

Employer Attitudes and Practices Affecting Health Benefits and the Uninsured

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Issue Brief

- This *Issue Brief* presents the findings of a study of what employers think and do about providing health benefits for their own workers and what they think about covering the population without health benefits. Most Americans under age 65 received health coverage through employers. Yet, about 16 percent of this population was uninsured in 2000. Government programs generally do not target workers whose employers do not offer them health benefits or who cannot afford their share of premiums. In the current policy framework, the decisions that America's 6 million employers make about offering, pricing, and designing health benefits have a major impact on the number of people with and without health coverage.
- With funding from the Robert Wood Johnson Foundation, a literature search, a Web-based survey, and focus groups were conducted to probe present and past attitudes and practices toward health benefits and uninsured workers and their families. The research reveals several challenges and opportunities concerning the role that employers play in providing health coverage.
- The survey and focus groups showed that employers typically focus on running their own health benefit programs and not on the impact of their practices on the larger community or business sector as a whole. Employers offer health benefits as part of their competition for the best workers. Improving the health status of their work force is a secondary motive to employers, but also an important one.
- Offering coverage as part of firms' competition for labor cuts both ways in affecting aggregate health coverage levels. On one hand, most large firms must offer coverage to full-time employees to be regarded as viable employers. However, because in today's economy a husband and wife often work for different organizations, employers are sensitive to the risk that offering "too-generous" family coverage may draw a disproportionate share of dependents. Therefore, some offer financial and other incentives for employees and their dependents not to enroll in their plans.
- Some employers realize that passing along greater costs to employees may cause low-wage workers to forgo coverage. A few are calibrating employee premium contributions to wage levels or exploring the possibility of doing so. Some provide employees with information about government programs that may be available to them or their families, but usually only upon request.
- Under current policy, if a goal is to increase coverage levels, efforts need to be made to increase employer awareness of the value of health coverage to the success of their businesses and to facilitate employer involvement in community-wide efforts to increase coverage levels.

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Introduction

Among the leading developed nations, the United States was the only country

that did not provide at least basic health insurance coverage to nearly all of its citizens in 1997. Twenty-four of the 29 Organization for Economic Cooperation Development (OCED) countries cover more than 99 percent of their citizens through government programs (Anderson and Poullier, 1999). Only three countries—Mexico, Turkey, and the United States—did not have universal coverage. In the United States, government programs, primarily Medicare and Medicaid, provide coverage for 24 percent of the total U.S. population.¹ Public- and private-sector employers provide coverage for 63 percent of the total U.S. population through the voluntary provision of employment-based programs, while 9 percent purchase health insurance directly from an insurance company. Despite combined public- and private-sector efforts, 14 percent of the total U.S. population and about 16 percent of the population under age 65 were without any health insurance coverage in 2000, accounting for about 39 million people (Fronstin, 2001b).²

In the United States, the employment-based health benefits system is the dominant source of health insurance coverage. In 2000, more than 163 million Americans under age 65 received health insurance coverage through public- and private-sector employment-based health benefits programs. Government health insurance programs, such as Medicare and Medicaid, are designed to provide access to health care services to specific populations that are least likely to have employment-based health benefits, such as the elderly,

low-income families, and the medically needy. But government programs generally do not attempt to cover workers whose employers do not offer them health benefits, workers who do not accept coverage when it is offered, and (by definition) those individuals who have resources that exceed government program requirements but do not purchase individual coverage. Thus, what nearly 6 million employers each voluntarily decide to do (or negotiate with employee representatives) in terms of offering, pricing, and designing health benefits has a major impact on the number of Americans with and without health coverage.³

Those Americans without access to employment-based health benefits and ineligible for government programs may purchase coverage directly from an insurance company. While some can obtain affordable individual policies (typically younger, healthier applicants), individual health insurance tends to be significantly more expensive than employment-based coverage, and older, sicker applicants may be denied coverage based on medical underwriting in most states and frequently cannot purchase individual policies at any price.

About 33 million individuals—or more than 80 percent of the uninsured—are either workers or dependents of workers who have not enrolled in a plan offered by their employers or who were not offered coverage by their employers and did not obtain it from another source. This represents a gap between private and public programs that has existed for many years and shows no signs of closing. The availability and affordability of employment-based health benefits is a function of the strength of the economy. When the economy is strong and unemployment is low, the percentage of Americans with employment-based health benefits is likely to expand. In fact, between 1997 and 2000, the percentage

of Americans with employment-based health benefits increased because of the strong economy, despite rising health benefit costs (Fronstin, 2001b). In contrast, when the economy has been weak, fewer Americans historically have been covered by employment-based health benefits as some firms go out of business, other employers are forced to downsize, and some individuals are unable to afford to purchase health insurance either from their employer or directly from an insurer. As a result, during periods of little or no economic growth, it is likely that the number of uninsured will increase because government programs do not automatically expand with the business cycle to cover all Americans who may have lost employment-based health benefits. In fact, government agencies are likely to be under financial pressure themselves during economic downturns.

The likelihood that a worker has health insurance coverage is also related to the size of the worker's employer and wage level. More than 60 percent of uninsured workers earn \$10 per hour or less, while 61 percent are either self-employed or employed in small firms (with no more than 99 employees) (Fronstin, 2001b). Overall, 40 percent of uninsured workers are both employed in firms with fewer than 99 employees and earning less than \$10 per hour. Among the uninsured population who are either employed or the dependents of a worker, 32 percent are either low-wage workers employed in small firms (as defined in the previous sentence), or are the dependents of one.

Of the working uninsured, 29 percent had access to employment-based health benefits through their employer (Cooper and Schone, 1997). Fifty percent of those offered coverage did not take it due to the amount of premiums they were asked to pay (Fronstin, 1999b). For many, health insurance coverage is simply unaffordable.

However, among the 48 percent of the uninsured population who are above 200 percent of the federal poverty level, the evidence seems to suggest that, for the most part, the perceived value of coverage for these individuals does not justify the cost (California HealthCare Foundation, 1999).

The gap between private and public programs has changed only marginally over the past 15 years, despite numerous efforts to reform the individual and small-group markets for insurance and incrementally expand public programs. Even with the advent of the State Children's Health Insurance Program (S-CHIP) aimed at covering uninsured children (and in some cases their parents), expansion of health insurance among low-wage workers employed in small firms, along with their adult dependents, in large part has not been effectively addressed through public policy.

One reason for the persistence of the coverage gap is that under current policy, private and public health insurance programs do not work in tandem and their fundamental differences make convergence virtually impossible. Employment-based programs exist to support the success of businesses. As such, they are subject to numerous contingencies based on internal and external forces affecting the employer's enterprises. Many individual employers exercise considerable discretion with regard to the establishment, maintenance, and design of health benefit programs, especially in difficult economic times. In contrast, public programs provide specified benefits to strictly defined populations and can be changed only by the appropriate governmental bodies. Given the current policy framework, coverage expansion would seem to depend in large part on actions taken by employers, both in terms of covering their own employees and in playing an active role in efforts to strengthen public coverage.

Are The Uninsured Relevant to Employers?

That 39 million Americans lack health insurance is not only a health and humanitarian problem, but also an economic problem. Some critics argue the uninsured impose an “invisible tax” on the business community and public, paid by firms that provide health coverage and those that don’t, as well as by government. In order to recoup financial losses for providing uncompensated care, hospitals and physicians attempt to shift costs to health plan purchasers or seek reimbursement from the government through tax revenues. Uninsured people receive far fewer medical services than those with coverage and are more likely to have untreated conditions; workers with health deficits are absent more often and less productive when they’re present.

Growing numbers of uninsured people also put increasing pressure on community medical resources and may reduce the quality of care for all patients. In recent months there have been increasing reports of medical facilities, particularly in areas with substantial immigrant populations, overwhelmed by the cost of providing unreimbursed required care.⁴ The uninsured are more likely to use high-cost emergency facilities, which must serve them, instead of the lower-cost facilities that are available to those who are insured. The uninsured also are more likely to avoid seeking care until their problems have become more severe and expensive to treat.

Although employers provide health coverage to the majority of Americans, no reliable data currently exist to show how employers are directly affected (if at all) by the uninsured, especially in terms of measurable costs; rather, the impact of the uninsured, if it exists, is more indirect (such as hidden costs in health premiums) or long-term. For instance, most large employers value the benefits of coverage to their businesses and the flexibility they currently

enjoy in program design and maintenance. But some observers believe that if the uninsured grow to point where they become an urgent political issue, the federal and state governments will take action—just as Congress recently did by extending subsidies for COBRA health benefit coverage for workers who lose their jobs to foreign competition.⁵ New laws and regulations could increase employer mandates and costs and reduce or minimize employer influence and managerial discretion with regard to health benefits. The net result for employers could be higher costs and loss of control over a major business cost-driver.

