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The Status of New Jersey's Employer-Based Health Insurance Coverage

Background Information for . . .

THE NEW JERSEY HEALTH POLICY FORUM

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TABLE OF CONTENTS

INTRODUCTION AND THE ISSUES	1
“JUST THE FACTS”	2
THE SPECIAL CHALLENGES OF SMALL BUSINESSES AND THE UNINSURED	4
NEW JERSEY AND HEALTH INSURANCE COVERAGE	5
<i>The Costs of Providing Insurance</i>	6
<i>Uninsured in New Jersey</i>	6
HEALTH COVERAGE MANDATES - NEW JERSEY LEGISLATIVE ACTION	7
EMPLOYERS RESPOND: TRENDS IN COST-SAVINGS STRATEGIES	8
<i>Cost Sharing</i>	10
<i>Higher Employee Premium Contributions</i>	10
<i>Changing Plans and Carriers</i>	10
<i>Offering Fewer Services and Setting Tighter Eligibility Rules</i>	10
<i>Retiree Health Care Eligibility — Cuts And Caps</i>	11
<i>Defined Contributions</i>	11
<i>Elimination of Coverage</i>	12
FEDERAL INITIATIVES AND EMPLOYER HEALTH COVERAGE	12
CURRENT FEDERAL TRENDS	13
<i>Medical Savings Accounts</i>	13
<i>Health Credits</i>	13
<i>Patient Bill of Rights</i>	14
<i>Association Health Plans</i>	14
<i>Restructuring Medicare/Medicaid</i>	14
EMPLOYEES RESPOND: EROSION IN CONFIDENCE	15
POLICY EXPERTS RESPOND: VARIOUS SYSTEM REFORM STRATEGIES	18
REFERENCES	18





THE ISSUES: *The New Jersey Policy Forums on Health and Medical Care held a forum in March 2000 that focused on the future of employer-based health plans. At that time, the system was already showing a pattern of escalating costs and coverage erosion – a trend that has continued and accelerated. Employer-based health insurance premiums in New Jersey and throughout the nation are now rising annually at double-digit rates. We are in a cycle of surging health costs, state budget shortfalls and an overall economic downturn that is severely stressing the ability of employers to offer and maintain worker coverage.*

The status of health coverage provided by employers – both small and large – has significant implications for state policymakers, to whom the administrative and regulatory authority for health care has primarily fallen. Several policy questions emerge for an analysis of the current employer-based health coverage market, including:

- *What implications do the current budgetary and economic challenges carry for employer-based health plans in New Jersey?*
- *Is there a commitment and will to explore how employer health plans and public programs can coordinate resources to extend coverage for New Jersey's workers?*
- *It is 10 years since the promulgation of the state's small employer insurance market reforms – what is the status of these reforms in New Jersey?*
- *How are small businesses being affected by current economic and market forces?*
- *What part do health insurance mandates play in the viability and costs of health coverage being provided by employers?*

INTRODUCTION

Trends in employer-based health insurance are critical to understanding how health care costs, coverage, quality and access to care are evolving, and analysis of such issues as employer health plan costs, employee cost sharing, covered benefits, and mandates offers insight into the broader health care system and carries implications for access to and affordability of health and medical care. The system of an employer's providing its workers with health insurance benefits has often been called the linchpin of the amalgam of policies and programs within the larger health insurance market.

Paul Fronstin of the Employee Benefit Research Institute is one of the country's leading experts who has been tracking trends in employer-based health coverage over several years. He stresses that 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" (EBRI, 1999; "EBRI Research Highlights: Health Benefits," *Special Report*, May 2003). The United States "is unique among nations in relying on private employers to voluntarily provide health insurance coverage for all employees" (emphasis added) (Iglehart, 1999). In all other industrialized nations, societies have assigned the task to government or require private employers to provide coverage on a heavily regulated basis. As the link between employment and voluntary provision of health insurance coverage becomes all the more tenuous, there is absence of agreement among the public and its policymakers on alternatives to our current system of employment-based insurance.

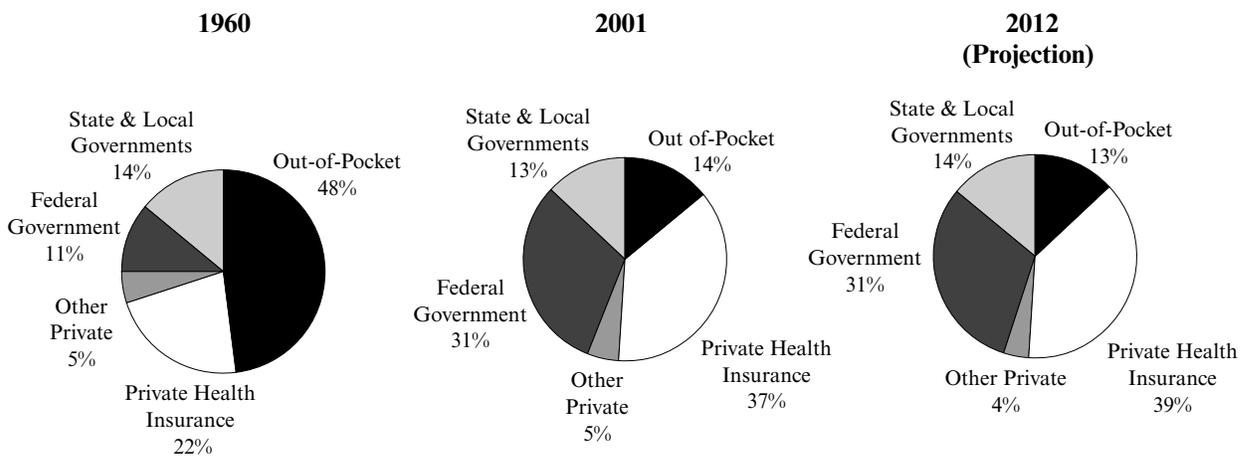




“JUST THE FACTS . . .”

Employer-sponsored health care is the largest component in the health insurance system, enrolling fully 74 percent of the adult working population (Fronstin, 2003). Employers now cover close to 160 million workers and their family members and contribute almost \$335 billion toward health insurance coverage (Davis and Schoen, 2003). Total 2001 national health expenditures reached \$1.424.5 trillion, including \$454.8 billion (31.9 percent) from the federal government and \$191.8 billion (13.5 percent) from state and local governments. A 2002 Kaiser report on trends and indicators in the changing health care marketplace found that national health care expenditures per capita increased by 69 percent over a recent 10-year period – from \$2,738 in 1990 to \$4,637 in 2000 (Kaiser Family Foundation, 2002).

