E-HEALTH OPTIONS FOR BUSINESS: EVALUATING THE CHOICES

Sharon Silow-Carroll
Economic and Social Research Institute

Lisa Duchon
State University of New York Downstate Medical Center

FIELD REPORT

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ABOUT THE AUTHORS

Sharon Silow-Carroll, M.B.A., M.S.W., a senior research manager at ESRI, has conducted health policy analysis for more than 10 years, specializing in assessment of health care reform strategies that expand coverage to vulnerable populations. Ms. Silow-Carroll is the author of the book *In Sickness and In Health? The Marriage Between Employers and Health Care* (ESRI, 1995), which analyzes the corporate/employer role in providing health care coverage to workers and families from economic, social, and cultural perspectives. The Economic and Social Research Institute (ESRI) is a nonprofit organization that conducts research and policy analysis in health care and in the reform of social services. ESRI specializes in studies aimed at enhancing the effectiveness of social programs, improving the way health care services are organized and delivered, and making quality health care accessible and affordable.

Lisa Duchon, Ph.D., formerly deputy director of The Commonwealth Fund Task Force on the Future of Health Insurance, is currently a senior health analyst at the State University of New York Downstate Medical Center. Prior to joining the Fund, Dr. Duchon was executive director of Healios Health Network, an independent practice association of skilled nursing facilities. She has also served as director of public affairs for Denver Health Medical Center, one of the largest urban public health systems in the United States.

EXECUTIVE SUMMARY

Numerous health-related Internet, or "e-health," companies have recently developed market tools to help employers, employees, and health care providers manage health insurance functions. Some of these tools allow employers to outsource benefits administration to online companies that handle enrollment, benefits selection, claims, and other services. Other e-health products take outsourcing a few steps further, by transitioning coverage toward a consumer-driven health care model. Supporters of this trend call for expanded consumer involvement in choosing a health plan based on cost and quality, in deciding which health care services to use and when, and in bearing the financial consequences of those decisions. A conference in June 2001, sponsored by the New York Business Group on Health, focused on e-health plans and information tools for consumer decision-making. This report synthesizes the conference's content.

There are many potential advantages of e-health benefit and information products. Defined contribution plans and other tools that give greater control and responsibility to consumers could help contain employers' health benefit costs and lead to more informed medical care choices. These e-health models and products could result in higher quality, better value care and lower overall health care spending. But many questions remain, as well as possible negative outcomes, that could undermine or outweigh the benefits. In this report, we identify and discuss key issues and potential risks that employers and policymakers should address as the development of e-health plans and products unfolds. These include cost, risk selection, access, choice, quality/accountability, and patient protection/liability.

Cost and Financial Risk

E-health tools that limit an employer's financial responsibility could lead to cost reduction across the board (e.g., through more prudent consumer purchasing) or may only place a greater financial burden on workers as costs escalate faster than employer contributions. Administrative savings from e-health products may be offset by greater underwriting costs as the focus of insurance moves to the individual consumer level. Potential savings to employers could include lower health benefit and administrative costs, and improved health and productivity of employees. Potential costs include purchasing e-health tools, training and educating workers to use the tools, and productivity costs if employees spend more time managing their health care during work hours. It is important to compare savings with costs in order to gain a clear understanding of the risks and benefits involved in implementing e-health products. Further, any long-term savings are limited because

none of the e-health options address the major underlying factors that raise health care costs, especially the demand for new technologies and the aging of the population.

Risk Selection

The flexibility of e-health benefit models could make coverage more attractive to the 22 percent of workers who have declined coverage in the past.[1] But this same flexibility could disturb the natural risk pooling that employer-based coverage currently provides, where healthier workers implicitly subsidize sicker workers. If more personalized health benefit strategies induce people to move out of group coverage and into the non-group market and individual coverage, older employees and families with above-average medical risks will face higher premiums. This raises the issue of whether employers should (and are able to) vary their contributions according to each employee's health risk. If expanded choice puts some insurers and providers at risk of insuring employees with above-average risk profiles, it might become necessary to adjust contributions according to risk, but such efforts are often difficult to implement effectively.

Access

E-health products designed to give employees control over their employer-sponsored health savings accounts can enhance portability, allowing workers to carry their coverage from job to job. But when greater financial risk is passed along from employers to consumers, access for certain groups may decrease when individual underwriting and risk selection raise costs for higher-risk people. Policymakers and small business leaders need to explore whether online insurance models and information tools can increase access for the non-working uninsured, or for those ineligible for employer-based coverage, particularly in the context of tax credits for individuals or small firms. Some state-based coverage programs are beginning to use e-health technology to improve enrollment efficiency and quality for Medicaid/CHIP beneficiaries. This raises possibilities for public-private partnerships that could increase access to both employer and public coverage.

Choice

E-health defined contribution products give employees more choice in selecting plans and/or level of benefits and in exchanging health benefits for other benefits they may prefer. Yet studies show that most employees with job-based coverage say employers do a good job selecting quality health plans. Rather than delegating plan or benefit selection to employees, employers could explore ways to use e-health administrative functions more efficiently without abdicating their role in managing health benefits. As health costs rise,

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[1] Lisa Duchon, Cathy Schoen, Michelle Doty, Karen Davis, Erin Strumpf, and Stephanie Bruegman, *Security Matters: How Instability in Health Insurance Puts U.S. Workers at Risk: Findings from The Commonwealth Fund 2001 Health Insurance Survey* (New York: The Commonwealth Fund, December 2001).

employers tend to offer fewer choices, not more, to achieve more leverage over negotiating premiums and to monitor quality. It is still unclear whether e-health defined contribution plans will be able to expand choice without affecting employers' ability to negotiate discounted rates, based on guaranteed volume, with carriers and providers.

Quality/Accountability

Reliable, accessible, and understandable information on quality for employees could help produce significant health and productivity gains for insured workers. In selecting e-health information products, employers will need to ensure that they are choosing vendors who in turn use high quality, reliable sources. Coverage models need to be structured so that incentives reward good care, taking cost *and* quality into consideration, rather than the lowest cost care. Providers must be accountable to consumers through financial rewards and penalties tied to medical outcomes.

Patient Protection/Liability

Consumers often need employers to advocate on their behalf when they encounter problems or a new health plan or network provider. If employers significantly reduce their role in managing health benefits, changes in existing insurance rules or another type of regulation may be needed to provide standards and safeguards. As workers obtain more information about their illnesses, treatment options, and provider performance comparisons, liability issues may arise about who will bear responsibility for errors, incorrect information, unwanted outcomes, and "bad" decisions by workers who obtained information from e-health vendors.

All of these issues are ripe for exploration and research. Independent monitoring and evaluation of e-health benefit plans and information tools are critical to help ensure that they actually improve the overall cost effectiveness of health care without hurting access and quality. Employers, policymakers, and other stakeholders need to gain a better understanding of the potential risks and benefits involved with e-health benefit models and information tools in a rapidly evolving marketplace.

E-HEALTH OPTIONS FOR BUSINESS: EVALUATING THE CHOICES

INTRODUCTION

Numerous health-related Internet, or "e-health," companies have recently developed market tools to help employers, employees, and health care providers manage health insurance functions. Some employers are already using these tools to outsource their benefits administration to companies that handle eligibility, enrollment, benefits selection, claims, and other services.[2] Some e-health products help employers select and evaluate coverage arrangements while other e-health products take outsourcing a few steps further, by transitioning coverage toward a consumer-driven health care, or "self-directed," model. Supporters of this trend call for expanded consumer involvement in choosing a health plan based on cost and quality, deciding which health care services to use and when, and bearing the financial consequences of those decisions.

How should business respond to these new e-health products and technologies being promoted under the banner of consumer-driven health care? The response may depend on whether employers are prepared to change their traditional role in designing health plans, overseeing quality, providing information to employees, advocacy, handling financial and administrative tasks, and grouping their workforce into natural "risk pools." There may, however, be practical limitations to the responsibilities that employers can give up.[3] And we do not yet know whether employees are ready to assume the responsibilities of the complex decisions and financial consequences of some e-health coverage models. For example, giving more responsibility for benefit design and provider choice to individuals could lead to more effective and efficient health care, or it could simply shift costs to the individual. How can employers choose among the e-health options now emerging in the marketplace? What are the long-term implications for cost, quality, and access?

A conference sponsored by the New York Business Group on Health (NYBGH) focused on some of these issues.[4] Presenters discussed options in e-health products and the availability and credibility of information needed for a consumer-driven market. This report synthesizes the meeting content; categorizes and describes e-health products;

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[2] James Maxwell et al., *Corporate Health Care Purchasing Among the Fortune 500* (Washington, D.C.: National Health Care Purchasing Institute, May 2001).

[3] This was among the questions raised by G. Lawrence Atkins, Ph.D., President of Health Policy Analysts and Coordinator for Corporate Health Care Coalition, at NYBGH E-health Conference, 28 June 2001.