For the past several years, employers and their associations have, for the most part, focused more on issues concerning health insurance affordability and regulation, rather than on other health care issues—especially covering the uninsured. While employers have understood the reasons for making insurance available to their own employees, employers have not generally accepted that there is a business reason for supporting a reduction in the remaining uninsured population. It is especially apparent during the recent economic slowdown that business bases its priorities on financial considerations. Providing affordable coverage for more Americans to close the coverage gap, whether through private or public programs, could raise premiums and/or taxes. It stands to reason that there must be a business reason—or “business case”—for thinking about and acting on options for covering the uninsured in order for businesses to embrace subsidized health insurance coverage expansion beyond the provision of access.

Absent a major change in public policy that either provides stronger incentives for employers to expand coverage or significantly expands government insurance programs, it seems that an important ingredient in reducing the number of uninsured would be a compelling business case that causes employers voluntarily to cover more of their own workers through private programs and/or join with other employers and policymakers in

actively supporting federal, state, and local coverage initiatives. Furthermore, as public policymakers consider a wide variety of coverage expansion initiatives, ranging from incremental to comprehensive, they can benefit from the input of information and potential support of employers and unions that currently provide most Americans with health coverage.

The EBRI/CHEC Study

With funding from the Robert Wood Johnson Foundation, the Employee Benefit Research Institute (EBRI) and the Consumer Health Education Council (CHEC) conducted a study (the EBRI/CHEC study) that was designed to identify employer attitudes and practices regarding the design, administration, and communication of health benefits and their effect on the likelihood that workers have health insurance coverage. The study also focused on documenting employers' interest in actively addressing the problem of America's uninsured population. The purpose of this *Issue Brief* is to report findings from this project. The study included a literature review, a Web-based survey of employers, and employer focus groups in order to understand employer attitudes and practices, and whether and how employers are interested (or could become interested) in addressing expansion of health insurance coverage among America's uninsured population. Ultimately, CHEC and EBRI will use this project to identify and prioritize future research and education efforts. The next section of this paper discusses the methodology. The following sections present findings first from the literature review, then from the Web-based survey and the focus groups. The conclusion summarizes the findings and implications for research and public policy.

Methodology

In order to identify employer attitudes and practices regarding the design, adminis-

tration, and communication of health benefits, their effect on the likelihood that workers have health insurance coverage, and whether and how employers are interested in actively addressing the problem of America's uninsured population, this study conducted:

- A *literature review* to document past employer attitudes and practices regarding the provision of health benefits to employees and their attitudes toward the uninsured.
- A *Web-based survey* of employers to provide new evidence regarding the extent and nature of coverage offerings made by employers, encouragement of take-up and retention of coverage, and encouragement of coverage replacement if an employee is no longer eligible for coverage.
- Four half-day meetings (*focus groups*) with employers in different regions of the country to probe more deeply the factors investigated and identified in the survey in order to better understand employers' rationale behind their health benefit practices, as well as the range of practices and their potential impact on coverage levels.

Literature Review

The literature search focused on finding surveys, reports, articles, and other sources that addressed employer attitudes and practices regarding their health benefits and the uninsured. This study searched the

research literature, the mass media (such as newspapers), and business literature. Knowledge of employer beliefs and behaviors (that either demonstrated or contradicted those beliefs) was the desired outcome.

Survey

This study used a Web-based survey to collect information about employer practices toward providing health benefits to employees. The survey included questions about the availability of health benefits, eligibility for benefits, employee participation, employer premium contributions, the impact of health benefits on various aspects of the business, and employer practices to either encourage employee take-up of health benefits or to increase participation rates and the number of people covered generally. The study also collected data on employer characteristics and demographics. The survey was designed to learn more about health benefit “practices,” and also to identify the practices that employers consider especially effective to increase the number of employees with health benefits.⁶

Overall, employers were asked to answer 35 questions. Business groups and other membership-based organizations were contacted to distribute the survey to their members. A total of 11 organizations, which in large part represented human resource administrators; benefit administrators; small, medium, and large business; insurers; insurance brokers; and health care providers, made available information about the survey to more than 53,500 individuals interested in health care, health insurance, and health benefits in the work place. Slightly more than 800 employers responded to the survey. These employers collectively represent 2.6 million full-time employees and 422,000 part-time employees. However, while the sample size is not large enough to be statistically representative of all employers

in the United States, and the survey was distributed only to selected organizations, findings from the survey provide useful insights into a variety of employer practices in relation to their role in providing health benefits and their attitudes toward the uninsured. Findings from the survey were also used to stimulate discussion during the focus group meetings.

The survey data were collected during July and August 2001. By the time the survey was fielded, it was clear that the United States had entered a recession, which, coupled with a substantial increase in the cost of providing health benefits to employees, was challenging the ability of many employers to keep health benefit costs affordable for themselves and their employees. Responses to the survey may have been affected by its timing related to the economy and rising health benefit costs.

Because the survey was made available mostly to employers with an interest in employment-based health benefits, nearly all of the employers responding to the survey (97 percent) offered health benefits to full-time employees. One-third offered them to part-time employees. Overall, 60 percent of responding employers offered health benefits to more than 90 percent of their employees.

Focus Groups

The study conducted four focus groups in different regions of the United States to gain a better understanding of employers’ rationale behind their practice of offering health benefits to employees and their families as well as to better understand their actual practices in providing health coverage. During the focus groups, the study engaged employers in discussions on topics including their attitudes and practices, what it would take to get employers more involved in promoting health benefits, whether all Americans should have health insurance, and the role of business in expanding health

benefits. Much of the discussion focused on a wide variety of strategies that employers use. Employers were generally candid, both about practices intended to increase coverage levels and strategies intended to minimize their benefit costs that might end up having the effect of covering fewer employees in the process.

Business organizations and other groups interested in health coverage and access issues were contacted in various regions of the country to identify employers to participate in the meetings. The meetings were conducted between February and June 2002. By then, the slow economy made it extremely difficult to convince employer representatives to participate in a three-hour meeting. However, rising health benefit costs brought some employers to the meetings, presumably in the hope of learning something to help them address those rising costs. Ultimately, representatives from 48 employers participated in these meetings, including firms of all sizes, ranging from one employer with two employees to another with 300,000.⁷ The business owner usually represented small employers, while a human resources or benefits specialist usually represented large employers. Collectively, the employer representatives who attended the meetings represented over 900,000 full-time and part-time employees.

Literature Review

Employers offer health benefits for competitive reasons. They often report that they offer

health benefits in order to improve recruitment and retention of employees. They also report that they offer health benefits because “it’s the right thing to do” (Fronstin and Helman, 2000). In general, however,

employers’ decisions to offer or not offer health benefits are business decisions and are made for financial reasons, rather than altruistic ones. This literature review provides a background and historical context for the information garnered by the employer survey and focus groups. Below is first presented what was learned in the literature review, ordered in a series of topics, before presenting the results of the survey and focus groups.

Employer Attitudes About Health Coverage

In general, surveys of employers and health benefits focus on business practices to provide benefits and control costs, rather than asking about the employers’ attitudes regarding the provision of health benefits. An exception is research by the Economic and Social Research Institute (ESRI), which has conducted studies to assess employer attitudes in this topic area. In 1995, ESRI interviewed 40 business executives about employers’ role in health care and about health reform. Most of the executives believed reform was needed to contain health care costs and to expand access to health care. They also showed a strong desire to continue or strengthen the employer’s role in managing and financing health care benefits, especially among large employers. They were skeptical that the government would be able to improve the health care system, and believed employers should drive reform efforts (Silow-Carroll, Kutyla, and Meyer, 2001). In 1996, ESRI surveyed more than 600 firms and found that employers showed a strong sense of responsibility toward their workers, a lesser degree of sympathy to the plight of the uninsured, and a reluctance to commit to helping solve the problems of access to health care (Meyer, Naughton, and Perry, 1996). When the subject turned to the uninsured, most businesses expressed concern, especially

for uninsured children. However, two-thirds said that their company would not be very willing to do more in order to help provide coverage to uninsured people who are not their employees, such as paying into a common pool. The majority was more likely to view covering the uninsured as the responsibility of the state or federal governments.

In 1998, ESRI surveyed 1,200 firms regarding their attitudes about health care for their employees and their dependents. They found that 9 in 10 businesses felt at least some obligation to provide health insurance for their employees (a near-majority said it was a “large” obligation), and one in five felt obliged to pay for 100 percent of the cost of that coverage. Fewer employers (84 percent) felt at least some obligation to provide health insurance for their employees’ children (heavily concentrated in the “some” rather than “large” obligation category), and only 1 in 10 felt obliged to cover 100 percent of the children’s premiums (Perry, Marshall, and Robertson, 1999). Two-thirds of businesses said that government programs should be expanded to ensure health care coverage for all otherwise uninsured children. However, they viewed government subsidies for employer-sponsored coverage as better than state or federal insurance programs.