I. National health expenditures by source of funds 1960, 2000 and 2012



Source: For years 1960 and 1970, see Katherine R. Levit et al., “National Health Expenditures in 1997: More Slow Growth,” Health Affairs (November/December 1998): 99–110; and EBRI tabulations. For years 1980–2012, see U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, <http://cms.hhs.gov/statistics/nhel>.

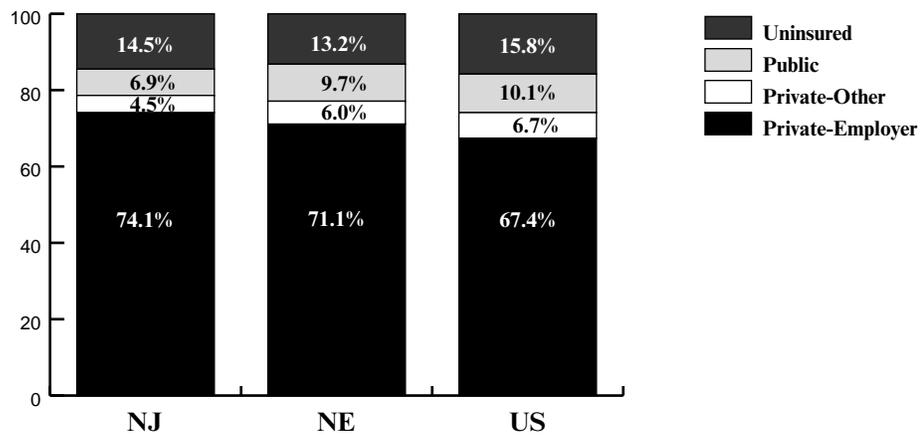
Projections for health care cost trends show continued national increases: the Centers for Medicare and Medicaid Services (CMS) projects that by 2011, health spending will comprise 17 percent of the Gross Domestic Product (GDP). In 2001, health spending constituted 14.1 percent of the GDP. Research studies conducted by the Center for Studying Health System Change and the National Coalition on Health Care (a business alliance working to improve the nation’s health care system) project that health insurance premiums will increase by more than 50 percent by 2006, at least 10 million people will become uninsured within three years and employers will continue shifting costs to workers (MacDonald, 2003).

As health care cost trends increase, so do the numbers of uninsured and underinsured. The Congressional Budget Office estimates that for each one percent increase in the cost of premiums, 200,000 individuals lose health insurance coverage. Although at present the generally accepted overall number of uninsured nationally stands at approximately 41 million (U.S. Census Bureau), a recent Congressional Budget Office report found that between 57 million and 59 million nonelderly Americans lack health insurance at some point during the year (*State Health Notes*, June 2, 2003). Hispanics and those with lower incomes were more likely to go for extended periods of time without any coverage (www.cbo.gov).





II. Health Insurance Coverage by Source for Non-Elderly in New Jersey, the Northeast, and the U.S., 2000



Source: Rutgers Center for State Health Policy, 2002: Current Population Survey, 2001

Employers in New Jersey and nationwide are struggling with double-digit annual premium increases. Premiums rose 8.3 percent in 2000 and 11.0 percent in 2001, a sharp reversal from the low rates of growth from 1994 to 1998 (Trude, 2003). In 2002, the cost of employee-only coverage, nationwide, averaged \$3,392 annually, up from \$3,008 in 2001 (Fronstin, 2003). In New Jersey, the numbers grew at even higher rates: average employer premium costs in New Jersey have increased 35 percent in the last three years (Biddle, 2003). Since the rate of increase for health insurance costs far exceeds the overall rate of inflation, the cause for this trend cannot be simply attributed to routine inflationary pressures. The explanation lies instead with an interrelated mix of factors.

The New Jersey Business and Industry Association attributes these unprecedented increases to:

- An aging population and the medical expenses associated with that demographic
- New medical technologies that are the source of more effective – and costly – treatments that sustain life but also increase the length and cost of treatment
- New costly prescription drugs (which are now being aggressively promoted by commercial advertising)
- Health industry consolidations that weaken the price controls fostered by competition (Biddle, 2003).

The Rutgers Center for State Health Policy cited additional reasons for the upsurge in premium costs:

- Federal and state laws that mandate the services that carriers must include in their insurance packages (Those mandates, when processed by insurance plan underwriters, emerge as increased premium charges.)
- The insurance underwriting cycle, and the inevitable upward pressure on rates
- The reduced discounting of hospital costs as health care providers begin to resist the contract demands of managed care providers
- Rising labor costs for nurses and other medical professionals (Health Insurance Coverage, 2002).

Sally Trude, senior researcher with the Center for Studying Health System Change, identified an additional trend contributing to runaway health costs. Trude asserted that “loosened” managed care plans are giving enrollees greater choice of physicians and broader service packages, thereby compromising the key cost controls originally offered by managed care. That trend emerged when managed care companies sought greater market share by responding to consumer demands for fewer restrictions and more services. As summarized by Lesser and Ginsburg in their findings from community site visits (including Newark, New Jersey):





Two years ago, new cost and access problems emerged in the U.S. health care system as managed care lost its bite in the wake of a powerful consumer backlash. . . Fewer restrictions on care led to higher utilization and taxed the capacity of many hospitals and physicians to meet demands. With broad provider networks and tighter capacity the norm, plans lost leverage over providers to negotiate price discounts – a key element in lower health cost trends throughout much of the 1990s. Facing rising premiums and reduced profits, some employers began to increase patient cost sharing in a bid to control health benefit outlays (Lesser and Ginsburg, May 2003).

THE SPECIAL CHALLENGES OF SMALL BUSINESSES AND THE UNINSURED

Small Businesses

Rising premiums and a weak economy are generating questions about the erosion of health insurance coverage throughout the business world. But those problems are especially acute for the more than 46 million Americans who work for small firms. Coverage generally costs more for firms with fewer than 50 workers. Those Americans and the employers for whom they work are facing serious financial challenges as health care costs escalate (Short, 2002). Of covered employees, low-income workers – many of whom are concentrated in small businesses – were the most likely to experience these reduced benefits and increased health coverage costs (Edwards, 2002).