[4] The theme of the NYBGH E-health conference was "Sorting It All Out: Options for Employers in E-health Plans and Information."

assesses the implications of moving toward consumer-driven health care; raises questions and challenges for businesses and for researchers; and concludes with a note of caution to employers and policymakers.

SYNTHESIS OF E-HEALTH CONFERENCE

Responding to a Changing Health Care Market

Double-digit increases in health care costs, employee and provider dissatisfaction with managed care, and legislative forces such as patient protection legislation are among the trends driving employers to explore alternative health benefit arrangements for their workers. Employers want predictable and reasonable health benefit costs, but they also want to give employees more choice among health plans and coverage options.

In response to these forces, some large companies are instituting or contemplating variations of "defined contribution" plans, where the employer contributes a designated dollar amount toward health coverage and workers select a plan that best meets their needs. Workers who prefer a more expensive option pay the cost differential out of their own pockets. Less expensive options (such as those with fewer benefits, higher cost-sharing , or more restricted or lower-cost provider networks) require smaller or no contributions on the workers' part. The intent is to make individuals more cost-conscious purchasers of health care, while allowing employers to contain their costs.

E-health options use the Internet as a vehicle to vary and extend the defined contribution approach, with an emphasis on consumer-driven choices of plan benefits and providers. These approaches generally shift more financial risk and control to individuals. They span a continuum that ranges from offering more medical care, benefit or provider information via the Internet, and electronic administrative services to restructuring plan benefits, premium sharing, and overall financial risk.[5]

E-health vendors offer employers a variety of innovative tools for shifting to defined contribution plans, asserting that health care is indeed moving toward a consumer focus. They note that health-related websites are among the most widely used and they cite research indicating that consumers want more information about and control over health coverage decisions. Other studies, however, show conflicting results on this issue. E-health vendors contend that although managed care, as a "supply-side" strategy for containing costs, has been successful for two decades, it has run its course. According to this argument, a new strategy is needed that focuses on the *demand* for health care. The

[5] Paul Fronstin, "Defined Contribution Health Benefits," (Washington, D.C.: Employee Benefit Research Institute Issue Brief, March 2001).

goal is to reduce workers' perceived sense of entitlement to comprehensive, "free" health coverage and to encourage individual care management. Such management, of course, requires an exchange of information between individual consumers and health plans. Consumers need to relay information about their medical conditions and individual preferences and priorities. Health plans in turn must communicate the cost of services and the qualifications of providers.

The Internet is an ideal vehicle for such personal dialogue and price/quality transparency, and e-health vendors are developing, packaging, and marketing the technology. The target audience for these products is employers, who, according to e-health vendors, have a responsibility and an opportunity to train employees to become better consumers. Billed as "consumer-driven solutions," these strategies vary widely in the level of consumer engagement required and in consumer incentives.

The maximum level of consumer involvement comes with the "pure defined contribution" model, where employers give a set level of funding to employees to purchase coverage entirely on their own. Health care experts acknowledge that we are not yet ready for this option because neither consumers nor the market is prepared for a mass transition to individual insurance.[6] As the market adjusts, however, some believe that individual market approaches may become more feasible.

The various participants in health care demonstrate a range in understanding and acceptance of e-health models. According to one benefits expert, health care providers are generally supportive of an enhanced consumer role in decision-making.[7] Health plans have some concerns about underwriting and risk selection in the new health benefit models and their current involvement in Internet-based insurance or information products is limited but growing. Consumers do not yet know much about e-health benefit models or consumer choice concepts, but they will ultimately drive product development.

Using E-health Information to Make Decisions

The quality of health care in the United States can and should be improved. There is mounting evidence of misuse, underuse, and overuse of medical services as well as great variation in medical practices and outcomes from region to region and from provider to provider.[8]

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[6] Stephen Blakely, "Defined Contribution Health Benefits: The Next Evolution?" (Washington, D.C.: Employee Benefit Research Institute Notes, August 2001).

[7] Presented by J. T. Thompson, Senior Benefits Consultant, Hewitt Associates (NYBGH E-health Conference, 28 June 2001).

[8] Institute of Medicine, *Crossing the Quality Chasm: A New Health System for the 21st Century* (Washington, D.C.: National Academy Press, 2001). Also, Donald M. Berwick, testimony before the Subcommittees on Health, on the Environment, and on Oversight and Investigations of the Committee on Commerce, February 9, 2000; and Mark A. Schuster, Elizabeth A. McGlynn, and Robert H. Brook, "How Good Is the Quality of Health Care in the United States?" *Milbank Quarterly* 76 (1998): 517–563.

Poor quality has a high dollar cost as well as a human cost in pain, suffering, and lost productivity.

Research on health care quality indicators is being conducted across the country and there are both public and private sources to draw upon. Clinical research on medical outcomes and best practices, health plan and provider "report cards," health plan accreditation services, Health Plan Employer Data and Information Set (HEDIS) indicators, patient safety records, and patient satisfaction surveys are among the quality indicators being used to rate and compare health plans and providers.[9]

Advocates of consumer-driven approaches contend that information on quality is available to facilitate informed choice. The problem, they claim, is that patients cannot get to it easily, so the information needs to be better integrated and made accessible. The best medical decisions, these advocates maintain, are based on scientific evidence combined with and adapted to an individual's situation, perceptions, and desires.

New e-health products that perform some or all of these functions are being marketed now. Some websites provide free clinical information about a wide range of diseases and treatments while others charge fees for information about health plans or provider performance. A few e-health products combine and expand on these functions, with an interactive component that factors in personal preferences. All of these products are intended to provide patients with:

- Access to an understandable synthesis of clinical data, quantitative information, and evidence-based outcomes
- The ability to combine clinical data with personal medical conditions and priorities to obtain individual treatment recommendations
- Comparisons of provider performance, based on such indicators as patient safety and satisfaction, public data, and provider input, to help them make informed selections of providers, and
- An understanding of what to expect and what kinds of information and services to seek in hospital and outpatient settings for specific conditions.

[9] According to the federal government's Center for Medicare and Medicaid Services, "HEDIS is a set of standardized performance measures that assess the quality of health care and services provided by managed care plans." Source: http://www.hcfa.gov/stats/hedis.htm.

These e-health information tools are generally based on collaboration or partnerships with major research or provider organizations (e.g., the RAND Corporation or the American Hospital Association) and they can be integrated with other products. They are just beginning to gain acceptance, so it is too early to know how consumers will respond. General Electric, for example, is piloting Ihealer, a treatment/provider selection tool, and Subimo, a provider selection tool.

One quality expert contends that employers, as they pursue new e-health tools, have a responsibility and an opportunity to train employees to be good consumers.[10] Businesses can influence and improve employee choices through education; publishing information about provider performance; ensuring that employees know their involvement is welcome and expected; and introducing financial incentives to select high quality, high value care. The last activity may involve screening initial coverage options based on quality as well as cost and charging employers less if they choose better-performing hospitals, physicians, and other providers.

TYPES OF E-HEALTH PRODUCTS AND APPLICATIONS

The e-health market is extremely dynamic, with new vendors and products appearing and disappearing at a rapid pace. The following taxonomy sorts out the different kinds of e-health products that have emerged through Fall 2001. Although we provide examples of existing companies and products for illustrative purposes, we have not included all product names or vendors, and we do not endorse or critique these ventures. The vendors listed are national companies unless otherwise noted, although their products may be available only in selected cities or states or through specific firms that are testing the products.

We categorize products according to primary function but the distinctions are not always clear-cut. Some vendors provide multiple applications, some collaborate with each other to offer combination packages, and still others offer variations on the basic model. Also, employers or health plans may choose to mix and match or combine services.

Internet Tools from Existing Health Insurers

Traditional health insurance and managed care organizations are rapidly entering the market with online services for employers, individual plan members, providers, and insurance brokers. A recent Watson Wyatt employer survey found that 83 percent of employers reported using the Internet to administer and communicate with their health plans, up from 63 percent the prior year.[11] Most insurance companies have websites that

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[10] Presented by Ian Jones, M.D., Senior Vice President and Chief Quality Officer, Crozer-Keystone Health System (NYBGH E-health Conference, 28 June 2001).

[11] Watson Wyatt Worldwide, "Changing Role of Health Care Benefits—2001 Survey Report," 2001.

provide, at a minimum, contact information and a description of services. For benefits managers/administrators, they provide information on eligibility; provider profiles and utilization reports; claims and referral processing; the ability to transfer company files; and benefit administration. For consumers and patients, they offer provider directories; personalized benefits and claims information; customer service; information about diseases, preventive care, wellness programs and other health concerns; and personal web pages tailored to specific medical needs and interests and links to other sites. For physicians and hospitals, they provide access to secure patient and physician information; electronic transfer of eligibility information; authorization processing; claims status; prescription benefits/formulary inquiries; provider directories; and medical management reminders about patients. For insurance brokers, the sites offer the ability to obtain quotes and download enrollment forms as well as access to underwriting guidelines and benefit plans.

