	–5.3 ^a	–2.8 ^c	–2.2 ^b	–2.1
Family Income as a Percentage of Poverty				
Under 100% of poverty	–	–	–	–
100%–149% of poverty	1.3	–0.2	–1.8	1.6
150%–199% of poverty	2.8	1.2	2.2	6.2 ^a
200%–299% of poverty	3.1	4.5 ^c	7.2 ^a	6.6 ^a
300%–399% of poverty	4.9 ^b	5.4 ^b	7.7 ^a	11.5 ^a
400% or more of poverty	7.5 ^a	12.0 ^a	11.8 ^a	14.1 ^a
Education				
Less than high school	–	–	–	–
High school	6.6 ^a	6.7 ^a	9.0 ^a	7.3 ^a
College	13.8 ^a	15.6 ^a	15.7 ^a	18.0 ^a
Graduate degree	15.6 ^a	19.8 ^a	19.0 ^a	19.5 ^a
Race/Ethnicity				
White	–	–	–	–
Black	–6.9 ^a	–9.1 ^a	–8.6 ^a	–10.5 ^a
Hispanic	–3.7 ^a	–3.1 ^c	–5.5 ^a	–6.1 ^a
Other race	–8.7 ^a	0.7	–6.0 ^a	–5.7 ^a
Occupation				
White collar	–	–	–	–
Service collar	–2.4 ^a	–3.9 ^b	–3.1 ^a	–5.1 ^a
Blue collar	–5.2 ^a	–4.4 ^a	–4.2 ^a	–9.5 ^a

Source: Authors' estimates from the March 1999 Current Population Survey.

^aSignificant at the 1% level.

^bSignificant at the 5% level.

^cSignificant at the 10% level.

health status, increasing our confidence that reported health status reflects true health status. For about every additional 10 years of age, the probability of reporting being in excellent or very good health falls between 7 and 9 percentage points. Thus, although health status can be enhanced through investment in human capital, there is a natural decay in health status accompanying age, of which we are all painfully aware. Other results in table 3.3 reflect some of the health enhancing investments in human capital. The data show, for example, that high school graduates, college graduates, and those with graduate training report a significantly higher health status than those without a high school education. The health-improving benefits from education seem to peak with a college education, suggesting that these returns to education are subject to diminishing returns. This is not surprising. Health information access that might be attributable to more education, for example, is likely to be exhausted with a college education—unless one is trained as a physician.

It appears that marriage contributes to better health, especially for men employed full time, full year. This may be due to the fact that women generally make health care decisions for their families; they are more likely to go to the doctor than men and might have an influence on spousal behavior, although other reasons may exist as well (Sandman et al., 2000). Finally, the health status equation suggests that the lack of health care access for blacks, Hispanics, and other races is leading to lower health status, a result consistent with a number of previous studies (Braveman et al., 1989; Lieu et al., 1993; Pappas et al.; 1997; and Weissman et al., 1991). In general, the statistical results appear completely plausible and consistent with the human capital model of health insurance.

■ Earnings and Health Status Findings

As shown above in equation (2), it is assumed that earnings are affected by a worker's health status and other variables, denoted as m . Mincer (1974) and the research that has followed since 1974 have shown that earnings are mainly a function of education and experience, although they are affected by other variables. This section examines

how health status affects earnings, while controlling for other variables that have an independent effect on earnings. In order to implement this, a multivariate analysis on earnings is used, as shown with the following equation:

$$(4) \log(\text{Earnings}) = a + b_1 * (\text{Health Status}) + b_2 * (\text{Education}) + b_3 * (\text{Experience}) + \sum c_i m_i + \varepsilon,$$

where the dependent variable is measured as the natural logarithm of annual earnings, and b_1 , b_2 , and b_3 are parameters that describe the intensity of the relationship between the exogenous variables (health status, education, and experience) and earnings. Furthermore, c_i are the parameters that describe the relationship between earnings and other variables that influence earnings, and ε indicates the error term.

Because the natural logarithm of earnings is used to implement the multivariate analysis, the parameter b_1 , which measures the relationship between health status and earnings, does not equal $(\partial E / \partial H)$ from equation (3). Instead, b_1 represents $(\partial \log E / \partial E) * (\partial E / \partial H)$. In order to calculate the difference in earnings between any two groups, it is necessary to first predict earnings. The predicted earnings from any particular value for an independent variable can be derived from the following equation:

$$(5) \text{Earnings} = e^{[a + b_1 * (\text{Health Status}) + b_2 * (\text{Education}) + b_3 * (\text{Experience}) + \sum c_i m_i]}$$

where $e \approx 2.71828$.

Table 3.4 shows the explanatory variables included in the multivariate analysis on earnings and the change in earnings associated with various health status and firm size combinations, education, and age. In addition to the variables mentioned in equation (4), control variables are included for marital status, gender, race/ethnicity, hours of work, and industry. Age is used as a proxy for work experience. Furthermore, the measure of health status is combined with firm size. In general, the results are consistent with the basic human capital approach to explaining earnings and consistent with prior expectations. Earnings increase with age, but the rate of increase peaks at age 50 for full-time, full-year men and age 44 for full-time, full-year women because of the negative

Table 3.4
Marginal Effects of Explanatory Variables on Annual Earnings

Variable	Percentage Change in Annual Earnings Relative to Base Category			
	Men		Women	
	full time, full year	less than full time, full year	full time, full year	less than full time, full year
Firm Size and Health Status				
Fewer than 10 employees and bad health	—	—	—	—
Fewer than 10 employees and good health	11.9 ^a	17.7 ^a	10.1 ^a	10.6 ^c
10–24 workers and bad health	10.0 ^a	2.3	6.3 ^c	16.6 ^b
10–24 workers and good health	21.4 ^a	23.1 ^a	16.4 ^a	23.2 ^a
25–99 workers and bad health	15.4 ^a	20.7 ^a	7.4 ^b	18.4 ^a
25–99 workers and good health	27.7 ^a	38.7 ^a	20.9 ^a	30.9 ^a
100–499 workers and bad health	19.1 ^a	28.3 ^a	13.6 ^a	33.2 ^a
100–499 workers and good health	32.0 ^a	47.1 ^a	22.9 ^a	36.8 ^a
500–999 workers and bad health	21.3 ^a	35.5 ^a	11.0 ^a	41.8 ^a
500–999 workers and good health	32.8 ^a	42.9 ^a	27.1 ^a	43.7 ^a
1,000 or More workers and bad health	28.1 ^a	30.3 ^a	23.7 ^a	31.6 ^a
1,000 or More workers and good health	36.7 ^a	48.1 ^a	29.9 ^a	39.8 ^a
Age (change from each additional year)	6.0 ^a	16.1 ^a	5.4 ^a	10.3 ^a
Age–Squared	–0.1 ^a	–0.2 ^a	–0.1 ^a	–0.1 ^a
Marital Status				
Married	—	—	—	—
Widowed	–23.9 ^a	–17.9	–1.1	12.1
Divorced	–12.1 ^a	–26.0 ^a	0.6	22.7 ^a
Separated	–14.8 ^a	–22.0 ^b	–3.3	10.0
Never married	–19.3 ^a	–32.7 ^a	–1.4	12.1 ^a
Education				
Less than high school	—	—	—	—
High school	30.2 ^a	27.0 ^a	36.8 ^a	33.4 ^a
College	68.0 ^a	65.1 ^a	74.8 ^a	78.5 ^a
Graduate degree	96.0 ^a	85.8 ^a	96.4 ^a	124.2 ^a
Race/Ethnicity				
White	—	—	—	—
Black	–19.8 ^a	–31.8 ^a	–8.6 ^a	–7.4 ^c
Hispanic	–18.7 ^a	–11.0 ^a	–10.3 ^a	–5.6 ^c
Other race	–12.3 ^a	–13.8 ^b	–4.5 ^b	2.8
Industry				
Agriculture, forestry, fishing, mining, and construction	—	—	—	—
Manufacturing	2.6 ^b	–2.5	2.1	39.8 ^a
Wholesale and retail trade	–5.0 ^a	–30.4 ^a	–8.6 ^a	4.0
Personal service	–15.7 ^a	–45.2 ^a	–11.4 ^a	9.8
Public administration	–2.7	–34.3 ^a	1.8	7.1

Source: Authors' estimates from the March 1999 Current Population Survey.

^aSignificant at the 1% level.

^bSignificant at the 5% level.

^cSignificant at the 10% level.

Table 3.5
**Average Annual Earnings Gains from Health Insurance, Full-Time,
 Full-Year Workers, by Firm Size and Gender Workers Age 40
 With a High School Education^a**

	Total Gain in Average Annual Earnings due to Health Insurance ($\partial E/\partial I$)	Gain in Average Annual Earnings Due to Better Health ($\partial E/\partial H$)	Increase in Probability of Being in Excellent or Very Good Health Due to Health Insurance ($\partial H/\partial I$)
Males			
Fewer than 10 employees	\$301	\$ 3,785	8.0%
10–24 employees	141	3,999	3.5
25–99 employees	264	4,549	5.8
100–499 employees	381	4,984	7.6
500–999 employees	143	4,539	3.1
1,000 or more employees	97	3,578	2.7
Females			
Fewer than 10 employees	47	2,353	2.0
10–24 employees	113	2,502	4.5
25–99 employees	168	3,436	4.9
100–499 employees	167	2,460	6.8
500–999 employees	467	4,282	10.9
1,000 or more employees	64	1,786	3.6

Source: Authors' estimates of the 1999 Current Population Survey.

^aIncludes workers who are married, white, and employed in the manufacturing industry.

coefficient associated with age squared. Also earnings increase as education increases.

From this model, we predict that a healthy 40-year-old, male, with a high school degree, working full time, full year, in the smallest firm earns an average of \$33,654.⁵ In comparison, we predict that a worker with the same characteristics, with the exception that his health is not excellent or very good, has annual earnings of \$29,869. The difference in earnings between these two workers, \$3,785, is therefore due to the fact that one worker is healthier than the other.

Table 3.5 shows the difference in earnings for male and female workers with the above-mentioned characteristics. In general, the increased earnings associated with good health are substantial in all employment categories, suggesting that employment-based health insurance may be a good investment. In general, healthy men working full time, full year earn between \$3,500 and \$4,900 more per year than less healthy men. Similarly, healthy women working full time, full year earn

between \$1,700 and \$4,200 more than less healthy women. Of course, the goal of this analysis is to determine the returns to employment-based health insurance.

As indicated in the discussion of equation (3) above, the earnings gains from good health must be multiplied by the increased probability of attaining good health for those with health insurance to obtain the expected earnings gains from health insurance. These expected earnings gains are also shown in table 3.4 for men and women. In general, we find that the gain varies by firm size for both men and women. Specifically, it was found that the annual increase in earnings ranges from \$97 to \$381 for men working full time, full year and from \$47 to \$467 for women. Employment-based health insurance costs have been estimated to be \$2,127 for men and \$1,803 for women between the ages of 35 and 39 (Sheiner, 1999). Thus, in firms with 100–499 employees, expected gains in earnings attributable to health insurance account for 18 percent of the cost of insurance for males and for 9 percent of the cost of insurance for females.

If returns to health insurance are reasonably high, why is the market failing to provide health insurance coverage to many wage and salary

⁵ Age 40 is the average age of full-time, full-year workers in our sample.

Table 3.6
Average Annual Earnings Gains from Health Insurance, Part-Time or Part-Year Workers, by Firm Size and Gender, Workers Age 40 With a High School Education^a

Firm Size	Total Gain in Average Annual Earnings Due to Health Insurance ($\partial E/\partial I$)	Gain in Average Annual Earnings Due to Better Health ($\partial E/\partial H$)	Increase in Probability of Being in Excellent or Very Good Health Due to Health Insurance ($\partial H/\partial I$)
Males			
Fewer than 10 employees	\$ 81	\$3,396	2.4%
10–24 employees	404	4,157	9.7
25–99 employees	91	4,274	2.1
100–499 employees	157	4,846	3.2
500–999 employees	253	1,925	13.2
1,000 or more employees	245	4,648	5.3
Females			
Fewer than 10 employees	42	949	4.4
10–24 employees	(5)	681	-0.7
25–99 employees	57	1,253	4.6
100–499 employees	27	440	6.1
500–999 employees	26	251	10.4
1,000 or more employees	14	994	1.4

Source: Authors' estimates of the March 1999 Current Population Survey.

^aIncludes workers who are married, white, and employed in the manufacturing industry.

workers? Some workers may remain uninsured because the economic return to either employers or workers from providing insurance to them is too low. To make this point more vivid, we calculate expected earnings gains from good health, and expected earnings gains from employment-based health insurance programs for workers employed less than full-time full-year with the same basic characteristics as reported earlier. These estimates are reported in table 3.6. Although some of the net gains from insurance for workers employed less than full time, full year are substantial, many of the returns are very small, and in some cases close to zero.

Assuming that the nonearnings benefits of health insurance and the cost of health insurance are the same for workers employed less than full time, full year as they are for full-time, full-year workers, some part-time or part-year workers have a much lower rate of return from the purchase of health insurance. It may simply be that the purchase of health insurance is not a good investment for a substantial proportion of uninsured workers, particularly those in low-paying, part-time jobs.

Low earnings and shifting of insurance cost

present another problem for part-time, part-year workers. That is, insurance costs are such a large proportion of the part-time, part-year workers' earnings that they cannot afford to purchase health insurance by sacrificing earnings. In fact, minimum-wage laws usually make such sacrifices impossible. Low-income workers, then, may not be able to afford employment-based health insurance. Low incomes and low rates of return on health insurance may make limited purchases of routine medical care and dependence on public emergency care the only option available to low-income workers.

Table 3.7 presents findings for full-time, full-year male workers age 50 and full-time, full-year female workers age 44. As mentioned above, these ages represent the peak-earning year for male and female full-time, full-year workers in our sample. Overall the annual increase in earnings due to health insurance is much larger for workers at their peak earnings year than they are at the mean age of the sample. This may be due to the fact that the potential effects of health insurance are larger among older workers who are more likely to be less healthy than younger workers. However,

Table 3.7
**Average Annual Earnings Gains from Health Insurance,
 Full-Time Workers, by Firm Size and Gender Working Men Age 50
 and Working Women Age 44 With a College Education^a**

	Total Gain in Average Annual Earnings Due to Health Insurance ($\partial E/\partial I$)	Gain in Average Annual Earnings Due to Better Health ($\partial E/\partial H$)	Increase in Probability of Being in Excellent or Very Good Health Due to Health Insurance ($\partial H/\partial I$)
Males			
Fewer than 10 employees	\$464	5,838	8.0%
10–24 employees	218	6,169	3.5
25–99 employees	407	7,016	5.8
100–499 employees	588	7,688	7.6
500–999 employees	220	6,994	3.1
1,000 or more employees	149	5,519	2.7
Females			
Fewer than 10 employees	71	3,529	2.0
10–24 employees	169	3,754	4.5
25–99 employees	253	5,155	4.9
100–499 employees	251	3,690	6.8
500–999 employees	700	6,423	10.9
1,000 or more employees	96	2,680	3.6

Source: Authors' estimates of the March 1999 Current Population Survey.

^a Includes workers who are married, white, and employed in the manufacturing industry.

it should be noted that the expected gains in earnings attributable to health insurance account for 15 per-cent of the cost of insurance for males working in firms with 100–499 employees. This is not much different from the return presented for workers age 40 because expected health costs are higher for older workers.⁶ The results in this table, when compared with the results in tables 3.5 and 3.6, illustrate that the returns to health insurance will vary for workers with different characteristics.

■ Summary and Policy Implications

This analysis shows that there are substantial economic returns to employment-based health insurance that go beyond the basic purpose of insurance: to provide workers and their families with protection from financial losses that can accompany unexpected serious illness or injury.

The economic benefits of health insurance accrue because many of the insurance-paid purchases of health care are investments that increase workers' earnings. For the vast majority of American workers, the pure insurance benefits and the enhanced earnings benefits from employment-based health insurance may justify the investment in health insurance. However, low incomes and low returns to investments in health insurance appear to prevent the purchase of health insurance by the most economically disadvantaged workers.

As indicated, a large number of benefits from health insurance are not related to employment. There are public health gains from providing care to those who cannot afford care. And publicly provided care of last resort may be inefficient compared with privately provided care. In addition, there is suffering and loss of life attributable to lack of medical care. All this may make social insurance, employment-based or not, a good investment, but we have not yet estimated the social returns. Certainly they must be considered along with the economic gains discussed in this paper. In general, the greater the economic benefits such as those computed in this study, and the

⁶ Expected health costs were \$3,835 for men and \$2,332 for women ages 45–49 (Sheiner, 1999).

greater the benefits to society of universal coverage, the lower the net cost of any health care plan, whether provided through an employer or through a public program.

Although this study does not provide all the information that might be desired to implement wise public policy, there are important public policy implications that follow from this study. First, as is well understood, the public commitment to a fully employed economy benefits all. As more Americans are attached to the labor market and as part-time workers become full-time workers, spending on employee benefits such as health insurance increases, leading to higher rates of return for all. However, these results should not be generalized to the 44 million uninsured Americans, as their characteristics may be different from those of the general population. As a result, the potential return to insurance for the uninsured may be less than the average return for workers with insurance. Second, public investments in education complement investments in health, both of which ultimately have the effect of raising workers' earnings and public health in the long run.

■ References

- Braveman, P. G. Oliva, M.G. Miller, R. Reiter, and S. Egerter. "Adverse Outcomes and Lack of Health Insurance Among Newborns in an Eight-County Area of California, 1982 to 1986." *New England Journal of Medicine* 321 (1989): 508–513.
- Brown, M.E., A.B. Bindman, and N. Lurie. "Monitoring the Consequences of Uninsurance: A Review of Methodologies." *Medical Care Research and Review*. Vol. 55, no. 2 (June 1998): 177–210.
- Burstin, H.R., S.R. Lipsitz, and T.A. Brennan. "Socioeconomic Status and Risk for Substandard Medical Care." *Journal of the American Medical Association*. Vol. 268, (November 4, 1992): 2383–2387.
- Centers for Disease Control. "Self-Reported Use of Mammography and Insurance Status Among Women Aged Greater Than or Equal to 40 Years — United States, 1991–1992 and 1996–1997." *MMWR Weekly* (October 9, 1998): 825–830.
- Fronstin, P. "Employment-Based Health Insurance: A Look at Tax Issues and Public Opinion," *EBRI Issue Brief* no. 211 (Employee Benefit Research Institute, July 1999).
- _____. "Workers and Access to Health Care: Consequences of Being Uninsured." In this volume. 2000.
- Fronstin, P., and S.C. Snider. "An Examination of the Decline in Employment-Based Health Insurance Between 1988 and 1993." *Inquiry* 33 (Winter 1996/97): 317–325.
- Grossman, M. "On the Conception of Health Capital and the Demand for Health." *Journal of Political Economy*. Vol. 80 (March 1972): 223–255.
- Himmelstein, D.U., and S. Woolhandler. "Care Denied: U.S. Residents Who Are Unable to Obtain Needed Medical Services." *American Journal of Public Health*. Vol. 85 (1995): 341–344.
- Holtmann, A.G., and T. L. Idson. "Information, Employer Size, Training and Wage Growth." *Eastern Economic Journal*. Vol. 21 (Spring 1995): 187–196.
- Holtmann, A.G., and E.O. Olsen. *The Economics of the Private Demand for Outpatient Health Care*. DHEW Publication No. (NIH) 78-1262. John E. Fogarty International Center for Advance Studies in Health Science, 1978.
- Institute of Medicine. *Employment and Health Benefits: A Connection at Risk*. M. J. Field and H.T. Shapiro, eds. Washington, DC: National Academy Press, 1993.
- Lieu, T.A., P.W. Newacheck, and M.A. McManus. "Race, Ethnicity, and Access to Ambulatory Care Among U.S. Adolescents." *American Journal of Public Health*. Vol. 83 (1993): 960–965.
- Mincer, J. *Schooling, Experience, and Earnings*. New York, NY: National Bureau of Economic Research, 1974.
- Newhouse, J.P., and The Insurance Experiment Group. *Free for All? Lessons from the RAND Health Insurance Experiment*. Cambridge, MA: Harvard University Press, 1993.
- Pappas, G., W.C. Hadden, L.J. Kozak, and G.F. Fisher. "Potentially Avoidable Hospitalizations: Inequalities in Rates Between U.S. Socioeconomic Groups." *American Journal of Public Health*. Vol. 87 (1997): 811–816.
- Pauly, M., and B. Herring. *Pooling Risk Health Insurance Risks*. Washington, DC: AEI Press, 1999.

Sandman, D., E. Simantov, and C. An. *Out of Touch: American Men and the Health Care System*. New York, NY: The Commonwealth Fund, March 2000.

Sheiner, L. "Health Care Costs, Wages and Aging." Stop 83. Washington, DC: Federal Reserve Board of Governors, 1999.

Weissman, J.S., R. Stern, S.L. Fielding, and A.M. Epstein. "Delayed Access to Health Care: Risk Factors, Reasons, and Consequences." *Annals of Internal Medicine*. Vol. 114 (February 15, 1991): 325-331.

Health Insurance, Employment, and Health Status: Results From the California Work and Health Survey

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■ Introduction

Most of us believe that health insurance plays a critical role in making health services accessible. Many of us believe, in turn, that health services play a critical role in the health of the population. Evidence to support the first proposition is plentiful and includes the results of innumerable observational studies (Newhouse, 1978; National Center for Health Statistics, 1998; Schauffler and Brown, 1999; 2000) and the findings from a large randomized trial, the RAND Health Insurance Experiment (Newhouse et al., 1981).

Evidence to support the second proposition is, at best, ambiguous. In a noted study, the British physician and epidemiologist Thomas McKeown (1976) observed that almost all of the increase in life expectancy preceded the advances in medical care that were thought to extend life, including the use of antibiotics, and was no doubt due to such simple measures as improving the safety of the food and water supplies and waste removal (for the U.S. evidence, see McKinlay and McKinlay, 1977). A more contemporary version of this argument holds that the principal determinants of contemporary health status are the extent to which resources are equitably distributed (Wilkinson, 1996), the extent to which individuals adapt healthy behaviors—smoking cessation, limited alcohol consumption, adoption of exercise (Jarvis and Wardle, 1999)—and the extent to which the quality of the air, water, and work environment are maintained (Yen and Kaplan, 1999a; 1999b).

However, in a famous rejoinder to McKeown's argument that medical care was not

crucial to the health of the population, an American physician, Walsh McDermott (1978), argued that the function of medical care was as much to improve the quality of life as to extend its length. Seen in this light, the provision of joint replacement, bypass surgery, and other such procedures are valued as much for giving life to years as years to life. Moreover, in a few instances, results from the RAND Health Insurance Experiment suggest that the provision of insurance is consistent with better health outcomes (Brook et al., 1983; Keeler et al., 1985); it should be pointed out that the latter studies minimize the probability of finding an effect since those without insurance were limited to \$1,000 in expenditures in a year. Ascertaining the impact of health insurance on health status may be more timely now, because the proportion of the population with health insurance is at best stagnant or may be declining slightly, as is the proportion with an employment-based policy (Schauffler and Brown, 2000; McDonnell and Fronstin, 1999).

This analysis is designed to provide evidence on both propositions: the extent to which the provision of health insurance improves the accessibility of medical care and the extent to which the provision of health insurance affects health status one year later. In addition, we will evaluate whether any association between health insurance coverage and health status differs for those receiving their coverage from an employment-based plan versus those who receive it through a privately purchased or public plan and for those who are actually employed versus those who are not. The latter distinction is an important one because evidence is mounting that employment has

a protective effect on health status (Wilkinson, 1996), suggesting that it may be employment rather than the provision of employment-based insurance that confers a health benefit. However, since the spouse of a worker may receive employment-based insurance without being employed, it is possible to provide estimates separately of the two sets of effects. Finally, we will assess whether the impact of unemployment or job loss on health status is due to the presence or absence of health insurance.

The data for these analyses derive from the California Work and Health Survey (CWHS). The CWHS is funded as part of the Work and Health Initiative of the California Wellness Foundation. This initiative began with the hypothesis that a good job may be the best health policy, and has sought to prove the hypothesis through research and demonstration projects designed to improve the employability of vulnerable populations (including those without technical skills and displaced workers), to extend the reach of health insurance coverage, and to provide statistical evidence for the connection among the kind and extent of employment, health insurance, and health status. The CWHS fulfills the latter mission.

■ Methods

Data Source

The CWHS is a longitudinal study that began in 1998. In that year, 1,771 working age adults were interviewed, of whom 1,500 were from a random-digit dial sampling frame, while the remaining 271 were from oversamples of African-Americans, Asian/Pacific-Islanders, or persons with limitations in activities as a result of long-term physical or mental impairments. The 1999 CWHS included 2,044 adults, of whom 913 were part of the 1998 CWHS, 700 were from a new random-digit sample, and the remainder were from oversamples of the same three groups as in 1998 as well as persons ages 45–70. All together, the CWHS has included 2,902 respondents.

The CWHS survey assesses current and past employment status and, among those working, the nature of their current principal job. In addition, it collects information on the presence of chronic conditions, ability to function, health behaviors, and presence of health insurance, by

type. A more thorough description of the sampling methodology and content of the questionnaire and a summary of the results from both 1998 and 1999 may be found on the CWHS Web site, <http://medicine.ucsf.edu/programs/cwhs/>.

Measures

In the CWHS, respondents report whether they currently have health insurance. Those who do not indicate whether they have had insurance in any of the past 12 months. Those who do have insurance report its source: an employment-based policy through one's own employment or through a spouse's policy, a privately purchased policy, or a public program such as Medi-Cal, California's Medicaid.

The CWHS includes these principal measures of access to medical care: whether the respondent has seen a physician in the past year or in the past three years or has a regular source of care, and the number of physician visits in the past 12 months.¹

Health status measures in the CWHS include whether the respondent reports fair or poor health status (vs. excellent, very good, or good status), reports greater than the 75th percentile of days spent in bed for health reasons, reports two or more chronic conditions, has a high level of depressive symptoms as measured by the Geriatric Depression Scale (Sheikh and Yesavage, 1986), or is limited in major activities.

In the CWHS, employment status is measured using items from the Current Population Survey, the source of monthly federal employment data. Accordingly, persons who were working in the first year of the survey by this measure but had left work as of the second year are said to have lost their jobs.

Analyses

In all of the analyses described here, we limit our analysis to persons who were no more than age 65 when interviewed for the CWHS (we also elimi-

¹ *The number of physician visits in the past 12 months have been capped at three standard deviations above the mean to preclude the effect of a few outliers on the results, a strategy common in studies of access to medical care.*

nated persons younger than age 65 who receive Medicare because they are disabled recipients of Social Security Disability Insurance). We begin by using contingency table analysis to compare the health status of persons with and without health insurance, as well as the health status of persons with each kind of insurance, to those without insurance. This cross-sectional analysis is accomplished by pooling new respondents to the CWHHS in each of the two years it has been conducted to increase the sample size. To ascertain whether any differences in health status may be due to factors other than health insurance coverage, we estimate logistic regression models of the health status measures that include the following characteristics as well as the insurance variables: age, gender, race, Hispanic status, level of education, whether someone lives in an urban or rural environment, immigrant status, marital status, and whether there are children in the household. For both the contingency table and logistic regression analyses, the chi-square statistic provides an indication of whether insurance status affects each health outcome.

The analysis of the impact of insurance status on the access measures proceeds in the same fashion: contingency table analysis among the pooled respondents to the CWHHS in either year to establish whether insurance status is associated with access, followed by logistic regression to establish whether the association remains after taking other factors into account. In addition, we use a t-test (for the bivariate association) and weighted least squares regression (for the multivariate) to estimate the impact of health insurance status on the number of physician visits. In both the logistic and weighted least squares models, the independent variables other than insurance status are the same as in the analysis of the impact of health insurance on health outcomes.

In the third set of analyses, we limit our analysis to those individuals interviewed in both 1998 and 1999 and use logistic regression to ascertain whether insurance status in the former year affects health status in the latter. In these estimations, the independent variables other than health insurance status are the same as in the cross-sectional analysis of health insurance and health status outlined above. In order to determine whether the relationship between health insurance

status in 1998 and health status in 1999 differs by employment status, we estimate three additional sets of logistic regression models: in the first, we include a variable indicating whether the respondent was employed in 1998; in the second, we limit the analysis to those who were employed in 1998; and in the third, we limit the analysis to respondents who were not working in that year.

In a previous analysis (Yelin and Trupin, 1999), we established that persons who lost their jobs in the year prior to the interview or in the three years prior to the interview were more likely to sustain a worsening in their health status. The present analysis extends that line of inquiry by ascertaining via logistic regression whether the worsening in health is associated with the absence of health insurance for an entire year or part of a year. The latter analysis is limited to persons who worked at some point in the three years prior to the 1998 interview and who were, therefore, at risk for work loss. The independent variables other than insurance status are the same as in the analyses outlined above.

■ Findings

Cross-Sectional Association Between Health Insurance and Health Status

Table 4.1 presents the evidence that persons with health insurance differ in health status from those without when other factors are not taken into account. Compared with persons without insurance, those with insurance are about two-thirds as likely to report being in fair or poor health (12.9 percent vs. 18.5 percent) and just slightly more than half as likely to report high levels of depressive symptoms (6.2 percent vs. 10.9 percent). However, the two groups do not differ significantly in the proportions reporting three or more bed days in the year prior to interview (23.1 percent among persons with insurance versus 20.8 percent among those without) and in the proportion reporting limitations in activities (16.3 percent and 13.6 percent of the two groups, respectively, reported such limitations). Differences between persons with and without insurance in the proportion reporting fair or poor health and high levels of depressive symptoms were even more pronounced when the analysis was limited to persons who were employed. Thus, among those who were employed, persons

Table 4.1
Health Outcomes by Insurance Status for all Persons and for Currently Employed Persons, CWHS—Pooled 1998 and 1999 Baseline Interviews

Four Category Insurance Variable	Insurance Status					
	Total	Any insurance	Employer-based	Public source	Other private	None
All Persons (sample n)	2,339	1,760	1,387	163	210	579
Population (in 1,000s)	19,655	14,550	11,398	1,270	1,882	5,105
Percentage of Respondents:						
In fair/poor health	13.4	12.9 ^a	9.3 ^a	38.7	6.7	18.5
employed only	9.1	7.5 ^a	7.4 ^a	7.7	3.6	16.2
With 3+ bed days in past year	22.3	23.1	22.0	30.6	22.7	20.8
employed only	21.3	21.0	21.3	20.3	24.3	20.3
With high depressive symptoms	7.2	6.2 ^a	4.7 ^a	16.3	6.1	10.8
employed only	4.7	3.7 ^a	3.6 ^a	4.0	4.0	8.2
With activity limitations	12.6	16.3	10.4 ^b	31.5	10.4	13.6
employed only	8.8	11.2	8.2	13.6	9.2	9.7
Percentage Ever Diagnosed With:						
Arthritis	10.4	14.3	10.9	15.7	8.6	8.7
employed only	8.7	11.6	9.5	8.1	6.2	7.4
Back problems	22.7	25.3	22.3	28.3	21.7	22.5
employed only	22.1	24.3	22.1	23.0	21.8	21.8
High blood pressure	13.6	16.9 ^b	14.2 ^b	19.4	13.8	10.7
employed only	12.2	14.9 ^b	13.4 ^b	10.1	11.7	9.2
Migraines	11.9	12.7	12.0			11.6
employed only	10.2	12.0 H	10.7 H			7.8
2+ chronic conditions ^c	26.7	31.3	26.9	37.0	22.9	25.1
employed only	24.3	27.9	25.1	19.5	22.8	22.8

Source: Edward Yelin and Laura Trupin.

^ap < .01 H < .10 for statistical test of any insurance and employer-based insurance (vs. none).

^bp < .05

^c Includes repetitive strain injuries, heart disease, diabetes, cancer, asthma, chronic lung disease, ulcers, and kidney or bladder disease, along with the four conditions included here.

with insurance were less than half as likely as those without to report fair or poor health (7.5 percent versus 16.2 percent) and high levels of depressive symptoms (3.7 percent versus 8.2 percent).

After controlling for demographic characteristics in multivariate analyses, the relationship between health insurance status and having a high level of depressive symptoms remained significant; the relationship between the presence or absence of insurance and reporting fair or poor health did not. This suggests that characteristics of the individual that are correlated with health insurance status accounted for its impact on the probability of reporting fair or poor health. The characteristics that increased the probability of reporting this outcome include increasing age; female gender; being an African-American, a Latino, or an immigrant; being widowed, separated, or divorced; and having low levels of education.

Persons with health insurance are a

heterogeneous group, including the more than three-quarters who report receiving employment-based health insurance through their own employment or that of another family member, the approximately 10 percent who receive it through a policy they purchase privately, and the similar proportion who receive it through a public source—principally Medi-Cal, California’s Medicaid program. The latter group is more likely to report adverse health on all measures than those receiving employment-based insurance or having a privately purchased policy or than those without insurance, for that matter. When persons with insurance from a public source are eliminated from the analysis, persons with employment-based insurance are significantly less likely to report fair or poor health, high levels of depressive symptoms, and limitations in activities than those with no health insurance.

Among the employed, persons with employ-

ment-based policies are significantly less likely to report fair or poor health and high levels of depressive symptoms than those without insurance (but not, as in the analysis of the entire sample, limitations of activity).

Because the relationship between having employment-based health insurance and the probability of reporting fair or poor health and high levels of depressive symptoms is of the same magnitude and direction when limiting the analysis to the employed as when including the entire working age population, the association cannot be said to be an artifact of being employed.

Similarly, the relationship between having employment-based health insurance and the probability of reporting adverse health outcomes remained after controlling for other characteristics that might affect health status, suggesting that the association between employment-based health insurance and health outcomes is not due to those other characteristics (multivariate results not in table).

Table 4.1 also shows the relationship between having insurance (or having insurance from a specific source) on the probability of having received a diagnosis of several common chronic conditions—arthritis, back problems, high blood pressure, or migraines—or reporting a total of two or more chronic conditions from a list of 13. Perhaps because one cannot report having received a diagnosis without having been to a physician, persons without insurance are significantly less likely to report having received a diagnosis of high blood pressure as those with insurance (10.7 percent of the former, but 16.9 percent of the latter reported a diagnosis of high blood pressure). Despite being more likely to be in fair or poor health, the uninsured do not differ significantly from those with insurance in the proportion reporting a diagnosis of arthritis, back problems, migraines, or having two or more chronic conditions simultaneously.

■ Cross-Sectional Association Between Health Insurance Status and Health Access

In this analysis, we estimate the impact of health insurance status (or source of health insurance) on the probability that the respondents to the Califor-

nia Work and Health Survey will report no medical visits in the past one or three years or that they have no regular source of care. We also estimate the impact of health insurance status (or source of coverage) on the number of physician visits in the 12 months prior to interview. Not surprisingly, health insurance would appear to be more strongly related to these measures of access than to overall health status. Thus, persons with health insurance are less than half as likely as those without to report no medical visits in the past year (13.0 percent of the former group versus 31.3 percent of the latter report no visits during this time frame, table 4.2), and they are about a quarter as likely to report no visits in the past three years (2.8 percent versus 10.5 percent). Finally, persons with insurance are less than a third as likely to state that they do not have a regular source of care as those without health coverage (16.6 percent versus 51.8 percent).

Recall from table 4.1 that persons with health insurance coverage from a public source are much more likely to report several adverse health outcomes than those with employment-based or privately purchased insurance. However, those with health insurance coverage from a public program are about as likely as persons with employment-based or privately purchased insurance to report not having had medical care visits in the past one or three years. They are more likely to state that they do not have a regular source of care, but even so, they are less than half as likely to do so as persons without insurance.

The impact of having health insurance on the foregoing access measures remains strong when the analysis is limited to persons who are currently employed, suggesting that the effect of insurance is independent of employment status. In addition, the impact of having insurance remained strong even after controlling for demographic characteristics in a multivariate model, again suggesting that the impact of health insurance on access is not due to the kinds of persons who report insurance but, instead, is due to the insurance itself (multivariate results not in table). Finally, adding variables measuring health status to the multivariate models that include demographic characteristics has no effect on the association of health insurance and the access measures, consistent with the hypothesis that health insurance has a strong effect on access

Table 4.2
Health Access by Insurance Status and Employment Status CWHS—
Pooled 1998 and 1999 Baseline Interviews

Four Category Insurance Variable	Insurance Status					
	Total	Any insurance	Employer-based	Public source	Other private	None
All Persons (sample n)	2,339	1,760	1,387	163	210	579
Population (in 1,000s)	19,655	14,550	11,398	1,270	1,882	5,105
Percentage of Respondents:						
With no medical visits in 1+ years	17.5%	13.0% ^a	13.2%	10.8%	13.3%	31.3%
employed only	17.5	13.6	13.7	11.1	13.1	32.3
With no medical visits in 3+ years	4.7	2.8	2.9	1.3	3.6	10.5
employed only	4.5	2.6	2.7	–	2.5	11.7
With no regular source of care ^b	25.3	16.6	15.7	22.8	17.9	51.8
employed only	23.2	15.7	15.6	16.2	16.4	50.7

Source: Edward Yellin and Laura Trupin.