In 2000 and 2001, ESRI found that when it came to the management aspects of health benefits, such as selecting, negotiating, and administering the benefits, employers felt strongly that they should be managing health benefits for their own employees. This support was not as strong as for financing coverage, however. Reasons for believing employers should manage employees’ health benefits included the beliefs that employers are better equipped to conduct management functions, employers can make better choices, and employers have a stake in maintaining control and ensuring that money is being spent wisely (Silow-Carroll, Kutyla, and Meyer, 2001).

Employer Practices Affecting Health Coverage

A recent Kaiser Family Foundation/Health Research and Educational Trust survey found that the waiting period prior to eligibility and the eligibility criteria for part-time workers were the most significant factors that determine employee eligibility for employment-based health benefits (Gabel et al., 2001a). The two most significant factors affecting employee take-up rates were the minimum monthly employee contribution for single coverage and the percentage of the work force earning less than \$20,000 annually. Other findings from the survey include the following:

- *Waiting Periods:* About 1 in 3 employees becomes eligible for health benefits immediately upon starting employment with a firm that provides health benefits. The average waiting period for all firms in 1999 was 1.5 months. Waiting periods tend to be longer for small firms and shorter for large ones.
- *Part-Time and Temporary Workers:* Forty-one percent of part-time workers were eligible for health benefits in 1999, while only 3 percent of temporary employees were eligible. The percentage of workers eligible for health benefits (eligibility rate) at firms that require fewer than 25 hours per week to be eligible for coverage was 11 percentage points higher than at firms that require more than 30 hours per week.
- *Spousal Coverage:* The survey found that only 4 percent of covered employees worked in firms that encouraged employees to enroll in their spouse’s health plan.
- *Incentives to Decline Employer Coverage:* Almost 14 percent of employees in firms that offer health benefits worked for firms that provided cash-back payments to

employees who decline the employer's health benefits. This was twice as common in firms with 5,000 or more workers than in firms with three to 199 employees.

- *Income-Related Premiums or Deductibles:* In 1999, less than 1 percent of employees (in firms that offer coverage) worked in firms that offered income-related deductibles or premiums.
- *Medical Underwriting and Open Enrollment:* In 1999, 1 in 3 employees worked for a firm that required medical underwriting for employees who enrolled outside of the regular open-enrollment period.
- *Pre-Existing Conditions:* Forty-three percent of employees were employed in firms with pre-existing condition clauses in all non-HMO plans in 1999. Small firms were most likely to include such clauses in their plans.⁸
- *Financing Choice of Plans:* In 1999, only about one-fifth (19 percent) of employees worked for firms that set the employer's contribution to equal the price of the lowest-cost plan and contributed that amount to each plan offered, regardless of the cost of the plan, in effect leaving at least one plan with no employee contribution.

Other surveys have asked employers whether they are using some of these practices. For example, a survey of member companies (42 respondents) by the Washington Business Group on Health in 2002 found that one-fourth (24 percent) used income-related contributions in their current plan, 14 percent had previously used but eliminated them, and 31 percent were considering pay-related contributions for the future (Lee, 2002).

Another survey, conducted in the winter of 2001-2002, assessed how employers were sharing the burden of increasing costs with their employees. While 59

percent of employer respondents said they were increasing the employee share of the premium, only 1 percent was restricting spousal eligibility to only spouses with no access to their own employment-based coverage, 1 percent was introducing a new waiting period for new enrollees, 3 percent were eliminating late enrollments and only recognizing HIPAA⁹ special enrollments, and 5 percent were eliminating retiree health coverage. Twenty-three percent of employers said they had instituted a cash-out option for employees to drop their health plan coverage (Aon Consulting, 2002).

In contrast to many employers, Starbucks is a well-known example of a company that has offered subsidized health benefits for part-time employees. In 1996, the coffee retailer made health benefits available to all employees that work at least 20 hours per week, after a 90-day waiting period. Starbucks contributed about 75 percent of the premium, and based employee premiums on income (which varied depending on salary level) (Barnett, 1996).

Spousal Coverage

In an effort to avoid paying for health benefits for employees of other businesses, some companies were reported to have taken action to eliminate duplicate coverage of their employees' spouses and to cover only those spouses who did not have access to other coverage. JC Penney was one of the first companies reported to take this kind of action. In the early 1970s, the company instituted a policy, termed the "head of household" rule, under which employees' spouses would be eligible for health coverage only if they earned less than the employee (Adler, 1988). Several other companies, including General Electric and Proctor & Gamble, started charging more for spouses who had access to insurance through their own employer than for those who did not work or

did not have access to employment-based coverage, adjusted for income-level (Bernstein, 1991; Holzman, 1991; Block, 1992). Still others, such as Owens-Corning, denied coverage altogether to spouses who were eligible through their own employers (Holzman, 1991).

Employer Attitudes Toward Health Reform Initiatives

Various policy strategies have been introduced in order to cover more Americans with health insurance. These have received a mixed response in the employer community and often a very negative response once the legislative proposals have developed to the point where interest groups can identify potential “winners and losers” of particular policies. Proposals for national health insurance (NHI) in the United States date back at least 70 years, when there was support for including NHI in the Social Security Act of 1935 (Koch, 1993). Since that time, a number of bills have been introduced and debated on the topic, and employers have spoken out on both sides of the issue. In 1989, some executives, such as Lee Iacocca and Walter Maher of Chrysler, talked of the merits of NHI (Freudenheim, 1989; Association of American Physicians and Surgeons, 1990). At the same time, however, a survey by the Health Insurance Association of America found that 94 percent of executives opposed nationalization of health insurance. Sixty percent of the executives thought the private sector should take responsibility for solving the financing crisis, and 30 percent said they supported a private-sector approach with some government involvement (Thompson, 1990).

One recurring theme in the effort to cover more Americans with health insurance is an employer mandate, which would require all employers (usually above a certain size) to provide health benefits to their employ-

ees. These efforts date back at least as far as 1971 and President Nixon. The idea has resurfaced periodically, and even now is back on the table in a bill sponsored in 2002 (S. 2639) by Sen. Edward Kennedy (D-MA). Proponents of an employer coverage mandate cite universal coverage or near-universal coverage and a reduction in cost shifting as benefits of the requirement, while critics fear increased costs (especially for small employers), possible loss of jobs or companies going out of business, and slower wage growth for employees. The increase in firms’ payroll expenses, unless they were able to recoup the costs with higher prices for their products, possibly would be shifted back to employees in the form of layoffs (unemployment) or lower wages (Reinhardt, 1989).

Generally, employers oppose mandates of all types. However, some employers have supported employer mandates for health insurance. For example, Robert Crandall, president and later CEO (from 1980 to 1998) of AMR Corporation, the parent company of American Airlines, was a vocal proponent of an employer mandate. He testified to this effect before the Health Subcommittee of the House Committee on Ways and Means in 1987. Crandall’s view of an employer mandate reflected an economic and business concern that his company was paying twice for health benefits—once for his own employees and again for employees of companies without health benefits, through taxes and inflated insurance premiums (Crandall, 1987; Moss, 1989). Walter Maher, the employee benefits director for Chrysler at the time, shared this concern about subsidizing the health care of other employers’ workers. He spoke about the difficulty of competing with Japanese car manufacturers while paying for the health care of employees of other companies, whose employers did not cover them (Karr, 1987). Karl Bays, CEO of IC Industries, later Whitman Corporation, also supported the employer mandate before Congress.

Another reason some employers gave for supporting an employer mandate was that it was a way to make sure provision of health insurance remained in the private sector, rather than moving to a government system (Young, 1987). As employers saw growth in the possibility of a national, government-run health care system, some viewed an employer mandate as a preferable alternative. Some feared that the pressure to raise taxes to fund a government-run system would lead to the deterioration of the system, while in an employment-based system employers would pressure the system toward good quality and more efficiency.¹⁰ However, the National Association of Manufacturers (NAM), the U.S. Chamber of Commerce, and the National Federation of Independent Business (NFIB) opposed legislation that would require employers to offer coverage to their employees (Young, 1987).

A MetLife survey in 1991 asked nine groups, including corporate executives, union leaders, doctors' organizations, and others, about health care in America (MetLife, 1991). The most popular option for the future of the health care system was to provide universal access through a combination of mandated benefits and government coverage of the uninsured. The corporate executives, however, were the least likely group to agree with the statement, "Everyone should have health insurance, even if this means an increase in taxes." They were also the least willing to compromise to achieve health care system reforms.