Existing health plans with Internet tools include Aetna, Blue Cross Blue Shield (various regional plans), GHI (New York State), Humana, Health Net (Northeast and Arizona, California, and Oregon), Oxford (Northeast), and UnitedHealthcare.[12]

E-health Benefits Administrators ("Consolidators")

E-health benefits administrators, or "consolidators," whether they are existing third party administrators or new firms, contract directly with employers to provide online administrative functions. Vendors generate revenues by charging monthly or annual fees to employers or health plans that have outsourced health benefits functions.[13]

Services include online enrollment, eligibility, benefits selection, claims, and other administrative tasks. These services may be combined with other e-health products. E-health benefits administrators include eBenX, eHealthClaim, Sageo, and Automated Data Processing, among others.

Point-of-Care Discounters ("E-network Discounters")

Point-of-care discounters do not provide insurance but rather an online marketplace for out-of-pocket medical expenses by contracting with providers, including physicians, pharmacies, and hospitals, to provide discounted services to paid members. Individuals may pay the membership fee on their own (typically $10 to $50 per year per person) or be covered through employers.[14] Members may use the service to complement their existing

[12] See the following websites: www.aetna.com, www.bluecrossblueshield.com, www.ghi.com, www.Humana.com, www.Healthnet.com, www.oxhp.com, and unitedhealthcare.com.

[13] "E-health Insurance: Overview of an Emerging Industry and Implications for the Uninsured." Report prepared by Medimetrix for the Robert Wood Johnson Foundation, March 2001.

[14] Ibid.

coverage or they may be uninsured. They may obtain bids for procedures and services and learn about participating providers on the e-health vendor's website. The vendor charges a small transaction fee when the patient selects a service.

HealthAllies, for example, is an e-network discounter that gives 10 to 50 percent savings on services for enrolled members who use the company's participating providers.[15] No referrals or claims are required. The vendor, who markets the product to employers as a way to ease the transition toward reduced employer contributions, offers four discounted product categories:

- Supplemental/ancillary benefits (e.g., orthodontics, laser eye surgery, acupuncture) for insured employees
- Services available to employees through the employer's flexible health care spending account. Covered services are typically ancillary benefits (e.g., chiropractic care, massage therapy, and those listed above). Employees can track their use of benefits and remaining funds of their flexible spending account online.
- A comprehensive set of health care services (e.g., primary care, emergency care, prescription drugs, dental checkups) for part-time, seasonal, and transitional workers who are not offered insurance by their employer
- Services not covered by the employer's plan for its pre-Medicare retirees.

Health Savings Accounts/Defined Contribution Plans ("E-health Plans")

A number of new companies and existing health insurers have created a health plan model that combines a defined contribution plan with a health savings account and tools to manage benefits online. Many of the larger health insurance companies such as Aetna, Humana, Cigna, and United Health Group are adding this type of health plan to their product line in 2002 and 2003 by first offering it to their own employees along with traditional managed care plans.[16] A few thousand employees are currently enrolled in these plans, but the number could reach 100,000 by the end of 2002.[17]

The basic model includes an employer's fixed contribution of pre-tax dollars into an employee's annual health savings account (sometimes referred to as a personal care or

[15] www.healthallies.com.

[16] Milt Freudenheim, "A New Health Plan May Raise Expenses for Sickest Workers," *New York Times,* 5 December 2001, A1.

[17] Estimates made by Scott Keyes of Watson Wyatt Worldwide (benefits consulting firm). Reported by Reuters Health, 26 October 2001, in "Employers May Jump to Defined Contribution Products to Cap Health Costs."

medical savings account) and high deductible coverage. The employee draws down on the account to pay for preventive and routine care. Unspent funds are rolled over to the following year. The employer pays for a major medical "wrap-around" plan that requires the employee to meet the deductible before this coverage begins. Services are usually available through the health plan's own provider network or by contracting with a preferred provider organization. These plans also include online tools for decision support and medical education to help consumers manage their accounts and make treatment decisions.[18]

Definity Health, for example, markets its defined contribution plan to self-insured firms nationwide, thus bypassing the need to be licensed in individual states.[19] An employer using Definity Health funds a personal account for each employee with pre-tax dollars, ranging from $500 to $1,000 for individuals and $1,000 to $2,000 for families. Once the employee has used up the personal care account to cover health and wellness care, the employer's self-funded insurance plan covers the costs after the employee has reached the deductible limit (from $1,000 to $3,500). This high deductible coverage is intended for unexpected expenses. Preventive care may be fully covered (not subject to the deductible) even after exhausting the personal care account.[20] (See box on next page for more detail.)

HealthMarket and Lumenos are other examples of the health savings/defined contribution health plan model. Both use a health savings account that provides first dollar coverage for preventive and routine care.[21] Major medical coverage comes with coinsurance (usually 20 percent) and a deductible combined with a total out-of pocket-limit. HealthMarket provides online tools for price and quality comparisons and account management. Lumenos offers access to a network of providers offering discounted fees and partners with DoctorQuality to help employees select providers, obtain information on specific conditions, and access nurse advice.

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[18] Jon B. Christianson, "Defined-Contribution Health Insurance Products: Development and Prospects," *Health Affairs* (January/February 2002): 49–64.

[19] Carolyn McMeekin, Company Profile on Definity Health, from "Defined Contribution," a Vertical Industry Briefing for Health Care Executives, July 2001.

[20] www.Definityhealth.com.

[21] Carolyn McMeekin, Company Profiles: Health, Health Market, Inc. and Lumenos Inc., from "Defined Contribution" (see note 18).

DEFINITY HEALTH

Founded in 1998, Definity Health is an e-health plan that contracts with a national PPO network (Beech Street) and reimburses providers on a fee-for-service basis. Enrollees may choose providers through the Definity network posted on its website and compare providers' customary fees and discounts offered to Definity enrollees. Patients, however, are not limited to network providers.[22]

Enrollees may use the Definity site to set up a private, personalized record of their health spending and history or obtain medical information through an agreement with Johns Hopkins University that offers online access to its medical library.[23] Definity contracts with several other vendors to provide or manage its services. Wells Fargo Bank of Minnesota manages the personal care accounts of enrollees. Synertech manages Definity Health's claims, billing, enrollment, and customer service.

Recent figures put Definity Health's enrollment at 6,500.[24] Its first clients were Aon (3,000 employees in Minnesota and Illinois) and Ridgeview Medical Center (800 employees in Minneapolis). Several large Minnesota-based companies such as Medtronix (offered to 9,000 employees initially) and the University of Minnesota (16,000 employees) have begun offering Definity Health to their employees in addition to traditional managed care offerings. Several national companies have begun offering Definity Health to some or all of their employees: Charter Communications (17,000 employees), Raytheon Company (offered to 26,000 employees in Texas and Arizona), Textron (1,700 employees initially and later to all 45,000), and Budget (rental car) Group (8,000 employees).

The Pacific Business Group on Health (PBGH) is offering Definity Health to its 44-member employer coalition, made up of 3 million employees, retirees, and dependents. PBGH developed a "Breakthrough Plan" with Definity Health that is expected eventually to integrate the coalition's hospital and medical group quality measurement system into the health plan's consumer tools. This will enable quality measurement at the individual physician level.[25]

Other e-health plans allow employers to make defined contributions but do not necessarily include a health savings account component. Some allow employees to design their own coverage and benefits based on price, providers, and individual/family needs and preferences. ChoiceLinx, for example, allows employees to design a custom package, sometimes called a "point of enrollment" plan. Morgan Stanley recently announced it will offer a ChoiceLinx tool to 10,000 of its 50,000 employees.[26] Employees will be able to select different copayment options in each benefit area using online tools.

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[22] See note 18.

[23] Ibid.

[24] Barbara Martinez, "Employers Expect Health Care Costs to Rise," *Wall Street Journal,* 10 December 2001, B8.

[25] www.definityhealth.com; see "Pacific Business Group on Health Unveils Alternative to Managed Care," 8 November 2001.

[26] "Morgan Stanley and ChoiceLinx Unveil New Customer Designed Health Care Benefits Plan," Press release, ChoiceLinx Corporation, 16 July 2001.

As another example, Vivius applies the defined contribution model to a quasi-prepaid provider network. Participating providers develop their own capitated (per member per month) rates that Vivius adjusts for enrollees based on their age, sex, and the copay level they choose.[27] Enrollees select the individual specialists, hospitals, laboratories, and other Vivius providers online, based on these rates.[28] However, because many providers preferred to avoid any financial risk associated with a capitation reimbursement scheme, Vivius decided to pay providers on a fee-for-service basis, even though enrollees are selecting providers based on capitated rate.[29] The employer contributes a fixed amount into the enrollees' health spending accounts to fund their personalized Vivius network. The employer also determines how to share with employees the additional premium cost of a wrap-around plan that covers services outside the Vivius network and typically includes a deductible and co-insurance.