^aAll statistical tests for the difference in access variables between insurance status or the individual categories of insurance are statistically significant at $p < .01$.

^bIncludes 36 respondents who state that their regular source of care is a hospital emergency department and 10 who report never visiting a medical provider.

to medical care independently of the extent of medical need.

Persons without health insurance reported fewer physician visits in the 12 months prior to interview than those with insurance, an effect not due to their demographic or medical characteristics and not affected by those with an extremely large number of visits (data not in table). In analyses comparing those with specific kinds of insurance versus those without any coverage, persons with employment-based and public insurance had a significantly greater number of physician visits than those without insurance, but persons with a privately purchased plan did not. These effects were also not dependent on the demographic or medical characteristics of the respondents or on the utilization of those with an extremely large number of visits.

■ Longitudinal Impact of Health Insurance Status on Worsening Health

The cross-sectional association between health insurance and health status is probably the result of those without health insurance experiencing poorer health because their medical conditions do not receive treatment, but one cannot rule out the alternative hypothesis: that health plans attract

healthy individuals or shun unhealthy ones or that some independent factor—higher socioeconomic status, for example—simultaneously determines who is to receive coverage and who experiences good health. However, in a longitudinal study, it is possible to ascertain that a change in health insurance coverage preceded a change in health status, in effect increasing the probability that the health impact is due to the insurance itself.

In the analyses conducted for this paper, we developed several sets of models to test the impact of health insurance coverage in the year prior to the 1998 CWHS interview on the probability that an individual experienced a worsening of health in the subsequent year; these analyses were limited to persons who reported that they were in excellent, very good, or good health in 1998 and included demographic characteristics that independently could affect the probability of worsening health. The results of the analyses are uniformly consistent with the view that the absence of health insurance coverage results in worsening health, but the magnitude of the effect is small (perhaps as a function of the short passage of time) and not statistically significant. Thus, compared with persons with health insurance in 1998, those without are more likely to report being in fair or poor health in 1999; similar results were obtained when we evaluated the impact of having employment-based insurance, or coverage from a public

program or privately purchased health plan versus having no insurance. Similar results were also obtained when we included 1998 employment status in the analyses, suggesting that the impact of health insurance on the probability of worsening health is not due to employment, but rather stems from the insurance itself. The magnitude of the impact of having health insurance or having specific kinds of insurance versus not having any was not affected when we limited the analysis to those who were employed when interviewed in 1998 or when we limited the analysis to those who were not employed at that time.

Although all of the above analyses yielded results consistent with the notion that not having health coverage in one year was associated with a worsening of health status as of the next, it should be emphasized again that in no instance was the effect of health insurance statistically significant. Thus, we should interpret the findings with caution, perhaps concluding that, at best, there was an insignificant trend in the data that the passage of time might render significant as the potentially adverse consequences of not having insurance accumulate.

Two other findings bear mention. There was no evidence to support the notion that one form of insurance was more or less likely to result in a worsening of health status. And, although having health insurance coverage in 1998 was not *significantly* related to the probability of reporting worsening health by 1999, several other characteristics *were* related to this probability in most of the analyses, including increased age, being an African-American, and having lower levels of education.² Seen in this context, health insurance status plays a much less important role than these other factors in determining the probability that one's health will worsen.

■ Is the Longitudinal Impact of Losing One's Job Due to the Loss of Health Insurance?

In the 1998 California Work and Health Survey, we asked the respondents who had worked at some point in the three years prior to interview to report whether they had lost a job during this time or in the year prior to the interview. As previously reported (Yelin and Trupin, 1999), those who had

lost a job were twice as likely as those who had not to experience a worsening in their health status as of the 1999 interview. For this paper, we refined the former analyses to ascertain whether the lack of health insurance for part or all of the year between the 1998 and 1999 interviews could account for the impact of job loss on the likelihood of experiencing worsening health. We could find no evidence consistent with the hypothesis that health insurance accounts for the relationship between job loss in the year or three years prior to the 1998 interview and the probability of worsening health, even when we eliminated persons who were consistently uninsured. Thus, the lack of health insurance is not the reason that those who lose their jobs sustain a worsening in their health status.

■ Summary and Conclusions

The results of the analyses of the California Work and Health Survey presented here indicate that:

- Persons without health insurance are more likely to report fair or poor health and a high level of depressive symptoms than those with insurance.
- With persons receiving insurance from a public program eliminated from the analysis, those receiving coverage from an employment-based policy are less likely to report fair or poor health, high levels of depressive symptoms, and activity limitation than persons without insurance. This relationship would not appear to be due to employment, since respondents who are employed and report employment-based insurance are also less likely to report fair or poor health and high levels of depressive symptoms. The relationship also would not appear to be due to other demographic characteristics.
- However, with respect to health status, we could discern no clear advantage or disadvantage of having an employment-based versus a privately purchased health plan.
- Persons with health insurance are less likely to report not having seen a physician in the past

² Lower levels of education were associated with an increased probability of worsening health in all models tested except those limited to persons not employed in 1998; age and being an African-American were associated with this outcome in all models that included both the employed and unemployed simultaneously.

year or three years and not to have a regular source of care than persons without coverage. The impact of health insurance on these access measures does not differ by the type of coverage, however.

- Persons without health insurance reported significantly fewer physician visits in the year prior to interview than those with insurance; persons with employment-based and public insurance reported a significantly greater number of visits than those without insurance, but persons with a privately purchased plan did not.
- The absence of health insurance coverage for any or all of the year prior to the 1998 CWHHS interview is associated with an increased probability of worsening health by 1999, but the magnitude of the effect is small and not statistically significant. The effect of insurance on health outcomes does not differ among the different sources of insurance—employment-based, privately purchased, or a public program.
- The impact of job loss on the probability of experiencing a worsening of health is independent of whether or not an individual has health insurance.

In the analyses of the California Work and Health Survey reported here, persons with health insurance are unambiguously healthier than those without. Net of the persons receiving coverage from a public program who are much less healthy, those receiving insurance from employment or a privately purchased plan are especially healthier than persons without insurance. Regardless of the form of insurance, those with coverage are less likely to report problems with health access.

While it is clear that persons with employment-based and privately purchased health coverage are healthier than persons without insurance, the evidence that the insurance itself accounts for the health differences is ambiguous. The finding that those with insurance are healthier than those without held when the analysis is limited to the employed is consistent with the hypothesis that it is the insurance, not the fact of employment, that accounts for the relationship. However, the finding that the longitudinal relationship between lacking insurance and reporting a worsening in health status is a weak and statistically insignificant one

suggests that any effect of insurance may be small, as does the finding that health insurance does not account for the impact of job loss in one year on health status the next. It is possible that the weak relationship between health insurance status and worsening health is an artifact of small sample size in the longitudinal analyses or that small effects may become larger as the adverse consequences of lacking insurance take effect.

Nevertheless, we are left to conclude that the results reported here show that persons lacking health insurance coverage experience poorer health and poorer access to care, but that it is too early to tell whether the lack of insurance accounts for the poorer health. We are also left to conclude that persons with employment-based and privately purchased plans do not differ on most measures of health status or access, that those with insurance from public programs do achieve relatively good access to care, but that the latter group is even less healthy on many measures than persons without insurance.

■ References

- Brook R., J. Ware, W. Rogers et al. "Does Free Care Improve Adults' Health?" *New England Journal of Medicine*. Vol. 309 (1983): 1426–1434.
- Jarvis M., and J. Wardle. "Social Patterning of Individual Health Behaviors: The Case of Cigarette Smoking." In M. Marmot and R. Wilkinson, eds., *Social Determinants of Health*. New York: Oxford University Press, 1999.
- Keeler E., R. Brook, G. Goldberg et al. "How Free Care Reduced Hypertension in the Health Insurance Experiment." *Journal of the American Medical Association*. Vol. 254 (1985): 1926–1931.
- McDermott, W. "The Health Impact of the Physician." *American Journal of Medicine*. Vol. 65 (1978): 569–571.
- McDonnell, K., and P. Fronstin. *EBRI Health Benefits Databook*. Washington, DC: Employee Benefits Research Institute, 1999, p. 72.
- McKeown, T. *The Role of Medicine: Dream, Mirage, or Nemesis*. London: Nuffield Provincial Hospitals Trust, 1976.
- McKinlay, J., and S. McKinlay. "The Questionable Contribution of Medical Measures to the Decline of Mortality in the United States in the Twentieth Century." *Milbank Memorial Fund Quar-*

- terly: *Health and Society*. Vol. 55 (1977): 405–428.
- National Center for Health Statistics. *Health: United States, 1998*. USDHHS Publication 98-1232. Hyattsville, MD: National Center for Health Statistics, 1998, pp. 124–137.
- Newhouse, J. *The Economics of Medical Care*. Reading, MA: Addison-Wesley, 1978.
- Newhouse J., W. Manning, C. Morris et al. “Some Interim Results from a Controlled Trial of Cost Sharing in Health Insurance.” *New England Journal of Medicine*. Vol. 305 (1981): 1501–1507.
- Schauffler H., and E. Brown. *The State of Health Insurance in California, 1998*. Berkeley, CA: University of California Center for Health and Public Policy Studies; and Los Angeles, CA: University of California Center for Health Policy Research, 1999.
- _____. *The State of Health Insurance in California, 1999*. Berkeley, CA: University of California Center for Health and Public Policy Studies; and Los Angeles, CA: University of California Center for Health Policy Research.
- Sheikh, J., and J. Yesavage. “Geriatric Depression Scale: Recent Evidence and Development of a Shorter Version.” *Clinical Gerontology*. Vol. 5 (1986): 165–173.
- Wilkinson, R. *Unhealthy Societies: The Afflictions of Inequality*. New York: Routledge, 1996.
- Yelin E., and L. Trupin. *Who Succeeds and Who Fails in the New World of Work*. <http://medicine.ucsf.edu/programs/cwhs/1999/dayone/report.html>.
- Yen, I., and G. Kaplan. “Neighborhood Social Environment and Risk of Death: Multilevel Evidence from the Alameda County Study.” *American Journal of Epidemiology*. Vol. 149 (1999a): 898–907.
- _____. “Poverty Area Residence and Changes in Depression and Perceived Health Status: Evidence from the Alameda County Study.” *International Journal of Epidemiology*. Vol. 28 (1999b): 90–94.

Health Management for the Insured and the Uninsured

by Dee W. Edington, Health Management Research Center, University of Michigan

■ Introduction

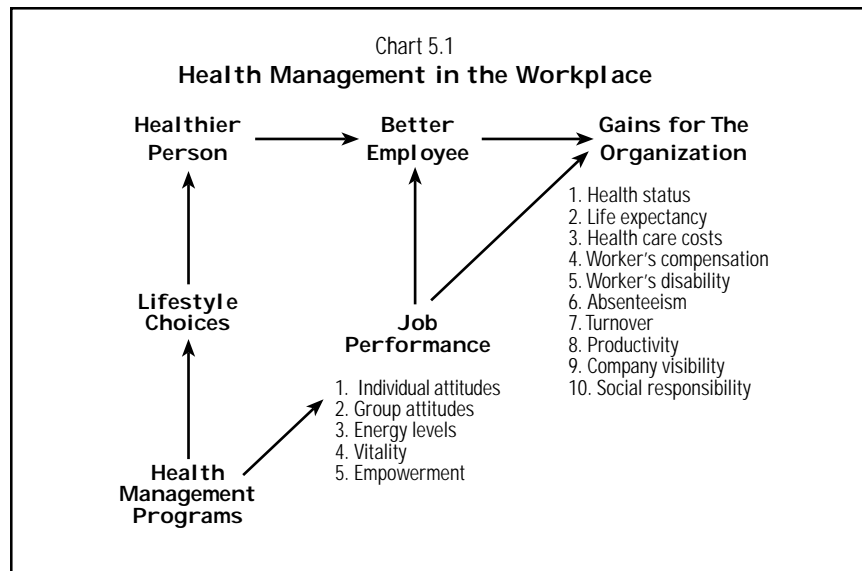
There is more than one approach to the management of the consequences of poor health status. The purpose of this analysis is to discuss the rationale for insuring the health of workers, with or without health insurance, and the consequences of such a Health Management approach. That is, can health risk management add value to the overall strategy for health care management?

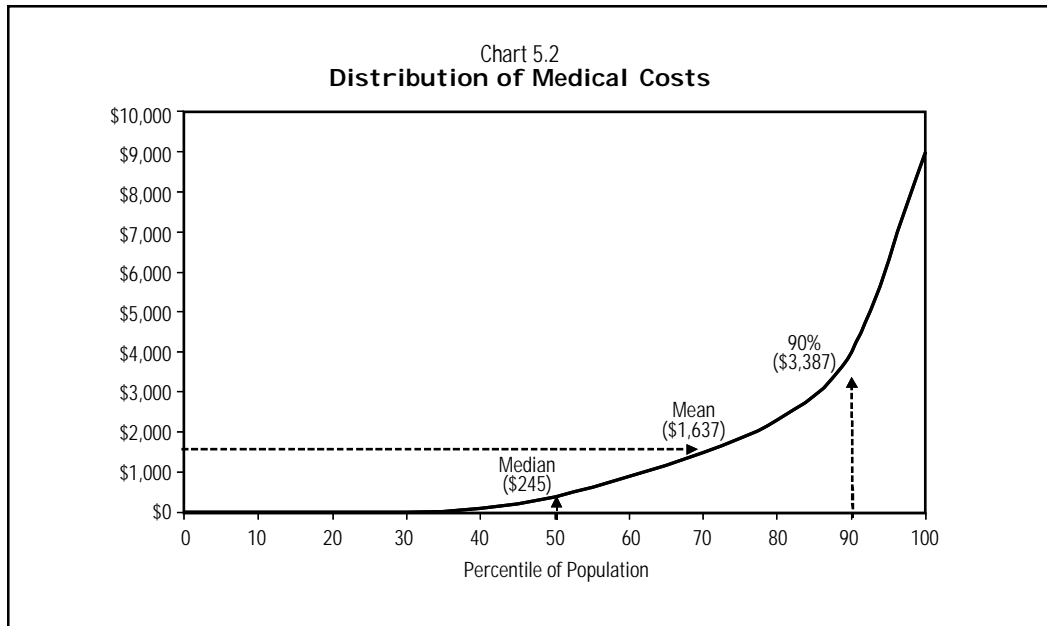
The data in this analysis come from the experience of the seven major corporations in the University of Michigan Health Management Research Center (UMHMRC) Corporate Consortium. The longitudinal data extend from seven to 18 years and include nearly two million covered lives. In the experience of these companies, health risk management programs costs between \$10 and \$100 per year per employee whereas health care

insurance per contract is approximately \$6,000.

The objectives of the paper are 1) to examine the natural flow of a population in terms of health care costs and health risks and behaviors and 2) to examine low-risk maintenance and high-risk reduction as important strategies in managing the health of a population. The focus of the discussion is health care costs, but it could be productivity, absenteeism, or short-term disability since the data are nearly as convincing and add to the economic return to Health Management strategies.

The basic model for Health Management is shown in chart 5.1: healthier people are better employees, who result in gains to the organization. The basic premise is that health management programs impact the health of employees; however, it may be that people also feel better about the organization. The primary outcome measure is, of course, health. Are people feeling good? Are they





working well? Are they doing the right thing? We measure health in terms of health care costs, worker's compensation, worker's disability, absenteeism, or productivity.

Health Care Costs

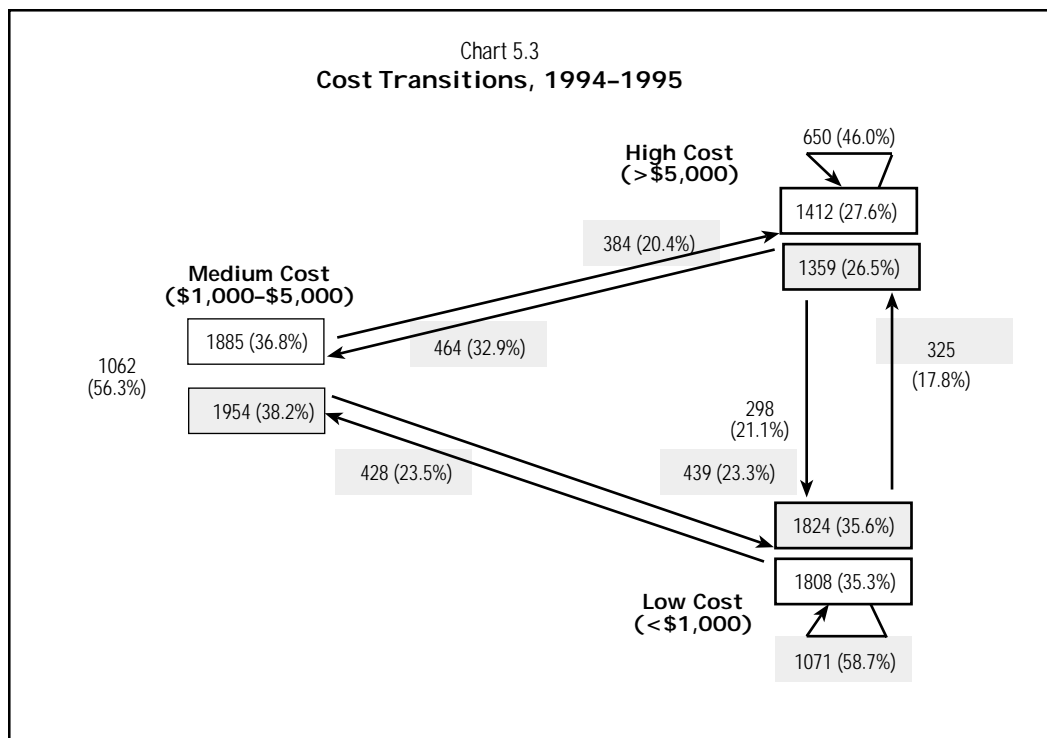
The distribution of health care costs for any population is illustrated in chart 5.2. Most of the population is very low cost, with a minority of the population with much higher costs. Fifty percent of this particular corporate population is less than \$245 but the mean of the population is \$1,637 due to the higher-cost individuals. Many organizations are now experiencing average costs of over \$2,000. Opportunities to manage costs are in working with the low-cost and high-cost individuals. The traditional approach has been to concentrate program strategies on the high-cost opportunity. Our 20 years of experience now tells us that you have to do both, but the primary opportunity is to ensure that the low-cost people stay low-cost.

The data in chart 5.3 illustrate a technique to examine health care costs over time, designated as cost transitions. The specific data in this figure are the costs of a population of 55–64 year-old men with no history of disease. We have similar data for other age groups and for women. In 1994, 27 percent of the cohort cost more than \$5,000 for health care, 36 percent cost \$1,000 to \$5,000, and 35 percent cost less than \$1,000. For these same men in

1995, the distribution was 26 percent, 38 percent, and 35 percent, respectively. At first glance you would conclude there was no change: a steady state situation. What did not change is that some of the people that were high-cost (46 percent) stayed high-cost. Some of the people who were medium-cost (56 percent) stayed medium-cost, and nearly 60 percent of the people who were low-cost stayed low-cost.

But what did change? The interesting part of chart 5.3 is in examining what happened to the individuals who changed cost categories. For some of them, the system actually worked and they went from high-cost to medium-cost or medium-cost to low-cost or some of them high-cost to low-cost. So we can conclude the system working well. However, upon further examination you see there were some people going the other way: from low-cost to high-cost or medium-cost to high-cost.

Chart 5.3 represents what we call the natural flow. Since we have had a relatively stable health care system for many years, these transitions represent a steady state. Without an intervention the population will continue to flow through these cycles. To impact health care costs or utilization or health status, you need a strategy to facilitate moving more people to the low-cost category. This could be called market share: the percentage of the population at low-cost. Given what you know about mathematics, engineering, statistics, or intuition, what would you do to ensure



that you end up with the highest market share of low-cost individuals in your population?

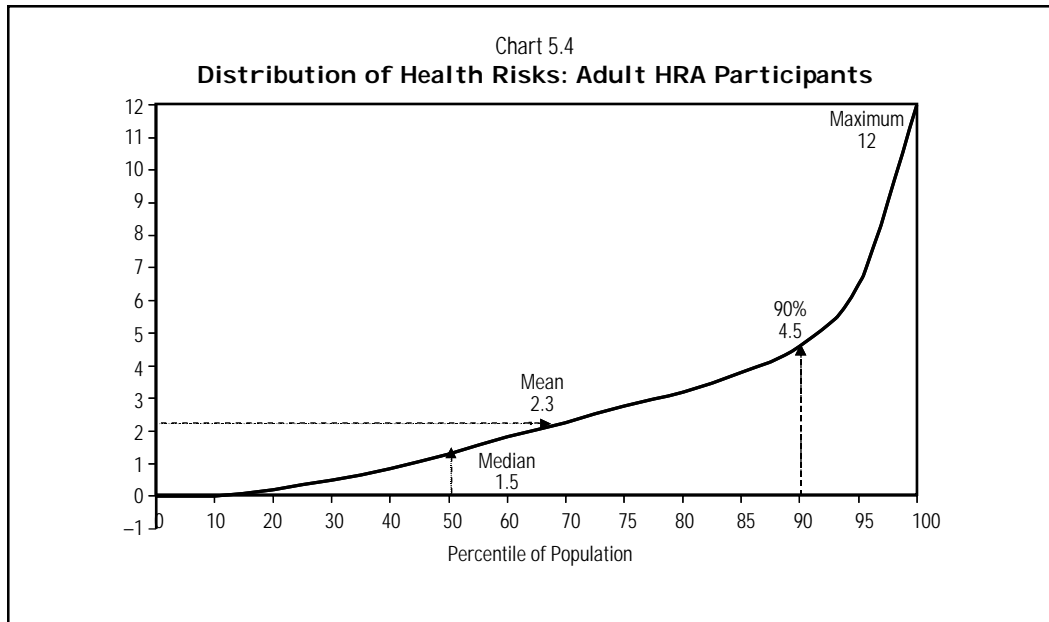
Obviously, the solution to these equations is to stop the upward flow of people going to higher costs. The only solution is to stop the source of high-cost people. You can “pull” as much as you want from the high-cost down to the low-cost, but as long as there’s a continuous supply of high-cost people, you never win. Based upon the history of trying to control health care costs, successful “pull” efforts may be difficult or impossible from a program strategy point of view. We will return to this dilemma later.

■ Health Risks and Behaviors

Now shift your attention to individual health risks and behaviors which come from the administration of a health risk appraisal. The distribution of health risks and behaviors throughout a population is shown in chart 5.4. The distribution is very similar to the cost distribution in chart 5.2: most people are low-risk with a minority having many risks. The first thought is whether these are the same people that were on the cost curve? That is, are the low-risk people also low-cost and are the high-risk individuals also high-cost? The answer is maybe. In general they are but not always. If we

follow the same logic as with the cost data, we would ask where is the program opportunity? Some people would say the opportunity is to reduce those people at high-risk, and that’s probably true. In terms of health management programs this is what we call a high-risk reduction strategy. However, as a society, we know that it is very difficult to get people to exercise, to lose weight, to stop smoking, to reduce blood pressure, to reduce cholesterol, etc. Not only is it difficult, it is very expensive, and often individuals end up going right back to the behavior they had in the first place.

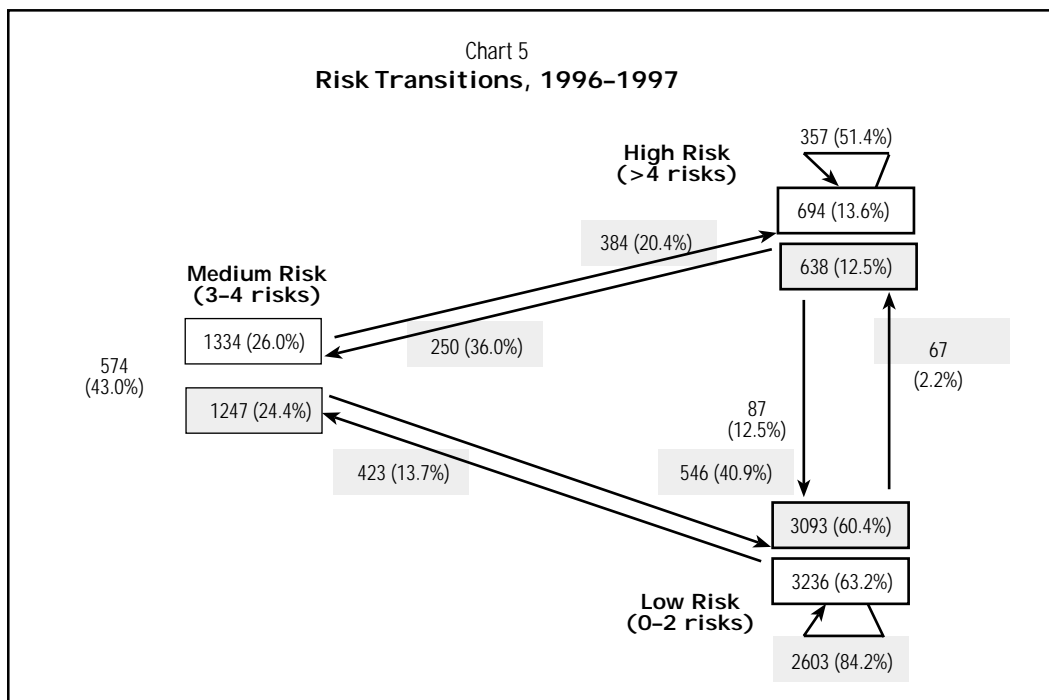
Based upon the data in chart 5.4, we propose that there’s a low-risk strategy for the purpose of keeping people low-risk. The conceptual basis for the strategy comes from the data in chart 5.5. The risk transitions are very similar to the analytical discussion related to the cost transitions. In 1996, among this cohort of 55–64 year-old males, 13 percent were high-risk (five or more risk factors). Twenty-six percent of this cohort had three or four risk factors, and 60 percent had zero to two risk factors. The data show that by 1997 the distribution was essentially unchanged with 13 percent, 24 percent, and 63 percent in the respective risk categories. It is a stretch to claim this is a natural flow of risk because once you distribute a health risk appraisal, you have made an interven-

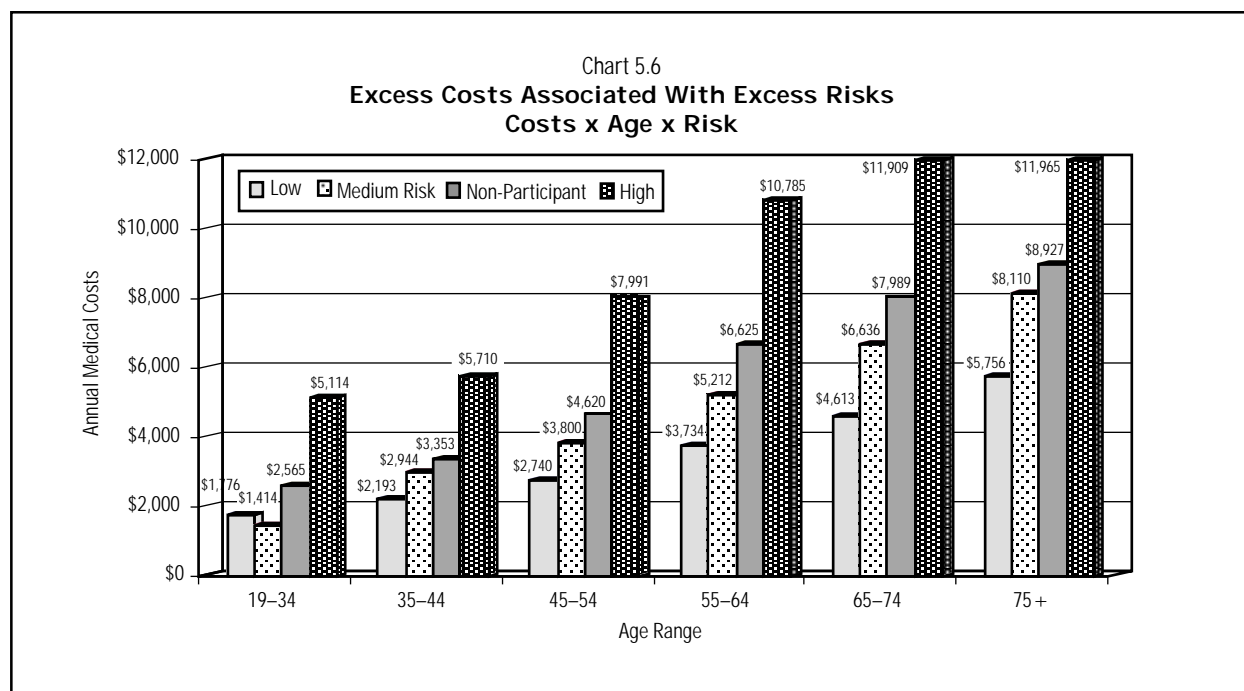


tion. However, it is as close as we can get to describing the typical flow of risks within a population. The flow shows that some of the people stayed high-risk (51 percent). Forty-three percent stayed medium-risk, and the good news is that 84 percent of the low-risk people stayed low-risk. In the world of health management, percent low-risk is the benchmark health measure, 63 percent in this case.

When we examined the flow of the population in chart 5.5, we see that many of the people

were going from high-risk to lower-risk categories. Risk reduction programs are advertised all the time in newspapers, magazines, and television. Organization commit resources to help people change to lower-risk lifestyles. However, often society and organizations do not pay attention to everybody, especially the low-risk individuals. In fact, the data show that some of the lower-risk people are moving to higher risk groups. This is the explanation why the percentage of the population at low-risk re-





mains relatively constant, rather than increased. The obvious question is what is the best strategy to increase the market share of low-risk individuals. As with the cost transition, the strategy should be to stop the people from going to higher risk categories. The translation of this logic to health management program strategy is to invest in low-risk maintenance programs. If you're going to make a difference in the organization, you need to change the natural flow of risks in your population.

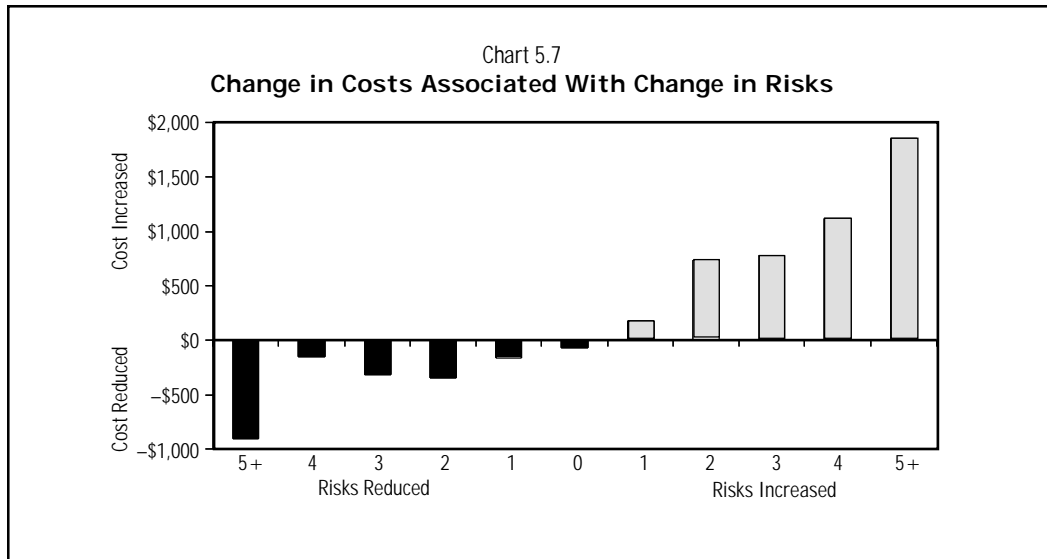
The next question one should ask is what is the relationship between medical care costs and health risks and behaviors. The premise of health management is that you manage costs by managing risks. You don't manage costs. You just get people mad when you try to manage costs, but by managing risks you're working on health status, life satisfaction, quality of life and so forth. Most individuals are much more receptive to this approach, and, as a population, you end up in the same or better place.

Chart 5.6 shows the medical costs (charged amounts) of a large population of individuals by age groups and risk-groups. From our experience, the low-risk group within the several age groups is as low-cost as a population can be. If we were going to propose a defined medical care benefit, which we don't necessarily recommend, we would use these dollar values adjusted for existing disease as a

starting point,

There are three learnings from the data in chart 5.6. The first is that as age goes up, costs go up, regardless of the age group. Learning number two is that, in any one age group, as risks go up, costs go up. Number three and the reason why health management programs might work is that, as one ages and changes age groups, there are only three places to go. For example, if you are at medium-risk, you can either stay at three or four risk factors or either add risk factors, which people do, or you could lose risk factors. By reducing risks or maintaining the same number of risks, you minimize the cost increase. If, however, the individual becomes high-risk (five or more risks) the medical cost increase is dramatic. Therefore, this is where the opportunity is: managing risks within a population. By doing so, you manage the health and eventually costs.

To further illustrate the opportunity suggested in chart 5.6, we examined the cost changes in populations of people as a result of the risk changes they made during the previous year. Chart 5.7 shows the dollar values and consequences of those changes in risk. The graph shows the number of risks either lost or gained from one year to the next. On average, the value of one risk reduced in one person per year is \$150 minimum. The cost of one risk increased in one person per



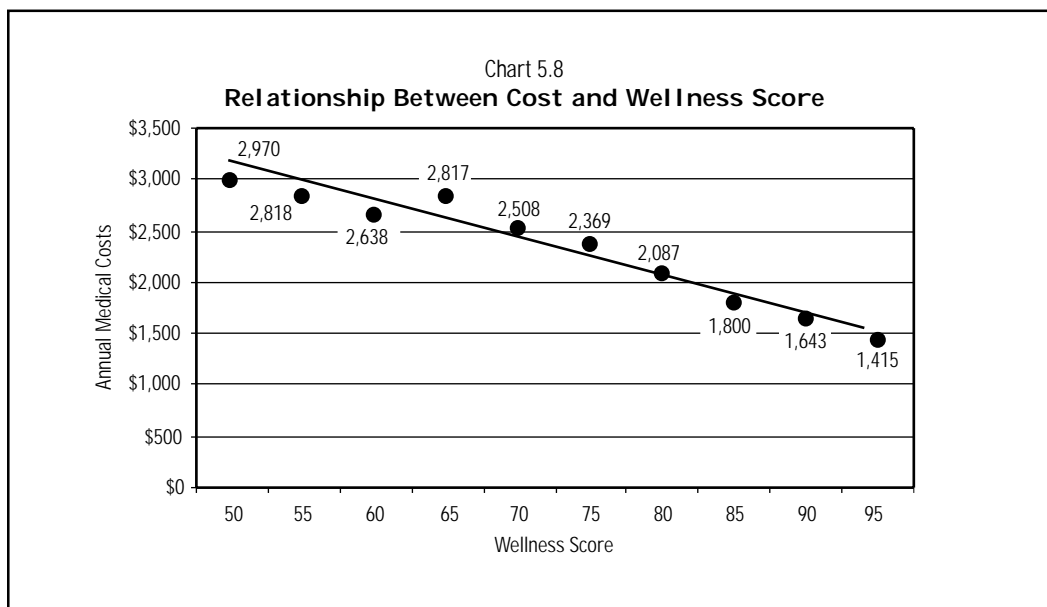
year is \$350. These results support the program strategy of maintaining low-risk profiles.

