

Future of the Employer Role in Provision of Health Insurance

The United States has a health insurance system that developed accidentally and without outside direction. It began as a way for employers to attract and retain employees and many employers still view it as playing that role. Additionally, employers now tend to view health insurance as a way for the organization to promote and assist employees in remaining healthy and, therefore, productive at work.

Employment remains the primary factor enabling individuals to obtain health insurance, although employment itself is not enough to guarantee coverage. Researchers found that employees' coverage acceptance rates are affected primarily by the lowest premium cost to employees and by the percentage of an organization's workforce earning less than \$20,000 annually.

A theoretical base has developed around the study of the employer-based health financing system. Olson (2002) and Blumberg (1999) discuss the concepts and implications behind Compensating Wage Theory. *Compensating Wage Theory* states that employers are indifferent to the form employee compensation takes and therefore a dollar of wage should be substitutable for a dollar of benefits. They found that employers do, to some extent, trade off the cost of benefits for wages. It is not a dollar for dollar exchange, however, which implies that employers are considering other issues when constructing a compensation package and that employees consider other issues when accepting these packages.

The literature investigating the future of the employer role in providing health insurance lies primarily on theoretical discussion and prediction. The system is complex and difficult to study quantitatively because of the limited ability to provide alternatives to the current employer model. Employers appear to move somewhat incrementally in adjusting benefits programs to alter incentives rather than making dramatic changes. Additionally, employers may find themselves with limited choices to offer employees because of elements outside their organization—plan offerings are dependent on the health care services resources available. This is a primary reason for the limited managed care penetration in rural settings and could be expected to limit the potential for competition among providers needed to change system incentives.

Trends

The cost of job-based insurance rose between 4 and 5 percent, on average, from 1977 to 1998, but then started to rise dramatically (8.3% in 2000, 11% in 2001 and 12.7% in 2002). Employers have shifted some costs to employees, but mostly have absorbed the costs of premium increases. Instead, employers have been more likely to use changes in cost sharing mechanisms such as copayments and deductibles to control premium rates rather than raising employee contributions to premiums. The

dramatic shift to managed care and HMOs has now reversed; conversely, preferred provider organization enrollment rose to 48% in 2001. The most recent employer attempts to control costs have focused on prescription drugs—formularies and three-tier cost-sharing formulas.

Retiree Health Benefits

Employers are increasingly less likely to offer retiree health benefits, even though they view it as a potential recruitment and retention tool. Large firms, state and local governments were more likely to offer coverage than other organizations. Low-wage workers are less likely to be offered coverage than higher-wage workers. (McCormack 2002) Solutions under consideration include expanding COBRA rules, tax credits, expand Medicare, and encourage employer coverage. (Neuman 2001)

Long-term care

Long-term care is not adequately covered by medical insurance plans. Approximately one-third of long-term care costs are funded by Medicare and Medicaid; the majority of costs of long-term care are paid directly out-of-pocket or indirectly through the use of informal caregivers. (Mulvey 2002) Proposed solutions include the addition of long-term care insurance to more employment benefits packages, individual purchase of long-term care insurance, increased individual savings, and expanded coverage by entitlement programs (eg, Medicare). These authors support the addition of long-term care insurance to employment compensation packages.

Future

Defined Contribution.—Some authors predict the movement from defined benefit to defined contribution—this is seen as a way to cap employer costs, protect employers from litigation and enhance employee satisfaction through increased choice. Only 8 % of US workers have defined-contribution health benefits.

There is a need to provide choice to employees along with the need to increase employees' involvement in their health coverage decisions—this provides for increased satisfaction due to a better match between employee desires and benefits received and controls costs by exposing employees to some level of cost sharing.

Managed Competition.—Managed competition intends to change incentives by reallocating risk and decision making to result in more economical choices by consumers, plans and practitioners. Managed competition has not yet—and may never—become the force for reform that was predicted (Enthoven 2002, Maxwell 2002) Some employers do not trust employees to make sound decisions related to health benefit plans and purposefully continue to serve as a steward and advocate for employees. (Maxwell 2000) These employers will be unlikely to move to a full, managed

competition model. Additionally, although they do want a wide selection of options to choose their health benefits from, employees do not necessarily want to act as their own agents for health insurance. (Lave, 1999)

Genetic Information in the Workplace.—Pagnatarro (2001) reviews the issue of predictive genetic information and how to protect the privacy of genetic information while providing employers with information to maintain a safe work environment.

Single Payer System.—For the present, it appears that discussion of a single-payer system has disappeared from the literature. Although some reform discussions may mention such finance reforms or propose altered systems (see, for example, Ballard and Goddeeris [1999] and Weil [2001] in the *Proposed Health Care System Reforms* section of this report), such discussions are rare. Since the failure of the Clinton reforms the window of opportunity for systemic appears to have closed. The literature reflects this closure with its focus on incremental reform plans.

Policy Implications

Gabel and colleagues point out how financial burden of health insurance is higher for low-income workers and that they are more sensitive to the price of their health insurance than other groups. Hirschberg (2001) warns against framing public policy on health insurance-related issues based on the myth that small business creates the majority of new jobs. The presence of this maldistribution is predicted to get worse, given the slow economy and the growth of low-wage service-sector jobs.

