COMMISSION ON A HIGH PERFORMANCE HEALTH SYSTEM

WORKERS' HEALTH INSURANCE: TRENDS, ISSUES, AND OPTIONS TO EXPAND COVERAGE

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ABSTRACT: In recent years, employer-sponsored health insurance has been eroding. An increasing number of working adults are without health insurance coverage, and forecasts indicate continuing declines in coverage. To reverse these trends and expand coverage for workers and their families, a range of public and private policy options are under discussion. The approaches vary in the extent to which they would build on the employment-based system, adapt the non-group or individual market, or expand public programs. Many health coverage expansion policies would combine public and private approaches. Proposals in the 109th Congress address four major options: expansion of tax credits; creation of new federal–state roles in regulating insurance markets; expansion of purchasing options for small firms; and expansion of public programs for the under-65 population.

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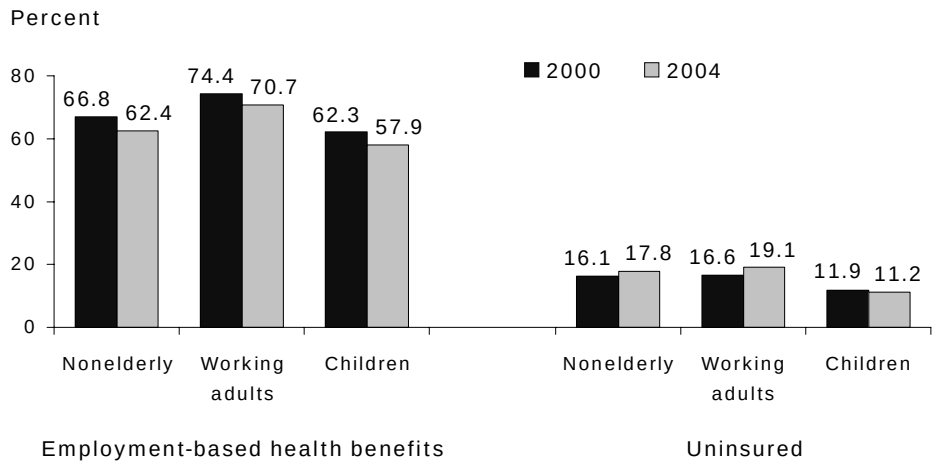
INTRODUCTION

Since World War II, employment-based health benefits have been the foundation of health insurance for the under-65 population, providing the primary source of coverage for the vast majority of workers and their dependents. In 2004, more than 100 million workers, or 71 percent of the adult working population, were covered by employment-based health benefits.[1] Taking into account all adults under age 65, the employment-based health benefits system covered 159.1 million individuals, or 62 percent of the nonelderly population (Figure 1).

Figure 1. Working Adults Account for Growth in Uninsured, But Erosion of Employment-Based Health Benefits Felt by All



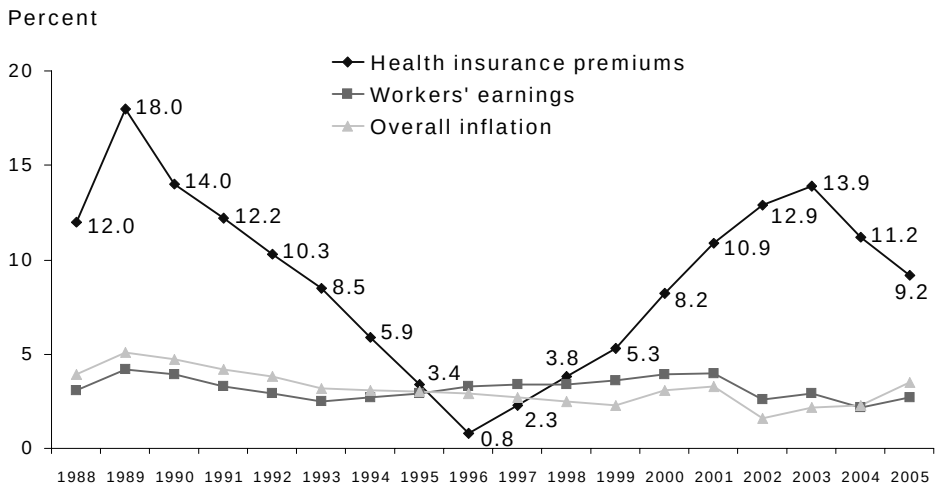
Source: Employee Benefit Research Institute estimates from the March 2000 and March 2005 Current Population Surveys.

In recent years, this foundation has been eroding, resulting in an increasing number of working adults without health insurance coverage and forecasts of continuing declines in coverage. The growing share of the workforce without health insurance has negative implications for individuals and the larger economy. The Institute of Medicine (IOM) conducted a series of studies on the consequences of uninsurance and found the following:[2]

- Compared with the insured, uninsured adults and children are in worse health and die sooner. The IOM concluded that being uninsured was the sixth-leading cause of death among adults ages 25 to 64 in 1999.
- High rates of uninsurance are associated with financial instability for health care providers and institutions at the community level, including reduced hospital services and capacity as well as significant cuts in public health programs that may affect access to health care services, even among insured individuals.
- The nation is at an economic disadvantage as a result of the poorer health and premature death of uninsured individuals. The IOM estimates that the lost economic value due to the uninsured is between $65 billion and $135 billion annually.