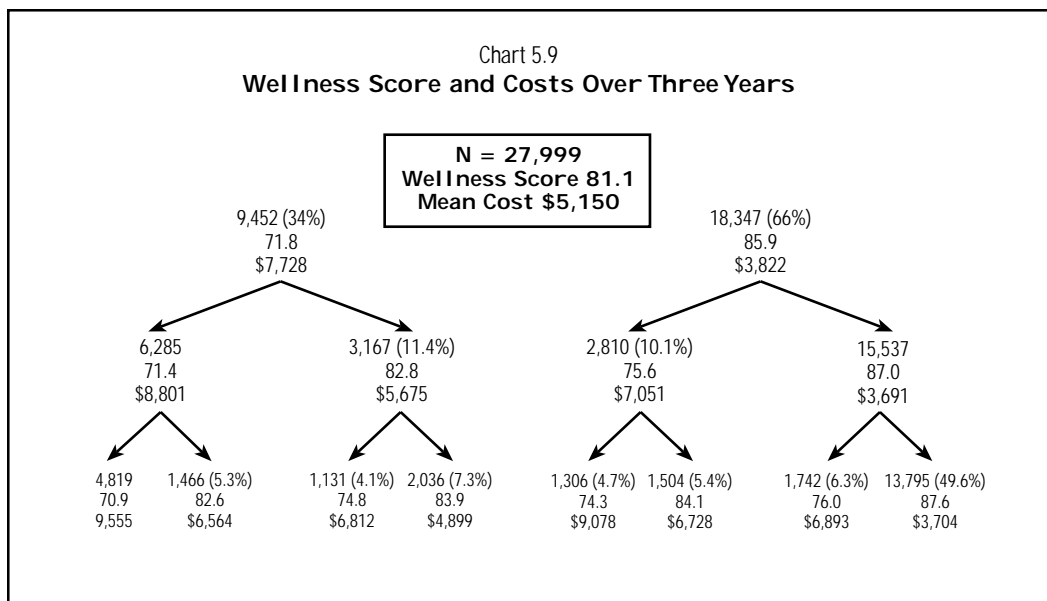
Wellness Score

Our work over the past 20 years has led us to create a wellness score to reflect the overall status of an individual in terms of health status, mortality, and morbidity and short-term utilization of the health care system. Our wellness score has three major components: the number of risk factors, the interaction of the risk factors, and the use of preventive services. All three of these factors

contribute to health care costs. The relationship of the wellness score to future health care costs is illustrated in chart 5.8. The wellness score has a mean score of 80 and a standard deviation of 10. The chart illustrates that higher wellness scores are associated with lower future health care costs.

Chart 5.9 shows the results of changes in wellness scores and the resulting changes in health care costs for 30,000 people who did the health risk appraisal three times in three different years. This result is consistent in every organization we have studied. As people made changes in their wellness score, future costs changed in the opposite direc-



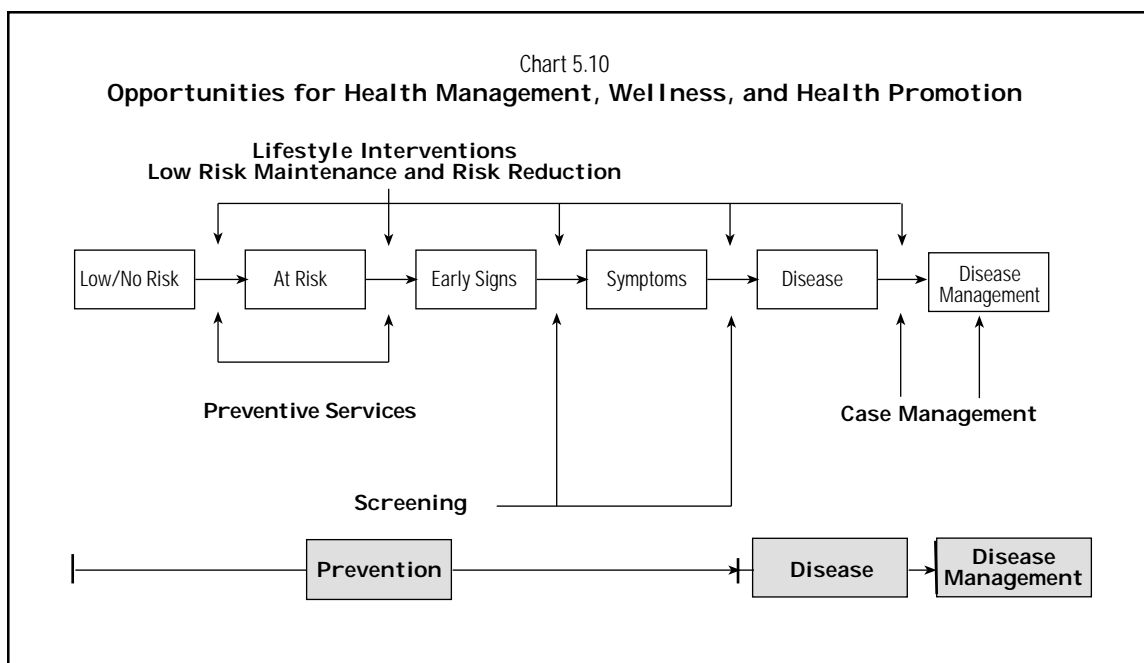


tion. That is, as the wellness score went down, the costs went up. Also, in every case, as the wellness score went up, costs in the next year went down.

Managing the Risks

Given the above evidence of cost and risk transitions and relationships of changes in risks and wellness scores, how might corporate program strategies be effective in positioning a population to find an optimal way to create a low-risk and thus a low-cost population? Chart 5.10 is a model for

health management programs within a defined population. Everyone in an organization is someplace along the continuum from none or low-risk, to early signs or symptoms to disease (in the acute care of the medical system) to disease management. You can think of distribution representing a corporate population, a whole community, a whole state, or a whole country. Now the question becomes what are the opportunities in managing the health of the population or, more specifically, in terms of managing the risks within the population? The first thing we suggest is a disease



The Economic Costs of the Uninsured

management program. Take care of the people with existing disease. The worst case in terms of costs is for a person to get off their disease management protocol. The second opportunity is in preventive services and screenings. Make sure people are getting preventive services to the extent recommended. Whether insured or uninsured, at the work site you can still do blood pressure screenings, cholesterol screenings, and so forth. You might argue that we have a health maintenance organization (HMO) to do that. In our experience HMOs have only slightly better performance than what we

find in the non-HMO population. So, unfortunately, employers have to do it. The third strategy or opportunity for health management programs is the risk-reduction programs (e.g., smoking cessation) and low-risk maintenance (e.g. healthy eating or fitness center) programs. Employers can be successful in controlling costs (by controlling risks) by encouraging employees to participate in health risk appraisals, to track their wellness scores, and to participate in screenings and appropriate health management programs.



**Private- and Public-Sector
Initiatives to Increase Access
to Health Coverage**

Increasing Health Insurance Access Through Inner City Business Development: The Inner City 100

by Stephen J. Adams, Initiative for a Competitive Inner City (ICIC)

■ Introduction

This discussion introduces readers to a category of businesses that few come in contact with, and in particular, a category of businesses that most people don't even know exist—fast-growing, successful inner-city companies. It also describes how inner-city business development can increase access to health insurance for low-income families.

The companies discussed here—the ICIC/Inc. magazine *Inner City 100*—are interesting for a number of reasons. They are succeeding in places that most people consider an economic wasteland. They are succeeding largely because of their location, not despite it, and they are providing quality jobs to their employees, many of whom are low-income, inner-city residents. Moreover, their record in providing wages and benefits runs counter to common understandings of other small and midsize companies.

■ The *Inner City 100*

The *Inner City 100* is a project of the Initiative for a Competitive Inner City (ICIC), a nonprofit organization that works on inner-city economic development around the United States. ICIC was founded in 1994 by Harvard Business School Professor Michael Porter. Its mission is to improve inner-city economies by helping increase jobs, income, and wealth of inner-city residents. The premise of ICIC's work is that the best hope for sustainable economic growth in inner cities is a business strategy built on the competitive assets of those inner cities.

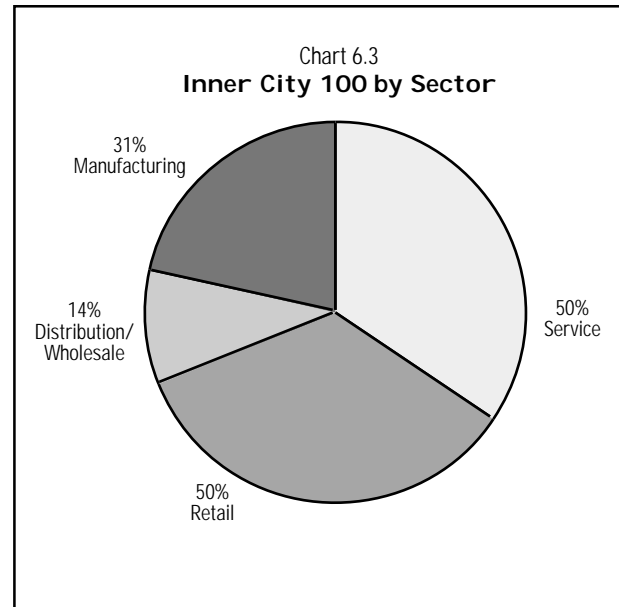
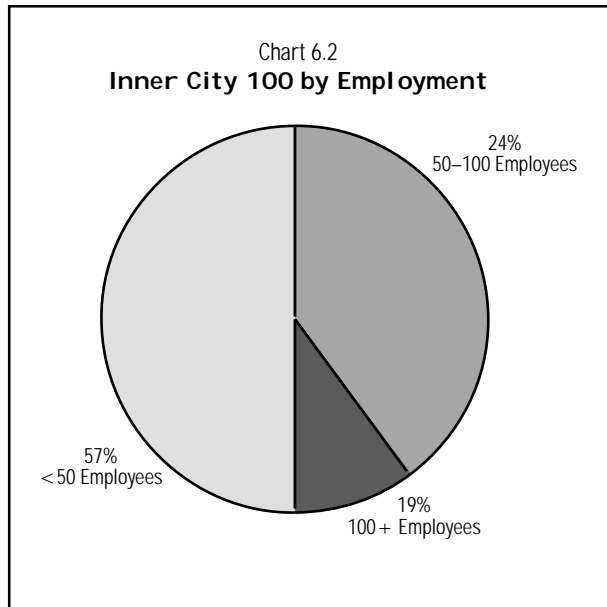
ICIC has conducted extensive research in cities all around the country. We have learned that most inner cities in the United States contain competitive advantages unique to those places upon which sustainable business development strategies can be built. Armed with a more accurate understanding of the economic opportunities in inner cities, companies, investors, and business development officials can pursue profitable ventures that will create jobs, raise income, and build wealth for inner-city residents.

■ Changing Perceptions

The annual *Inner City 100* is one of our most successful strategies for changing perceptions about inner cities. In partnership with *Inc.* magazine, ICIC identifies and celebrates 100 of the fastest-growing companies in inner city areas across the United States. Qualifying criteria for the *Inner City 100* list are described in chart 6.1. Like the *Inc.* 500, upon which it is modeled, the *Inner*

Chart 6.1
Qualifying Criteria for the ICIC/Inc
Magazine *Inner City 100*

- Companies must be headquartered in the inner city or have 51% or more of physical operations in inner-city areas;
- Employ 10 or more employees at year-end 1998;
- Have a five-year operating sales history that includes sales of at least \$1 million in 1998; and
- Cannot be a holding company, regulated bank, or utility



City 100 are ranked by revenue growth. By highlighting these business success stories in places people do not expect to find them, we hope to breed more success.

By creating and publicizing the list, ICIC hopes to achieve its purpose in two ways. First, the *Inner City 100* program seeks to fill information gaps that are preventing private investment in inner cities. By highlighting successful companies, the *Inner City 100* helps private capital to recognize that inner-city areas are places where investments are showing positive returns. Second, the program also encourages public-sector leaders to focus more attention on supporting business success in inner cities. ICIC research has found that fast-growing inner-city companies often relocate out of the inner city for reasons related to land assembly, a factor that city government can often influence.

A Research Asset

The *Inner City 100* is also a valuable research asset. To participate, companies complete a 12-page survey on a broad array of business factors that affect their performance. Consequently, ICIC is gathering data on hundreds and, over the years, thousands of inner city companies and the business dynamics of inner-city areas. This database will allow us to identify practices that are allowing these companies to succeed in these economic spaces. A review of these data reveals that successful inner-city companies can be important vehicles

for providing health insurance to low-income residents.

■ Characteristics of *Inner City 100* Companies

In many respects, the characteristics of *Inner City 100* companies are not especially interesting. They range in size from 10 employees to 750 employees (companies must have at least 10 employees to qualify), with an average employment size of about 70 employees. About 20 percent of the companies employ 100 or more workers, 25 percent employ between 50 and 100, and the remaining 55 percent to 60 percent employ fewer than 50 employees. Chart 6.2 illustrates the distribution of *Inner City 100* companies by employment.

These companies also represent a broad array of sectors. The largest share of companies—50 percent—is in the service sector. Another 31 percent are in manufacturing, a share well above that of the national economy. The remainder are in distribution, wholesale, and retail sectors, as shown in chart 6.3.

Far more interesting than their demographic profiles are the competitive characteristics of the *Inner City 100*. First, they are competing on factors other than cost. Contrary to common perception, these firms are not in inner cities for cheap labor and cheap land. In fact, few are the low-cost providers to their customers. Instead, they are competing on customizing their goods and

Chart 6.4
Fast-Growing Firms

	Total IC 100	Top 3
Average Compound Annual Growth (CAG) rate:	50%	202%
Average revenues in 1998:	\$12M	\$10.2M
Collective sales in 1998:	\$1.2B	\$30.7M
Average sales growth rate:	742%	9,330%

Collectively, the Inner City 100 created 4,300 jobs between 1994 and 1998

services and responding rapidly to their customers' shifting demands. These inner-city companies are getting their services and products to customers quickly, and making rapid changes in the structure and shape of those products and services as demanded in a just-in-time economy.

Second, these companies are succeeding because of their location, not despite it. The top three competitive locational advantages cited by *Inner City 100* companies are highway access, proximity to customers, and access to an available labor pool.

In addition, these inner-city companies are very fast-growing firms. On average, this year's *Inner City 100* saw annual revenue growth of 50 percent over the last five years. Among the top three companies, revenues averaged 200 percent annual growth. With this revenue growth has come significant job creation. The current class of *Inner City 100* companies more than doubled their employment base between 1994 and 1998, creating 4,300 full-time jobs as shown in chart 6.4.

■ Quality Jobs

Perhaps most significant, successful inner-city companies are providing quality jobs (chart 6.5).

Chart 6.5
Inner City 100: Providing Quality Jobs

- Average hourly wage for "rank & file" — \$12.82, above national average
- 76% provide bonus plan
- 72% provide retirement plan
- 66% provide life insurance
- 53% provide tuition reimbursement

Source: 2000 Inner City 100.

The average wage of this year's *Inner City 100* companies for rank and file employees, was \$12.82 an hour, just above the national average of about \$12.70. Moreover, 77 percent of these companies provide bonus plans, 72 percent provide retirement plans, 66 percent provide life insurance, and 53 percent provide tuition reimbursement.

■ Health Insurance

The *Inner City 100* also outperform their national counterparts in providing health insurance. Fully 96 percent of these companies are providing employer-sponsored health care to their employees (chart 6.6). Among the companies that have more than 100 employees, 100 percent provide employer subsidized health care, well above the national average of 82 percent for employers of more than 100. Of the *Inner City 100* companies that employ fewer than 100, 93 percent are providing health care, compared with the national average of 73 percent.

The *Inner City 100* show that successful inner-city companies are providing good jobs with employer-sponsored health care at rates that exceed the average among American companies. This is one of the reasons we think that creating inner-city business growth based on the competitive advantage of the inner city can increase the pool of jobs available to low-income families and increase their access to health insurance.

The *Inner City 100* show that distressed urban areas can and do support growing companies that provide good jobs. The principal challenge to expanding employer-sponsored health care among inner-city residents is increasing the number of inner-city residents employed by these firms. Currently inner-city residents make up about 40 percent of the employees of the *Inner City 100*.

Chart 6.6
Inner City 100: Providing Health Insurance

- 96% provide employer-subsidized health insurance
 - 100+ employees = 100% compared to national average of 82%
 - Under 100 employees = 93% compared to national average of 73%

Source: 2000 Inner City 100.

While this is not insignificant, the proportion could be much higher, and we believe it will be, given the labor-force constraints these companies are facing.

■ **The *Inner City 100* Labor Force**

In the current tight labor market, fast-growing inner city companies are learning that they have to grow their own skilled labor and future managers. This summer ICIC will take fuller advantage of the data collected through the *Inner City 100* program to gain a much more sophisticated understanding of how these companies are attracting, retaining, and promoting inner-city workers within their companies. By exploring the successes and failures of the *Inner City 100* in building a productive work

force from the inner city labor force, we will help more companies to apply successful strategies for employing and promoting inner city workers.

■ **Conclusion**

America stands at a unique economic moment in its history. We are enjoying one of the longest economic expansions in American history. Unemployment is reaching record lows across the country, and many U.S. cities are experiencing an economic and cultural renaissance. This is the most opportune time in 50 years to apply creative strategies to increase jobs, income, and wealth of families in America's most distressed inner cities.

Employer Health Care Alliance Cooperative

by Chris Queram, Employer Health Care Alliance
Cooperative, Madison WI

■ Introduction

I was going to subtitle this discussion “Tales from the Real World” or “Real World Experience,” but thought better of it considering that I’m from Madison, WI, which is one of the few cities in the country with a foreign policy. I think Ann Arbor, MI and maybe Eugene, OR and a few others share that distinction.

Wisconsin is a state of contradictions. About a week and a half ago I opened the New York Times to the national page and saw in a fairly large font that Wisconsin once again leads the nation in consumption of alcohol per capita. Shortly before that I saw a similar article that said that we’re second on the list of 50 states in terms of the percentage of our population with access to health insurance coverage. I think our uninsured rate is around 8 percent in our state.

There are numerous theories for that, not the least of which is a very strong economy and very progressive insurance regulation in the fully insured market for health insurance in our state.

I would like to tell you about our experience as a private-sector, employer-owned and directed health care coalition relative to our experience trying to bring the benefits of pooled or group purchasing to the small group market.

By way of background, the Alliance, as I mentioned, is an employer-owned and directed health care cooperative. We are structured as a cooperative, in the grand tradition of dairy cooperatives in our state (chart 7.1, chart 7.2).

We are celebrating our 10th year of operation this year, which makes us one of the longer tenured organizations in the country. We started operations in 1990 with seven companies. We have now grown to encompass about 165 to 170 large

Chart 7.1

The Alliance Profile

- Structured as an employer-owned, nonprofit cooperative
- Incorporated in the spring of 1990 with seven founding companies
- Currently represents over 170 large to mid-size employers and 1,000 small employers— combined nearly 110,000 lives

Chart 7.2

The Alliance Mission

- To unify and lead all member employers in the pursuit of a value-based, market-driven health care system. This means:
- purchasing on the basis of quality and cost;
 - promoting improvement in individual and community health status; and
 - creating and sustaining value-added partnerships between employers and providers.

employers that are self-funded. That is the core of our membership—our self-funded constituency—along with about 1,000 small employers that are accessing our products and our services on a fully insured basis. This latter group will be the focus of my comments.

Just to orient you a little bit to some of our more well-known members, companies like Lands’ End, Oscar Mayer, Rayovac, and Ameritech are all owners of our company and access our services on the self-funded side.

■ The Small Group Initiative

Why did we pursue a small group initiative? The history goes back to about 1993–1994. Part of the reason was a commitment on the part of our founding board, which was carried forward into successive years of governance, to be a good corporate citizen; that is, to the extent that we have

Chart 7.3
Why Pursue a Small Group Initiative?

- “Good corporate citizens”
- Mitigate effects of cost shifting
- Increase access to basic coverage among a traditionally under-served market segment
- Strengthen/enhance position in the marketplace

Chart 7.4
A-CHIP: Background

- Initiated by Madison-area Chambers of Commerce
- Product launched in October 1996
- Available to chamber-member small businesses (2–99 employees)
- Began with four founding Chambers, currently 27 Chambers are participating

achieved success in bringing the benefits of pooled purchasing to the large companies, the self-funded group, we didn’t want that success to exacerbate the difficulties of small employers in access to health insurance or to come at their expense in the form of increased costs (chart 7.3).

Certainly, we thought there would be an opportunity for us to increase access to basic coverage, because in our state, like many others, small employers tend to have the most difficulty in providing a stable and predictable form of health insurance coverage to their employees.

While this was certainly a good reason to pursue this, there also was self-interest involved as well. That was to look for ways to strengthen and enhance our position in the marketplace.

Our first foray into the small group market was in 1994, hard on the heels of the demise of comprehensive health care reform, not only at a national level but in Wisconsin as well. Our Governor Thompson, who continues in office, had sponsored an initiative, similar in many respects to what President Clinton had proposed, that was not successful for a number of reasons.

That created an opportunity for groups like ours to enter the small group market. The way we did that was with two indemnity carriers, Blue Cross/Blue Shield of Wisconsin and a small carrier in La Crosse called Midwest Security, to which we leased the provider network that we had developed for our self-funded employers.

The insurers offered that network in conjunction with a traditional small group product for companies between the size of 2–99. If you recall, back in that period of time (1994) there was very aggressive pricing on the part of health insurers to demonstrate the market’s ability to solve what comprehensive health reform was designed to deal with.

As a result, our initial experience with small group purchasing was very positive. We saw

a very dramatic increase in the enrollment and the participation by small companies, because rates were very favorable. We have a good provider network. It was a very attractive arrangement for everybody.

However, we were not satisfied that that type of product was really the best that we could do for the market, and like many others, we were enamored with the principles of managed competition and small group health insurance purchasing cooperatives (HIPCs).

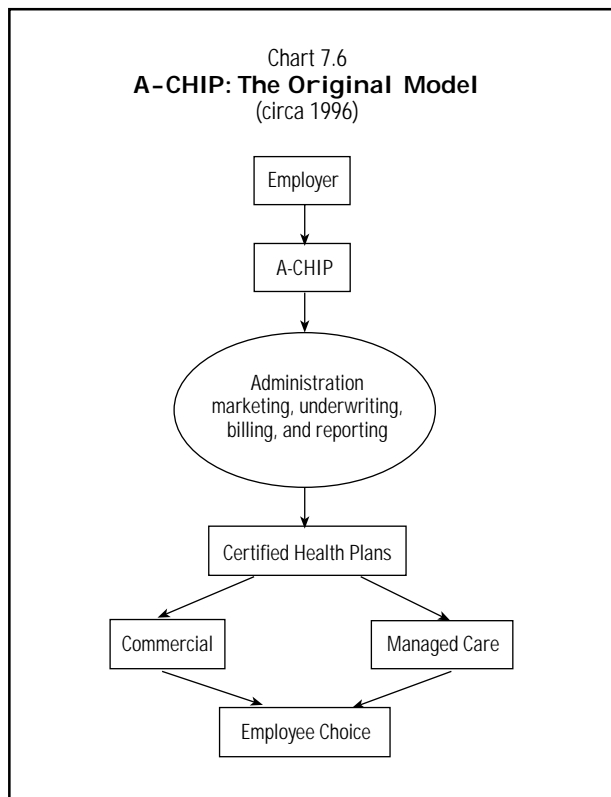
■ **A-CHIP**

So, beginning in 1996, we began to work with a number of area chambers of commerce toward the development of a program that we call A-CHIP, the Alliance Chamber Health Insurance Program (chart 7.4). Initiated with the Greater Madison Chamber of Commerce, A-CHIP has grown to include 27 chambers throughout a three-county region of south central Wisconsin—Dane County (in which Madison is located), Green County immediately to our west, and Jefferson County immediately to the east.

The chambers were looking for a way to help their members increase access to insurance, but brought little specialized expertise in health care to the table. They were really looking to us to be the source of creative and intellectual energy

Chart 7.5
A-CHIP: Original Design Concepts

- Goal: To provide “Group” coverage for small employers similar to Wisconsin state employees’ options
- Ceilings on annual premium increases
- Community rating
- Coverage for one-life groups
- Provider network in surrounding areas
- Employee choice among health plans
- Centralized administration
- Standard benefit plan



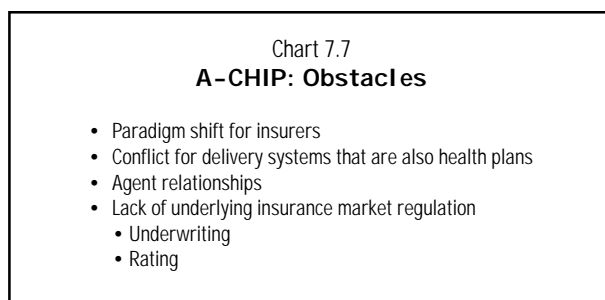
behind this program.

Our original goal was to achieve as many of the classic HIPC model concepts as possible. We were interested in ceilings on annual premium increases, because rate stability is certainly one of the most important characteristics that small employers are looking for in their health insurance (chart 7.5).

We were interested in community rating and beginning to move toward more of a common-pool approach for pricing of the product. Coverage for one-life groups was a significant issue for many of the chambers because, while Madison is a relatively large community of about 200,000, the contiguous counties of Green and Jefferson are largely rural. Creating a means for farm families to have access to health insurance was a significant issue for many of the participating chambers from outside the Madison area.

We were interested in employee choice. We were interested in centralizing administration and stripping away some of the redundancies that might be present if we had multiple participating health plans, and we were also looking to standardize benefit plans to facilitate comparisons and choice (chart 7.6).

We issued an RFP—this is just a schematic



that summarizes many of those principles—to about 10 health plans, and through an iterative process we began to realize that the goals that we had established and the reality of what either our market or the supporting insurance regulatory environment would allow us to accomplish were two very different things.

Some of the obstacles that we encountered in this iterative process of meeting with the health plans and the employers and seeing where we might have common ground in terms of program requirements are summarized on chart 7.7.

Certainly, to move in the direction of centralizing administration, offering standard benefit plans and community rating across all product offerings, was a significant paradigm shift for the insurers. While we were in the active negotiating stage in 1996—just two years after the demise of comprehensive health reform which had motivated health plans and carriers to consider more significant reform of the insurance regulatory market—much of that interest and that commitment to change had softened. And, we might have overestimated our ability—even though we represented at that time about 75,000–80,000 total lives and 27 chambers—to drive this degree of change into the market on a voluntary basis.

In other words, the absence of support from a government entity, whether that is the legislature or the administration, was, I believe, very significant in terms of our relationship with the plans and the carriers.

Another contributing factor relates to the unique phenomenon in Madison of a very well organized medical marketplace with several large, multi-specialty group practices.

In fact, Wisconsin has four of the largest multi-specialty groups in the country. Three of them are located in Madison: the University practice plan, Dean Medical Center, and another group called Physicians Plus, each of which at that

time owned their own health maintenance organizations (HMOs), their own health plans.

So for them to maintain a direct contract with their delivery system side for our self-funded employers and also offer a health plan through the small group product presented a very difficult conflict for them to resolve.

The other factor that I think was significant was, as I alluded to, the lack of underlying insurance market or regulatory support. Many of the program requirements that we were seeking to accomplish in A-CHIP would have meant that the health plans had to make a voluntary concession to more stringent program guidelines than is required outside of the program.

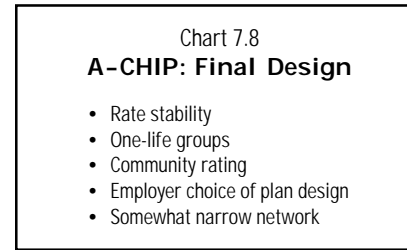
There was a concern that there was an opportunity for those plans that did choose to participate in A-CHIP to face competition outside of the program.

So the bottom line in our negotiations with the health plans was that the program commitments were too significantly different from the requirements of the insurance regulations for virtually all of the plans that we had asked to participate in the program.

■ Marketing the Product

Nonetheless, we were able to bring a product to market in conjunction with a staff model HMO in Madison called Group Health Cooperative (GHC). Three years ago GHC was recognized by *U.S. News and World Report* as the number one health plan in the country in its annual health plan ratings.

The reason that GHC was interested in working with us is partly philosophical. They're structured as a cooperative, as we are. They were at all of the meetings and the negotiating sessions. They felt that their staff model had inherent advantages: the medical management infrastructure, the systems that they had in place to truly manage care, coupled with the capitated arrangements, and financial arrangements that they have not only with their own physicians but many of the providers in their network. These advantages would enable them to successfully offer this product and build a market share of enrollees and participants in the plan that would allow them to begin to establish themselves in the market in a way that would be different from their traditional identity as a staff model HMO.



They also were interested in expanding their geographic reach beyond Dane County. We “cobbled together” a delivery system in Green County and in Jefferson County on a discounted fee-for-service basis so that we could offer to employers in those two counties access to the major clinic providers and hospitals in two large communities in those contiguous counties, and we launched this product with the following program features (chart 7.8):

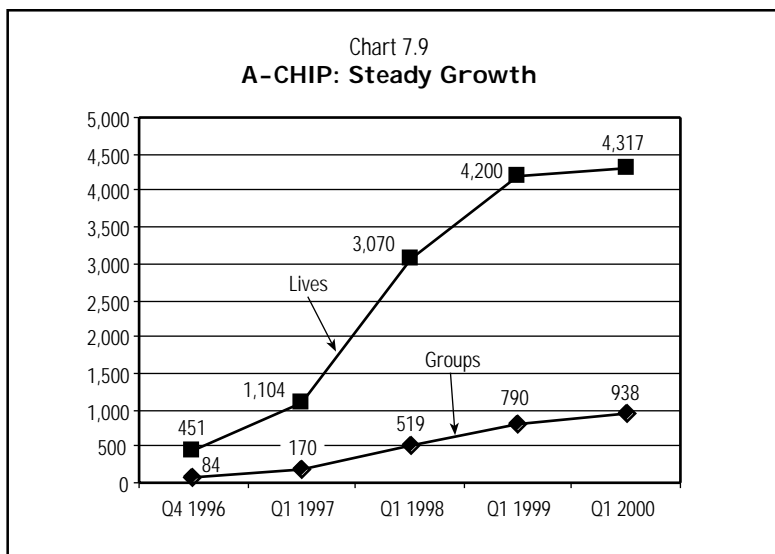
- Rate stability: GHC committed to no more than a 6 percent increase in the first three years of the program for all groups that enrolled in the program. So there was a real commitment to keep premiums at a competitive level, both initially and in successive years, which was mentioned earlier, the most significant feature that the small employers were looking for.
- GHC was willing to extend this product to single life groups, which was a significant concession and very attractive to the participating chambers, as mentioned earlier.
- They were willing to community-rate the product so that all groups that came into the A-CHIP program would have the same premium, depending on the plan choice that they selected, and there were three different plan designs; low, medium, and rich plan coverage.

As I mentioned, while it was still somewhat of a narrower network than what we were hoping for in terms of geography, we were able to extend this beyond Madison and beyond Dane County.

The growth that we've seen in the time that A-CHIP has been operating has been steady, and it's been on an upward slope—after about three years of operation, we are just short of 1,000 groups and just short of 4,400 lives (chart 7.9). The average group size is around four in the product.

■ Lessons Learned

That leads me to give you a little bit of a glimpse of



some of the lessons that we have developed to this point (chart 7.10).

We are experiencing some challenges with this product. Financially, the health plan has lost money on it. The losses are confined to the two contiguous counties, Green and Jefferson.

The product is marginally profitable in Dane County. Our analysis to this point suggests that that's partly because of the structural design of the program, where we have a staff model HMO with a managed care infrastructure in the center of the A-CHIP product in Dane County, coupled with delivery systems in the two contiguous counties that are not aligned either financially or integrated from a managed care standpoint in terms of truly managing the processes of care between the medical groups and the hospitals in these small communities.

We also believe that we have a disproportionate share of one-life groups. About 60 percent of the employers that are in the A-CHIP product are single-life groups, and while we were hoping against hope that by pooling enough groups together we would see this entire pool function as one large community-rated group, the reality is, when you bring this many single-life groups together,

people who have historically had difficulty accessing coverage, you attract people who truly need medical services, with the result that utilization has been an issue.

We have also found that there are two other potential barriers to our ability to grow this program as aggressively as we would like. One is due to agent relationships.

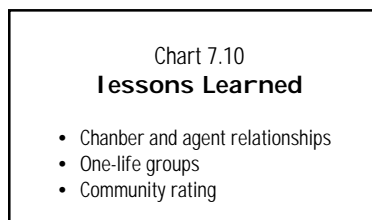
This is because the staff model HMO operates differently from some of the provider-owned health plans in our market, and has a relatively small sales force of its own.

As a result, we are dependent on external relationships, which is particularly true given the chamber connections that we have. We found that many of the agents, while they have been trained on the product—made knowledgeable about the philosophy, design, and characteristics of A-CHIP—see this as but one of many alternatives that they offer to their clients.

As a result, we think that agent relationships in this instance have been an issue in terms of our ability to attract a better mix of groups.

The other issue from a competitive standpoint is that community rating has been a problem for us, because it's made A-CHIP uncompetitive with other health plans that age and gender rate consistent with the rules of the marketplace for plans that compete against A-CHIP outside of our own program requirements.

So we are in the process of analyzing all of the different factors that are contributing to the growth that we have experienced thus far and,



The Economic Costs of the Uninsured

more importantly, the financial results. While we remain committed to the small group market, our attempt to do innovative programming on a voluntary basis has thus far been a very challenging proposition, with mixed results and with a potentially guarded future.

Public-Sector Initiatives to Expand Private-Sector Insurance Coverage in Oregon

by Mark Gibson, Office of the Governor, Oregon

■ Introduction

Before I begin an inventory of the public-sector initiatives we have undertaken in Oregon to help expand private-sector insurance coverage, I think it is important to first set the context within which these initiatives play out. Without this contextual framework, it would be easy to say that government's only role in supporting and broadening private-sector insurance coverage is to create programs similar to the specific initiatives we have undertaken in Oregon. Nothing could be further from the truth. A case can be made that, while these focused initiatives are very important, their overall impact on supporting and encouraging the use of commercial coverage is far less than some of the other systemic roles government plays.

■ The Four Payers

There are four major payers in the U.S. health care system. Private insurance is joined by two public insurance programs, Medicare and Medicaid, and by individuals. Actions taken by any one of these players will inevitably have an impact on the others.

The primary reason the four payers are so closely related is that they share the same provider base. With the occasional exception of a public hospital or a county health clinic, these four payers use the same doctors, the same hospitals, the same drugstores, and the same physical therapists. The economic viability of the health care industry depends on each of these payers. As a consequence, if one payer pays less than the cost of the care the persons it covers receive, or pays at a rate that allows a lower than acceptable profit margin for a provider, the provider is forced to raise prices to the

other payers or to tolerate an erosion of its own income and margin. When any payer underpays, either costs are shifted or provider solvency is threatened.

Understanding this interrelationship is key to understanding all of the ways in which the public sector helps support private health insurance. Within this interdependent system, there are four primary ways in which government supports the use of private health insurance: tax expenditures, direct purchasing, covering some of the populations that are unattractive to the commercial market, and specific initiatives designed to encourage private insurance coverage.

■ Government Support for the Use of Private Health Insurance

The simplest way in which the government supports private health insurance is through an enormous tax expenditure. Because businesses and employees are able to buy this benefit with pretax dollars, it is a bargain compared with other forms of compensation. This creates a substantial incentive for businesses and employees to use health insurance as a major part of their compensation schemes. The tax expenditure from federal, state and local government combined was almost \$125 billion in 1998. This expenditure is an entitlement in its nature because no matter how fast the cost of health insurance might rise, the tax break keeps on growing along with it.

Beyond this subsidy, the public sector purchases an enormous amount of private health insurance. Federal state and local employee benefit systems spent just short of \$200 billion in 1998. In Oregon, for example, the state is the single largest

purchaser of commercial insurance, and local governments and school districts spend in the aggregate roughly 75 percent of the amount the state spends.

These purchases are important to the commercial insurance system because the more broadly an insurance system can spread risk the more stable it is. In addition, these purchases contribute to the overall investment in health care that allows us to finance one of the most sophisticated provider bases in the world. Imagine for a moment the impact in Oregon if the state and local governments decided to create their own system for health care similar to what the U.S. military provides for uniformed personnel. The risk pool for private insurance would be substantially reduced. This means that the stability of large numbers in the risk pool of insureds would decrease. In addition, the fixed costs of insurers would be higher per policy or there would be fewer insurance companies and less variety in the system. The provider base available to private insurance subscribers would also shrink considerably. This could compromise the ability of some communities to invest adequately in the health care infrastructure available to the commercially insured whether it be hospitals, diagnostic equipment, or specialty treatment.

Government does much more than expand the good risks in the private insurance pool by insuring its employees. Through Medicaid, Medicare, and state-only programs for the mentally ill and developmentally disabled, government minimizes the adverse risk of commercial insurers by covering large numbers of those in ill health. Because these public programs either do not create their own provider systems or, in the case of mental health and developmental disability, have been actively dismantling their systems for decades, they also contribute substantially to supporting the provider base that the commercial market depends on.