Self-insured employee health insurance plans create problems with policy implementation and enforcement. ERISA allows such plans to circumvent state regulations by self-insuring, and many large corporations chose to do so. With little federal action toward health care reform, this limits the extent of reform that is possible by making state reform efforts difficult to enforce widely. (Park 2000)

Summaries—

Battistella R, Burchfield D. The future of employment-based health insurance. *Journal of Healthcare Management*. 2000; 45(1): 46-56.

Keywords: Defined contribution, employee benefits, health insurance

Purpose: Predict the trends in employment-based health insurance

Data and Methods: Commentary, not applicable

Results: The authors predict that the form of employment-based health insurance is expected to change from being a defined benefit to defined contribution arrangement. The forces driving this change include: rising premiums, the limits to further cost savings achievable by managed care, increased government regulation, benefit management costs, and the possible loss of ERISA protection. The discussion is based in the presumption that alternatives to its current form "must cost less, require less administrative oversight, and ensure that employees still maintain a measure of choice." Medical savings accounts and vouchers are proposed as solutions that meet these requirements. Additionally, such moves would make employees more active in their health coverage decisions and possibly reduce moral hazard.

Uses: Provides an overview of the health insurance-related pressures experienced by employers

Limitations: Article focuses on employer and, as commentary, does not provide employer-behavior data to support predictions.

Blumberg LJ. Who pays for employer-sponsored health insurance? *Health Affairs*. 1999; 18(6): 58-61.

Keywords: Employer health benefit decision-making behavior, health insurance costs, wages

Purpose: Present a summary of the literature on employer-sponsored health insurance payments and the gaps in our understanding of how employer payments for health insurance benefits impact wages.

Data and Methods: Literature overview, not applicable

Results: Some of the findings reported include: An added dollar of health benefits was associated with an 83-cent reduction in wages for teachers; wages and health/life insurance were relatively substitutable for one another; 59-90 percent of maternity benefit mandate-related costs were passed on to employees by the employers. Blumberg uses these studies and others to support the argument that, contrary to the position supported by most economists that employers are neutral as to whether these costs are due to health benefits or wages, there are other factors playing into both employers' and employees' decisions regarding health insurance. She reminds us that such factors must be considered when forming public policy that intends to impact such behavior.

Uses: Provides an interesting snapshot of the dynamics of health policy and employer/employee decision-making dynamics.

Limitations: The article brings in several studies that readers must locate in order to determine their quality. This is a relatively brief discussion of the issues involved, which is both a positive (readability) and a negative (depth of coverage).

Custer WS, Ketsche P. *Employment-Based Health Insurance Coverage*. Washington, DC: Health Insurance Association of America. 2000. <http://membership.hiaa.org/pdfs/001211CusterStudy.pdf> (October 27, 2002).

Keywords: Employee benefits, health insurance coverage and uptake rates

Purpose: Examination of who accepts and who declines employer-based health insurance coverage

Data: 1996 Medical Expenditure Panel Survey

Methods: Regression analysis

Results: Employment is the primary factor enabling individuals to obtain health insurance. Even so, employment by itself does not guarantee coverage as many are not offered coverage due to employment restrictions or the employee may decline coverage due to cost issues. Income is also correlated with coverage (higher income employees were more likely to be offered and less likely to decline coverage). Other factors related to coverage included firm size (smaller firms were less likely to offer coverage), education (the more education, the more likely to be offered coverage), hours worked (full-time employees were more likely to be offered coverage), and gender (men are slightly more likely to be offered coverage and women are more likely to decline coverage and more likely to remain uninsured if they do decline coverage). Those without insurance spend less than 50 percent of the amount that those with insurance do on health care.

Uses: Provides a good overview of the characteristics of those with employer-based health insurance coverage and those who decline such coverage and the types of employers who offer health insurance coverage to their employees.

Limitations: None as presented

Enthoven AC. The Fortune 500 model for health care: is now the time to change? *Journal of Health Politics, Policy and Law*. 2002; 27(1): 37-48.

Keywords: Employer health benefit decision-making behavior, health insurance, managed competition

Purpose: To define managed competition and to explain and critique the adoption, and non-adoption, of managed competition by employers

Data and Methods: Commentary in response to Maxwell and Temin (2002), not applicable

Results: Enthoven is credited with introducing the managed competition concept. The author rebuts the assertion that managed competition is "a 'theory' of employer behavior in health care purchasing." It intends to change incentives by reallocating risk and decision making to result in more economical choices—with the ultimate goal of health care system reform. Managed competition has three components, which are broader than those defined by Maxwell and Temin (2002): 1) risk adjustment of premiums; 2) a "critical mass" of consumers in a market must participate in the managed competition process; 3) the ultimate goal is reorganization of the health care delivery system. Competition among delivery systems—not just carriers—will add the most value to the entire process. Managed competition creates an environment open to value-increasing innovations such as selective delivery networks and prepaid group practices. Reasons given for non-adoption of managed competition within the Fortune 500 included: 1) employee perspectives of "take-aways" and "give-aways"; 2) collective action problem, with a lack of the necessary critical mass adopting managed competition within each market; 3) the bureaucracies administering plans subsidized the company plans in order to protect its existence; 4) defined contributions make explicit the employer contributions that were previously implicit (eg, subsidization of family plans), which can lead to conflict; and 5) large employers often prefer to provide uniform benefits programs at the national level. A critique of the Fortune 500 model (use of preferred provider networks) focused on the following arguments: 1) model was primarily fee-for-service based; 2) employer subsidization of premiums at 80 to 100 percent provides little incentive to employees to make economical choices; 3) employee complaints that managed care networks did not include particular health care providers resulted in employer demands to include providers, thus the network had no bargaining power to change provider behavior; 4) single-plan approach decreases innovation and deprives employees of alternatives; 5) lack of choice matters and may have been the basis of the recent consumer backlash against managed care; 6) employers constrained their network-based products and impaired these products' effectiveness.