E-health Insurance Brokers

E-health insurance brokers offer conventional brokerage services but use the Internet for online applications, quotes, and purchasing, with the expectation of reducing operating costs and increasing sales volume.[30] Revenues come from sales commissions, currently at the same rate paid to traditional brokers (approximately 10 percent).[31] Conventional insurance companies (e.g., various Blue Cross Blue Shield groups) and new, online companies may operate as e-health insurance brokers. Examples of new companies include eHealthInsurance, HealthAxis, and Simply Health.

Quality Assessment ("Connectivity")

A number of new Internet-based companies have sites that allow consumers and employers to obtain quality ratings and comparisons of physicians, hospitals, and other health care entities (nursing homes, mammography centers), as well as health plans. Some sites, such as HealthGrades, are accessible to anyone online. In other cases, access is restricted to members and requires a password, as with Subimo. Quality assessment sites, referred to as "connectivity" products, are intended to help consumers and purchasers (and in some cases providers) make informed choices, but they disclaim any liability for the decisions made.

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[27] John Harkey, "Vivius Inc," company profile in *Vertical Industry Briefing for Health Care Executives: Defined Contribution,* July 2001.

[28] www.vivius.com.

[29] See note 18.

[30] See note 13.

[31] Katherine B. Wilson, Janlori Goldman, Zoe Hudson, and Richard M. Smith. "Health Insurance Purchasing and Privacy Online for Individuals and Small Groups," Report for the California HealthCare Foundation, 2000.

HealthGrades, for example, is a connectivity product that lets consumers view ratings or comparisons of hospitals, nursing homes, home health agencies, hospice programs, and fertility clinics nationwide, based on specific procedures or criteria.[32] Consumers can choose from a number of procedures for cardiac care, orthopedics, and obstetrics, among others, and obtain a hospital's rating for that procedure based on HealthGrade's analysis of recent discharge data. A detailed description of the rating methodology is available online.

HealthGrades does not provide physician ratings but consumers can obtain a physician "profile" that includes information about where the doctor completed medical school and residency training, years in practice, and specialty areas as well as gender and location of practice. HealthGrades also provides quality assessment services for insurance underwriters, benefit consultants, hospital and nursing executives, and employers.

Another connectivity product, DoctorQuality, allows consumers to rate their physician or hospital online and compares their responses to others and to the average ratings across all doctors or hospitals. The number of participants contributing to the average, however, is unknown. Other examples are Subimo and IHealer, which help patients assess and select providers and treatment options with evidence-based research, personal information, and publicly reported quality measures.

The New York State Health Accountability Foundation is a public-private venture (cofounded by the New York Business Group on Health [NYBGH] and the Independent Peer Review Organization for New York State [IPRO]) that maintains a website with access to the state's HMO report cards. It also compares HMOs and providers using established assessment tools developed by organizations such as the National Committee for Quality Assurance.[33] For example, consumers can choose a type of procedure and see how many were performed by a specific New York hospital or physician. They can also rate their physician care online and compare the results with the average of other consumers' ratings.

Medical Treatment Information ("Content Provider" or "Portal")

DoctorQuality, IHealer, Subimo, and other companies have developed online quality comparison assessments that include a "content provider" or "portal" to medical guidance information on best practices and innovations. These often include consumer-specific conditions and preferences to help users make treatment decisions.

[32] www.healthgrades.com.
[33] http://nyshaf.rkhosting.com.

For example, DoctorQuality offers employers an online product that gives their employees access to "health guides" on hospital safety and best practices recommendations for ambulatory diseases.[34] Users can create a personal database to help them track their medical outcomes and prescription drug use. The site also features "disease libraries," and an interactive guide for describing one's symptoms and obtaining suggestions on a course of action.

IMPLICATIONS FOR BUSINESSES

Employers considering e-health benefit options expect these strategies to help contain costs and improve employee satisfaction. Information on quality of care combined with financial incentives for making benefit and provider choices has the potential to lead to higher quality, better value care, and a reduction in overall spending. But these are new approaches, and many questions and concerns remain about cost, risk selection, access, choice, quality, and patient protection/liability. We need more data on how employees may react to the new models and whether hidden costs could undermine or outweigh the benefits.

We explore many of these questions in the following sections. Researchers and employers will undoubtedly find that these questions only begin to address the complex issues involved.

Cost and Financial Risk

Online technologies for insurance administration may result in big savings, perhaps 40 to 50 percent of current administrative costs.[35] But these efficiencies generally depend on high volume and it is hard to predict how long it will take before actual savings are realized and whether they will be passed along to consumers. A possible outcome is that administrative savings will be offset by greater individual underwriting costs as the focus of insurance moves to the consumer level.

When considering e-health benefit options, employees, providers, employers, and insurers need to understand their respective financial risks. Many e-health plans limit an employer's financial responsibility by putting employees at financial risk for a high deductible once they have used up the employer's fixed contribution toward care and before the wrap-around insurance takes effect. Will this lead to cost reductions across the board or just place greater financial burdens on workers as costs continue to rise?

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[34] www.doctorquality.com.
[35] See note 13.

When market pressures result in more efficient and effective care, everyone wins. But when the burden on employees rises faster than efficiencies are realized, out-of-pocket costs increase and low-wage workers, in particular, may find coverage less affordable, leading some to drop coverage altogether. Thus, the challenge is for employers to ensure that these e-health options will not lead to more people becoming uninsured or underinsured, particularly during an economic downturn.

The true costs of transitioning to an e-health benefits model include the costs of purchasing and upgrading e-health software tools and training workers to use the tools. There could also be potential productivity costs if employees spend more time managing their health care during work hours. The true benefits for employers could include lower health plan expenditures and reduced administration costs, possibly allowing employers to reduce the size of their benefits departments.

Another issue is the potential impact on utilization of services. The health care account model eliminates gatekeepers and utilization management for many health care services. This change could increase demand and costs; alternatively, greater individual financial risk could moderate demand.

E-health information tools on provider quality and treatment protocols that are integrated with benefit models are also likely to affect consumer utilization. New resources to improve quality and reduce medical errors will lead to a reduction in errors of *omission* (underuse) as well as *commission* (overuse). While better utilization and better health may result in the long term, higher costs may be the immediate result.

Finally, we must acknowledge that any long-term savings are limited since none of the e-health options address the underlying factors that raise health care costs, especially the demand for new technologies and the aging of the population.[36]

Risk Selection

E-health plans permit employees to tailor benefits to their individual preferences and thus may decrease insurance pooling across age and health risks. Allowing employees to separate into groups based on their own health needs will probably affect cost *distribution,* if not the total cost of health care. If more individuals choose and design their own coverage plans, the "natural" employer pools that exist today would most likely disappear.

[36] See note 13.

If more personalized health benefit strategies induce people to move out of group coverage and into the non-group market and individual underwriting, higher costs for older employees and families with above average medical care risks might follow. Research indicates that applicants with relatively minor or treatable health conditions (e.g., asthma), or applicants who are healthy but have needed medical care in the past, have great difficulty obtaining affordable coverage in the individual insurance market.[37] Health plans and brokers in the non-group market use aggressive risk selection to cover only those at low risk. Health plans that attract older, sicker people could spiral into high-risk pools, resulting in ever-increasing rates for people with greater medical needs.

Protections such as guaranteed issue and renewability, rate restrictions, alternative pooling mechanisms, and other insurance reforms are clearly necessary. ERISA rules, which exempt self-insured businesses from many state insurance requirements, may no longer be applicable. Further, a reliable way to risk-adjust rates to protect insurers and providers who get patients with higher-than-average risk profiles is needed.

Unless employer contributions vary according to each employee's health risk, premiums may rise substantially for many higher risk individuals and families, and there may not be an alternative form of risk pooling and/or strict rate restrictions to ensure that higher risk employees can afford their premiums. Conversely, new tools would be required under some e-health benefit options that would adjust the employer contribution according to each employee's projected health needs. Identifying higher cost employees, however, could provide information that allows employers to discriminate against them. We need to examine whether ERISA rules adequately guard against such discrimination by self-insured businesses and what other protections might be necessary. [38]

Access

Cost and risk selection issues clearly affect access to coverage and care. Access will indeed decrease for certain groups if greater financial risk is passed on to consumers and if higher risk people face increased insurance costs due to risk selection. There may, however, be ways that e-health benefit strategies and tools can *increase* access. For example, employees with personal health care accounts may be able to transfer unused funds to their next job, creating portable benefits. Although many of the current e-health products are geared to large, self-funded employers, there may be some potential to use e-health technology to

[37] Karen Pollitz, Richard Sorian, and Kathy Thomas, "How Accessible Is Individual Health Insurance for Consumers in Less-Than-Perfect Health?" Report for Georgetown Institute for Health Care Research, June 2001.

