

Fending for Themselves

Nonstandard Workers, Health Insurance Coverage and the Labor Market

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September 2011

Final Report to the U.S. Department of Labor,
Employment and Training Administration

The Iowa Policy Project

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Preface

This final report, *Fending for Themselves: Nonstandard Workers, Health Insurance Coverage and the Labor Market*, is the second of two reports prepared by the Iowa Policy Project for the Employment and Training Administration of the U.S. Department of Labor, in fulfillment of Agreement #: EA-18258-09-60-A-19.

Fending for Themselves and an earlier report, *Not Your Father's Health Insurance: Discount Medical Plans and the Health Care Crisis*, both were produced by the Iowa Policy Project and funded fully from this \$335,043 contract for research on employment and training costs of uninsurance and the impact on contingent workers. The conclusions and recommendations contained in this report do not necessarily reflect the views of the Department of Labor.

The earlier report, *Not Your Father's Health Insurance: Discount Medical Plans and the Health Care Crisis*, was released in September 2010; it is summarized here. Both of these reports may be found on the Iowa Policy Project website at www.iowapolicyproject.org.

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The Iowa Policy Project

The Iowa Policy Project, formed in 2001, is a nonpartisan, nonprofit public policy research organization based at 20 E. Market Street, Iowa City, IA 52245. IPP examines trends and policy impacts on economic opportunity and family prosperity, budget and tax issues, and energy and the environment. Reports are available free of charge online at www.IowaPolicyProject.org.

The mission of the Iowa Policy Project is to promote public policy that fosters economic opportunity while safeguarding the health and well-being of Iowa's people and the environment.

By providing a foundation of fact-based, objective research and engaging the public in an informed discussion of policy alternatives, IPP advances effective, accountable and fair government.

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EXECUTIVE SUMMARY

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Employer-provided health insurance is the foundation of access to health care in the United States. In recent years, however, the stability of this foundation has been found lacking. The rapid increase in health costs is only a partial explanation for the steady erosion of employer-sponsored health insurance.

This report offers a fresh look at another contributing factor: the changing labor market. A shift from manufacturing-centered to service-centered jobs and from long-term employment to short-term employment has left fewer Americans with full-time, permanent jobs that offer employer-provided health insurance. The recent recession has only intensified those general trends. At the same time, federal policy makers began to move on assuring better access for all to health coverage, with the passage and signing of the Patient Protection and Affordable Care Act in 2010.

Until full implementation of the law in 2014 — or the resolution of court challenges to it — what do workers do, what can workers do, and what have they done, when their employer does not provide them with insurance? As employer-provided health insurance has become more rare and more expensive, the economically weakest working families must fend for themselves. In this climate, a small but not insignificant number of the uninsured turned to discount medical plans, a product that feeds on the distress of the uninsured. Despite increased scrutiny and enhanced state-level regulation, major problems remain for customers of this industry: gaps in regulation, fly-by-night companies, deceptive marketing strategies, uneven participation by providers, and elusive benefits. Earlier work by IPP on this topic revealed that some cardholders were paying the monthly fee with the belief that the discount medical plan was indeed health insurance, when instead the plan merely offers discounts at selected health care providers. Though these plans have appropriated the language of health insurance, they are not health insurance by any definition.

Beyond the use of a discount medical plan, this research has produced evidence of the need to further explore the world of nonstandard work (including part-time, temporary, on-call and contract workers). A 2009 national survey conducted for this report finds nonstandard work to be more prevalent since 2005. While the 2005 BLS estimate is a nonstandard rate of 27 percent of the labor force, our own 2009 survey estimates the share of nonstandard workers at 40 percent of the labor force. Similarly, BLS data show the numbers of involuntary part-time workers have more than doubled — from 4.2 million in 2005 to

9.3 million in 2009. Recent economic trends and the economic literature point to the role of the recession in diverting workers from full-time to part-time work. These developments demand attention from BLS for a new and thorough study for policy makers, academics and the public to better understand the nature of the American work force. The prevalence of more nonstandard service work and less full-time manufacturing work raises considerable job-quality issues that will pose challenges that may only be met by public policy.

For health coverage — especially as the future of the new national health reform law is still debated — these issues are present now. Even measuring uninsurance can be difficult. Our survey found that while 82 percent of our employed respondents claimed to have some health insurance, some had only a medical discount plan, reducing the real coverage rate shown by our survey to 78 percent. The distinction between real and perceived coverage is important because it indicates other measures, including the Current Population Survey, may overstate the rate of insurance coverage, and this may affect public policy choices. Unlike our study, CPS does not follow up to determine if some of the self-identified insured have only a discount card.

Our analysis revealed that workers with no health insurance are significantly more likely to experience job loss and job change compared to insured workers. We also found that nonstandard workers are significantly less likely when compared to standard workers to have health insurance. Ultimately, nonstandard workers are significantly more likely to experience job loss and job change than standard workers. This supports the findings from our previous report, and is especially disconcerting considering the remarkable rise in nonstandard workers noted above (from 27 percent in 2005 to 40 percent in 2009).

Lastly, we discovered that the demographic variables of age, education and income are significantly related to health insurance and worker status. Older, better-educated and better-earning individuals are significantly more likely to be insured and to be standard workers. We also found a significant race effect — when comparing Black, Hispanic and White workers, Hispanic workers are significantly less likely to be insured and to be standard workers. This last finding is most alarming, as it may suggest a discriminatory labor market, in which Hispanics are employed in inferior jobs that do not carry the same benefits as other jobs do. It may also suggest a language barrier issue, or a lack of awareness of worker benefits and rights. We can only hypothesize as to the explanation of this finding.

To summarize, about 22 percent of workers in our survey lack health insurance. The intent of the Affordable Care Act is to dramatically reduce the share of the population who are uninsured. If fully implemented, the law will reduce the number of uninsured workers by expanding Medicaid coverage, providing new avenues of purchasing insurance for individuals and small businesses, induce some small businesses to offer health benefits, and encourage larger businesses to more evenly offer insurance benefits to their workforces. This offers some hope to nonstandard workers and even to workers in more standard work arrangements. Moreover, continued economic recovery could lead to regaining some of the ground workers lost in terms of job-based insurance rates and long-term employment. The prevalence of discount medical cards should drop, particularly if state-level scrutiny of these organizations continues.



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Introduction

Employer-provided health insurance is the foundation of access to health care in the United States. In recent years, however, the stability of this foundation has been found lacking. The rapid increase in health costs is only a partial explanation for the steady erosion of employer-sponsored health insurance.

The changing labor market is another factor resulting in that erosion. As the labor market has transitioned from manufacturing-centered to service-centered jobs and from long-term employment to short-term employment, fewer Americans have full-time, permanent employment, which means fewer Americans have employer-provided health insurance. In addition to those general trends, the recent recession pushed even more Americans involuntarily into part-time jobs, and the rate of employer-provided health insurance declined further still.

The issue of health insurance was a national concern long before President Obama signed the Patient Protection and Affordable Care Act into law in 2010. The Affordable Care Act, designed to make health coverage more accessible, expands Medicaid eligibility and offers federal assistance to those purchasing insurance in newly created private insurance marketplaces. Moreover, in order to encourage employers to offer more affordable coverage, the Affordable Care Act grants a new tax credit to qualifying small businesses that offer their employees affordable insurance, and, beginning in 2014, will impose a new tax penalty on larger businesses in which at least one employee purchased insurance in the private market with the help of premium tax credits.

As the number of Americans with job-based insurance steadily declines, and rising insurance costs price many out of the insurance market, the Affordable Care Act, if fully implemented, will offer relief and health coverage to many Americans. Until full implementation of the law, however, what do workers do, and what have they done, when their employer does not provide them with insurance? Earlier work by IPP on the topic revealed that a certain portion of the uninsured pay for discount medical plans — fee-bearing plans that offer discounts on various medical expenses. IPP found that some cardholders were paying the monthly fee with the belief that the discount medical plan was indeed health insurance. Though these plans have appropriated the language of health insurance, they are not health insurance by any definition.

Whether or not an uninsured worker uses a discount medical plan, we suspected that there might be significant relationships between not receiving insurance from an employer, and the worker's performance at work and stability of employment. In addition, we were interested in comparing full-time traditional workers to "nonstandard" workers — those working in part-time, temporary, or contract jobs. Lastly, we were interested in exploring possible relationships between health insurance status and workers' characteristics (age, sex, education, etc.).

In the following report we explore the relationship between worker characteristics and performance, employer-sponsored health insurance, and discount medical plans. The report will begin by discussing the American system of employer-provided health insurance, followed by a discussion of the Affordable Care Act and its potential effects on employment and health coverage. We will continue with an overview of discount medical plans, their operations and their prevalence. Finally, we will describe our survey findings, and conclude with a summary and discussion of the entire report.

Health Insurance, Employment and the American Worker

Unlike most of the rest of the world, the United States relies largely on employers to provide employees and their dependents with health insurance coverage.* In 2009, almost 56 percent of the population received health insurance through either their employer or their spouse's employer.¹ For those of working age, the percentage is higher.

As health insurance costs have risen and the American employment structure has changed, the number of Americans with insurance through an employer has steadily declined, from over 68 percent in 2000 to 58.9 percent in 2009.² Since 2000, the average health insurance premium has nearly doubled — far outpacing the normal inflation rate as measured by the Consumer Price Index.[†] An individual health insurance policy in 2000 had a premium of \$2,655. By 2009, individual plans cost, on average, \$4,669. Family health insurance premiums reached \$13,027 in 2009, up from \$6,772 in 2000.³

To offset the rising insurance costs, firms have required employees to contribute more to their premiums. Employees with individual plans contributed an average of \$450 per year to their insurance in 2000; by 2008 they were contributing an average \$882. Employees with family plans saw their annual contributions increase by over \$2,300, reaching an annual average contribution of \$3,394 in 2008.⁴

The changing nature of employment in the United States also has contributed to the erosion of employer-sponsored insurance. The employment sectors that once dominated the American labor market no longer hold the same labor market share they did 30 or even 10 years ago. Further, the steady decline in union membership has reduced bargaining power for a growing share of workers.

* For a brief description of the historical accidents that led to our present health insurance system, see Thomas A. Buchmueller and Alan C. Monheit, "Employer-Sponsored Insurance and the Promise of Health Insurance Reform," National Bureau of Economic Research, Working Paper 14839. April 2009.

[†] The average annual inflation rate between 2000 and 2009 was 2.57 percent. Average annual premiums increased during this same time by 6.3 percent for individual plans 7.5 percent for family plans.

Over 30 years, employment in the higher-paying goods-producing sector has dwindled, while employment in the lower-paying services sector has increased. In 1979, goods-producing jobs — including manufacturing, mining, and construction — comprised almost 28 percent of American jobs. By 2007, however, just 16 percent of American jobs were in goods-producing sectors.⁵ At the same time, the share of jobs within the service sector has grown from 26 to nearly 40 percent.⁶ It should be noted that both manufacturing and service have high-paying and low-paying jobs, but the average hourly compensation rate (that is, wages plus all benefits) in the manufacturing sector was almost \$29.47 in 2005 — almost \$6 more than the average service-sector hourly compensation rate.⁷

In 2005, over 30 percent of the U.S. workforce held “nonstandard jobs” — working part time, a temporary position (either through a temp agency or a direct hire), in self-employment, or as an independent contractor, day-laborer or on-call worker.⁸ In addition to being paid less, nonstandard workers receive health insurance through their employer at a far lower rate than standard workers. While nearly 72 percent of standard workers received health insurance through their employer, only 21 percent of nonstandard workers have health insurance through an employer.⁹

Despite the protections unions afford workers, union membership has steadily declined in the past several decades. In 1978, over 43 percent of workers were members of a union. By 2005, fewer than 20 percent were union members.¹⁰ The drop in union membership has coincided with a nearly 14 percent drop in the fraction of workers covered by an employer-sponsored health insurance plan, to 55 percent in 2006.¹¹ In addition to ensuring workplace safety and fair treatment of workers, unions provide members with bargaining power in wage and benefits negotiations with employers. The erosion of unionization has not only weakened the wages of union members, but also of non-union workers, as the threat of unionization became less potent to employers.¹² In addition to earning higher wages than their non-union peers, unionized workers are 28 percent more likely to have employer-based health insurance.¹³ Data also suggest that employers pay a larger portion of unionized workers’ premiums, and that union workers have lower deductibles than their non-union peers.¹⁴

There are a number of reasons employers offer health insurance benefits to employees. First, employers do not have to pay taxes on health benefits.[‡] The payroll tax — which finances Social Security and Medicare — is a joint contribution by employers and employees. Insurance benefits, however, are exempt from payroll tax. Furthermore, neither the employer nor the employee pays income taxes on the employer contribution to health insurance. These tax exemptions reduce the effective price of health insurance by about 27 percent on average.¹⁵ Employees benefit, too. Comparable plans to those offered in the group market, if purchased on the individual market, would be far more expensive, as insurance companies assess the medical risk of one individual (and possibly their family) rather than spreading medical risk across a larger group. Furthermore, fewer dollars from group health insurance go to insurance administration and overwriting costs, further contributing to lower premiums.

[‡] For a small number of American workers, this will change in 2018, as high-value health insurance plans, or “Cadillac” plans begin to be taxed under the recently passed Patient Protection and Affordable Care Act.