■ State Initiatives

These larger supports are actually more important in a global sense than the specific programs states have initiated to directly support the expansion of private insurance. However, because we are still far short of having coverage for everyone, states have

attempted to create incentives to expand coverage even further. These attempts are more narrowly focused, but nonetheless are showing substantial benefits.

In Oregon, there are four such programs: a high risk pool for persons who cannot get coverage in the commercial market due to a pre-existing medical condition, a set of insurance market reforms designed to make the small group market work better, a subsidy program to assist low-income Oregonians in purchasing private coverage, and a public/private purchasers' coalition.

The high-risk pool subsidizes a guaranteed issue product for persons who have been denied coverage due to a pre-existing medical condition. To qualify for the program a person must demonstrate that such a denial has occurred. Once qualified for the pool, he or she must pay for coverage. To help buffer the high premiums necessary to cover persons at high risk, the state subsidizes the coverage so the premiums do not exceed 150 percent of the average individual market premium. This is not cheap coverage, but it solves the biggest problem these high-risk individuals have, which is that no one will sell them insurance at any price. Now they have a product that is available in all cases, although some eligible persons still cannot afford it.

The state funds the subsidy through a per capita assessment on insurers. This is slightly different from the most common form of insurance tax, which is levied as a percentage of premium collected. Instead, the state calculates the cost of the subsidy in a year, divides the amount by the total number of insured lives in the commercial market, and then assesses each insurer an amount based on its number of covered lives. To reach into the self-insured market to the greatest extent possible, this tax is levied on re-insurers as well. The reason this was necessary was because the fear of being made uncompetitive due to adverse selection caused insurers to refuse to cover these bad risks. To the credit of the insurance industry, its leaders did not object to this method of spreading the adverse risk proportionately across the market. However, as the cost of the pool rises, we are beginning to hear some grumbling that it is forcing an increase in premiums in general.

■ Small Group Insurance Reforms

Our small group insurance reforms were enacted in 1995, two years earlier than the federal Health Insurance Portability and Accountability Act (HIPAA). In many ways it is quite similar to HIPAA, but there are some differences as well.

In Oregon, we have defined the small group market as groups of two to 50 lives or families. In our state reforms, we covered groups of two to 25 until the federal law required us to go up to groups of 50. Any product offered in the small group market is guaranteed issue.

We also have modified rate bands or, if you prefer, modified community rating. Our rate bands allow a differential of two to one between the lowest premium and the highest premium charged. The only other factors that may be considered are geography (a slight variation allowed), age, and family composition.

We also have portability requirements and limits on pre-existing condition exclusions. The portability requirements differ slightly from the federal approach, which moves the person losing coverage into the open individual market. In Oregon, if the carrier providing the original coverage has an individual product, we require the carrier to make individual coverage available and to price that coverage at a level that is similar to the rates paid by members of the groups the persons came from. This helps keep the premium affordable for the person or family losing coverage.

These changes in the small group market have been well received. Demand for a bare-bones policy for small employers, which at one time was fairly popular, actually diminished to the point that we discontinued it.

■ Family-Based Subsidy

The other program I want to cover is some detail is our family-based subsidy for purchasing insurance. This subsidy is designed to help Oregonians with a family income between 100 percent of the poverty level—about \$17,000 a year for a family of four—up to 170 percent (\$29,000) of the federal poverty level. This initiative, called the Family Health Insurance Assistance Program, provides a sliding subsidy based on family income for the purchase of

commercial coverage. The state pays 95 percent of the family's cost if its income is between 100 percent and 125 percent of the poverty level. A family with an income between 125 percent and 150 percent of poverty receives a 90 percent subsidy, and between 150 percent and 170 percent the subsidy is for 70 percent of costs.

This program was begun in 1998, and currently covers approximately 6,000 families. It is capped by a budget appropriation, and currently has a waiting list of over 20,000 applications. Not all of those on the waiting list will qualify, but the list illustrates the level of interest in the program. As we designed this program, one critically important factor emerged. Employers were very clear that it should not burden them with additional administrative complexity. Therefore, we designed the subsidy to be absolutely transparent to employers, and it goes directly to the individual or family being insured.

The program also places a priority on employer-sponsored coverage. If an individual who applies has coverage available in his or her work place but cannot afford the cost sharing required, he or she must accept that coverage in order to receive the subsidy. Moreover, the subsidy is not available for individual market coverage to applicants whose employers offer group coverage. Applicants who do not have work-based group coverage available, however, can join the individual market, with the state subsidizing the premium at the same level.

Oregon encourages family coverage by allowing applicants to enroll their children only, but not adults only. If there are children in the family, the children must have coverage, either through the same policy as the adults or through some other insurance, including public-sector coverage.

These are very low-income families. A family of four with an income between \$17,000 and \$29,000 per year will have substantial difficulty in making the first month's premium payment without a subsidy. To overcome this difficulty, we distribute the first month's subsidy prior to the time the payroll deduction takes place. After that, the recipient need only provide ongoing proof of coverage and the subsidy will continue. There has been virtually no abuse of this provision.

■ Coalition of Public and Private Purchasers

Our final initiative is a coalition of public and private purchasers whose primary objectives are to improve quality and contain costs. Membership is voluntary, and currently consists of companies from a broad cross section of businesses, including high-tech firms, more traditional manufacturing companies, and utilities. Public-sector purchasers include the state, municipalities, counties, and the Oregon School Board Association. The coalition is a 501(c)(3) nonprofit organization.

Currently, the coalition's main project is convening a group of purchasers and health system representatives to determine how to address the needs of purchasers for better management information from their health care suppliers. These discussions include issues such as how to refine

data currently supplied so that it is more useful, how to use data and communications technology to increase provider accountability and encourage best practices, and how administrative waste within health care purchasing systems can be reduced through standardization.

■ Conclusion

Commercial health insurance, with and without state subsidy, is a critical part of our effort to provide health care access to all Oregonians. We have reduced the percentage of uninsured Oregonians from 18 percent in 1994 to just over 10 percent at present. The ratio of commercial coverage to public coverage among the newly insured is approximately 5:1. In Oregon, public policy to support commercial insurance is a blend of general subsidization, risk management, market regulation, and focused incentives and partnerships.

Public- and Private-Sector Initiatives to Increase Access to Health Coverage: The Experience in Maryland

by John Colmers, Maryland Health Care Commission

■ Introduction

As we consider anew the various ways of addressing the problems of the uninsured, it is important to recognize that the states and the business community are, in fact, very strong partners, and their interests in addressing this problem are more closely aligned than many people realize. A silver lining in the failure of the national health care debate of 1994 was a greater understanding and appreciation of the similarities of interest that states, acting as both purchasers and providers of care, have with the business community.

States are where the action is right now. Across the 50 states, there is considerable activity and innovation in improving access to affordable health insurance coverage. Indeed, many of the ideas that are finding their way into the public policy debate in Washington had their genesis in the states, and much of that innovation is still going on.

One of the engines driving this activity is the national economy, which is providing budget surpluses in many of the states. In addition, the states also have the advantage right now of determining how to use the money they will be receiving over the next 25 years as a result of the tobacco settlement. Although many states are dedicating these funds to broadly defined health uses, a number of them are looking to use that tobacco money directly toward improving access and improving health care services. As a result, I believe that, together, we have a unique opportunity to advance coverage through cooperative efforts.

In addition to the financial capacity to expand access, states have an interest in addressing the uninsured for a variety of reasons. First,

from an economic development standpoint, lower levels of uninsured lead to lower health insurance costs and therefore lower costs for businesses. Today the uninsured are receiving some health care—albeit late and often expensive. The cost of that care is being shifted to the private sector and to the government sector in the form of higher prices for the services they receive, which ultimately leads to higher insurance premiums (chart 9.1). So to the extent that states can work with the business community to figure out ways to get people covered, it actually can be seen improving the business climate.

States also have a self-interest in reducing the number of people who are uninsured. Private involvement is preferable to public involvement. To the extent that the private sector can fund the coverage through job creation and through private dollars, this is far preferable to spending public money.

■ States' Initiatives

What are the activities states can undertake to expand access? First, as Mark Gibson has said,¹

¹ See Mark Gibson, "Public-Sector Initiatives to Expand Private-Sector Insurance Coverage in Oregon," in this volume.

Chart 9.1

State Interest in the Uninsured

- Economic Development
 - Cost shift increases insurance premiums
- Self Interest
 - Private involvement is preferred to public involvement
 - Pressure to fund safety net providers

Chart 9.2
State Activities to Expand Access

- Public Programs
 - Medicaid, S-CHIP, state-only programs
- Individual insurance market
 - Market reforms, high risk pools
- Small Employer Programs
 - Market reforms, tax incentives, purchasing alternatives
- ERISA

Chart 9.3
Review of Maryland's Small Group Insurance Market Reforms

- Applies to Groups of 2–50 Eligible Employees
 - Guaranteed issue / renewal
 - Modified community rating with bands
- Age & Geography +/- 40%
 - Eliminated pre-existing condition restrictions
 - Standard comprehensive benefit plan
- Average Rate May Not Exceed 12% of Maryland's Average Annual Wage

there are the public programs to expand coverage that states operate either in conjunction with the federal government or entirely through the use of state funds. In the former category, Medicaid programs are being revised and rethought, particularly in light of changes that have occurred in the welfare program at the state level.

The advances in S-CHIP, or the state children's health initiative program, have vastly expanded the opportunities for coverage for low-income children. The number of children who are actually enrolled are gradually ramping up in a number of the states, and, in addition to that, some states are undertaking state-only programs such as the one described by Mark Gibson in Oregon, where they are doing a low-income subsidy program for the whole family as well.

In addition to directly expanding access by providing coverage, states can indirectly expand access by altering insurance underwriting rules. In the individual or nongroup insurance market, some states have undertaken significant market reforms. New York and New Jersey, for example, have moved to create guaranteed issue reforms in their individual markets, meaning that individuals can purchase individual insurance without regard to pre-existing conditions. Other states have been less aggressive and have instead opted for a high-risk pool for those individuals who cannot pass medical underwriting standards.

But the individual insurance market is a tricky business, because unlike most other services, one has to sell insurance before it is needed. The individual market, in particular, is very sensitive to problems of adverse selection. So steps that states can take to improve the individual market without disrupting it are hard to accomplish. It is hard to guarantee access to individuals at an affordable price if only those who are going to actually use the

benefit buy it.

Perhaps the area where states have done the most—and Wisconsin and Oregon are described in other chapters—is the small group market. In this area, states have had traditional authority over the regulation of insurance products in their states, and over the last six years, most states have enacted some reforms. In the next section, I describe the reforms we are implementing in Maryland.

Finally, chart 9.2 contains the five-letter word that is near and dear to the heart of most states. As I mention the Employee Retirement Income Security Act of 1974 (ERISA), however, I recognize that to a significant degree, ERISA is no longer the bugaboo that it had been in earlier years. To the extent that large businesses are providing health insurance coverage within federal guidelines, they are not the problem to states that they once were before ERISA plans received congressional attention.

In fact, the degree of partnership that I mentioned earlier has been enhanced over the years. Does ERISA present barriers to states, particularly as it relates to some of the smaller business activities? Yes, it does. To the extent that we can get a clearer definition of where that dividing line is between state authority and federal authority in this area, I think we would all benefit.

■ Small Group Reforms in Maryland

We have undertaken some small group reforms in Maryland, and I would like to discuss the degree of success that we have had and also some of the problems that we are facing going ahead (chart 9.3).

In Maryland, the reforms implemented in

Chart 9.4
Standard Comprehensive Benefit Plan

- Statutory Requirements
 - Actuarial equivalent of federally qualified HMO
 - Average rate may not exceed 12% of Maryland's average annual wage
 - Can exclude any mandated benefit
 - Additional benefits may be offered

1994 cover employer groups of 2–50 eligible employees. The law requires guaranteed issue, guaranteed renewal, and modified community rating. Our rating bands are a little bit broader than the ones in Oregon, plus or minus 40 percent, and the rates can vary only for age and geography. Maryland eliminated pre-existing condition restrictions effective January 1, 1995.

One of the unique features of Maryland's reform, however, is the Comprehensive Standard Health Benefit Plan (CSHBP), which all carriers participating in the market must offer (chart 9.4). Carriers can offer enhancements on top of that, but they cannot sell anything underneath it.

Having a standard plan in place avoids some of the adverse risk selection that can occur through benefit plan design—e.g., carriers offering a slimmed down benefit plan to the young and healthy and a more comprehensive plan to the higher risk groups. Under this arrangement, everybody is offered, at a minimum, the same basic set of benefits. When the General Assembly adopted a standard plan, it recognized that the single most important barrier to insurance coverage is cost. As a result, we had to design a plan that not only offered sufficient benefits, but also one whose ultimate premiums did not exceed 12 percent of Maryland's average annual wage.

When the legislature passed these broad reforms, some naysayers predicted carriers would leave the small group market en masse. The good news is that after five years, we still have a competitive insurance market here in Maryland. Carriers still price their products following rules of the insurance market, but at the end of each year we have to go back and compare what the average premium is to that 12 percent measure. Keeping the benefit plan affordable has been an important aspect of the reforms in Maryland.

As I mentioned, there are certain statutory requirements that we must meet in designing the

benefit package, such as the floor or ceiling. It has to at least be the actuarial equivalent of a federally qualified health maintenance organization (HMO), and it may not exceed this 12 percent of Maryland's average wage.

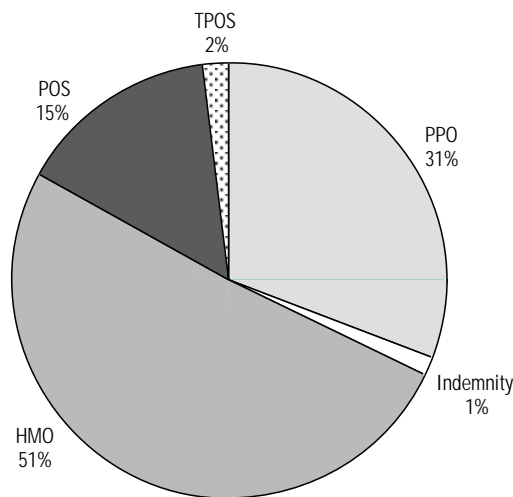
We are permitted to exclude any mandated benefit and, in fact, have excluded a number of the mandated benefits that have been adopted by the Maryland General Assembly.

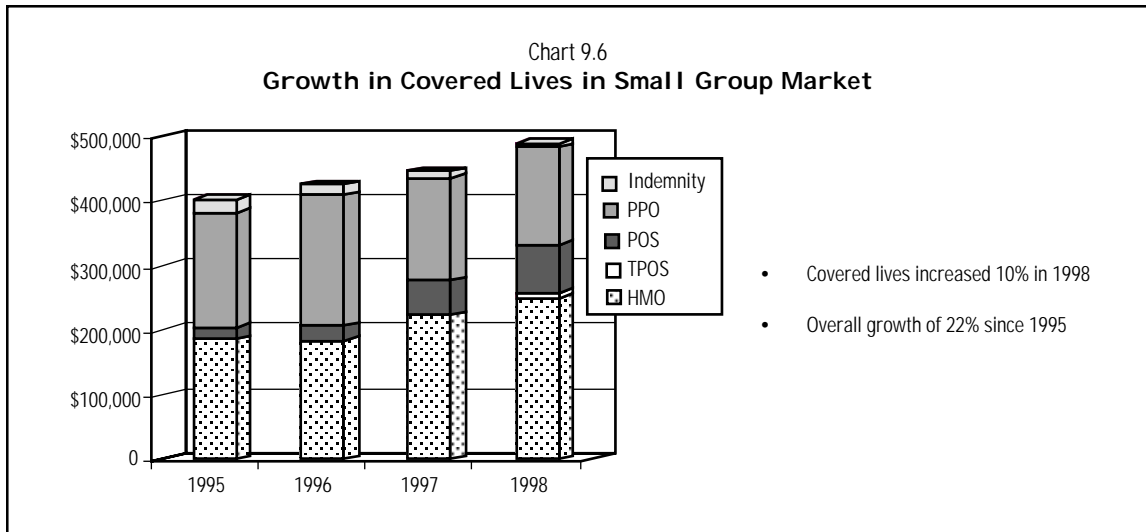
Additional benefits can be offered via a rider. Carriers are permitted to sell additional benefits beyond the standard plan on a guaranteed issue and guaranteed renewal basis through these modified community-rating bands, and many of them do. But, at the base, they have to offer the standard plan.

In terms of covered lives, in 1998 we had almost half a million covered lives in Maryland. Chart 9.5 illustrates the distribution of lives by delivery system. As you can see, HMOs represent roughly 50 percent of the covered lives in Maryland, and Maryland is a state that has a very significant HMO penetration, to begin with.

This 50 percent figure is somewhat higher than it is in the general fully insured employed market. What is different and what happened as a result of the reforms in Maryland was that alternatives other than HMOs and indemnity plans began to grow, and because of the reforms that we put

Chart 9.5
1998 Small Group Covered Lives
 Almost 500,000 Covered Lives in 1998





into place in the design of the benefit plan, we have seen significant growth in the point-of-service and the triple option point-of-service products, which were not available prior to the reforms (chart 9.6).

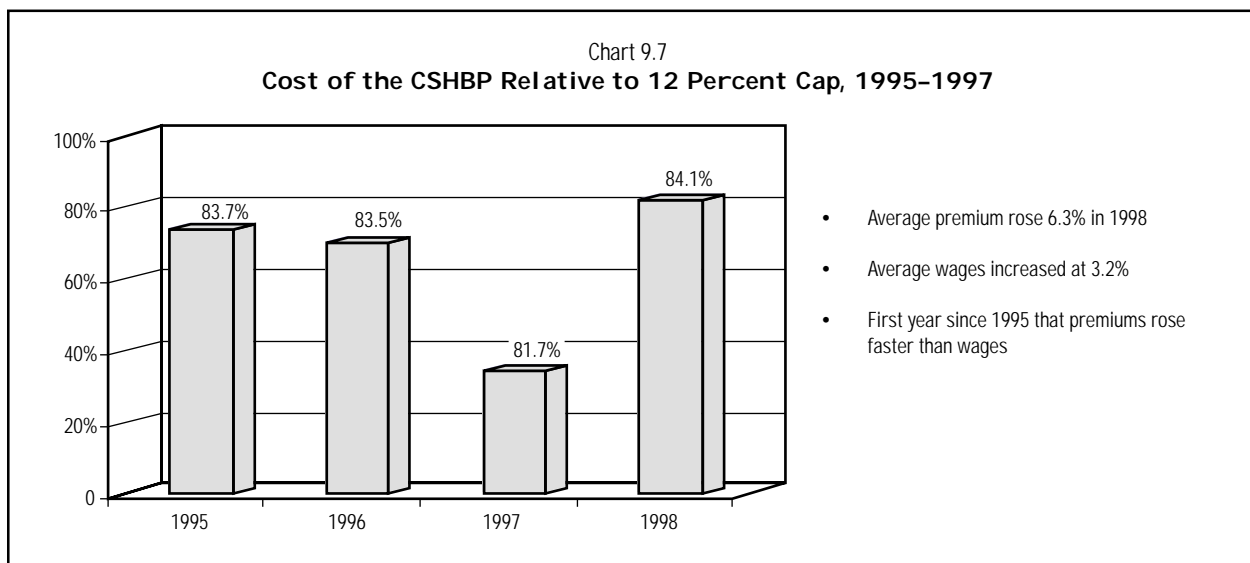
The growth of the market since 1995 has been fairly steady and significant. In 1998 alone, for example, we saw a 10 percent increase in the number of covered lives, and the overall growth since 1995 has been 18 percent.

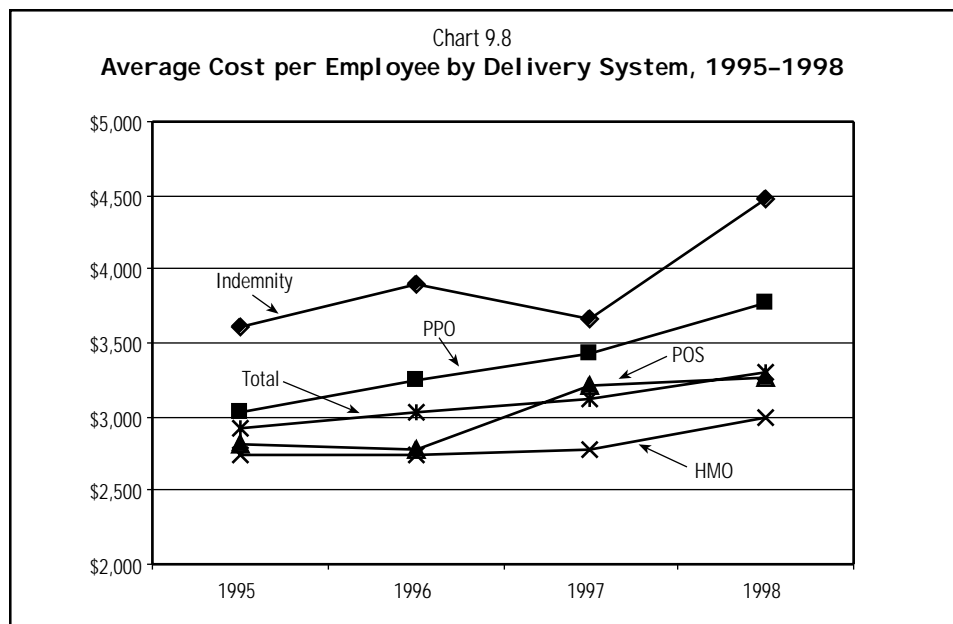
Certainly, this growth rate has been fueled in part by the growth in the number of small businesses, but the proportion of small businesses in Maryland that are offering insurance today has increased from roughly 40 percent of small businesses to roughly 50 percent of small businesses.

How are we doing in terms of the relationship to the cap? In 1998, the average premium

increased 6.3 percent (chart 9.7). Average wages increased 3.2 percent. That was the first time since 1995 that premiums rose faster than wages. We were fortunate in the early years that income kept pace with premiums. Now medical costs are surpassing income.

We are still, however, under the 12 percent cap. As you can see, we were about 84 percent of that upper limit in 1998. In 1999, we were 89 percent. Obviously, we never want to get to the point where we have to cross that line. So we are already taking steps to modify the benefit plan to take into account these increases in premiums. Further, not unlike our counterparts in the private sector, we are most concerned with the costs associated with prescription drugs and, in Maryland's case, the concerns about increases in nonhospital





expenditures.

Chart 9.8 breaks out the rate of growth between 1995 and 1998 by delivery system. Indemnity membership has decreased from about 20,000 lives in 1995 to 4,000 in 1999.

The preferred provider organization (PPO) product initially saw some growth. This growth has been moderated of late. Since 1997, the most rapid growth has been in the point-of-service model. The HMO product remains the least expensive, although the gap is narrowing with the point-of-service model. It remains the largest in terms of covered lives, although membership declined in 1999.

As a result of action in this year's General Assembly, there is now a relationship between the small group market and Maryland's Children's Health Insurance Program. Maryland enacted S-CHIP two years ago, and had it go up to 200 percent of the federal poverty limit.

Effective July 1 next year, the state has increased the participation in S-CHIP to 300 percent of the federal poverty limit, and for people who are in the 200–300 percent range, there will be an employment-based alternative available (chart 9.9).

Under 200 percent of poverty, it is done through a Medicaid expansion through private-sector HMOs. Between 200 and 300 percent, people can participate through their employers. In Maryland, because of the standard benefit plan that we have, we are hoping that some of the barriers that

exist—on the border between S-CHIP and the private market—will be less, because what we can develop is a standard rider that would go on top of the standard benefit plan in the small group market that, by its very nature, would meet the federal loopholes of being eligible for coverage. This rider would eliminate co-payment requirements where they conflict with federal rules.

We are also very concerned, as Gibson mentioned, with figuring out ways to make this process as seamless for both the employer and, in the case of the small employer, the agent/broker community, since they often act as the H.R. department for these small businesses.

There is a requirement that the employer contribute 50 percent of family coverage in order to get this. This is a federal requirement. States worked with the federal government to have this contribution lowered from the previous 60 percent requirement down to a 50 percent coverage requirement. This private-sector alternative will begin July 1, 2001.

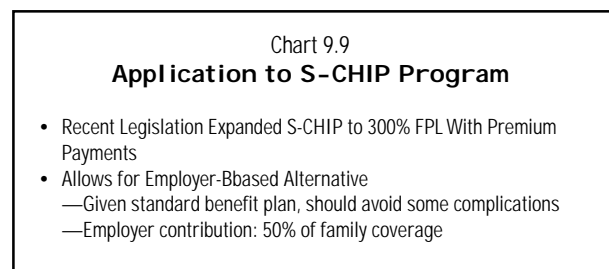


Chart 9.10
Outlook

- Considerable Premium Increases
—Concern with carrier overhead allocation
- Retrenchment on Reforms
—Attempts to re-introduce pre-existing condition restrictions in groups 2–10
—Market segmentation
- Further Erosion of Benefits

Chart 9.11
For More Information

- Maryland Health Care Commission
—www.mhcc.state.md.us
- Review of Small Group Market
- List of Benefits
- Annual Mandated Benefit Evaluation
- Other MHCC Information

■ The Outlook

What is the outlook? Unfortunately, the outlook is no different for our program than for the business community (chart 9.10). Premiums are on the increase. We have been lulled or rewarded with relatively low premium increases for a number of years.

We are seeing the end to that, and it is beginning to show up in the form of double-digit premium increases that I think we have to be seriously concerned with, particularly if it is at all coupled with the slowing in the economy.

One of the concerns that we have specifically in the small group market is the extent to which carriers may be allocating overhead expenses among their small group product, their large group product, and their TPA business. It is important that we be sure that those who are most price sensitive—i.e., the small employers—do not bear the administrative burden of a carrier's other business. In Maryland, small group carriers must report their loss ratios, and the Insurance Commissioner can order a premium change if the loss ratio is below 75 percent. My commission, in cooperation with the Department of Health and Mental Hygiene, is undertaking another initiative this year, a survey to more accurately determine the number of uninsured by county.

We are already seeing carriers, for example, in the small group market starting to eliminate, completely eliminate, agent/broker commissions to the smallest of the small groups, and starting with groups of one, which we include in Maryland. For example, there is a carrier that has dropped providing it at all to groups of under 10.

There have also been some attempts in the General Assembly to back off on reform, attempts to reintroduce pre-existing condition restrictions on

some of the smallest groups. This is going to be, I think, increasingly problematic, and it is driven primarily by the increase in premiums.

So at the state level, we are going to have to work very hard to figure out ways in which we can try to preserve some of the benefits that we have had in supporting the insurance market and keeping those premiums down.

Because of that, I think any attempt to retrench on those reforms would result in a return to market segmentation and the introduction of problems associated with adverse risk selection.

Finally, in Maryland, because of the increase in premiums, we are going to have to make the difficult choices associated with eliminating or reducing benefits. I think that is the important and appropriate tradeoff to make.

As I said earlier, the cost of health insurance is the number one determinant of whether or not people purchase it, and you have to make those tradeoffs in order to keep it affordable. Having that 12 percent limit in Maryland, I think, is critical.

The last point that I will make is that, as we increasingly rely on incremental or sequential approaches to improving health insurance coverage, we must know more about the uninsured—where they are, who are—and the differences within parts of a state are going to be critically important to targeting programs.

We are past the time when we can rely on national estimates at the state level. The Current Population Survey and the Medical Expenditure Panel Survey data are no doubt helpful. But, to be innovative within state programs, we must be able to recognize our groups in coverage if we are ever to fill them.

Note: See chart 9.11 for additional sources of information.



The Influence of Business and Labor on the Delivery of Health Care and Population Health

The Influence of Business and Labor on Health Care

by David Hirschland, United Auto Workers

■ Introduction: The Hospital Project

Our hospital project is designed to give consumers information about quality and cost. The targeted audiences are employees and retirees and also the general public (chart 10.1).

We also give hospitals the information that they can use to improve care. When some of the hospitals didn't rate well in comparison with some of their peers, there were some immediate reactions. First, there was criticism of the inadequacy of the data analysis. Then there was some real process improvement.

I can think of one case where a teaching hospital was rated terribly for satisfaction on maternity care. We were convinced that making sure that physicians went around every day and said, "Hi, I'm your doctor, how are you doing today?" would improve greatly satisfaction. So we have given hospitals information they can use, and have also given purchasers and consumers information to enable them to make better decisions.

This project came out of years of discussions with the Michigan Hospital Association (MHA), the Big Three Auto companies, and the UAW (chart 10.2).

In 1996 and 1997, we developed claim-based profiles (chart 10.3). We have distributed them at both GM and at Chrysler. In 1999, we distributed more information, the American Hospital Association joined as a partner, and the project expanded beyond Michigan.

Currently, we are expanding the profiling effort to regions with high auto population concentrations: Buffalo, Atlanta, Indianapolis, and Cleveland. We are working with coalitions in all of these areas (chart 10.4).

Chart 10.1
Hospital Project Goals

- Give consumers information about quality and cost
 - Employees and retirees
 - The general public
- Give hospitals information that they can use to improve care
- Give purchasers and employers information to make better decisions

Chart 10.2
Project Partners

- Autos and the UAW
- Participating Employers in Regions
- Participating Hospitals
- The American Hospital Association

Chart 10.3
Background

- (1986-96) Ten years of claims-based profiles with no public distribution
- (1996) Southeast Michigan Purchaser Consortium forms
- (1997) Claims-based profiles distributed by GM, Chrysler
- (1998) Three Autos/UAW distribute discharge-abstract-based profiles w/MHA
- (1999) AHA joins as a project partner: project expands beyond Michigan

Chart 10.4
Current Status

- Expanding profiling effort to regions w/high auto population concentrations: Buffalo, Atlanta, Indianapolis, Cleveland
- Working with regional stakeholders and participating hospitals on implementation
- Preparing year 2000 reports with hospital submitted data when possible, and with the best other data sources available when not possible

We are working with regional stakeholders and participating hospitals on implementation, and we prepared year 2000 reports with hospital submitted data, when possible, and with the best other data sources when not possible.

One of the issues we have run into in Cleveland is that two large institutions decided they did not want to be part of these kinds of projects anymore. That makes life more difficult, but we have continued, using available data, such as Health Care Financing Administration (HCFA) data, and employer claim data.

The core components of these projects are: using uniform tools and vendors across the regions; using a consistent reporting format across the regions; and using uniform indicators across regions. We have used indicators for childbirth, surgical care, and medical care (chart 10.5).

Some of the indicators used in the reports are: patient reports of care, which are prepared by the Picker Institute; quality indicators on mortality; length-of-stay data; ACE inhibitor rates; and cost (chart 10.6).

■ HMO Information Project

I would like to describe the environment in which we started work on our health maintenance organization (HMO) information project. A number of us were providing information to auto company employees about HMO quality, and we all had our own methodologies for doing that.

In some cases, GM and Ford evaluated the same HMO using the same data sources and different data weighting. As a result, a plan could look very good at GM and not so good at Ford. There were other players as well, so it was confusing. It also seemed like a wasteful use of resources to do all of these different analyses.

Our goal was to provide enrollees with information that could help them choose a high-quality health plan from among all indemnity, preferred provider organization (PPO), and HMO offerings (chart 10.7).

This project includes the three auto companies and the UAW (chart 10.8). RAND Corporation is our primary contractor. We have worked with the National Committee of Quality Assurance (NCQA) and the Foundation for Accountability to make sure that we were using valid measures in a way that is meaningful to participants.

Chart 10.5
Core Components

- Uniform tools and vendors across regions
- Consistent report format across regions
- Uniform indicators across regions
 - Childbirth
 - Surgical Care
 - Medical Care

Chart 10.6
Indicators included in Reports

- Patient Reports of Care (Picker)
- Quality Indicators: Mortality, LOS, and ACE Inhibitor rates
- Cost

Chart 10.7
HMO Information Project Goal

To provide enrollees with information that helps them choose a high quality health plan from among all indemnity, PPO, and HMO offerings

Chart 10.8
Participating Organizations

- Three autos and the UAW
- Rand Corporation primary contractor
- NCOA and FACCT
- Greater Detroit Area Health Council
- Observers include: State of Michigan, FEHP and HCFA
- Health Plan Feedback

The Greater Detroit Area Health Council, which had been running a parallel project, is also a participant. We have invited, as observers, the State of Michigan, the Federal Employee Health Plan, and HCFA. An important component has been to get health plans to give us feedback on what we were doing. In two or three cases they kept us from making serious mistakes.

We have used generally available information (chart 10.9). So we use the Consumer Assessment of Health Plans (CAHPS) survey, which is a survey that any health plan that participates with NCQA now performs; Health Plan Employer Data and Information Set (HEDIS) measures; and accreditation status. Thus we have not created any additional data collection burden for health plans.

That is an issue that HMOs and other health providers had raised with us. So we use information that they already have.

We are trying to expand this to PPO and indemnity plans, since more than half of our populations at all three companies are in either a PPO or an indemnity plan. There are more difficult data issues there, but we are beginning to work on them this year.

We use a five star rating system with several ranking categories (chart 10.10):

- Staying healthy.
- Getting better and living with illness.
- Doctor communication and service.
- Access and health.
- Accreditation.

The first four of these are based on five different categories that the Foundation for Accountability developed through surveys that they conducted and focus groups that they ran, trying to understand what was important to consumers. Thus we are using categories based on what people say is important to them in evaluating a health plan. Scoring is relative—the best plans get five stars and the worst plans get one star.

Accreditation is reported since we require health plan accreditation our collective bargaining agreements with the autos.

Because we believe it is important to determine the effectiveness of the project, we ran some focus groups at GM after the first year to determine how we had done. The news was not great.

Chart 10.9
Process

- Data sources
 - CAHPS survey
 - HEDIS measures
 - Accreditation status
- No additional data collection burden on HMOs
 - PPO and indemnity data issues
 - Five star ranking system

Chart 10.10
Comparative Scoring of Plans

- Ranking Categories
 - Staying Healthy
 - Getting Better and Living with Illness
 - Doctor Communication and Service
 - Access and Service
- Accreditation (yes/no)

Chart 10.11
Impact of Project

- After first year participant focus groups indicated that there were presentation issues
- Health Plans have been very focused on improving scores on measures that are used

We asked the focus groups, “What do you think of our mailings?” They said they didn’t remember them. When we showed the material to them, they said, “We don’t think it’s very good.”

We took that and spent a lot more time on communications the second year. We are going to go through that same feedback process again (chart 10.11).

In all of these areas, we are going to start thinking about measuring the extent to which these efforts drive behavior. For example, we will look to see whether people move from hospitals that do not rate well to hospitals that do rate well.

In recent years many people have become familiar with some of the data on open-heart surgery rates indicating that it is preferable to have surgery at a hospital with a high volume of this type of surgery. We know that an appallingly large number of people are going to hospitals that don’t perform as well as these high-volume hospi-

tals. We want to see if the information can be made more effective and get people's attention.

Certainly, these same kinds of issues show up in the health plan area as well.

■ The Michigan Antibiotic Resistance Project

This project is in its initial stages, and is one that was primarily inspired at General Motors (chart 10.12). Its genesis was the recognition that often when an individual has a viral infection, antibiotics are prescribed, and although these antibiotics do no good, they can do some harm in that they build up resistance. Later on, if antibiotics are needed, they may not work.

After we identified the issue, we formed a coalition. We received some initial funding from an outside source, and started developing physician education materials (chart 10.13).

The goal was to reduce inappropriate utilization of antibiotics. Again, the participants include the autos, the UAW, several universities, consumer groups, drug companies, physician organizations, the Michigan Hospital Association, health plans, the Michigan Nurses Association, and the State of Michigan.

Chart 10.12

Michigan Antibiotic Resistance Reduction (MARR) Project

- Goal: to reduce inappropriate utilization of antibiotics
- Participants: Auto companies, UAW, several universities, consumer groups, drug companies, physician organizations, Michigan Hospital Association, health plans, Michigan Nurses Association, State of Michigan

Chart 10.13

Michigan Antibiotic Resistance Reduction (MARR) Project

- Process
 - Identified issue
 - Formed coalition
 - Received initial funding
 - Developed physician education materials
- Website: www.mi.marr.org

The Role of Business and Labor in the Delivery of Health Care

by Gary N. Pheley, General Motors

■ Introduction

The UAW and General Motors have memorialized their mission statement in our collective bargaining agreement. Basically, it states that we are committed to encourage the development of community health care delivery systems, particularly those in which we have large populations of General Motors employees and retirees (chart 11.1).

We are committed to do that by encouraging high-quality and cost-effective health services, promoting disease and accident prevention, expanding health education, and improving community health status.