[38] The Health Insurance Portability and Accountability Act (HIPAA) of 1996 amended ERISA to prohibit discrimination against individuals based on health status-related factors.

help small firms, which employ most of the working uninsured. It is worth exploring how Internet-based insurance tools could facilitate pooling small groups, although market reforms may be required as well. If e-health plans can sell to small firms more profitably by using e-health technologies, it might improve how the small group market functions and its access to insurance.

E-health plans or administrative tools might also improve access for the working uninsured and for the millions of workers ineligible for employer-based coverage. Point-of-care discounters who negotiate lower prices for specific services, for example, are inducing some employers to offer limited health benefits to otherwise ineligible employees (part-time, temporary, and seasonal workers) or at least give them access to less expensive care. Other e-discounters target individuals without insurance or with high deductibles, but they are no substitute for a comprehensive health plan.

Medicaid and other public coverage programs are also using e-health technology to facilitate enrollment, improve coverage rates, and streamline administrative efficiencies. California leads the nation with online enrollment in its health care programs for low-income families.[39]

Choice

As health costs rise, employers tend to offer *fewer* choices, not more, to gain greater leverage over negotiating premiums and monitoring quality.[40] There is thus a trade-off involved in expanded consumer choice. As the choices offered to workers grow, patients are likely to be spread more thinly across providers, meaning less volume for each provider. There may not be enough volume to allow providers to continue offering discounts and they may not be willing to participate at all in health plans that have large provider networks.

Advocates of consumer-driven health care contend that patients will have a more direct relationship with the physicians and other providers they select. But it is still unclear how these new arrangements might affect the patient-provider relationship and provider satisfaction. Reducing oversight by health plan administrators (as would occur under some e-health models) could make it easier and more satisfying for providers to practice. But if patients are more involved with financial and medical decisions about their care, it might create an adversarial relationship between providers and patients that could negatively affect care. Or, providers might appreciate having better-informed patients.

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[39] http://www.chcf.org/press/index.cfm; see "California Tests First-in-Nation Web-Based System to Enroll Children in Public Health Insurance," 23 January 2001.

[40] See note 2.

Employers also have to decide how involved they want to remain in coverage decisions. One can argue that the employee benefits manager is more efficient and effective in making health benefit decisions than individual employees, so we need to explore ways to take advantage of e-health technology without eliminating the employer role in managing health benefits. Employers may still have a vital part in screening, selecting, and negotiating health benefits. And in some cases, there may be union issues that need to be resolved before employers can introduce e-health options.

It is important to anticipate how employees might react when presented with greater choice and accountability for their health coverage. Would they be able to make more informed selections, as well as design or negotiate coverage on their own, with the help of e-health tools? Employee access to the Internet at work and at home will in part determine their interest and ability. Many e-health vendors contend that employees want a greater role in health coverage decisions and that employers want "out" of health plan management. Research reveals a range of views:

- In a 2001 survey conducted by The Commonwealth Fund, three of four workers with job-based health plans thought employers generally did a good job of selecting quality health plans.[41]
- A recent study sponsored by the Robert Wood Johnson Foundation involving in-depth interviews with small, medium, and large firms found a strong sense among employers that they are better equipped than workers to choose and manage health plans. While employers were concerned about rising health care costs, most did not plan to give up their health benefit, financial, or management responsibilities.[42]
- A 2001 Watson Wyatt survey found that 20 percent of employers said they were likely or somewhat likely to adopt a defined contribution approach in the next 12 months as a means of managing their health care costs.[43]
- A recent Towers Perrin survey of very large businesses concluded that employers are committed to an active role in health care despite concerns about rising costs. Large employers expect e-health to drive efficiency and information exchange,

[41] Lisa Duchon, Cathy Schoen, Michelle Doty, Karen Davis, Erin Strumpf, and Stephanie Bruegman, *Security Matters: How Instability in Health Insurance Puts U.S. Workers at Risk—Findings from The Commonwealth Fund 2001 Health Insurance Survey* (New York: The Commonwealth Fund, December 2001).

[42] Sharon Silow-Carroll, Todd Kutyla, and Jack A. Meyer, *The State of Employment-Based Health Coverage and Business Attitudes About Its Future* (Washington, D.C.: Economic and Social Research Institute, April 2001).

[43] See http://www.watsonwyatt.com/homepage/us/resnew.asp.

although they have concerns about employee confusion, lack of computer access, and lack of readiness to use the technology.[44]

Thus, it is difficult to predict whether employers and employees will embrace greater consumer involvement in health benefit decisions. A number of factors, both internal and external, will influence the change in employers' insurance contributions and benefit design practices. Internal factors include size of firm, characteristics of workers, the firm's financial situation, the relationship between employer and employees, and the presence of labor unions or contractual obligations. External factors include the rate of insurance premium growth, unemployment levels, and the state of the economy.

Quality/Accountability

The quality of health care under new benefit options and e-health alternatives will hinge largely on whether these products can actually help consumers make smart, efficient, and health-promoting decisions. These decisions range from initial enrollment in a plan to selection of providers, treatment, preventive care, health promotion, and ongoing use of the health care system. Consumers are influenced by *information* about available options and financial *incentives* to favor one option over another. Employers must determine whether employees are getting the right information and incentives to promote high quality care. Health care providers must also be held accountable for their performance.

Information

Employers have to ensure that the information employees are getting is reliable. When considering an e-health information/quality measurement tool, employers should ask about the sources of information, the factors included and the weight assigned to each factor. They should know if assessments are based on professional standards, self-reports, patient surveys, public databases, clinical and outcomes data, or customer service factors, and ascertain whether the severity of illness of patients treated (patient case mix) is considered in provider and plan comparisons.

A recent report evaluating online information about physicians concluded that most of 40 websites with physician directories had incomplete, outdated, or unverified information, or some combination.[45] There are currently no standards for the format, content or verification of websites with provider information. The evolving role of employers in quality improvement may help promote standards that improve ways to

[44] "Facing Health Care Challenges in an Era of Change." Report of survey of 200 large organizations conducted in late 2000 by Towers Perrin, May 2001.

[45] Elliot M. Stone, Jerilyn W. Heinold, Lydia M. Ewing, and Stephen C. Schoenbaum, *Accessing Physician Information on the Internet* (New York: The Commonwealth Fund, January 2002).

measure the quality of care. The agreement between Pacific Business Group on Health and Definity Health is one example of a partnership to improve quality.

Employers must ensure that information is not only reliable but user-friendly. It must be accessible and understandable by their employee population. Further, performance measurements should include factors that are important to the workers. "Report cards" for employees that compare performance of health plans have generally not been useful so far.[46]

Educational tools are needed that teach employees with various levels of education and computer sophistication how to use the information available and how to assess certain performance indicators. Employers should also consider what alternative sources of information are available for employees without computer access.

Employers should also consider how access to information about provider quality may steer consumers to higher quality providers. If the quality information tool directs employees to providers who are not in their networks, this could lead to frustration. It could, alternatively, pressure employers and health plans to be more selective in building their networks with quality providers or simply to broaden their networks.

Financial Incentives

Coverage must be structured so that incentives promote high value, high quality care, not merely low-cost care. How can we be sure that *consumer* incentives to avoid over-utilization will not result in under-utilization? Under the e-health medical savings account model, for example, if employees see their accounts dwindling, they may forgo needed care or second opinions or choose less expensive care even if it is lower quality. Consumers dealing with the emotional aspects of illness or injury may not be able to weigh cost and quality factors objectively.

Finally, employers should consider whether their benefit plans offer incentives to *providers* to provide high quality care versus just keeping costs down. Ideally, reimbursement schemes would tie financial rewards and penalties to medical outcomes to make providers accountable to consumers and other payers. Proponents of e-health plans

[46] Elliot K. Wicks, Jack A. Meyer, Lise S. Rybowski, and Michael J. Perry, *Report on Report Cards, Volume II* (Washington, D.C.: Economic and Social Research Institute, April 1991); and Judith H. Hibbard and Jacquelyn J. Jewett, "Will Quality Report Cards Help Consumers?" *Health Affairs* 16 (May/June 1997): 218–228.

are optimistic that consumers will manage their health care dollars in a cost conscious way without putting their health at risk; others are not so sure.[47]

Patient Protection/Liability

Shifting responsibility and accountability toward consumers raises a number of patient protection and liability issues. With so much consolidation on the supply side (mergers among health plans and provider groups), if employers assume a smaller role in managing health care, it is unclear who will look out for employees. Responsibility is not yet assigned for enacting safeguards against fraudulent and sub-standard practices, for enforcing quality standards and penalizing providers with poor quality records, and for patient advocacy.