Uses: Provides background on what is and is not managed competition and an understanding of what weaknesses may exist in corporations' current approach of self-insuring and the current configuration of managed care. This article would be of interest to policymakers, health plan administrators, corporate executives, and others interested in health-care system reform and cost-control measures.

Limitations: None if viewed as commentary and as response to the Maxwell and Temin (2002) article

Ford E, Hollman KW, Hayes RD. The future of defined-contribution health plans. *Journal of Financial Service Professionals*. 2002; 56(3): 55-66.

Keywords: Defined contribution, consumer/employee role, employee benefits, health insurance

Purpose: Overview how a defined contribution model would change the current health care and employer-provided benefits environments

Data and Methods: Commentary, not applicable

Results: Defined-contribution health plans have been purported as a possible health care system that could cap employer costs, protect employers from litigation, and enhance employee satisfaction. Currently, approximately 8 percent of all US workers have defined-contribution health benefits. Two primary forms of defined-contribution plans have been proposed: the first where a set monetary amount is provided to the employees and they each devise their own plans; the second, where the employer provides cash or a voucher and a menu of predetermined plans from which an employee may select. Promoters of the defined-contribution model point to the change in consumer role as key to positive change—it increases consumer exposure to cost and thus makes them more sensitive to price and quality of care. Other consequences of a move to a defined-contribution model include: the potential for poor decision making by employees; employer litigation risk and administrative costs are minimized; some employees will be unable to obtain insurance; employers lose health coverage as a recruitment and retention tool; a lessening of the importance of group insurance; managed care organizations will need to focus on marketing to and products for individuals; may increase the conflict between patient and health-care provider; and potentially impact taxes paid by individuals and firms and collected by governments.

Uses: Informs policymakers, health plan administrators, corporate executives, and others interested in how to control health-care expenses about how such changes may impact their organization, their employees and the local health care system.

Limitations: None as presented

Fronstin P. The history of employment-based health insurance: the role of managed care. *Benefits Quarterly*. 2001; 17(2): 7-16.

Keywords: Employee benefits, health care financing, health insurance, managed care, public policy

Purpose: To present a history of the evolution of the employment-based health benefits system

Data and Methods: Historical account, not applicable

Results: This historical account covers the origins and development of the employer-sponsored health benefits system. It includes early history, the role of public policy in this history, composition of the employer-based model, and the success and limitations of managed care. It comments on some of the challenges now faced by the managed care system and concludes that there is need for substantial improvements in the system to attain high-quality care at the lowest possible cost.

Uses: This article would be helpful for anyone who desires an understanding of how the current system of employer-sponsored health benefits developed—including policy makers and analysts, legislators, and others.

Limitations: None as presented

Gabel JR. Job-based health insurance, 1977-1998: the accidental system under scrutiny. *Health Affairs*. 1999; 18(6): 62-74.

Keywords: Health insurance coverage and uptake rates, employee benefits

Purpose: To characterize changes in the employer-based health insurance system between 1977 and 1998

Data: National survey data from the Agency for Health Care Policy and Research, the KPMG Peat Marwick/Kaiser Family Foundation survey of employer-based plans and the Health Insurance Association of America survey on job-based insurance

Methods: Descriptive and multivariate statistical analyses

Results: Between 1977 and 1998, the cost of job-based insurance increased 2.6-fold, and employees' contributions for coverage increased 3.5-fold. Coverage of nonelderly Americans fell from 71 to 64 percent during this same period. Part of this decrease was due to a decreased uptake rate among lower-wage workers. Those with less education were affected more than the more highly educated. Premiums rose between 4 and 5 percent each year and employee contributions to those premiums rose from an average of 20 percent in 1977 to 27 percent in 1998. Employer offerage of an indemnity plan dropped from 90 to 33 percent. The shift from fee-for-service to managed care appeared to keep employee cost sharing from increasing. Additionally, managed care appeared to increase the covered benefits. The author predicts an increase in those without health benefits that corresponds to the broadening gap between those who have and those who lack wealth.

Uses: Provides a complete image of the US employer-based health insurance system for those who want or need to see the trends within and character of this system.

Limitations: None as presented

Gabel JR, Levitt L, Pickreign J, Whitmore H, Holve E, Hawkins S, Miller N. Health tracking: trends: Job-based health insurance in 2000. *Health Affairs*. 2000; 19(5): 144-151.