We consider this truly a quality initiative. It is our philosophy that by focusing on quality and by eliminating waste in the system, health care costs will eventually be reduced as well. Cost is certainly an issue, but the driving force is quality.

We are interested in improving the health status of our communities. We are a large company.

We can provide health care to approximately 1.2 million individuals, and we spend about \$3.5 billion a year.

While we are concerned about both quality and cost, we recognize that we do not operate in a vacuum and that we need to address health care at the community level, where it is delivered.

Additional efforts are aimed at stimulating community activity and coalitions or collaboratives consisting of consumers, purchasers, caregivers, and providers who are dedicated to improving the health care system by promoting the delivery of high quality care.

That is not necessarily less care, but it is appropriate care. We want to address both overuse and underuse. We want to help establish cultures of best practice and promote the use of state-of-the-art data collection systems and information systems at each of the community initiatives.

■ The Initiatives

We start with an assessment. We contracted with the Lewin Consulting Group to do a needs analysis and a health status assessment of the whole community to provide a common base of data for the coalition to work from in order to move forward.

One of our efforts is to promote the balancing of community health care needs with the community's resources. Examples of this effort are discussed in the following paragraphs.

Chart 11. 2 shows the areas where we have joint UAW/management teams. I say joint UAW and management, because it is not just General Motors. All three of what used to be known as the domestic autos have partnered with the UAW.

General Motors and the UAW have initia-

Chart 11.1 GM/UAW Community Initiatives Vision - Mission Statement	
• Committed to:	Encourage high quality/cost effective health services Promote disease and accident prevention Expand health education Improve community health status
• Stimulate community activity, coalitions, collaboration (consumers, purchasers, caregivers and providers)	
• Promote	Delivery of high quality care Culture of best practice State of the art data collection and information systems Balancing community health care resources with community needs

Note: This chapter is an EBRI-ERF-edited version of Mr. Pheley's oral presentation.

Chart 11.2
**Community Initiatives Sites
Joint Management/UAW Teams**

Anderson, IN	UAW/GM
Flint, MI	UAW/GM
Warren/Youngstown, OH	UAW/IUE/GM
Kokomo, IN	UAW/D-C
Wilmington/Newark, DE	UAW/D-C
Kansas City, KS/MO	UAW/Ford

tives in Anderson, IN; Flint, MI; and Warren/Youngstown, OH. The one in Warren/Youngstown is particularly interesting in that we have a third partner there, which is the IUE, another union that represents a number of our employees.

Similarly, Daimler-Chrysler and UAW have initiatives in Kokomo, IN and Wilmington, DE. I should note that the autos try to support one another in these efforts. So while Chrysler is the lead there, we try to support them in Kokomo and Wilmington, and likewise they do the same thing for us where appropriate. Also, Ford has an initiative in Kansas City, MO.

There is quite a commitment here on behalf of the parties. There are at least one full-time management and one full-time union representative dedicated to each project, actually living in the community and working with other community stakeholders. We look at ourselves not as the owners of the project, but as catalysts providing support and data, where possible.

I would like to focus on Anderson, IN, in Madison County, located in the central part of the state, as an example of one of these initiatives.

The coalition or collaborative that is now known as Madison Health Partners Madison for Madison County began in 1996 and has evolved in the following way (chart 11.3).

Health Search, as shown on the chart, was a previously existing organization. It is about 10 years old, and was started by a former mayor. It addressed certain issues such as teen pregnancy and elder care.

It was in place and working effectively. The coalition wanted to be broader than that, but this was a project that they thought should not be duplicated. It could fit well with the collaborative.

Similarly, the Minority Health Coalition is an independent group that is working well with Madison Health Partners. Some of its priorities are childhood immunization and teen pregnancies, and again it fits in well.

Madison Health Partners started with an initial membership of about 25 people, and it has grown to about 125. It has a lot of support from the local government, including the mayor and his staff.

■ The Subcommittees of Madison Health Partners

These subcommittees are critical to the success of the Madison Health Partners.

The Quality Committee works on clinical issues. It is led by two primary care physicians (PCPs), and this leadership is critical to its effectiveness.

The Health Status Committee deals with access issues and education, using such vehicles as health fairs, diabetes education and screening, and cardiovascular education.

The Facilities and Technology Committee includes CEOs from all three hospitals. They work on joint clinical training programs in areas such as the asthma initiative (discussed later) and are involved in establishing an environment that

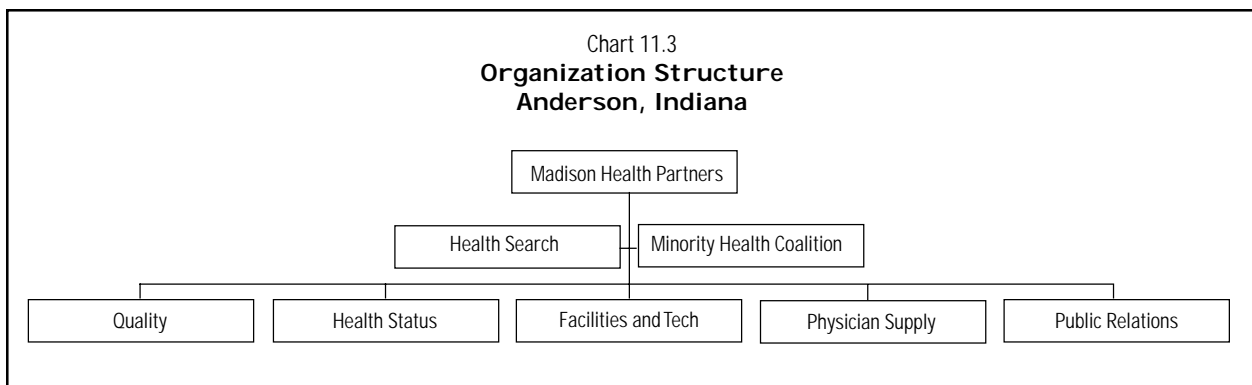


Chart 11.4 Madison Health Partners Objectives
<ul style="list-style-type: none"> • To Improve the Health Status of the Residents of Madison County • To Improve the Efficiency and Effectiveness of the Health Care Delivery System

Chart 11.5 Madison Health Partners Top Ten Areas of Focus
<ul style="list-style-type: none"> • Increase Number of Primary Care Physicians • Change Consumer Expectations and Lifestyle Decisions • Encourage Physician Practice of Evidence Based Medicine • Improve the Quality and Lower the Cost of Health Care • Improve Health of Low Income and Minority Residents • Improve Education and Care for Cardiovascular Disease and Cancer • Reduce Teenage Pregnancy Rates • Improve Maternal and Child Health Outcomes • Improve Access to Care • Improve Hospital Collaboration and Sharing of Resources

fosters collaboration among the hospitals.

One of the things that they are dealing with—although progress in this area is slow and is expected to be slow—is how to handle overcapacity across the county.

The Public Relations Committee is dedicated to getting the message out in terms of who Madison Health Partners are and what their objectives are. One of the things that they discovered in Madison County was that they were trying to accomplish a lot of good things, but without getting the word out they were not getting anywhere. They didn't have much leverage.

So they've recruited the PR directors from one of the hospitals, someone from the Chamber and, as I understand it, the PR director from the racetrack.

■ Objectives of the Madison Health Partners

The objectives, briefly stated, are to improve the health status of the residents of Madison County (chart 11.4). This is broader than UAW and General Motors. The philosophy is that we can't just address our little corner of the world; we have to address the whole community, and we need to improve the efficiency and effectiveness of the health care delivery system.

The top 10 areas of focus developed by the original 24 members from Madison Health Partners—not only General Motors and UAW but various stakeholders as well (chart 11.5). These were developed as a result of looking at the data generated in the independent assessment prepared by the Lewin Group. Some of the needs identified included:

- The need to increase the number of PCPs. This has been done. A recruiting process was con-

- ducted, and the number of PCPs was increased.
- The need to change consumer expectations and lifestyle decisions: This is one of the key initiatives of the Health Status Committee through their educational programs.
- The need to encourage physician practice of evidence-based medicine—one of the key initiatives of the Quality Committee.
- The need to improve the quality and lower the cost of health care: basically everybody is involved in this. It includes the need to improve health of low-income and minority residents, which is the responsibility of the Minority Health Coalition in conjunction with all of the other committees.
- The need to improve education and care for cardiovascular disease and cancer. Cardiovascular disease has been addressed by both the Quality and Health Status Committees. There have not been any interventions yet in the area of cancer. That remains to be done.
- The need to reduce teenage pregnancy rates. This was already one of the charges of the Health Search Group, as listed on chart 11.5.
- The need to improve maternal and child care—child health outcomes. This is part of the Health Search activity. Similarly, there is a need to improve access to care and improve hospital collaboration, and to share resources.

These have been the priorities for the last four years, and the team is going off-site this summer to reassess these priorities and see which ones can be checked off and which ones need to be tweaked and which new ones need to be addressed.

Chart 11.6
Quality Committee Initiatives

- Asthma Education Partners
- Diabetes Management
- Hysterectomy Appropriateness
- Prescription Drugs
 - Gastrointestinal Drugs
 - Generic Education Program
 - Physician Office Technology
 - Community Profiling

Chart 11.7
Asthma Education Partners Objectives

- Increase Physician knowledge/skills with NHLBI guidelines
- Improve patient education
- Reduce emergency room visits for asthma
- Reduce hospital admissions for asthma
- Increase patient quality of life

■ Specific Initiatives

The Quality Committee is involved in a number of initiatives, including asthma education, diabetes management, and hysterectomy appropriateness (chart 11.6).

We are also working on some prescription drug initiatives, including gastrointestinal. There is an indication that utilization is very high in the community. We also want to do some work relative to generic education, and we are beginning to work with physicians on office technology, working with PBMs on electronic prescription writing to reduce error.

In that regard, we are working on a project of community profiling. So far we have been limited to the GM database, but we are searching for ways to expand this. We are working on looking at a broader base across the community so that we can give physicians feedback on their prescribing profiles.

Asthma Education

The Quality Committee initiative on asthma education is the most mature program in Madison County. We are working with the National Heart, Lung and Blood Institute (NHLBI) guidelines to increase physician knowledge and skills (chart 11.7).

Physician leadership is critical here. Physicians meet with other physicians to review the guidelines and proper care and prescribing practices. A key component of the initiative to improve patient education is a clinic that is free to participants. Respiratory therapists sit with patients and give them proper instructions on how to treat their asthma.

The program aims to reduce unnecessary emergency room visits for asthma, as well as reduce hospital admissions. We think that will

increase patients' quality of life, and surveys are being put in place to see how effectively the program does this.

This program's goal is to teach patients to manage their asthma better (chart 11.8). It is jointly administered by all three county hospitals.

Physician training uses the NHLBI guidelines. Patients are referred to the clinic by the PCP. The PCP develops a care plan, and a respiratory therapist reviews it with the patient. There is a communication loop whereby the PCP gets feedback from the therapist concerning how the patient's treatment is progressing.

The program consists of three one-on-one education sessions conducted by the respiratory therapist. Peak flow meters are provided as well as spacers, and the patients are taught their proper use. A patient's quality of life survey is completed quarterly, and again all services are free of charge.

During the sessions with the therapists, patients are given information on recognizing the signs and symptoms of asthma; the medication they are taking, including what it is and what to expect, how it will affect them; and the proper use of peak flow meter and the spacer. They are instructed in awareness and avoidance of allergens and other triggers and how to react to an attack (chart 11.9).

The funding comes from contributions from

Chart 11.8
Asthma Education Partners Program Description

- Goal: Teach patients to manage asthma
- Jointly administered by all three county hospitals
- Physician training using NHLBI guidelines
- Referral and care plan development by PCP
- Three education sessions conducted by RTs
- Peak flow meters and spacers provided
- Patient QOL survey completed at regular intervals
- All services are free of charge

Chart 11.9
**Asthma Education Partners
Content of Sessions**

- Recognizing signs and symptoms
- Information about asthma medication
- Proper use of peak flow meter and spacer
- Awareness and avoidance of allergens and other asthma triggers

various community organizations and companies. Some drug companies have contributed. Hospitals get a nominal fee for their therapists' training, but all parties are pulling together to make this service available free to anyone who needs it.

Unfortunately, we don't have communitywide data yet on hospital admission rates for asthma. These are GM-only data. However, if hospital admissions are considered as a sign of failure, the downward trend on chart 11.10, obviously, is good.

It appears that we have good community awareness of this asthma program and the need for proper treatment, but in the future we want to improve our ability to measure this.

We do not know yet how the hospital admission rate has changed for the people who go to the clinic. That is one of the things we are interested in studying over a longer period of time.

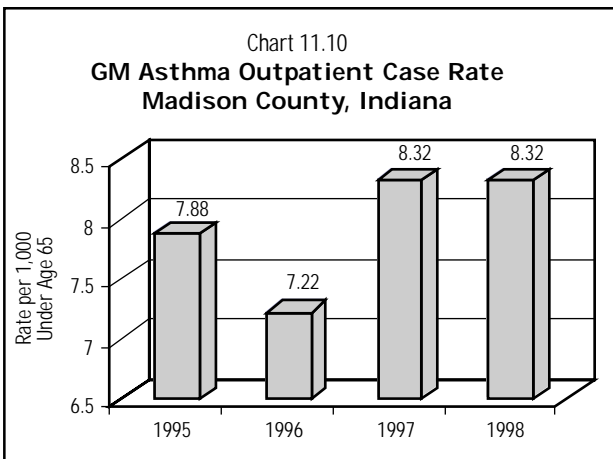
Diabetes

The Quality Committee's diabetes management initiatives are working toward increasing the physician knowledge and skills with ADA guidelines and monitoring Hba1c test compliance and values (chart 11.11). The hospitals now report every two months the number of tests they have conducted and the values. Work is continuing on improving education through health fairs and other health education programs.

One of the big problems is trying to identify undiagnosed patients with diabetes. Estimates are

Chart 11.11
**Diabetes Management
Objectives**

- Increase Physician knowledge/skills with ADA guidelines
- Monitor Hba1c test compliance and values
- Improve patient education
- Identify undiagnosed patients with diabetes



that up to half the people with diabetes go undiagnosed.

Hysterectomy

Another objective of the Quality Committee is the hysterectomy appropriateness objective, using ACOG guidelines. The quality managers of the hospitals are doing 100 percent chart reviews.

Historically, the hysterectomy rate for Anderson has been far above the national average. So quality managers of hospitals are doing chart reviews. They are reporting back to the Quality Committee. They are also reporting results in peer review relative to clinical appropriateness as well as case file documentation.

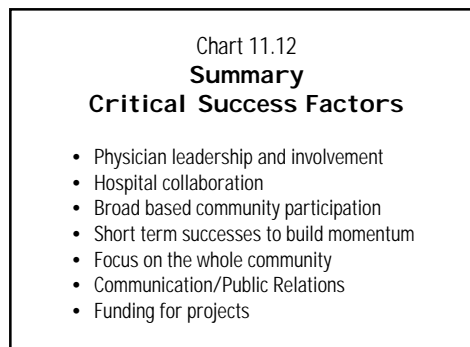
We are also involved in improving patient education in women's health issues, and working in coordination with the patient, the PCP, and the OB/GYN.

These data will be more useful as we begin to get experience with interventions. Again, this is only GM data; what we really need is communitywide data. We started this project in 1997. When the final numbers become available for 1999, we think they will show a lower rate for that year.

Conclusion

In summary, we are not at a point where we would claim total success, by any means. But we think that we have some initiatives in place that are going to pay dividends in quality and effectiveness in the long run (chart 11.12).

Physician leadership and involvement are critical, as is hospital collaboration. It is important



for the providers to work together. Broad-based community participation is critical and needs to include all of the stakeholders.

Short-term successes were important to start building momentum. We think that, even though we don't have great measurements yet for asthma, the process is place and the cooperation that occurred in putting this initiative in place was very important.

Again, the focus is on the whole community, not just GM, UAW. In terms of what is being

done relative to helping small business, one of the coalitions in which GM and the UAW participate is committed to studying how it might be feasible to offer low-cost policies to small businesses.

As I mentioned, we determined that communication and public relations are critical, and now that the effort has been stepped up, it has helped.

Funding for projects is always an issue. It is a matter of seeking funds wherever you can appropriately find them.



Options to Enhance the Employment-Based Health Insurance System: The Commonwealth Fund

The Commonwealth Fund Task Force on the Future of Health Insurance

by Lisa Duchon, The Commonwealth Fund

■ Introduction

I would like to begin by giving some background on the larger efforts of The Commonwealth Fund that are behind the work that is discussed in the following chapters. The Commonwealth Fund launched the Task Force on the Future of Health Insurance in 1999, naming Janet Shikles as Executive Director of the Task Force. She is vice president for health services research and consulting at Abt Associates.

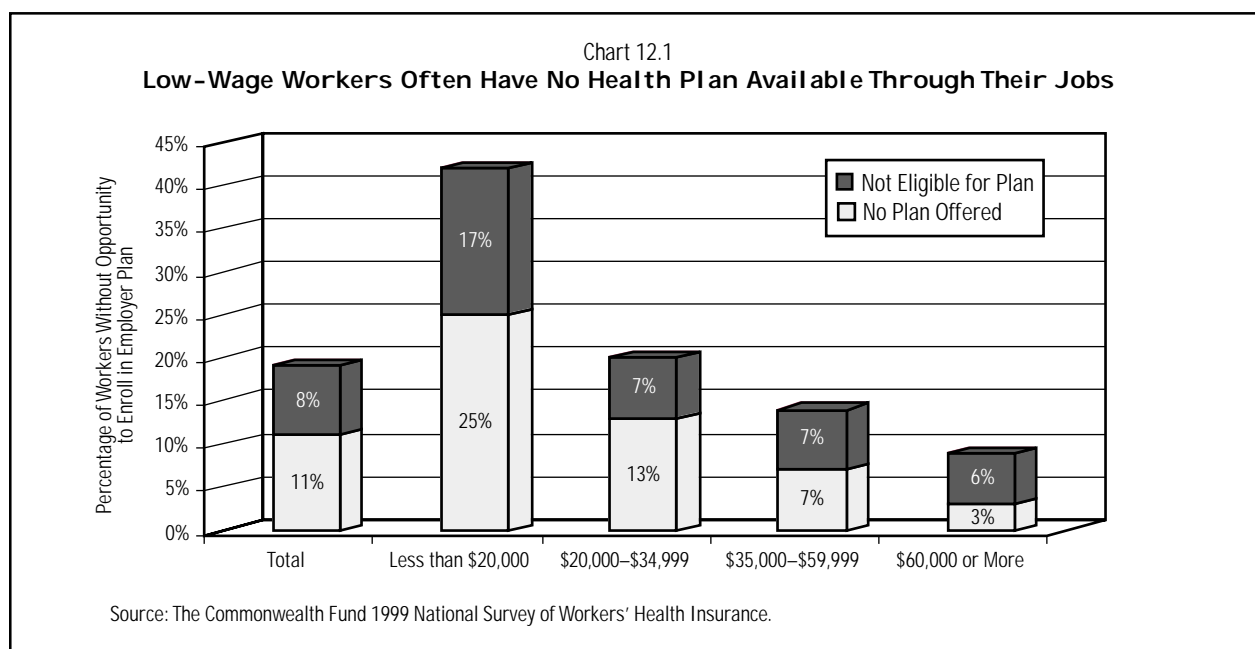
The Task Force has the overall mission of improving health insurance coverage and trying to develop ways to make the health insurance system meet the needs of a 21st century work force. One way that the Task Force has sought to fulfill this mission is to issue reports that highlight groups that are often lacking insurance or lacking access to

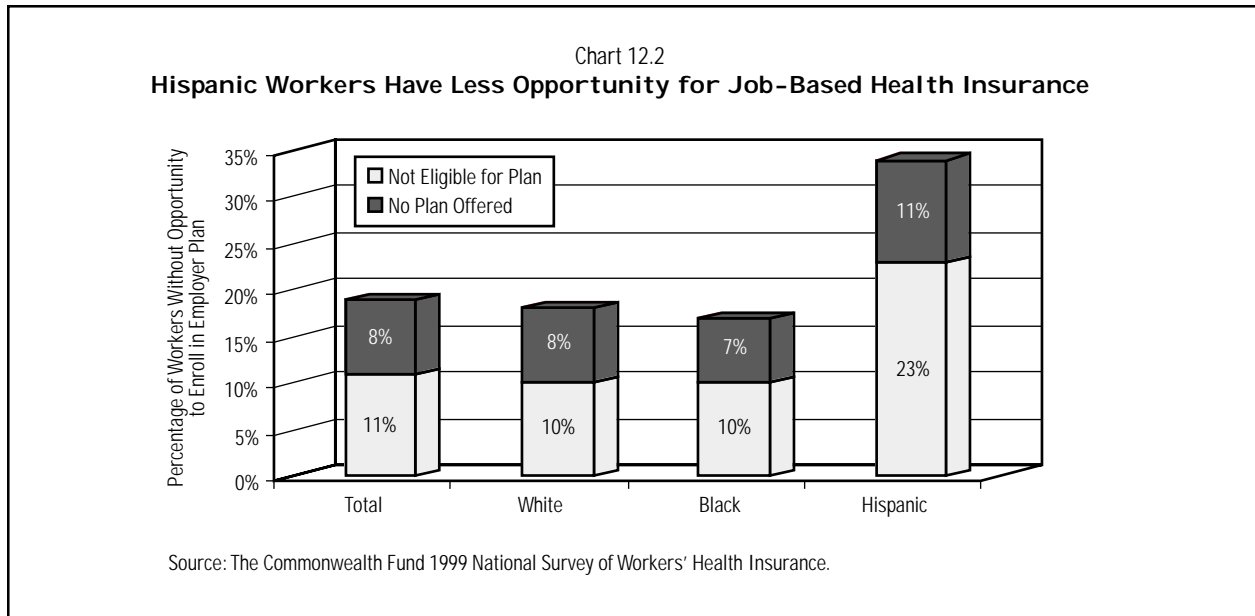
employment-based coverage—the predominant source of coverage for the working-age population.

■ Reports on the Diversity of the Uninsured Population

The Task Force has issued four reports to date. In one report we looked at low-income workers, of which four in 10 are without access to employment-based coverage, compared with only one in 10 among high-income earners (chart 12.1).

We also issued a report recently on the insurance crisis facing the U.S. Hispanic population. One-third of Hispanic workers have no opportunity to obtain employment-based coverage, compared with just one-fifth of all workers (chart 12.2). The result is that 41 percent of





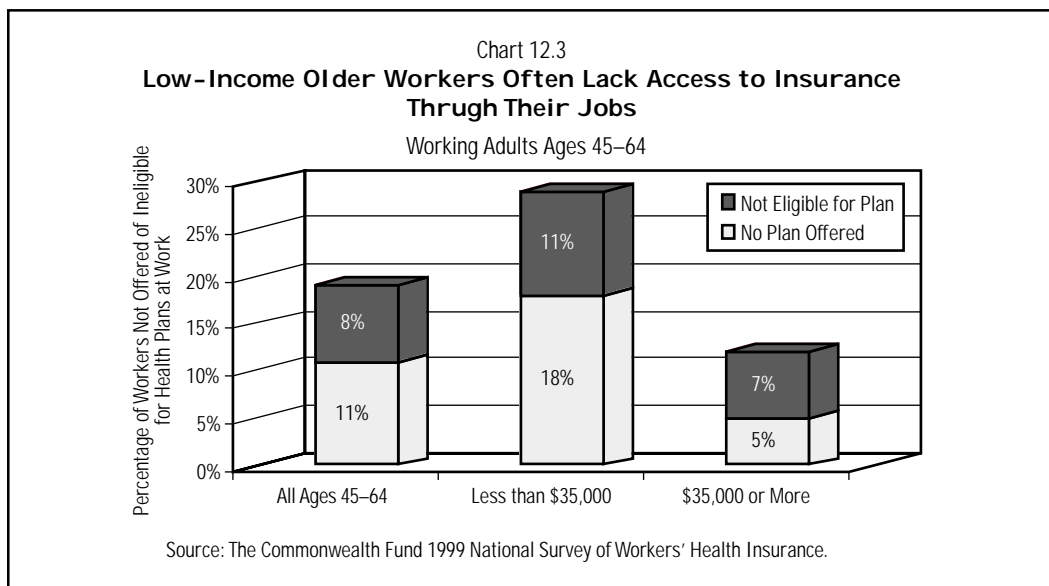
Hispanic adults under age 65 are uninsured.

We also examined adults in the “mid-life” age group ages 45–64 who are at risk of being uninsured at a time when they are also at growing risk for having health problems. Three of 10 workers with incomes below \$35,000 who are in this age group cannot get insurance coverage through their jobs (chart 12.3).

The Task Force will soon release a report on younger adults, ages 19–29, the age group with the highest uninsured rate. We learned that nearly four out of 10 college-age adults who are not lucky

enough to be in school full time—mainly because they have to work either part time or full time—are uninsured. In contrast, full-time students can typically stay on their parents’ plan by virtue of being full time students, or they can get health insurance through their school’s student insurance plan (chart 12.4).

The purpose of these reports is to help policymakers better understand the diversity of the uninsured population as they grapple with incremental strategies to make insurance coverage more accessible and more affordable. As will become



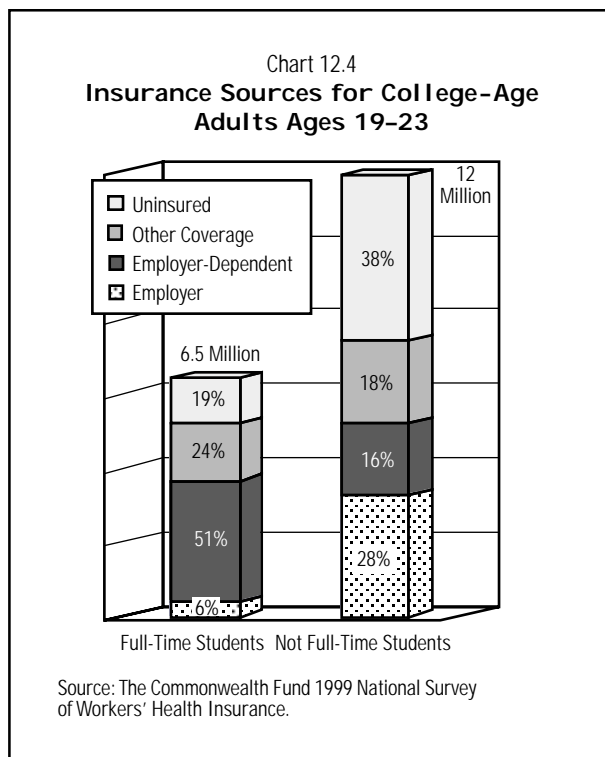
clear, even incremental approaches are complex and costly, and there is practical limit to what we can do.

With the political appetite for large, sweeping reforms diminished, and with the presidential and congressional elections on the horizon, the Task Force was designed to serve as an “honest broker” in assessing incremental expansion options that we call workable solutions. These are approaches that can provide a new Congress and a new president, state legislatures, and governors some practical strategies to consider, that they can adapt and modify to fit their own constraints and priorities; we have already started working with a few states in this way.

We will be issuing some reports later this year that group the different incremental approaches that we considered. These reports will explain the tradeoffs involved and have side-by-side comparisons of the costs and estimates of newly insured individuals for each of these options, and we will also describe ways that these different options can be packaged and combined.

■ Expanding Coverage

Three authors—Jack Meyer, Mark Meyer, and Vernon Smith—present three approaches that involve employers or employer-based insurance to expand coverage to workers. In the next chapter, Sherry Glied, director of the Task Force’s Workable Solutions project, gives an overview of this project.



Workable Solutions for Improving Health Insurance Coverage

by Sherry Glied, Columbia University

■ Introduction

As project director of this project of the Commonwealth Fund's Task Force on the Future of Health Insurance, I am working with a group of 10 authors to develop some proposals for workable solutions. These 10 proposals take three different approaches to incrementally expanding the number of people who have health insurance in this country (chart 13.1).

The first set of approaches is directed at individuals. These are the approaches we have heard about from the presidential candidates. They include tax credits to individuals and public program expansions (expansions of the Children's Health Insurance Program (CHIP) or Medicaid). We are looking at some options within this category.

A second group of approaches that we are considering are those that focus on purchasing arrangements. One such approach would be to open the Federal Employee's Health Benefit Program (FEHBP) and allow individuals and small firms to purchase coverage through this program. An alternative along the same lines would be to use purchasing groups or coalitions to allow individuals and small employers to buy coverage. These

approaches would allow new venues for coverage to be opened up for individuals and small employers.

The third set of approaches, which are examined in more detail in the following discussions, are approaches that focus on employers.

■ Working Through Employers

There are some significant advantages to working through employers in terms of expanding insurance coverage (chart 13.2). I think some of them don't get enough press.

A lot of attention has been focused on the price advantages of operating through employers. These advantages are partly a consequence of the tax system, which subsidizes employment-based coverage, and partly a result of the fact that employers are better at purchasing coverage than individuals could be.

I note also that there are significant economies of scale in expertise and administration in getting coverage through employers. These economies make it easier for employers to provide individuals with coverage, not simply through lower prices but through better enrollment procedures and better procedures for actually paying for

Chart 13.1
Workable Solutions to Expand Coverage

- Individual approaches
 - tax credit to individuals
 - public program expansions
- Purchasing approaches
 - FEHBP
 - purchasing groups
- Employer approaches

Source: Sherry Glied.

Chart 13.2
Advantages and Disadvantages of Working Through Employers

- Individual take-up rates
 - Medicaid expansions: 50–60%
 - HITC: 25%
 - Employer-sponsored coverage: 80–90%
- Employer take-up rates for subsidies
 - low level, low elasticity
- Crowd-out issues

Source: Sherry Glied.

coverage.

This becomes manifestly apparent when you look at take-up rates. If you compare the number of people who actually sign up for coverage that they are eligible for under Medicaid, for example, under the Medicaid expansions, only between half and two-thirds of those eligible actually take up that coverage.

When the health insurance tax credit effort was undertaken in the early 1990s, the total share of eligibles who took up the credit under that approach was only 25 percent. In contrast to that, when employers offer coverage to their employees, a very substantial proportion of employees take up that coverage. That is a benefit that we do not recognize enough.

The flip side of this is that there are some real weaknesses in working through employers. First, it is hard to get employers to participate. Evidence on take-up rates for employment-based subsidies from programs that have already been implemented, demonstration projects, are low. The effect of lowering prices does not seem to be as strong as we would want it to be.

A second kind of problem that affects employer-focused solutions is that employers have been, in some respects, too successful. No matter where the income limit is put on an employment-based subsidy program, you are going to pick up a lot of people who are already insured. Thus, employment-based approaches have real crowd-out problems that have important policy implications.

■ Workable Solutions

One thing we have recognized already in working through this project is that we need to look at combinations and permutations (chart 13.3). The uninsured are a very diverse group. No one solution is going to work for all uninsured people, and we have structured the workable solutions project in a

Chart 13.3
Combinations and Permutations

- The uninsured are diverse— no one solution will work for all
- Proposals within and across categories could be mixed and matched
 - e.g., employer tax credit + individual tax credit
 - e.g., employer purchasing group + individual coverage expansion

Source: Sherry Glied.

Chart 13.4
Parameters of a Basic Individual Tax Credit
(Larry Zelenak, UNC Law School)

- Tax credit of \$2000 individual, \$4000 family
- Full credit to households with incomes < 200% FPL, phasing out through approximately 300% FPL
- Not available for ESI

Source: Sherry Glied.

way that encourages thinking about solutions that could be mixed and matched.

For example, an individual tax credit approach could be combined with an employer tax credit approach. We might open up an employer purchasing option through a public expansion and combine it with new options for people to get individual coverage through public programs.

In this context, I want to discuss the parameters of the individual tax credit approach that is part of our package, because several of the other projects build off this individual tax credit approach.

This tax credit approach would be based on a credit of about \$2,000 for an individual and \$4,000 for a family, focusing most strongly on families under 200 percent of poverty and phasing out through approximately 300 percent of poverty (chart 13.4). People could not use this individual tax credit to buy employment-based coverage. Some of the approaches discussed in the following chapters involve combining this particular individual tax credit with an approach that would allow individuals to buy into employer coverage.

We have asked the authors to do some very specific things in thinking about these proposals (chart 13.5). First, we have asked them to give us the very best possible design for the model that they have selected. Some of the authors have come to feel that their basic model does not really work that well. We have emphasized that they should describe how best to make this model work if, despite their misgivings, it were the one selected by policymakers.

Second, we have asked the authors to focus on implementation issues: not merely to think of a great idea, but to explain how it is actually going to work. How is the money going to flow? Who is going

Chart 13.5
Charge to Authors

- Given the basic model, develop the very best possible design.
- Focus on implementation issues — how would this actually work?
- Address advantages and disadvantages
- Address interaction with other programs

Source: Sherry Glied.

to fill in the forms, and who is going to collect the funds?

Third, we have asked them to address the advantages and disadvantages of their approach and to consider the interaction between what they are doing with other approaches that are already being used.

Federal Health Insurance Tax Credits for Employers: A Strategy to Encourage Offering of Health Insurance Coverage

by Jack A. Meyer, Economic and Social Research Institute

■ Introduction

I would like to describe a strategy that involves using tax credits to provide incentives for employers to offer health coverage to their workers. I want to credit my co-author Elliot Wicks. He and I developed this proposal together.

Let me start by setting some key parameters. I want to say at the outset that there are various ways to do this. I am going to give you an illustration of how to do it, but what you would really want to do with any of these proposals is load them into a spreadsheet, adjust the parameters, and see how the coverage rates and costs vary when you change the parameters—because you get what you pay for.

■ The Tax Credit Amount

First, let us start by noting that one thing we want to do is to have a tax credit that is set at a fixed-dollar amount (chart 14.1). You want firms to have an incentive to select cost-effective health plans. If you have a fixed-dollar tax credit, that credit will be a higher proportion of the cost of a lower-priced health plan and, therefore, help the employer

choosing that plan relatively more. So it creates the right incentives.

Second, you want the credit to be a large enough proportion of the cost of the health plan premium to induce a significant number of employers to participate. Let's say, for the purpose of discussion, that the credit will be \$200 a month for family coverage. We know from reviewing the literature and the experience with studies involving pilot projects sponsored by the Robert Wood Johnson Foundation that small tax credits induce a very low take-up rate among companies.

We looked at some states that have tax credits for employers as low as \$25 per month per worker, and these generated very little interest. In fact, two of the lessons coming out of that experience are that states need to set the credit at a decent amount and they need to widely publicize the availability of the subsidy. If you don't tell employers about subsidies and don't put some money into them, you'll just have a cheap program with poor results. The studies I've seen suggest that a decent percentage has to be at least one-third and probably one-half the cost of a health plan. So it is some real money.

We decided to gear the value of the credit to the value of a standard benefit package available from a *cost-effective* health plan, again to create incentives to contain costs. You could determine the nationwide average cost of family policies offered by managed health plans with a good record. Let's assume that is \$4,800 a year. If the credit were set to equal one-half of that, as we suggest, it would be \$2,400 a year, or \$200 a month. Thus, any firm with a yearly premium in excess of \$2,400 per worker would get a subsidy of \$2,400 a year for each employee who accepts coverage.

Chart 14.1
Key Design Features

- The tax credit is set at a fixed-dollar amount per worker
- The credit is a large enough proportion of the cost of health coverage to induce a meaningful take-up rate
- The credit is tied to the price of a "standard" cost-effective benefit package

Source: Jack A. Meyer

Chart 14.2
Key Design Features

- The credit is uniform across the nation
- Firms must contribute toward the premium an amount equal to at least 50 percent of the cost of the standard benefit package
- The credit amount per worker for single coverage will be one-half the value of family coverage

Source: Jack A. Meyer

Chart 14.3
Key Design Features

- The credit will be available only to low-wage firms—those with average wage levels below \$10 per hour—and would be graduated so that the amount of the credit would be largest for firms with the lowest average wage levels
- The credit will be offered to all low-wage firms, including those already contributing to the cost of health coverage.

Source: Jack A. Meyer.

We decided to make the credit uniform across the nation (chart 14.2). This probably doesn't meet a pure equity standard, because we know that health costs are much higher in Boston and New York than they are in places such as San Francisco or Seattle. So a fixed-dollar uniform tax credit will not go as far in some areas as it does in others. However, it would probably be an administrative nightmare to vary tax credits by region. The Internal Revenue Service would be the first to tell you that, and they would oppose any proposal that included that—and administrative simplicity is one of the advantages of this approach. So you don't want to vitiate the plan by making it too complex. You may just have to accept geographic inequities.

