The Future of Employer-Based Health Plans

Background Information
for

THE POLICY FORUM
On Friday March 24, 2000
9:00 AM – 1:00 PM
The War Memorial
Trenton, New Jersey

Sponsored by
The Forums Institute for Public Policy

Underwritten by a grant from
THE ROBERT WOOD JOHNSON FOUNDATION

TABLE OF CONTENTS

ISSUE BRIEF No. 33
New Jersey Policy Forums on Health & Medical Care
101 Campus Drive, University Square, Princeton, New Jersey 08540• v (609) 720-0136 • f (609) 720-0134
Cynthia Baltazar, Director • Joanne T. Fuccello, Associate Director
Sponsored by The Forums Institute for Public Policy
Underwritten by a grant from
The Robert Wood Johnson Foundation

THE FUTURE OF EMPLOYER-BASED HEALTH PLANS

The Issue: Trends in employer-based health insurance are critical to understanding how health care costs, coverage and access to care are changing. Policymakers are grappling with the shifts effected in the employer-based system as a result of overall changes in the health care financing and delivery systems. What are the current trends regarding such issues as employer-sponsored health plan eligibility, coverage and costs and what are their implications for public policymakers? How will the integrity of the system be retained as policymakers look at mechanisms to expand coverage among uninsured individuals, whose numbers both nationally and in-state continue to increase?

INTRODUCTION

Ask a health economist what is the leading issue regarding employer-based health plans and he may respond by discussing the implications of coverage mandates imposed on employers and their potential impact in such areas as employees' wages and increased numbers of uninsured. When the same question is posed to any member of such groups that include insurance regulators, health lawyers, ERISA experts, corporate health benefits administrators, small business owners or the director of a state Medicaid program, the responses will contain a wide range of identified problems and proposed solutions. At present, approaches to the issues related to the future of employer-based insurance range from overhauling the entire system to a continuation of the incrementalist approaches already in effect on both federal and state levels. [1]

"We join spokes together in a wheel, but it is the center hole that makes the wagon move" (Mitchell, 1988). Employer-based health insurance has often been called the linchpin of the intricate "system" of policies/programs/systems of the larger health insurance market. How it ebbs and flows into public programs and other insurance markets is a work in progress. As summarized by health insurance analyst Paul Fronstin, the employment-based health insurance system simultaneously offers several advantages and drawbacks. "The advantages include reduced risk of adverse selection, group-purchasing efficiencies, employers acting as a workers' advocate, delivery innovation and health care quality. The disadvantages include an unfair tax treatment, lack of portability and job lock, little choice of health plans, and lack of universal coverage" (1999). Analysis of such issues as employer health plan eligibility, coverage, enrollment patterns, plan choice, premiums, employee cost sharing, covered benefits and retiree health benefits offer insight to public policymakers on gaps in the system and implications for access to and affordability of health and medical care.

THE CURRENT HEALTH CARE CLIMATE AND THE ROLE OF POLICY MAKERS

[1] See, for example, views presented by health policy analysts, economists, employers and insurers in a special issue devoted to "The Future of Insurance," published in the journal *Health Affairs*, November/December 1999.

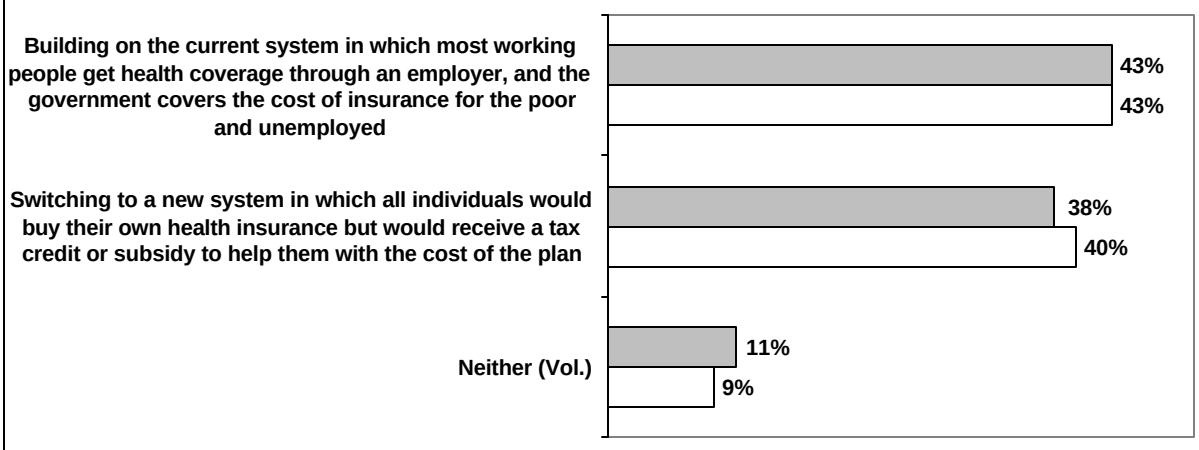
The National Conference of State Legislatures reports that health care issues made up a greater proportion of bills in state legislatures throughout the country than any other topic in 1999: approximately 27,000 bills out of 140,000 (Goldberg, 2000). Of those 27,000 bills, 1,400 were enacted as laws. For the 2000 legislative year – where 44 legislatures (as opposed to 49 last year) are in session -- health care bills continue to dominate legislative activity: 16,000 health care proposals out of 104,000 bills carried into this new year (ibid.). The focus of these bills covers a wide range of issues, including access to care, oversight of managed care practices and the cost of health care.

On national and state levels, laws, policies and reforms have been implemented to address the fragmented health insurance coverage of our health care system. A recent Kaiser Family Foundation/Harvard School of Public Health Survey on Health Care and the 2000 Election found that there are mixed views on "re-structuring" the employment-based health insurance system (See, Chart 1, on survey respondents' views). Forty-three percent of those surveyed chose the option of building on the current system "in which most working people get health coverage through an employer, and the government covers the cost of insurance for the poor and the unemployed"; this compared to 38 percent who felt that "switching to a new system in which all individuals would buy their own health insurance but would receive a tax credit or subsidy to help with the cost of the plan" was the better alternative. Eleven percent of those surveyed did not agree with either option (*National Survey on Health Care and the 2000 Elections*, January 19, 2000).

Chart 1

Mixed Views On What Approach to Take

Percent Who Choose Each Option



* Vol. means respondent volunteered the response
* Don't knows not shown
* "Health Care Voters" refers to those registered voters who named health care or Medicare as one of their top two issues in their vote for President.

Source: Kaiser Family Foundation/Harvard School of Public Health National Survey on Health Care and the 2000 Elections, January 19, 2000 (conducted Dec. 1999)

EMPLOYER-BASED HEALTH INSURANCE – THE EVOLUTION OF A VOLUNTARY SYSTEM

In an editorial focusing on employer-based health insurance, *Health Affairs* editor John K. Iglehart states that the United States "is unique among nations in relying on private employers to voluntarily provide health insurance coverage for all employees" (1999). During the 1930's and 1940's, the growth in employer-based health insurance was facilitated by the federal tax treatment of health benefits offered to employees (Alliance for Health Reform, *Briefing Paper*, June 1999). By the late 1950's, the federal government offered health coverage to all of its workers. The evolution of the system was framed by tax code amendments to provide incentives to employers to offer health coverage on a voluntary basis.

In all other industrialized nations, societies have assigned the task directly to government or require private employers to provide coverage on a heavily regulated basis (Iglehart, 1999). Based on industry trends regarding changes in coverage of employed-based insurance over the past decade (currently 65 percent of the workforce is insured through employment), it is expected that in the future the link between employment and insurance coverage will become even more tenuous. While there are many unknowns regarding the issue, what is known is that there is absence of agreement among the public and its policymakers on an alternative to employment-based insurance. Potential answers range from implementing reform measures for improving the cost and access to individual insurance (especially potential limitations associated with high risk), to a system of tax credits and deductions to allow employees to purchase their health insurance on their own.