Small firms are less likely to offer health insurance, and the employees in small firms – who on the average get paid less than the employees of larger firms – are less likely to sign up for insurance when it is offered. Workers in the smallest firms tend, therefore, to be the least likely to have health benefits from their employer. In 2001, only 28 percent of workers in firms with fewer than 10 employees had employer-based health insurance. That is in dramatic contrast to the 68 percent of covered workers in companies with 1,000 or more employees (Fronstin, 2003).

Large employers generally made only modest changes to their insurance offerings in response to rising premiums, such as increasing worker copays. But small firms often have greater difficulty than larger employers in funding health insurance for their workers. Insurance premiums rose rapidly for all firms in 2001 and 2002, but small firms were hit particularly hard, with an average hike in New Jersey of 16 percent in 2001 (Biddle, 2003).

Among employers not offering health benefits, 30 percent said they would be much more likely to offer them if the government provided tax breaks to reduce health benefit costs for low-wage workers. In general, small employers support tax breaks to reduce the health insurance costs of low-wage workers (Fronstin, 2003). Nearly a quarter of small business employers think they would change coverage if premiums go up five percent or more. Three percent said such a rise would cause them to drop health benefits.

The Uninsured

There is a clear-cut relationship between the uninsured and the nation's workforce: the uninsured represent 14.6 percent of workers in America. More than 80 percent of the uninsured live in families headed by a full-time worker ("Who are the Uninsured," 2003). The National Federation of Independent Businesses estimates that 60 percent of the over 41 million Americans who lack medical insurance are members of families who own or work for small businesses.





Employed but uninsured citizens either work for employers who do not offer coverage or opt not to buy coverage because it is too expensive. Even though the percentage of employers offering health care is stable, the number of people receiving such coverage is declining. That apparent inconsistency is explained by the fact that more people are now under-employed. More than half of employers who do not offer health benefits indicate that fewer than 80 percent of their employees work full-time. Firms not offering health benefits also tend to have larger proportions of:

- women,
- workers under age 30, and
- minority employees.

Nearly 50 percent of employers not offering health benefits pay annual wages of less than \$15,000 to 40 percent of their employees, compared to 13 percent of companies that do offer health benefits (Fronstin, “Small Employers,” 2003). Even when insurance is offered to low-wage workers, they often cannot afford the accompanying copays or coinsurance mandates. The 2002 *Small Employer Health Benefit Survey* confirmed that employers not offering health benefits are more likely to report that they have a high employee turnover and that employees stay with the business for only a few months (Fronstin, 2002).

The recent loss of employment is another reason for being uninsured and also being ineligible for Medicaid. The unemployment rate in January 2002 was higher by a third than the rate the year before. That corresponds to a significant increase in uninsured workers. Many of those workers are eligible for private insurance at group rates under the COBRA (Comprehensive Omnibus Budget Reconciliation Act of 1985) regulations that permit former employees of businesses employing more than 20 people to maintain insurance for 18 months after separation at the lower group rates. However, many workers cannot avail themselves of that coverage because its cost, even with recent tax subsidy provisions, is more than they can or want to spend.

NEW JERSEY AND HEALTH INSURANCE COVERAGE

New Jersey is generally viewed as a leader in promoting access to affordable health insurance coverage for its residents. The state is good on “guaranteed issue,” “guaranteed renewal,” limitations on pre-existing conditions, and community rating laws prohibiting the use of past claims in setting premiums for small groups. New Jersey has repeatedly exhibited its commitment to citizen insurance coverage by:

- instituting, in the 1990s, the most comprehensive insurance reforms in the country for the individual-purchase and small-group insurance markets.
- legally guaranteeing (1993 Individual Health Coverage Program (IHC) law) access to coverage for those who do not have employer-based group insurance or Medicare.
- permitting the deduction of insurance premiums paid by self-employed workers.

As part of New Jersey’s health insurance market reforms, the IHC Program has been in operation in New Jersey since August 1993, and the Small Employer Health (SEH) Benefits program went into effect in January 1994. Enrollment census as of 2001 in the IHC program stood at 83,896 and for the SEH program at 875,306. Although current enrollment for the SEH program shows an increase from the 779,299 persons covered in the 4th quarter of 1995, current enrollment for the individual health coverage program declined from a high of 186,130 in the 4th quarter of 1995. These enrollment numbers are representative of the issue that even with its strong recent history of advocacy for health insurance coverage, New Jersey is nonetheless experiencing many of the same health insurance problems occurring in states throughout the nation. According to Rutgers Center for State Health Policy research, “evidence from program data has emerged to indicate that those who remained covered under individually purchased plans may be disproportionately high-risk and high-cost, raising questions about whether this last-resort source of private-coverage is sustainable” (*Health Care Coverage*, 2002).





Health insurance premiums have begun to rise sharply in the state, paralleling national trends. According to a study by the Rutgers Center for State Health Policy, “rising premium costs, combined with a softening economy may lead to a leveling off or decline in the number of individuals and families with employer-sponsored coverage” (*Health Care Coverage*, 2002). As of 2000, premium increases did not appear to be leading to defections of New Jersey employers. However, to offset rising premium costs, employers in the state are increasingly requiring employees to contribute a greater share of the premiums, particularly for single coverage. This appears to be having an impact on the proportion of employees who enroll in coverage, which has declined in recent years (*Health Care Coverage*, 2002).

The Costs of Providing Insurance

According to the most recent New Jersey Business and Industry Association (NJBIA) survey, New Jersey employers are reeling from the upward surge in health insurance costs. The average cost of employee health benefits rose 15 percent in 2002 and over 35 percent in the past three years. In 2002, the average cost of insuring one employee rose to \$6,323, an increase of \$823 (15 percent) from the year before. As was the case nationally, the smaller New Jersey companies (2-50 employees) had an even tougher time of it, with average small employer costs reaching \$6,489, a 16 percent increase from the previous year (Biddle, 2003).