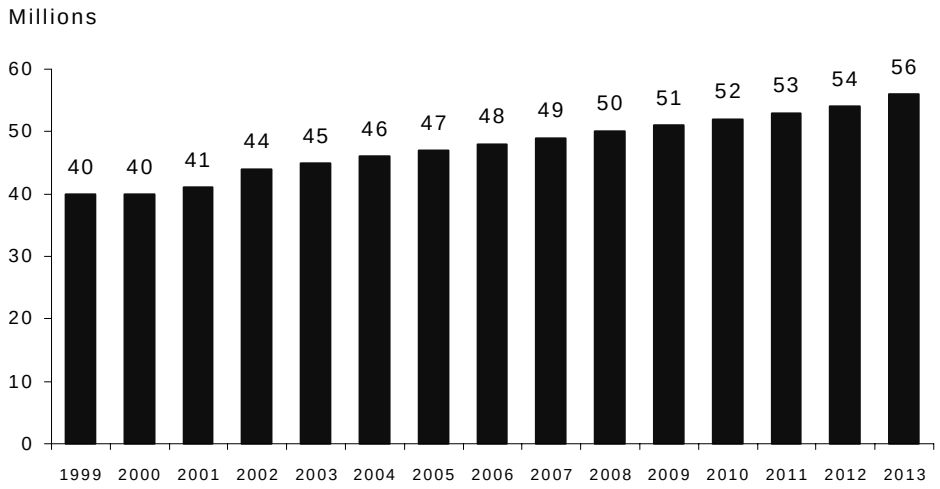
Trends in employment-based health benefits are driven in part by the rising cost of providing health benefits relative to worker earnings and overall inflation (Figure 2). The rapid increase in the cost of providing health benefits relative to income has led to a drop in the percentage of employers offering health benefits as well as a decline in the percentage of workers who are eligible to participate. A recent study predicts that if premium increases continue to outpace wage and income growth, the number of uninsured will reach 56 million individuals in 2013, or 20.5 percent of the under-65 population (Figure 3).[3] The same study estimates that 27.8 percent of workers—or more than one of four—will be uninsured by 2013.

Figure 2. Increases in Health Insurance Premiums Compared with Other Indicators, 1988–2005



Source: Henry J. Kaiser Family Foundation, KFF/HRET Employer Health Benefits: Annual Survey (1988–2005).

Figure 3. Number of Uninsured Individuals in the United States, 1999–2013



Source: T. Gilmer and R. Kronick, "It's the Premiums, Stupid: Projections of the Uninsured Through 2013," Health Affairs Web Exclusive (Apr. 5, 2005):W5-143–W5-151, available at http://content.healthaffairs.org/cgi/content/abstract/hlthaff.w5.143v1.

To reverse these trends and expand coverage for workers and their families, a range of public and private policies are under discussion. The approaches vary in the extent to which they would build on the employment-based system, adapt the non-group or individual market, or expand public programs. This report highlights recent trends in employment-based health benefits and compares an array of policy approaches that seek to expand coverage.

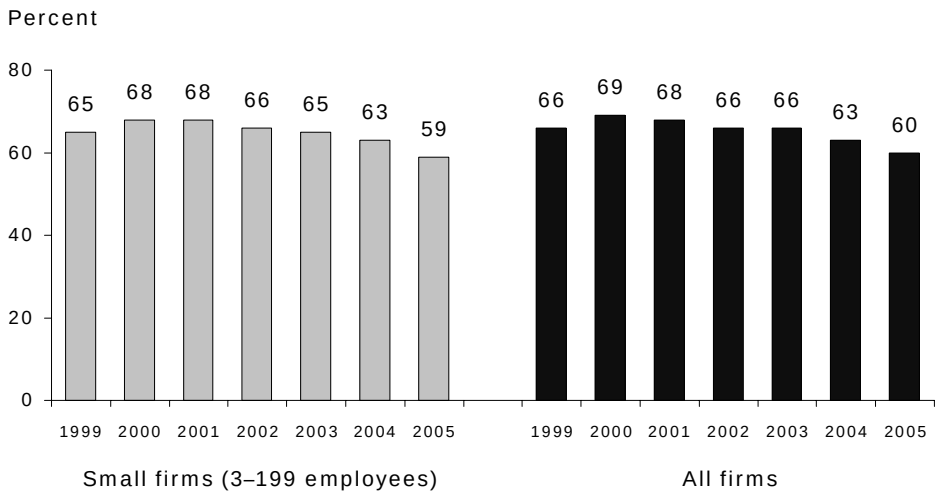
TRENDS IN COVERAGE AND BENEFITS

Although employment-based health benefits remain the most common form of health insurance, eligibility for these benefits has changed, as have the kinds of benefits offered. Workers covered by health benefits have experienced premium increases and increased cost-sharing. Currently active workers are much less likely to qualify for retiree health benefits than their retired counterparts.[4] Double-digit premium increases have fueled the spread of new benefit designs known as "consumer-driven" health plans, characterized by high deductibles and patient cost-sharing at the point of service.[5]

The percentage of employers offering health benefits has been falling since 2000, a decline that is particularly acute among smaller employers. In 2005, 60 percent of all employers offered health benefits, down from 69 percent in 2000.[6] By 2005, only 59 percent of small employers (i.e., firms with fewer than 200 employees) offered health benefits to their employees (Figure 4). As a result, the percentage of workers offered

health benefits declined from 65 percent in 2001 to 60 percent in 2005, with most of that decline occurring among workers in small firms.