EROSION OR STABILITY? – RELYING ON THE SURVEYS FOR ANSWERS

Analysts are debating various research results in order to gain an accurate and comprehensive picture of the current status of employer-based health plans in this country. A recent (November 1999) RAND study offered new evidence that "contrary to widespread belief," the number of uninsured is not increasing because of erosion in job-based health benefits (Long and Marquis, 1999). The study is unique in relying on two of the largest employer surveys ever conducted - The National Employer Health Insurance Survey for 1993 (34,600 interviews) and the 1997 Robert Wood Johnson Foundation Employer Health Insurance Survey (21,500 interviews). The economists' findings suggested that the widely reported decline in employer coverage – based on data collected through the Current Population Survey, the National Medical Expenditure Survey (NMES), the Medical Expenditure Panel Survey (MEPS) and Health Insurance Association of America (HIAA) surveys – may have ended in the early 1990's. In one of their general findings, they report that while in 1993, 56 percent of employees enrolled in their employers' plans, this number increased to 60 percent in 1997. In their final analysis, Long and Marquis indicated that they found an "overall stability" in employment-based insurance over the 1993-1997 period" (id. at 138).

Their study further confirmed that there is a "revolutionary shift" to managed care in employment-based plans. By 1997, only 27 percent of employees were being offered an indemnity coverage option,

compared to 59 percent in 1993. However, private employers are not employing managed competition in that employees are limited in the number and types of plans from which they can choose: e.g., only 43 percent were offered more than one plan option in 1997.

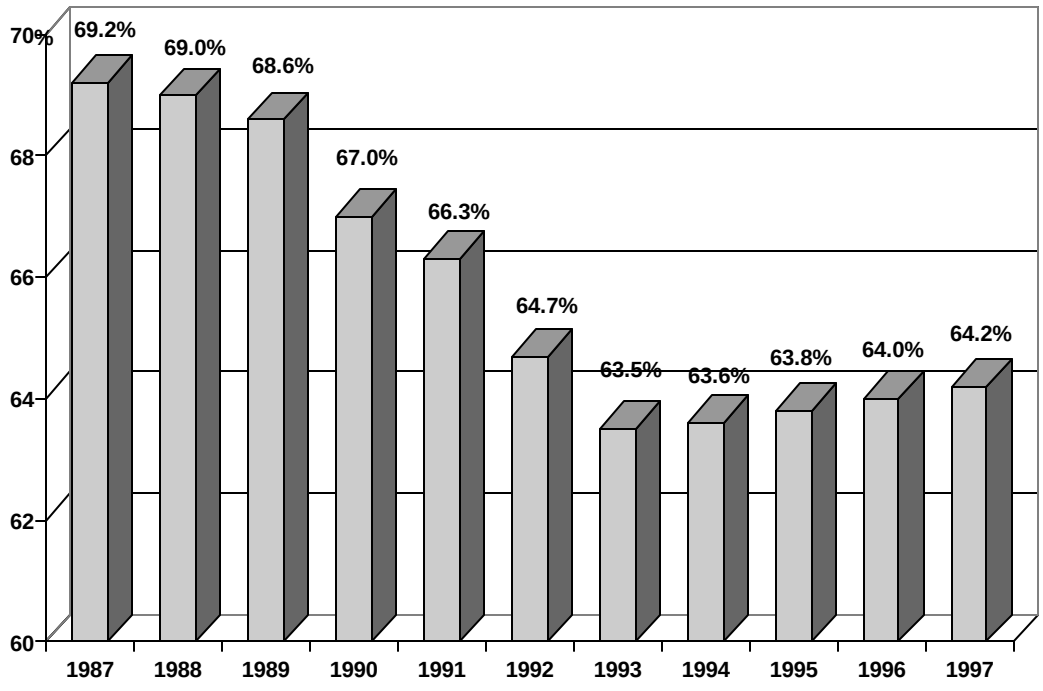
"Employment status is the most important determinant of health insurance coverage" (Fronstin, 1999; 2000; Kaiser Family Foundation, 1999). In 1940, fewer than 10 percent of Americans were covered by private health insurance; by 1977, 71 percent of the nonelderly were covered by private insurance – 90 percent of them were covered under an employment-based health plan (Alliance for Health Reform, *Briefing Paper*, 1999).

By 1998 (the most recent data available), the Employee Benefit Research Institute reports the following, based on its analysis of the March 1999 Current Population Survey:

On Who Has Employer-Sponsored Health Insurance

- 194.7 million nonelderly Americans – 81.6 percent – had some form of health insurance. More than 64 percent had it through an employment-based health plan; 6.5 percent purchased it on their own; and 14.3 percent were covered by a public program, mostly through Medicaid (10.4 percent) (Fronstin, 2000). (See, Chart 2, "Percentage of Nonelderly Americans Covered by an Employer-Based Health Plan, 1987-1997" and Appendix B, Table

Chart 2
PERCENTAGE OF NONELDERLY AMERICANS COVERED BY AN EMPLOYMENT-BASED HEALTH PLAN 1987 - 1997



Source: Employee Benefit Research Institute estimates from the March 1988-1998 Current Population Survey

3, "Nonelderly Population with Selected Sources of Health Insurance, by Region and State, 1998.")

- In the mid-Atlantic region, 65.8 percent of the nonelderly had employment-based health coverage, while 6.2 percent purchased their own insurance and 14.4 percent received their health coverage through a public program. The highest percentage (12.0 percent) was comprised of Medicaid program enrollees. The percentage of uninsured was at 17.0 percent.

- In the state of New Jersey, 69.5 percent of the nonelderly population had employment-based health coverage, 6.4 percent purchased their own insurance and 8.0 percent were covered through a public program. Six percent of those served under a public program were Medicaid enrollees. In 1998, 17.0 percent of the population was uninsured, or 1.3 million individuals (ibid.).

- Although the percentage of working adults with employment-based high insurance coverage remained constant between the years 1994 and 1997 (at approximately 72.3 percent), that percentage increased between 1997 and 1998 – from 72.2 percent to 72.8 percent – even against the backdrop of health care cost inflation in 1998.

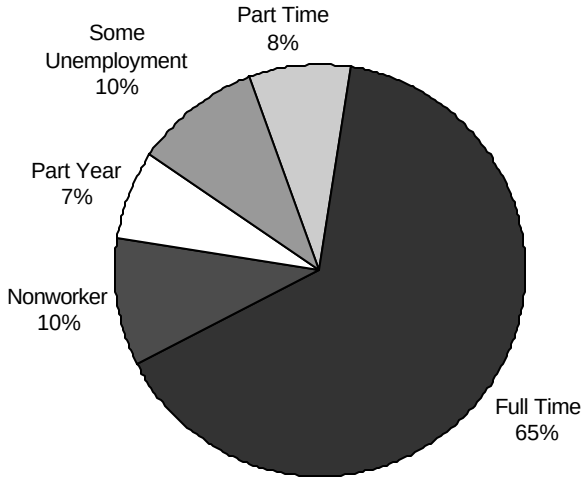
On the Uninsured

- In 1998, 18.4 percent of the nonelderly population was uninsured (43.9 million people). According to Fronstin's report, prior to 1993 the increase in the number of uninsured could be attributed to the erosion of employment-based insurance. However, since 1993, the percentage of non-elderly individuals who are covered by an employment-based health plan has increased from 63.5 percent to 64.9 percent (ibid.).