Keywords: Health insurance coverage and uptake rates, employee benefits

Purpose: To examine the employer-based health insurance system in early 2000

Data: National survey data from the Agency for Health Care Policy and Research, the KPMG Peat Marwick/Kaiser Family Foundation survey of employer-based plans and the Health Insurance Association of America survey on job-based insurance

Methods: Descriptive and multivariate statistical analyses

Results: Changes noted since the 1999 report include an 8.3 percent increase in premiums from spring 1999 to spring 2000—a rise greater than 2.5 times the inflation rate. Firms located in the Northeast experienced more rapid growth in premiums than did firms in the West. These increases are attributed to two factors: the health insurance underwriting cycle and an increase in underlying medical claims expenses. Prescription drug costs contributed largely to the increased premiums, as did hospital expenses, medical technology, physician expenses, insurer profits, and richer benefits packages. Worker contributions to their premiums did not increase, but there were small increases in cost-sharing requirements.

Uses: Provides a complete image of the US employer-based health insurance system for those who want or need to see the trends within and character of this system.

Limitations: None as presented

Gabel JR, Levitt L, Pickreign J, Whitmore J, et al. Job-based health insurance in 2001: inflation hits double digits, managed care retreats. *Health Affairs*. 2001; 20(5): 180-193.

Keywords: Health insurance coverage and uptake rates, employee benefits

Purpose: To examine the employer-based health insurance system in early 2001

Data: National survey data from the Agency for Health Care Policy and Research, the KPMG Peat Marwick/Kaiser Family Foundation survey of employer-based plans and the Health Insurance Association of America survey on job-based insurance

Methods: Descriptive and multivariate statistical analyses

Results: Health insurance premiums increased 11% between spring 2000 and spring 2001. Enrollment by Americans in health maintenance organizations (HMO) fell 6%, the lowest level since 1993; preferred provider organization (PPO) enrollment rose to 48%. Potential choice among physicians increased for consumers, also pointing to a trend toward less strict managed care models. The percentage of firms offering coverage remained statistically unchanged. The relatively strong labor market continued to protect workers from having to share the higher premium costs, but employers again modestly increased cost-sharing measures (eg, copayments and deductibles).

Uses: Provides a complete image of the US employer-based health insurance system for those who want or need to see the trends within and character of this system.
Limitations: None as presented

Gabel JR, Levitt L, Holve E, Pickreign J, et al. Job-based health benefits in 2002: some important trends. *Health Affairs*. 2002; 21(5): 143-151.

Keywords: Health insurance coverage and uptake rates, employee benefits

Purpose: To examine the employer-based health insurance system in early 2002

Data: National survey data from the Agency for Health Care Policy and Research, the KPMG Peat Marwick/Kaiser Family Foundation survey of employer-based plans and the Health Insurance Association of America survey on job-based insurance

Methods: Descriptive and multivariate statistical analyses

Results: Health insurance premiums rose 12.7% between spring 2001 and spring 2002. Employee contributions to these premiums rose from \$30 to \$38 for single coverage and from \$150 to \$174 for family coverage during the same period. Other changes included a rise in deductibles and copayments, and prescription drug cost-control measures (eg, formularies, three-tier cost-sharing formulas). The percentage of small employers offering health benefits fell. The authors conclude that because increasing claims expenses rather than the underwriting cycle are the major driver of rising premiums, double-digit growth appears likely to continue.

Uses: Provides a complete image of the US employer-based health insurance system for those who want or need to see the trends within and character of this system.

Limitations: None, as presented

Gabel JR, Pickreign J, Whitmore H, Schoen C. Embraceable you: how employers influence health plan enrollment. *Health Affairs*. 2001; 20(4): 196-208.

Keywords: Health insurance coverage and uptake rates, employee benefits, employer coverage policies

Purpose: To determine how firms' policies affect the percentage of workers eligible for and enrolled in their health plans

Data: National survey of employers—Henry J. Kaiser Family Foundation/Health Research and Educational Trust 1999 Employer Health Benefit Survey

Methods: Multivariate analysis

Results: The waiting time before new employees are deemed eligible for benefits and the eligibility standards for part-time workers were the strongest determinants of eligibility rates. The coverage acceptance rate was affected primarily by the lowest premium cost to employees for single coverage and by the percentage of an organization's workforce earning less than \$20,000 per year. These results point to the need to consider the differing reactions of lower-wage and higher-wage workers in policy development; lower-wage workers are more sensitive to their price for health insurance.

Uses: Employers (benefits administrators and executives) can use this to better understand their employees' responses to benefits-related decisions. Policymakers can potentially correspond employee responses to policy changes that affect employers.

Limitations: None as presented

Hirschberg D. The job-generation issue and its impact on health insurance policy. *Challenge*. 2001; 44(4): 82-107.

Keywords: Economic impact, employee benefits, government mandate, small business, uninsured

Purpose: To clarify the role of small business on the uninsured rate

Data and Methods: Theoretical discussion, not applicable

Results: Small business is a sensitive topic as it relates to health insurance coverage for employees. Most of the uninsured are employed by small businesses; however, the small business lobby has

argued that small businesses create the majority of new jobs and that mandating employer-financed health insurance will destroy jobs and increase unemployment. The author asserts that this statement is based on myth. Small businesses are not the primary source of job generation. They lay off workers at faster rates during recessions, pay their workers less, and provide fewer benefits than do larger businesses. The misleading interpretation of job-generation/job-destruction processes is used to gain preferential treatment of small businesses. This interpretation leads to inaction regarding the large number of uninsured low-wage workers.