Taxation alone, however, does not fully explain why employers offer health insurance. Employers use health insurance benefits as a recruiting tool. Employers offer wages along with health insurance because they find that offering both “is more profitable than providing wages alone.”¹⁶ Workers attracted to such benefits may be the type of workers firms seek to hire — more “forward-looking or less mobile (e.g., workers with children).”¹⁷ The reason it works as a cost-effective recruiting tool is precisely because employers can provide comparable health insurance at a lower cost. For example, to provide a new employee with an extra \$1,000 in after-tax take-home pay the employer might have to offer \$1,300 more in salary, but \$1,000 worth of health care benefits (in terms of the cost to the individual) might cost the employer only \$750.

In addition to attracting desirable workers, offering wages and health insurance benefits may also keep workers more satisfied with their job, and less likely to seek alternate employment. Nearly three-quarters of workers in one survey stated that employer-sponsored health insurance was a major factor in their decision to take and remain in their job.¹⁸ In a survey of employers conducted by the Employee Benefits Research Institute (EBRI) and the Consumer Health Education Council (CHEC), nearly 80 percent of business executives expressed their belief that insurance benefits were “extremely important” or “very important” in retention efforts.¹⁹

Perhaps the most important reason for offering health insurance benefits from an employer’s perspective is remaining competitive in the labor market. Jobs with health insurance benefits are generally viewed as “good jobs.” Nearly two-thirds of employees rank health insurance as the most important benefit.²⁰

As a highly valued benefit by workers, insurance may improve worker morale, and consequentially improve productivity. However, the increased productivity is difficult to quantify, and unsurprisingly, lacks robust support from business leaders. Still, 42 percent of employers in the EBRI/CHEC survey expressed belief that increased employee productivity was an extremely or very important reason for offering health insurance.

The economic concept of efficiency wages, the idea that employee efficiency and productivity are in part a function of their wages, offers some guidance. This theory suggests that employees choose how hard to work based on whether they could find replacement employment that offered the same wage. Because health insurance is part of the total compensation package, it follows that those employees offered health insurance, under this theory, would work harder than if they were offered only wages and not the insurance.²¹ All other things being equal, if one employee were offered actual monetary wages equal to the amount spent on wages and health insurance and a second employee received wages and health insurance in the same amount, the efficiency wage theory alone does not predict a clear difference in productivity between these two workers.²²

The literature describes the effect of health insurance on an employer’s ability to retain employees positively as “reduced turnover/good job effect” or negatively, as “job lock.”²³ Regardless of its characterization, a number of studies have found that employer-sponsored health insurance reduces turnover.²⁴ One study estimated a strong effect on turnover: Provision of employer-sponsored health

insurance reduced the job turnover rate by as much as 35 to 59 percent for married men, 37 to 53 percent for married women, and 18 to 35 percent for single adults.²⁵ Between 2001 and 2010, an average of 1.9 percent of the nonfarm workforce voluntarily quit their jobs.²⁶ Thomas C. Buchmueller and Robert G. Valletta's model estimates that, depending on the marital status and sex of the worker, provision of employer-sponsored health insurance could reduce the voluntary quit rate to well under 1 percent.²⁷ The reduction in turnover lowers recruiting and training costs, thus increasing the share of firm revenue that can go to capital investments, expansion of products or services, and profits. Buchmueller notes that the bulk of the job-lock studies were done prior to the 1996 HIPAA legislation that was intended to erode the connection between health insurance coverage and job mobility; therefore the relationship between insurance and turnover might be weaker than when the research was performed.²⁸

There is little evidence to support the theory that offering health insurance reduces employee absenteeism. One study estimates that providing employees with full health insurance coverage would reduce work absences by 9 percent on average.²⁹ However, this study also estimates that providing health insurance while simultaneously providing paid leave in fact increases the number of days missed by 11 percent.³⁰ Another study suggests that providing health insurance actually increases employee absence.³¹ Buchmueller imagines some scenarios in which health insurance provision increases absenteeism: "For some workers, insurance will mean the difference between ignoring minor ailments (and continuing to work) and seeing a doctor. Not only might such workers miss work to make the visit, but in some cases the doctor may recommend that the workers stay home until well. Similarly, by increasing access to the health care system, health insurance may raise workers' awareness of certain health conditions or allow them to seek elective treatment for minor chronic conditions, which in turn may result in more lost time from work."³²

Though the majority of research does not find health insurance as an explanatory variable for reductions in absenteeism, there is a wealth of research on the effects of health insurance on actual health. In a review of the literature, 43 of 54 analyses found a statistically significant relationship between having health insurance and receiving medical care and improved health outcomes.³³ This is due to several potential reasons.

First, the insured are more likely than their uninsured counterparts to receive screenings and preventive care.³⁴

Second, when they fall ill, the insured are more likely to receive timely, appropriate care. For example, breast cancer patients without health insurance were more likely to have cancer diagnosed at a late stage than patients with health insurance.³⁵ Among prostate cancer patients, the uninsured were found to have a similar health-related quality of life as insured patients at diagnosis, but reduced quality of life over a three-year observation period.³⁶ Similar findings were found across a variety of illnesses.

Finally, other research efforts have found that the uninsured have a higher risk of death than insured persons. Uninsured women with breast cancer had a 50 percent lower probability of survival than

insured breast cancer patients.³⁷ Heart attack patients without health insurance were less likely to receive needed procedures and more likely to not survive.³⁸

Because health insurance increases prevention and early detection, its provision means a higher success rate in treatment and management of a number of health conditions. A patient's failure to manage and treat health conditions is likely to result in more absenteeism and even withdrawal from a job. In some cases, effective health care treatments may pay for themselves by reducing productivity losses, and even increasing productivity.³⁹ Indirect costs, such as temporary replacement workers, overtime wages, and unforeseen schedule changes due to worker absenteeism, may outweigh the cost of investing in worker health, partly through health insurance.

The Impact of Health Reform

The March 2010 enactment of the health insurance reform — the Patient Protection and Affordable Care Act (the Affordable Care Act) — was met with widely different reactions. Among health consumer advocates, the new law was seen as a long-overdue expansion of health coverage for the most vulnerable Americans. Economists hoped that some pilot Medicare payment reforms and other provisions in the new law would “bend the cost curve” of health care spending in the country.

But business groups, including the National Federation of Independent Business and the U.S. Chamber of Commerce, expressed fear that the law's requirements would be onerous for business. Siding with the business groups, economist Douglas Holtz-Eakin declared that the new law's penalties on businesses that do not offer health insurance to employees “will be an impediment to smooth functioning of labor markets by interfering with decisions on education, career choice, hiring, job-switching, second jobs, and a myriad of aspects of the most crucial economic activity in the United States today.”⁴⁰

“If you like your health plan, you can keep it” was one of President Obama's major pitches for Congress' health reform proposals. Rather than overhauling the entire system, the Patient Protection and Affordable Care Act (the Affordable Care Act) will build on the tradition of employment-based health insurance coverage. Small businesses, which have frequently been priced out of providing health insurance, will receive tax credits for contributing to health insurance, individuals who purchase insurance through an insurance exchange may qualify for sliding-scale premium subsidies, and employers that do not provide some level of insurance to employees will face tax penalties.

Addressing the Erosion of Employer-Based Health Insurance

Employment-based health benefits are the source for most Americans' insurance arrangements. Since 2000, however, the percentage of Americans with job-based health insurance has steadily shrunk — from 68.3 percent to 56 percent in 2009.⁴¹ This contrasts starkly with the 1990s, which saw an increase in the number of Americans with employer-sponsored insurance.⁴² The recent recession worsened the trend, as high unemployment caused by the recession has severed the traditional means of access to

Insurance for millions of Americans.[§] Research has shown that unemployment and uninsurance are highly correlated: A 1 percentage-point increase in the unemployment rate leads to a 0.43 to 0.57 percentage-point decrease in the insurance rate.⁴³

At the same time traditional means of receiving health insurance have changed, the U.S. labor market has altered. In 2000, over 13 percent of the American labor force was in a manufacturing job, which traditionally has had high rates of employer-sponsored insurance provision. By 2009, the percentage of the American labor force in the manufacturing sector had shrunk to 9 percent.⁴⁴ Similarly, union membership is a good predictor of employer-sponsored insurance coverage: Nearly 83 percent of union workers have insurance coverage, compared to 58.2 percent of non-union workers.⁴⁵ The decline of employer-sponsored health insurance has occurred as fewer and fewer private-sector jobs enjoy union protections.⁴⁶

In addition to a shifting labor market, the nature of employment in the United States has changed. Employment has largely evolved from a long-term relationship between an employer and the employee to a more short-term basis, thus reducing the employer's interest in employees' long-term health.⁴⁷ This change is borne out by our survey data that shows that the number of part-time, seasonal, temporary, independent contractors and other contingent work arrangements, has grown from 27 percent of the American labor force in 2005 to 40 percent in 2009.

The steady erosion of employer-based health insurance coverage, coupled with the changes in the labor market — both the sectoral changes and the relationships between employers and employees — was a central factor in the push for health insurance reform, which was signed by President Obama in March 2010.

The health care overhaul builds on the existing tradition of employers offering health insurance to employees, while expanding the health insurance options for those who do not have employer-sponsored health insurance. One of the key reforms is the creation of health insurance exchanges — regulated marketplaces in which insurance can be purchased by those who do not receive health insurance through their employer, find their employers' health plan offerings unaffordable, have retired but are not yet eligible for Medicare, or are self-employed. To help lower-income and middle-income workers obtain insurance through the exchanges, the federal government will provide sliding-scale subsidies, based on an individual's income.

Health insurance options will also be increased for low-income Americans through the expansion of Medicaid. Since its creation in 1965, Medicaid has been available to low-income pregnant women, children, persons with disabilities, and other groups. In recent decades, Medicaid has been expanded to

[§] Workers laid off from their jobs for reasons other than gross misconduct can continue their health insurance arrangement for up to 18 months under the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA). However, workers using COBRA benefits must pay the entire cost of their insurance premium, plus a 2-percent administrative fee. The cost of fully paying for health insurance is prohibitively expensive for many laid-off workers, and COBRA take-up rates have traditionally been quite low. The American Recovery and Reinvestment Act of 2009 provided laid-off workers with a 65 percent subsidy for COBRA benefits for up to nine months.

cover low-income parents of dependent children. However, in most states, only those with the lowest incomes have been eligible to receive Medicaid coverage. Eligibility for parents varies from state to state, with a high of 215 percent of the Federal Poverty Level (FPL) in Minnesota to a low of 17 percent in Arkansas.⁴⁸ On average, Medicaid eligibility across the 50 states and the District of Columbia in 2009 was 87 percent FPL.⁴⁹ Though some states have expanded Medicaid coverage to childless adults, federal law does not require that they be covered. The Affordable Care Act expands Medicaid eligibility for all adults — whether parents or not — up to 133 percent of the federal poverty level.

In addition to creating exchanges and expanding Medicaid, the Affordable Care Act attempts to bolster and build upon the employer-sponsored provision of health insurance. Small businesses that offer health insurance to employees and cover at least half the cost of the premium may be eligible for new tax credits. Due to their size, small businesses often face higher insurance costs than larger businesses do. Firms with many employees gain economies of scale in selecting health insurance, as many of the administrative costs are reduced. A national study estimated that the smallest businesses pay up to 18 percent more in premiums than the largest firms.⁵⁰

The new small business tax credits are highly targeted — benefiting only those firms with 25 or fewer full-time equivalent employees with low- to middle-income workers. The maximum credit — 35 percent of the portion of the premium paid by the employer — is only available to firms with 10 or fewer employees, with an average annual wage of less than \$25,000.⁵¹

Effective upon enactment of the Affordable Care Act, this tax credit will be offered on the same scale until 2014, when the maximum credit will be bumped up to 50 percent of the employers' share of the premium cost. At that point, firms will be eligible for the credit for up to two consecutive tax years.

Though data have not yet been gathered on how many firms will take up the credit, research by the Lewin Group on behalf of Families USA suggests that as many as 11 million workers in small firms may benefit from the small business health insurance tax credit.⁵² Bernstein Research found that among firms with three to nine workers, the percentage offering health insurance to employees increased from 46 percent in 2009 to 59 percent in 2010 — a change the researchers attributed to the small business tax credit.⁵³

While the small business health insurance tax credit could help thousands of small firms offer health insurance to their employees, its impact is likely to be surpassed by other provisions in the law.

The Affordable Care Act requires job-based insurance plans for large employers to spend at least 85 percent of the premium on medical care beginning in 2011. The National Association of Insurance Commissioners (NAIC) was tasked by the Affordable Care Act with determining what expenses constitute “medical spending.”⁵⁴ For some firms — particularly those with low-value insurance and high employee turnover — the new medical loss ratio requirements make the provision of insurance to employees more difficult. *The Wall Street Journal* reported that McDonald's Corp. was considering dropping the “mini-med” plans it offers to 30,000 employees.⁵⁵ The health insurance plans McDonald's

offers employees has a maximum annual benefit of either \$2,000, \$5,000 or \$10,000, and is priced according to this maximum annual benefit.