- Uninsured workers comprise 18 percent of the workforce – nearly 25 million Americans. One third of workers (31 percent) earning under $20,000 a year are uninsured, compared to 5 percent of workers earning over $50,000 a year (Kaiser Commission on Medicaid and the Uninsured, 2000). (See, Chart 4,

Chart 4

More than six in ten uninsured Americans live in families headed by a full-time worker



Source: William S. Custer, Ph.D., Center for Risk Management and Insurance Research

"More than Six in Ten Uninsured Americans Live in Families Headed by a Full-Time Worker.")

On Workers' Declining Coverage

- In 1997, 40.6 million American workers did not have health insurance through their own employer. Forty-five percent of these workers without coverage were employed at a firm where the benefit of health insurance was not offered to any workers. Thirty-three percent of the workers without coverage were offered health insurance but declined it (ibid.)

- The 13.7 million workers who were offered coverage but declined it gave a number of reasons for doing so. In 61 percent of the cases, the worker was covered by another health plan; of the remainder, 20 percent reported that health insurance was "just too costly" (ibid.)

On Children

- During the period from 1994 to 1998, the percentage of children covered by an employment-based plan increased from 58.1 percent to 60.2 percent. In comparison, the number of adults increased only a small percentage – from 66.1 percent to 66.9 percent (ibid.).

Fronstin (2000) also conjectures that changes in federal programs and the resulting "decline in public sources of health insurance would mostly explain the recent increase in the uninsured" (ibid.). He points to reductions of those lives covered under the military CHAMPUS/CHAMPVA (Civilian Health and Medical Program of the Uniformed Services/Civilian Health and Medical Program of the Veterans Administration) programs and the declines in Medicaid enrollees related to those who are no longer recipients of economic assistance.

GAPS IN THE EMPLOYER-BASED SYSTEM

In a health care system that is employer-based, what happens to those who fall within the "gaps" of that system: those who are unemployed, part-time employed, sporadically employed, employed by small businesses, independent contractors, and retirees? The strength of our economy and the creativity of our employment sector have created a wide array of employment possibilities; yet, access to health care when based on an employer-sponsored system holds fundamental problems. Although the percentage of employers offering health coverage has stabilized, the number of those eligible to receive such coverage has decreased, owing to the trend of part-time workers and those working in alternative work arrangements.

For example, part-time and part-year workers are at higher risk of being uninsured – over 25 percent compared to 15 percent of full-time workers (Kaiser Commission on Medicaid and the Uninsured, 2000). Policy implications regarding the uninsured relate to the fact that they are less likely to have access to appropriate health care services, and that the care provided by physicians and hospitals to the uninsured is uncompensated – and costs may be shifted to other private and public payers (Fronstin 2000). (See, Chart 5, "Percentage of Working-Age Adults Who Postponed or Did Not Obtain Needed Care in Past Year.")

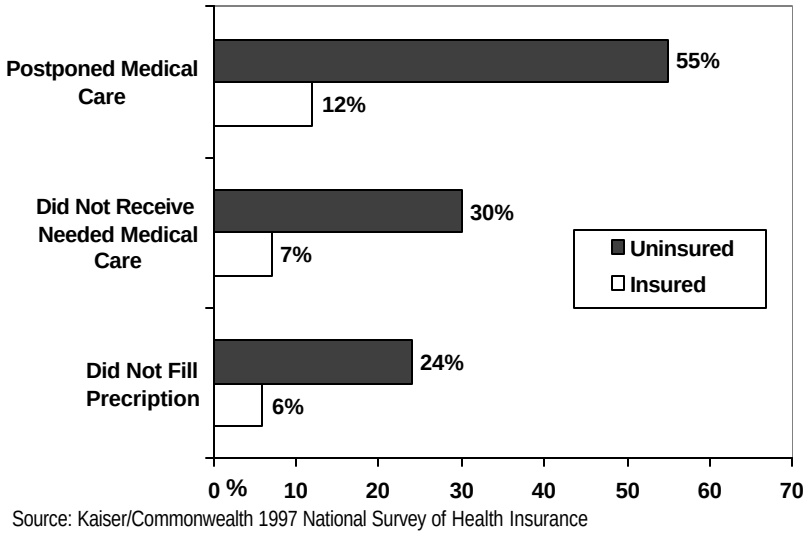
Low-income workers and their families are the least likely to be offered health coverage through their employers. They are also required to pay considerably more in premiums and are less likely to have discretionary funds in order to purchase health insurance coverage (Kaiser Commission on Medicaid and the Uninsured, 1999). While 93 percent of workers who earn $15.00 or more an hour are offered health benefits by their employer, only 43 percent of employees earning $7.00 an hour or less are offered such benefit.

Fronstin's research also indicated that firm size makes a difference regarding health insurance coverage sponsored by an employer. For example, workers employed in small firms are "less likely" to work for an employer that sponsors a health plan or offers them coverage, compared with workers in large firms." His findings include that 56.6 percent of workers in small firms reported that they were offered health insurance, compared with 85.5 percent of workers in large firms (Fronstin, 1999). Nationally, more than 60 percent of uninsured workers are employed by a firm with fewer than 100 employees (ibid.)

In a recently published analysis piece on the future of job-based health insurance, health researcher Jon R. Gabel observes that in the absence of any large-scale national legislation, and with "the twin economic forces of globalization and the information revolution," the disparities in health coverage and income among skilled and unskilled workers will continue to grow (1999). This forecast has significant implications for New Jersey, a state in which there is significant predicted growth in technological sector jobs.

Branscome et al (2000) reported that data from the Medical Expenditure Panel Survey-Insurance Component (MEPS-IC) show state-to-state differences in private employer-sponsored health insurance which are significant in such areas as offer rates, plan choice and employer premiums. The study concurs with earlier research findings that smaller firms are less likely to offer health insurance to their employees than larger firms, and that the low-wage workers are disproportionately affected by the fact that their employers may not offer health coverage. Although the study found that the states of New Jersey and North Carolina had relatively high health plan offer rates, it was unclear as to whether or not this was a function of specific insurance reforms or unknown underlying economic factors (Branscome et al, 2000).[2]

Chart 5
Percentage of Working-Age Adults Who Postponed or Did Not Obtain Needed Care in Past Year



Source: Kaiser/Commonwealth 1997 National Survey of Health Insurance

[2] The researchers point out that for their survey the overall response rate was 66 percent (23,000 private

THE 1990'S – AN OVERVIEW OF FEDERAL INITIATIVES AFFECTING HEALTH PLANS AND INSURANCE

Following the demise of the Clinton Administration's universal health coverage proposal, which envisioned a large-scale re-structuring of the health care system, the theme of incrementalism has prevailed on both national and state levels. At present there are several House and Senate bills pending regarding aspects of insurance market reform and measures to reduce the rate of uninsured lives. (See, Appendix A, for a list of selected pending federal legislation on the issue.)

Whether purchased plans or self-insured, all plans are subject to specific federal mandates, including the 1978 Pregnancy Discrimination Act and the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). After a long hiatus in the enactment of any significant federal mandates, since the mid-1990's there have been federal activities regarding health insurance plans. In 1996 Congress passed the Health Insurance Portability and Accountability Act (HIPAA), Mental Health Parity Act, and the Newborns' and Mothers' Health Protection Act; these three acts established coverage requirements for most group employment-based plans across the country (Jensen and Morrisey, 1999).