Uses: Hirschberg provides an interesting counterpoint to the usual arguments against mandated health care coverage. This could be useful to policymakers, lobbyists, and the public

Limitations: It is intended to be an argument against a well-known stance on the role of small business in the provision of health insurance coverage and is thus somewhat biased toward that end. However, coverage is otherwise fairly balanced.

Hodgkin D, Horgan CM, Garnick DW, Merrick EL, Goldin D. Why carve out? determinants of behavioral health contracting choice among large U.S. employers. *The Journal of Behavioral Health Services and Research*. 2000; 27(2): 178-193.

Keywords: Behavioral health, benefits carve-outs, employer plan purchasing decisions, managed care

Purpose: To understand why employers carve out behavioral health coverage from their medical plans

Data: Mailed survey of Fortune 500 corporations (68 percent response rate)

Methods: Bivariate and multivariate analysis

Results: When employers carve behavioral health services out of their medical plans, they change the way their employees access care. Employers who carve out contract directly with vendors specializing in behavioral health services. The authors found that enrollees in health maintenance organizations are less likely to have their employer carve out behavioral health services than those enrolled in other types of plans. Organization size is the strongest predictor of the decision to carve out behavioral health. Employers who value specialized expertise, service quality, cost savings and employee satisfaction are more likely to carve out. Employers who value coordination of care and who are concerned with administrative burden are less likely to carve out.

Uses: Policymakers, employers, benefits managers and others who want to understand how employers decide to configure their benefits plans

Limitations: Survey was limited to Fortune 500 corporations and is therefore not generalizable to smaller organizations

Lave JR, Peele PB, Black JT, Evans JH III, Amersbach G. Changing the employer-sponsored health plan system: the views of employees in large firms. *Health Affairs*. 1999; 18(4): 112-117.

Keywords: Employee attitudes, employee benefits, employer-sponsored health plan configuration

Purpose: To examine proposed policy changes relating to health insurance coverage from the employees' perspectives

Data and Methods: Focus groups at 24 large companies (>1000 employees)

Results: Criticism of the current employer-based health insurance system has prompted proposals to limit or sever the role of employers and modify the tax code to accommodate such changes. These proposals would force employees to use a more market-based system to purchase health insurance and place greater burden on employees as decision makers. The authors found that employees did want choice among insurance plans, but that did not want to act as their own agents. The reasons cited for this included: lack of individual bargaining power, the advocacy role of the employer, and market complexity.

Uses: Policymakers, insurers, employers (administrators, benefits managers), and others interested in the employer role in providing health insurance coverage

Limitations: Generalizability is limited due to the study's narrow coverage—focus groups were conducted in two metropolitan areas (Cleveland and Pittsburgh) with relatively large employers.

LoSasso AT, Perloff L, Schield J, Murphy JJ, Mortimer JD, Budetti PP. Beyond cost: 'responsible purchasing' of managed care by employers. *Health Affairs*. 1999; 18(6): 212-223.

Keywords: Employee benefits, employer health insurance purchasing decisions, quality, responsible purchasing, values

Purpose: To determine the extent to which employers collect and use nonfinancial information in selecting and managing their health plans

Data: 1997 Mercer/Foster Higgins National Survey of Employer-Sponsored Health Plans and a 1999 survey of two business coalitions conducted by the authors

Methods: Multivariate analysis

Results: The authors are interested in determining whether employers use responsible purchasing. *Responsible purchasing* is defined as the use of nonfinancial data in selecting and managing employee health plans. They find that most firms feel responsible to some extent for assessment of health plan quality. Fewer employers attend to characteristics such as access to providers and customer satisfaction. A limited number of employers do act based on this information. Organizations with self-insured plans were less likely to attend to satisfaction surveys. The author-administered survey found more responsible purchasing behavior, with increased interest in access to providers and quality indicators. The authors note that conflict will arise when employee satisfaction measures such as large, inclusive, provider networks are matched against employers' need to control quality and cost because the inclusive networks undermine employer leverage in negotiations.

Uses: Policymakers, employers, and others who want to understand the values underlying employers' decisions about health insurance coverage

Limitations: Sample is not representative and therefore results cannot be generalized to all corporations.

Maxwell J, Briscoe F, Temin P. Corporate health care purchasing and the revised social contract with workers. *Business & Society*. 2000; 39(3): 281-303.

Keywords: Employee benefits, employee role, employer health plan purchasing decisions, health insurance benefits configuration

Purpose: To explore the relationship between the revised social contract and changes in health benefits

Data and Methods: Interviews with officials at 15 organizations, the health plans they contracted with, their consultants, and any health care purchasing coalitions in which they participated.

Results: Recently, the implicit social contract between corporations and their employees has been revised. It now emphasizes workforce flexibility and financial responsibility of individual employees for their own employment and benefits-related decisions, rather than the more paternal approach toward employees that was common in years past. Health benefits are the most recent item to change in the contract. The authors find that use of managed competition aligns health benefits purchasing with this revised social contract. A few companies, however, adopted an employer-responsibility approach to health benefits because they viewed employees as resources who would return the investment in greater productivity and corporate performance. These employers refrained from increasing the cost sharing with employees or from coverage cuts.