A third feature of this proposal is that firms must contribute at least 50 percent of the cost of the standard benefit package. We want to make the subsidy large enough to induce a high employer take-up rate, but we also want to ensure a high *employee* take-up rate. We don't want the employer contribution to be so skimpy that employees are left with a share that holds down their acceptance rate. If employees were to put in only 20 percent of the premium cost, for example, that's going to leave 80 percent for the employees. So we felt that employers ought to have to put in 50 percent. Again, that is still a reasonable standard. Many firms currently pay 75 percent or 80 percent of the premium cost. Then we determined that we would have two rates, one for family coverage—in this example, a \$200 a month tax credit—and one for single coverage that would be half that amount—in this example, \$100 a month. The \$200 a month is really a blend of different types of family coverage. As you know, insurers tend to offer one rate for a couple with no kids, another for a single parent and a kid, and yet another for a husband, wife, and kids. We are saying we will take a blended average of those family policy rates—again, for simplicity. But the

market for single coverage is quite different. So we make that a separate premium category.

■ Targeting the Subsidy to Low-Wage Firms

The most innovative feature of this approach—one that distinguishes it from prior proposals—is targeting the tax subsidy to only lower-wage firms, not all firms or even all small firms (chart 14.3). We propose to target firms with an average wage level of \$10 an hour or less. That's the *average* rate to qualify for eligibility; firms could have some employees that make more than that.

What we're trying to do is to avoid giving tax subsidies to affluent professionals, when the tax revenue that supports such subsidies is paid for with hard-earned, middle-class tax payers' dollars. We don't want to subsidize firms that have very few needy employees. We really want to target those firms that are least likely to find health coverage to be affordable and whose employees are either uninsured or making a real sacrifice, perhaps in forgone wages, to take health coverage.

The way our system would work is that firms whose average wage level is less than \$7 an hour would get the complete subsidy—which, remember, is about one-half the cost of the standard plan. So this firm would get the \$200 a month tax credit.

If a firm's average rate was in the range of \$7.00 to \$8.50 per hour, it would get 40 percent of the standard benefit or, in this case, \$160 a month instead of \$200; and if a company were in the \$8.50 to \$10.00 an hour range, it would get 30 percent or, in this case, \$120 a month. Above \$10 an hour, the firm would get nothing.

This graduated subsidy reduces, but does not eliminate, "notch" problems: firms that are just below a cutoff point and increase their average

Chart 14.4
Supportive Policies

- Financial support for lower-wage workers to assist them in paying their share of the premium
- Insurance market reforms
- small employer market
- individual insurance market
- Aggressive marketing campaign

Source: Jack A. Meyer.

wage just slightly could take a substantial cut in their subsidy. Could we reconfigure the arrangement to make the descent smoother? Of course: we could have five or more categories instead of three, but we do have to worry about more administrative complexity.

So again, there's a trade-off between administrative management and feasibility, on the one hand, and trying to completely eliminate notch problems and work disincentives, on the other. A fourth notable feature of this proposal is that we advocate offering the subsidy to all low-wage firms, including those companies already contributing to the cost of health coverage. I will briefly outline the pros and cons of this approach compared with an approach that targets the subsidy only to firms not offering coverage.

The approach of assisting all lower-wage firms, even if they've been buying coverage, meets two key tests. First, it passes the fairness test. If we give a subsidy only to firms that have *not* been offering coverage, we lower their labor costs and thereby give them a competitive edge relative to firms that have "been doing the right thing" for years by offering and paying for coverage for their employees. In addition, this approach is more fair to workers: Why should a low-wage worker who accepts employer-sponsored coverage and thus accepts lower wages or less in nonhealth benefits (plus contributes to a premium) get no help, while a subsidy is given to comparable workers who get higher wages because they work for firms that previously offered no coverage?

Second, this approach will make the program much more politically popular—and we do have to pay attention to such things. On the other hand, a plan like this will obviously cost more. There are many more firms with more than 10 employees that offer coverage than firms that don't; and we will be giving them a kind of a

windfall gain, in a sense, and underwriting the costs of doing something that they are already doing. So the cost will go up, and the target efficiency, as we like to say, will go down. You could make a case either way, but we decided to avoid the difficult equity problems even though it would increase the government's price tag.

■ Supportive Policies

A tax credit for employers has to be complemented by some supporting policies, and I will mention just a few (chart 14.4).

First, if you adopted our option, you would want to do some version of Mark Merlis' option¹ that may be complementary. Of course, as Merlis points out, we're both spending the employees' money. It's just a matter of who writes the checks. But even with the design features that Elliot Wicks and I have tried to build into this proposal, there'll be some hardships for workers affording their share of the premium, which, as I say, may be as high as 50 percent. Particularly in small firms, 50/50 premium splits are not uncommon. So if the policy costs \$5,000 per year, the employee pays \$2,500. For a family making \$16,000, \$18,000, \$20,000, or \$22,000 a year, that's about 10 percent to 15 percent of their income for health coverage. That's going to make it an expense that competes with paying the rent and buying food and child care. It would be a real burden.

Massachusetts is experimenting with a program that's just being put in place this year; it may merit careful review. It's a combination of a tax credit for employers and a corresponding credit for employees.

Second, we could couple tax credits for employers with some further insurance market reforms, because in many cases we're talking about small employers. Jon Gabel's study shows that among firms with 3–10 workers, only 55 percent offer health coverage. When you go out to 10–24 workers, more than 7 of 10 firms offer coverage. Above 50 employees, it's well over 90 percent. So, although we would not explicitly target small firms, the preponderance of the firms affected would be small firms. They're going to be buying in the

¹ See Mark Merlis, "Subsidies for Employer-Sponsored Insurance," in this volume.

Chart 14.5
Strengths

- Provides incentives directly related to an important force driving the problem of uninsured workers—low offer rates among small firms
- Administratively simple
- No federal budget authorization required

Source: Jack A. Meyer.

Chart 14.6
Strengths

- Eligibility requirement related to low-wage workers targets subsidies to need
- Relies on the market with flexibility for employers about what kind of benefits to offer workers

Source: Jack A. Meyer.

small-employer market, and premiums are higher in the small employer market. There is substantial risk selection in that market in many states, as there is in any individual market; and that means that there's a lot of "leakage" of tax subsidy dollars to middlemen, so to speak. You may have to pay \$4 in premium to get \$3 back in health services delivered. Thus, the leakage is higher than would occur in the large-group market. Some believe the difference is as much as 25 percent.

Anything we could do to reduce that leakage so that we wouldn't have to pay as much over and above the cost of medical care would be helpful. One approach is health insurance purchasing cooperatives (HIPCs). We just finished a study of HIPCs around the country that serve smaller firms. It was a fairly discouraging study. HIPCs have had a lot of trouble getting sizable enrollment because of a number of barriers, especially lack of enthusiasm and participation by health plans and insurance agents.

One of the things that bothers me about some of the tax-subsidy proposals that are being debated in Congress is that they would pull people out of the employer market and drive them into the individual market, which is just the opposite direction I think we need to go. Making the individual market work effectively involves even more difficulties than reforming the small-group market. I know that we have rate bands in many states, along with federal guaranteed-issue requirements for small employers, etc., but I think we may need further reforms to make coverage affordable for smaller employers and individuals.

Finally, we need an aggressive marketing campaign for tax credits. Experience with other tax credits has shown that many employers just are not aware they are out there. We do surveys, interviews, and focus groups with employers asking them about various tax credits, and they really

don't know what we're talking about. That has been the experience in health care, too, so we really have to go sell these things.

■ Strengths of the Tax Credit Approach

A key strength of this strategy is that it targets government money to one important force driving the problem of uninsured workers, and that is low offer rates among smaller firms (chart 14.5). We know, of course, from a review of recent literature that this is not the only factor. An increase in turn-downs of coverage by employees is more responsible for the recent increase in the number of uninsured. But while the lower offer rates don't seem to be getting worse, they're stuck at a pretty bad level, and this policy is directly aimed at that.

The credit approach is administratively fairly simple. No ideas that we economists come up with are truly simple, but this one, compared with some others, is fairly straightforward. Employers would only have to figure out their average wages, which isn't too hard, and how many workers they have. Some board would have to figure out the cost of a standard plan and update that annually. It could be done. It's not a Rube Goldberg approach. Politically, the credit approach has some advantages. I don't mean to imply that a tax subsidy is something different in terms of federal money than an expenditure—it's all money. Nevertheless, unlike a discretionary spending program, we wouldn't have to go through the messy reauthorization problem every year. It would be fairly automatic.

A couple of other strengths: Tying the eligibility requirement to low-wage workers targets the subsidy to need (chart 14.6). Although it probably could be even better targeted to need if you wanted to zero in only on the non-offerers, we

Chart 14.7
Weaknesses

- Many employers not now offering coverage are likely to stay on the sidelines because even with the tax subsidy, their cost of providing coverage may be significant
- Some employees will decline coverage unless ample subsidies for workers accompany employer tax credits

Source: Jack A. Meyer.

Chart 14.8
Weaknesses

- This approach is likely to extend coverage to only a portion of the uninsured—most likely well less than half
- Adds a new layer of complexity to the current system of subsidies built on Medicaid and CHIP

Source: Jack A. Meyer.

think it's better targeted than some of the proposals we've looked at, which would give an awful lot of money to people who don't need much of a helping hand. Compared with what we've had over the years with the tax exclusion—where most of the money goes to people who don't need much help—our tax credit approach hits the mark pretty well.

Finally, this strategy relies on the market to determine the type of health plan, giving flexibility to employers and workers to decide what kind of benefits they want. You don't have to enroll in a staff model health maintenance organization if you don't like that—you can take a group model or a point-of-service plan. We don't want to have a say in that decision. We do want to incentivize decision-makers to choose a cost-effective plan and then let companies and workers figure out the design features and the covered services that meet their needs and desires.

■ Weaknesses of the Tax Credit Approach

We believe that a number of employers will take this up; we're going to try to make it as attractive as possible. But health care costs are high and

coverage is expensive, particularly for smaller companies (chart 14.7). Even though we may be picking up one-half of \$4,000 or \$5,000, or \$6,000, as the case may be, there is still that other half. And as I said, some *employees* will decline coverage unless we really pay attention to subsidizing them as well.

Finally, this approach, like all tax subsidy proposals that are floating around these days, would probably cover, under the most reasonable assumptions, only a *portion* of the uninsured, probably well less than one-half (chart 14.8). I don't think this is a fatal flaw. It's true of any incremental strategy. We are going to have to think about packaging up a *series* of measures, because no one of them is likely to wrap up a large number of the uninsured.

The problem is that the proposals that would cover most of the uninsured are very difficult to sell because they involve elements of coercion and/or much larger amounts of government money. Finally, as simple as we tried to make it, the tax credit subsidy would have to be integrated with Medicaid and the Children's Health Insurance Program (CHIP), and that would probably present a few challenges.

Subsidies for Employer-Sponsored Insurance

by Mark Merlis, Institute for Health Policy Solutions

■ Introduction

I would like to discuss the option of providing some assistance to workers, rather than employers, by helping them with their share of premiums for employer-sponsored insurance. The two other options discussed in this book basically focus on helping employers who are not offering coverage; my focus is on employers who are offering coverage but whose workers are not taking it.

Table 15.1 shows the 1996 numbers from the Medical Expenditure Panel Survey (MEPS). Even at very low income levels, a substantial number of uninsured workers do have access to employer plans through their own work or through a spouse or a parent. About one in seven of those below the poverty level could have gotten employer coverage, one in four of those above poverty.

Presumably, the reason that these workers are not participating in the plans—although there are some kids who don't care—is because of employee contributions, in particular, rising levels of contributions required for dependent coverage. These numbers include a fair number of cases in

which the worker took coverage but did not cover his or her dependents.

Therefore, if some of these people could somehow be helped with the cost of buying into their employer plans, participation would improve. There are a lot of ways that can be done.

■ The Options

The particular option I have developed is a tax credit that is tied to the basic tax credit Sherry Glied described,¹ and it is available to the same people. Basically, their entire employee share would be paid up to 200 percent of poverty and then there would be a phase-down above that.

Many states have bought into employer plans to some extent under Medicaid. A few have begun to do so under the Children's Health Insurance Program (CHIP). John Colmers² described Maryland's plan to do that. There are some independent state programs—programs offered with no federal funds, like Oregon's—that are buying into employer plans. If we went as a group to coverage expansion similar to the Clinton administration's proposal to let adults into CHIP, this could again be a component of that.

Another approach—this is part of the Health Insurance Association of America (HIAA) insurance proposal—is to exclude the employee's contribution to health plans, as well as the employer's contribution, from taxable income. That

Table 15.1
Uninsured People with Access to Employer Coverage, January 1996

Family Income as a Percentage of Poverty	Percentage With Access to Employer Coverage
Under 100%	13.2%
100%–195%	26.6
200% and Over	30.3
Total	24.0

Source: Institute for Health Policy Solutions, based on 1996 Medical Expenditure Panel Survey (MEPS). Access and coverage status are for January; family income is for the entire year.

¹ See Sherry Glied, "Workable Solutions for Improving Health Insurance," in this volume.

² See John Colmers, "Public- and Private-Sector Initiatives to Increase Access to Health Coverage: The Experience in Maryland," in this volume.

does not actually provide very much assistance to low-income workers, because they are in a low tax bracket and the exclusion is not all that helpful. But that is another option.

Then there are various kinds of three-way funding schemes—state, employer, employee—programs like the one Vernon Smith³ described. Another example in addition to the Wayne County program is one that is already under way in Massachusetts.

There are a few basic issues that arise under any of these approaches, and I think it would be helpful to describe them generically, focusing on the issues that are common to the approach in general, rather than discussing my specific proposal.

■ Advantages and Disadvantages of Helping Low-Income Persons to Enroll in Employer-Sponsored Health Insurance

Obviously, there are a lot of surface advantages to helping low-income people enroll in available employer-sponsored insurance instead of trying to provide coverage directly, either through a tax credit or a public program.

You would probably save money, because the employer is paying something. You might get higher participation, because it is easier for people to join an employer plan than to find coverage on

their own.

The policies are likely to be cheaper and better. You could keep whole families together.

But there are two very important drawbacks. The first is illustrated in table 15.2, and it is that most people with access to employer coverage have already taken it, even at the very lowest income level. If I throw out the second row in this table, which is people who are not in their employer plan because they had coverage elsewhere such as Medicaid, the take-up rate is really about 70 percent for people below poverty and 80 percent for those between 100 percent and 200 percent of poverty.

What that means is that, if you just offer to pay the employee share of premiums for everybody below 200 percent of poverty, you are going to pick up three or four people who already have coverage for every one who is uninsured. That would probably be more costly than not doing this and just trying to reach those people directly through a tax credit or a public program.

The solution that is often advanced—the one, for example, adopted in the Oregon program—is to somehow try to lock out the people who already have coverage and just help the uninsured. You can say that you will not give assistance to anybody who has employer coverage now. You can say you will not give it to an individual who has had it in the last six months or the last 12 months.

That kind of rule is fairly difficult to enforce. States that have tried to do it generally wind up relying on an honor system. That is particularly true if the rule includes this kind of look-back provision—no coverage in the last six or 12 months—because there is no way to track

³ See Vernon Smith et al., “Allowing Small Business and the Self-Employed to Buy Health Care Coverage Through Public Programs,” in this volume.

Table 15.2
Coverage of People With Access to Employer Plans, January 1996

	Family Income as a Percentage of Poverty			Total
	Under 100%	100–199%	200%+	
Employer	57.1%	72.9%	92.6%	88.2%
Other coverage	18.4	10.0	3.5	5.1
Uninsured	24.4	17.1	3.9	6.7
Total	100.0	100.0	100.0	100.0

Source: Institute for Health Policy Solutions, based on 1996 Medical Expenditure Panel Survey (MEPS). Access and coverage status are for January; family income is for the entire year. Excludes Medicare beneficiaries.

people's coverage status that long ago. You have to rely on their assertion.

Even assuming that you could develop some tracking mechanism and enforce it, it is obviously inequitable. You could have in a single firm two workers side by side, earning the same wages, one of whom receives government assistance with his or her insurance premium, and the other who does not.

If we only have a finite amount of money to spend, it seems to make sense to target the uninsured, even at the price of a little inequity. But I don't think a lock-out policy works for very long. People with modest income change jobs. They leave the work force, and they gain and lose health coverage all the time.

Among people below 200 percent of poverty who had coverage through their own employment in January of 1996, 13 percent were uninsured by December of 1996. A lot of turnover occurs at this income level, and a lock-out just is going to wear off in effect over time.

So I think you have to anticipate, whatever you do, that if you offer this kind of subsidy, you are eventually going to be reaching most of the covered workers in the target income range at considerable cost.

Whether you think of that as a problem depends in part on what you are doing at the same time for people who don't have access to employer-sponsored insurance. For example, if we offer the very generous tax credit for nongroup coverage that Sherry Glied illustrated, if we undertake a large expansion of public insurance programs such as extending CHIP to adults, if we make coverage outside the employer system virtually free for people in a given income range, workers in that same range who have employer-sponsored insurance are going to have a big incentive to drop it, to find some other job that will pay higher wages instead of health benefits.

In discussing employer-provided coverage, there has been little reference to the common theory, at least among economists, that all of those dollars are not being paid by the employers. They are being paid by the workers in the form of forgone wages.

If you provide a much cheaper alternative in the form of some kind of publicly subsidized coverage, you have to expect that those workers are

going to want to shift to that alternative.

There is perhaps at least some possibility—which is discussed later—that employer-sponsored insurance subsidies, subsidies for the employee share, could prevent at least some of that shifting.

The second big issue with this approach is whether, if you start giving workers money to pay their share of premiums, employers are going to respond by raising the worker's share. This seems most likely in low-wage firms where a lot of the workers might qualify for employer-sponsored insurance assistance. It could result in public funds replacing what had been employer funds, dollar for dollar.

One solution—this is in the CHIP rules—is a minimum employer contribution requirement. You could say that we won't help with the employee share unless the employer is contributing 50 percent of the premium, or 60 percent, or whatever figure you wind up with.

That does at least prevent employers from dropping from, say, 80 percent to 20 percent. It puts some kind of floor on the extent to which they can substitute public dollars for their current dollars. But you would have to decide, if you impose that kind of minimum contribution test, what to do with the workers in the firms that don't meet it.

In the case of CHIP, kids whose employers are not contributing enough can go into the public program. So the rule becomes sort of self-defeating. You have lost whatever employer dollars you could have drawn on.

The alternative is to leave people in plans that require high contributions from the employee, permanently obliging them to pay those contributions with no assistance. That does not seem like an acceptable outcome, either.

It seems less likely that the mixed wage firms, in which some people are potentially eligible for assistance and others are not, would cut their contribution levels. Presumably, they are not going to do that, i.e., cut their contributions for all employees to take advantage of a benefit that is only available to some of them.

The real issue is whether they could somehow cut their contributions just for their low-wage workers, and I think that they probably could. There are enough loopholes in the Health Insurance Portability and Accountability Act and in

the Tax Code that it is possible for many firms to isolate the workers who are potentially eligible for the credit. There are also, I think, some games that could be played with cafeteria plans.

I am not sure that it is politically possible to tighten those rules. The last federal effort, at least, to try to impose nondiscrimination requirements collapsed pretty rapidly in the 1980s, and states, of course, have no authority to regulate employer plans.

So I think you have to expect some slippage, some replacement of private spending, if you provide these subsidies, even in the mixed wage firms.

■ Administrative Issues

I think administering a tax credit is pretty straightforward. It could run rather like the current earned income tax credit, through the employer's payroll system. In effect, the worker would say, I'm eligible for the credit. The employer would deduct the worker's share of premiums from the paycheck, as is done now, and then restore it in the same paycheck through advance payment of the health insurance credit. Then the employer would recover what it had paid out by reducing its periodic payment of payroll taxes. That is the way the earned income tax credit works now.

It becomes considerably more complicated, I think, if you try to run the assistance through a public program such as Medicaid or CHIP.

You have to have an application process. You have to find out what the person's contribution level is, which is fine if he or she is already participating and can show you a pay stub. But if the person is not participating, then it is not so easy to get that information, because people don't always have it.

You have to get the money out, and I think most states have reached the same conclusion as Oregon, that they want to be transparent to the employers. They want to pay the money directly to the individual, and that is not just because employers don't want to be bothered with the paperwork, but because the individuals don't want the employers to know that they are getting this subsidy, for some reason.

Again, as Mark Merlis mentioned, if you are going to do that, if you are going to deal with individuals directly and pay something to them

directly, you have to somehow verify that they got coverage with the money. Merlis makes it sound like this has not been a big problem in Oregon, but I have the impression that people are more worried about this in other states.

Finally, there is the issue of standards for plans. Basically, under the CHIP rules there are minimum benefits that Vernon Smith⁴ described, including limitations on the amount of cost sharing that can be imposed.

Under CHIP, if you are going to take CHIP money and buy into employer coverage, you have to assure that that coverage meets those minimum standards, or you have to supplement the coverage to make sure that the kids are as well protected as they would have been if they had been in the public CHIP program.

What that requires states to do is, first, assess every employer plan. And it is not as though there are only four or five plans out there in the market, there are thousands of different plans. You have to look at the plan for every single applicant.

Then if it is inadequate, you have to somehow provide a wrap-around benefit. This has been the major barrier to states in implementing any kind of buy-in into employer coverage—this requirement, particularly, because almost no employer plan meets the cost-sharing limits. Every employer plan has some cost sharing, and there can arise under every plan an instance in which a kid is going to exceed the allowable limits.

In the particular option I have sketched out, which is a tax credit, I have no minimum standards for plans. But there will then, obviously, arise the question of whether we should be assisting with plans that are lousy. So I think that is a difficult political matter.

■ Summary

There are advantages and disadvantages to some form of employer-sponsored insurance assistance.

First, for the uninsured with access to employer-assisted insurance, it is potentially cheaper to get them into those plans than to furnish coverage in some other way.

There is also relief for the currently insured, if it is decided to let them in. It is worth

⁴ *Ibid.*

remembering that the subsidy we are now providing through the tax system for health insurance tends to benefit higher-income people more than lower-income people. So some form of further assistance to lower-income people would seem to be warranted.

Again, there is the risk that whatever we do outside the employment system to reach the uninsured is going to accelerate the erosion of employer coverage, and maybe help with employer-sponsored insurance could alleviate that for a while.

There are disadvantages. This assistance is poorly targeted. A lot of the money is sooner or later going to go for people who are currently insured.

It is hard to control the employer's response and make sure the employers just don't take a dollar away for every dollar you put in.

Finally, I think that it can only work for a little while to prevent the erosion that might otherwise occur. If we do something in the nonemployer realm that is really adequate to get

lower-income people covered, the incentives to prefer wages to employer-provided coverage are, I think, going to be pretty dramatic.

If we make coverage outside the employer system affordable, health benefits just are not going to be a part of the compensation package for low-income workers. That is too bad, because for a variety of reasons, employer plans are a great way of organizing and administering insurance. They are just a terribly regressive way of financing it, because the ostensible employer contributions are really coming from the workers themselves.

If we really want to maintain the current structure and the advantages of the current structure, it is not going to be enough to help with the employee share. Public funds are also probably, for the very lowest-income people, going to have to support what we now think of as the employer share.

So for low-income workers, employer coverage might evolve into a mechanism for administering funds rather than a funding source.

Allowing Small Business and the Self-Employed to Buy Health Care Coverage Through Public Programs

by Vernon Smith, Health Management Associates, Sara Rosenbaum, George Washington University, and Phyllis Borzi, George Washington University

Introduction

The perspective I bring is that of a former Medicaid director and an economist. My wife reminds me that an economist is someone who is trained in the use of financial data but who didn't have the personality to become an accountant.

My Medicaid policy staff used to tell me that the definition of an economist that most applied to me was the one that says an economist is someone who sees something actually working in practice and wonders if it would also work in theory.

The Proposal

I will describe a proposal we devised to address one of the most critical issues in the area of health care for the uninsured: coverage for persons who work in small businesses and who have relatively low incomes. We believe it is an approach that would actually work in practice (chart 16.1).

In designing this proposal, we tried to build on the existing employer-sponsored health system, and to address two issues. Experience indicates that some employers do not purchase health insurance because they believe it to be too expensive, or they fear large increases in costs in the future. The cost issue is addressed through a system of subsidies that reduce the actual costs borne by the employer and low-income employees. The fear about cost increases is addressed by adjusting subsidies annually to limit future cost increases, as a way to bring some stability, certainty, and predictability to expected costs.

The proposal began with the idea of building on Medicaid. The idea was to find a way for states to use Medicaid to support increased coverage through employers. It turns out, however, that Congress recently provided us with a much better vehicle, and that is the State Child Health Insurance Program (SCHIP), which was adopted in 1997 as Title XXI of the Social Security Act (chart 16.2).

The SCHIP program provides a better

Chart 16.1
What Does the Proposal Do?

- Encourages small business and self-employed to offer health coverage
—Through subsidies to employers
- In future years subsidy is adjusted to reflect premium increases that exceed health care inflation

Source: Vernon K. Smith.

Chart 16.2
How would the proposal work?

- It is based on the state CHIP model
- Program is administered by states
- Qualified employers would receive a subsidy for a share of actual premiums paid for qualifying health insurance
- A state would pay the subsidy, and receive federal matching funds at same rates as for S-CHIP; i.e., 65% to 85%

Source: Vernon K. Smith.

vehicle for several important reasons. First of all, SCHIP is not an entitlement. SCHIP is a state program, and the law gives states the option of building their programs either as an expansion of their Medicaid program or as a separate program using the private health insurance market.

Within the criteria and standards specified in law, states have many choices in CHIP: eligibility, coverage, exactly what they buy, and how they do it. There is a lot of flexibility and ability to tailor the program to the way the state wants the program to look, within these standards.

Under this proposal, qualified employers would receive a subsidy from the state program for a share of actual premiums that were paid for health insurance which met these standards.

The state would then receive federal matching funds, just as it does under SCHIP or Medicaid, which would help finance the subsidies that it paid to employers. Based on the current SCHIP formula, a state would receive a minimum of 65 cents back for every dollar that it paid. Depending on the state, it could be as high as 85 cents back in federal reimbursement.

■ The Issues

Who would qualify? We started with the premise that any entity defined as an employer under the Employee Retirement Income Security Act (ERISA) should be able to qualify (chart 16.3). It is noteworthy that this definition includes the self-employed. Other proposals usually exclude the self-employed, and require a minimum of two or three employees.

We thought that a state should be able to define how many employees a business might have and still be considered “small,” but it should be at least 10. In other words, one state might restrict the program to small employers with up to 10 employees, but in another state the program

might allow small businesses with as many as 25 or 50 or maybe 100 employees. We would allow the state to make that decision.

Next is the issue of how much the employer would contribute. We propose that states require an employer contribution of 50 percent or more, so there is at least a 50/50 matching contribution between employer and employee. That would be something each state would define. A state might define the employer contribution based on the state subsidy of state employee health coverage or a similar benchmark, such as the average employer, or average small employer contribution in that state.

Who would be eligible employees? We thought all employees should qualify, full time and part time, and their dependents. Each state would define “part time,” but obviously there would need to be a real connection to the employer in this definition.

What would be a qualifying health coverage? Under the SCHIP program, coverage must meet certain requirements and standards relating to benefits and cost sharing, so there is meaningful coverage (chart 16.4). For example, a state can choose the same coverage as its Medicaid program, it can require that plans match the coverage in the state employee program, or it can be the coverage offered by the state’s largest health plan or the federal employee health plan. But it has to be a genuine coverage, including, for example, prescription drug coverage, maternity coverage, well-child care, and that sort of thing.

Regarding co-pays and other out-of-pocket costs, there would be some limits to make sure that people did not pay an extraordinarily high percentage of their income for health coverage. But basically, this builds right on to the SCHIP model.

Crowd-out is always an issue (chart 16.5). It’s an issue that states must address in their

Chart 16.3
**Who Would Qualify
For the Subsidy?**

- Employers who meet:
 - ERISA definition of employer (includes self-employed).
 - State’s definition of “small”
 - State’s employer share contribution requirements
- Employees: all full, part-time, and dependents.

Source: Vernon K. Smith.

Chart 16.4
What is a Qualifying Plan?

- A plan that meets S-CHIP benchmarks
 - Coverage: e.g., state employee plan, largest HMO.
 - Includes Rx, maternity coverage.
 - Limits on copays, out-of-pocket costs not greater than 5% of income.

Source: Vernon K. Smith.

Chart 16.5
How Does the Plan Address Crowd-Out?

- Qualifying businesses must not have offered health coverage for a period specified by the state (min. 3 months, max. 12 months).
- Participation limited to businesses where the median wage is not greater than a wage specified by the state (range:\$10–\$15/hour).

Source: Vernon K. Smith.

SCHIP programs. Again, a state would have an opportunity to make decisions here, but we propose that a business could not drop its existing coverage to get into this program without going through a waiting period of at least three and maybe 12 months. There is some experience that indicates that at least six months is appropriate here, so folks don't just drop an existing coverage and then wait it out for 90 days.

We also propose to limit participation to businesses that have a significant portion of their employees who are reasonably low wage. We propose, for example, that in order for the business to qualify, at least half the employees would have a wage rate less than \$10–\$12 an hour.

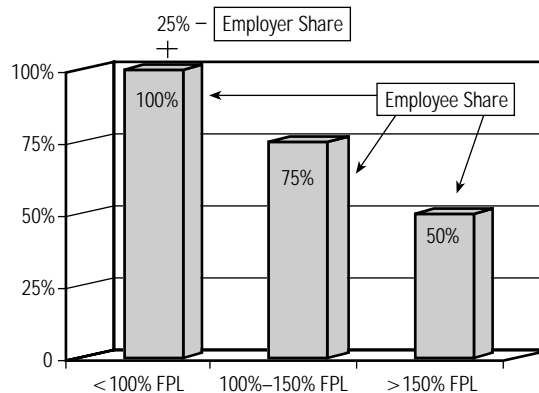
■ Calculating the Subsidy

What would be the subsidy, and how would it be calculated? This is a complex area, which ideally would be simple to describe and understand (chart 16.6). The subsidy ideally would provide greater support to lower-wage employees, and phase-out as income increased. The difficulty of doing this is illustrated by the relationship between the federal poverty level (FPL) and the employee wage rate as the basis of the subsidy. The FPL varies with the number of persons in the household, and may be the better measure of economic need for the subsidy. The employee's wage rate also indicates economic need, and is known to the employer without the need to track changes in household size and composition, but offers less precision.

For purposes of this illustration, we use a graph with a scale expressed as a percentage of FPL, but operationally it might be expressed in terms of a wage rate. For example, the FPL for family of three is roughly \$7 an hour.

As illustrated in chart 16.6, the subsidy for employees with incomes below the federal poverty level would be 100 percent of the employee share

Chart 16.6
How Much is the Subsidy?



Source: Vernon K. Smith.

and 25 percent of the employer share. The rationale for the 25 percent employer subsidy is that for businesses with employees at that income level, both the employer and employee may struggle to pay for this coverage. Above the poverty level, the employer subsidy ends and as incomes go up, the employee subsidy is phased out.

■ How the Subsidy Would Work

How would this all actually work? In a nutshell, this is an example of how it would work (chart 16.7). First, the state would define specific health plans that meet all requirements. It might choose three or four qualifying plans. The employer would then choose the health plan from the list of qualified plans.

The employer then would pay the premium. Depending on the method chosen by the state, the premium amount might be paid to the state program or to the health plan. For this example, let's assume first that the employer would pay the premium to the health plan just the way the unsubsidized business next door would. Then, the employer would complete an (easily computerized) form to calculate the subsidy for each employee based on wage rate, and transmit the form to the state. The state would process the form very quickly, in less than 30 days, so the employer would have that subsidy check to use to help pay the premiums for the following month. The state then would submit its claim to the federal government to get its federal matching funds.

Chart 16.7
How Would It Work?

Employer Role	State Role
Employer chooses health coverage from list of qualifying plans	State rebates subsidy payment to employer in less than 30 days
Employer pays premium to insurer	State claims federal matching funds on its payments to employers
Employer calculates subsidy for each employee	
Employer submits claims for subsidy to state	

Source: Vernon K. Smith.

An alternative method would have the employer pay a discounted premium to the state program, and the program would in turn pay the health plan. A program in Wayne County, Michigan, illustrates this alternative (chart 16.8). The program is called Health Choice, and it has been in operation now for about seven years. Health Choice had its roots in another model known as the One-Third-Share Plan that operated in Michigan in the 1980s.

Health Choice now covers 18,000 lives in 1,800 businesses in Wayne County. The estimate is that about 20 percent of eligible businesses have chosen to participate. Health Choice has received very favorable reviews and editorials in the newspapers in Detroit. The economic development office uses this plan to sell Wayne County as a good place to locate a business. Wayne County is to receive a national award in a few weeks, for its success in improving health coverage among small businesses through this plan.

Under the Wayne County plan, subsidized health coverage is available to businesses with at least three employees (the average business has 10 lives covered), that have not offered insurance for the previous year, and in which at least half the employees have wages of \$10 an hour or less

Chart 16.8
Is There an Example of Where a Similar Approach is Working?

- Wayne County, Michigan
 - Health Choice plan is sponsored by the County.
 - Currently 18,000 employees and dependents are covered in 1,800 businesses. (About 20% of targeted businesses participate.)

Source: Vernon K. Smith.

Chart 16.9
Is There an Example of Where a Similar Approach is Working?

- Wayne County, Michigan
 - Qualifying businesses must have fewer than 99 employees, have not offered health insurance in 12 months, and have median wage less than \$10/hr.
 - Subsidy is 1/3 of premium, averaging \$42 per month.

Source: Vernon K. Smith.

(chart 16.9). The County has contracts with four participating health plans

The subsidy is one-third of the full premium. In 2000, the full premium is \$126 per person per month, and the subsidy is \$42. The employer collects the employee share, which is allowed to be any amount up to \$42 (i.e., the employer share must be at least 50 percent of the premium net of the subsidy). The employer then pays the \$84 (i.e., the full premium net of the subsidy) to Health Choice. Health Choice then pays the full \$126 to the selected health plan. The County subsidy is financed in part with funds from the State of Michigan.

The Wayne County Health Choice program provides an example of one way a state might choose to implement its program within the framework of our proposal.

Finally, in terms of estimating cost, it all depends on the options chosen. It is possible to estimate the cost, but the actual cost will depend on which options are chosen by participating states (chart 16.10).

A key issue from a state perspective is that there will be offsetting cost reductions for states. Some persons covered under this plan would have been on SCHIP or on Medicaid. This coverage would disqualify children from participation in SCHIP, and would be third party coverage primary to Medicaid. So that there would offsetting cost reductions in those programs.

Chart 16.10
What Would This Subsidy Program Cost?

- Total cost can be estimated, once parameters are defined
- State and federal governments would see cost-saving offsets in the form of reduced Medicaid and S-CHIP expenditures, as more people have employer-sponsored health coverage

Source: Vernon K. Smith.



Small Employers and Health Benefits

Small Employers and Health Benefits: Findings from the 2000 Small Employer Health Benefits Survey

by Paul Fronstin, EBRI, and Ruth Helman, MGA¹

■ Introduction

Employment-based health insurance is by far the most common form of health insurance coverage in the United States. Nearly 100 million workers, or 73 percent of the adult working population, were covered by employment-based health benefits in 1998 (Fronstin, 2000). Overall, the employment-based health insurance system covered nearly 155 million Americans under age 65, or 65 percent of the nonelderly population. In contrast, public programs such as Medicaid, Medicare, Tricare,² and CHAMPVA³ covered 14 percent of the nonelderly population.

Employers offer health benefits to workers for a number of reasons. Health benefits provide workers and their families with protection from financial losses that can accompany unexpected serious illness or injury. Health benefits can also be used to promote health, to increase worker productivity, and as a form of compensation to recruit and retain qualified workers. When asked to rank the importance of all employee benefits, health benefits are by far the benefit most valued by workers and their families. Sixty-five percent of workers responding to a recent survey rated employment-

based health benefits as the most important benefit (Salisbury and Ostuw, 2000).

Most workers who have access to employment-based health benefits take up coverage from that employer. In 1997, 83 percent of workers whose employer offered them health benefits were covered by that plan (Fronstin, 1999). Of the remaining 17 percent not participating in their employers' benefits plan, 61 percent were covered by another health plan. In other words, of workers offered health benefits by their employer, 83 percent were covered by that plan, 10 percent had coverage elsewhere, while 7 percent remained uninsured. Furthermore, only 5 percent of workers not covered by their own employers' health benefits purchase health insurance coverage on their own.