HIPAA, for example, sets federal standards for pre-existing condition clauses and requires portability. HIPAA was intended to aid individuals enrolled in employer-sponsored health plans gain access to health insurance, regardless of health status, and to keep it if they had to change jobs or if they became unemployed (Polzer, 1999). It is significant to note that these HIPAA provisions amended the Employee Retirement Income Security Act of 1974 (ERISA), the Internal Revenue Code and the Public Health Service Act (ibid.). Although several recent U.S. Supreme Court opinions limit ERISA's impact on state authority, many courts have held that ERISA "supercedes some state health care initiatives, such as employer insurance mandates and some types of managed care plan standards, if they have a substantial impact on employer-sponsored health plans" (Butler, 2000).[3]

State-level accomplishments as a result of their following HIPAA provisions have been varied. Based on state surveys and reports, 37 states designed their own "alternative mechanism" to implement HIPAA-mandated group-to-individual portability, while13 states took the "federal fallback approach." This approach requires insurance carriers "to offer all their individual market plans, their two most popular plans or two "representative" plans with high- and low-level coverage, all subject to some risk spreading or financial subsidy" (Carlson, 1999).

Over the past five years, federal governmental activities to address the issue of insurance coverage and access to health care have included: its focus on expanding

business establishments); states' response rates ranged from a low of 59 percent in New Jersey to a high of 77 percent in Arkansas.

[3] ERISA was enacted "primarily to establish uniform federal standards to protect private employee pension plans from fraud and mismanagement. But the federal statute also covers most other types of employee benefit plans, including health plans….It applies to all employee pension, health and other benefits plans established by private-sector employers (other than churches)…" (Butler, 1999). (Reference is made to the comprehensive work by Patricia Butler: "ERISA Preemption Manual for State Health Policymakers," jointly published by the Alpha Center and the National Academy for State Health Policy.)

health coverage for children through such significant public initiatives as the Child Health Insurance Programs to be run by the individual states; its new Medicare restructuring initiatives; and the exploration of medical savings accounts, which focus on individual choice and individual financial accountability in health coverage.

NEW JERSEY

An Overview of New Jersey's Health Insurance Environment

According to the New Jersey Business and Industry Association's (NJBIA) 1998 survey of employers, the state's employers show higher than average health plan coverage for employees, when compared to the rest of the country in general.[4] Ninety-four percent of survey respondents provided coverage to their employees in 1998 (unchanged from 1997) and 78 percent provided coverage to employees and their families (down from 80 percent in 1997) (*NJBIA 1998 Health Benefits Survey*, 1999).[5] What are the implications for policy makers? In light of survey findings and the strong economic environment in New Jersey, what factors are contributing to the estimated 1.3 million uninsured New Jersey residents (1998)?

Through Executive Order No. 92 (July 1999), New Jersey Governor Whitman created the Task Force on the Affordability and Accessibility of Health Care in New Jersey to conduct a comprehensive study of health care and health insurance in the state. The 25-member task force's charge includes that it: "assess the impact on the quality of health care and the cost of health insurance from mandated health benefits currently required by State law and regulations; assess the anticipated health benefits and estimated costs resulting from pending legislative efforts to impose additional mandated benefits; and evaluate the amount that employees contribute to the cost of employer-sponsored health coverage through co-payments, contributions toward premiums or other forms of cost sharing." Other research activities will include a comparison with other states and identifying ways that state laws and regulations can increase access and affordability.

History in Insurance Market Reform

When compared to other states, New Jersey is one with a high level of activities regarding insurance market reform. Similar to other states where insurance market reforms have been implemented, New Jersey's reforms were enacted during the early 1990s and set certain standards with regard to: guaranteed issue, guaranteed renewal, modified community rating and limitations on pre-existing condition exclusions (McDonough, 1999).

These market reform programs reflected the state's commitment to increase access for individuals and small employers regardless of health status, age, risk factors or claims history (Health Policy Tracking Service, 1999). Regarding state individual market insurance reform laws, New Jersey is one of seven states which offers guarantee issue for all insurance products; it is one of two states (New York is the other) which has pure community rating; and it is one of 30 states whose law limits pre-existing conditions (State of the States Report, 2000).

[4] According to a New Jersey Business and Industry Association representative, results from its 1999 survey of employers will be released in early April 2000.

[5] The NJBIA survey is based on responses from over 1,500 New Jersey employers in every industry across the state.

New Jersey's Individual Health Coverage Program (IHCP) was implemented in 1993; it offers insurance to those who do not have access to employer-based group insurance or Medicare. By the end of 1995, enrollment in IHCP increased to 192,000. However, by mid-March 1998, enrollment decreased to 147,000, and by mid-1999, this number decreased to 121,000 (State of the States Report, 2000). Factors for the decrease may be related to "a combination of the strong economy and rising premiums," according to the program's deputy executive director Ellen DeRosa (ibid). The Small Employer Health (SEH) Benefits Program (effective January 1994) offers to small employers standardized health benefits plans.

Current Legislation And Program Initiatives

In early February of this year, the Assembly Labor Committee released two bills which, if passed, may have an effect on employer-sponsored health benefits. Assembly bill A-1095 (Cohen, Geist, Previte and Conaway) provides a tax credit for certain corporate taxpayers that provide health care benefits to employees; A-1096 (Cohen, Geist) provides gross income tax credit for certain small business employers that provide health care benefits to employees. While bill supporters see both bills as being positive incentives for employers to provide health benefits for their employees, opponents are concerned about the negative revenue impact to the state and potential tax implications vis-à-vis medical expenses.

The Senate Health Committee held a public hearing on February 23, 2000 to discuss the views of insurers on the affordability and accessibility for health insurance for New Jersey residents. Senate President Donald DiFrancesco (R-22) has called for a comprehensive analysis of the state's health care system with a focus on four major areas: health care affordability and accessibility; the financial status of New Jersey's hospitals; Medicaid fees for physicians and hospitals and ensuring quality health care for all segments of New Jersey's diverse population. To further his initiative he set up this first public hearing, which will be followed by three others to be held over the next several weeks. In their presentations, insurers that included Horizon-Blue Cross/Blue Shield, Aetna/US Healthcare, AmeriHealth Insurance and the New Jersey Individual Health Care and Small Employer Health Care Program stressed that there are obstacles to affordable and accessible health care in the state. The insurers asserted that one of these obstacles is that there are mandates imposed on insurers by the state, which increase premium costs and hospital utilization.

In 1999, the New Jersey Legislature continued its efforts to reform the insurance market by enacting L. 1999, c.222, s. 1 to allow self-employed individuals to deduct insurance premiums – including those of a spouse or dependent – from their gross income for tax purposes (see N.J.S.A. 54A:3-5). The New Jersey Legislature also established -- under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) – tax deductions for Medical Savings Accounts for individuals and tax exemptions for employers (see N.J.S.A. 17B:27A-33 et seq.)

New Jersey is one of a few states which has an innovative proposal to expand access to its uninsured citizens through a combination of financial support from state general funds, employers and beneficiaries (State of the States, 2000). In addition to its Medicaid expansion programs, including its

CHIP supported NJ KidCare program, New Jersey has proposed the Equity Program, which would extend coverage to parents and would subsidize employer-sponsored health insurance premiums after the employer pays at least 50 percent of the monthly premium and the employee contributes $25.00. The state will assume the remainder of the premium, up to a $45 maximum. Eligible working families would have to meet two criteria: (1) their incomes are between 133 and 200 percent of the federal poverty level, and (2) they currently made the choice to pay for health insurance that is ostensibly "unaffordable," as opposed to choosing not to purchase health insurance because of its cost (ibid.). It is expected to cost $13.6 million per year, but has the potential to insure and sustain coverage for at least 50,000 low-income employees and their families.

The states of Massachusetts, Mississippi and Wisconsin have each received a family coverage variance from the Health Care Financing Administration (HCFA) (ibid.). Each state is exploring initiatives through subsidized employer buy-in programs that will extend coverage to parents as well as children.