Uses: Provides insight into another facet of employer and employee behavior related to health benefits. Employers, policymakers, researchers, and others interested in the social construction of the workplace would find the information presented useful.

Limitations: Organizations were selected because they were early adopters of managed care and they are not, therefore, typical. Rather, they represent the proposed direction of innovation and change in health benefits.

Maxwell J, Temin P. Managed competition versus industrial purchasing of health care among the Fortune 500. *Journal of Health Politics, Policy and Law*. 2002; 27(1): 5-48.

Keywords: Employer health plan purchasing decisions, health benefit configuration, industrial purchasing, managed competition

Purpose: To examine the extent of dissemination of managed competition among large corporations, specifically, the Fortune 500

Data and Methods: Telephone interviews with senior human resources executives of the Fortune 500 (85 percent response rate) corporations and corporate demographic and financial information from Compustat

Results: The authors define managed competition as having three primary characteristics: consumer choice among health carriers, defined (fixed-dollar) contribution, and dissemination of quality information. These characteristics allow managed competition to remedy imperfections in both the consumer and provider sides of the market for health insurance. This study found that Fortune 500 companies are not using the managed competition approach to health care purchasing. Instead, most of these corporations are purchasing health care in the same way as they do other production inputs—a pattern the authors label *industrial purchasing*. These corporations provided limited choice among carriers to their employees, only 24 percent of the companies used a defined-contribution approach, and do not generally provide their employees with quality information on carriers. Fortune 100 companies were noted to be more likely to act as sponsors than were Fortune 500 companies, perhaps revealing a diffusion process that is starting with the largest corporations. Many corporations felt that it was too great a cost and too much a burden on employees to adopt the managed competition approach. The industrial purchasing approach was characterized by competitive bidding and vendor management techniques common in production processes. They used competitive bidding to gain the greatest leverage over carriers and to pressure carriers on price—not on consumer choice. They used quality information to aid their own selection of appropriate carriers—not to provide such information to employees. The authors conclude that there is currently no clear advantage for change to the managed competition approach. Employers view health benefits as a part of their overall employment policy and as a strong recruitment and retention tool and as one of many ways to promote health (and productivity) in the workplace.

Uses: Provides background on managed competition and information on health benefit patterns. Of use to policymakers, health plan administrators, corporate executives, and others interested in health care system reform.

Limitations: Study limited to very large corporations and is therefore not generalizable to other organizations. Also see Enthoven (2002) for commentary in response to this article.

McCormack LA, Gabel JR, Berkman ND, Whitmore H, et al. Retiree health insurance: recent trends and tomorrow's prospects. *Health Care Financing Review*. 2002; 23(3): 17-34.

Keywords: Employee benefits, Medigap, retiree health insurance, supplemental health insurance

Purpose: To present trends in employment-based supplemental health insurance coverage for older adults and predict the future direction of these trends

Data: Kaiser/HRET survey of human resource and benefits managers and the MCBS, and key informant interviews

Methods: Descriptive statistics and multivariate analysis

Results: Retiree health coverage can be influential in recruiting and retaining mid- to late-career employees. This study finds that fewer employers now offer retiree health insurance benefits than did a decade ago. Factors discouraging the use of retiree health insurance include: rising premium costs, a sluggish economy, changes in the tax incentives for employers who might offer retiree coverage, legal and accounting challenges, and the uncertain status of the Medicare+Choice program. Larger firms were more likely to offer retiree health benefits, as were

state and local governments. The percentage of low-wage employees was inversely related to the chance that an employer would offer retiree health benefits. With the increasing cost of Medigap-type coverage, such trends will place an added financial burden on retirees. Additionally, employees who desire to retire early may delay retirement or seek employment in large organizations that offer retiree health benefits.

Uses: To aid understanding of the dynamics underlying the offering and acceptance of retiree benefits. Policymakers, employers (eg, executives, benefits managers), labor representatives, elder advocacy groups, and those interested in health policy and aging issues would find this article of interest.

Limitations: None to the study as presented. Limitations occur with the timing and context of this work. The data used are as current as 2000, but the volatile economy and its impact on retirement behavior cannot be accounted for or predicted from this data. Likely, the data portray a best-case scenario compared to the current environment for health insurance benefits.

Mulvey H, Li A. Long-term care financing: options for the future. *Benefits Quarterly*. 2002; 18(2): 7-14.

Keywords: Employee benefits, employer health plan purchasing decisions, long-term care

Purpose: To project the magnitude of the impact that the aging population will have on long-term care service financing

Data and Methods: Commentary based on the Current Population Survey and published reports