Under benefit models that restructure financial risks, existing insurance rules may not be adequate. A government entity may be needed to monitor the e-health industry and defined contribution arrangements and establish new standards and regulations. Do federal and state patients' bill of rights rules, both proposed and existing, cover e-health companies? With workers obtaining more information about their illnesses and treatment options as well as performance comparisons of providers, it is unclear who will bear liability for errors, incorrect information, unwanted outcomes, and "bad" decisions. E-health vendors insist that they are not "prescribing" treatment but rather giving consumers information to discuss with their physicians. They maintain that doctors are generally very supportive of these efforts because patients are asking better questions. Will this hold up in court?

The privacy issue is also important because some e-health products give employers information about certain employee decisions. Employees need assurances regarding the privacy of their health records and their use of various Internet sites.

Businesses purchasing e-health products must consider the staying power of the vendor, including whether the firm is an established insurance company or a start-up venture. Employers should carefully examine a vendor's business plan for future financing, anticipated profitability, and the consequences if profit goals are not met. They also need to know the implications if the vendor is bought out and talk with the vendor's venture capital investors.

[47] Milt Freudenheim, "A New Health Plan May Raise Expenses for Sickest Workers," *New York Times,* 5 December 2001, A1.

CONCLUSION

Emerging e-health products could facilitate a transition toward a consumer-driven model of health coverage. This model emphasizes greater consumer involvement both in making decisions and in assuming the financial consequences. At the same time, this model promises to limit employers' financial contributions toward health benefits and reduce the role of business in managing health benefits. This approach could lead to more cost-effective choices, improved quality of care and outcomes, and overall savings.

But such consumerism in health care is still essentially untested, and there are numerous risks and unanswered questions. E-health plans are now being offered to thousands of employees around the country. Researchers need to study these experiences and objective parties must gauge their impact on cost, access, and quality of care. As yet, we have minimal experience in evaluating or comparing e-health plans.

Meanwhile, employers should note that there are many kinds of e-health products, reflecting varying levels of employer involvement in financing and managing health benefits. Some but not all of the new models and tools shift financial risk and create more complex benefit choices for individual employees. Many of the new Internet-based tools are designed to improve the efficiency of health insurance administration or to provide information for making health care decisions. Some employers may decide to maintain their role in screening and selecting health plans in the near term but to outsource benefit administration functions. Others may choose to offer employees access to information comparing providers within existing employer-selected health plans.

Employers must consider where along the continuum they are comfortable, taking into account what makes sense for the firm and its employees. While workers tend to like having choices, they may not want or be prepared to spend the time and energy on the research needed for informed decisions on health coverage. Employers who do implement coverage changes must decide how to educate their employees about the shift, encourage them to participate in the new setup, and ensure appropriate incentives and adequate safeguards.

Finally, while there is great temptation for employers to institute policies that limit their financial obligations, this "protection" shifts costs back to workers. With rapidly rising insurance costs, the greater burden on employees (particularly higher risk workers or their families) could result in more uninsured and underinsured individuals, eventually reducing health and productivity.

In a rapidly evolving health care marketplace, it is vital that employers, researchers, policymakers, and other stakeholders ask critical questions and gain a better understanding of the potential risks and benefits of the new e-health benefit models and information tools.

RELATED PUBLICATIONS

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#507 *Lessons from a Small Business Health Insurance Demonstration Project* (February 2002). Stephen N. Rosenberg, PricewaterhouseCoopers LLP. This report finds that the recently concluded pilot project, the Small Business Health Insurance Demonstration, launched by the New York City in 1997, was successful in providing a comprehensive, low-cost insurance option for firms with two to 50 workers. But poor implementation and marketing, plus flaws in product design, prevented the program from catching on among small businesses.

#512 *Security Matters: How Instability in Health Insurance Puts U.S. Workers at Risk* (December 2001). Lisa Duchon, Cathy Schoen, Michelle M. Doty, Karen Davis, Erin Strumpf, and Stephanie Bruegman. This report, based on The Commonwealth Fund 2001 Health Insurance Survey, finds that in the past year one of four Americans ages 19 to 64, some 38 million adults, was uninsured for all or part of the time. Lapses in coverage often restrict people's access to medical care, cause problems in paying medical bills, and even make it difficult to afford basic living costs such as food and rent.

#513 *Maintaining Health Insurance During a Recession: Likely COBRA Eligibility* (December 2001). Michelle M. Doty and Cathy Schoen. This issue brief, based on The Commonwealth Fund 2001 Health Insurance Survey, examines the potential as well as limits of COBRA eligibility as a strategy for protecting workforce access to affordable health care benefits.

#514 *Experiences of Working-Age Adults in the Individual Insurance Market* (December 2001). Lisa Duchon and Cathy Schoen. This issue brief, based on The Commonwealth Fund 2001 Health Insurance Survey, describes the difficulties faced by those without access to group health coverage in obtaining adequate, affordable individual health insurance.

#478 *Universal Coverage in the United States: Lessons from Experience of the 20th Century* (December 2001). Karen Davis. This issue brief, adapted from an article in the March 2001 *Journal of Urban Health: Bulletin of the New York Academy of Medicine,* traces how the current U.S. health care system came to be, how various proposals for universal health coverage gained and lost political support, and what the pros and cons are of existing alternatives for expanding coverage.

#511 *How the Slowing U.S. Economy Threatens Employer-Based Health Insurance* (November 2001). Jeanne M. Lambrew, George Washington University. This report documents the link between loss of health insurance and unemployment, estimating that 37 percent of unemployed people are uninsured—nearly three times as high as the uninsured rate for all Americans (14%). The jobless uninsured are at great financial risk should they become ill or injured.

#485 *Implementing New York's Family Health Plus Program: Lessons from Other States* (November 2001). Rima Cohen and Taida Wolfe, Greater New York Hospital Association. Gleaned from research into the ways 13 other states with public health insurance systems similar to New York's have addressed these matters, this report examines key design and implementation issues in the Family Health Plus (FHP) program and how Medicaid and the Child Health Plus program could affect or be affected by FHP.

#484 *Healthy New York: Making Insurance More Affordable for Low-Income Workers* (November 2001). Katherine Swartz, Harvard School of Public Health. According to the author, Healthy New York—a new health insurance program for workers in small firms and low-income adults who lack access to group health coverage—has so far been able to offer premiums that are substantially less than those charged in the private individual insurance market.

#475 *Business Initiatives to Expand Health Coverage for Workers in Small Firms* (October 2001). Jack A. Meyer and Lise S. Rybowski. This report weighs the problems and prospects of purchasing coalitions formed by larger businesses to help small firms expand access to health insurance. The authors say that private sector solutions alone are unlikely to solve the long-term problem, and the public sector will need to step in to make health insurance more affordable to small businesses.

#473 *Coordinating Care for the Elderly: A Case Study of a Medicaid Long-Term Care Capitation Program in New York* (October 2001). Korbin Liu, Sharon K. Long, Matthew Storeygard, and Amanda Lockshin, The Urban Institute. According to the authors, a New York State demonstration program offering managed care to low-income adults who require long-term care appears to be enrolling more patients than previous programs and offering an expanded range of services.

Managed Care and Market Power: Physician Organizations in Four Markets (September/October 2001). Meredith B. Rosenthal, Bruce E. Landon, and Haiden A. Huskamp. *Health Affairs,* vol. 20, no. 5. Copies are available from *Health Affairs,* 7500 Old Georgetown Road, Suite 600, Bethesda, MD 20814-6133, Tel: 301-656-7401 ext. 200, Fax: 301-654-2845, www.healthaffairs.org.

#493 *Diagnosing Disparities in Health Insurance for Women: A Prescription for Change* (August 2001). Jeanne M. Lambrew, George Washington University. In this report, the author concludes that building on insurance options that currently exist—such as employer-sponsored insurance, the Children's Health Insurance Program (CHIP), and Medicaid—represents the most targeted and potentially effective approach for increasing access to affordable coverage for the nation's 15 million uninsured women.

#472 *Insuring the Uninsurable: An Overview of State High-Risk Health Insurance Pools* (August 2001). Lori Achman and Deborah Chollet, Mathematica Policy Research, Inc. The authors argue that high premiums, deductibles, and copayments make high-risk pools unaffordable for people with serious medical conditions, and suggest that by lifting the tax exemption granted to self-insured plans, states could provide their high-risk pools with some much-needed financing.

#470 *Medicare+Choice: An Interim Report Card* (July/August 2001). Marsha Gold, Mathematica Policy Research, Inc. *Health Affairs,* vol. 20, no. 4. The author explains that the Medicare+Choice options available to beneficiaries have diminished: existing plans have withdrawn from M+C, few new plans have entered the program, greater choice has not developed in areas that lacked it, and the inequities in benefits and offerings between higher- and lower-paid areas of the country have widened rather than narrowed.