A recent press report informed that the Whitman Administration has proposed a program that would offer subsidized health insurance to 125,000 working-class New Jerseyans using funding derived from the national tobacco settlement. The newly proposed FamilyCare program – which would be supported by $100 million annually – is modeled after New Jersey's KidCare program (Leusner, 1999). Parents would qualify based on their income and family size. It is estimated that benefits would cost the state between $1,400 and $2,500 per person. Several other states are experimenting and launching such expansion programs aimed at family-based health coverage to children and parents in low-income working families, including Connecticut, California, Rhode Island, Wisconsin and Washington, D.C.

EMPLOYER TRENDS

There are several ongoing debates over health plan liability, remedies, accountability and processes in handling health benefit claims. In a 1998 survey conducted of 25 mid- to large-sized companies in the mid-Atlantic region, the researchers found that many dynamics in employer-sponsored health insurance are changing (Draper, Thompson and Hurley, 1999). There appears to be an intentional move to shift to more of a shared process between employer and employee regarding medical care decision-making and responsibility. Of the 25 respondent firms, all except one (which had a strong unionized work force), had designed a level of employee premium contribution to their plans. Other important trends were the importance of offering health plan choice to their employees, and offering less-restrictive plans, such as point of service and preferred provider plans. Across the board, employers were compelling their employees to become more active health care consumers, most significantly through the use of cost-sharing arrangements (ibid.).

Health insurance researchers Jensen and Morrisey in their analysis of employer-sponsored health insurance and the effects of federal and/or state mandated benefit laws found that: "there is clear evidence that the increase in numbers of uninsured Americans can be partly tied to mandates" (Id. at 19). Pointing to Sloan and Conover's research on the effects of state reforms on health insurance coverage of adults, they report that a fifth to a quarter of the uninsured are

without health insurance as a result of state mandates (Sloan and Conover, 1998). According to the Congressional Budget Office estimates, every one- percent increase in health insurance premiums results to 200,000 more uninsured in America. Another dramatic conclusion reached by the Jensen and Morrisey study points out that "both economic theory and a growing body of empirical evidence suggest that workers pay for health insurance mandates in the form of lower wages" (ibid.).

The period of "flat" growth in insurance premiums is over and double-digit increases are expected to continue. A 1999 nationwide survey of employers by William M. Mercer, Inc., found a 6.1 percent increase in the amount spent by employers on health care benefits in 1998 (*Managed Care Interface*, 1999). This increase represents the largest rise in employer costs since 1993. Forecasts for the coming year project that health insurance costs for employers will increase to 7.5 percent, to close to $4,404 per worker (*The New York Times*, December 1999, quoting a William M. Mercer study of employers). Last year's NJBIA health benefits survey found that in New Jersey, the average cost of health benefit premiums per covered employee rose by 3.3 percent last year, up from 2.9 percent in 1997 and a low of 1 percent in 1995. Forty percent of the surveyed New Jersey employers anticipated that their health benefits costs would increase by 7 percent or more in 1999, while the remainder expected that their costs would rise "more moderately" (*NJBIA 1998 Health Benefits Survey*, 1999).

A recent lead article in *The Wall Street Journal* addressed an emerging trend among U.S. employers to "retreat from their middleman role" by letting workers bear the responsibility of making their own decisions about health benefits (Winslow and Gentry, 2000). Citing recent health care environment changes – including employers' fear regarding liability for their selection and administration of health benefits plans, the popularity of 401(k) retirement plans, the growth of Internet Web sites aimed at helping consumers make health and medical decisions, and the recent resurgence in health costs even against the backdrop of managed care's efforts to control them – employers feel that full accountability in the health care market will be reached only when consumers "hold the purse strings" (ibid.). Through a system of medical vouchers, employees would choose and purchase their own health benefits plan; the employer would provide a set amount of money for each employee's health benefits. The Xerox Corporation, for example, has proposed to eliminate its role of administrating health insurance to its employees and would instead offer a fixed sum of $5,000 or $6,000 per year for each employee to select his/her own plan. The employees would have a choice of plans administered by private carriers, not by Xerox (Mitchell, 1999).

ALTERNATIVE PROPOSALS – PUBLIC AND PRIVATE

While some critics find that the employer-based system is fundamentally inadequate to provide health care insurance, they do not see the answer of tearing down the system but developing a complementary system that will evolve over time.

The Health Insurance Association of America (HIAA) initiatives to increase health coverage combine: "targeted subsidies, incentives, cost-control measures and education" (www.insureusa.org). Its reform proposal focuses on the foundation of our employer-based system and integrates

it with current and proposed governmental programs. For example, of those whose incomes are below 100 percent of the federal poverty level (approximately $8,500 for one person), only 14 percent have employment-based coverage (ibid.). HIAA's proposal calls for a jointly funded federal-state program (using the State Children's Health Insurance Program as a model) to create a public health insurance program for adults whose incomes are below 100 percent of poverty. The plan also proposes for those whose incomes fall at 100 percent but below 200 percent, a federal voucher of approximately $2,000 to help these low-income workers to obtain affordable coverage. Their proposal also offers various forms of tax incentives and subsidies for businesses, individuals and the self-employed, including the simplification of medical savings accounts.

One part of the Clinton Administration's 2001 budget is a 10-year $110 billion proposal to expand health insurance access and affordability to families through the State Children's Health Insurance Program (S-CHIP). Similar to one of the initiatives proposed by HIAA, the American Hospital Association and the American Association of Health Plans, the proposed "FamilyCare" initiative would channel money to the states to help pay for employment-based coverage that meets certain specified standards and for which an employer pays half of the premium (*Business & Health*, 2000).

The creation of tax subsidies for health insurance is another example of an incremental reform in response to the growing number of uninsured lives on a national level. On both political sides of the issues, there is a trend towards supporting the plan of using federal tax credits as a way to expand health coverage (Gruber and Levitt, 2000). The elements of each plan comprise a range of tax-based approaches, each with its own implications for policymakers.

Health economists Gruber and Levitt maintain that although there are some compelling arguments setting forth the benefits of tax subsidies -- e.g., they would offer to individuals the same types of financial benefits currently available to self-employed and employer-sponsored coverage, the ability of tax subsidies to reduce the number of uninsured persons -- in a meaningful way -- remains "uncertain and unproven" (id at 73).

CLOSING REMARKS

A recent *New York Times* lead story pointed out that state lawmakers believe that "they are carrying the burden as they struggle to fill the most gaping holes in the medical system," in the absence of federal regulatory activity (Goldberg, 2000). At last count, nearly two-thirds of the country's nonelderly population is covered through employment-based health insurance. The system has been acknowledged as the "hub" of our system of health insurance. Yet, there are identified trends in the employer-based health insurance -- which include rising premium costs, the shift towards temporary and part-time work (e.g., in 1997 almost 30 percent of workers held "non-standard, full-time" jobs) which often does not carry health coverage, and reductions in dimensions of explicit coverage, such as costly pharmaceutical benefits -- which may weaken the hub's stability. How will these changes affect the status and future of employer-sponsored insurance coverage?

POLICY IMPLICATIONS

Changes Confronting the System of Employer-Based Health Insurance

An August 1999 survey conducted for the Economic and Social Research Institute on "Business Attitudes Towards Health Insurance Coverage of Employers and Their Dependent Children" found that among businesses now offering health coverage, there was an almost universal consensus of feeling a "significant obligation to provide health insurance for their employees" (Perry et al, 1999). Of the 1200 small, medium and large businesses surveyed, 20 percent felt obligated to provide 100 percent of coverage, 50 percent felt they should contribute at least 75 percent on the cost of an employee's premium, and 75 percent felt they should contribute at least half of the cost. Will such a level of commitment from employers continue if forecasts projecting significant health insurance cost increases bear out?