The likelihood that a worker has health insurance coverage from his or her employer varies substantially by firm size. Workers in the smallest firms tend to be the least likely to have health benefits from their own employer. In 1998, 27 percent of workers employed in firms with fewer than 10 employees were covered by the employer's health benefits (Fronstin, 2000). Nearly 40 percent of workers employed in a firm with 10 to 24 employees had coverage from their employer, and 54 percent of workers in firms with 25 to 99 employees had coverage from their employer. In contrast, 67 percent of workers in firms with 1,000 or more employees were covered by their employers' health benefits.

The likelihood that a worker has coverage from his or her own employer is a function of whether the employer offers health benefits and whether the employee takes it when offered. Overall, workers in small firms are less likely to be offered health benefits. In 1997, 57 percent of

¹ Mathew Greenwald & Associates, Inc.

² Tricare, formerly known as CHAMPUS (the Civilian Health and Medical Program of the Uniformed Services), covers military retirees as well as families of active duty, retired, and deceased service members.

³ CHAMPVA, the Civilian Health and Medical Program of the Veterans Administration, covers dependents of totally disabled veterans and certain survivors of veterans.

workers in firms with fewer than 100 employees were offered coverage, compared with 85 percent of workers in firms with 100 or more employees (Fronstin, 1999). When offered coverage, workers in small firms are also less likely than workers in large firms to take coverage. In 1997, 75 percent of workers in firms with fewer than 100 employees took the coverage when it was offered, compared with 86 percent of workers in firms with 100 or more employees.

As mentioned above, the employment-based health insurance system is the most common form of health insurance in the United States. While most workers participate in their employers' health plan when it is offered to them, many workers are clearly not offered health benefits or do not participate in the plan when it is offered. Of the 44 million Americans who do not have health insurance coverage, 36 million (or 82 percent) are in a family with a worker, and 60 percent of uninsured workers are employed by small firms (Fronstin, 2000). Since workers in small firms are less likely to be offered health benefits than workers in large firms, it is important to understand why small employers are less likely than large employers to offer health benefits, and what factors would persuade more small employers to offer health benefits to workers.

This chapter presents findings from the 2000 Small Employer Health Benefits Survey (SEHBS). The survey examines a number of issues related to small employers (between two and 50 workers) and their decision to offer—or not offer—health benefits to workers. The goal of the survey was to gather information to better understand what would make more small employers offer health benefits. Since the vast majority of large employers offer health benefits, but many small employers do not, small businesses are seen as perhaps the most crucial element in efforts to expand health insurance coverage in the current health insurance system and reduce the growing number of uninsured Americans.

■ Tax Treatment

Currently, health insurance premiums paid by employers on behalf of workers are tax-deductible for employers. They are treated the same way other labor costs and general business expenses are treated under the tax code: The costs of health

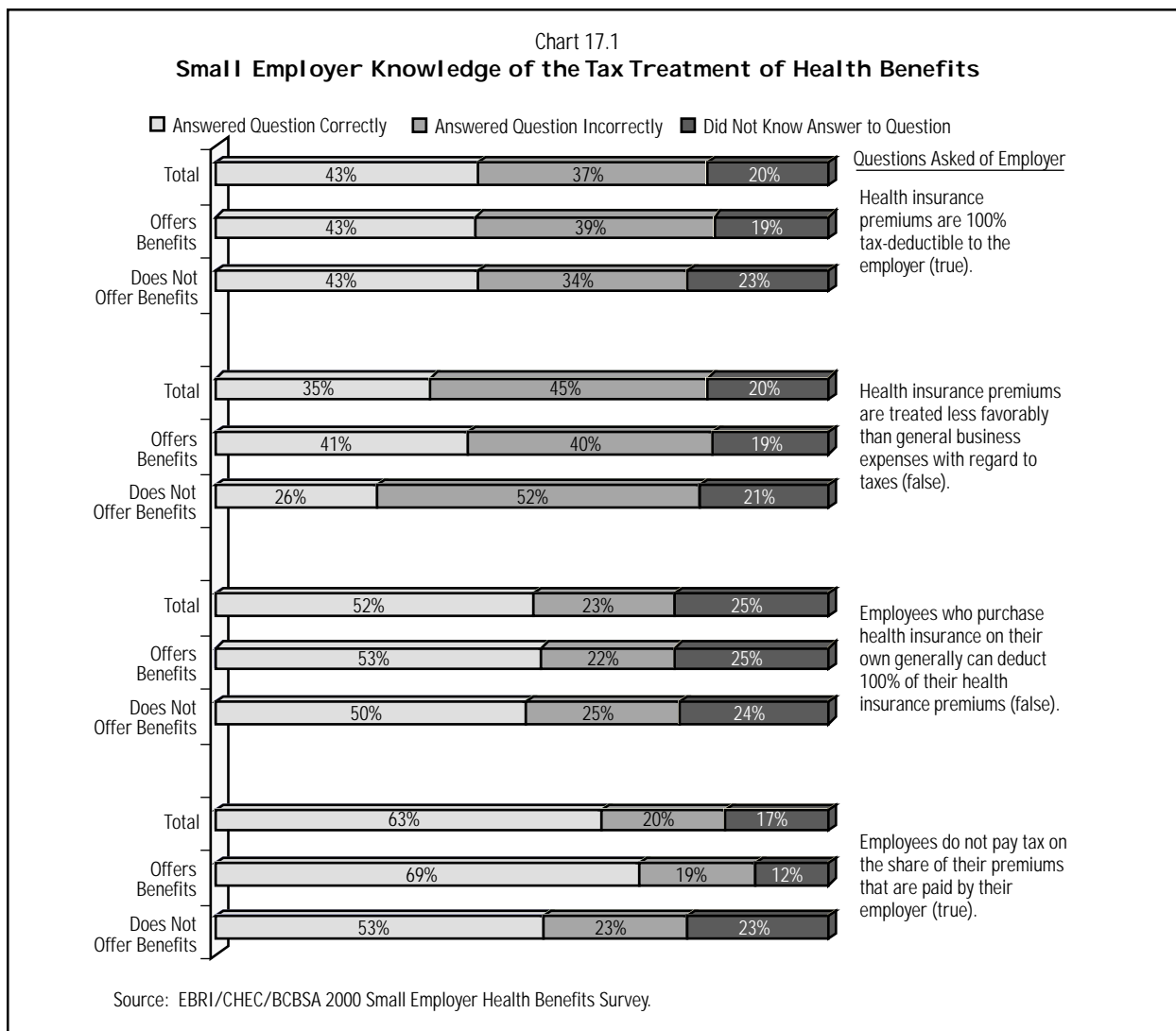
benefits are tax-deductible as a business expense, just like wages and salaries.

Tax-favored treatment is extended to the recipients of health benefits as well as the sponsors: The amount that employers pay on behalf of workers is excluded, without limit, from workers' taxable income. However, under the existing tax code, workers who purchase health insurance directly from an insurer generally cannot deduct any of the premium from their taxable income. For individuals who do not receive employment-based health benefits, total health care expenses (including premiums) are deductible only if they exceed 7.5 percent of adjusted gross income, and only the amount that exceeds 7.5 percent of adjusted gross income is deductible.

The health insurance premiums of the self-employed are treated differently from those for active workers. Under current law, the self-employed are able to deduct only 60 percent of the cost of their own health insurance. However, beginning in 2003 they will be able to deduct 100 percent of the cost of their health insurance premiums.

Many small employers are making decisions about whether or not to offer health insurance coverage to their workers without being fully aware of the tax advantages that can make this benefit more affordable. For example, 57 percent of all small employers surveyed in the 2000 SEHBS did not know that health insurance premiums are 100 percent tax deductible (chart 17.1). Furthermore, 65 percent of respondents to the survey did not realize that health insurance premiums are treated like general business expenses with regard to taxes. On this point, it was found that small employers *not* offering health benefits were even less aware than employers that *do* offer health benefits: Nearly 60 percent of employers offering health benefits did not know that health insurance premiums are treated like general business expenses, compared with 73 percent of employers that did not offer health benefits.

With respect to employers' knowledge about the tax treatment of health benefits as it affects their workers, many employers continue to make false assumptions. Nearly one-half are not aware that employees who purchase health insurance on their own generally cannot deduct 100 percent of their health insurance premiums. Also, 37 percent did not know that employees do



not pay tax on the share of their premiums that are paid by their employer. However, employers offering health benefits were much more likely to be aware of this provision in the tax code. Specifically, 69 percent of employers offering health benefits understood that the employer share of the premium was not included in an employee’s taxable income, compared with 53 percent of employers not offering health benefits.

While the survey found a number of cases where employers offering health benefits were more knowledgeable than employers not offering health benefits about the tax treatment of health benefits as it applies to themselves or their workers, a surprisingly high percentage of employers offering health benefits still do not understand how those benefits are treated by the tax code. It is important for employers to understand the tax treatment of

health benefits for a number of reasons, probably the most important being that misperceptions about how health benefits are taxed may prevent employers from offering health benefits to begin with. In addition, if employers are unaware of how the tax code affects their workers, it is likely that the workers are also unaware, and also do not know the true value of the health benefits they are being offered.

Insurance Regulation

During the mid-1990s, nearly every state in the nation passed laws designed to make health benefits more affordable and accessible for small employers. In addition, in 1996, the federal government passed the Health Insurance Portability and Accountability Act (HIPAA), which set minimum

accessibility standards across the states. Laws to improve accessibility included “guaranteed issue” and “guaranteed renewal” requirements. *Guaranteed issue* generally requires insurers offering coverage in the small group market to offer coverage to *any* small group regardless of the health status or prior claims experience of the group’s members. *Guaranteed renewal* generally requires insurers offering health benefits in the small group market to renew an employer’s health coverage at the employer’s option.

Rating Bands and Small-Group Pooling

Laws that affect affordability were enacted to change the way premiums were determined by insurers offering health insurance in the small group market. In some states, insurers were required to use “rating bands,” which are restrictions on the difference between the highest and lowest premiums an insurer can charge its group members. Rating restrictions vary by state. Some states limit the use of worker health status and

prior claims experience in determining premiums. The limits can be loose or very tight depending upon the state. Some states even passed laws, known as community rating laws, which essentially prohibit the use of past claims experience or health status in setting premiums for small groups. Some community rating laws even go so far as to prohibit the use of demographics in determining premiums.

Overall, state rating regulations were designed to require insurers to “pool” small employers together in order to provide cross-subsidies for employers with high-cost workers. As a result, all small employers buying insurance in a geographic region would experience less variation in the premium due to the prior claims experience or the health status of their own particular workers. In effect, insurers group all small employers into one large “pool” in order to determine premiums.

Employer Awareness

Small employers are largely unaware of the state and federal laws that have been enacted with the

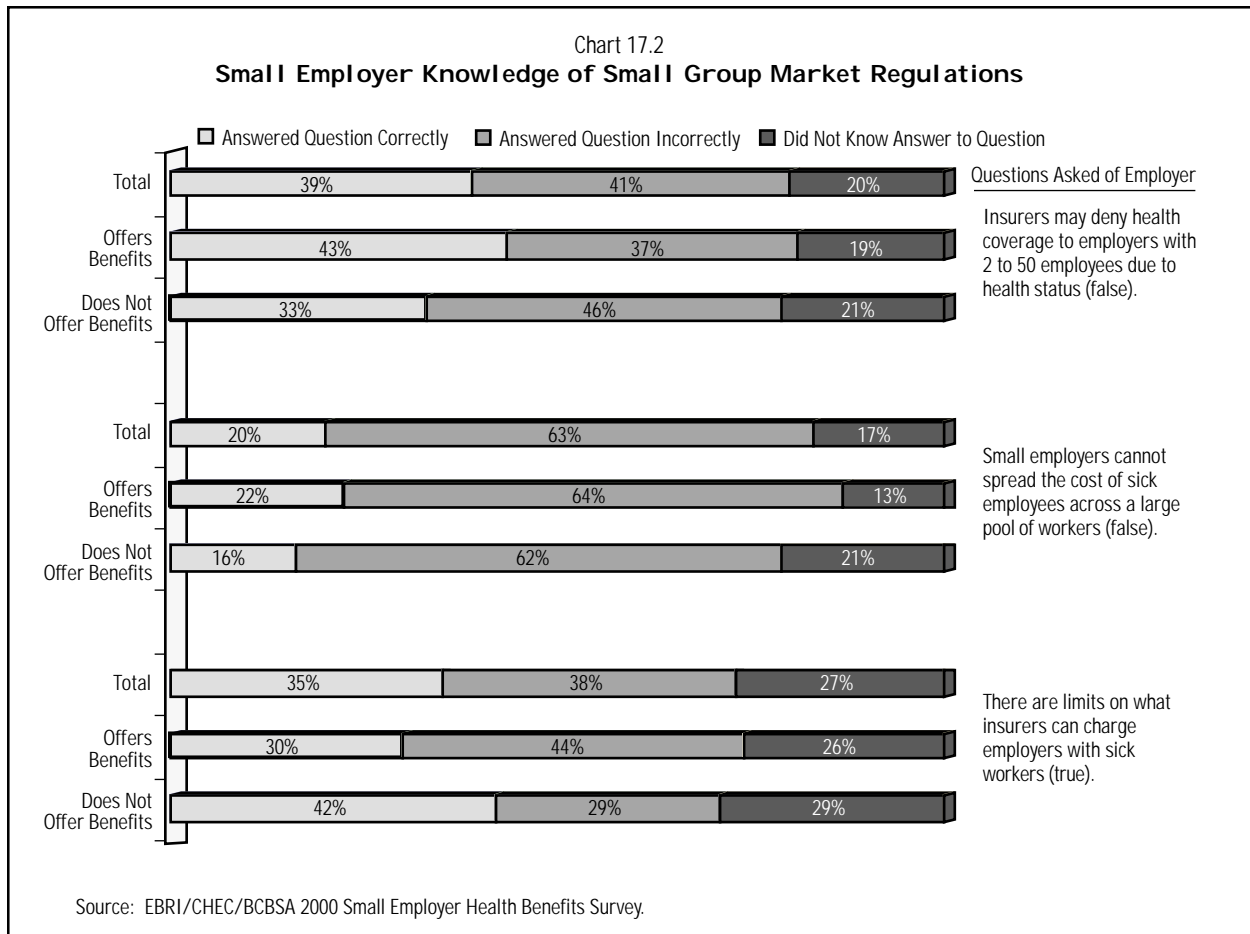


Table 17.1
Reasons for Offering Health Benefits

	Reason	Major Reason	Minor Reason
It is the right thing to do.	88%	71%	17%
It helps with employee recruitment.	80	58	22
It increases loyalty and decreases turnover.	80	53	27
It increases productivity by keeping employees healthy.	70	37	33
Employees demand or expect it.	69	38	31
It reduces absenteeism by keeping employees healthy.	68	31	37
Competitors offer it.	65	35	30
Tax deductible for the employer.	61	23	38
Tax treatment for employees.	46	11	35
One or more employees have medical problems.	34	11	23

Source: EBRI/CHEC/BCBSA 2000 Small Employer Health Benefits Survey.

specific intent of making health insurance more accessible and more affordable for them. Thirty-nine percent understood that insurers may not deny health insurance coverage to small employers even when the health status of their workers is poor (chart 17.2). Consistent with earlier findings, employer-sponsors of health benefits were more likely than nonsponsors to be aware of these guaranteed issue and renewal laws (43 percent and 33 percent, respectively).

Only 20 percent of employers responding to the survey realized that states have in effect required insurers to spread the cost of small employers with sick employees across a large pool of workers through the use of rating restrictions. In addition, only 35 percent of small employers are aware that there are limits on what insurers can charge employers with sick workers compared with employers that have healthier workers.

In general, small employers are not knowledgeable about state small-group market reforms passed during the mid-1990s that essentially make it easier for them to obtain and afford coverage. These laws prevented insurers from denying coverage to small employers with unhealthy workers, and also prevented them (through the use of rating restrictions) from charging unhealthy groups more than healthy groups. It is important for small employers to understand how the insurance market is regulated: Misconceptions about the market may result in fewer employers offering coverage because they are under the impression

that they cannot obtain or afford coverage due to the health status of their workers.

■ Impact of Offering Benefits

As mentioned earlier, employers offer health benefits for a number of reasons. Most employers generally offer sound business reasons for offering health benefits to workers. Among the small employers responding to the survey, 80 percent report that it helps with recruitment and retention (table 17.1). In addition, 70 percent report that it increases productivity by keeping employees healthy; 69 percent report that employees demand it; and 68 percent report that it reduces absenteeism by keeping workers healthy. Interestingly, 88 percent of employers report that they offer health benefits because it is the right thing to do.

When specifically asked whether offering health benefits has a beneficial impact on their business, most small employers with benefits agree that it does. Nearly 80 percent say that offering this benefit has had an impact on employee recruitment, with almost one-half reporting that it has had a major impact (46 percent) (table 17.2). Three-fourths indicate it has had a major or minor impact on employee retention and employee attitude and performance, 67 percent report an impact on the health of their employees, and 58 percent state that offering health benefits has had an impact on absenteeism.

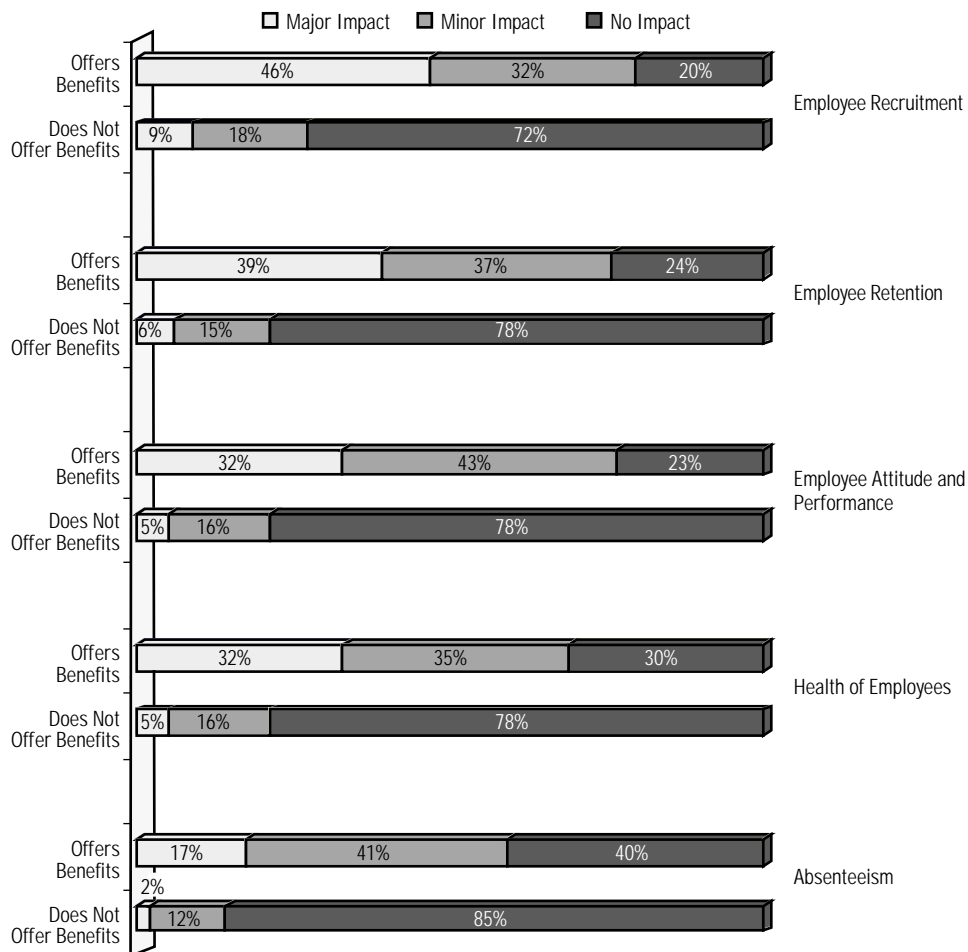
The likelihood of reporting an impact is

Table 17.2
Impact of Offering a Plan, by Size of Business

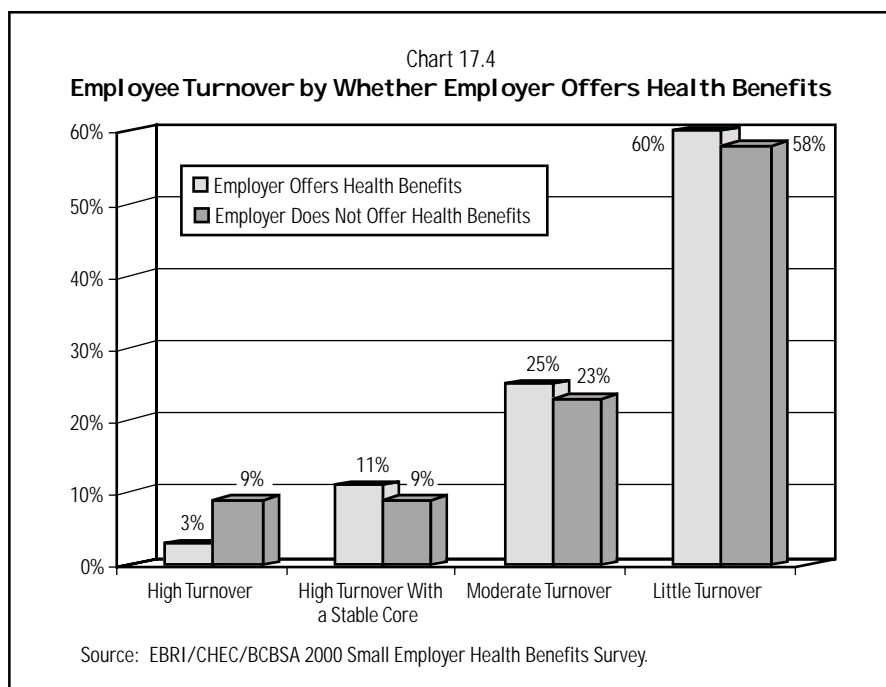
	Total		2-9 Workers		10-24 Workers		25-50 Workers	
	Major impact	Minor impact	Major impact	Minor impact	Major impact	Minor impact	Major impact	Minor impact
Employee Recruitment	46%	32%	42%	32%	51%	31%	57%	31%
Employee Retention	39	37	34	37	47	35	49	35
Employee Attitude and Performance	32	43	29	43	35	47	41	40
Health of Employees	32	35	29	32	37	42	43	38
Absenteeism	17	41	17	37	17	47	17	51

Source: EBRI/CHEC/BCBSA 2000 Small Employer Health Benefits Survey.

Chart 17.3
Impact of Offering or Not Offering Health Benefits to Employees



Source: EBRI/CHEC/BCBSA 2000 Small Employer Health Benefits Survey.



higher for larger than for smaller firms, but even among those with two to nine workers, majorities indicate that offering health benefits has had an impact on each of these factors. According to table 17.2, 74 percent of those with two to nine workers say it has had a major or minor impact on employee recruitment, compared with 88 percent among employers with 25 to 50 workers. About 70 percent of employers with two to nine workers report that health benefits have had an impact on retention, compared to 84 percent among employers with 25 to 50 workers.

In contrast to the value perceived by respondents from firms with health benefits, most of those from companies that do not offer workers health coverage tend to think that not having health benefits has no impact on these factors. Roughly 75 percent of employers not offering health benefits report that not offering them has had no impact on employee recruitment, employee retention, employee attitude and performance, and the health of their employees (chart 17.3). In addition, 85 percent report that not offering health benefits has had no impact on absenteeism.

While employers not offering health benefits generally do not perceive that the lack of health benefits has an impact on employee retention, those without coverage are more likely than those with coverage to report that most of their

employees stay only a few months. Specifically, 9 percent of employers not offering health benefits reported high turnover of workers, compared with 3 percent of employers offering health benefits (chart 17.4). It is possible that some decision makers may be unaware of, or underestimating, the effect that their firm's lack of coverage has on turnover. However, respondents without health benefits who describe their employee turnover as high or moderate are more likely than those with little turnover to report that not offering health insurance has an impact on recruitment, retention, performance, health status, and absenteeism (table 17.3).

Just as larger employers are more likely than smaller employers to experience an impact from offering benefits, larger employers that do not offer health benefits are more likely than their small employer counterparts to report an impact due to their lack of employee health coverage. More than 50 percent of employers with 25 to 50 workers report that not offering health benefits has had a major or minor impact on employee recruitment (table 17.4). In addition, 46 percent report that not offering health benefits has had an impact on employee retention, and 44 percent report that not offering health benefits has had an impact on employee attitude and performance. In contrast, roughly 20 percent of employers with two to nine

Table 17.3
Impact of Not Offering Health Benefits, by Employee Turnover

	High or Moderate Turnover		Little Turnover	
	Major impact	Minor impact	Major impact	Minor impact
Employee Recruitment	15%	27%	6%	11%
Employee Retention	11	20	3	10
Employee Attitude and Performance	7	26	5	8
Health of Employees	6	20	4	13
Absenteeism	3	18	2	7

Source: EBRI/CHEC/BCBSA 2000 Small Employer Health Benefits Survey.

Table 17.4
Impact of Not Offering Health Benefits, by Size of Business

	Total		2–9 Workers		10–24 Workers		25–50 Workers	
	Major impact	Minor impact	Major impact	Minor impact	Major impact	Minor impact	Major impact	Minor impact
Employee Recruitment	9%	18%	8%	15%	12%	34%	15%	40%
Employee Retention	6	15	5	12	10	27	12	34
Employee Attitude and Performance	5	16	5	14	9	23	7	37
Health of Employees	5	16	4	15	8	22	6	19
Absenteeism	2	12	2	10	2	22	4	31

Source: EBRI/CHEC/BCBSA 2000 Small Employer Health Benefits Survey.

workers perceive that not offering health benefits has had an impact on recruitment, retention, performance, health status of workers, and absenteeism.

■ Employer Profiles

Small employers that offer health benefits to workers tend to be distinctly different from small employers not offering health benefits. This may partially explain why some companies find that offering or not offering health benefits has an impact on employee recruitment, retention, and performance, while others do not. It may also help explain why some firms do not offer workers health benefits in spite of experiencing an impact on their business as a result of not offering health benefits.

Worker Income

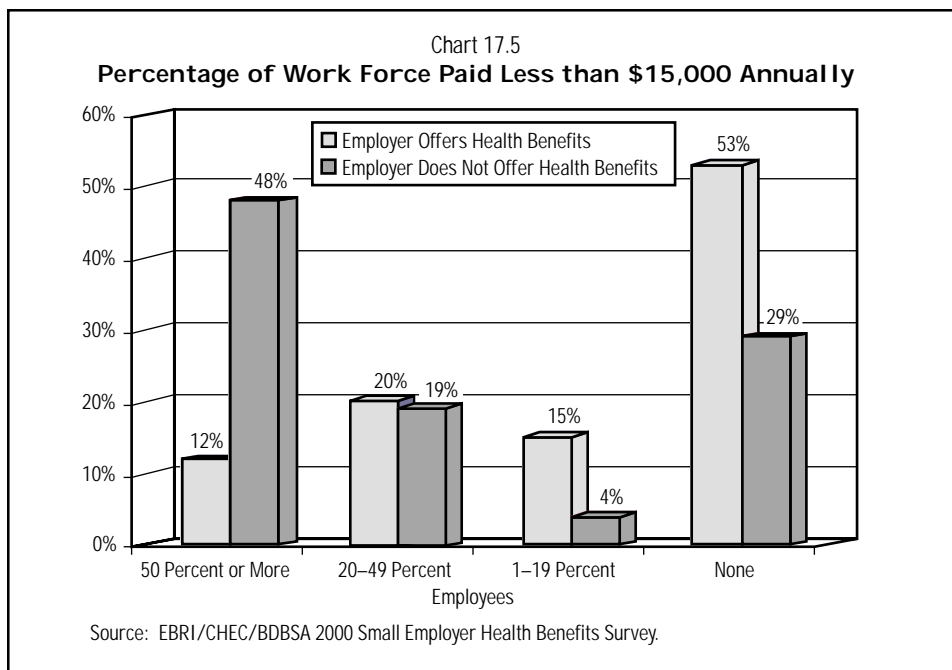
The income of workers in firms *not offering* health benefits tend to be considerably lower than worker income in firms that *do offer* health benefits. Nearly 50 percent of employers not offering health benefits pay wages of less than \$15,000 per year to 50 percent or more of their employees, compared

with 12 percent of companies that do offer health benefits (chart 17.5).

In addition to differences in income, companies not offering health benefits are more likely than employers offering health benefits to have a smaller proportion of full-time employees. One-half of employers not offering health benefits, and 22 percent of employers offering health benefits indicate that fewer than 80 percent of their employees work full time (table 17.5). Firms that do not offer health benefits also have larger proportions of females, workers under age 30, or minority employees.

Firm Size and Revenue

Firms that do not offer health coverage tend to be smaller than those that offer coverage. Of the employers that do not offer health benefits, 83 percent employed fewer than 10 workers (chart 17.6). In contrast, of the employers that do offer health benefits, 66 percent employed fewer than 10 workers. In addition, employers not offering health benefits are more than twice as likely to have annual gross revenues of less than \$500,000. Sixty percent of employers that do not offer health



benefits had annual gross revenue of less than \$500,000, compared with 27 percent among employers that do offer health benefits (table 17.6). While 29 percent of companies offering health benefits report annual gross revenues of \$1,000,000

or more, only 8 percent of employers not offering health benefits report this level of revenue. Some of the differences in revenues between companies with and without benefits result from the fact that firms with benefits tend to have more workers than those without benefits. However, companies with health coverage generally have higher gross revenues than those without benefits, even when comparing companies with similar numbers of employees.

Table 17.5
Work Force Characteristics

Percentage of Work Force	Employer Offers Health Benefits	Employer Does Not Offer Health Benefits
Full Time		
100%	56%	43%
80%-99%	21	6
50%-79%	15	26
Less than 50%	7	23
Female		
100%	6	16
80%-99%	7	5
50%-79%	28	32
Less than 50%	59	46
Under Age 30		
50% or more	17	30
20%-49%	37	27
1%-19%	20	6
None	26	38
Minority		
100%	3	8
50%-99%	8	13
20%-49%	13	11
1%-19%	15	6
None	58	56

Source: EBRI/CHEC/BCBSA 2000 Small Employer Health Benefits Survey.

Firm Tenure

Companies that do not offer workers health coverage generally have been in business for less time

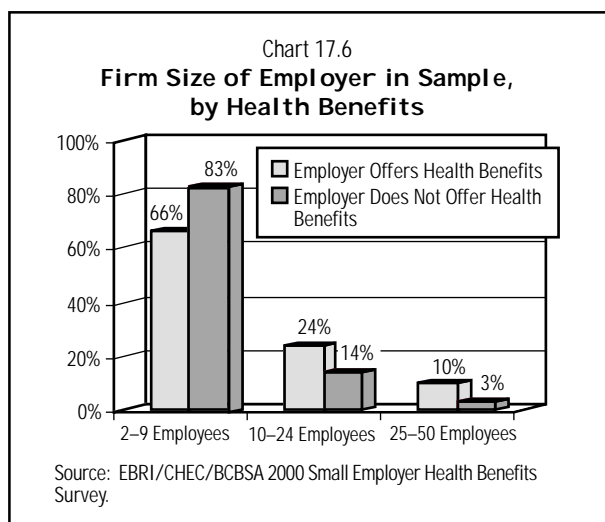


Table 17.6
Annual Gross Revenue of Employers in Sample

Annual Gross Revenue	Employer Offers Health Benefits	Employer Does Not Offer Health Benefits
Less than \$500,000	27%	60%
\$500,000–\$999,999	24	13
\$1,000,000–\$1,999,999	16	6
\$2,000,000–\$4,999,999	10	2
\$5,000,000 or More	3	0
Don't Know/Refused	20	20

Source: EBRI/CHEC/BCBSA 2000 Small Employer Health Benefits Survey.

Table 17.7
Age of Business of Employers in Sample

Age of Business	Employer Offers Health Benefits	Employer Does Not Offer Health Benefits
Less than 5 Years	14	18
5–9 Years	17	25
10–14 Years	12	17
15–29 Years	30	25
30 Years or More	26	13

Source: EBRI/CHEC/BCBSA 2000 Small Employer Health Benefits Survey.

than have those that offer coverage. While both groups are equally likely to have been in business for less than five years (14 percent with health benefits; 18 percent without health benefits), 25 percent of those not offering benefits, compared with 17 percent of those offering health benefits, have been in business for five to nine years (table 17.7). Contrary to general belief, however, more than one-half of all employers not offering health coverage have been in business for at least 10 years. Seventeen percent have been in business for 10 to 14 years and 25 percent have been around for 15 to 29 years. Thirteen percent without benefits have been in business for 30 years or more.

Other Benefits

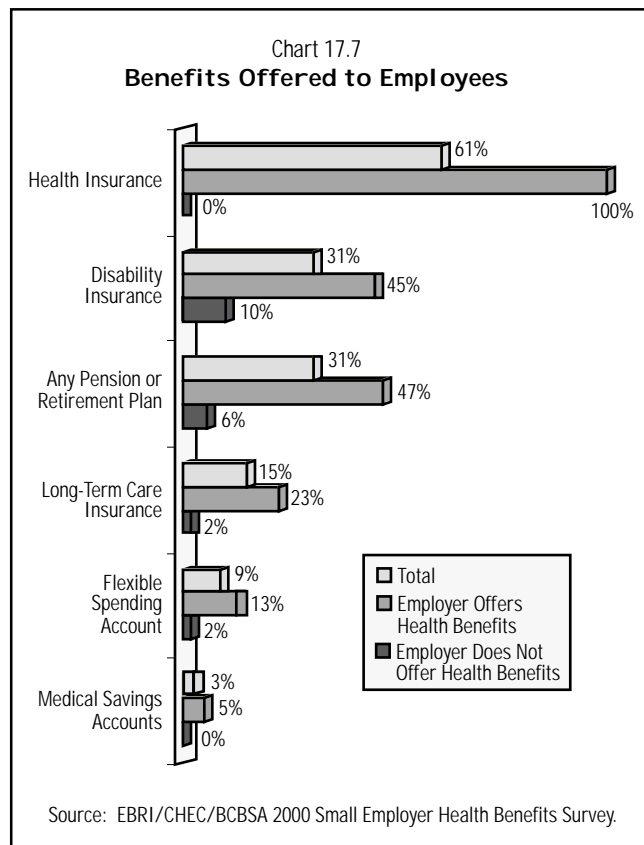
Firms that do not offer workers health coverage are unlikely to provide any of the other employee benefits examined in the survey. Just 10 percent of those not offering health benefits offer disability insurance (chart 17.7). Even fewer offer a pension or retirement benefit plan (6 percent), long-term care insurance (2 percent), or flexible spending accounts for health

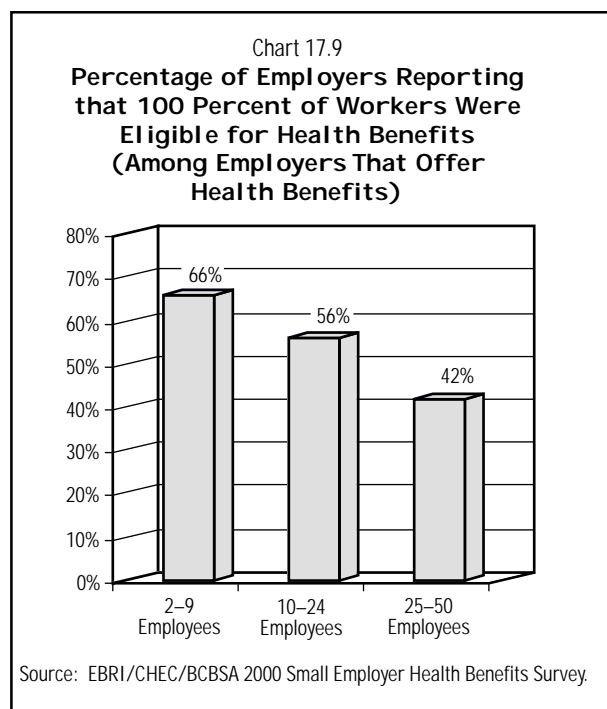
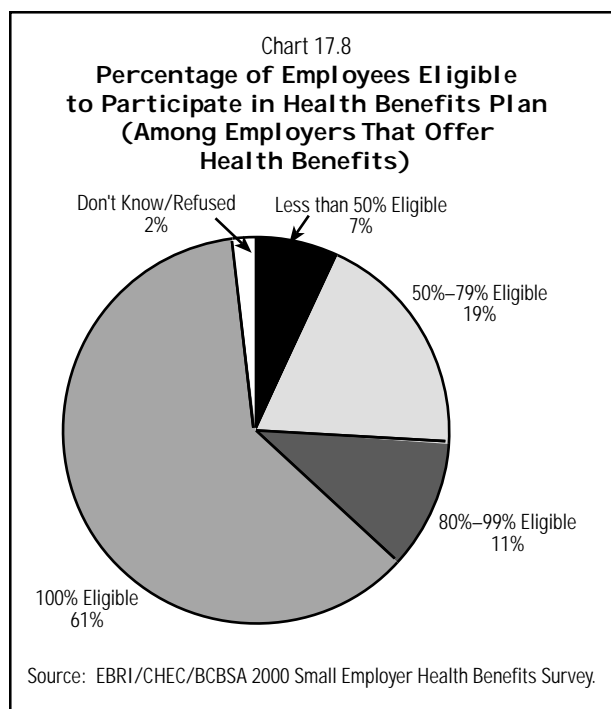
care (2 percent). In contrast, nearly one-half of companies that offer health benefits also offer pension or retirement benefits (47 percent) or disability insurance (45 percent). Twenty-three percent report that they provide long-term care insurance, 13 percent offer flexible spending accounts for health care, and 5 percent have medical savings accounts.