Also in 1991, the consulting firm Noble Lowndes surveyed 500 senior corporate executives and found that 43 percent would support NHI. Twenty-four percent would support government-provided benefits only for the uninsured. Twenty-eight percent said they would support an employer mandate, while 34 percent thought a national health care policy was unnecessary (Bureau of National Affairs, 1991).

One version of an employer mandate, and the one most commonly entertained by states, was termed "play or pay." It would require employers either to cover their employees or to pay into a common fund that would be used to cover those people who did not have employment-based health benefits. Various proposals for play or pay were introduced at the national level, and this type of health care system was signed into law in the state of Massachusetts in the late 1980s, but it was never implemented and was ultimately repealed.

Play or pay found some support among employers. For example, in 1990 several large companies joined to create the National Leadership Coalition for Health Care Reform, which proposed its own version of a play or pay health care system (Greer and Swenson, 2000; White, 1992). The coalition was comprised of about 60 large companies, some unions, and special interest groups. However, the coalition was unable to satisfy the interests of both large and small businesses, and several members dropped out of the group when they saw the government regulation element of the proposal growing too large (Garland, 1991).

Hawaii is the only state requiring employers to provide a minimum level of health benefits to workers. This requirement has been in effect since 1974, when Hawaii passed the Prepaid Health Care Act. Other states are precluded from implementing similar employer coverage mandates, because the Employee Retirement Income Security Act of 1974 (ERISA) pre-empts state authority to regulate private-sector employee benefit plans. (After Hawaii's coverage mandate was successfully challenged in court on grounds that it was pre-empted by ERISA, Congress granted the state law a limited exemption from ERISA.)

Hawaii has been viewed as a model for national health reform, but the mandate has not resulted in universal coverage in the state. Many workers are excluded, such as new hires who have been employed

less than four consecutive weeks, part-time workers who work fewer than 20 hours per week, low-earning workers, government employees, seasonal workers, and commission-only workers (Thurston, 1997). Anecdotal evidence suggests that employers intentionally manipulate their work forces to avoid the mandate, such as by laying off otherwise full-time, permanent workers for a few days every four weeks or by limiting employees' work time to 19 hours per week (Law, 2000).¹¹ Despite these anecdotes about employers shifting labor into exempt sectors, research found that exempt workers were still more likely to receive health benefits from their employer in Hawaii than in the nation as a whole (Thurston, 1997). Coverage of dependents is not mandated under the law, although the vast majority of employers offer it, and employees who are covered as a dependent on their spouse's plan are excused from their own employer's coverage (Lewin and Sybinsky, 1993).

A 1994 report by the General Accounting Office (GAO) found that insurance premiums were lower in Hawaii than in the nation as a whole as a result of reduced cost shifting and the use of modified community rating for small businesses (U.S. GAO, 1994). The GAO report also stated that premiums for small businesses in Hawaii were similar to those for large businesses, and while small businesses viewed the mandatory system as a burden, they were largely satisfied with it. Further, the system had not resulted in large disruptions in the small-business sector or in increased hiring of part-time workers. However, health care costs in the state were rising at a rate similar to the national average.

A survey by the U.S. Chamber of Commerce found Hawaii to be the only state where a majority of its members supported an employer mandate (Clymer, 1994). On the other hand, a survey released in 1994 by NFIB found that the Hawaii mandate hurt small businesses, that 31 percent of businesses were restricting

wages, 35 percent were cutting the number of employees, and 29 percent hired part-timers rather than full-time employees, due to the mandate (Oleck, 1994).

A large element of the Clinton administration's health care reform bill, developed in the early 1990s, was another version of an employer mandate. Under the plan, employers, in general, would have been required to contribute 80 percent of the costs of health insurance for their employees, while capping employer premiums at 7.9 percent of payroll. Health coverage was to be purchased for most employees through purchasing organizations unlike any that existed in the marketplace. During this time, when health reform was on the political "front burner" and when myriad reforms were proposed, many surveys were taken of employers' attitudes and responses to the various policy proposals.

Many large employers supported the idea of health reform. As with a straightforward employer mandate, large employers that already offered coverage would see some relief from the Clinton plan, as they would no longer have to pay extra for the uninsured and could reduce their contributions to 80 percent if they already contributed a greater percentage. But small firms or firms with many part-time workers, and those that did not currently offer coverage, feared possible increases in their costs and opposed the plan.

In December 1992, one year before the Clinton plan was officially submitted, Hewitt Associates surveyed human resource executives (from mostly large companies) about their companies' expected involvement in the health care reform debate in 1993. The focus seemed to be on using managed care to control costs. Eight in 10 agreed that government intervention was necessary to contain health care costs, and 91 percent thought government health policy should encourage the use of managed care. Seventy-four percent agreed that employers should be required to subsidize at least part of the

cost of coverage for full-time employees (Hewitt Associates, 1993).

In March 1994, Buck Consultants surveyed 92 large companies about health reform legislation. Because of the great amount of interest in the survey, the questionnaire then was sent to approximately 6,500 business executives across the country. Data were obtained from 778 business executives from 722 companies (Buck Consultants, 1994). They found surprisingly little variation between large and small companies and little regional variation. Businesses clearly were very concerned about health care issues, and the survey report included several major findings (Davey and O'Donnell, 1994). Buck reported the following major conclusions:

- Employers would at least tolerate, if not endorse, an employer mandate, but only if the cost was shared equitably and not placed entirely or substantially on their shoulders; if they were given the flexibility to manage their own plans and cost; and if the potential for cost-shifting was eliminated.
- Employers would be willing to have government set reasonable but flexible standards for the financing and delivery of health care, but they wanted uniformity of rules across the country, a minimum of federal and/or state involvement, the financing and delivery system to remain in the private sector, and reasonable flexibility in determining how they would provide coverage.
- Employers did not want the existing health care financing and delivery systems completely reinvented. New but untested methods should be tried, but not mandated.
- Employers did not want quality of health care sacrificed for short-term financial or political gain.
- Employers wanted a realistic basic benefit package that would not bankrupt the system and the flexibility to

improve upon it for their own employees if they so chose.

- Employers wanted realistic financing for the program from existing revenue sources, not from new taxes—regardless of how these taxes might be characterized.
- Employers wanted the program implemented over a realistic period of time (Davey and O'Donnell, 1994).

A Washington Business Group on Health survey of members in 1994 (90 respondents) showed large employers in support of an employer mandate (72 percent) but less supportive of requiring companies to pay a portion of the premium (59 percent). They were similarly supportive of requiring individuals to have health insurance (72 percent) (Innovations in Human Resources, 1994). The employers did not support capping employer contributions to employees' health benefits. In addition, 91 percent favored maintaining ERISA pre-emption for self-insured companies, and 89 percent opposed giving states the option of establishing single payer systems (Findlay, 1994).

The Web-based Survey and Focus Group Findings

The feedback of the benefit managers and employers during the focus groups that were conducted reflected the pressure their

companies were encountering both from the weakened economy and rising health care costs. Most participants reported that their health benefit costs were rising between 10 and 20 percent annually. (A few reported very little or no cost increase, while at the other end of

the scale one had experienced a 45 percent rate hike.) In response, many employers were considering or implementing actions designed to constrain the growth of their health benefit costs, such as by raising employee premium amounts (especially for family coverage), raising cost-sharing in the form of co-payments, co-insurance, or deductibles, and making benefit changes such as moving to multi-tiered pharmacy programs. A few employers reported that despite the slow economy, they continued to operate in a tight labor market and thus were adding health benefits or extending eligibility as a way to retain and recruit skilled workers.

The four focus group discussions conducted for this research confirmed that it is much harder for small firms—especially those with a high proportion of low-wage workers—to offer health benefits. However, the focus groups and the findings from the Web-based employer survey also revealed a variety of coverage vulnerabilities among large employers, who were generally less likely to offer coverage (or subsidized coverage) to family members of employees than to employees themselves. They also were less likely to offer coverage to part-time, seasonal, and temporary employees. Reflecting a trend found in national data (Fronstin, 2001a), some large employers reported that they were cutting back or dropping retiree health benefits.

Employer Attitudes Toward the Uninsured

While most employer representatives were comfortable discussing their own organization's health benefits, most appeared at a loss for answers when asked what could be done to cover more of the uninsured. Many said that they realized, either as individual citizens or as business people, that the large uninsured population was detrimental to the country and to the business

community as a whole, but that there was little they could do as individual employers or benefit managers to make progress on the issue. Some even reported that they had trouble receiving permission from superiors to attend the focus group meetings to talk about the uninsured issue, because the topic did not appear to directly affect their firm's bottom line.