In its proposal for reforming the private health insurance system, the Health Policy Group of the American Medical Association points out that Americans' confidence in the future of the employer-based system is eroding – pointing to survey results that only 40 percent of persons enrolled in managed care plans, which are the dominant type of employer-sponsored coverage, report a high level of confidence that they will be able to afford health care without suffering financial hardship over the next 10 years. What factors must be considered in taking steps to restore confidence in a system that has been the linchpin of our health care insurance system since the Second World War?

Legislative changes are currently being considered that would increase managed care organizations' vulnerability to civil liability suits in cases of alleged withholding coverage or failing to deliver needed care. Although advocates of such liability reform feel that such remedies are necessary in order to protect the health and welfare of individuals, and the quality and accountability of care provided through health plans, employers and health plans present counter-arguments: health plans argue that litigation will result in increased premiums and drive up the cost of care and employers assert that increases and the fear of litigation will push them towards cutting benefits packages or eliminating insurance coverage options for their employees. What are the implications for policy makers and regulators in evaluating liability reform strategies?

Tax Credits and Subsidies

In their analysis of the potential effects of subsidizing tax credits for health insurance, health economist Gruber and Leavitt caution that "even the most effective tax subsidies would cost almost $40 billion a year and cover only 30 percent of the uninsured." How will policymakers discern the best way to use tax policy as part of a general overall strategy to address the challenge of the uninsured?

In discussing state-level proposals regarding tax credits and/or tax subsidies, Alpha Center President David Helms cautions that "experience has shown us that states have a hard time sustaining subsidies solely funded at the state level" and points out that the success of any tax credit "will depend on the commitment of federal government." How will these caveats potentially affect the efforts of New Jersey's legislators towards tax credits?

The Quality Care for the Uninsured Act (H.R. 2990), passed by the U.S. House of Representatives, contains several provisions aimed at aiding individuals to purchase health insurance coverage. These provisions range from tax incentives (providing deductibility of health insurance premiums phased-in over time) to purchasing arrangements for small groups. Fronstin, however, points out that utilization of these provisions may do little to reduce the uninsured. He notes the Joint Committee on Taxation estimate that only 200,000 individuals would gain health insurance coverage in 2002 if 25 percent of the cost of health insurance premiums were tax deductible; this number increases over time as full deductibility is effected (Fronstin, 2000; *Congressional Record*, October 6, 1999). Should policymakers continue to investigate the route of tax subsidies and incentives as strategies to address the issues related to access and affordability of health insurance coverage?

Retirees

A 1999 Henry J. Kaiser Family Foundation and Hewitt Associates survey found that although employer-sponsored health coverage remains the largest source of supplemental health insurance for Medicare beneficiaries, the incidence of such coverage is declining among employers. Further findings indicate that nearly all employers who offer such coverage require a premium contribution from employee retirees and pre-retirees (*Business & Health*, December 1999). What are the implications for policy makers regarding health care coverage for retirees, particularly in New Jersey with its high percentage of elderly residents?

Private and Public Sector Models

In a recently published study, health economists Long and Marquis compare employee health benefits in the public and private sectors in an effort to determine "best practices" in each sectors and identify potential replicability (1999). One of their findings focused on data showing that the Federal Employees Health Benefit Program (FEHBP) is "ahead of other employers" in its adoption and utilization of managed competition principles. The researchers found that one of the benefits of using these principles results in the offering of a wide array of health plan choices for employees – for both plans and plan types – in contrast to the private sector. However, when the cost of health care premiums paid by the federal government vs. the private sector are compared, researchers have identified that in 1998, premium increases for the federal government was twice those of the private sector. What can be extrapolated from these findings and what lessons can be learned from continued comparison of public and private sector health benefits administration?

REFERENCES

Alliance for Health Reform. "Employer-Sponsored Coverage. Changes in the Wind?" *Briefing Paper*. June 1999.

American Medical Association. "Rethinking Health Insurance. The AMA's Proposal for Reforming the Private Health Insurance System." 1999.

Branscome, J. M., P. F. Cooper, J. Sommers and J. P. Vistnes. "Private Employer-Sponsored Health Insurance: New Estimates by State." *Health Affairs*. January/February 2000.

Carlson, Bob. "What's Happened to HIPAA in the Real World?" *Business & Health.* March 1999.

Draper, D. A., J. M. Thompson and R.E. Hurley. "Changing Dynamics in Employer-Sponsored Health Insurance." *MGM (Medical Group Management) Journal*. July-August 1999.

"Employer Health Care Spending on the Rise." *Managed Care Interface*. April 1999.

"Forces Align to Help Uninsured." News & Trends. *Business & Health.* February 2000.

Fronstin, Paul. "Employment-Based Health Insurance: A Look at Tax Issues and Public Opinion." Employee Benefit Research Institute. *Issue Brief* Number 211. July 1999.

Fronstin, Paul. "Employment-Based Health Benefits: Who is Offered Coverage vs. Who Takes It." Employee Benefit Research Institute. *Issue Brief* No. 213. September 1999.

Fronstin, Paul. "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 1999 Current Population Survey." Employee Benefit Research Institute. *Issue Brief* Number 217. January 2000.

Gabel, Jon, K. Hurst, H. Whitmore and C. Hoffman. "Class and Benefits at the Workplace." *Health Affairs*. May/June 1999.

Gabel, Jon. "Job-Based Health Insurance, 1997-1998: The Accidental System Under Scrutiny." *Health Affairs*. November/December 1999.

Goldberg, Carey. "For Many States, Health Care Bills are Top Priority." *The New York Times*. February 6, 2000.

Gruber, J. and L. Levitt. "Tax Subsidies for Health Insurance: Costs and Benefits." *Health Affairs*. v. 19, no. 1. January/February 2000.

Gruber, J. "Tax Subsidies for Health Insurance: Evaluating the Costs and Benefits." (Report for the Henry J. Kaiser Foundation, 1999; www.kff.org).

Jensen, Gail A. and M. A. Morrisey. "Employer-Sponsored Health Insurance and Mandated Benefit Laws." The Milbank Quarterly. A Journal of Public Health and Health Care Policy. V. 77, no. 4, 1999.

Kaiser Family Foundation/Harvard School of Public Health. *National Survey on Health Care and the 2000 Elections.* January 19, 2000 (conducted December 1999).

Kuttner, R. "The American Health Care System – Health Insurance Coverage." *The New England Journal of Medicine*. V. 340, no. 2, January 14, 1999.

Kuttner, R. "The American Health Care System – Employer-Sponsored Health Coverage." *The New England Journal of Medicine.* V. 340, no. 3, January 21, 1999.

Leusner, Donna. "N. J. to Plug Gap in Health Insurance." *The Star-Ledger*, December 2, 1999."

Long. Stephen H. and M. S. Marquis. "Comparing Employee Health Benefits in the Public and Private Sectors, 1997." *Health Affairs*. November/December 1999.

Long. Stephen H. and M. S. Marquis. "Stability and Variation in Employment-Based Health Insurance Coverage, 1993-1997." *Health Affairs*. November/December 1999.

McDonough, John E. Healthcare Policy. The Basics. The Access Project. Boston, Massachusetts. 1999.

Mitchell, Stephen (trans.). The Book of Changes. San Francisco. 1986.

National Conference of State Legislatures. Health Policy Tracking Service. Major Health Care Policies 50 State Profiles. 1999. Eighth Edition. January 2000.

New Jersey Business and Industry Association. *1998 Health Benefits Survey*. April 1999.

Pauly, Mark V. Health Benefits at Work: An Economic and Political Analysis of Employment-Based Health Insurance. Ann Arbor. University of Michigan Press. 1997.

Perry, M. J., C. G. Marshall and N.J. Robertson. "Business Attitudes Toward Health Insurance Coverage of Employees and their Dependent Children." Economic and Social Research Institute. Lake Snell & Perry Associates. August 1999.