Though the dropping of its “mini-med” plans would be disruptive to thousands of McDonald’s employees, *The New York Times*’ David Leonhardt suggested that such “mini-med” plans illustrate many of the problems with the status quo, and that their disappearance would be progress. In response to the *Wall Street Journal* report, Leonhardt wrote, “[t]he fact that [the Affordable Care Act] is beginning to disrupt the status quo — that some insurance policies will eventually be eliminated and some inefficient insurers will have to leave the market altogether — is all the proof we need.”⁵⁶

By 2014, when the exchanges and premium subsidies are up and running, McDonald’s workers, and employees of other companies offering only mini-med plans, will have better options for health insurance outside their employment arrangement. As most McDonald’s employees are low-wage employees, they will likely qualify to purchase a highly subsidized insurance plan through the exchange, leaving them far better insured than they were under a mini-med plan.

Employment Effects of Reform’s Employer Responsibility Requirements

Another provision of the Affordable Care Act, however, may have far broader impacts on whether employers offer insurance, and even on their hiring practices. Though not mandated by the Affordable Care Act to offer health insurance to employees, firms with 50 or more employees, in which at least one employee receives a premium subsidy through the exchanges, will be assessed a tax penalty.

Health insurance is simply an alternative form of compensation. If a firm is required, either through a mandate or a “play-or-pay” provision, to offer health insurance to employees to whom it otherwise would not have offered insurance, the firm will reduce the employees’ wages to compensate for the increase in compensation through health insurance benefits. If the employer cannot fully offset the costs of complying with the mandate by lowering wages because this would require a wage below the legal minimum, economic theory suggests that some employees may be laid off. There is considerable dispute over the importance of such layoffs, however; the situation is analogous to an increase in the minimum wage, and many economists have found that the employment losses resulting from such an increase are minimal.⁵⁷

Employer mandates and their estimated effect on the labor market helped doom the Clinton Administration’s health reform attempt in 1993.⁵⁸ Estimates of job losses from the mandates in the Clinton proposal ran from 600,000 to as high as 2 million.⁵⁹

Several earlier state and municipal efforts at health reform have imposed an employer mandate, or a “play-or-pay” requirement. Hawaii was the earliest state to implement an employer mandate, passing its Prepaid Health Care Act (PHCA) in 1974.⁶⁰ Because of legal challenges under the federal Employment Retirement Income Security Act (ERISA), the PHCA was not fully implemented until Hawaii was granted an ERISA exemption by Congress in 1983. Under PHCA, private-sector employers are required

to finance at least 50 percent of health insurance premiums to employees working 20 or more hours per week, with exemptions for new hires, commission-only workers, and seasonal employees. Employee contributions to insurance cannot exceed 1.5 percent of their wages.

Hawaii employers have sought to circumvent the costs associated with the law by hiring a greater proportion of exempt part-time workers. Over a 27-year period, Thomas C. Buchmueller and his colleagues uncovered a trending increase in “low-hours” — less than 20 hours a week — employment in Hawaii relative to other states.⁶¹ This effect was greatest among the lowest-wage earners, who are the group least likely to receive employer-sponsored insurance in the first place.

However, despite the shift toward part-time workers, Buchmueller found no discernible change in the distribution of wages — there was no evidence of the added cost of the health insurance mandate translating into lower overall wages. Similarly, no measurable change in overall employment was detectable in the sample.

A number of researchers have estimated the employment effects of a national employer mandate or “play-or-pay” provision (though it is important to note that this research occurred prior to the ACA). Estimating the effects of a mandate requires knowing several things: the specifics of mandated coverage; what portion of the increased cost of employing workers is borne by employees; and how many workers without employer-sponsored health insurance at the baseline are so close to the minimum wage that their wages cannot be lowered enough to offset the cost of the new mandate.⁶²

Baicker and Levy found that a third of uninsured workers earn within \$3 per hour of the minimum wage, putting them at significant risk of unemployment in the wake of a mandate. Further, these workers are disproportionately racial minorities and workers with low education levels. Assuming an employment elasticity of -0.10 — that a 10 percent increase in the minimum wage would result in a reduction in employment of 1 percent — Baicker and Levy estimate that an employer mandate could reduce employment nationwide by more than 220,000.⁶³

Burkhauser and Simon had even starker predictions, estimating that for every 100 workers who gained health insurance through a play-or-pay, 14 would lose their jobs, resulting in a total of 750,178 lost jobs.⁶⁴ However, in his June 2009 modification of the Baicker and Levy model to then-current proposals, Phillip Cryan estimates that only 48,813 workers were likely to become unemployed as a result of a “play-or-pay” policy.⁶⁵

It is important to note, however, that all of these models made assumptions about the mandate that did not come to fruition in the Affordable Care Act. First, Baicker and Levy assumed that the average cost of compliance for employers would be 40 percent of payroll.⁶⁶ The cost of compliance is likely to be far smaller, which is accounted for in Cryan’s study. It is difficult to put employers’ cost of compliance with the Affordable Care Act into a percentage of payroll because of the complicated formula used to assess fees. However, the “pay-or-play” fees apply only to firms with more than 50 employees that do not offer employees health insurance and have at least one employee who receives subsidized coverage

through the exchange. Nationally, over 96 percent of firms with 50 or more employees offered insurance,⁶⁷ suggesting that very few large firms will be subject to the penalty.

Further, both models are based on a straightforward play-or-pay policy, in which all employers are subject to the mandate; the Affordable Care Act's play-or-pay mandate offers a large exemption for smaller businesses. As noted above, only those employers with more than 50 full-time-equivalent employees, that have at least one employee who receives a health insurance premium credit in the exchange, will be subject to the "pay" policy. Additionally, when calculating the employer penalty, the first 30 employees on a firm's payroll are exempted from the calculation of the penalty.

Though not as disruptive as an employer mandate, the employer penalties, coupled with the expansion of Medicaid and the creation of the exchanges and premium tax credits for individuals, are likely to alter the way many employers offer health insurance. The employees most likely to take advantage of the premium credits in the exchange are workers for whom the credit would be the greatest — low-wage workers. Thus it is the employers of low-wage workers who are most likely to end up paying the penalty. With wages so near the wage floor that the full costs of the penalty cannot be passed on to the workers through lower wages, low-wage labor in effect becomes more expensive and some reduction in employment may result. The negative job effects of the Affordable Care Act may thus be concentrated among low-wage workers.⁶⁸

At the same time, other research suggests that health reform has the potential to spur economic growth by removing a significant cost of employment from the purview of employers. David Cutler and Nareej Sood (2010), building on their previous research,⁶⁹ estimate that health reform could result in hundreds of thousands of new jobs a year in the American economy.⁷⁰

President Obama's Council of Economic Advisers also predict positive effects on the labor market. Their estimates focus less on jobs created or lost and more on the functioning of the market. As more workers have access to care and treatment for common ailments such as migraine headaches, depression and asthma, their productivity would increase. Similarly, the expansion of insurance options would reduce "job lock" — when employees stick with a job when their interests, abilities and talents are underused in that job, simply because they have health insurance benefits.⁷¹ Ending job lock not only benefits the worker but increases productivity, as workers' skills are better matched with jobs.

The nonpartisan Congressional Budget Office (CBO) estimates that the Affordable Care Act will encourage some workers to work more and others to work less. High-value, employer-sponsored health insurance plans will be subject to a new excise tax, encouraging workers to work more. CBO estimates that the Affordable Care Act will cause a net reduction of labor used in the economy by one-half of 1 percent. The majority of this reduction in labor usage will come in the form of a voluntary reduction in the supply of labor, as many workers will be able to get insurance through the expansion of Medicaid or by purchasing subsidized insurance through the exchange.⁷² Low-cost health insurance options — whether Medicaid or subsidized private insurance — will free up financial resources that individuals

would have previously used on health insurance or health care costs. The increase in financial resources will induce some to reduce their work hours or leave the labor force entirely.

John Holahan suggests that employment losses will be minimal, as changes in spending on health benefits by employers, new taxes on pharmaceutical and medical device companies, and tax penalties on employers with at least one employee receiving premium tax credits in the exchange are small relative to the size of the overall economy.⁷³ New spending on the health law will amount to less than 0.4 percent of gross domestic product from 2014 to 2019.⁷⁴ Further, many of the law's new taxes — increased payroll taxes on income above \$200,000, the excise tax on high-value ESI plans, and the like — affect a relatively minor number of people. What's more, the small increase in taxes on wealthier Americans is unlikely to significantly reduce their consumption habits.

A good example of the low cost of implementation in relation to the size of the economy can be seen in the pharmaceutical industry. Though the Affordable Care Act will impose \$27 billion in fees on the pharmaceutical industry between 2012 and 2019, that figure represents less than 1 percent of the anticipated \$3 trillion in revenues the industry is projected to experience over the same period.

In addition, any such employment losses will be offset by employment gains in the health sector, as demand for services increases. The increase in demand for medical equipment and prescription drugs will likely far outstrip the new fees faced by these industries. Similarly, cuts in Medicaid payments will be more than offset by the expansion of Medicaid.

Lastly, insurance premiums for small businesses will fall considerably within the exchange, making small businesses more competitive and making them more attractive employers to workers.⁷⁵

Employer-Sponsored Insurance Effects of the Affordable Care Act

While Hawaii has experienced similar growth in premiums as the rest of the United States since its Prepaid Health Care Act (PHCA) was implemented in 1983, it has not experienced the same drop-off in employer-based health insurance. By 2005, over 70 percent of private-sector workers in Hawaii were covered through employment-based health insurance, compared to just 57 percent across the rest of the nation.⁷⁶ Among workers with a high school degree or less, employer-sponsored insurance coverage has hovered around 65 percent in Hawaii; in the rest of the United States, coverage for this cohort has fallen from over 60 percent in 1979 to below 45 percent in recent years.⁷⁷ However, as mentioned previously, the positive trends in coverage have been partially offset by rising trends in low-hours employment, as Hawaiian employers attempt to circumvent the PHCA's mandate.

The City of San Francisco adopted a pay-or-play mandate in 2006 through its Health Care Security Ordinance (HCSO). Employers with 20 or more employees in the city are required to contribute to an employee health plan (either insurance, a reimbursement account, or a health savings account) or contribute to a city-run “public health insurance option.”

HCSO's mandated benefits are not as costly as the PHCA, though the HCSO provides fewer exemptions than either the Affordable Care Act or the PHCA. Under HCSO, only workers who averaged fewer than 10 hours of work per week were exempt. Carrie Hoverman Colla and her colleagues surveyed San Francisco employers and employers just outside the San Francisco area as a control group, to gauge if and how firms were changing their benefits. Hoverman Colla and her colleagues found that about 21 percent of firms ended up paying into the city public insurance option, though 87 percent of these firms did so only for some of their employees.⁷⁸

The Massachusetts health reform — An Act Providing Access to Affordable, Quality, Accountable Health Care of 2006 — is perhaps the best comparison to the Affordable Care Act, as many of the national law's provisions were modeled on the Massachusetts law. The Massachusetts reform expanded eligibility for public programs, created a regulated marketplace in which individuals and small groups could purchase insurance, and provided subsidies to low- and middle-income families purchasing health insurance on their own. Like the Affordable Care Act, the Massachusetts reform also required employers to contribute to their employees' health insurance or face a penalty. Employers with 11 or more employees are required to make a "fair and reasonable" contribution to every full-time equivalent employee's health insurance, or face an annual penalty of \$295 per uncovered worker.

Despite the low cost of the penalty, employer-based coverage increased.⁷⁹ Though the cost of the penalty is far less than the cost of contributing to an employee's insurance policy, researchers have found no drop in the number of firms that offer health insurance coverage.⁸⁰ Similarly, there was no negative change in the proportion of employees offered employer-based insurance coverage, even among the worker groups least likely to be offered insurance — part-time workers and those with short job tenure.⁸¹ Because providing health insurance costs so much more than the penalty, researchers doubt it has induced employers to begin offering insurance.⁸²

Rather, the requirement that all individuals have insurance coverage — the individual mandate — seems to have been the cause.⁸³ With an additional motivation for individuals to seek jobs that offer health insurance — avoiding the individual mandate penalty — firms face greater pressure from their employees to offer coverage, and have a competitive advantage in the labor market if they offer quality coverage.⁸⁴

A number of experts have also attempted to ascertain what will happen to employer-sponsored insurance under the Affordable Care Act. According to the Lewin Group, the number of people with employer-sponsored coverage will decrease by 2.8 million. The Lewin Group notes, however, "this small loss of coverage masks extensive shifts to and from employer plans."⁸⁵ As small businesses are allowed to create larger risk pools through the exchange, receive premium tax credits, or attempt to avoid being penalized, many firms will begin offering coverage. Over 14 million workers and their dependents will gain employer-sponsored coverage.⁸⁶ Richard Foster, Chief Actuary for the Centers for Medicare & Medicaid Services, also foresees a dropoff in employer-sponsored coverage, though not as steep as Lewin's; he estimates 1.4 million fewer Americans would have job-based coverage than otherwise

would have happened, with nearly 16 million getting coverage through the exchange and an additional 20 million finding coverage through Medicaid.⁸⁷

At the same time, as options to receive insurance coverage are expanded — either through Medicaid or the subsidized exchanges — many firms will discontinue offering coverage, resulting in 17.2 million workers losing coverage.⁸⁸ Of those 17 million who lose their employer-sponsored coverage, about half will purchase subsidized insurance through the exchange, about 8.6 million will either gain coverage through the exchange without premium subsidies or gain coverage through Medicaid, and about a million will go uninsured.⁸⁹

Holtz-Eakin suggested that for thousands of firms, the option to drop insurance coverage makes sense if the cost of the insurance to the employer exceeds the \$2,000 penalty firms face per worker receiving a premium tax credit. Holtz-Eakin estimates that 43 million workers could be vulnerable to their employers dropping coverage for economic reasons.⁹⁰

Nonstandard Workers and the Affordable Care Act

The lesson from Hawaii, as described by Buchmueller, DiNardo and Valletta, is that employers will respond to the cost obligations of the law by altering their hiring practices. Hawaii saw a measurable increase in the number of part-time employees who were exempt from the PHCA's requirements.