Figure 4. Percentage of Employers Offering Health Benefits, Small Firms and All Firms, 1999–2005



Source: Henry J. Kaiser Family Foundation, KFF/HRET Employer Health Benefits Annual Survey (1999–2005). See charts 9 and 10 in http://www.kff.org/insurance/7315/sections/upload/7375.pdf.

When offered coverage, the vast majority of employees participate. Data from 2002 indicate that only 15.2 percent of uninsured workers were eligible for health benefits from their own employers.[7] The majority (two-thirds) of uninsured workers eligible for health benefits in 2002 reported that they declined coverage because of cost. Another 19 percent of uninsured workers were employed by firms that offered health benefits to some workers but were themselves ineligible. Among uninsured workers who were not eligible for employee benefits, most either did not work enough hours or weeks (44.4%) or had not yet completed the waiting period for benefits (41.8%).

Who Has Coverage and Who Does Not

The likelihood of having employee benefits and of being uninsured varies widely among economic sectors and worker groups. In general, low-wage, minority workers (especially Hispanics) and workers employed in small firms are least likely to have employee benefits and most likely to be uninsured (Table 1). Jobs in service sector industries are less likely than jobs in the manufacturing or public sectors to provide health benefits.[8] Although nearly all large firms offer benefits to at least some employees, a recent study found an increase in the percent of uninsured workers employed by large firms. This increase was concentrated among lower-wage workers employed by large service sector and retail firms.[9]

Table 1. Percentage of Workers with Employment-Based Health Benefits or Uninsured, by Selected Job and Worker Characteristics, 2004

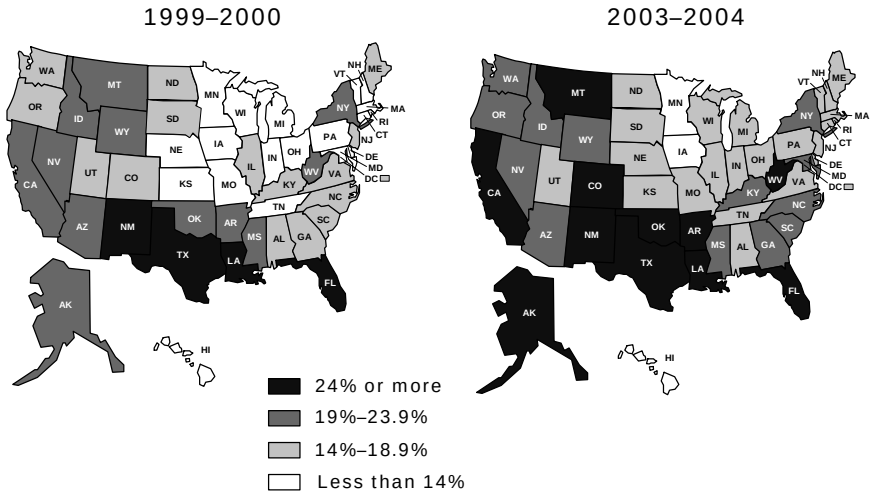
	Employment-Based Coverage			
	Total	**Own Name**	**Dependent**	**Uninsured**
Total	70.7%	54.0%	16.7%	19.1%
Firm Size				
Self-employed	49.6	24.2	25.4	27.0
Public sector	87.4	74.4	13.0	6.9
Private sector	70.2	53.8	16.3	20.5
Under 25	52.9	32.2	20.6	33.0
25–499	73.4	57.6	15.8	18.6
500 or more	79.2	65.2	14.0	13.7
Industry				
Manufacturing	79.7	68.5	11.2	14.4
Personal services	63.9	42.4	21.5	23.2
Annual Earnings				
Under $20,000	48.4	23.8	24.6	33.2
$20,000–$39,999	75.4	61.5	13.9	17.9
$40,000 or more	88.3	76.7	11.6	6.3
Hours Worked				
Full-time	74.1	61.5	12.7	17.9
Part-time	54.4	18.6	35.8	25.1
Race				
White	75.6	56.5	19.1	14.3
Black	65.5	55.1	10.4	23.4
Hispanic	50.1	40.3	9.8	40.4
Union Status				
Member	95.4	86.0	9.4	2.5
Non-member	77.8	59.5	18.3	15.0

Sources: P. Fronstin, *Sources of Coverage and Characteristics of the Uninsured: Analysis of the March 2005 Current Population Survey,* EBRI Issue Brief no. 287 (Washington, D.C.: Employee Benefit Research Institute, 2005); P. Fronstin, *Union Status and Employment-Based Health Benefits,* EBRI Notes 26(5) (Washington, D.C.: Employee Benefit Research Institute, 2005); and author estimates of the March 2005 Current Population Survey.