Results: The number of elderly is expected to almost double by 2030. This change in the composition of the US population will have an enormous impact on the future of long-term care costs. Currently, Medicare and Medicaid funds approximately one third of long-term care costs and individuals pay the majority of costs either directly out-of-pocket or indirectly through the use of informal (usually family) caregivers. This article compares three options for financing future long-term care services: 1) increasing personal savings, 2) raising payroll taxes, and 3) expanding employer-sponsored private long-term care insurance coverage. Increased personal savings is unaffordable for most individuals. If government, through Medicare or another federal entitlement program, were to fund long-term care, at least a 10 percent increase in payroll taxes is needed to fund such an initiative. Copayments for long-term services, as a cost-sharing device to reduce an entitlement program's costs, would still remain too heavy a burden for many individuals. The inherent message currently being sent from policymakers is that individuals need to take more responsibility for their anticipated long-term care costs, which makes such an entitlement expansion appear unlikely. Less than five percent of the population is currently covered by long-term care insurance. Twenty-nine percent of employers offered long-term care coverage in 2001, although most required the employee to pay the entire premium cost. Employers view long-term care coverage as a new and untested benefit. Employee uptake rates for these plans average at about 10 percent. The authors conclude that with the exception of certain industries (wholesale and retail trade), almost two-thirds of workers over age 40 could afford a long-term care policy and suggest that this is the most viable option for future funding of long-term care needs.

Uses: Health policy analysts, policymakers, employers, advocates for the elderly, the long-term care industry, the insurance industry and others interested in the difficulties of long-term care financing for individuals. The authors provide policy options and project their likelihood of success, which lays the foundation for discussion and further analysis of financing and policy options.

Limitations: None as presented

Neuman P. *The future of retiree health benefits: challenges and options. Retirement Security for the American Worker: Opportunities and Challenges: A Hearing of the Subcommittee on Employer-Employee Relations Committee on Education and the Workforce*. 2001.

Keywords: Employee benefits, Medigap, retiree health insurance, supplemental health insurance

Purpose: To inform the House Subcommittee on Employer-Employee Relations on the status and future of retiree health benefits

Data and Methods: Testimony, not applicable

Results: This article provides the text for testimony made by Tricia Neuman, the Vice President and Director of the Medicare Policy Project, before the House Subcommittee on Employer-Employee Relations on retiree health coverage for older Americans. She summarizes elders' health needs and the role of health insurance coverage in their lives, comments on the challenges faced by early retirees in obtaining and retaining health insurance coverage, and the issues faced by retirees covered by Medicare. Her testimony outlines several policy approaches: 1) modification of existing COBRA rules to make termination of retiree health benefits a qualifying event that makes them eligible to purchase health insurance through their former employer; 2) provide tax credits to early retirees to assist in their purchase of health insurance; 3) permit early retirees to buy into the Medicare program before they are age 65; and 4) encourage employers through some incentive to continue covering their retirees.

Uses: Provides general background into the issues and currently proposed options for retiree health benefits. Of use to policymakers, advocacy groups, employers, and others interested in elder issues and health care access and insurance coverage.

Limitations: None as presented

Olson CA. Do workers accept lower wages in exchange for health benefits? *Journal of Labor Economics*. 2002; 20(2): S91-S114.

Keywords: Employee benefits, health insurance, wages

Purpose: To test theory that predicts that workers who receive more generous health benefits are paid a lower wage than those who receive fewer health benefits

Data: Current Population Survey

Methods: Two-stage least squares estimation

Results: The author models the wages of married women with full-time employment in the labor market to predict employer-provided health insurance. This model is based on compensating wage theory, which predicts that workers who receive more generous fringe benefits receive a lower wage than comparable workers who receive less generous fringe benefits. The study finds that wives who have their own employee health insurance accept a wage that is approximately 20 percent lower than what they would have accepted if working a job without health insurance.

Uses: Policy analysts, researchers and economists would find this a useful overview of labor market dynamics as they relate to health insurance benefits

Limitations: Few studies have found full support for compensating wage theory with health insurance benefits. While not specifically a limitation of this study, it does raise questions as to why a different finding occurred. Additionally, the data are limited to married couples who both work in the paid labor market. This raises the question of how applicable to the general population these findings might be.

Pagnatarro MA. Genetic discrimination and the workplace: employee's right to privacy v. employer's need to know. *American Business Law Journal*. 2001; 39: 139-185.

Keywords: Discrimination, ethics, genetic information, medical information

Purpose: To explore the workplace ramifications of increased access to genetic information

Data and Methods: Discussion based on law literature, not applicable

Results: The author concludes, based on a review of current law and consensus among the scientific community, that comprehensive federal legislation is necessary to prohibit discrimination based on predictive genetic information and to provide standardized protection for individuals across the United States. Effective legislation is defined as law that protects the privacy of genetic information; prohibits discrimination by employers in hiring, promotion, firing, and other employment decisions; prohibits discrimination by insurers; also provides employers with the

information necessary to maintain a safe workplace. Extensive discussion is provided on the difficulties in defining what information is required to maintain a safe workplace. She concludes that the proposed Genetic Nondiscrimination in Health Insurance and Employment Act of 1999 does follow this definition.

Uses: Provides a thorough overview of the legal issues involved with employer access to predictive genetic information and would be useful to policymakers, lawyers, employers, unions, advocacy groups, industry organizations and others interested in employee privacy and workplace safety.

Limitations: None as presented

Park CH. Prevalence of employer self-insured health benefits: national and state variation. *Medical Care Research and Review*. 2000; 57(3): 340-360.