Though the Affordable Care Act contains provisions designed to discourage an increase in the use of part-time workers — eligibility for the Small Business Health Insurance Premium Tax Credit is determined by the number of full-time equivalent employees — the structure of its employer responsibility portion is limited to full-time employees.⁹¹ If one of an employer's full-time employees receives a premium tax credit through the exchange, that employer will be subject to a penalty. As the penalty only applies to full-time employees, there is an incentive for employers to maximize their use of exempt employees.

Further, firms might find it advantageous to begin using or expand their use of nonstandard workers — including seasonal workers, independent contractors and temporary workers. The Patient Protection and Affordable Care Act defines seasonal workers as those working 120 days or less, and are exempted from the employer's responsibility. However, temporary workers who are employed by the firm and not a separate temporary agency, who are or have been employed for more than 120 days, will subject the firm to the employer responsibility requirement.⁹² Temporary agencies that remain the *de jure* employer of temporary workers will, if their size and insurance offerings warrant, be liable under this portion of the law.

Similarly, employers may respond to the employer responsibility requirement by a more extensive use of independent contractors. At the same time, individuals will still be subject to the individual mandate. If the insurance plans offered in the exchange are or are perceived to be of lesser value than the employer-sponsored plans, individuals who otherwise might have accepted a contractual work

arrangement might be induced by the individual mandate to seek more traditional employment. Further, individuals whose earnings preclude them from receiving a premium tax credit in the exchange might find it more financially advantageous to seek traditional work arrangements.

Conclusion

Between the creation of exchanges and the expansion of Medicaid to all low-income adults, the Affordable Care Act will create new insurance coverage options for 31 million Americans.⁹³ While many will find their health insurance situation more secure, the Affordable Care Act may have unintended consequences in the way workers are hired and the types of employment made available to low-income workers.

Previous health reform efforts at the state and municipal level make it clear that employers and workers will respond to new cost requirements. These responses range from the predictable to the unforeseen. In Hawaii, the response of employers to increase their use of part-time workers exempt from the Prepaid Health Care Act was predictable, at least from the standpoint of economic theory. Alternatively, the increase in employer-sponsored health insurance in Massachusetts seems to contradict economic theory, with the cost of insuring an employee being significantly greater than the “fair share” penalty.

Undoubtedly, some firms will find it strategically advantageous to stop offering health insurance to employees, when the cost of insuring employees is comparable to the cost of potential penalties. Other employers will find it advantageous to offer health insurance benefits from a financial, recruitment and retention perspective. Yet others may well find that the costs of compliance with the Affordable Care Act means restructuring their labor force, whether it is through reducing lower-wage workers, increasing part-time workers, or use of contingent work.

Discount Medical Plans

The rapid growth of health costs and employment growth in sectors that do not offer health insurance benefits have contributed to the erosion of job-based health insurance coverage over the past decade.⁹⁴ Spending on health costs is growing even more quickly for those who rely on private, nongroup health insurance.

The result is well documented: more than 50 million uninsured Americans, and millions more “underinsured,” whose out-of-pocket and deductible spending consumes more than 10 percent of their income.⁹⁵

These conditions animated the passage of federal health reform, but also encouraged a sprawling and unregulated market of scam coverage. Further, confusion among the general public about the Affordable Care Act, created, as one health industry watchdog observed, “an ideal breeding ground for scams.”⁹⁶

The most prevalent of these products is the *discount medical plan*. Discount medical plans first appeared in the 1990s, and were originally designed to offer discounts on ancillary medical services not covered by conventional insurance. They provided a sort of “buyers’ club” access to discounted rates on prescriptions, dental care, eye care, chiropractic services, and alternative health services. Such plans are still common, but many now offer (or promise) similar discounts on conventional medical expenses.

Over the years, discount medical plan organizations (DMPOs) have acquired and sold access to provider networks and consolidated, leading the industry to be dominated by just a few firms. Nevertheless, it is a ragged and sprawling industry. In part, this reflects its unscrupulous fringes, in which fly-by-night membership plans have become common targets of attorneys general and insurance commissioners.

Prevalence of Discount Medical Plans

Given the wide range of discount cards and the benefits offered, it is difficult to pin down the scope of the industry. State-level registration and reporting offers more precision than company estimates of enrollees, but remains uneven across the states.

National household surveys do a notoriously poor job of measuring anything but the rough parameters of coverage, as even astute respondents are often unable to untangle the terms (deductibles, spending caps, exclusions) of their insurance.⁹⁷ In our 2005 survey of nonstandard workers (representing 34 million workers, or about one quarter of the 2005 U.S. workforce) we found an uninsurance rate of 24 percent (nearly double that of the rate for standard workers). About the same number reported subscription in a medical discount plan, most of which (18 percent of the total) listed this as their only form of “insurance.”⁹⁸ This would suggest a discount card enrollment among nonstandard workers alone of about 8 million.

In our 2009 survey (prompted by surprising frequency of discount card uses reported in 2005), 9 percent of all respondents indicated that they had a medical discount card. This rate was slightly higher for those employed (8.97 percent) and for those employed *and* insured (10.35 percent), and 4 percent of employed and insured respondents listed the medical discount plan as their only form of insurance. These results confirm the general picture, but also underscore the prevalence of ancillary service discount cards marketed to accompany conventional insurance. Most (65 percent) of the discount cards held by employed respondents were provided by the employer or union rather than purchased on the private market.

Terms and Benefits of Discount Medical Plans

The terms and benefits of these plans vary widely. Almost all plans begin with a laundry list of discounts on ancillary services (dental, vision, chiropractic, prescription, alternative); some stop there, others also offer discounts on doctor and hospital charges — often in a “premium” or “gold” plan. Alongside the promised discounts, plans often include other benefits and services that are difficult to value or assess — such as “24-hour nurse hotline assistance,” patient advocacy, online health services (basic medical information or provider search engines), “VIP health and wellness,” or billing negotiation

and mediation services.⁹⁹ Some plans offer flat-rate pricing on basic services (such as screening or blood tests). And some offer discount plans bundled with catastrophic (accidental death and dismemberment) or limited benefit insurance products.¹⁰⁰

Advertised discounts also vary widely. The standard marketing pitch cites discounts “up to” 50 or 80 percent, but the high end is almost tied to the regular retail price of selected services such as blood tests. Our 2010 survey of DMPOs found that 18 plans made specific claims as to discounts, most citing savings of between 10 and 50 percent on doctor and hospital charges.¹⁰¹ The 18 plans cited 12 different discount rates, including a range from “10 to 60 percent” to “10 to 20 percent,” and a few that promised slightly smaller (15 or 20 percent) average or guaranteed savings.

Costs also vary, although not as widely. Of the surveyed plans, 28 listed clear financial terms. Half of these offered an individual medical discount plan (including doctor’s and in most cases hospital services) for between \$19.95 and \$29.95 a month (only a few of these offered family coverage for a higher rate). Only one plan was priced less, charging an annual fee of \$129.95. A few fell into the \$40.00 range although there is no appreciable difference in the benefits, network access, or discounts provided by these plans.¹⁰² Much of the disparity in pricing reflects the way in which plans are sold, as much of the business is conducted by third-party marketers who re-brand and re-price the plans and programs of leading firms like New Benefits or Careington.¹⁰³ Two plans offer family-only coverage (priced at \$39.95 and \$59.95, respectively). Those plans at higher price points (five plans at between \$80 and \$250/month) all combined medical discounts with catastrophic or limited health insurance coverage. Most plans also charge a onetime membership or enrollment fee, most commonly \$30.

Industry Problems

This is a sprawling and lightly regulated industry. At its worst, marginal and unscrupulous firms have prompted thousand of consumer complaints, state investigations and legal actions. The Consumer Health Association exists largely to sustain and build confidence in an industry in which, as one member admitted in 2005, there are “lots of bad players right now ... total scams.”¹⁰⁴ But even at its best, the industry has struggled to deliver on often sweeping claims of health savings. These problems — identified and documented by investigators for the General Accounting Office (February 2004), the State of Maryland (November 2004), the Commonwealth Fund (March 2005), the State of Florida (November 2006), and numerous state insurance commissions, better business bureaus, and attorneys general — fall into three areas: deceptive marketing, uneven participation by providers, and elusive benefits.¹⁰⁵

Regulatory Challenges

In recent years, states have paid closer attention to the inflated claims, limited benefits and aggressive marketing of discount medical plans. But consistent and effective state action is hampered by the very nature of the plans: These plans are not insurance, and one of the principal state concerns is to control claims or implications that they are. But because these plans are not insurance, state regulatory authority is uncertain. State insurance commissions have in some cases hewed to the view that they hold no

jurisdiction over a product that is not insurance, while in other cases (more commonly and recently) have claimed that they have clear authority to rein in schemes that masquerade as insurance.¹⁰⁶

Regulation has spread rapidly in recent years. As of 2004, the industry estimated that about 20 states had a DMPO law on the books, most which mandated basic “this is not insurance” disclaimers in advertising materials.¹⁰⁷ In addition to disclosure, the most common state regulations require DMPOs to document provider agreements, be registered or licensed with the state, and lay out cancellation rights. Several states require certification or guarantee of financial stability, document agreements with marketers, and issue annual reports.

Survey Findings

In October and November 2009, the Iowa Policy Project and Princeton Survey Research Associates, International fielded a national telephone survey of 1,303 respondents between the ages of 16 and 65. The questions covered several issues, including medical discount cards, health insurance, work type and hours, and productivity. The methodology is in Appendix A and the complete questionnaire is in Appendix B.

This survey questionnaire is motivated by the responses gleaned from a survey of nonstandard work and benefits that the Iowa Policy Project published in 2005. That survey, also funded by the U.S. Department of Labor, found that nonstandard workers were more likely to be uninsured than to be covered by their employer’s plan. Moreover, a surprisingly large share of nonstandard workers — almost 1 in 5 — had a medical discount card without any health insurance. The IPP Survey raised the distinct possibility that other surveys have overstated the extent of health insurance coverage by failing to identify those who think of themselves as insured but in fact possess only a discount card.

The questions asked in this survey are more detailed with respect to health insurance and discount cards, and include similar questions on work, in order to provide more detailed and updated data on these questions.

In general, 65 percent of our survey respondents are employed, which is consistent with employment rates nationally (68 percent for ages 16-65 in September 2009, according to our analysis of the Bureau of Labor Statistics’ Current Population Survey).

Standard vs. Nonstandard Worker

The term “standard” refers to regular, full-time jobs that employees reasonably expect will continue into the future — for example, a teacher who works 40 hours a week on a contract that renews annually. This teacher would reasonably expect to be employed with the same employer for the indefinite future, and can thus be classified as “standard.”

By contrast, the term “nonstandard” includes part-time workers (regardless of whether they think their jobs will last), temporary help workers, day laborers, and contract workers. Our analysis of the 2005 Contingent Work Supplement of the Current Population Survey found that about 27 percent of employees fell in this category. Our new national survey finds, not surprisingly, that this number has increased. We find that nonstandard workers now make up about 40 percent of the workforce.

For example, from 2007 to 2009, the percent of all workers ages 16 and up in part-time jobs increased from 19.1 percent to 21.7 percent.¹⁰⁸ The current state of the economy explains some portion of this increase; even as businesses start to see improved activity, they remain cautious about hiring full-time workers with benefits.¹⁰⁹

In the 2005 BLS Contingent Work Supplement, contingent workers were estimated at 4.1 percent of the labor force by the broadest definition (accounting for all persons who do not expect their jobs to last or who reported that their jobs are temporary). Alternative workers (independent contractors, on-call workers, temp agency workers and contract firm workers) were estimated at 10.7 percent of the workforce. After accounting for the overlap of contingent and alternative workers, we estimate the total at 13.4 percent.