As employers sought savings by cost-shifting, workers in New Jersey saw increases in copays, and cut-backs in explicit coverage. The majority of the state’s employers are not optimistic about the future. Almost two-thirds (64 percent) anticipate double digit increases in 2003 (New Jersey Business and Industry Association, 2003). This is a lose-lose situation for employers and workers alike and is, according to survey findings, viewed by employers as a cost spiral that offers “no relief in sight.” Kiplinger projects that, given this trend, a doubling of employer costs is likely by 2008 (Biddle, 2003).

Uninsured in New Jersey

When compared nationally and regionally, the percentage of uninsured New Jersey residents (14.5 percent) is lower than the national figure of 15.8 percent, but slightly higher than the nine-state Northeast Census Division (13.2 percent) (2000). As is the case nationally, people in New Jersey who are unemployed or are employed part-time are more often without insurance than those who work full-time or are out of the labor force. Dependents in New Jersey are significantly less likely to be uninsured than dependents nationally.

The expansion of public funding for coverage and a strong private market can be credited with a significant decline in the state’s uninsured rate among the state’s non-elderly, from a high of 19.1 percent in 1996 to 14.4 percent in 2000. The decline in the number of uninsured has been much greater among children than non-elderly adults, due largely to the expansion of public coverage through the New Jersey KidCare and FamilyCare programs. As of September 2002, there were also 93,409 children and 178,243 adults enrolled in New Jersey in FamilyCare, the federally and state subsidized program for low-income families (*Health Insurance Coverage*, 2002).

But sustaining the state’s progress in reducing the number of uninsured is becoming increasingly more difficult. High enrollment rates coupled with state revenue shortfalls led the state to freeze enrollment of adults in the FamilyCare program (*Health Insurance Coverage*, 2002).





NEW JERSEY LEGISLATIVE ACTION REGARDING HEALTH CARE BENEFITS COVERAGE MANDATES

New Jersey has long been a leader in legislating improved citizen access to mandated services. In recent years, the New Jersey legislature has mandated full or partial insurance coverage for:

- In vitro fertilization
- Pap smears
- Formula for infants with mild intolerance
- Hearing loss screenings for newborns.

Those laws come on top of legislation already mandating group health coverage for numerous conditions and services, including:

- alcoholism treatment,
- blood products associated with hemophilia treatment,
- breast reconstruction,
- childhood immunizations,
- diabetes treatment,
- home health care,
- lead poisoning and screening,
- coverage of those dependent by reason of mental retardation or physical handicap,
- mammography screening,
- maternity benefits,
- newborn coverage,
- prostate cancer screening,
- second opinions.

With S-2275/A-3137 — a bill to create a 13-member Mandated Health Benefits Advisory Commission — pending in the legislature, New Jersey joins other states that are working to assess and evaluate the impact of mandates on the insurance market in general and on costs for purchasers in particular. According to NJBIA, even with the implementation of small group health insurance reforms, plans with large numbers of mandates continue to make the cost of health insurance coverage prohibitive for some small companies. Up to 20 percent of the cost of health insurance is attributed to the imposition of legislative mandates (NJBIA *Business Voice*, vol. 6, no. 4, April 2003).

The National Conference of State Legislatures reports that since 2001 six states — California, Florida, Louisiana, North Dakota, North Carolina and South Carolina — enacted legislation to study the financial impact of assessing new coverage requirements and/or evaluating current coverage mandates. An additional 12 states have introduced similar bills. Both enacted laws and bill proposals are incorporating the requirement that cost-benefit analyses accompany mandated health benefit proposals.

In the current legislative session, there are also several bills proposing actions to increase health insurance coverage and use, and to strengthen systems oversight, including:

- a corporation business tax credit (A-1687),
- an income tax deduction (A-1118),
- an income tax credit (A-1681),
- mandated unlimited treatment for alcohol and drug addiction (A-2379, S-1520),
- expanded coverage to a broad range of “behavioral disorders” (A-2487; S-1633),





Governor James E. McGreevey, speaking at the June 11, 2003 “Governor’s Conference on Healthcare Coverage,” observed:

New Jersey is one of many states that tried in the past dozen years to reform its individual and small group markets. New Jersey's last major reforms took place a decade ago. As a young Senator I was embroiled in that debate, leading the charge against balance billing of Medicare patients. We tried many things with the focus always on attempting to strike the balance between accessibility and cost. States tried to guarantee that policies are written and renewed. They put limits on effect of pre-existing conditions. They tried to make coverage move with people from job to job. They capped how much a person's age or health status could affect what they pay in the individual market.

Only now have states started to look at the results. In New Jersey, we saw our small group markets enroll more people between 1994 and 2000. But since then, the erosion has been steady. Three years ago, 930,000 people were covered through the small group market; by 2002, the number had dropped to 875,000. In a weak economy, employers have tough choices, and many small employers have simply opted out of the system. In the individual market, rising premiums led to declining enrollment as early as 1996. That year, we had 220,000 people enrolled. Today we have only about 90,000. Some have likened the decline in the individual market to a "death spiral." We provided bare bones coverage in the individual and small group markets and what we found is that people didn't buy it. They won't spend money for coverage that is not complete- they would rather do without. It is a situation we cannot tolerate as a society.

Our first step must be to find ways to avoid the double-digit increases. I know what employers are feeling because I know what the cost of health insurance is doing to the state budget. For Fiscal Year 2004, all state-paid health insurance costs - including employee benefits, post-retirement medical and Medicaid — accounted for \$4.5 billion, a full 20 percent of the state budget.

Employers of all sizes need relief. We also need a better answer to the question: Who are the uninsured? How did they end up that way?

(Symptoms & Cures, v. 1, no. 22. HealthSense, Inc. June 2003.)
<http://www.healthsensenj.org/news-06-10.htm>

EMPLOYERS RESPOND: TRENDS IN COST-SAVINGS STRATEGIES

The overarching trend both nationally and locally, and both by government and by private insurers, continues to be one of incrementalism — of patching holes as holes appear in the voluntary employer-based system of health care coverage. Can this approach, however, be a viable mechanism to maintain an acceptable equilibrium between cost and benefits?

Many employers feel that, if they want to compete successfully for the best new workers to fill their career professional, skill, and key support positions, they must include health insurance as part of their compensation package (R. Christensen et al, 2002). For those employers, the issue is not whether to drop or retain worker health insurance, but how best to fashion a health care package that will continue to satisfy current employees, that will attract good prospective employees, and that will at the same time trim business costs. The consequences of that fiscal balancing act on worker health benefit packages is best described by the word “erosion.” By and large, workers continue to get health insurance coverage, but each year their packages cover less and cost them more. More workers today are being required by employers to pay more toward their insurance premiums and/or or to make greater co-pays on services (Edwards, 2002).