Keywords: Employer self-insurance, employer health plan purchasing decisions, ERISA

Purpose: To report the prevalence of employer self-insurance of health benefits in 1993 and determine what employer characteristics and state policies are associated with self-insurance

Data: National Employer Health Insurance Survey

Methods: Multivariate regression

Results: Large employers often prefer to self-insure employee health plans to save costs and to avoid the compliance burden of varying state mandates; 85 percent of large firms (>1,000 employees) self-insured. Twenty-one percent of all private-sector employers had at least one self-insured plan, with these employees comprising half of the workforce employed by companies who offered health insurance coverage. The bypassing of state regulations through federal Employer Retirement Income Security Act (ERISA) of 1974 regulations is problematic in that it limits states' abilities to reform and otherwise impact their health care services and insurance markets. Firm size is the strongest determinant of self-insurance prevalence rates. State benefit mandates and premium tax rates were found to have no significant impact on self-insurance prevalence rates. Small-group reforms had a significant and positive affect on self-insurance prevalence rates.

Uses: Explains the impact of ERISA and the complex issues involved with self-insuring employers. Interested parties would include policymakers, employers, advocates, state policymakers, policy analysts, insurance industry representatives, and others interested in the impact of ERISA and self-insurance of policies

Limitations: NEHIS data undersamples some establishments (eg, new, farm sector). The analysis is cross-sectional, which limits the ability to determine causal relationships among variables. Additionally, self-insured has many definitions and comes in many forms, thus there may be a specification error on the outcome measure. State policies are defined broadly in this study as present or not present, which limits the ability to determine the impact of variations in these policy categories.

Pauly M, Percy A, Herring B. Individual versus job-based health insurance: weighing the pros and cons. *Health Affairs*. 1999; 18(6): 28-44.

Keywords: Individual health insurance market, large-group insurance market, market efficiency, reform

Purpose: To discuss and critique the current system of employer-based selection and financing of health insurance

Data and Methods: Commentary and review, not applicable

Results: Most insured Americans receive employer-based group health insurance; however, some (<7%) depend on the individual health insurance market. Rising criticism of limited options in group coverage and some proposed options for decreasing the uninsured rate may force the individual market to increased prominence. The authors conclude that there will be a continued role for efficient large-group insurance. The individual market has improved, though, with control of high administrative costs and protection against high premiums associated with high risk (eg, pre-existing medical conditions). This improvement makes the individual market more attractive as a policy option for addressing options to employer-based insurance coverage. Further improvements to the individual market include provision of tax incentives similar to those allowed

employer-based health insurance coverage. The authors suggest that a reformed individual market might not be as inefficient and unfair as often believed when compared to the group insurance market.

Uses: Provides a provocative assessment of the group and individual markets and should be of interest to policymakers, insurance industry representatives, researchers and others interested in alternatives to the employer-based model currently in use in the United States.

Limitations: None as presented

Robinson JC. Renewed emphasis on consumer cost sharing in health insurance benefit design. *Health Affairs Web Exclusive on Cost Sharing*. 2002: W139-W154.

Keywords: Cost control, cost sharing, employee benefits configuration, employer health plan purchasing decisions

Purpose: To determine if and how employers are revising coverage and sharing costs of health insurance with employees

Data and Methods: Commentary, not applicable

Results: Employers are implementing cost sharing and benefit redesign to help control rising health-care costs. Costs are rising due to inflation and the consumer backlash against tightly managed health insurance plans. Employers shift more of the financial burden for health insurance and health care expenses to employees and may redefine the range of benefits included in plans offered to employees. One of the results of this shift is the increased use of preferred provider organizations over health maintenance organizations. These changes increase consumer choice and out-of-pocket costs. Policy issues raised by this move include possibility of adverse selection, increased administrative complexity, the regressive nature of this financing approach, and the financial barriers to access created. The author concludes that this approach, even with its problems, does work to resolve the cost-unconscious consumer problem that creates such difficulties in the current health-care financing system.

Uses: Useful discussion of the trends in benefit structure and cost sharing among employers and how these trends could impact key stakeholders in the health care delivery system; of interest to policymakers, health care administrators, executives and financial officers, employers, insurance industry representatives, and others interested in the potential impact of these trends.

Limitations: None as presented

Studdert DM, Sage WM, Gresenz CR, Hensler DR. Expanded managed care liability: what impact on employer coverage? *Health Affairs*. 1999; 18(6): 7-27.

Keywords: Employer liability, ERISA, managed care, public policy

Purpose: To examine the response of health plans and ERISA plan sponsors to the expansion of liability and to predict the policy impact of this response

Data and Methods: Interviews with key informants and theoretical analysis

Results: Legislative changes could increase managed care organizations' exposure to civil liability for withholding coverage or failing to deliver needed care. Through interviews and theoretical analysis this study evaluates the possible responses of health plans and Employee Retirement Income Security Act (ERISA) plan sponsors to such a change in liability. The authors conclude that the direct costs of liability are uncertain, partly due to the varying local regulatory and market forces. They predict that the possibility of litigation may affect coverage decisions, information exchange, risk contracting, and the extent of employers' involvement in health coverage.

Uses: This overview of liability issue related to public policy changes would be of interest to federal and state policymakers, insurance industry members, employers (particularly those with self-insured plans), lawyers, and others interested in the affect of increased liability exposure among insurers

Limitations: Authors use a strictly rational decision-maker approach that does not accommodate other factors in the sociopolitical environment in which these organizations operate.