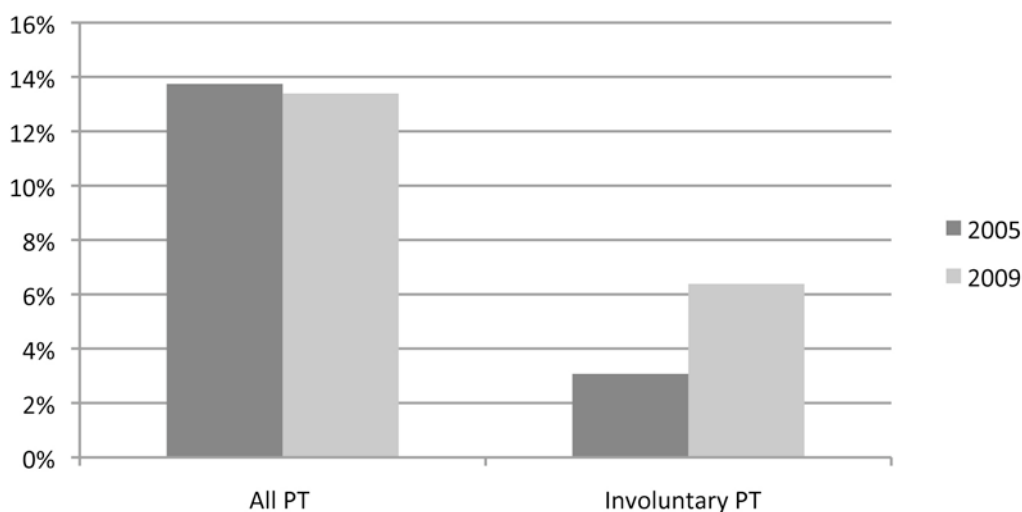
Part-time workers were estimated in 2005 at 18.1 percent. Adding full-time contingent and alternative workers to that rate, our estimate of nonstandard workers that includes part-time workers (though with no accounting for overlap of contingent and alternative) is 28.3 percent. With the overlap, the real number is probably a little lower, likely closer to 27.3 percent.¹¹⁰

In our own survey, 40 percent of respondents were categorized as nonstandard workers. This represents a marked increase over the rate of nonstandard work in the Contingent Work Supplement of 2005. According to Current Population Survey data, the rate of involuntary part-time workers out of all employed respondents was up dramatically between the two survey periods. While the rate of those who usually work part time is virtually unchanged from 2005 to the 2009 census data, the number of workers employed part time for economic reasons has more than doubled, from 4.2 million workers to 9.3 million.^{**},¹¹¹ However, part-time worker trends cannot explain the increase in the rate of nonstandard workers between 2005 and 2009, as the total number of part-time workers did not go up. Figure 1, below, illustrates the changes in the part-time workforce between the two periods.

The Contingent Work Supplement has not been fielded since 2005, and the Current Population Survey does not get at nonstandard work relationships other than part time work. Thus it is not possible to find data corroborating the apparent upward trend in nonstandard work that we found in 2009.

^{**} Part-time for economic reasons means those workers who were only able to find part-time work, though they would have preferred to work full time.

Figure 1. Rate of part-time workers out of all workers, 2005 and 2009



Health insurance and worker status

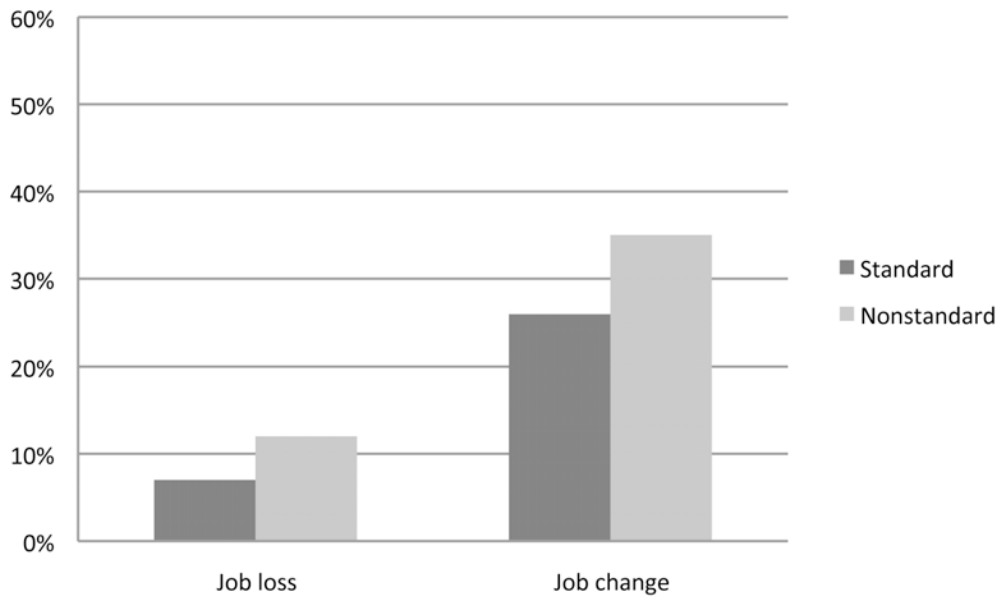
Of all nonstandard workers, 59 percent work part time and 41 percent work full time. Because part-time nonstandard workers and full-time nonstandard workers did not differ significantly on any of the survey questions, we will report the survey results for full-time and part-time workers combined.

Compared to nonstandard workers, standard workers are significantly more likely to say they are covered by health insurance. While 87 percent of standard workers say they are covered, only 75 percent of nonstandard workers do. Standard and nonstandard workers did not differ significantly in rates of having a medical discount card, in rates of having *only* a medical discount card, or in rates of thinking that they are covered when they have only a medical discount card.

Job loss in the past year is significantly more common among nonstandard workers: 12 percent vs. 7 percent, though not job loss specifically due to health reasons (see figure 2). Similarly, job change (or considering a job change) in the past year is significantly more common among nonstandard workers: 35 percent vs. 26 percent, though not job change specifically due to the availability of health insurance. A logistic regression analysis revealed, however, that the effect of worker status on job loss or job change disappears completely once we control for health coverage. It is actually *the uninsured* who are significantly more likely to experience job loss or job change, and not nonstandard workers. An insured worker has one-third of the likelihood of an uninsured worker to experience or consider a job change, and one-tenth of the likelihood of an uninsured worker to lose his job. That is, nonstandard workers have higher rates of job loss and job change only because they have higher rates of uninsurance. This finding is consistent with the job lock effect, or the tendency of workers to stay in “good jobs.” Figure 2 demonstrates the differences in rates of job loss and job change:

The two groups did not differ in rates of absenteeism due to health reasons or in rates of difficulty concentrating at work due to health reasons.

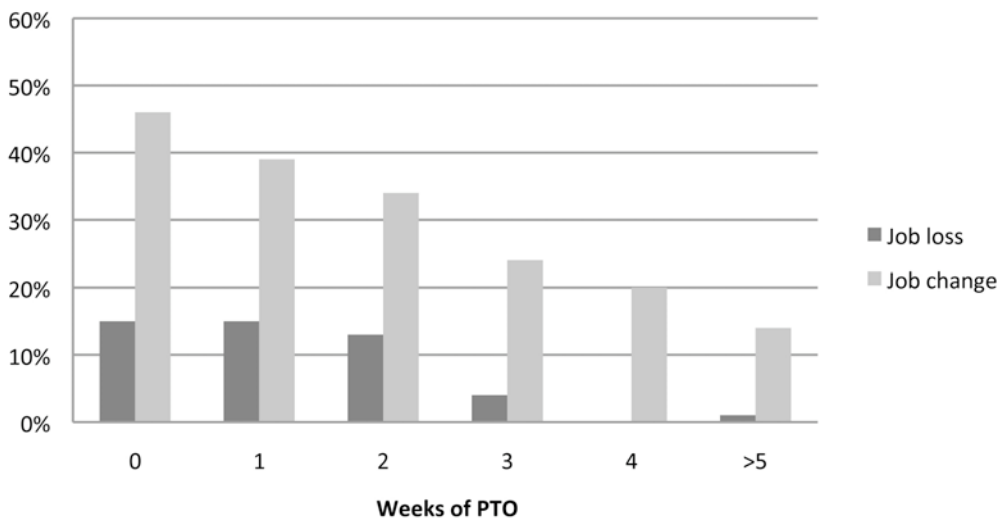
Figure 2. Percent experiencing job loss/change by worker status



We found job loss and job changes in the past year to be related to paid time off (PTO). About 15 percent of those with fewer than three weeks of PTO have lost a job in the past year, compared to less than 5 percent of those with three or more PTO weeks. Similarly, with every additional week of PTO, the worker is less likely to have experienced job change. While almost 50 percent of those with no PTO experienced job change, less than 15 percent of those with more than four weeks of PTO did. Jobs offering more weeks of PTO are more attractive and more competitive than jobs offering fewer weeks, which is most likely the reason behind these findings. Figure 3 below illustrates both relationships.

No relationship was found between PTO and absenteeism due to health reasons or between PTO and difficulty concentrating at work due to health reasons.

Figure 3. Percent experiencing job loss/change by weeks of PTO



Health insurance and medical discount cards

Nine percent of all employed respondents have medical discount cards. Of those, 35 percent were purchased on the private market, and 65 percent were provided by an employer or union. Sixty percent attempted to use their discount card while 40 percent had not tried.

We set out to establish exactly how many respondents who think they have health insurance are actually only card holders and are not insured. First, we had to determine which of our respondents believe that they are insured. We made sure that respondents are explicitly aware of what “health insurance” entails, using the phrase “any private **insurance** plan through an employer, union, or a plan you purchased yourself, as well as a government program such as Medicare or Medicaid.” Once we successfully established which of our respondents believe they are insured, we asked them whether they have a medical discount card, and then asked twice whether the card is their only form of insurance, once by asking, “Is your medical discount card the only form of health ‘coverage’ that you have?” and then by asking, “When you said earlier that you were covered by health insurance, is your medical discount card the insurance you were referring to?” We found that 82 percent of employed respondents stated that they have health insurance, and of those, 4 percent have *only* medical discount cards (30 weighted cases). This 4 percent is the total of respondents who think they have health insurance, but actually do not. This lowers the rate of insured individuals from 82 percent to 78 percent. If we were to carry this finding and apply it to the entire labor force, there are potentially 6 million (4 percent of 150 million) workers in the nation right now who believe they are insured, but are not.

Looking at the entire population, 76 percent of our survey respondents (both employed and not employed) identified themselves as covered by health insurance. This fraction should be lowered to 72 percent, taking out those with just medical discount cards. In comparison, the U.S. Census Bureau in its Annual Social and Economic Supplement figures for 2008, estimated the total coverage rate of 18- to 64-year-olds at 79.7 percent¹¹² Notably, since the Census questionnaire does not account for medical discount cards, those who think they are insured because they are card holders are counted by the Census as insured. For example, once a respondent claims to have health coverage, he is asked “What type of health insurance were you covered by in 2009?” The multiple-choice answer has 15 options, 14 of which are types of insurance that are not medical discount cards, and the 15th option which is reserved for “other.”¹¹³ Our questionnaire, on the other hand, asks explicitly about medical discount cards.

The insured and the uninsured

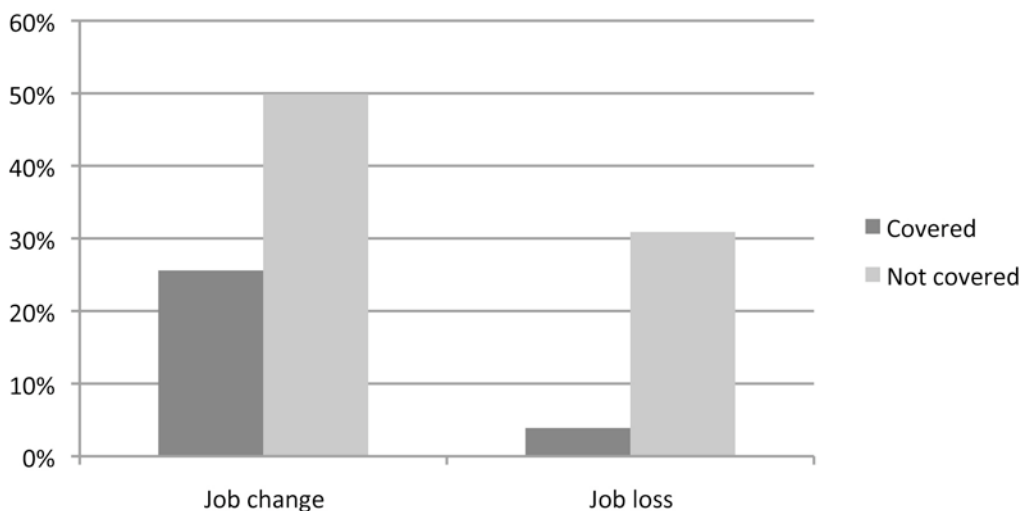
Job change is significantly more common among the uninsured: 50 percent of the uninsured have changed their jobs or considered changing their jobs in the past year, compared to 26 percent of the insured. Similarly, job loss in the past year is significantly more common among the uninsured: 31 percent vs. 4 percent (see figure 4), though not job loss specifically due to health reasons.

The two groups did not differ significantly in rates of absenteeism due to health reasons: 48 percent among the uninsured and 55 percent of the insured. They did differ significantly, however, in difficulty concentrating at work due to health reasons: 42 percent of the uninsured vs. 26 percent of the insured.

This difference remained statistically significant even after we controlled for worker status in a logistic regression model. In addition, the number of days of having difficulty concentrating at work due to health reasons is significantly tied to insurance: in a Wilcoxon rank sum test, we found that uninsured workers were having difficulty concentrating at work during a significantly larger no. of days than insured workers.

Together with the data showing that the uninsured were less likely to be absent from work, these results suggest that the uninsured are more likely to come to work sick rather than take unpaid time off, and that this contributes to the greater incidence of difficulty concentrating at work. To the extent that this also leads to the spreading of illness within a workplace, it suggests that absence of health insurance might well diminish productivity.