Some thought that expanding government health insurance programs may be a way to provide health benefits to more of the uninsured, but noted that the current political environment probably would not be favorable to such an approach. Some pointed to the failure of the Clinton administration's push for universal health coverage a decade ago and Americans' distrust of "socialized medicine." Others noted that, while some large employers remained committed to offering health plans, others were becoming increasingly disenchanted with rising costs and the increasing complexity of sponsoring health benefits and might be seeking a long-term exit strategy (especially if tax policy should become less favorable for health benefits or if employers become liable for medical injuries resulting from coverage decisions under a patients' rights bill). Many employers were considering shifting more costs and responsibility for health care purchasing onto employees. Yet, many also remained strongly paternalistic toward their employees and remained committed to offering benefits.

On the issue of covering the uninsured, there appeared to be both a lack of leadership on the part of organizations representing businesses as well as a lack of potential "followership" on the part of individual employers. When asked who might provide leadership on the uninsured issue for the business community, the president of one large employer health coalition noted that business coalitions would be the natural drivers of such issues. But he added: "If members aren't interested, we won't do it." Some employer representatives suggested that CEOs should

become involved in the issue, because they have the authority to make changes in company policy. However, it was also noted that the human resource department also needs to be involved because they have knowledge of companies' benefit strategies and employees' utilization patterns and health care needs that CEOs might lack—and yet need—to make informed decisions. Focus group participants also pointed out that the country's political leaders needed more support (“cover”) from business leaders and other segments of society in order to push increased coverage of the uninsured onto the public policy agenda.

Some said that quantifying the cost to *business* of having a large uninsured population might provide a financial basis for bringing the issue to the attention of corporate senior managers and might increase activity on their part. For example, Institute of Medicine (1999) evidence on the pervasiveness of medical errors has helped rally many large corporations to support efforts to improve the quality of medical care.¹²

Many employers operating small firms and many benefit managers in large ones said they lacked the time to think about health care issues beyond running their own benefit plan. One medium-sized employer said he and many other employers did not feel qualified to enter the policy debate against lobbyists and policy experts who understood the issues more thoroughly than they and who easily might manipulate them. Others said they might be more willing to participate in discussions about what to do to cover more people, but said that the political climate was unfavorable for much to be accomplished, at least in the near future.

Despite the barriers facing employers in becoming more involved in the issue of reducing the size of the uninsured population, many employers recognized that their involvement was a necessary ingredient in developing workable solutions, especially because more than 80 percent of the uninsured are in families in which some-

one works. Also, voluntary, employment-based health benefits are the predominant form of coverage for the population under age 65. The discussions revealed a possible opportunity for a group or groups both in particular communities and on the national level to take up this issue by organizing and representing employers.

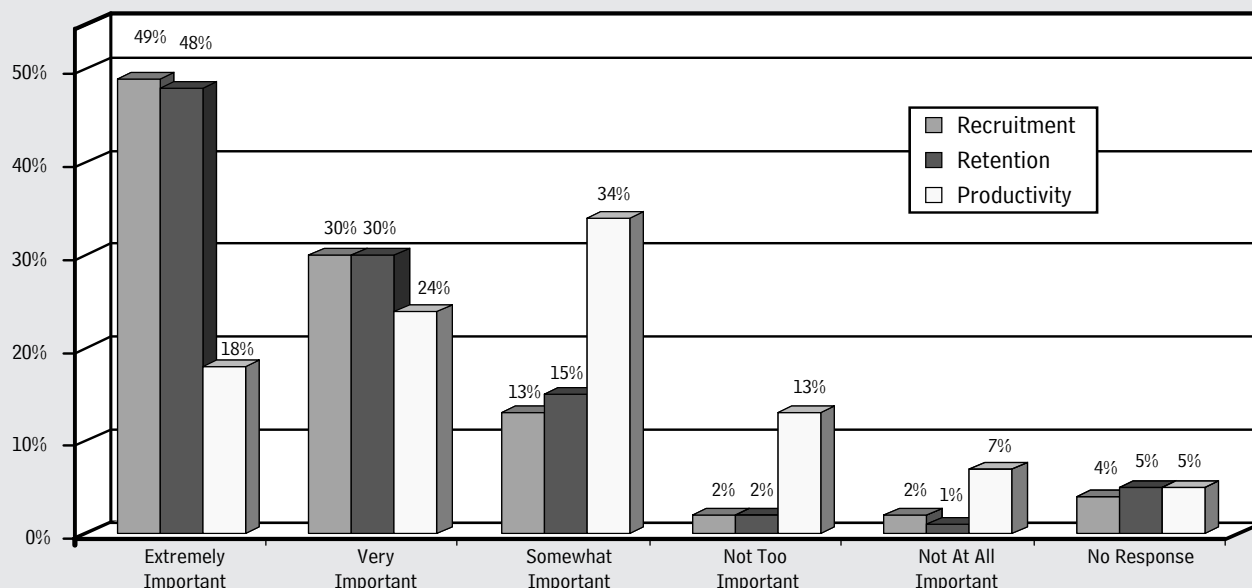
A benefits manager at one large corporation said that having a large uninsured population is a problem that needs attention. He said he believed that businesses end up paying for much of the care that the uninsured receive (because providers increase their fees to third-party payers to compensate for providing free care). He said that advocates of covering the uninsured, including some business leaders, have been unsuccessful in engaging employers in thinking of ways to expand coverage in part because they need to put forth a workable solution. He said that to cover millions more people than we do now would involve a mandate on individuals or employers to finance such a change. Citing the restaurant industry's opposition to the employer mandate in the Clinton health reform plan, he said that mandates to finance such coverage would engender political opposition, but he noted that they could be implemented incrementally.

Another employer said that employers would not take a vocal position on the issue of the uninsured unless some other group put forth a reform proposal. He noted that while the Clinton plan was being debated, health care costs went down in part because of “the Hillary factor.”¹³

Employer Motivation for Providing Health Benefits

In the Web-based employer survey, the principal reason employers cited for offering health benefits to their employees was one that is generally known: they do

Figure 1

EMPLOYERS' PERCEPTION OF HOW VARIOUS ASPECTS OF BUSINESS ARE AFFECTED BY HEALTH BENEFITS

Source: EBRI/CHEC Web-Based Survey (2001).

it for *business* reasons. Employers offer health benefits in order to attract and retain the best available workers to help their organizations achieve their missions. For private-sector firms, the mission is to produce goods and services as competitively as possible. Although many benefit managers indicated a deep concern for the welfare of employees, it was clear that they believed that their organizations were motivated primarily by business reasons, and not charitable or ethical motivations, to cover employees.

In the survey, nearly 80 percent of responding employers reported they thought their organization's health benefits were extremely or very important in both attracting new employees and retaining existing employees (Figure 1). Fewer employers (just over 40 percent) reported that health benefits were extremely or very important for improving employee productivity, but this still represents an important source of motivation for employers to offer coverage.

Employers who reported that health benefits were extremely or very important for either recruitment or improving productivity were more likely than other employers to provide incentives to workers to take up health benefits. Among employers reporting that health benefits were extremely or very important for recruitment, 57 percent had a company practice of making sure

all employees had health insurance (Figure 2). This compares with 49 percent among employers who did not think health benefits were extremely or very important for recruitment.¹⁴ Similarly, among employers reporting that health benefits were extremely or very important for productivity, 65 percent had a company practice of making sure all employees had health insurance, compared with 49 percent of employers who did not think health benefits were extremely or very important for productivity.

Employers who reported that health benefits were extremely or very important for either recruitment or improving productivity reported that a higher percentage of employees were eligible for health benefits than other employers, and they also subsidized a larger share of the premium for both employee-only and family coverage. As a result, these employers also had a higher rate of participation in their health plan than employers that did not report that health benefits were extremely or very important for either recruitment or improving productivity. These findings may be due to the fact that employers who reported that health benefits were extremely or very important for either recruitment or improving productivity were also slightly more likely to report that they automatically enrolled employees in their health plan (although only one-quarter did so).

In the focus groups, many large employers said that they must offer health benefits to be considered viable employers. Employees simply expected it of them and they offered coverage because other employers like them offered it. Many employers used consultants to “benchmark” their benefits to what competitors in their industry were offering. Benchmarking, however, was more difficult in instances where a company contained many different types of businesses that were operating in very different labor markets.

Some employers said that developing a greater understanding of the relationships among health benefits, health status of employees and their dependents, and productivity might help employers become more willing to make a greater investment in health benefits. For example, if an employer’s provision of health benefits serves to keep an employee and his family healthy, thereby reducing sick leave and keeping the employee productive, the “business case” for providing the benefit would be demonstrated. Some benefit managers cautioned that increased cost sharing in terms of premium and plan out-of-pocket costs could lead to reduced access to medical care and higher absenteeism among employees, which ultimately could reduce productivity. For example, some employers noted that if more employees opted not to sign up for family coverage due to a rise in their share of premium costs, their children might be more likely to become ill and take employees away from their jobs more frequently. Some illnesses and chronic conditions require parents to administer medication several times a day, one benefit manager pointed out. Higher-level corporate executives often have little understanding of the dynamics of life and productivity among single parents and low-wage workers (those most likely to forgo coverage due to increased cost-sharing requirements), and such an understanding was needed for senior management to appreciate how health benefits

increased productivity, the benefit manager noted.