In January 2003, General Electric (GE) employees organized the company’s first strike since 1969 in protest over the increase in their health plan copayments. In mid-June 2003 negotiators from GE faced employees’ share of health insurance costs as one of the most “contentious” issues throughout talks with its two largest unions – the International Union of Electronic Workers/Communications Workers of America and the United Electrical, Radio and Machine Workers of America (kaisernetwork.org, June 16, 2003). In the first phase of negotiations, GE had asked that employees pay 30 percent of health insurance expenses – compared to their current 19 percent contribution – in order to offset the company’s health costs. Between 1999 and 2002, the company’s health costs increased by 45 percent – from \$965 million to \$1.4 billion. The unions rejected the initial terms; tentative agreements have been reached among the parties but details are not yet available (ibid).

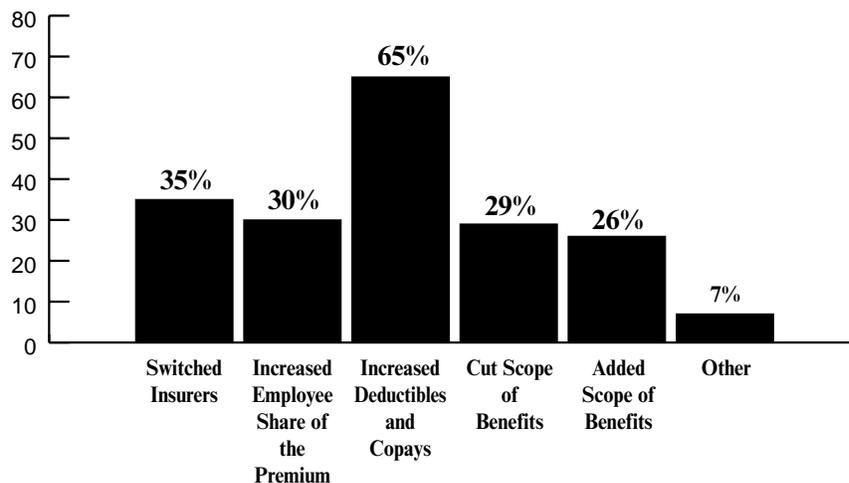
The escalation of employer health care costs is a nationwide and systemic problem, but the responses to that problem by employers can be characterized as ad hoc, reactive, and variable from business to business and from region to region.

Of the employers who amended their benefits plans between 2001 and 2002, the most common change was to ask employees to pay more toward their health care services. In a study published in January of this year, the Employee Benefit Research Institute reported that, in 2001-2002:

- Sixty-five percent of employers who made changes reported increasing deductibles and co-pays
- About 30 percent increased the share employees were required to pay for coverage and also cut back on the scope of the benefits offered
- 35 percent switched insurers, seeking a better deal (Fronstin, 2002).

Even when confronted with large premium increases, employers made only moderate changes to health benefits in the past two years. Health benefit consultants in several markets mentioned that large employers were passing on less of the premium increase than they would like to because of the tight labor market. By increasing co-payments and deductibles and changing their pharmacy benefits, employers shifted costs to those who use services. Employers recognize those actions as short-term fixes, but most have not developed strategies for the future. Although interested in “defined-contribution” benefits, employers do not agree about what that option entails and have no plans for moving to a defined contribution system in the immediate future (Trude, 2003).

III. Benefit Design Changes Between 2001 And 2002



Source: EBRI/CHEC/BCBSA 2002 Small Employer Health Benefits Survey





Employers sought specific savings by:

1. Cost Sharing

Firms sought to minimize their liability for premium increases by:

- increasing deductibles;
- mandating co-payments;
- instituting co-insurance (requiring employees to pay part of the cost of the premium) (Short, 2002);
- establishing three-tier prescription drug benefit standards with employees required to pay progressively more for generic, non-preferred brand name, and preferred brand name drugs (Trude, 2003).

The primary goal of those actions was to reduce costs by placing a higher cost burden on the consumers who used the services. A secondary outcome for the employer was that, by making medical care more expensive, the worker would likely use those services less frequently, thereby suppressing future premium increases driven by employee utilization (Short, 2002).

2. Higher Employee Premium Contributions

To cut back on premium costs, employers tried a number of strategies. Some employers:

- set their premium contributions at a fixed percentage, thus transferring some of the burden of premium increases to employees;
- decreased the percentage they contributed to the premium;
- abandoned the fixed percentage approach in favor of making a fixed dollar contribution, leaving employees responsible for any premium costs above that amount;
- reduced cost by dropping all contributions for dependent coverage (an action that also creates the potential for “adverse selection,” since higher costs tend to deter healthier families who need the services less from enrolling their dependents and paying the higher premium);
- replaced fixed dollar co-payments with a percentage coinsurance, increasing workers’ costs even more (Short, 2002).

3. Changing Plans and Carriers

Employers also sought savings by finding different carriers at lower rates. Some employers:

- moved from preferred provider plans to point-of-service plans, or from PPOs to HMOs;
- haphazardly switched carriers, shopping for small savings advantages.

4. Offering Fewer Services and Setting Tighter Eligibility Rules

Even employers who kept the same carriers sought relief by tightening coverage scope. Some employers:

- trimmed certain previously covered services from their plans – for instance, eliminating coverage for fertility treatment, or reducing coverage for mental illnesses;
- tightened program eligibility requirements, adding, for instance, stricter rules for participation by spouses and dependents;
- specified waiting periods before a new employee would be eligible for coverage
- encouraged employees to enroll in their spouse’s health plan;
- offered cash-back payments to workers who declined enrollment (R. Christensen et al, 2002).





Although not yet widely used by employers, there are some other, more extreme, cost savings measures on the radar screen. These include cutting or entirely eliminating retiree health benefits, going to a defined contribution system, or completely dropping employee health insurance coverage.