Figure 4. Percent experiencing job loss/change by health insurance status



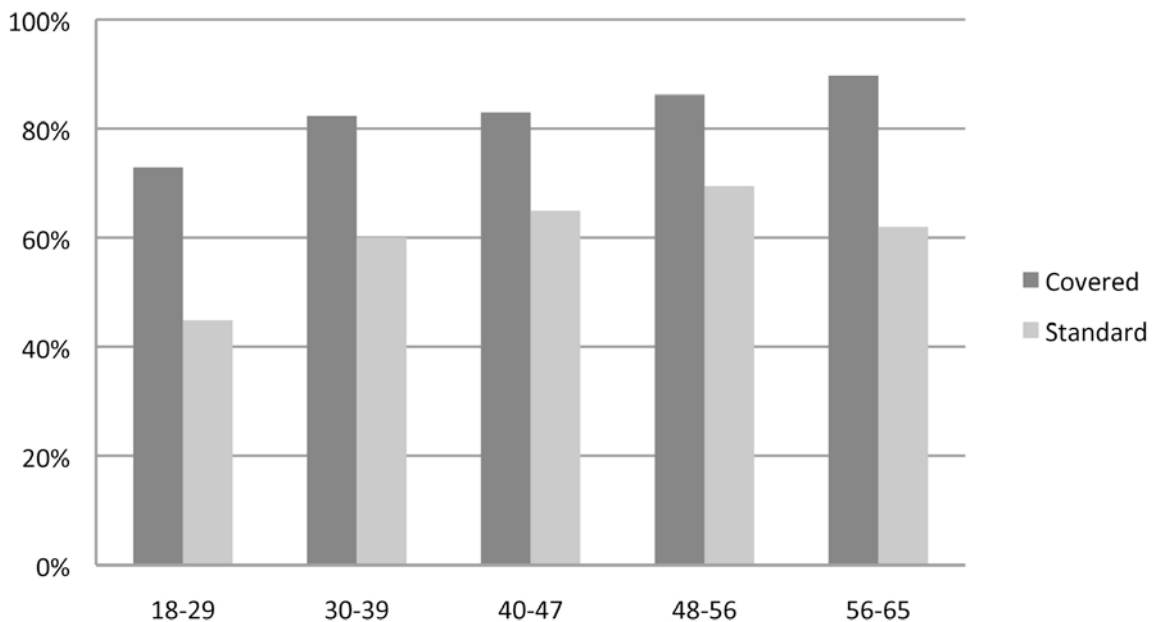
Demographic effects

As a part of our survey analysis, we looked at the relationships of demographic background variables with insurance status and with workplace outcomes.

Age

We created five age groups by quintiles (each group is exactly 20 percent of the sample): 18-29, 30-39, 40-47, 48-56 and 56-65. We found that older workers are more likely to be covered by health insurance, though that finding was not statistically significant. We did find that as workers age, they are significantly more likely to be standard workers, a likelihood that then drops for the last age group (see Figure 5). We also found that as workers age, they are significantly less likely to experience job changes. We found no relationship between age and medical discount cards.

Figure 5. Health coverage and standard work status by age group



Sex

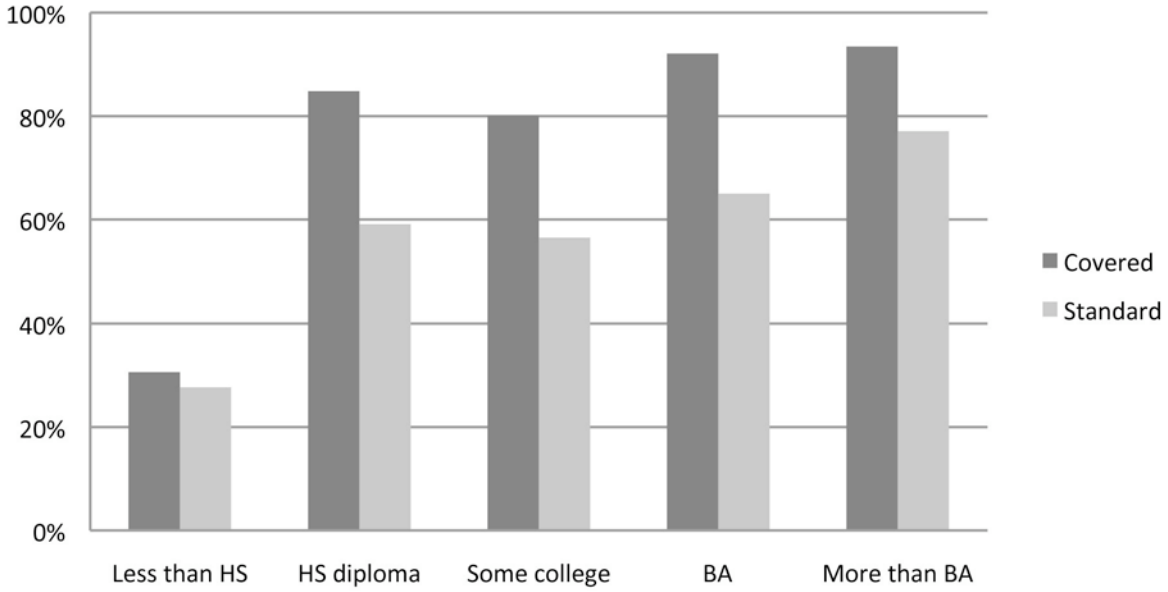
A logistic regression analysis of gender revealed that controlling for worker status, health insurance and children, women are significantly less likely than men to experience job loss: Men are about twice as likely as women to lose their job. We found no gender effect on job change.

Using the same controls, we found that women are also significantly more likely than men to face difficulties concentrating at work, and significantly more likely to be absent due to health reasons. Women are about twice as likely as men to have a hard time concentrating and to be absent. Indeed, when we use no controls, we find that 63 percent of women and 45 percent of men missed work due to health reasons. Parents, irrespective of sex, are significantly more likely to be absent due to health reasons.

Education

A significant relationship of education level exists with health coverage and with nonstandard work status. The higher the education level, the more likely the worker is to be covered and to be a standard worker (see Figure 6). The figure also demonstrates one noticeable exception — high school graduates are slightly more likely than respondents with some college education to be standard workers and to have health coverage.

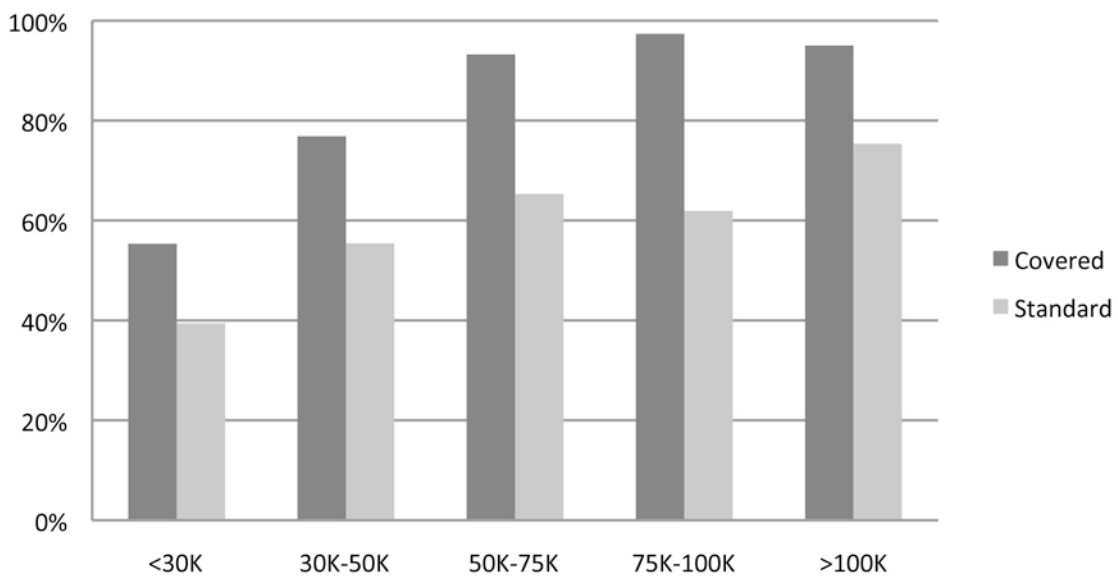
Figure 6. Health coverage and standard work status by education



Income

We created five income groups of similar sizes: less than \$30,000 annually, \$30,000-50,000, \$50,000-75,000, \$75,000-100,000, and over \$100,000. Group sizes ranged from 15 percent of the sample to 24 percent of the sample. The groups showed significant differences in rates of job loss and job change, as well as in health coverage and standard employment (see Figure 7). Moreover, in a logistic regression analysis we found that income and insurance status are highly associated, even after introducing controls for standard employment, age, race, gender and parental status.

Figure 7. Health coverage and standard work status by income

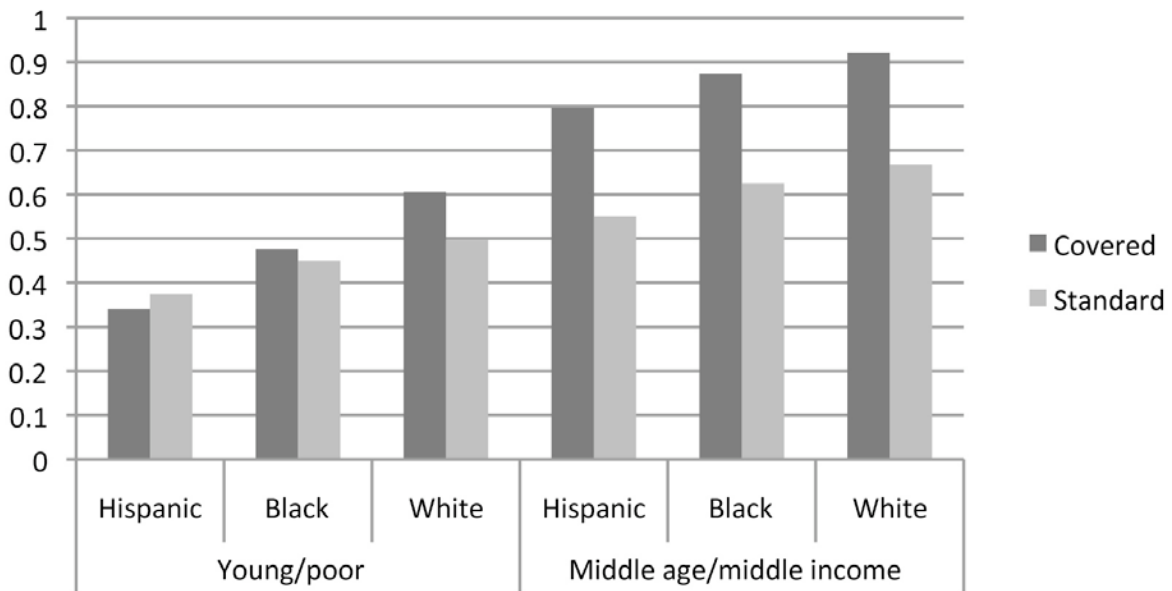


Race and ethnicity

We found that Hispanics are significantly less likely to have health insurance compared to whites and blacks: Only 60 percent of Hispanics are covered, compared to 77 percent of blacks and 87 percent of whites. Not only that, but in a logistic regression we found that the significant insurance disadvantage of Hispanics remains significant even after we control for income, age, gender and parental status. Hispanics are only about one-third as likely as whites to be insured. In contrast, the statistical significance of the disadvantage of black workers compared to white workers disappears once we control for income. This means that the reason blacks are at an insurance disadvantage is their lower income, while low income cannot account for the insurance disadvantage of Hispanics. Hispanics are also significantly less likely to be standard workers, even after controlling for the other demographic variables.

Figure 8 demonstrates the intersections of age, race and income. Based on our logistic regression models, we graphed the likelihood of six individual men to be standard workers and to have health coverage: three in their 20s earning less than \$30,000, and three in their 40s earning between \$50,000-75,000. The Hispanic disadvantage within each group is noticeable. The one least likely to be standard and insured is the young Hispanic earning less than \$30,000. The one most likely to be standard and insured is the white worker in his 40s making \$50,000-75,000.

Figure 8. Health coverage and standard work status by race, age and income



Discussion and Summary of Findings

In this report, we showed that employer-provided health insurance has become more rare and more expensive, leaving the economically weakest among the workers to fend for themselves. Among the uninsured, a small but not insignificant number turned to discount medical plans, an industry that would not have existed had it not been for the distress of the uninsured. Our review revealed that despite the increased scrutiny of the industry, including enhanced state-level regulation, in recent years, it is still plagued by major problems: There are gaps in the regulation, and fly-by-night companies and companies using deceptive marketing strategies are still a problem, as are uneven participation by providers, and elusive benefits.

In the analysis of our 2009 national survey, we found that nonstandard work has become more prevalent since 2005. While the 2005 BLS estimate is a nonstandard rate of 27 percent of the labor force, our own 2009 survey estimates the share of nonstandard workers at 40 percent of the labor force. Similarly, BLS data on involuntary part-time workers shows that their numbers have more than doubled — from 4.2 million in 2005 to 9.3 million in 2009. These figures go hand-in-hand with recent economic trends that we pointed to in our literature review, mainly the role of the recent recession in shifting workers from full-time to part-time work, as well as changes in the nature of the labor market during the last 20 years, resulting in more nonstandard service workers and fewer full-time manufacturing workers.