One employer said that the productivity of a business also might suffer due to a “health deficit” in a key supplier that does not offer health benefits. He explained that his manufacturing firm had become increasingly reliant on small suppliers that have trouble offering health benefits. If these suppliers experienced higher absenteeism or reduced productivity because their uninsured employees were sick or delayed going to the doctor, product shipments might be missed and his firm, which depends on those products to meet its own obligations, would be adversely affected.

Competition and Benefits

In the United States, most people under age 65 receive health coverage through their job or the job of a family member. While the competition for workers leads many employers to offer health benefits to all or most full-time employees, competition among employers can also produce practices that decrease the number of Americans with health insurance. During periods of economic expansion, when labor markets are tight or certain types of workers are scarce, employers will tend to make health benefits more comprehensive. In economic recessions, they may be more concerned about trimming costs (or, in the case of health benefits, simply reducing the rate of health benefit cost increases). Most of the employers interviewed said that they were looking for strategies to control costs. Of course, during economic downturns, many employees lose their jobs and not all keep their health coverage before re-entering the work force.

Despite the cost pressures they face, many employers offering coverage said they make efforts to ensure that their employees have health coverage. In the Web-based survey, 97 percent of employers reported that they offer health benefits to full-time employees, while 33

Figure 2

**USE OF INCENTIVES TO WORKERS FOR HEALTH BENEFITS,
BY EMPLOYERS' PERCEPTION OF EFFECT OF BENEFITS ON RECRUITMENT AND PRODUCTIVITY**

	Extremely or Very Important for Recruitment	Not Extremely or Very Important for Recruitment	Extremely or Very Important for Productivity	Not Extremely or Very Important for Productivity
Company Practice to Make Sure All Employees Have Health Benefits				
Yes	57%	49%	65%	49%
No	39	39	32	43
Don't know/no response	4	13	3	8
Percentage of Employees Eligible for Health Benefits				
100%	40	46	45	39
91%–99%	23	12	22	20
75%–90%	23	16	20	22
50%–74%	6	11	4	8
1%–49%	3	8	3	4
Zero	0	1	0	0
Don't know/no response	5	7	5	6
Percentage of the Premium Paid by Employer for Employee-Only Coverage				
100%	35	35	39	32
91%–99%	7	5	6	7
75%–90%	37	25	34	35
50%–74%	11	15	11	12
1%–49%	5	6	5	6
No employer subsidy	0	1	0	1
Don't know/no response	5	13	5	7
Percentage of the Premium Paid by Employer for Family Coverage				
100%	10	9	12	8
91%–99%	4	3	3	5
75%–90%	32	18	30	29
50%–74%	19	20	18	21
1%–49%	8	10	11	7
No employer subsidy	18	24	18	20
Don't know/no response	9	16	9	11
Employer Automatically Enrolls Employee into Health Plan				
Yes	22	18	26	18
No	77	75	73	80
Don't know/no response	1	7	1	2
Percentage of Employees Participating in Health Plan				
100%	17	24	21	16
91%–99%	22	16	22	20
75%–90%	36	24	36	33
50%–74%	15	14	12	16
1%–49%	4	9	3	6
Zero	0	1	0	0
Don't know/no response	6	11	5	8

Source: EBRI/CHEC Web-Based Survey (2001).

percent said they offered it to part-time employees. Forty percent of those offering coverage said that all employees were eligible for it. Eighteen percent said that all eligible employees were participating in their organization's health benefit plans.

Thirty-two percent said that their company (or its health insurer) required employees to participate in the plan (unless they had coverage elsewhere). Only 10 percent, however, required participation in family coverage. Twenty-one percent said that employees were automatically enrolled in health benefit programs. Thirty-four percent said they paid 100 percent of premium costs for employees' health benefits, while 10 percent said they paid the full cost for families' health benefits.

In the Web-based survey, when asked the general question: "Is it company practice to make sure that all employees have health benefits?" 54 percent reported "yes" and 38 percent reported "no." Those answering "yes" were asked a follow-up question inquiring how the company implemented that practice. There were a wide variety of responses, demonstrating a range of commitments to making sure all employees were covered. In the survey and subsequent focus groups, the practices that employers said they used to make sure employees had coverage included the following (ranging from the most compulsory for employees to the least):

- Health coverage was compulsory for employees (either they were automatically enrolled or were required to enroll);
- Enrollment was mandatory unless employees could show proof of other coverage;
- Enrollment was mandatory unless employees were covered elsewhere but this policy was not strictly enforced;

- Strong incentives were offered to sign up for health coverage, such as providing rich benefit plans with the employer paying most of the cost, but employees were not required to enroll;
- Good benefits were offered, but employees were not actively encouraged to sign up.

Although small firms are much less likely to offer coverage than large ones and employees of small firms are less likely than employees of large firms to be covered by health benefits (Fronstin, 2001b), small firms were generally more likely than large firms to report that 100 percent of employees were eligible for health benefits. In the Web-based survey, 63 percent of firms with one to 25 full-time employees reported 100 percent eligibility, while only 31 percent of firms with 1,000 or more full-time employees did. This difference may reflect the fact that most small firms that offer coverage buy health insurance and must meet employee minimum participation requirements as part of the underwriting process. (Many large firms, in contrast, self-insure their health benefits.) Small firms offering coverage were also more likely to require participation than large firms.

In industries where it is unconventional to offer health benefits, employers are under little pressure to do so. In such industries, some employers find that offering health benefits may give them a distinct advantage in attracting the best workers. For example, a manager of a large farm said it covered all employees and their dependents even though its larger competitors did not do so. Offering health coverage helped the company attract "the cream of the crop" of workers, he explained. Radically increased premium costs were forcing this company to significantly raise employees' share of family coverage, and, thus, might cause some to drop family coverage. But, because its competitors typically did not offer any

coverage, the company would probably continue to attract high-quality workers, he said.¹⁵

Although many large employers continued to offer health benefits to attract and retain qualified employees, some offering relatively comprehensive benefit plans were wary of having the “plan of choice” for family members of employees in which one spouse worked for another employer. Several employers offered financial incentives for employees to sign up for their spouse’s employer plan. Noting that employers will be asking employees to pay increasing amounts for family coverage, one benefit manager of a large corporation commented that there was nothing better for his health plan’s bottom line than to have an employee find coverage somewhere else.

Those employers offering the financial incentives to opt out of the company’s health plan (which ranged from a few hundred dollars to more than \$2,000 a year) often said they required employees who opted out to have coverage elsewhere but in most instances they did not require employees to show proof of other coverage. Some large employers had been advised by consultants to consider adding such an incentive, but had decided against it for a variety of reasons.¹⁶ A few firms appeared to be giving employees mixed signals, reporting that they “actively encouraged” employees to enroll in their plans while also providing financial incentives to find coverage elsewhere.

Small firms that compete with large firms may be at a competitive disadvantage in attracting workers, because providing comparable health benefits is usually more expensive and difficult for them. In the focus groups, representatives of two very small employers (with two and three employees, respectively) said that they could not afford to offer health benefits. One of these companies had recently dropped its health plan because of rapidly rising premiums.¹⁷ The owner com-

plained that tax laws did not allow some small firms, including partnerships and S corporations, to deduct health benefit expenses to the same extent that large firms could.¹⁸ He said that he really wanted to provide himself and other employees with health insurance but could not afford the cost.

One landscaping company employing several hundred workers provided coverage only to office personnel and foremen, groups comprising only about 25 percent of its work force. Job turnover was too high among laborers to offer coverage, according to the firm’s benefit manager. Many benefit managers reported that high employee turnover rates created difficulties in trying to offer health coverage. Some firms said they were extending initial waiting periods in response to problems posed by high employee turnover. In contrast, at least one benefit manager said her company was reducing its initial waiting period because the waiting period had made a large percentage of employees ineligible.

Some smaller firms complained about inflexibility of insurers in setting prices, and one employer perceived brokers to be ineffective in helping the employer negotiate with insurers to keep rates affordable. Another said her broker had been helpful in negotiating ways to trim a very high rate increase. One employer complained that a recent health underwriting process had been extremely disruptive to employee morale because employees had to provide personal health information to four different carriers, each using different underwriting criteria.

Small employers reported the most friction with health insurers and brokers. Many large employers self-insure at least some of their health plans. It is generally more difficult for small employers to self-insure their health plans, a strategy that can reduce their insurance costs, reduce or eliminate premium taxes, and provide them with greater flexibility to design benefit plans. Self-insuring, however, may put small firms and their

employees at greater financial risk, and depending on claims experience, may be more expensive.