Wide Variation Among States

The proportion of uninsured individuals varies considerably across the 50 states—a result of varying levels of employment-based health insurance and varying criteria for eligibility for publicly financed coverage programs. Furthermore, the erosion in coverage has been spreading across the country. A comparison of uninsured rates for 2003–2004 with 1999–2000 reveals a sharp increase in the number of states with more than 19 percent of its population uninsured and a decline in the number of states with an uninsured population of less than 14 percent (Figure 5). This increase largely reflects rising rates of uninsured adults ages 18 to 64 in 11 states, 24 percent or more of adults were uninsured as of 2003–04.[10]

Figure 5. Percent of Adults Ages 18–64 Uninsured by State

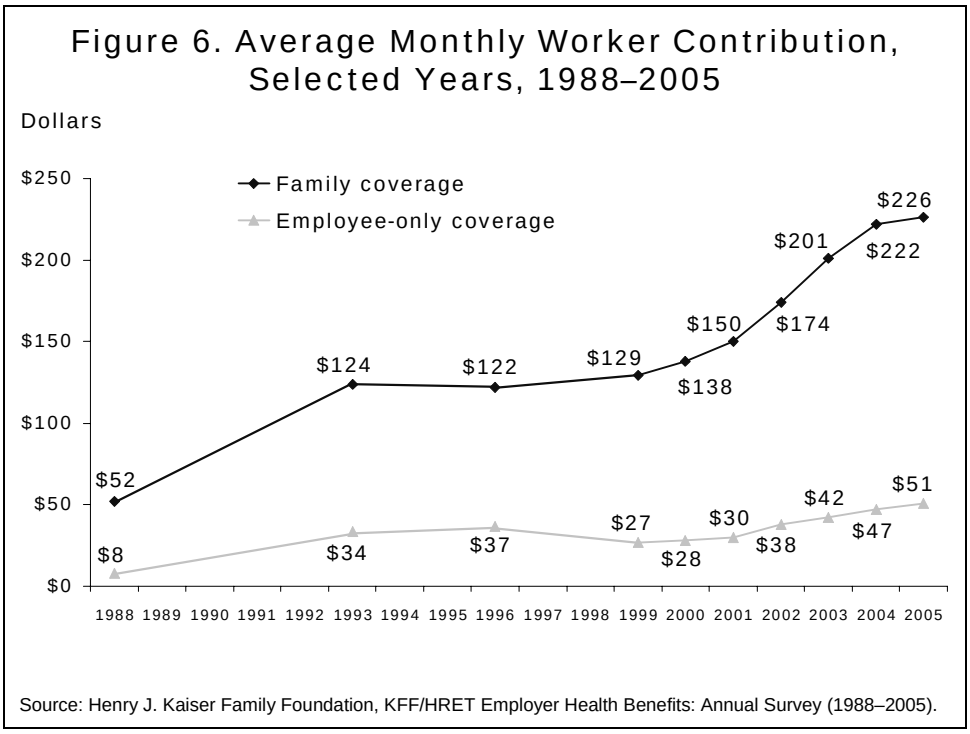


Source: Two-year averages 1999–2000 and 2003–2004 from the Census Bureau's March 2000, 2001 and 2004, 2005 Current Population Surveys. Estimates by the Employee Benefit Research Institute.

Higher Premiums and Cost-Sharing

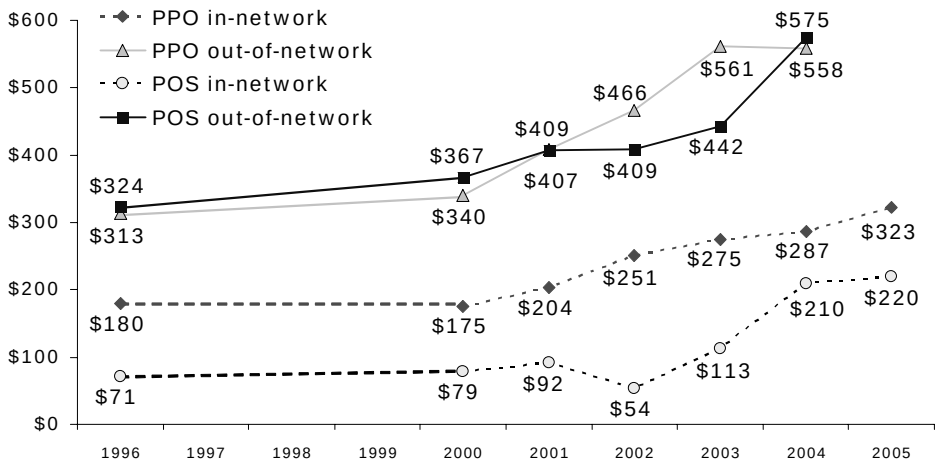
In addition to affecting coverage rates, double-digit increases in health insurance costs have led to higher monthly premiums and greater cost-sharing for employees. Both of these trends have increased the health costs faced by employees and their families.

Worker contributions to premiums have nearly doubled since the late 1990s—rising from an average of $27 per month for employee-only coverage and $129 per month for family coverage in 1999 to $51 per month for employee-only coverage and $226 per month for family coverage by 2005 (Figure 6).[11] This reflects the overall increase in premium rates, rather than higher proportions of premiums paid by employees: to date, the percentage of premiums that workers pay has remained in the range of 14 and 16 percent for employee-only coverage and 26 and 28 percent for family coverage.



During this same period, there has been a trend toward higher employee cost-sharing, including sharply higher deductibles and copayments for physician visits and prescriptions. Employers also have introduced more complex benefit structures, with differential cost-sharing for hospitals, doctors, and other services. Deductibles have increased significantly across different types of health plans, including increases for in-network and out-of-network providers (Figure 7).[12] Between 2000 and 2005, in-network deductibles in preferred provider organizations (PPOs) rose from $175 to $323, nearly doubling. Deductibles for using out-of-network providers also jumped, with rates considerably higher than deductibles for in-network providers. By 2004, the PPO deductible for out-of-network providers was $558 and $575 for point-of-service(POS) plans.[13]

Figure 7. Average Annual Deductibles for Employee-Only Coverage, Selected Years, 1996–2005



Source: Henry J. Kaiser Family Foundation, KFF/HRET Employer Health Benefits: Annual Survey (1996–2005).