We found that 82 percent of our employed survey respondents identified as having some health insurance, including 9 percent who identified themselves as having a discount medical plan. Of those, 4 percent have only a discount medical plan. Since medical discount plans are not insurance, the real total coverage rate is 78 percent, not 82 percent. We emphasize this distinction between the perceived coverage rate and the “real” coverage rate, because it implies that other surveys, including the Current Population Survey, may well overstate the rate of insurance coverage, since these surveys do not include any follow-up questions to determine if some of those claiming to be insured have only a discount card.

As the literature in the field suggests, health insurance was found to be related to lower job turnover, but not related to lower absenteeism. Our analysis revealed that workers with no health insurance are significantly more likely to experience job loss and job change compared to insured workers. In addition, workers with no health insurance are significantly more likely to have difficulty concentrating at work due to health reasons, and more likely to experience this difficulty for a significantly higher number of days. Though our review of the literature found no concrete evidence for an effect of health insurance on worker productivity, these findings may suggest that employers could benefit from providing insurance in terms of worker stability and concentration at work.

Our analysis also showed that nonstandard workers are significantly less likely when compared to standard workers to have health insurance. As a result, nonstandard workers are significantly more likely to experience job loss and job change than standard workers. This supports the findings from our previous report, and is especially disconcerting considering the remarkable rise in the rate of nonstandard workers (from 27 percent in 2005 to 40 percent in 2009).

Lastly, we discovered that the demographic variables of age, education and income are significantly related to health insurance and worker status. Older, better-educated and better-earning individuals are significantly more likely to be insured and to be standard workers. We also found a significant race effect — when comparing Black, Hispanic and White workers, Hispanic workers are significantly less likely to be insured and to be standard workers. This last finding is most alarming, as it may suggest a discriminatory labor market, in which Hispanics are employed in inferior jobs that do not carry the same benefits as other jobs do. It may also suggest a language barrier issue, or a lack of awareness of worker benefits and rights. We can only hypothesize as to the explanation of this finding. While one is tempted to speculate that the findings are the result of undocumented workers among the Hispanic population, it is unlikely that our survey in fact included any significant number of such workers, if for no other reason than their presumed reluctance to answer surveys.

About 22 percent of workers in our survey lack health insurance. The intent of the Affordable Care Act is to dramatically reduce the rate of uninsurance. If fully implemented, the law will reduce the number of uninsured workers by expanding Medicaid coverage, providing new avenues of purchasing insurance for individuals and small businesses, induce some small businesses to offer health benefits, and encourage larger businesses to more evenly offer insurance benefits to their workforces. Moreover, continued economic recovery could lead to regaining some of the ground workers lost in terms of job-based insurance rates and long-term employment. The prevalence of discount medical cards should drop, particularly if state-level scrutiny of these organizations continues.

Appendix A: Survey Methodology

There are particular methodological difficulties with surveying on the specifics of a respondent's insurance policy. The survey contained limited questions on this topic due to research indicating that individuals often do not know the finer points of their health insurance coverage. For a detailed discussion on this topic, please see M. Susan Marquis, "Consumers' Knowledge about Their Health Insurance Coverage" (1981), which is part of the RAND Health Insurance Experiment series.

The 2009 Health Discount Cards Survey obtained telephone interviews with a nationally representative sample of 1,303 adults between the ages of 18 and 64, living in the continental United States. IPP reviewed proposals from several survey companies, and ultimately partnered with Princeton Survey Research International, that conducted the survey based on IPP specifications. The interviews were conducted in English and Spanish by Princeton Data Source LLC from October 8 to November 23, 2009. The margin of sampling error for the complete set of weighted data is ± 2.9 percentage points.

Pilot survey:

A pilot survey was administered beforehand to a small group of respondents to identify potential problems with the survey instrument. The survey was administered to 20 respondents, and based on their reactions, several changes were made to the survey instrument.

Sample design:

The survey used a combination of landline and cellular random digit dial (RDD) samples. Both samples were provided by Survey Sampling International, LLC (SSI) according to PSRAI specifications. As many as 15 attempts were made to contact every sampled landline telephone number and as many as 10 attempts were made to each sampled cellular telephone number. Calls were staggered over times of day and days of the week to maximize the chance of making contact with potential respondents. In addition, each number received at least one daytime call.

For the landline sample, interviewers first asked to speak with the youngest adult male or female currently at home based on a random rotation. If there was one age-eligible resident, an interview was conducted with that person. If there was more than one age-eligible resident, an interview was conducted with one selected at random. Households with no 18- to 64 year-old residents were screened out as ineligible.

For the cellular sample, interviewers first verified the age of the person who answered the phone. If the person was age 18 to 64, an interview was conducted with that person. If the person who answered the phone was not age-eligible, then the number was screened out as ineligible.

Response rate:

The response rate was 29 percent for the landline sample and 21 percent for the cellular sample.

Weighting:

Weighting is generally used in survey analysis to compensate for sample design and patterns of non-response that might bias results. A two-stage weighting procedure was used to weight this dual-frame sample. The first stage weight balanced the phone use distribution of the entire sample to match population parameters, and accounted for unequal probabilities of selection based on the number of adults in each household. The second stage of weighting balanced the sample demographics to match national population parameters for sex, age, education, race, Hispanic origin, region (U.S. Census definitions), population density, and telephone usage.

Analysis:

Survey analysis was conducted by IPP researchers in-house. Several statistical techniques were used in analyzing the data:

Crosstabulation — A crosstabulation is a joint frequency distribution of cases based on two categorical variables, also known as contingency table analysis. In our crosstabulation analyses, we used two measures of association: the chi-square statistic (χ^2) and Cramer's V statistic.

- Chi-square is used in cases of two nominal variables when each is divided into two categories, generating a 2 x 2 table. The test generates a *phi* value, which can be read as the level of association between the two variables. A statistically significant phi value implies an association.
- Cramer's V statistic is useful when at least one of the two nominal variables are divided into more than two categories. In those cases, the chi-square is inadequate as a measure of association. Cramer's V ranges from -1 to 1, with 0 indicating no relationship at all between the two variables, and -1 or 1 indicating a perfect relationship. A Cramer's V value greater than 0.2 is commonly considered to imply a moderate, yet statistically significant, association.

Wilcoxon rank sum test — this is a non-parametric significance test, designed to compare two groups when we cannot make any assumptions about the nature of the dependent variable. In this case, the test was used to evaluate the relationship between a set of binary nominal variables (such as standard vs. nonstandard workers) with the number of days of having difficulty concentrating at work due to health reasons. The latter is a highly skewed, right-tale, non-parametric variable and could not meet the statistical assumptions of a traditional t-test. A statistically significant test indicates a relationship between the two variables.

Binary logistic regression — this is a form of regression used when the dependent variable is binary. The regression predicts the value of the dependent variable based on the independent variables, which could be on any scale. Unlike a simple crosstabulation, the regression allows for multiple independent variables to be checked in the same model, estimating the effect of each while controlling for all the others. An independent variable that is found to be statistically significant is perceived to have an association with the dependent variable.

In our analysis, we used cross-tabulations to check for associations between two binary variables, or between one binary variable and one categorical variable; we used Wilcoxon rank sum test to check for association between a binary independent variable and an ordinal dependent variable; and we used binary logistic regressions to check for association between a set of independent variables and a binary dependent variable.

Appendix B: Questionnaire with Topline Results

2009 Health Discount Cards Survey

Prepared by:

Princeton Survey Research Associates International

for The Iowa Policy Project

Final Topline

December 4, 2009

N= 1,303 18-64-year-olds nationwide (752 landline/551 cell phone interviews)

Margin of Error: +/- 3 percentage points

Dates of Interviewing: October 8-November 23, 2009

Interviewing Conducted in English and Spanish

PSRAI Job # 29054

NOTE: In the tables that follow each question, the numbers in the left-hand column refer to the weighted percent of all respondents choosing that answer.

LANDLINE INTRODUCTION: Hello, my name is _____ and I'm calling for Princeton Survey Research. We're taking an important national survey about some topics of interest. (This will only take about 10 minutes.)

S1. 1. May I please speak with the YOUNGEST MALE, age 18 or older, who is now at home? **(IF NO MALE AT HOME NOW, ASK:** May I please speak with the YOUNGEST FEMALE, age 18 or older, who is now at home?) /2. May I please speak with the YOUNGEST FEMALE, age 18 or older, who is now at home? **(IF NO FEMALE AT HOME NOW, ASK:** May I please speak with the YOUNGEST MALE, age 18 or older, who is now at home?)

CELL PHONE INTRODUCTION: Hello, I am ___ calling for Princeton Survey Research. We are conducting an important national survey about some things that have been in the news. This will only take about 10 minutes. (If you are eligible for our survey, we will send you \$5 as a small token of our appreciation.)

This is not a sales call. **(IF R SAYS DRIVING/UNABLE TO TAKE CALL:** Thank you. We will try you another time...).

VOICE MAIL MESSAGE (LEAVE ONLY ONCE -- THE FIRST TIME A CALL GOES TO VOICEMAIL): I am calling for Princeton Survey Research. We are conducting a national survey of cell phone users. This is NOT a sales call. We will try to reach you again.

MAIN INTERVIEW

Q1. We're interested in people's work status... Are you currently employed at a paying job, or not? **NOTE: IF RETIRED OR DISABLED, RECORD AS NOT EMPLOYED**

Q1a. Were you employed at a paying job at any time in the last 12 months?

65	Yes, employed for pay
35	No, not employed for pay
12	Yes, employed for pay in the last 12 months
23	No, not employed for pay in the last 12 months
0	Don't know/Refused
*	Don't know/Refused

Q2. Now I have a few questions about your job. If you have more than one job, please think only about the job where you work the most hours.

Which of the following best describes your job? Are you an employee of a private company or business, an employee of a non-profit organization, a government employee, or are you self-employed in your own business or professional practice?

Based on those who are employed (n=852)

59	Private company or business
10	Non-profit organization (includes private schools, colleges or universities)
16	Government (INCLUDES federal, state, or local government, public schools, college and universities)
13	Self employed or business owner (INCLUDES independent contractor, freelance worker)
1	Other (VOL.—SPECIFY)
1	Don't know/Refused

Q3. Can you please tell me what kind of work you do? **CHECK CATEGORY BELOW THAT BEST DESCRIBES THE RESPONDENT'S MAIN JOB. IF UNABLE TO CLASSIFY, ASK RESPONDENT TO CHOOSE:** Which one of the following BEST describes the kind of work you do?

25	Professional worker
12	Manager, executive, or official
4	Business owner (with two or more employees)
9	Clerical or office worker
5	Sales worker
4	Sales representative
15	Service worker
11	Skilled trade or craft worker
8	Semi-skilled worker
6	Laborer OR
*	Something else? (SPECIFY)
1	Don't know/Refused

Q3a.-Q3k Not shown. Used for Coding Q3.

Q4. What kind of business is (**IF Q2=1,5:** the company or organization you work for/**IF Q2=4:** your company or organization)? That is, what does it make, or do?

(IF COMPANY IS INVOLVED IN MORE THAN ONE BUSINESS, PROBE FOR ONE

ANSWER: What does it make or do at the location, worksite, or branch office where YOU work?

Based on those who are employed by a private company/self-employed/other (n=606)

2	Agricultural Services/Forestry/Fishing
1	Mining
8	Construction
11	Manufacturing
8	Transportation/Public Utilities/Communication
4	Wholesale trade
21	Retail trade
7	Finance/Insurance/Real Estate
10	Health Services
9	Business Services/Law
3	Educational, Social, Membership Organizations
10	Other services
2	Insufficient information to be classified
5	Didn't name a business or industry/Refused

Q5a. Counting all the paying jobs you now have, IN TOTAL, do you work UNDER 35 hours per week or OVER 35 hours per week?

Q5b. Do you work AT LEAST 35 hours per week for the SAME EMPLOYER?

Based on those who are non-self employed (n=742)

22	Work under 35 hours per week
75	Work over 35 hours per week (includes 35 hours exactly)
74	Yes, work 35 hours for same employer
2	No, work 35 hours not for same employer
0	Don't know/Refused
2	(VOL.) It varies/Sometime 35 hours, sometimes less
*	Don't know/Refused

Q6. Some people are in temporary jobs that last only for a limited time or until the completion of a project. Is your job temporary, or not?

Based on those who are employed (n=852)

10	Yes, temporary
89	No
1	Don't know/Refused

Q7. Are you sent to jobs by a temporary help agency, such as Kelly or Manpower?

Based on those who are employed (n=852)

3	Yes, sent to jobs by temp agency
96	No
1	Don't know/Refused

Q8. Some companies provide employees or their services to others UNDER CONTRACT. Are you or your services contracted out by your employer?

Based on those who are employed (n=852)

10	Yes, contract worker
77	No
1	Don't know/Refused
12	Identified as temporary worker

Q9. Are you an ON-CALL WORKER who is part of a pool of workers only called to work as needed?

Based on those who are employed (n=852)

5	Yes, on-call worker
73	No
1	Don't know/Refused
22	Identified as temporary or contract worker

Q10. Are you a DAY LABORER who gets work by waiting at a place where employers pick up people to work for a day?