Polzer, Karl. HIPAA as a Regulatory Model: Early Experiences and Future Prospects. National Health Policy Forum. *Issue Brief No. 735*. April 1999.

"Shrinking Coverage for Retired Workers." News & Trends. *Business & Health.* December 1999.

Sloan, F. A. and C. J. Conover. "Effects of State Reforms on Health Insurance Coverage of Adults." *Inquiry*. 35:280-93.

State of the States. State Coverage Initiatives. An Initiative of The Robert Wood Johnson Foundation. The Alpha Center. Washington DC. January 2000.

Yoder, Eric. "Rising Rates – the Federal Employees Health Benefits Program." *Government Executive.* December 1999.

Winslow, R. and C. Gentry. "Medical Vouchers: Health Benefits Trend – Give Workers Money, Let Them Buy a Plan." *The Wall Street Journal*. February 8, 2000.

Appendix A

Selected Federal Legislation Regarding Health Insurance Affordability and Access

H.R. 225 - Self-Employed Health Affordability Act of 1999.

H.R. 611 - Small Business Owners' Health Insurance Deductibility Act.

H.R. 614 - Medical Savings Account Effectiveness Act of 1999.

H.R. 918 - To amend the Internal Revenue Code of 1986 to increase to 100 percent the amount of the deduction for the health insurance costs of self-employed individuals.

H.R. 1136 - Affordable Health Care Act of 1999.

H.R. 1687 - Patients' Health Care Choice Act of 1999.

H.R. 1819 - Working Uninsured Tax Equity Act of 1999.

H.R. 2020 - Tax Relief for Working Americans Act of 1999 (Introduced in the House). SPONSOR: Rep Johnson, Nancy L. (introduced 06/07/99). A bill to amend the Internal Revenue Code of 1986 to provide marriage penalty relief, incentives to encourage health coverage, and increased child care assistance, to extend certain expiring tax provisions, and for other purposes.

H.R. 2185 - Health Insurance for Americans Act of 1999 (Introduced in the House). SPONSOR: Rep Stark, Fortney Pete (introduced 06/14/99). A bill to amend the Internal Revenue Code of 1986 to allow individuals a refundable credit against income tax for the purchase of private health insurance through a pooling arrangement.

H.R. 2034 - Health Care Benefits Financial Protection Act of 1999. SPONSOR: Rep Maloney, James H. (introduced 06/22/99). A bill to amend the Internal Revenue Code of 1986 to allow employers who maintain a self-insured health plan for their employees a credit against income tax for a portion of the cost paid for providing health coverage for their employees.

H.R. 2362 - Fair Care for the Uninsured Act of 1999 (Introduced in the House). SPONSOR: Rep Armey, Richard K. (introduced 06/25/99). A bill to amend the Internal Revenue Code of 1986 to allow individuals a refundable credit against income tax for the purchase of private health insurance, and to provide for a report on State health insurance safety-net program.

H.R. 2488 - Financial Freedom Act of 1999. There are currently five versions of this bill in the House and Senate. One version is cited as the Taxpayer Refund Act of 1999 (Engrossed Senate Amendment) H.R. 2488 EAS

S. 135 - Health Insurance Tax Equity for Self-Employed Act.

S. 194 - Health Insurance Tax Relief Act.

S. 343 - Self-Employed Health Insurance Fairness Act of 1999.

S. 825 – A bill to amend the Internal Revenue Code of 1986 to allow small business employers a credit against income tax for employee health insurance expenses paid or incurred by the employer.

Sources: Health Insurance Association of America, 2000; Employee Benefit Research Institute, 1999.

Appendix B - Table 3

Nonelderly Population With Selected Sources of Health Insurance, by Region and State, 1998

Region and State	Total	Employment-Based Coverage			Individually Purchased	Public		Uninsured
		Total	Own name	Dependent		Total	Medicaid	
				(millions)				
Total	238.6	154.8	79.1	75.7	15.5	34.2	24.9	43.9
New England	11.7	8.2	4.1	4.1	0.8	1.7	1.3	1.5
Maine	1.1	0.8	0.4	0.4	0.1	0.2	0.1	0.2
New Hampshire	1.1	0.8	0.4	0.4	0.1	0.1	0.1	0.1
Vermont	0.5	0.4	0.2	0.2	0.0	0.1	0.1	0.1
Massachusetts	5.3	3.7	1.8	1.8	0.4	0.9	0.7	0.6
Rhode Island	0.8	0.6	0.3	0.3	0.1	0.1	0.1	0.1
Connecticut	2.9	2.0	1.0	1.0	0.2	0.3	0.2	0.4
Middle Atlantic	33.5	22.0	11.1	11.0	2.1	4.8	4.0	5.7
New York	16.0	9.7	4.9	4.8	0.9	2.9	2.4	3.2
New Jersey	7.2	5.0	2.5	2.5	0.5	0.6	0.4	1.3
Pennsylvania	10.3	7.3	3.7	3.6	0.8	1.4	1.1	1.2
East North Central	39.4	28.1	13.9	14.2	2.1	4.6	3.7	5.7
Ohio	9.8	7.2	3.5	3.7	0.5	1.3	1.0	1.2
Indiana	5.2	3.7	1.9	1.8	0.4	0.4	0.3	0.8
Illinois	11.0	7.6	3.8	3.8	0.6	1.2	1.0	1.8
Michigan	8.9	6.3	2.9	3.3	0.4	1.2	1.1	1.3
Wisconsin	4.5	3.3	1.7	1.6	0.3	0.5	0.4	0.6
West North Central	16.3	11.6	5.8	5.8	1.5	2.0	1.4	1.9
Minnesota	4.3	3.2	1.5	1.7	0.3	0.5	0.4	0.4
Iowa	2.4	1.8	0.9	0.9	0.3	0.2	0.2	0.3
Missouri	4.7	3.4	1.8	1.5	0.3	0.6	0.5	0.6
North Dakota	0.6	0.3	0.2	0.2	0.1	0.1	0.0	0.1
South Dakota	0.6	0.4	0.2	0.2	0.1	0.1	0.0	0.1
Nebraska	1.5	1.1	0.5	0.6	0.1	0.2	0.2	0.2
Kansas	2.2	1.5	0.7	0.7	0.3	0.3	0.2	0.3
South Atlantic	41.4	26.8	14.3	12.5	2.9	6.0	3.7	7.8
Delaware	0.7	0.5	0.2	0.2	0.0	0.1	0.1	0.1
Maryland	4.4	3.1	1.6	1.5	0.3	0.3	0.1	0.8
District of Columbia	0.4	0.2	0.2	0.1	0.0	0.1	0.1	0.1
Virginia	5.8	4.0	2.0	2.0	0.4	0.9	0.3	0.9
West Virginia	1.4	0.9	0.4	0.4	0.1	0.3	0.2	0.3
North Carolina	6.5	4.3	2.4	1.9	0.4	1.0	0.7	1.1
South Carolina	3.4	2.2	1.2	1.1	0.2	0.5	0.3	0.6
Georgia	6.9	4.3	2.3	2.0	0.4	1.2	0.9	1.3
Florida	11.9	7.2	3.9	3.3	1.0	1.6	1.0	2.5
East South Central	14.4	9.1	4.6	4.5	0.9	2.6	2.0	2.5
Kentucky	3.4	2.3	1.2	1.1	0.2	0.6	0.4	0.5
Tennessee	5.0	3.0	1.5	1.5	0.3	1.2	1.0	0.7
Alabama	3.7	2.4	1.2	1.2	0.2	0.5	0.4	0.7
Mississippi	2.4	1.4	0.7	0.7	0.2	0.3	0.2	0.6
West South Central	26.8	15.8	8.2	7.6	1.5	3.8	2.6	6.7
Arkansas	2.2	1.3	0.7	0.7	0.2	0.3	0.2	0.5
Louisiana	3.8	2.3	1.1	1.2	0.1	0.7	0.5	0.8
Oklahoma	2.8	1.7	0.9	0.8	0.2	0.5	0.2	0.6
Texas	18.0	10.4	5.5	4.9	1.1	2.3	1.7	4.9
Mountain	15.5	9.9	4.9	4.9	1.0	1.9	1.2	3.3
Montana	0.8	0.5	0.2	0.2	0.1	0.1	0.1	0.2
Idaho	1.1	0.7	0.4	0.4	0.1	0.1	0.1	0.2
Wyoming	0.4	0.3	0.1	0.1	0.0	0.1	0.0	0.1
Colorado	3.6	2.6	1.4	1.2	0.2	0.3	0.1	0.6
New Mexico	1.6	0.9	0.4	0.5	0.1	0.3	0.2	0.4
Arizona	4.3	2.4	1.3	1.2	0.3	0.6	0.4	1.2
Utah	1.9	1.4	0.6	0.8	0.2	0.2	0.1	0.3
Nevada	1.7	1.1	0.6	0.5	0.1	0.1	0.1	0.4
Pacific	39.6	23.3	12.2	11.1	2.7	6.6	5.0	8.7
Washington	5.2	3.5	1.9	1.6	0.4	0.9	0.6	0.7
Oregon	3.0	1.9	1.0	0.9	0.2	0.5	0.4	0.5
California	29.9	16.7	8.7	8.0	2.0	4.8	3.8	7.3
Alaska	0.6	0.3	0.2	0.2	0.0	0.1	0.0	0.1
Hawaii	1.0	0.7	0.4	0.3	0.0	0.2	0.1	0.1