Copayments for physician office visits and prescription drugs have increased, as have health plans' use of financial incentives to encourage patients to visit network providers. Tiered medication cost-sharing—based on drug class, generic status, brand name, mail-order availability, and other formulary arrangements—also has become more common. Some employment-based health plans now include tiered hospital networks, which mean patient cost-sharing varies with choice of hospital.[14]

For the most part, employment-based health plans rarely vary benefit designs to account for employee income. As a result, across-the-board increases in cost-sharing put low-income workers and their families at greater financial risk than higher-income workers. To the extent that lower-income workers also face a higher incidence of health problems and chronic diseases, they will be doubly at risk for high health costs relative to family income. In 2002, among workers with employment-based health benefits during the entire calendar year, those with annual incomes below $10,000 spent 34 percent of their income on out-of-pocket health care costs, while those with income at or above $50,000 spent just 4 percent on health care.[15]

The erosion in employer-sponsored coverage means that more workers are having problems paying their medical bills and more are accruing medical debt. Such financial troubles limit these workers' access to health services. A recent study found that two-thirds of people with a medical bill or medical debt problem went without needed care because

of cost. This compares to about 20 percent of individuals without medical bill or medical debt problems forgoing needed care because of cost.[16] Other studies have found that significant cost-sharing substantially reduces the use of all types of services, including preventive care, care for chronic conditions, and trauma-related care.[17] Cost-sharing tends to be a blunt instrument that does not selectively reduce inappropriate or ineffective use of health care services any more or less than it affects appropriate and effective utilization.[18]

PROPOSALS TO EXPAND HEALTH INSURANCE COVERAGE

With an estimated one of five working-age adults uninsured—the vast majority in low-income families—providing affordable coverage that meets families' health care needs is a great challenge. A range of federal policy approaches would attempt to expand coverage among the working population or stabilize employment-based coverage by making it more affordable to employees and employers. These approaches vary in the extent to which they target employees and employers; build on employment-based group coverage or public programs, including new public-private options; or look to the nongroup, individual market to expand coverage. They also vary in the extent to which they seek to make coverage more affordable by providing premium support, using reinsurance, or moving toward catastrophic health insurance plans with reduced coverage and increased patient cost-sharing.

Tax Credits

The Bush Administration has proposed making tax credits available for individuals to purchase high deductible health insurance. Such tax credits would be refundable, so that individuals who pay no or low taxes would be eligible for the full credit, and advanceable, so that funds would be available to pay premiums before annual tax filing. Tax credits could be used by workers or others who lack access to health insurance to purchase individual insurance, to pay premiums for workers who are in between jobs, or to help defray the costs of enrolling in employer, public, or other group insurance pools. Proposed credits typically target people with low or moderate incomes and phase out as income rises.

There are three key questions about tax credit policies: Who should be eligible? What size should the credits be? And what types of health plans should qualify? In one study, researchers concluded that small credits would "do little to reduce the number of uninsured but that credits covering half of the premium...may have a significant effect."[19] Recent estimates of the Administration's proposal to provide credits of up to $1,000 for individual coverage and up to $3,000 for a family of four found that credits in this range would reduce the overall U.S. uninsured rate by 1.7 percentage points. The proposed small firm tax credits would have even less of an impact.[20] The Congressional Budget

Office has also concluded that modest subsidies would only have a small effect on the nation's percentage of uninsured.[21] Even the recently enacted Health Coverage Tax Credit program for unemployed workers (part of the Trade Act of 2002, P.L. 107-210), which pays 65 percent of premiums of qualified coverage, has experienced very low take-up rates. Observers of various state programs believe that most eligible individuals fail to enroll in this program because they are unable to pay the 35 percent premium share.[22]

Reinsurance

Reinsurance—or insurance for insurers and for employers with self-insured plans—has been proposed as a way to make insurance more affordable and expand coverage. A government-backed reinsurance program would assume responsibility for the bulk of high-end claims (i.e., health care expenses above a given threshold). This would mean that insurers and employers would not have to bear the full risk for aggregate or individual expenses that exceed some predetermined level. Like tax credits, a reinsurance program aims to lower the costs of health insurance premiums.

As of 2004, several states had made reinsurance part of their efforts to stabilize or expand individual, small firm, or other group insurance coverage for working populations.[23] A recent examination of the reinsurance plans offered to low-income individuals and small, low-wage firms in New York found that premiums were between 15 and 30 percent lower than comparable policies. During the second year of the reinsurance program, premiums declined another 6 percent.[24]

Health Savings Accounts

Individuals can pay for health care services on a tax-preferred basis through health savings accounts (HSAs). Individuals with certain high-deductible health plans (HDHPs) can contribute to HSAs on a tax-free basis. Once established, funds in HSAs can build up tax-free, and distributions are also tax-free as long as they are used for qualified medical expenses and certain premiums. Premiums for HSA-based plans are generally lower than other, more comprehensive health plans because of their high deductibles.