1. Cutting Retiree Health Care Eligibility

More employers are beginning to cap or eliminate spending for retiree health benefits. Some are requiring employees to meet age and service requirements before becoming eligible for retiree benefits. Some other employers have completely dropped retiree health benefits. This is an especially tempting cost saving strategy for some employers because the affected parties – retirees – are neither being recruited nor are any longer a part of the company workforce. This growing trend in health care cutbacks for retirees makes it likely that few retirees in the future will retain employee health benefits. As Paul Fronstin of the Employee Benefit Research Institute noted, workers will have to start saving early and take into account reasonable estimates of their life expectancy if they expect to have the financial resources they will need to pay for health insurance and health care expenses in retirement (Fronstin, “Retirement” 2003). In May 2003, *The Wall Street Journal* examined the increased number of U.S. steel companies that have filed for bankruptcy, which has caused a number of retired workers to lose their health benefits. Other industries in the current economy with especially vulnerable retirees include the airlines and automobile manufacturers.

2. Going to Defined Contributions

Some employers have moved to or are considering a move to a health benefit system of “defined contributions,” with a strategic focus on consumer-driven health plans. In its simplest form, a defined contribution is a dollar payment made to the employee, who must then find and pay for private health insurance through his/her own initiatives. Of the employers reporting that they would drop coverage at various levels of premium increases, 27 percent were either extremely likely or very likely to provide cash assistance to employees to help them buy health insurance on their own. Nearly 40 percent were somewhat likely to provide cash assistance, and 31 percent were not likely to do so (Fronstin, “Small Business,” 2002).

The most commonly discussed defined contribution approaches fall into three categories:

- the simplest and most controversial defined contribution model has the employer giving the employee cash or a voucher and an invitation to shop for an insurance package as an individual agent in the private market. The feeling among most consultants is that this “cashing out” strategy will become popular among employers only if the economy takes a major downturn or if patient protection legislation increases employer liability. Some analysts, however, believe that employers could eventually go to this form of defined contributions (Trude, 2003). An obvious problem with the “cashing out” strategy is that it eliminates the advantages to the employee of group negotiated plan rates. Workers under such an arrangement not only have to do their own legwork but also have to negotiate with insurers with none of the leverage that comes with representing a large group of potential buyers.
- electronic benefit exchange in which an intermediary between the employer and the plan provides a choice of health plans for employees, administers enrollment, and risk-adjusts payments to health plans.
- a range of health plan options sometimes referred to as “self-directed” or “consumer-driven” health plans. (For example, an employee might receive \$2,000 in a personal care account that is tapped first for any health care needs.)

The last two cited variations offer the employee the advantages of group rated premiums and some administrative assistance.





3. Dropping Coverage Entirely

Of all the options available to employers, dropping insurance coverage completely is the most extreme solution. Survey findings show that 21 percent of the employers not offering health benefits reported offering them sometime within the last five years, with more than 40 percent reporting that the business decided to drop benefits because of the cost (Fronstin, “Small Business,” 2002). But while some employers may have dropped health benefits in response to cost increases, even more added health benefits, many for the first time, possibly because they needed to compete for qualified workers during a time of low unemployment (Ibid.).

Escalating employer health insurance costs affect not only the employer’s health care expenditures. Some employers reported that in addition to looking for relief by modifying their health care plans they took other actions as well to find savings to make up for health cost by deciding to:

- delay hiring added workers, or;
- lay off workers, or;
- reduce or eliminate pay raises or bonuses, or;
- reduce other employee benefits, or;
- put off equipment and other purchases. (“Few Small Firms,” 2003)

FEDERAL INITIATIVES AND EMPLOYER HEALTH COVERAGE

There are several federal protections, laws and regulations related to health care and employer coverage. These laws may mandate coverage for specific groups, needs, and conditions, or seek to improve employee access to group insurance through “guaranteed issue” and “guaranteed renewal” requirements and include:

- Employee Retirement Income Security Act of 1974 (ERISA)
- Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)
- Family and Medical Leave Act of 1993 (FMLA)
- Health Insurance Portability and Accountability Act of 1996 (HIPPA)
- Newborns’ and Mothers’ Protection Act of 1996
- Mental Health Parity Act of 1996
- Women’s Health and Cancer Rights Act of 1998 and
- Trade Adjustment Assistance Act of 2002 (TAARA) (EBRI Special Report, May 2003).

ERISA offers protections for individuals – including a grievance and appeals process – who are enrolled in health benefit plans sponsored by private-sector employers. ERISA pre-empts state regulation of self-insured health plans and pensions, which has significant implications for state policymakers and regulators.

The TAARA includes a new tax subsidy to help workers and retirees who have lost their employer-sponsored health coverage as a consequence of trade practices or bankruptcies. The tax subsidy is designed to assist individuals to purchase replacement health coverage. For those eligible, the TAARA subsidy covers 65 percent of the cost of health insurance purchased from certain specified sources. The program could benefit close to a quarter of a million workers and retirees each year who have lost their health coverage.

HIPAA has evolved into a key legislative instrument for shaping much federal and state legislation relating to the regulation of health insurance nationwide (Miller, 2001). The law sets minimum nationwide standards for accessibility to health care coverage, with an emphasis on resolving “job lock,” the dilemma created when an employee with a pre-existing health condition fears to leave his/her present job for fear of being rejected for coverage by a new employer’s carrier.





Critics of HIPAA characterize that law — and subsequent laws mandating access to services — as creating a system of “guaranteed access, not affordability” (Miller, 2001). Those laws, claim the critics, technically mandate access and coverage but actually have the effect of raising premiums and driving employers to cut back on the services they cover or the contributions they make toward employee health costs. And steadily raising premiums could well drive those employers entirely out of the business of providing employee insurance coverage. The laws, they say, reverse “decades of regulatory deference to the states,” and seek to lock into place “an outdated, employer-based insurance market structure” To those espousing this view, the solution instead is to return responsibility for coverage to the individual citizen by means of medical savings accounts, defined contributions, and individual tax subsidies (Miller, 2001).

In April 2003, S. 906 – the Health Care Access for Small Business Act of 2003 – was introduced in the U.S. Senate. Under the terms of the Act small business owners would be eligible for a refundable federal tax credit to defray the cost of providing health insurance. Under the proposed “Three-Share” plan – so-named for coverage programs currently operating at state and community-levels around the country through which premium costs are shared by employer, employee and state and/or local subsidies – the federal government would cover 40 percent of the premium. The employer and employee would share the remaining premium costs.