Some of the large employers said they were attempting to reduce the number of fully insured HMOs that they offer, especially if their rates were high or if they covered disproportionate numbers of the firm's low-risk employees, whom the firm might prefer to cover in their self-insured plans. One large firm's benefit manager said that it had cut the number of HMOs that it contracted with nationally; while doing this, the company had successfully steered most of its high-risk employees into remaining fully insured HMOs while providing incentives for low-risk employees to enroll in its nationwide self-insured plan.

Employee Education

In at least two of the focus groups sites, a large percentage of the uninsured were Latinos. Many worked in industries like construction, agriculture, and textiles. More than one employer said that people of Mexican origin often had difficulty understanding the concept of American employment-based health benefits. Many are not used to the idea of having to enroll in a health plan and follow plan rules, such as using specified physicians and hospitals that are under contract with the plan. Even those with coverage might end up going to hospital emergency rooms and neighborhood clinics instead of providers under contract with their health plans. One benefit manager noted that even when immigrants received information in Spanish, they often had trouble understanding how to use their benefits.

Many employers stressed the need for increased efforts to educate employees about how to get the most out of their health benefits, especially as employers seemed headed toward shifting more decision-making and financial exposure to employees. According to those

interviewed, employees and employers could benefit from employee education in the following areas:

- How to stay healthy (e.g., through better nutrition and exercise; better use of health benefits, such as having regular check-ups and flu shots; and better management of chronic diseases).
- Understanding the potential financial and health consequences of their actions, such as choosing or not choosing to sign up for health coverage.

Despite assertions by many about the value of trying to improve employee health, one benefits consultant noted that he and his colleagues get paid to help companies reduce their benefit costs and that it is difficult to show employers that wellness programs provide a return on investment in the short term, even though these programs might pay off in the long term.

One benefit manager said that most new employees coming into her organization did not have a regular physician. She advises them to have a full check-up right away even though it costs the plan money. This helps new employees establish relationships with physicians and gives physicians baseline knowledge of the employees in a healthy state, which then can be contrasted to their health status if they later become ill.

One benefit manager said that employers should investigate and advertise to their employees free or discounted health care services offered in their communities, regardless of whether the employees are insured. For example, some health care providers offer free flu shots and mammograms.

Strategies for Low-Wage Workers

As employers increase employee cost sharing in response to health benefit cost increases, many benefit

managers recognized that low-wage workers might be especially hard hit. Several large employers said that they made explicit attempts to help low-wage workers afford coverage. For example, some that continued to pay 100 percent or nearly all the cost of coverage said that one reason they did so was to make sure that everyone could afford it.

Employee Share of Premium—Some large employers interviewed said they based employee contributions for health benefits on income or were considering implementing such a policy. Some said that tiering premium contributions according to income levels helped improve participation rates among low-wage workers, while others said that the policy had been recently implemented and it was too early to discern whether, or how much, premium differentials might have affected participation.

Information About Government Programs—In the Web-based survey, 24 percent of employers said they provided information to employees about government programs, such as Medicaid and S-CHIP, for which they or their families might qualify. In the focus group meetings, only a handful of employers said they provided such information to employees. Of these, the only organizations that provided information in any detailed way were working in the health care field.¹⁹ Most of those that said they would provide employees with information about government programs said they took a passive approach, doing so only in response to employee inquiries.

Should health care costs continue to rise faster than employer profits and wage levels, building closer linkages between government programs and employment-based coverage may represent a possible opportunity to help low-wage workers find affordable coverage. For example, a benefit manager whose firm

had recently increased the cost of family coverage said she was interested in finding out about the availability of S-CHIP coverage for those who had opted out of family coverage. She also was interested in developing an ongoing relationship with someone in the state agency who was operating the program. She said that she was concerned about whether those families that had dropped family coverage had found it elsewhere. Many employers that had begun employee premium cost sharing for the first time or increased employee cost sharing said they did not know whether the new policy had caused any employees to drop coverage for themselves or for family members, while others said they had attempted to monitor the impact on coverage levels within their plans.

One employer that did not offer coverage to laborers said that government programs might be a more effective way to cover them. He noted that many small businesses simply did not have the profits to offer health benefits to low-wage workers.

Most employers interviewed appeared to take a practical view toward the availability of government coverage programs and said they did not consider such programs to carry the stigma often associated with cash welfare programs. They generally seemed to think that government programs to help low-wage people represent one alternative among many for dealing with the problem of covering uninsured workers and their families. However, that view was not entirely uniform. A benefit manager for a computer company said that if an employer is “producing wealth,” it should be taking care of its employees, adding that he would “cringe” if he had to send his employees to a government program to obtain health coverage.

A Medicaid official participating in one discussion noted that many Medicaid and S-CHIP programs might encounter capacity problems if they expanded too rapidly, especially in times when most state budgets are tight.

Unconventional Ideas and Products—One employer suggested an approach in which small employers might form coalitions or try to piggyback on what large employers are doing to purchase health coverage. He said that a large employer had provided such support to his firm on a voluntary basis in the past.

One employer had recently sold an insurance company that he developed for the purpose of selling low-cost “front-end” insurance to companies with high numbers of low-wage employees and with high rates of employee turnover. He explained that in the 1980s he had been hired as senior vice president of human resources for a convenience store chain and had been asked to reduce employee turnover and employee theft. After noticing that many employees waited until they became sick to enroll in the company health plan, he interviewed employees, most of whom were making near the minimum wage, and found that they wanted coverage that was “accessible” and that would cost them only about one hour of their pay per week. He subsequently structured a benefit plan costing employees about \$5 a week that provided \$1,000 of medical coverage annually along with two incidents of accidental coverage of \$2,500 each and a \$10,000 death benefit. Introduction of this coverage helped the company reduce employee turnover and theft, he said.

He then began marketing this insurance product independently and built a company whose clients included several major fast-food chains. Often companies used the scaled-down insurance product for new hires and graduated them to a major medical program after six months to two years. The limitations of the program, of course, include the fact that it does not cover catastrophic expenses and would not be very useful to many people with expensive chronic conditions. It primarily provides access to physician visits and wellness services, such as immunizations. Sixty-five percent of those enrolled in the program are mothers with children. The program can be combined with other

types of coverage, such as drug coverage and catastrophic coverage, he said.

One participant in the meetings said that the uninsured population was not homogenous; rather, it was made up of a variety of populations, each of which possibly required a different strategy to improve access to health care. He noted that many Hispanic immigrants were not familiar with conventional health insurance. He said that Hispanic workers often did not understand that employment-based health benefits provide access to health care services, which is one reason that they either did not take health insurance when offered or accepted jobs that did not offer health benefits. With support from a local philanthropic foundation, this individual developed a pilot program to negotiate rates with area physicians who, in turn, sell “discount cards” to uninsured or underinsured people who can use the cards to buy services from them at those discounted rates. About 3,000 people (98 percent Spanish-speaking and 70 percent undocumented immigrants) were using the discount cards, he estimated.

Conclusions and Implications

Each year, America’s 6 million employers make individual decisions

about offering, designing, and pricing health benefits for their employees. To a large degree, these decisions determine how many Americans will be uninsured. This is because most Americans under age 65 rely on their employers to provide them and their families with affordable health coverage. Making significant progress on reducing the number of uninsured Americans would

appear to require the involvement of employers, both in terms of their practices in providing coverage and their involvement in discussions about potential policy changes that might increase coverage levels.

This research on employer attitudes and practices toward health benefits reveals several challenges concerning the role that employers play in providing health coverage, especially if the goal is to significantly increase the number of Americans with coverage (or even to moderate a possible erosion of coverage). Among the principal challenges is that employers typically focus narrowly on running their own benefit plans and do not think about the impact of their coverage practices on the larger community or business sector as a whole. In spite of this, many employer representatives began grappling with the uninsured issue during the focus groups and said they recognized the need for greater employer involvement in developing ways to cover more Americans. Among the principal findings are the following:

- Employers provide health benefits primarily as a function of their competition for workers. They do it primarily to attract and retain the best workers possible in order to maximize productivity. For private-sector firms, the goal is to maximize profits. Although a secondary motive for offering coverage for many firms, especially large ones, is to increase productivity over the long term by trying to improve worker health status, employers generally do not offer health coverage for ethical or social policy reasons.
- Many large employers still attempt to cover all or most of their full-time workers, but double-digit health care cost increases over the past few years have pushed many employers to make changes such as shifting more costs to employees, especially for family coverage, and in some cases restricting eligibility or dropping coverage. Small firms with high

proportions of low-wage workers, of course, are the most likely to decide not to offer coverage. Large firms are increasingly likely to reduce their commitment to retiree health coverage, charge employees higher contributions for family coverage than individual coverage, or exclude part-time and temporary workers from their plans.