Proposals have been made to expand the use of HSAs by allowing individuals who purchase HSA-based plans in the non-group market to deduct the full premiums from taxable income, and by providing tax incentives (such as tax credits) to individuals and small businesses to take-up HSA-based plans. The availability of HSAs may expand health insurance coverage if previously uninsured individuals value such plans, and if the lower premiums (with or without the tax credits) make insurance more affordable. Recent estimates, however, indicate that HSAs would have a minimal net impact on the overall

rate of uninsured.[25] In addition, early evidence suggests that individuals with HDHPs and HSAs are significantly more likely to avoid, skip, or delay health care because of costs than are individuals with more comprehensive health insurance.[26]

Association Health Plans

Federal legislation designed to promote the formation of association health plans (AHPs) seeks to encourage small businesses to band together to offer health insurance without having to comply with state regulations. The goal of AHPs is to lower the cost of providing health insurance by allowing broad flexibility in benefit design, financial reserves, and eligibility terms. To the extent that their premiums would be low, AHPs are a possible means to expand the net number of people covered. The Congressional Budget Office has estimated that by 2010, about 620,000 more people would be insured through small employers offering AHPs.[27] Other research has found that multiple employer welfare arrangements (MEWAs), one form of AHP, have a long history marred by financial instability and even fraud. Due to licensing requirements that are often less stringent than those imposed on traditional insurers, MEWAs are at far greater risk of becoming insolvent when claims suddenly or unexpectedly exceed their ability to pay them.[28]

Insurer Competition Across State Lines

Recent congressional proposals have sought to override state regulations governing health insurance to enable groups and individuals to purchase coverage across state lines. Insurance purchased out of state would be exempt from the laws and regulations of the purchaser's state with respect to consumer protections, mandated coverage of services or benefits, and other rules affecting the offer, sale, rating (including medical underwriting and financial reserves), renewal, and issuance of individual health insurance coverage. After weighing the offsetting effects, the U.S. Congressional Budget Office recently estimated a small net increase in the number of covered individuals under such a proposal.[29]

State High-Risk Pools

State high-risk pools serve as a safety net for individuals who are unable to purchase health insurance coverage in the private market due to their preexisting conditions. Thirty-two states operate high-risk pools, collectively providing coverage for about 180,000 individuals. These pools provide a safety net for some individuals with high health risks and can reduce reliance on Medicaid programs in these states.

To date, however, limited funding has meant that some states had caps or waiting lists to restrict eligibility and stay within budget. High-risk pools often apply waiting periods for those who qualify before benefits begin or for preexisting conditions.[30]

Premiums in high-risk pools tend to be high, and they often have considerable front-end deductibles. As a result, many eligible individuals find that they cannot afford the premiums, which can be as high as 150 percent of the average for comparable plans. A number of studies have found that enrollment in high-risk pools could be expanded significantly if premiums were more affordable.[31] Expansions of high-risk pools to the uninsured with acute or chronic health problems would require additional funding targeted at reducing premiums. The Trade Adjustment Assistance Act included funds for high-risk pools; a study of this legislation found that federal guidelines are needed to tie funding to state efforts to expand coverage.[32]

Expansion of Public Programs

Public programs can be expanded in a number of ways to cover more workers and their families.[33] Currently, most state public insurance programs set very low income thresholds for adults, so that childless adults rarely qualify for public insurance unless they are disabled or age 65 or older.

The most direct way to expand public programs would be for the federal government to provide matching funds to states, permitting them to raise the income eligibility limits on public programs. This would, for example, enable poor or near-poor working parents or childless adults to quality for full or partial coverage through Medicaid, the State Children's Health Insurance Program (SCHIP), or new insurance options built on these programs. Parents of SCHIP-enrolled children could be allowed into Medicaid or SCHIP. Workers could be allowed to buy into public programs such as Medicaid, Medicare, the Federal Employees Health Benefits Program (FEHBP), or SCHIP. Alternatively, public funds could be used to subsidize employment-based premiums.

Recently, several states have developed innovative insurance expansion strategies that combine public and private approaches. For example, Maine's Dirigo program offers a new, privately insured group option and integrates the choices of coverage with publicly supported insurance.[34] Rhode Island has expanded public insurance options to low-income working adults and families through RIte Care and, at the same time, created the RIte Share program, which provides premium support for workers participating in coverage offered by their employers.[35] States that have included provisions to help low-income workers participate in employer plans indicate that such efforts have helped to stabilize coverage.[36] Illinois, Massachusetts, Minnesota, Washington, and other states have sought to stabilize existing job-based benefits while expanding options for low-wage workers and firms.[37] Several states are considering support of health insurance purchasing cooperatives.

Public program expansions face several challenges. These include identifying sources of financing to support and maintain expansions; maximizing employer participation and contributions; and designing buy-in arrangements for employees or employers that avoid complexity and administrative hurdles.

FEDERAL PROPOSALS

At the federal level, a range of legislative proposals exist that would build on existing state or federal public insurance programs or create public–private group options. Proposals in the 109th Congress address four major options: expansion of tax credits; creation of new federal–state roles in regulating insurance markets; expansion of purchasing options for small firms; and expansion of public programs for the under-65 population.

Expansion of tax credits:

- Expand tax deduction for health insurance premiums to all taxpayers, including the self-employed.
- Provide tax credits to low-income individuals and families for the purchase of health insurance premiums. Some proposals would make refundable tax credits broadly available. Others would link credits to HSA-based, high-deductible plans.
- Offer small businesses tax credits to encourage them to provide employee health benefits, including credits for contribution to employee HSAs.
- Expand the Trade Adjustment Assistance credits to cover a higher share of the premium for high-risk pools, with the option for eligible parties to participate in FEHBP. Other Trade Adjustment Assistance proposals would expand the industries qualifying for assistance.