#469 *Embraceable You: How Employers Influence Health Plan Enrollment* (July/August 2001). Jon Gabel, Jeremy Pickreign, Heidi Whitmore, and Cathy Schoen. *Health Affairs,* vol. 20, no. 4. In this article, the authors reveal that high employee contributions for health insurance often deter low-income workers from signing up for coverage, even when they are eligible.

#468 *Market Failure? Individual Insurance Markets for Older Americans* (July/August 2001). Elisabeth Simantov, Cathy Schoen, and Stephanie Bruegman. *Health Affairs,* vol. 20, no. 4. This new study shows that adults ages 50 to 64 who buy individual coverage are likely to pay much more out-of-pocket for a limited package of benefits than their counterparts who are covered via their employers.

#457 *Health Insurance on the Way to Medicare: Is Special Government Assistance Warranted?* (July 2001). Pamela Farley Short, Dennis G. Shea, and M. Paige Powell, The Pennsylvania State University. The authors conclude that the loss of employer insurance should not be used as the primary justification for implementing Medicare buy-in or other reforms for over-55 and over-62 age groups, but instead propose that the better justification for such reforms is the poorer average health status of those nearing age 65.

#449 *How the New Labor Market Is Squeezing Workforce Health Benefits* (June 2001). James L. Medoff, Howard B. Shapiro, Michael Calabrese, and Andrew D. Harless, Center for National Policy. To understand how labor market trends have contributed to the decline in the proportion of private-sector workers receiving benefits from their own employers—and to anticipate future trends—this study examines changes over a 19-year period, 1979 to 1998.

#488 *Inquiry* (Summer 2001). Vol. 38, no. 2. Articles based on the 10-report series *Strategies to Expand Health Insurance for Working Americans,* which was released by the Fund in December 2000 and is available online at www.cmwf.org.

#464 *Health Insurance: A Family Affair—A National Profile and State-by-State Analysis of Uninsured Parents and Their Children* (May 2001). Jeanne M. Lambrew, George Washington University. This report suggests that expanding Medicaid and State Children's Health Insurance Program (CHIP) coverage to parents as well as children may not only decrease the number of uninsured Americans but may be the best way to cover more uninsured children.

#453 *Running in Place: How Job Characteristics, Immigrant Status, and Family Structure Keep Hispanics Uninsured* (May 2001). Claudia L. Schur and Jacob Feldman, Project HOPE Center for Health Affairs. This report looks at factors that influence health insurance coverage for Hispanics, the fastest-growing minority population in the United States. The analysis shows that characteristics of employment account for much, but not all, of the problem. Family structure seems to play some role, as does immigrant status, which affects Hispanic immigrants more than other groups.

Preparing for the Future: A 2020 Vision for American Health Care (April 2001). Karen Davis. *Academic Medicine,* vol. 76, no. 4. Copies are available from Karen Davis, President, The Commonwealth Fund, 1 East 75th Street, New York, NY 10021-2692.

#462 *Expanding Public Programs to Cover the Sick and Poor Uninsured* (March 2001). Karen Davis. In invited testimony before the Senate Finance Committee, the Fund's president presented a compelling case for expanding existing public health insurance programs to provide coverage for the most vulnerable segments of the nation's 42.6 million uninsured. She stressed the importance of expanding Medicaid and the Children's Health Insurance Program (CHIP) to cover parents of covered children.

#458 *Expanding Access to Health Insurance Coverage for Low-Income Immigrants in New York State* (March 2001). Deborah Bachrach, Karen Lipson, and Anthony Tassi, Kalkines, Arky, Zall & Bernstein, LLP. This study of health insurance coverage among New York State's legal immigrants finds that nearly 170,000 low-income adults who would otherwise be eligible for public insurance programs are denied coverage solely because of their immigration status.

#441 *Medicare Buy-In Options: Estimating Coverage and Costs* (March 2001). John Sheils and Ying-Jun Chen, The Lewin Group, Inc. This paper examines the need for insurance expansions for Americans approaching retirement age and analyzes the probable impact of Medicare buy-in options on program costs and their effectiveness in reducing the numbers of uninsured.

Universal Coverage in the United States: Lessons from Experience of the 20th Century (March 2001). Karen Davis. *Journal of Urban Health: Bulletin of the New York Academy of Medicine,* vol. 78, no. 1.

Copies are available from the New York Academy of Medicine, 1216 Fifth Avenue, New York, NY 10029-5293.

#445 *Expanding Employment-Based Health Coverage: Lessons from Six State and Local Programs* (February 2001). Sharon Silow-Carroll, Emily K. Waldman, and Jack A. Meyer, Economic and Social Research Institute. As with publication **#424** (see below), this report describes the various ways states and local communities are making coverage more affordable and accessible to the working uninsured, but looks more closely at programs in six of the states discussed in the earlier report.

#444 *Creating a Seamless Health Insurance System for New York's Children* (January 2001). Melinda Dutton, Kimberley Chin, and Cheryl Hunter-Grant, Children's Defense Fund–New York. New York has recently brought Medicaid and Child Health Plus together, making the two programs more compatible. This paper takes a comprehensive look at both these programs in order to identify areas of continued programmatic disparity and explore ways to bridge differences.

#415 *Challenges and Options for Increasing the Number of Americans with Health Insurance* (January 2001). Sherry A. Glied, Joseph A. Mailman School of Public Health, Columbia University. This overview paper summarizes the 10 option papers written as part of the series *Strategies to Expand Health Insurance for Working Americans.*

#442 *Incremental Coverage Expansion Options: Detailed Table Summaries to Accompany Option Papers Commissioned by The Commonwealth Fund Task Force on the Future of Health Insurance* (January 2001). Sherry A. Glied and Danielle H. Ferry, Joseph L. Mailman School of Public Health, Columbia University. This paper, a companion to publication **#415,** presents a detailed side-by-side look at the 10 option papers in the series *Strategies to Expand Health Insurance for Working Americans.*

#459 *Betwixt and Between: Targeting Coverage Reforms to Those Approaching Medicare* (January/February 2001). Dennis G. Shea, Pamela Farley Short, and M. Paige Powell. *Health Affairs,* vol. 20, no. 1. The article examines whether eligibility for a Medicare buy-in should be based on age or ability to pay.

#439 *Patterns of Insurance Coverage Within Families with Children* (January/February 2001). Karla L. Hanson. *Health Affairs,* vol. 20, no. 1. Using the 1996 Medical Expenditure Panel Survey, this article examines patterns of health insurance within families with children, determining that 3.2 million families are uninsured and another 4.5 million families are only partially insured.

How a Changing Workforce Affects Employer-Sponsored Health Insurance (January/February 2001). Gregory Acs and Linda J. Blumberg. *Health Affairs,* vol. 20, no. 1. Copies are available from *Health Affairs,* 7500 Old Georgetown Road, Suite 600, Bethesda, MD 20814-6133, Tel: 301-656-7401 ext. 200, Fax: 301-654-2845, www.healthaffairs.org.

#425 *Barriers to Health Coverage for Hispanic Workers: Focus Group Findings* (December 2000). Michael Perry, Susan Kannel, and Enrique Castillo. This report, based on eight focus groups with 81 Hispanic workers of low to moderate income, finds that lack of opportunity and affordability are the chief obstacles to enrollment in employer-based health plans, the dominant source of health insurance for those under age 65.

#438 *A 2020 Vision for American Health Care* (December 11/25, 2000). Karen Davis, Cathy Schoen, and Stephen Schoenbaum. *Archives of Internal Medicine,* vol. 160, no. 22. The problem of nearly 43 million Americans without health insurance could be virtually eliminated in a single generation through a health plan based on universal, automatic coverage that allows choice of plan and provider. The proposal could be paid for, according to Fund President Davis and coauthors, by using the quarter of the federal budget surplus which results from savings in Medicare and Medicaid.

#435 *Emergency Department Use in New York City: A Survey of Bronx Patients* (November 2000). John Billings, Nina Parikh, and Tod Mijanovich, New York University. This issue brief, one of three produced from the authors' research, reveals that nearly three-quarters of patients who use New York City hospital emergency departments do so to get treatment for conditions that are either not emergencies or can be treated in a primary care setting.

#434 *Emergency Department Use: The New York Story* (November 2000). John Billings, Nina Parikh, and Tod Mijanovich, New York University. This issue brief, one of three produced from the authors' research, reveals that nearly three-quarters of patients who use New York City hospital emergency departments do so to get treatment for conditions that are either not emergencies or can be treated in a primary care setting.

#433 *Emergency Department Use in New York City: A Substitute for Primary Care?* (November 2000). John Billings, Nina Parikh, and Tod Mijanovich, New York University. This issue brief, one of three produced from the authors' research, reveals that nearly three-quarters of patients who use New York City hospital emergency departments do so to get treatment for conditions that are either not emergencies or can be treated in a primary care setting.