Based on those who are employed (n=852)

*	Yes, day laborer
73	No
*	Don't know/Refused
27	Identified as temporary, contract, or on-call worker

Summary Table of Questions 5a-10

39	Standard Worker
26	Non-Standard Worker
35	Not Employed

SECTION I: HEALTH INSURANCE/DISCOUNT CARDS

- Q11. Now on another subject... Are you, yourself, now covered by any form of health insurance?
- Q12. Just to confirm, health insurance includes any private insurance plan through an employer, union, or a plan you purchased yourself, as well as a government program such as Medicare or Medicaid. Are you now covered by ANY form of health insurance, or are you NOT covered by any form of health insurance at this time?
- | | |
|----|----------------------------------|
| 76 | Yes, covered by health insurance |
| 24 | No, not covered |
| 1 | Don't know/Refused |

- Q13. Which of the following is your MAIN source of health insurance coverage? Just stop me when I get to the right category. Is it... **(READ CATEGORIES NEEDED TO CLASSIFY):**

Based on those who are insured (n=1024)

- | | |
|----|---|
| 72 | A plan through your own or someone else's employer or union (including if the employee is responsible for paying the premium on an employer plan) |
| 9 | A plan you purchased yourself |
| 16 | Are you covered by Medicare, Medicaid, or another government program |
| 2 | Or do you get your health insurance from somewhere else? |
| 1 | Don't know/Refused |
- Q14. Thinking about all the OTHER people who live in your household – both adults and children – how many are covered by some form of health insurance? Are they all covered, OR are some covered but not others, or do none of them have health insurance coverage?
- | | |
|----|---|
| 66 | All covered |
| 16 | Some covered |
| 9 | None are covered |
| 8 | (VOL.) Live alone/No other person in household |
| 1 | Don't know/Refused |

Q15. Now, I'm going to ask you about some other types of health benefits that are DIFFERENT from health insurance plans. As I read each one, please tell me whether or not you have this type of benefit. (First/Next) what about...**(INSERT. READ AND RANDOMIZE)**.

READ AS NECESSARY: Do you have this type of benefit or not?

		Yes	No	DK/Ref.
a.	A health reimbursement arrangement or an H-R-A	10	80	10
b.	A flexible spending account or an F-S-A	17	77	6
c.	A health savings account or an H-S-A	11	83	6

Q16. What about a medical discount card that is NOT health insurance but offers discounts or payments for medical services from certain doctors, clinics, or other health care providers? **IF NECESSARY:** Do you have a medical discount card, or not?

8	Yes, have
89	No, do not
3	Don't know/Refused

Q17. What is the NAME of your medical discount card?

Based on those with medical discount card (n=103)

55	Named a care
40	Don't know/Not sure of name
5	Refused

Q18. Is your medical discount card in your own name or in the name of another family member?

Based on those with medical discount card (n=103)

78	Own name
20	Name of family member
2	Don't know/Refused

Q19. Was your medical discount card purchased on the private market, or was it provided by an employer or union?

Based on those with medical discount card (n=103)

30	Private market
56	Employer/Union
14	Don't know/Refused

Q20. Please tell me if your medical discount card covers each of the following kinds of services. (First,) what about... **(INSERT. READ AND RANDOMIZE)?**

READ AS NECESSARY: Does your medical discount card cover this, or not?

Based on those with medical discount card (n=103)

	Yes,	No,	DK/
Prescription drugs	85	10	5
Chiropractic care	40	47	13
Dental Care	54	39	6
Vision care	61	31	8
Alternative medicine	38	38	24
Doctor visits	70	26	4
Hospital visits	59	32	9

Q21. Have you attempted to use your medical discount card, or not?

Based on those with medical discount card (n=103)

60	Yes
40	No
0	Don't know/Refused

Q22. Were you able to find a provider who accepted the card, or not?

Based on those who have used medical discount card (n=62)

96	Yes
4	No
0	Don't know/Refused

Q23. Did the card provide the level of benefit that you expected, or not?

Based on those who found provider that accepted medical discount card (n=60)

97	Yes
2	No
1	Don't know/Refused

Q24. Why do you say the medical discount card did NOT provide the level of benefit you expected?
(RECORD VERBATIM RESPONSE)

NOTE: Too few respondents to Question 24

Q25. Were you unable to find a provider because... **(READ)**

NOTE: Too few respondents to Question 25

Q26. Is your medical discount card the only form of health "coverage" that you have?

Based on those with medical discount card (n=103)

46	Yes
51	No
2	Don't know/Refused

Q26a. When you said earlier that you were covered by health insurance, is your medical discount card the insurance you were referring to?

Based on those with medical discount card (n=103)

26	Yes, only form of health insurance
53	No, have other form of health insurance
9	No health insurance
12	Don't know/Refused/Missing Data

Q27. Do you have any reason to be concerned that your health insurance might end soon?

Based on those who are insured (n=1024)

16	Yes
82	No
2	Don't know/Refused

EMPLOYMENT EFFECTS OF UNINSURANCE

Q28. How much paid time off do you get at your job each year? This would include any SICK DAYS, vacation days, or personal days, but NOT holidays. Would you say you have... **(READ. STOP READING IF R GIVES AN ANSWER).**

Based on those who are employed (n=852)

25	No time off
8	Up to 1 week (1-5 days)
17	Up to 2 weeks (6-10 days)
14	Up to 3 weeks (11-15 days)
11	Up to 4 weeks (16-20 days), OR
20	More than four weeks (21 days or more)
5	Don't know/Refused

IF EMPLOYED IN THE LAST 12 MONTHS READ: Now thinking back to when you were last working...

Q29. Over the last 12 months, was there any time when you were unable to fully concentrate at work because you were not feeling well or you were worried about a sick family member?

Based on those who are employed or employed in last 12 months (n=997)

30	Yes
69	No
1	Don't know/Refused

Q30. In total, how many days during the past 12 months were you unable to fully concentrate at work because you were not feeling well or were worried about a sick family member? **IF NECESSARY:** Your best guess is fine.

Based on those who are unable to fully concentrate (n=285)

2	0
11	1-2 days
28	3-5 days
21	6-10 days
29	11 or more days
9	Don't know/Refused

Q31. In the past 12 months, have you ever MISSED WORK due to your own illness or the illness of someone else in your household or family?

Based on those who are employed or employed in last 12 months (n=997)

53	Yes
47	No
*	Don't know/Refused

Q32a. In the past 12 months, have you ever LOST your job?

Based on those who are employed or employed in last 12 months (n=997)

15	Yes
85	No
*	Don't know/Refused

Q32b. Did you lose your job because of missed work or decreased productivity due to your own illness or the illness of someone else in your household or family?

Based on those who lost job in past 12 months (n=133)

18	Yes
82	No
1	Don't know/Refused

Q33a. In the past 12 months, have you ever CHANGED jobs or CONSIDERED changing your job?

Based on those who are employed or employed in last 12 months (n=997)

33	Yes
67	No
*	Don't know/Refused

Q33b. Did the availability or quality of health insurance coverage play an important role in your decision whether or not to change jobs?

Based on those who are employed or employed in last 12 months (n=997)

30	Yes
69	No
1	Don't know/Refused

DEMOGRAPHICS

Now I have just a few more questions so we can describe the people who took part in our survey...

D1. RECORD RESPONDENT'S SEX:

49	Male
51	Female

D2. Are you currently married, living with a partner, divorced, separated, widowed, or have you never been married?

52	Married
8	Living with a partner
9	Divorced
3	Separated
2	Widowed
22	Never been married
5	(VOL.) Single
*	Don't know/Refused

D3. What is your age?

26	18-29
43	30-49
28	50-64
3	Undesignated

D4. Do you have any children under age 18 living at home, or not?

40	Yes
59	No
*	Don't know/Refused

D5. How many are children that are**(INSERT. READ ITEMS IN ORDER.)**

Based on those with children at home (n=487)

						4	DK/Ref.
			1				
		None		2	3		
a.	Under 5 years of age?						1
		55	33	10	1	*	
b.		47	32	15	5	*	*
	Between the ages of 5 and 12?						
c.		56	31	12	2	0	*
	Between the ages of 13 and 18?						

D6. What is the LAST grade or class that you COMPLETED in school? **(DO NOT READ)**

- 5 None, or grade 1-8
- 7 High school incomplete (grades 9-11)
- 31 High school graduate (grade 12 or GED certificate)
- 3 Technical, trade or vocational school AFTER high school
- 25 Some college, no four-year degree (includes associate degree)
- 18 College graduate (B.S., B.A., or other four-year degree)
- 11 Post-graduate or professional schooling after college (e.g., toward a
Master's degree or Ph.D; law or medical school)
- * **(DO NOT READ)** Don't know/Refused

D7. Are you, yourself, of Hispanic or Latino background, such as Mexican, Puerto Rican, Cuban, or some other Spanish background?

- 15 Yes
- 85 No
- * Don't know/Refused

D8. What is your race? Are you white, black or African American, Asian, American Indian or Alaska Native, or Native Hawaiian or other Pacific Islander? You may select more than one race. [ACCEPT MULTIPLE RESPONSES]

- 73 White
- 15 Black or African-American
- 3 Asian
- 2 American Indian or Alaska
Native
- 1 Native Hawaiian or other Pacific
Islander
- 4 Other or mixed race (**SPECIFY**)
- 4 **(DO NOT READ)** Don't
know/Refused

D9. Last year -- that is, in 2008 -- what was your total household income from all sources, before taxes? Was it under \$50,000 or \$50,000 or more?**(READ)**

D10. Now just stop me when I get to the right category. Was your household income... **(READ)**. **(IF NECESSARY: Your best guess is fine)**

D11. Now just stop me when I get to the right category. Was your household income... **(READ)**. **(IF NECESSARY: Your best guess is fine)**

46	Less than \$50,000
16	Less than \$20,000
10	\$20,000 to less than \$30,000
10	\$30,000 to less than \$40,000
7	\$40,000 to less than \$50,000
2	Don't know/Refused
42	\$50,000 or more
7	\$50,000 to less than \$60,000
8	\$60,000 to less than \$75,000
9	\$75,000 to less than \$100,000
15	\$100,000 or more
3	Don't know/Refused
12	Don't know/Refused

L1. Now thinking about your telephone use... Do you have a working cell phone?

Based on landline sample (n=752)

72	Yes, have cell phone
28	No, do not
*	Don't know/Refused

L1a. Does anyone else in your household have a working cell phone?

Based on those who do not personally have cell phone/DK (n=136)

18	Yes, someone in household has cell phone
82	No
1	Don't know/Refused

C1. Now thinking about your telephone use... Is there at least one telephone INSIDE your home that is currently working and is not a cell phone?

Based on cellphone sample (n=551)

47	Yes, has a home telephone
52	No, no home telephone
*	Don't know/Refused

L1/C1. Combined summary table, based on created variable of phone use.

PHONE USE SUMMARY

12	Landline only
63	Dual
24	Cell phone only
0	Undesignated

HH1. How many adults currently live in your household, INCLUDING YOURSELF? (**If necessary:** That is, how many people age 18 and over, INCLUDING YOURSELF?)

18	1 adult
56	2 adults
17	3 adults
6	4 adults
2	5 or more adults
*	Don't know/Refused

END OF INTERVIEW: That's all the questions I have. Thanks for your time.

Appendix C - Significance Testing Results

Health insurance and worker status

P.21

Compared to nonstandard workers, standard workers are significantly more likely to say they are covered by health insurance: $\chi^2=22.190$, $\alpha<0.001$

Job loss in the past year is significantly more common among nonstandard workers: $\chi^2=7.448$, $\alpha<0.01$

Job change (or considering a job change) in the past year is significantly more common among nonstandard workers: $\chi^2=10.185$, $\alpha<0.001$

It is the uninsured who are significantly more likely to experience job loss or job change: $\alpha<0.001$

P. 22

We found job loss and job changes in the past year to be related to paid time off: Cramer's $V>0.2$

Health insurance and medical discount cards

P. 23

Job change is significantly more common among the uninsured: $\chi^2=35.587$, $\alpha<0.001$

P. 24

Job loss in the past year is significantly more common among the uninsured: $\chi^2=97.519$, $\alpha<0.001$

The two groups differed significantly in difficulty concentrating at work due to health reasons: $\chi^2=13.080$, $\alpha<0.001$

The number of days of having difficulty concentrating at work due to health reasons is significantly tied to insurance: (Wilcoxon rank sum test) $z=-3.496$, $\alpha<0.001$

Demographic effects

P. 25

Sex: A logistic regression analysis of gender revealed that controlling for worker status, health insurance and children, women are significantly less likely than men to experience job loss: $\alpha<0.05$

Using the same controls, we found that women are also significantly more likely than men to face difficulties concentrating at work: $\alpha<0.001$

and significantly more likely to be absent due to health reasons: $\alpha<0.001$

Parents, irrespective of sex, are significantly more likely to be absent due to health reasons: $\alpha<0.05$

P. 26

Income: In a logistic regression analysis we found that income and insurance status are highly associated, even after introducing controls for age, race, gender and parental status: $\alpha<0.001$

P. 27

Race and ethnicity: In a logistic regression we found that the significant insurance disadvantage of Hispanics remains significant even after we control for income, age, gender and parental status: $\alpha < 0.001$
Hispanics are significantly less likely to be standard workers, even after controlling for the other demographic variables: $\alpha < 0.05$

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