Employee Participation

Not all workers are eligible to take advantage of the health benefits offered by their employers. Just over 60 percent of employers offering health benefits report that all workers were eligible to participate. Nearly 20 percent report that between 50 percent and 79 percent of workers were eligible to participate, while 11 percent report that between 80 percent and 99 percent were eligible.

As firm size increases, the per-





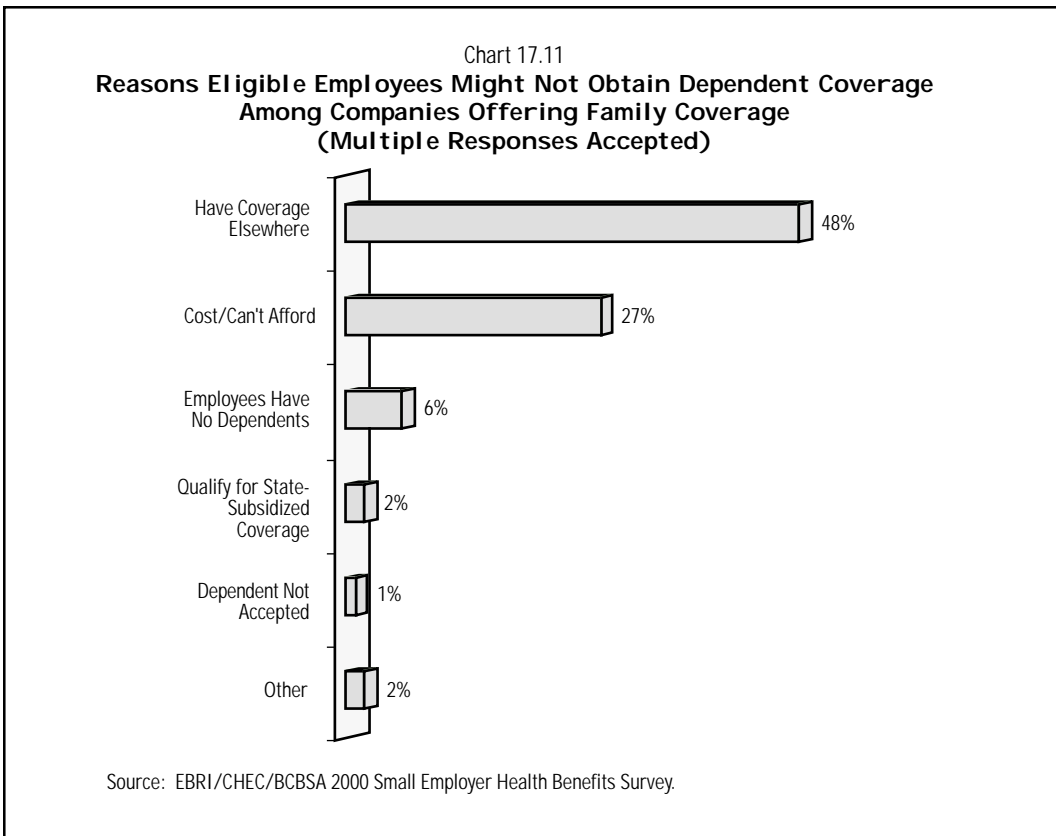
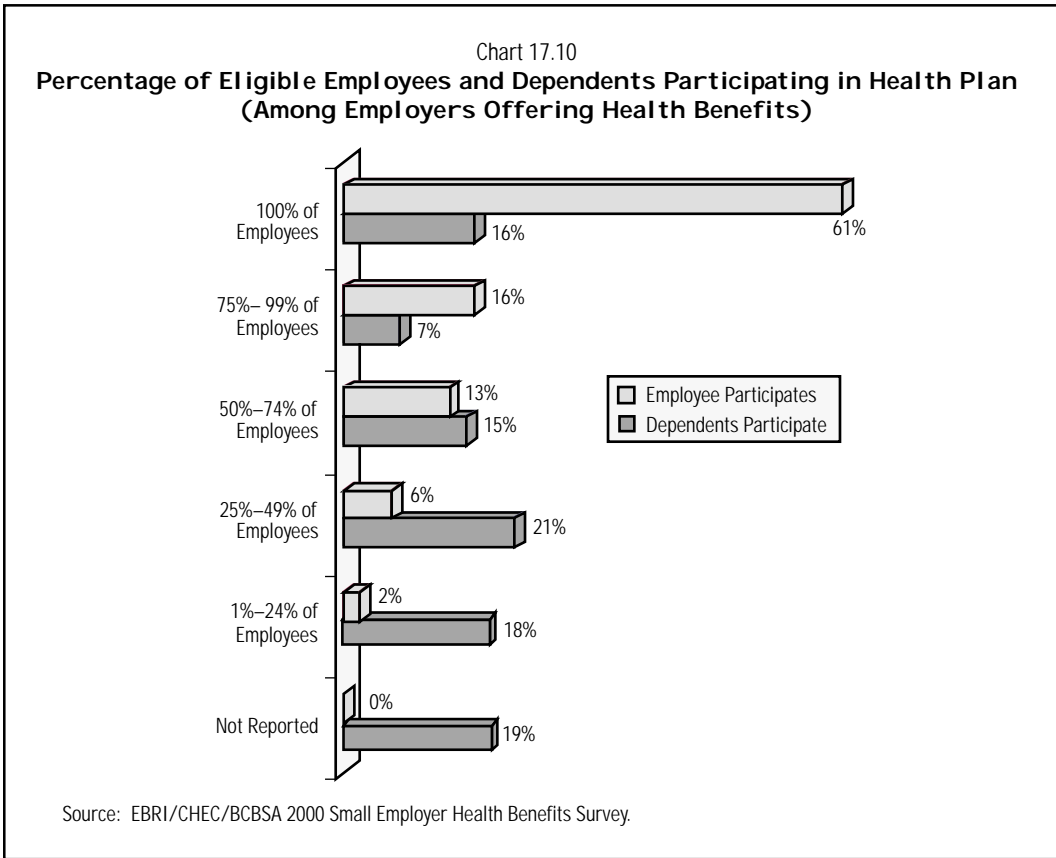
centage of workers eligible for health benefits when offered actually decreases. Specifically, 42 percent of respondents from firms with 25 to 50 employees report that 100 percent of their employees were eligible to participate in the health benefits plan (chart 17.9); this compares with 56 percent of employers with 10 to 24 employees and 66 percent of employers with two to nine employees. It is possible that the smaller firms have fewer part-time employees, who are generally not eligible for health benefits. Eighteen percent of the employers surveyed report that part-time employees were eligible for health benefits. Higher eligibility rates may be also due to minimum participation requirements. These requirements, in effect, require all workers to have health insurance coverage in order for an insurer to agree to provide coverage. It protects the insurer from the risk of adverse selection, in which healthy workers opt out of the health benefits plan and leave only the unhealthy (and more costly to cover) in the plan.

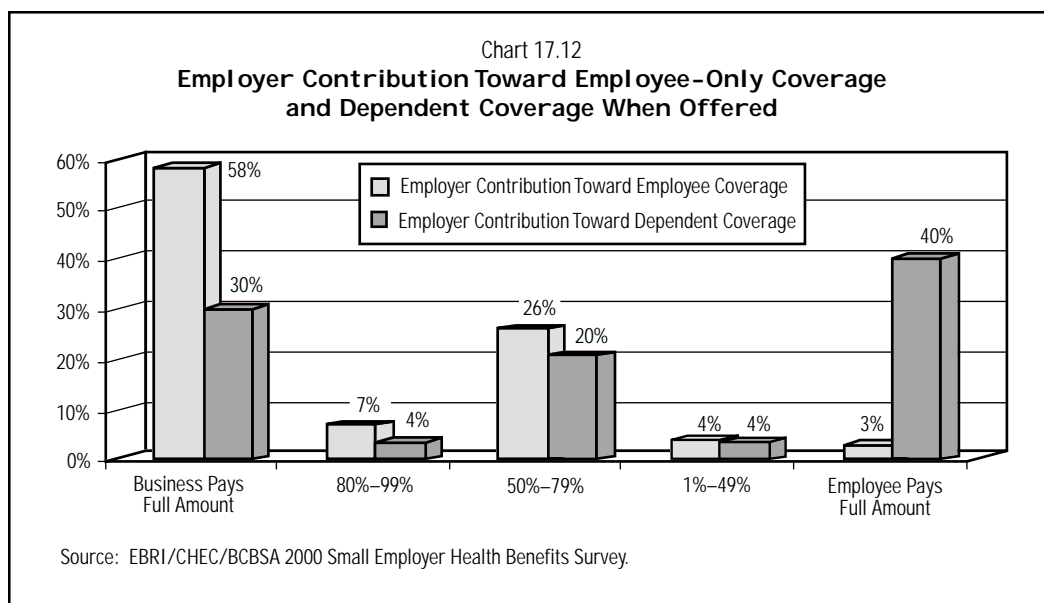
Not all employers that offer health benefits get full participation among eligible workers. Just over 60 percent of employers offering health benefits had 100 percent participation among employees (chart 17.10). Among employers that offer health benefits to dependents (13 percent did not offer health benefits to dependents), take-up rates were much lower for dependents. A mere

16 percent report that all employees eligible for dependent coverage actually included dependents in the health benefits plan.

Employers reported a number of reasons why workers do not accept health benefits for dependents, when this benefit is available. Nearly 50 percent of employers offering dependent coverage report that the workers decline dependent coverage because the dependents have coverage from elsewhere (chart 17.11). An additional 27 percent report their employees decline dependent coverage because they cannot afford the premiums. This finding is consistent with the fact that small employers tend to pay a greater share of the premium for employee-only coverage than they pay for dependent coverage. While nearly 60 percent of employers pay the full premium for employee-only coverage, just 30 percent pay the full amount for dependent coverage (chart 17.12). Conversely, only 3 percent require the worker to pay the full amount for employee-only coverage, but 40 percent require them to pay the full amount for dependents.

As might be expected, the dependent take-up rate is considerably higher in firms that contribute at least some percentage toward the cost of the coverage than it is in firms where the employee is required to pay the full amount. The average take-up among employers that contribute something toward coverage is 56 percent, compared with an





average take-up of 23 percent among employers that do not contribute toward the cost of dependent coverage.

■ Likelihood of Offering Benefits

Some employers not currently offering health benefits have offered them in the past. Overall, 12 percent of companies that do not currently offer health benefits report their business has offered some type of health benefits plan in the past five years (table 17.8). In fact, the larger the size of the employer, the more likely it offered health benefits in the past. Eleven percent of employers with two to nine employees have offered health benefits in the past five years, compared with 17 percent among employers with 10 to 24 employees, and 28 percent among employers with 25 to 50 employees.

Reasons For Not Offering Benefits

Financial concerns, together with the availability of coverage elsewhere, are the reasons most frequently mentioned by small employers for not offering health benefits to workers. Nearly 70 percent of employers not offering health benefits report that a major or minor reason was that their business cannot afford to offer them (table 17.9). In addition, 56 percent report that revenue is too uncertain to commit to offering a health benefits plan, and 61 percent report that their company does not have a plan because employees have coverage elsewhere. More than 50 percent report that they do not offer health benefits because the owner of the business has health insurance coverage from somewhere else, and nearly 55 percent reported that their employees were not able to

Table 17.8
Offered Plan in Past and Obtained Information, by Size of Business

	Total	2-9 Workers	10-24 Workers	25-50 Workers
Offered Health Plan in Past Five Years				
Yes	12%	11%	17%	28%
No	86	87	82	69
Don't know	2	2	1	3
Contacted Someone for Information in Past Two Years				
Yes	31	28	40	51
No	68	70	58	46
Don't know	2	2	3	3

Source: EBRI/CHEC/BCBSA 2000 Small Employer Health Benefits Survey.

Table 17.9
Reasons for Not Offering a Health Plan

	Major Reason	Minor Reason	Not a Reason
The business cannot afford it.	53%	16%	30%
Employees have coverage elsewhere.	43	18	35
Revenue is too uncertain to commit to a plan.	40	16	43
Owner has coverage elsewhere.	40	13	45
Employees cannot afford it.	37	17	43
Large portion of workers are seasonal, part time, or high turnover.	34	15	49
Employees prefer wages and/or other benefits.	30	20	47
Company does not need to offer a plan to recruit and retain good workers.	18	17	63
Setting up a plan is too complicated and time consuming.	11	20	68
Employees are healthy and do not need it.	10	17	71
Do not know where to go for information on starting a plan.	8	21	71

Source: EBRI/CHEC/BCBSA 2000 Small Employer Health Benefits Survey.

afford health benefits.

The reasons for not offering health benefits generally do not vary by size of firm, although there are some notable exceptions. Employers with between 10 and 50 workers are more likely than smaller firms to cite several employee-related reasons for not offering health benefits. They were more likely to report that their employees cannot afford it (53 percent with two to nine workers; 65 percent with 10 to 24 workers; 67 percent with 25 to 50 workers). They were more likely to report that a large portion of their workers are seasonal, part time, or high turnover employees (46 percent with two to nine workers; 68 percent with 10 to 24 workers; 69 percent with 25 to 50 workers), and they were more likely to report that they do not need to offer health benefits to recruit and retain workers (33 percent with two to nine workers; 46 percent with 10 to 24 workers; 51 percent with 25 to 50 workers).

Information

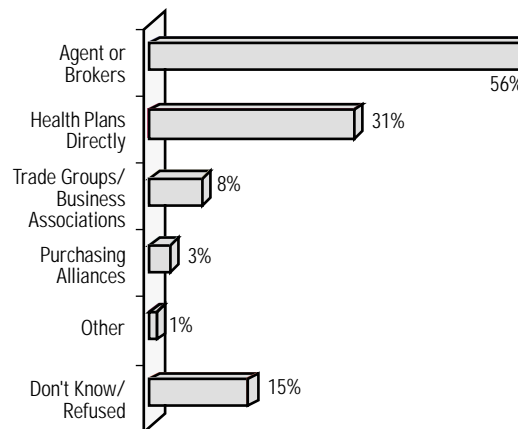
The survey also found that employers not offering health benefits have tried to get information about health benefits. Overall, 31 percent report that they have contacted someone for information on health benefits in the past two years (table 17.8). Again, larger firms are more likely than smaller ones to have contacted someone for information in the past two years. Nearly 30 percent of employers with two to nine employees have contacted someone for information, compared with 40 percent among firms with 10 to 24 employees, and 51 percent among firms with 25 to 50 employees.

Where did they go for help? Among those that contacted someone for information, 56 percent report that they contacted an insurance agent or a broker, and 31 percent contacted health insurers directly (chart 17.13). Nearly 10 percent report that they requested information from trade groups or business associations, and 3 percent obtained information from purchasing alliances.

Cost Awareness

Many employers that do not offer health benefits appear to have a fairly accurate idea of the cost of health insurance coverage. According to Levitt et al.

Chart 17.13
Information Contacts Among Companies Contacting Someone for Information in Past Two Years (Multiple Responses Accepted)



Source: EBRI/CHEC/BCBSA 2000 Small Employer Health Benefits Survey.

Table 17.10
Estimate of Monthly Cost and Amount Willing to Pay Toward Employee-Only Coverage (Among Employers Not Offering Health Benefits)

	Estimate of Cost	Amount Willing to Pay
Nothing at All	—	23%
Less than \$50	3%	6
\$50–\$99	10	10
\$100–\$199	23	8
\$200–\$299	11	5
\$300 or More	23	3
Don't Know	29	43

Source: EBRI/CHEC/BCBSA 2000 Small Employer Health Benefits Survey.

(1999), the average cost of health benefits for employers with three to 199 workers was \$189 per month. Twenty-three percent of the employers responding to the survey report that health benefits cost between \$100 and \$199 per month, and 11 percent think it costs between \$200 and \$299 per month (table 17.10). In contrast, 13 percent estimated the average cost per worker of employee-only coverage to be less than \$100 per month, and 29 percent reported they do not know how much this coverage costs.

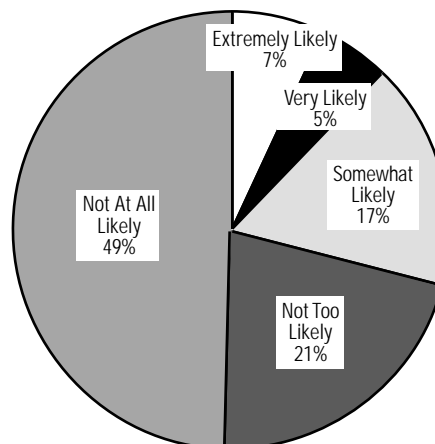
Cost Sharing

While the surveyed employers had a good sense of the actual cost of health benefits, they were willing to pay far less on behalf of their employees. In fact, most employers either did not know how much they were willing to pay or they were not willing to contribute anything. Specifically, 23 percent of employers that do not offer benefits report they are not willing to pay any amount toward the cost of their workers' health insurance coverage, and 43 percent do not know how much their company would be willing to pay (table 17.10). Only 8 percent report that they are willing to pay at least \$200 per worker per month. Another 8 percent report that they would contribute between \$100 and \$199.

Potential Benefit Sponsors

Nearly 30 percent of firms that do not currently offer health benefits are potential purchasers of health benefits for their employees. Twelve percent

Chart 17.14
Likelihood of Employer Offering Health Benefits in Next Two Years (Among Companies Not Offering a Health Plan)



Source: EBRI/CHEC/BCBSA 2000 Small Employer Health Benefits Survey.

of employers not currently offering health benefits said they are either extremely or very likely to start offering a health benefits plan for employees in the next two years (chart 17.14). An additional 17 percent are somewhat likely to start a health benefits plan. Still, 70 percent of employers not offering health benefits are not likely to offer them in the next two years.

Companies likely to start a health benefits plan differ in a number of ways from others not currently offering a plan. Those likely to start a health benefits plan are more apt to have been in business for less than 10 years. Nearly 70 percent of employers not offering a health benefits plan, but who are extremely or very likely to offer one in the next two years, report that they have been in business for less than 10 years (table 17.11). In contrast, only 35 percent of those not likely to offer health benefits have been in business less than 10 years. This indicates that a promising opportunity for expanding health insurance coverage lies among small employers that have not been in business for a very long period of time.

Employers who are extremely or very likely to offer a health benefits plan are also more likely to have contacted someone for information about health insurance in the past two years. They tend to report that they are willing to pay more toward the cost of health coverage on behalf of their

Table 11
**Likelihood of Offering Health Benefits in the Future,
 Among Employers Not Offering Health Benefits,
 by Selected Indicators**

	Extremely or Very Likely	Somewhat Likely	Not Too or Not at All Likely
Company Started Less Than 10 Years Ago	69%	56%	35%
Contacted Someone for Information on Health Insurance in Past Two Years	62%	44%	22%
Median Amount Willing to Pay per Worker on Monthly Basis on Behalf of Employees for Health Insurance	\$100	\$50	\$0
Not Offering Health Plan has Impact on:			
Employee recruitment	57%	36%	20%
Employee retention	36	30	15
Employee attitude and performance	40	30	16
Health of employees	34	31	17

Source: EBRI/CHEC/BCBSA 2000 Small Employer Health Benefits Survey.

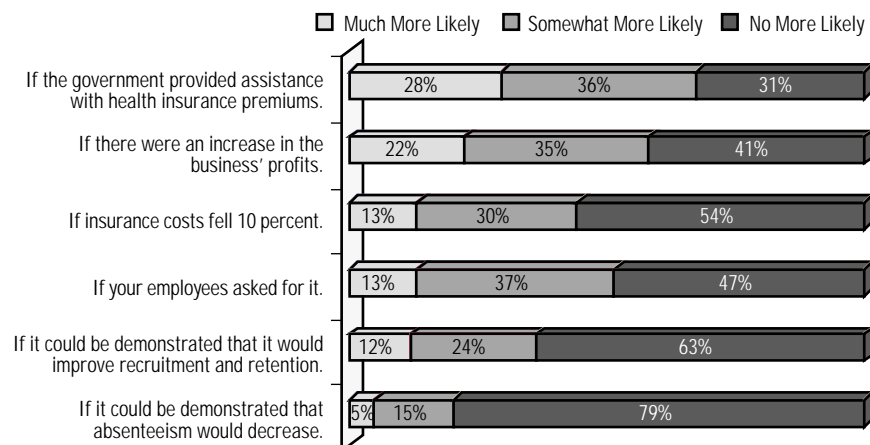
employees; however, the average amount they are willing to pay (\$100 per month) is still one-half the actual average cost of coverage. They are also more likely to report that not offering health benefits has had an impact on employee recruitment, retention, performance, and the health status of their employees.

Factors That Would Encourage Sponsorship

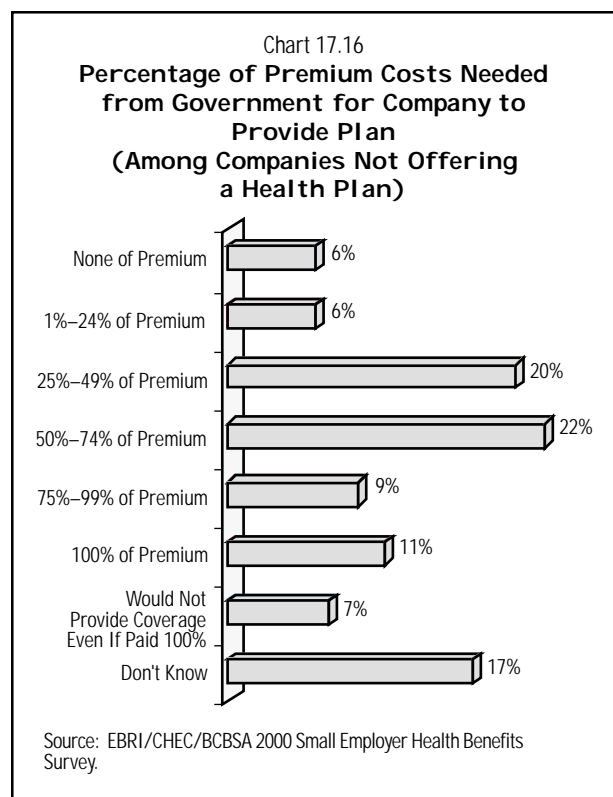
Employers not offering health benefits were read a list of factors that might make their business more likely to seriously consider offering a health

benefits plan. Not surprisingly, respondents are most inclined to say that factors having to do with increasing the affordability of health insurance coverage would make them more likely to consider offering health coverage. If the government provided assistance with premiums, 64 percent would seriously consider offering health benefits (chart 17.15). Also, 57 percent would consider offering health benefits if there were an increase in the business's profits, and 43 percent report that they would consider doing so if insurance costs fell 10 percent. However, 50 percent would be more likely to seriously consider offering a health

Chart 17.15
Factors Likely to Make Companies Seriously Consider Offering Plan



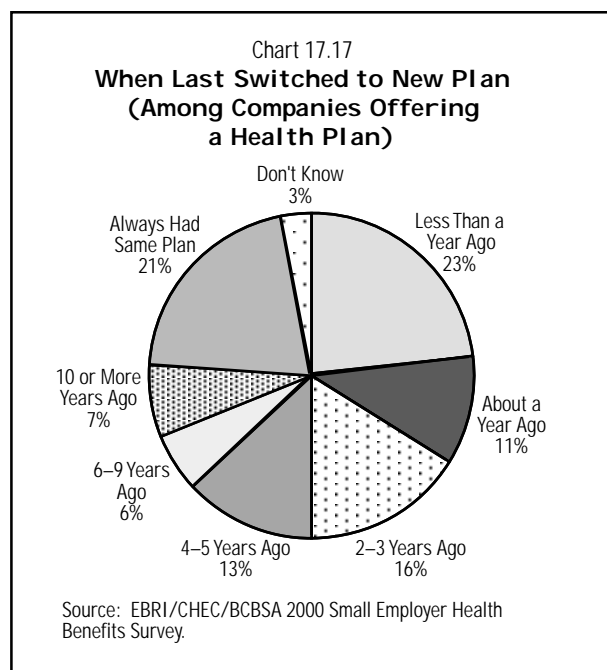
Source: EBRI/CHEC/BCBSA 2000 Small Employer Health Benefits Survey.



benefits plan as a result of employee demand. More than one-third (36 percent) would consider offering a health benefits plan if it improved recruitment and retention.

Respondents who say that their company is likely to start offering health benefits in the next two years are more likely than those not likely to offer health benefits to indicate the following: Among those extremely or very likely to start offering a health benefits plan, majorities say their company would be *much* more likely to seriously consider offering a plan if there were an increase in profits (73 percent) or if the government provided assistance with premiums (65 percent). Almost one-half would be *much* more likely to do so if insurance costs fell 10 percent (48 percent) or if it would improve recruitment and retention (48 percent).

A large number of companies not offering health benefits state they would need major government subsidies for them to provide health insurance coverage. Roughly 20 percent would need to receive a subsidy of between 25 percent and 49 percent of the premium, and 22 percent would need to receive a subsidy of between 50 percent and 74 percent of the premium (chart 17.16). One in 10 each would require a subsidy of between 75 percent and 99 percent, or a subsidy covering the entire

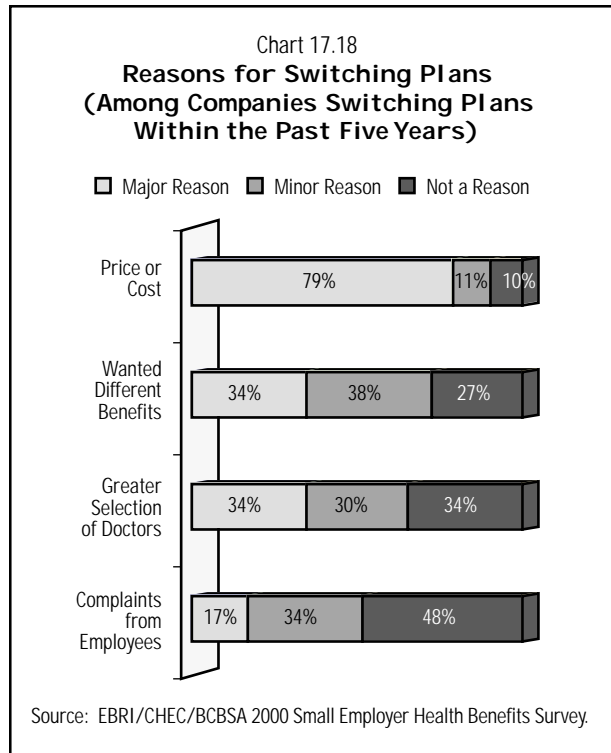


premium. Seven percent state they would not provide coverage even if the government paid the entire cost of the premium. Among those who indicate they would require subsidies of at least 50 percent to offer coverage, three-fourths say they would be more likely to consider offering health benefits if they were able to receive cash from the government for 50 percent of the premium on a quarterly basis and would not have to repay this money (38 percent much more likely; 38 percent somewhat more likely).

■ Future Costs and Tax Incentives

Many small employers with health benefits have recently switched health plans. Just over one-third report that they switched health plans within the past year, with 23 percent reporting that they switched plans within the past year and another 11 percent reporting that they switched plans about one year ago (chart 17.17). Overall, 63 percent report that they have switched plans within the past five years. Twenty-one percent indicate that their business has always had the same plan.

Affordability for the employer and the worker is a clearly a critical factor affecting the likelihood of switching health plans. Nearly all employers that have switched health plans within the past five years cite price or cost as a reason for the change (chart 17.18). Nearly 80 percent report



coverage if costs increase. This may not be easy to do in the currently tight labor market. For example, while costs were increasing 7 percent between 1998 and 1999, the percentage of small employers offering health benefits also increased (Levitt et al., 1999). Some employers dropped health benefits in response to the cost increase, but even more added health benefits, many for the first time.

In general, small employers support tax breaks to reduce the health insurance costs of low-wage workers. More than one-half (56 percent) strongly favor tax breaks that they could use to reduce health insurance costs for their low-wage workers (table 17.13). An additional 30 percent would somewhat favor such a proposal. Just 7 percent would somewhat or strongly oppose it. Companies that currently offer health benefits are slightly more likely than those that do not to strongly or somewhat favor it. Nearly 90 percent of employers offering health benefits favor the tax credits, compared with 82 percent of employers not offering health benefits.

that it is a major reason for having changed health plans. Other reasons for switching health plans include wanting different benefits, wanting a greater selection of doctors, and complaints from employees, though none had the impact that price or cost had on the decision.

Moreover, 33 percent of respondents from companies offering health benefits think their firm would change coverage and 5 percent think it would drop coverage if the cost of health insurance in general were to increase by 5 percent (table 17.12). If costs increased only 1 percent, 10 percent would change coverage and 3 percent would drop coverage. In contrast, if costs increased 10 percent, 46 percent would change coverage, while 14 percent would drop coverage.

Many employers report that they will drop

Conclusion

While employment-based health insurance is by far the most common form of health insurance coverage in the United States, many workers are not offered health benefits or do not participate in the plan when it is offered. Of the 44 million Americans who do not have health insurance coverage, 36 million are in a family with a worker, and small firms employ 60 percent of uninsured workers. Since the vast majority of large employers offer health benefits, but many small employers do not, small businesses are seen as perhaps the most crucial element in efforts to expand health insurance coverage in the current health insurance system and reduce the growing number of unin-

Table 17.12
Potential Small Employer Reaction to Increase in Health Insurance Costs

If Cost Increased:	Continue to Offer Current Coverage	Change Coverage	Drop Coverage	Don't Know
1 percent	84%	10%	3%	3%
5 percent	57	33	5	5
10 percent	34	46	14	6
25 percent	16	51	28	6

Source: EBRI/CHEC/BCBSA 2000 Small Employer Health Benefits Survey.

Table 17.13
Support for Tax Breaks to Reduce Health Insurance Costs for Low-Wage Workers

	Total	Employer Offers Health Benefits	Employer Does Not Offer Health Benefits
Strongly Favor	56%	59%	53%
Somewhat Favor	30	30	29
Somewhat Oppose	4	3	5
Strongly Oppose	3	2	3
Depends	4	3	6
Don't Know	3	3	3

Source: EBRI/CHEC/BCBSA 2000 Small Employer Health Benefits Survey.

sured Americans.

The 2000 Small Employer Health Benefits Survey was conducted in order to better understand how more small employers could be persuaded to offer health benefits. This *Issue Brief* presented a number of important findings from the SEHBS concerning small employers and their decision to offer health benefits to workers. Perhaps the most surprising finding is the fact that many small employers are making decisions about whether or not to offer health insurance coverage to their workers without being fully aware of the tax advantages that can make this benefit more affordable. Also, many small employers are largely unaware of the state and federal laws that have been enacted specifically to make health insurance more accessible and more affordable for them. The implications of these findings are significant.

It is important for employers to understand the tax treatment of health benefits for a number of reasons. Misperceptions about how health benefits are taxed may prevent employers from offering health benefits to begin with. Also, if employers are unaware of how the tax code affects their workers, it is likely that the workers are also unaware of it, and also do not know the true value of the health benefits they are being offered. Furthermore, it is important for small employers to understand how the insurance market is regulated. Misconceptions about the market may result in fewer employers offering coverage because they were under the impression that they could not obtain it or that they could not afford it due to the health status of their workers.

Other findings suggest that there are a number of ways in which the number of workers

(and their dependents) covered by health insurance could be expanded. First, most employers offer sound business reasons for offering health benefits to workers. Employers not offering health benefits generally do not perceive that the lack of health benefits has an impact on their business, although there is evidence that it does. This survey found that employers not offering health benefits are more likely than those offering them to report that most of their employees stay with the business for only a few months. Second, not all workers take advantage of the health benefits that are offered by their employers, and not all employers offer dependent coverage. The survey found that the average take-up rate is higher among employers that contribute at least something toward the cost of health benefits. Third, nearly 30 percent of small employers not currently offering health benefits say they are likely to offer it in the next two years. If employers were given financial incentives to offer health benefits, health insurance coverage might be expanded substantially. Finally, employers are sensitive to the cost of providing health benefits. As just mentioned, if the cost of providing health benefits were reduced, more small employers would offer them. In contrast, if the cost of providing health benefits continues to increase, some employers will drop health benefits, ultimately increasing the challenge to expand health insurance coverage. In a tight labor market, few employers will drop coverage—but if the economy were to weaken, the effects of cost increases on both the offering of health benefits by employers and the take-up by workers are likely to be substantial.

■ Methodology

The Small Employer Health Benefits Survey (SEHBS) was designed to examine the reasons America's small employers (with two to 50 workers) offer or do not offer health benefits to their workers and related issues. The survey was conducted within the United States between May 16 and June 30, 2000, through 20-minute telephone interviews with 506 companies with health benefits and 449 companies without health benefits. Within each group, quotas were established to ensure sufficient representation for analysis by number of employees. The resulting sample was weighted by presence of plan and number of employees to reflect

the national population of small employers with two to 50 workers.

In theory, the weighted sample of 955 yields a statistical precision of plus or minus four percentage points (with 95 percent certainty) of what the results would be if all nongovernment businesses with two to 50 workers were surveyed with complete accuracy. There are other sources of error on all surveys, however, that may be more serious than theoretical calculations of sampling error. These include refusals to be interviewed and other forms of nonresponse, the effects of question wording and question order, and screening. While attempts are made to minimize these factors, it is difficult or impossible to quantify the errors that may result from them.

■ References

- Fronstin, Paul. "Employment-Based Health Benefits: Who Is Offered Coverage vs. Who Takes It." *EBRI Issue Brief* no. 213 (Employee Benefit Research Institute, September 1999).
- _____. "Sources of Coverage and Characteristics of the Uninsured: Analysis of the March 1999 Current Population Survey." *EBRI Issue Brief* no. 217 (Employee Benefit Research Institute, January 2000).
- Levitt, Larry, et al. *Employer Health Benefits: 1999 Annual Survey*. Menlo Park, CA and Chicago, IL: Henry J. Kaiser Family Foundation and Health Research and Educational Trust, 1999.
- Salisbury, Dallas L., and Pamela Ostuw. "Value of Benefits Constant in a Changing Job Environment: Findings from the 1999 ACA/EBRI Value of Benefits Survey." *EBRI Notes*, no. 6 (Washington, DC: Employee Benefit Research Institute, June 2000): 5–9.

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CHEC

The Consumer Health Education Council (CHEC), a health education organization, was formed in 1998 to help the American public better understand, acquire, and utilize health insurance. CHEC's mission is to reduce the number of uninsured Americans and improve the health of the general public through information and research that helps individuals and plan sponsors understand the value and uses of private and public health insurance. CHEC is part of the Employee Benefit Research Institute Education and Research Fund (EBRI-ERF), a 501(c)(3) organization. Like its parent organization, CHEC is a nonpartisan group that does not lobby and does not take positions on specific policy proposals.

BCBSA

The 47 independent Blue Cross and Blue Shield member Plans collectively make up the Blue Cross and Blue Shield System. This System is coordinated by the Blue Cross and Blue Shield Association; however, all member Plans function as independent, locally operated companies. The Association is the owner of the BLUE CROSS® and BLUE SHIELD® trade names and service marks, and licenses their use to the independent Member Plans. Collectively, Blue Cross and Blue Shield Plans provide health care coverage for 76.9 million people in the 50 states, the District of Columbia, and Puerto Rico. This is the highest total enrollment for the Blues since 1987, and represents 25 percent of the U.S. population. In the United States, more than 80 percent of hospitals and nearly 90 percent of physicians contract directly with the Blue Cross and Blue Shield Plans.



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The Urban Institute

Stephen Adams
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Greg Ahern
State Street Corporation

Kristen Alexander
Morgan Stanley Dean Witter

Eric Baumgartner
HRSA

James Bentley
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