- The fact that firms offer coverage as part of their competition for labor cuts both ways in its impact on aggregate health coverage levels. On one hand, most large firms feel they must offer health coverage to full-time employees to be regarded as a viable employer. However, given that in today's economy husband and wife often work for different organizations, employers are sensitive to the risk that offering "too-generous" family health coverage may draw a disproportionate share of dependents. Consultants advise many large employers to offer employees financial incentives to forgo health benefits and take coverage elsewhere; yet employers seem less likely than before to make sure that employees taking such incentives actually end up with coverage somewhere.
- Some employers realize that passing along greater costs to workers may cause low-wage workers to forgo coverage. A few are calibrating employee premium contributions to wage levels and others are exploring the possibility of doing so. Some companies provide employees with information about government programs, such as Medicaid and S-CHIP, that may be available to them or their families, but usually only when an employee requests such information. Employers with high proportions of low-wage workers may be increasingly receptive to exploring alternatives to traditional comprehensive health coverage, including scaled-down insurance products. Uninsured employees increasingly may use nontraditional

financing alternatives (if available), such as prepaid discount cards that allow greater access to medical providers.

- Employers typically do not think about the issue of providing coverage for more of the uninsured. The people who buy employee health benefits and operate employee health plans (for example, the owner of a small business or human resources staff in a larger organization) typically focus on providing benefits to the employees eligible for their plans and containing the costs of those plans. They do not typically think about the larger societal issues, such as how to cover more of the uninsured, and often may encounter organizational resistance to doing so. Yet, as individuals dealing with employees' health issues on an everyday basis, many of these people understand that the issue of covering more of the insured is a major problem both for their communities and the nation, and at least indirectly may be a problem for employers as well.
- Because employers themselves do not perceive covering the uninsured as a priority, the business organizations representing them also do not focus on this issue. There are resulting gaps between employers and public policymakers, and among employers themselves, with regard to deliberation and coordination of strategies on this set of issues.

If the goal is to increase coverage levels in order to improve the nation's level of health and productivity, efforts need to be made to increase employer awareness of the value of health coverage to the success of their organizations, as well as to facilitate employer involvement in efforts to increase coverage levels. Given increasing health care cost pressures, employers increasingly will be evaluating what benefits to offer, which

employees and dependents will be offered coverage, and how to price whatever coverage is offered. As public policymakers consider their options toward the coverage issue, it would seem to be in employers' collective interest to become constructively engaged in discussions of possible public policy solutions. In the past, employers typically have become involved in such discussions in a defensive posture once a particular proposal threatens their interests. When one employer takes a public stand on a new way to cover the uninsured, resulting controversy may negatively impact his or her business. There currently appears to be a lack of leadership among business groups on this issue. This vacuum may present an opportunity for some group or groups to begin doing this.

This study has begun to explore how the dynamics among employers competing for workers while trying to minimize costs, impact the aggregate health and productivity of the American work force by producing a relatively large number of uninsured. Further study and understanding of how employers behave—both individually and in the aggregate—will assist both policymakers and employers themselves in developing strategies to increase the number of people with health benefits in ways that may be successful in the marketplace. This study used a Web-based survey and interview methods to detect and describe employer attitudes and practices affecting the number of uninsured Americans. Further research could continue the process of gaining a better understanding of employer attitudes and practices toward providing health benefits. For example, a typology of employer behaviors can be developed, and ultimately scientific methods will need to be used to investigate various key strategies and practices.

Designing practical and workable public-sector strategies around the decisions that 6 million employers unilaterally make concerning health benefits requires

deeper understanding of the reasons and beliefs behind employer practices regarding health benefits. Closer coordination of current private-sector and public-sector coverage in providing information to employees about available government programs, such as S-CHIP and Medicaid, might present an opportunity to increase coverage levels. Better understanding of employer behavior in offering benefits may also help employers develop better ways to coordinate their coverage strategies and to avoid costly forms of competition, should they choose to do so.

Investments in employer and employee education about the value of health care coverage in terms of increased productivity—specifically, why it might be in the interest of an individual firm or businesses collectively to cover more workers—continue to present opportunities to bolster the important role that employers play in providing health coverage for working Americans and their families. Investments in employee education about how to use health benefits most effectively also may have payoffs, especially with regard to immigrants, who often do not understand even rudimentary aspects of private health coverage.

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Endnotes

¹ For example, a substantial number of Americans are eligible for public programs but do not enroll in them. Recently released data indicate that 4.7 million uninsured children are eligible for either Medicaid or S-CHIP. See www.coveringkids.org/entrypoints/press/UrbanMethodology.pdf (last reviewed August 2002).

² The estimates for sources of health insurance and the uninsured will not sum to 100 percent because persons can have insurance from more than one source at the same time or during the course of a year. For example, nearly all of the population age 65 and older is covered by Medicare, while one-third also have (mostly supplemental) coverage through an employer, and another 28 percent purchase supplemental insurance directly from an insurance company. In addition, the nonelderly population may also be covered by more than one source of health insurance coverage during the course of a year. In some instances a person will have employment-based health benefits for part of the year and Medicaid for a different part of the year.

³ Employer decisions regarding health benefits often have a major impact on other aspects of work and life. For example, recent trends of erosion in private employer retiree health benefit plans will likely affect the retirement patterns of future retirees. See Fronstin (1999a), Fronstin (2001a), and VanDerhei and Copeland (2002) for more information regarding trends in retiree health benefits, the relationship between availability of retiree health benefits and retirement patterns, and the relationship between retirement income and living expenses in retirement.

⁴ Canedy, Danna, "Hospitals Feeling Strain From Illegal Immigrants, 'Free' Care Staggers Providers at Borders." *New York Times*, 25 August 2002, pg. A-12.

⁵ Sarbanes-Oxley Act of 2002, P.L. 107-204.

⁶ The survey was not designed to scientifically count the number of employers that offer coverage, the number of employees with coverage, or the cost of coverage and other variables usually associated with employer surveys on health benefits. Other studies, such as the Employer Health Benefits survey, conducted annually by the Kaiser Family Foundation and the Health Research and Educational Trust, already do that. See www.kff.org and www.hret.org for more information about that study.

⁷ It should be noted that it was especially difficult to attract small employers to participate in the half-day discussions, in part because smaller employers do not have full-time human resources staff and usually must rely on a person (often the owner) to oversee the health plan alongside many other more pressing functions that are more vital to the success of the business. In general, readers should be cautioned that these meetings may have attracted employers that were more likely to offer benefits, more likely to offer more comprehensive benefits, and more likely to make more employees eligible than the average employer in comparable industries.

⁸ The Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulates the use of pre-existing condition limitations in employment-based health benefit plans.

⁹ Health Insurance Portability and Accountability Act of 1996.

¹⁰ Personal communication with Robert Crandall, July 2002.

¹¹ This information also was provided in a personal communication with Pi'ilani Pang, Project Manager of The Hawaii Uninsured Project, in July 2002.

¹² See, for example, www.leapfroggroup.org (last reviewed July 29, 2002).

¹³ The "Hillary factor" is a phrase used by some analysts who speculated that the health industry imposed a sort of self-restraint in raising prices during the time when the Clinton health reform effort, led by then-first lady Hillary Clinton, was under consideration. During that time, many employers and employees were shifting to more tightly managed forms

of health care, a trend that most analysts cite as the principal reason for the flattening of health care costs in the early-to-mid 1990s.

¹⁴ The difference between these two groups may be due to the fact that 13 percent of those reporting health benefits were not important for recruitment did not know their company practice or refused to answer.

¹⁵ Presumably, however, this company's competitors offer higher wages since they do not offer health benefits. Whether higher wages or better benefits would be most attractive to the best qualified low-wage workers might vary, depending on various factors, including the type of industry involved, the age and family composition of typical workers, and workers' health status.

¹⁶ For example, one company said it did not believe in "dumping" and another said that it did not want to subject its risk pool to unpredictable types of segmentation including the possibility of having only higher-risk employees remain in its plan while lower-risk employees took the financial incentive and went elsewhere for coverage.

¹⁷ The firm had gone from premiums of about \$1,600 annually in 1993 with a \$500 deductible to about \$12,000 a year with a \$2,000 deductible, the owner reported.

¹⁸ Actually, the value of employment-based health benefits provided by the employer is excluded from employee's gross income and is fully deductible as a business expense to the business. Insurance paid for medical care to partners, Subchapter S owners, and self-employed individuals are also deductible from such individuals' gross income. However, for tax year 2002, only 70 percent is deductible, while for tax years 2003 and thereafter 100 percent is deductible from gross income. Sixty percent was deductible in tax year 2001.

¹⁹ For example, one was a managed care firm with Medicaid contracts and another was a multi-faceted charity that ran a free care clinic.

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