Creation of federal–state roles in regulating insurance markets:

- Enact new federal insurance rules to promote formation of small employer association health plans. Proposals vary in specifying federal–state roles.
- New federal regulations to enable insurance sales across state borders, overriding state-specific insurance regulations.
- Federal grants to create and support state high-risk pools.
- Funding support for state-based reinsurance arrangements for private coverage.

Expansion of purchasing options for small firms:

- Federal creation of small-group purchasing pools, with premium assistance for employees with incomes below 200 percent of poverty.
- Issue grants to states to plan, develop, and help start small-group purchasing pools. Proposals include grants to help establish health care purchasing cooperatives.
- New federal options to allow small businesses or the self-employed to buy coverage through a new, non-federal employee group insurance program sponsored by FEHBP, with reinsurance of health plans.

Expansion of public program options for the under-65 adult population:

- Proposals to expand Medicare to disabled and early retirees under age 65:
  - Allowing adults ages 55 to 64 to purchase insurance through Medicare.
  - Eliminating the two-year waiting period for Medicare for the disabled.
- Federal options to expand Medicaid/SCHIP to low-income parents; options to expand state programs to all up to poverty level.
- Issue grants to states to develop state systems to provide universal insurance.

NOTES

[1] P. Fronstin, *Sources of Coverage and Characteristics of the Uninsured: Analysis of the March 2005 Current Population Survey,* EBRI Issue Brief no. 287 (Washington, D.C.: Employee Benefit Research Institute, 2005).

[2] See summary of findings at http://covertheuninsuredweek.org/factsheets/display.php?FactSheetID=115. Full studies can be found at http://www.iom.edu/project.asp?id=4660.

[3] T. Gilmer and R. Kronick, "It's The Premiums, Stupid: Projections of The Uninsured Through 2013," *Health Affairs* Web Exclusive, April 5, 2005. http://content.healthaffairs.org/cgi/content/abstract/hlthaff.w5.143v1.

[4] P. Fronstin, *The Impact of the Erosion of Retiree Health Benefits on Workers and Retirees,* EBRI Issue Brief no. 279 (Washington, D.C.: Employee Benefit Research Institute, 2005).

[5] J. R. Gabel et al., "Employers' Contradictory Views About Consumer-Driven Health Care: Results from a National Survey," *Health Affairs* Web Exclusive, April 21, 2004. http://content.healthaffairs.org/cgi/content/abstract/hlthaff.w4.210.

[6] Henry J. Kaiser Family Foundation, Employer Health Benefits 2005 Annual Survey. http://www.kff.org/insurance/7315/index.cfm.

[7] P. Fronstin, *Employer-Based Health Benefits: Trends in Access and Coverage,* EBRI Issue Brief no. 284 (Washington, D.C.: Employee Benefit Research Institute, 2005).

[8] Fronstin, *Sources of Coverage,* 2005.

[9] S. Glied, J. Lambrew, and S. Little, *The Growing Share of Uninsured Workers Employed by Large Firms* (New York: The Commonwealth Fund, Oct. 2003). http://www.cmwf.org/publications/publications_show.htm?doc_id=221335.

[10] The Census Bureau recommends the use of two-year averages when examining differences in health insurance coverage by state.

[11] Henry J. Kaiser Family Foundation, Employer Health Benefits 2005 Annual Survey. http://www.kff.org/insurance/7315/index.cfm.

[12] Ibid.

[13] J. Gabel et al., "Health Benefits in 2004: Four Years of Double-Digit Premium Increases Take Their Toll on Coverage," *Health Affairs* Sept./Oct. 2004 23(5):200–09.

[14] Currently, 19 percent of large employers use a tiered network for some combination of physician and hospital services, up from 11 percent in 2003. Within the 19 percent of those using a tiered network, 95 percent included primary care services, 94 percent included specialist services, and 93 percent included hospital services. Source: Mercer Human Resources Consulting, *National Survey of Employer-Sponsored Health Plans: 2004 Survey Report* (New York: Mercer Human Resources Consulting, 2004); and personal communication.

[15] Unpublished Employee Benefit Research Institute estimates from the 2002 Medical Expenditure Panel Survey. Note that these estimates are for personal income and do not take into account family income. The estimates also do not include the amount spent on premiums.

[16] M. M. Doty, J. N. Edwards, and A. L. Holmgren, *Seeing Red: Americans Driven into Debt by Medical Bills* (New York: The Commonwealth Fund, Aug. 2005). http://www.cmwf.org/publications/publications_show.htm?doc_id=290074.

[17] See, for example, C. Schoen et al., "Insured But Not Protected: How Many Adults Are Underinsured?" *Health Affairs* Web Exclusive, June 14, 2005. http://www.cmwf.org/publications/publications_show.htm?doc_id=280812. Besides finding that underinsured adults are more likely than individuals with adequate coverage to forgo needed care, the study determined that 16 millions adults ages 19 to 64 were underinsured in 2003.

[18] For a summary of the literature, see L. Tollen and R. M. Crane, *A Temporary Fix? Implications of the Move Away from Comprehensive Health Benefits,* EBRI Issue Brief no. 244 (Washington, DC: Employee Benefit Research Institute, 2002).