CURRENT FEDERAL TRENDS

In recent years, and especially since the installation of the Bush Administration, there has been White House support for programs and proposals that shift responsibility for insurance coverage from the employer and the government to the individual citizen. Two of the programs that get steady administrative support are medical savings accounts (MSAs) and health tax credits (“Background,” 2003).

Medical Savings Accounts

The theory behind MSAs is that, by encouraging individuals to shop around for health care, we will be able to achieve a balance between cost containment and quality health care (“Perspectives,” 2003). Where introduced in demonstration projects, MSAs (which are basically IRAs with income tax exemptions for withdrawals used for medical care) have gotten mixed appraisals. Critics of MSAs say that they:

- require consumers to make unreasonably complex decisions about their health care expenditures;
- encourage consumers to save rather than get preventive care;
- cause “adverse selection” by attracting the healthy to forego regular coverage, ultimately resulting in higher premiums for everyone else;
- are essentially a tax break for the well-off.

Program supporters deny those charges, and see MSAs as one of the key elements (another being individual tax subsidies) that will shift health care from an employer-based model to a “consumer-based” model (Tanner, 2003).

Health Credits

Another element of the move toward individual consumer participation is the Bush proposal for “health credits” – tax credits of \$1,000 per individual and \$2,650 per family to pay for health premiums (Background, 2003). Opponents of that proposal note those credits are far less than the actual cost of health care insurance. The proposal subsidies, according to the Senate Democratic Leader’s Office are the equivalent of “offering someone a ten-foot rope to get out of a 40-foot hole” (“Ineffective,” 2003).

MSAs and health credits do not offer employers remedies to their insurance problems. Instead, those proposals offer alternatives to the employer-based system. Critics of White House proposals assert that the





president is ignoring America's over 41 million uninsured and instead offering proposals that are "an assault on employer based system and will drive individuals into the most restrictive coverage policies possible" (Id at 1).

Patient Bill of Rights

The proposed Patient Bill of Rights still continues to stir controversy on both sides of the aisle. That legislation seeks to empower managed care patients to have greater access to specialists, to be able to use emergency medical services without prior approval, to appeal HMO denials of coverage, and to sue for damages for denied coverage or poor care. Forty states have already passed some version of those laws, and federal laws give similar rights to the 80 million Americans covered by Medicare and Medicaid. But Congress is still considering national legislation and the U.S. Supreme Court is currently considering whether states can require an outside review of HMO decisions.

The House and Senate differ on specific bill provisions, with the House wanting a federal cap on settlements to limit damages paid in law suits. The White House supports the Bill in its more conservative House version. The more liberal package supported by the Senate is viewed by the health care industry and the White House as encouraging higher costs and, ultimately, higher insurance premiums ("Health Care Policy," 2000); "House Approves," 2003).

Association Health Plans

The White House also supports association health plans, which would make it easier for small employers to form pools to "get employees better health coverage" and to purchase insurance through associations, such as Chambers of Commerce (Background, 2003). Earlier in 2003, H.R. 660 was introduced in the U.S. House of Representatives and S. 545 was introduced in the Senate. The bills seek to establish federally regulated association health plans. Democratic opponents see this proposal, in its administration version, as structured to "undermine state benefit requirements" ("Ineffective," 2003), and the insurance industry's concern is that the plans would attract higher risk employees to the association plans and would not generate cost savings. Consumer advocates fear that if businesses were allowed to offer "stripped-down" health insurance plans and bypass state mandates on health insurance, consumers would face problems because they would lack guaranteed coverage and the protections provided by insurance mandates. On June 12, 2003, H.R. 660 was approved by the House Committee on Education and the Workforce through a 26-21 vote (http://www.kaisernetwork.org/daily_reports).

Association health plans are one type of group purchasing arrangements (GPAs) that state policymakers are examining as a means to achieve cost savings for small businesses (Kofman, 2003). Others include employer alliances or health insurance purchasing coalitions (HIPC's) and multiple employer welfare arrangements (MEWAs). At present, there is variation among states that allow association health plans. State-level regulatory decisions concerning which state insurance laws should apply to GPAs and who should sponsor and manage them carry significant implications for consumers (ibid.).

Restructuring Medicare/Medicaid

Another key feature of the Bush health coverage plan is Medicare and Medicaid restructuring that seeks numerous savings and efficiencies by promoting alternatives to the most expensive – usually hospital/institutional – options for care ("Managed Care," 2003). While few critics are opposed to efforts to make those public insurance programs more efficient and effective, they note that federal restriction on assistance to the states will cause cutbacks in medical expenditures due not to any efforts at greater efficiency but by the simple fact that the dollars will not be there to maintain those programs at current levels.





EMPLOYEES RESPOND: EROSION IN CONFIDENCE

While 85 percent of Americans who are covered by employer-based health insurance continue to express satisfaction with their coverage, their confidence in this system is diminishing. Only six of 10 workers questioned for the 2002 *Health Confidence Survey* conducted by the Employee Benefit Research Institute who had employer-sponsored benefits were “very confident” that their employer would continue to offer them benefits, down from seven in 10 in 2000 (Helman, 2002). Only 44 percent continue to be very confident about their ability to get high-quality health care through their job in the future (ibid.). Americans are more likely now than in 1998 to identify health care as a critical national issue, and more are dissatisfied now than in 1998 with the costs of health insurance and health care not covered by insurance (“Confidence,” 2002).

Confidence levels were even lower among low-income employees: only 30 percent of low-income employees were very confident in their continued ability to access high quality care, compared with 48 percent of those employees with higher incomes (Edwards, 2002).

Working adults with employer-sponsored insurance are faced with the triple burden of higher deductibles, higher co-payments, and reduced benefits. When surveyed in January 2000:

- One in four workers reported significantly higher premiums,
- Two in five reported higher premium payments or increased cost-sharing,
- One quarter of employees reported that their premiums increased more than “a little” – either “a lot” or “some,”
- One-third reported they had to shoulder more of their health care costs than a year ago because their benefits were reduced or their co-payments and deductibles increased (Id at 2).