(continued)

Table 3 (continued)

Region and State	Total	Employment-Based Coverage			Individually Purchased	Public		Uninsured
		Total	Own name	Dependent		Total	Medicaid	
				(percentage)				
Total	100.0%	64.9%	33.1%	31.7%	6.5%	14.3%	10.4%	18.4%
New England	100.0	69.7	34.9	34.8	7.0	14.5	11.1	12.6
Maine	100.0	68.8	35.4	33.3	7.0	15.4	9.3	14.6
New Hampshire	100.0	71.7	33.5	38.2	7.2	13.5	8.9	12.5
Vermont	100.0	67.3	34.6	32.7	7.7	19.4	16.1	11.0
Massachusetts	100.0	68.7	34.7	34.0	7.3	16.3	13.7	11.7
Rhode Island	100.0	71.4	35.8	35.5	8.4	11.5	8.5	11.5
Connecticut	100.0	71.0	35.4	35.6	5.7	11.3	7.4	14.3
Middle Atlantic	100.0	65.8	33.0	32.8	6.2	14.4	12.0	17.0
New York	100.0	60.7	30.6	30.1	5.3	17.9	15.3	19.7
New Jersey	100.0	69.5	34.1	35.4	6.4	8.0	6.0	18.0
Pennsylvania	100.0	71.2	36.0	35.2	7.5	13.4	11.0	12.1
East North Central	100.0	71.5	35.3	36.2	5.4	11.8	9.4	14.6
Ohio	100.0	73.3	35.9	37.4	5.1	13.6	9.9	11.8
Indiana	100.0	71.4	36.9	34.5	7.1	7.7	5.7	16.1
Illinois	100.0	69.6	34.6	35.0	5.7	11.2	9.0	16.6
Michigan	100.0	70.6	32.9	37.7	4.1	13.4	12.1	14.9
Wisconsin	100.0	73.8	38.5	35.3	5.7	10.8	8.5	13.2
West North Central	100.0	71.2	35.4	35.8	9.1	12.2	8.8	11.6
Minnesota	100.0	74.7	35.6	39.1	7.5	11.3	8.8	10.3
Iowa	100.0	73.1	35.2	37.8	10.7	9.1	7.0	10.9
Missouri	100.0	71.5	38.9	32.6	6.9	12.8	9.9	12.1
North Dakota	100.0	60.1	27.6	32.6	15.3	13.1	7.3	16.6
South Dakota	100.0	66.5	34.3	32.2	11.0	10.7	6.4	16.4
Nebraska	100.0	70.5	31.5	39.0	9.7	16.3	10.3	10.3
Kansas	100.0	66.4	32.8	33.6	12.6	13.4	8.5	12.2
South Atlantic	100.0	64.7	34.6	30.2	7.0	14.6	9.0	18.9
Delaware	100.0	69.7	34.9	34.8	4.9	13.4	9.7	17.1
Maryland	100.0	71.7	36.7	35.0	6.1	7.1	3.4	18.9
District of Columbia	100.0	56.1	39.3	16.8	6.8	25.0	22.0	19.2
Virginia	100.0	68.5	34.2	34.3	7.6	15.0	5.4	16.0
West Virginia	100.0	59.8	30.3	29.5	4.5	21.1	16.8	20.9
North Carolina	100.0	66.4	37.5	28.9	5.8	15.5	10.1	17.1
South Carolina	100.0	66.8	35.3	31.5	6.9	15.3	8.4	17.5
Georgia	100.0	62.6	34.1	28.5	6.1	17.6	12.8	19.5
Florida	100.0	60.7	32.8	27.9	8.5	13.6	8.6	21.3
East South Central	100.0	63.1	32.1	31.1	5.9	18.4	13.7	17.6
Kentucky	100.0	67.3	34.2	33.1	5.4	18.3	10.9	16.1
Tennessee	100.0	60.2	30.9	29.3	6.3	24.0	20.1	14.4
Alabama	100.0	66.1	33.4	32.7	5.2	13.5	10.0	19.5
Mississippi	100.0	58.9	29.5	29.4	6.9	14.2	9.9	23.1
West South Central	100.0	59.1	30.5	28.5	5.8	14.1	9.8	25.2
Arkansas	100.0	61.4	30.1	31.3	7.3	15.0	9.3	21.8
Louisiana	100.0	60.9	29.7	31.3	3.8	18.6	13.2	21.5
Oklahoma	100.0	62.1	32.1	30.0	5.6	17.1	7.8	21.4
Texas	100.0	57.9	30.5	27.4	6.0	12.6	9.4	27.0
Mountain	100.0	63.7	31.8	31.9	6.6	12.5	7.4	21.5
Montana	100.0	57.5	27.9	29.6	9.7	15.3	10.8	22.0
Idaho	100.0	63.9	30.9	33.0	9.8	12.8	9.4	19.7
Wyoming	100.0	64.6	30.2	34.3	6.8	12.9	6.5	19.0
Colorado	100.0	71.3	39.0	32.3	6.3	8.8	3.6	16.5
New Mexico	100.0	57.9	25.8	32.1	4.1	19.2	13.6	24.0
Arizona	100.0	56.3	29.1	27.2	6.6	15.0	8.6	27.2
Utah	100.0	70.3	29.2	41.1	7.8	10.8	7.4	15.1
Nevada	100.0	67.2	35.3	31.9	4.8	7.8	4.1	23.7
Pacific	100.0	58.7	30.8	27.9	6.8	16.7	12.6	22.0
Washington	100.0	67.7	36.4	31.3	8.0	18.0	11.5	13.5
Oregon	100.0	65.0	34.6	30.3	7.1	17.0	14.1	16.1
California	100.0	56.0	29.2	26.8	6.7	16.2	12.8	24.4
Alaska	100.0	58.5	27.5	31.0	6.1	23.1	7.0	18.6
Hawaii	100.0	71.9	38.0	33.8	3.9	19.6	11.1	11.6

Source: Employee Benefit Research Institute estimates from the March 1999 Current Population Survey.
Note: Details may not add to totals because individuals may receive coverage from more than one source.