[19] M. Pauly and B. Herring, "Expanding Coverage via Tax Credits: Trade-Offs and Outcomes," *Health Affairs* Jan./Feb. 2001 20(1):9–26.

[20] S. Glied and D. Gould, "Variations in the Impact of Health Coverage Expansion Proposals Across States," *Health Affairs* Web Exclusive, June 7, 2005. http://www.cmwf.org/publications/publications_show.htm?doc_id=279903.

[21] U.S. Congressional Budget Office, "The Price Sensitivity of Demand for Nongroup Health Insurance" (August 2005). http://www.cbo.gov/ftpdocs/66xx/doc6620/08-24-HealthInsurance.pdf.

[22] S. Dorn, T. Alteras, and J. A. Meyer, *Early Implementation of the Health Coverage Tax Credit in Maryland, Michigan, and North Carolina: A Case Study Summary* (New York: The Commonwealth Fund, Apr. 2005). http://www.cmwf.org/publications/publications_show.htm?doc_id=271904.

[23] D. Chollet, *The Role of Reinsurance in State Efforts to Expand Coverage,* State Coverage Initiatives Issue Brief, vol. 5, no. 4, Oct. 2004.

[24] K. Swartz, *Reinsurance: How States Can Make Health Coverage More Affordable For Employers and Workers* (New York: The Commonwealth Fund, July 2005). http://www.cmwf.org/publications/publications_show.htm?doc_id=286904.

[25] S. A. Glied and D. K. Remler, *The Effect of Health Savings Accounts on Health Insurance Coverage* (New York: The Commonwealth Fund, Apr. 2005). http://www.cmwf.org/publications/publications_show.htm?doc_id=274002.

[26] P. Fronstin and S. Collins, *Early Experience with High-Deductible and Consumer-Driven Health Plans: Findings From the EBRI/Commonwealth Fund Consumerism in Health Care Survey,* EBRI Issue Brief no. 288 (Washington, D.C.: Employee Benefit Research Institute, 2005). http://www.cmwf.org/publications/publications_show.htm?doc_id=326359.

[27] U.S. Congressional Budget Office, "Cost Estimate of Small Business Health Fairness Act of 2005" (Apr. 8, 2005). http://www.cbo.gov/showdoc.cfm?index=6265&sequence=0.

[28] M. Kofman, E. Bangit, and K. Lucia, *MEWAs: The Threat of Plan Insolvency and Other Challenges* (New York: The Commonwealth Fund, Mar. 2004). http://www.cmwf.org/publications/publications_show.htm?doc_id=221575.

[29] U.S. Congressional Budget Office, "Cost Estimate of Health Care Choice Act of 2005" (Sept. 12, 2005). http://www.cahi.org/cahi_contents/issues/CBOreporthr2355.pdf.

[30] L. Achman and D. Chollet, *Insuring the Uninsurable: An Overview of State High-Risk Pools* (New York: The Commonwealth Fund, Aug. 2001). http://www.cmwf.org/publications/publications_show.htm?doc_id=221291.

[31] See citations in Communicating for Agriculture and the Self-Employed (CA), *Comprehensive Health Insurance for High-Risk Individuals: A State-by-State Analysis 2005/2006,* 19th ed. (Fergus Falls, Minn.: CA, 2005).

[32] K. Pollitz and E. Bangit, *Federal Aid to State High-Risk Pools: Promoting Health Insurance Coverage or Providing Fiscal Relief?* (New York: The Commonwealth Fund, Nov. 2005). http://www.cmwf.org/publications/publications_show.htm?doc_id=323089.

[33] S. Glied and D. Gould, 2005; and E. C. Strumpf and J. Cubanski, *Options for Federal Coverage of the Uninsured in 2005* (New York: The Commonwealth Fund, July 2005). http://www.cmwf.org/publications/publications_show.htm?doc_id=289862.

[34] J. Rosenthal and C. Pernice, *Designing Maine's DirigoChoice Benefit Plan* (New York: The Commonwealth Fund, Dec. 2004). http://www.cmwf.org/publications/publications_show.htm?doc_id=253634.

[35] S. Silow-Carroll, E. Waldman, J. Meyer et al., *Assessing State Strategies for Health Coverage Expansion: Case Studies of Oregon, Rhode Island, New Jersey, and Georgia* (New York: The Commonwealth Fund, Feb. 2003), http://www.cmwf.org/publications/publications_show.htm?doc_id=229421; and Rhode Island Department of Human Services, *Rhode Island RIte Care and RIte Share Fact Sheet,* Apr. 2005, http://www.dhs.state.ri.us/dhs/reports/rc_rs_fact_sheet_eng.pdf.

[36] S. K. Long, S. Zuckerman, and J. A. Graves, "Are Adults Benefiting from State Coverage Expansions?" *Health Affairs* Web Exclusive, Jan. 17, 2006, http://content.healthaffairs.org/cgi/reprint/hlthaff.25.w1v1.pdf.

[37] S. Dorn et al., *Medicaid and Other Programs for Childless Low Income Adults: Overview of Coverage in Eight States,* Kaiser Commission on Medicaid and the Uninsured (Washington, D.C.: Henry J. Kaiser Family Foundation, 2006); and A. Weil, *Can Medicaid Do More with Less?* (New York: The Commonwealth Fund, Mar. 2006). http://www.cmwf.org/publications/publications_show.htm?doc_id=362793.

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