#424 *State and Local Initiatives to Enhance Health Coverage for the Working Uninsured* (November 2000). Sharon Silow-Carroll, Stephanie E. Anthony, and Jack A. Meyer, Economic and Social Research Institute. This report describes the various ways states and local communities are making coverage more affordable and accessible to the working uninsured, with a primary focus on programs that target employers and employees directly, but also on a sample of programs targeting a broader population.

Tracking Health Care Costs: Inflation Returns (November/December 2000). Christopher Hogan, Paul B. Ginsburg, and Jon R. Gabel. *Health Affairs,* vol. 19, no. 6. Copies are available from *Health Affairs,* 7500 Old Georgetown Road, Suite 600, Bethesda, MD 20814-6133, Tel: 301-656-7401 ext. 200, Fax: 301-654-2845, www.healthaffairs.org.

#411 *ERISA and State Health Care Access Initiatives: Opportunities and Obstacles* (October 2000). Patricia A. Butler. This study examines the potential of states to expand health coverage incrementally should the federal government decide to reform the Employee Retirement Income Security Act (ERISA) of 1974, which regulates employee benefit programs such as job-based health plans and contains a broad preemption clause that supersedes state laws that relate to private-sector, employer-sponsored plans.

Customizing Medicaid Managed Care—California Style (September/October 2000). Debra A. Draper and Marsha Gold. *Health Affairs,* vol. 19, no. 5. Copies are available from *Health Affairs,* 7500 Old Georgetown Road, Suite 600, Bethesda, MD 20814-6133, Tel: 301-656-7401 ext. 200, Fax: 301-654-2845, www.healthaffairs.org.

#392 *Disparities in Health Insurance and Access to Care for Residents Across U.S. Cities* (August 2000). E. Richard Brown, Roberta Wyn, and Stephanie Teleki. A new study of health insurance coverage in 85 U.S. metropolitan areas reveals that uninsured rates vary widely, from a low of 7 percent in Akron, Ohio, and Harrisburg, Pennsylvania, to a high of 37 percent in El Paso, Texas. High proportions of immigrants and low rates of employer-based health coverage correlate strongly with high uninsured rates in urban populations.

Inadequate Health Insurance: Costs and Consequences (August 11, 2000). Karen Donelan, Catherine M. DesRoches, and Cathy Schoen. *Medscape General Medicine.* Available online at www.medscape.com/ Medscape/GeneralMedicine/journal/public/mgm.journal.html.

#405 *Counting on Medicare: Perspectives and Concerns of Americans Ages 50 to 70* (July 2000). Cathy Schoen, Elisabeth Simantov, Lisa Duchon, and Karen Davis. This summary report, based on The Commonwealth Fund 1999 Health Care Survey of Adults Ages 50 to 70, reveals that those nearing the age of Medicare eligibility and those who recently enrolled in the program place high value on Medicare. At the same time, many people in this age group are struggling to pay for prescription drugs, which Medicare doesn't cover.

#406 *Counting on Medicare: Perspectives and Concerns of Americans Ages 50 to 70* (July 2000). Cathy Schoen, Elisabeth Simantov, Lisa Duchon, and Karen Davis. This full report of findings from The Commonwealth Fund 1999 Health Care Survey of Adults Ages 50 to 70 reveals that those nearing the age of Medicare eligibility and those who recently enrolled in the program place high value on Medicare. At the same time, many people in this age group are struggling to pay for prescription drugs, which Medicare doesn't cover.

#391 *On Their Own: Young Adults Living Without Health Insurance* (May 2000). Kevin Quinn, Cathy Schoen, and Louisa Buatti. Based on The Commonwealth Fund 1999 National Survey of Workers' Health Insurance and Task Force analysis of the March 1999 Current Population Survey, this report shows that young adults ages 19–29 are twice as likely to be uninsured as children or older adults.

#378 *Using Community Groups and Student Volunteers to Enroll Uninsured Children in Medicaid and Child Health Plus* (March 2000). Melinda Dutton, Sarah Katz, and Alison Pennington, Children's Defense Fund–New York. In this field report, the authors evaluate two innovative models for enrolling uninsured New York children into Medicaid or Child Health Plus.

#372 *The Role of WIC Centers and Small Businesses in Enrolling Uninsured Children in Medicaid and Child Health Plus* (March 2000). Inez Sieben, Terry J. Rosenberg, and Yoly Bazile, Medical and Health Research Association of New York City, Inc. In this field report, the authors evaluate two innovative models for enrolling uninsured New York children into Medicaid or Child Health Plus.

#370 *Working Without Benefits: The Health Insurance Crisis Confronting Hispanic Americans* (March 2000). Kevin Quinn, Abt Associates, Inc. Using data from the March 1999 Current Population Survey and The Commonwealth Fund 1999 National Survey of Workers' Health Insurance, this report examines reasons why 9 million of the country's 11 million uninsured Hispanics are in working families, and the effect that lack has on the Hispanic community.

#369 *Five Boroughs, Common Problems: Health Care in New York City* (February 2000). David Sandman and Elisabeth Simantov. This fact sheet summarizes, by New York City borough, the number of uninsured, the rates of Medicaid coverage, demographic characteristics, and access to health care.

#361 *Listening to Workers: Challenges for Employer-Sponsored Coverage in the 21st Century* (January 2000). Lisa Duchon, Cathy Schoen, Elisabeth Simantov, Karen Davis, and Christina An. Based on The Commonwealth Fund 1999 National Survey of Workers' Health Insurance, this short report shows that although most working Americans with employer-sponsored health insurance are satisfied with their plans, too many middle- and low-income workers cannot afford health coverage or are not offered it.

#362 *Listening to Workers: Findings from The Commonwealth Fund 1999 National Survey of Workers' Health Insurance* (January 2000). Lisa Duchon, Cathy Schoen, Elisabeth Simantov, Karen Davis, and Christina An. This full-length analysis of the Fund's survey of more than 5,000 working-age Americans finds that half of all respondents would like employers to continue serving as the main

source of coverage for the working population. However, sharp disparities exist in the availability of employer-based coverage: one-third of middle- and low-income adults who work full time are uninsured.

#364 *Risks for Midlife Americans: Getting Sick, Becoming Disabled, or Losing a Job and Health Coverage* (January 2000). John Budetti, Cathy Schoen, Elisabeth Simantov, and Janet Shikles. This short report derived from The Commonwealth Fund 1999 National Survey of Workers' Health Insurance highlights the vulnerability of millions of midlife Americans to losing their job-based coverage in the face of heightened risk for chronic disease, disability, or loss of employment.

#349 *Health Care in New York City: Understanding and Shaping Change* (September 1999). David R. Sandman. This issue brief highlights Fund programs that have been implemented to protect health care access for New York City residents—especially its low-income citizens—in the face of rising uninsurance, the move to mandatory Medicaid managed care enrollment, and the increasing strain on the city's safety net providers and academic health centers.

#347 *Can't Afford to Get Sick: A Reality for Millions of Working Americans* (September 1999). John Budetti, Lisa Duchon, Cathy Schoen, and Janet Shikles. This report from The Commonwealth Fund 1999 National Survey of Workers' Health Insurance finds that millions of working Americans are struggling to get the health care they need because they lack insurance or experience gaps in coverage.

#340 *A New Opportunity to Provide Health Care Coverage for New York's Low-Income Families* (July 1999). Jocelyn Guyer and Cindy Mann, Center on Budget and Policy Priorities. The authors show how New York could make a substantial dent in its number of uninsured working adults if it took advantage of a little-known legislative opportunity and raised the income eligibility level for subsidized health insurance.

#305 *Insuring the Children of New York City's Low-Income Families: Focus Group Findings on Barriers to Enrollment in Medicaid and Child Health Plus* (December 1998). Peter Feld, Courtney Matlock, and David R. Sandman. This qualitative study sheds light on why a large majority of New York City children who are eligible for Medicaid and New York State's Child Health Plus (CHP) program remain uninsured, even as the state is set to expand coverage to many more low-income families. The report reveals that parents face serious obstacles to getting their children on Medicaid and keeping them on, and have minimal awareness of CHP.

#274 *New York City's Children: Uninsured and at Risk* (May 1998). Cathy Schoen and Catherine DesRoches. This report, based on *The Commonwealth Fund Survey of Health Care in New York City,* finds that children living in New York City are more likely to be uninsured than children in other areas, and that children in low-wage working families are particularly at risk.

#264 *The Commonwealth Fund Survey of Health Care in New York City* (March 1998). David R. Sandman, Cathy Schoen, Catherine DesRoches, and Meron Makonnen. This survey of more than 4,000 New York City residents, conducted by Louis Harris and Associates, Inc., found that a New Yorker was 50 percent more likely to be uninsured than the average American, that the vast majority of the City's uninsured live in working families and have low incomes, and that the City's public hospitals, emergency rooms, and clinics provide an important safety net for the uninsured.