POLICY EXPERTS OFFER VARIOUS SYSTEM REFORM STRATEGIES

Incrementalism appears to be the prevailing tendency among public and private sector stakeholders as well as with American public. When polled, surveyed working Americans still seem to be essentially satisfied with – even if increasingly worried about — the present mix of public and private health insurance instruments. Surveys show that:

- 43 percent of adults favored employer-based coverage
- 22 percent favored individually purchased insurance

Yet only:

- 15 percent favored a new government program for the uninsured
- 10 percent favored single-payer Medicare or Medicaid models (Edwards, 2002)

Across the country, states and communities are experimenting with strategies and models of various types of coverage initiatives. Many communities are leveraging public funding with employer buy-in programs in order to work with local businesses to provide coverage to the working uninsured. (See New Jersey Policy Forums *Issue Brief* February 25, 2003 for a discussion of state coverage expansion strategies; reference is also made to www.statecoverage.net for comparative analyses of coverage initiatives.)

Other state and local coverage models include state high-risk pools and community or geography-based pools. Late last year, in November 2002, the U.S. Department of Health and Human Services (HHS) announced the availability of grants of up to \$1 million each for states to use as seed money to establish high-risk pools. In a more recent development, HHS announced the availability of \$80 million in grants to states to offset losses they incur in operating such high-risk pools, which are usually state-created non-profit associations that offer health coverage to individuals with serious medical conditions who have a





history of being unable to find affordable health coverage in the individual health market (April 2003). Nationally, over 153,000 are enrolled in state high-risk pools. It is significant to point out that at present, all state high-risk pools operate at a loss, with a medical loss ratio ranging from 1.14 in Oklahoma to a high of 4.84 in Washington (Katz and Dominguez-Karasz, 2002).

Recently released reform strategies offered by health policy experts from both conservative and progressive sides of the debate include a range of options:

Karen Davis and Cathy Schoen of Commonwealth Fund call for a new public-private framework for covering the nation's uninsured. Their plan calls for a new Congressional Health Plan that would offer community-rated health insurance coverage for the uninsured, small business employees and the self-employed. The proposed plan would also offer tax credits to the uninsured to help them buy into the program (*Health Affairs*, 2003).

The Davis-Schoen plan has drawn criticism from some conservative commentators. Joseph Antos of the American Enterprise Institute sees the plan as yet another insurance-related expense "imposing unaffordable expenses on consumers and taxpayers" (Ibid.). Jeff Lemieux of the "third way" Progressive Policy Institute suggests that the Davis and Schoen plan could be made more affordable if dollars were provided as a "pass-through" from employers to employees, thereby putting employers in the role of enrollment and payroll administrators and making the credit a seamless part of a group coverage plan.

From his perspective, Jeff Lemieux argues that the preferable — and possibly the only feasible — way to change the American health care system is to pursue a form of managed competition, with all health care providers, both public and private, testing their best practices in the marketplace. Lemieux asserts that the nation already has single health care system — although an informal and historically evolved one. He characterizes arguments about public and private insurance solutions as a kind of endless and circular "McDonald's is better — Burger King is better" debate.

The evidence, he states, is that both systems do some things better than, and other things not as well as, their counterpart. "Let both government-run and private health plans compete for business, and let the competition directly and quickly pressure both types of coverage to find efficiencies, new and helpful benefits, and other value improvements" (Lemieux, 2003).

The Lemieux proposal highlights an important issue: the public and private health care systems are, in fact and in reality, a single system. The health care costs not paid by employers' insurance and by other sources of private insurance become the responsibility of the taxpayers. In that sense, private employer-sponsored care and public health care are already a single system, though an uncoordinated one.

Another advocate for managed competition is Alain Enthoven, Professor Emeritus at the Stanford University Graduate School of Business. Dr. Enthoven argues in an recent article appearing in *Health Affairs* that employers should use regional exchanges and the full power of modern computerization now available to human resources offices to increase competition among insurance carriers. Under such a system, employees would be offered a wide choice among multiple plan providers and plans, rather than just a menu of options offered by a single contacted provider. By giving employees more than one insurance carrier to choose from, the system would, states Dr. Enthoven, become truly competitive and would realize the cost-savings that head-to-head competition for customers generate (Enthoven, 2003).

A comprehensive approach towards covering all of the country's uninsured would increase health spending's share of gross domestic product by less than one percentage point — or approximately 3 to 6 percent of total health spending — as reported by Urban Institute researchers Jack Hadley and John Holohan (www.healthaffairs.org/WebExclusives/). They study measures the direct costs of care if all the uninsured were provided coverage and they increased their use of the health system to the same rate as the insured





population. The conclusion: “the cost of expanding insurance coverage may be a relatively small or at least a very worthwhile investment when considered against the benefits of improved health, increased longevity and potentially greater national income.”

Surveys suggest that both employers and employees are, in fact, more comfortable with tweaking the current system to make it better. “Americans,” said Ray Werntz, the president of the Consumer Health Education Council, “do not seem to have been affected very much by the reported turbulence in health care costs and coverage arrangements. It is surprising that attitudes have not changed more dramatically.” Employers-sponsored health insurance continues to be the coverage of choice for most working Americans (Davis and Schoen, 2003). Any strategies to reform the structure of health insurance coverage must focus on keeping employer coverage as a keystone of the system in order to keep disruptions in coverage at a minimum for both covered lives and the uninsured (ibid.). The charge to public and private policymakers, purchasers and regulators is to work toward identifying a strategy that offers stability, fiscal security and long-term economic and social benefits to all stakeholders.

Leadership on both sides of the aisle and at all levels of government is offering strategies and plans to address the issues of access and affordability, using the research and analysis conducted by health policy experts and industry analysts. Among the various questions and answers remains critical need for collaboration. Millbank Memorial Fund president Daniel Fox, in a recent conference focusing on increased costs and the business of health care, identified two main areas for collaboration among businesses, employers, the government, private payers and consumers: how to apply evidence for health technologies and how to assess the best mix of spending for employers, the government and consumers (Fronstin and Roberston, 2003). Fox raised several controversial questions to be considered by all stakeholders:

What if employer spending for coverage benefits society because it contributes to the health of employees and their dependents in our highly mobile society but doesn't do much for firms' earnings? What if health coverage is like defense and domestic security – something that is more efficiently paid by taxes? What if it turns out that it is better for the economy — that is better for employment and earnings – to use taxes and consumer spending on health care? On the other hand, what if the opposite is true –that coverage based on employment combined with public programs for particular populations is the most effective way to serve the public interest?





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