

issue brief

Impact of the Economy on Health Care

Summary

In the United States, the economy shapes the complex interactions among employment, health coverage, and costs, as well as financial access to care and health outcomes. In economic downturns, few employers drop health coverage or restrict employee eligibility. More commonly, they reduce costs by changing benefits and cost-sharing provisions. Employees in low-wage jobs, those working in small firms, and those in certain industries have been far more likely than others to have been uninsured when they lost their jobs, but this recession is affecting a broader swath of the workforce. Research on the effects of economic cycles on health status is ambiguous. Apart from the current economic downturn, the design and cost of employer-sponsored coverage have also changed over time, and more people are finding work that does not offer health benefits. The recession has kept patients from seeking inpatient and elective services. Physicians and institutional providers are also seeing more patients who cannot pay for their care. Physicians and nurses appear to be re-entering or remaining in the workforce longer than previously planned, and many physicians are establishing new financial arrangements with hospitals and other provider groups to help ensure a steady income. Two dominant structural trends—growth and consolidation—are likely to continue to reshape health care delivery, but reform legislation could significantly affect the speed as well as direction of changes.

In the United States, the economy shapes the complex interactions among employment, health coverage and costs, and financial access to care and health outcomes. The effects of economic stress and surges can be observed directly, but may also surface in less obvious ways that can vary markedly across markets. In a system where employment-based coverage plays a dominant role, understanding the impact of economic shocks such as the current recession presents difficult analytical issues.

An off-the-record, facilitated discussion conducted under the Robert Wood Johnson Foundation's Changes in Health Care Financing and Organization (HCFO) Initiative provided impetus for planning new research to explore the interconnections among economic forces, health care access, costs, and outcomes. The session began a discussion about what we know, how comprehensive reforms may transform the health care landscape in the United States, and what can be done to increase our capacity to address vitally important policy questions about health care and population health in the wake of the worst recession ever experienced by the great majority of our population.

The Economy, Employment, and Health Coverage

Over the past two decades, there have been, in addition to a variety of downswings and recoveries, three "official" recessions, based on the criteria applied by the National Bureau of Economic Research (NBER):¹ one in the early 1990s (lasting eight months); one in 2001 (lasting eight months) and the current recession,

which officially began in December 2007, and is by far the most extensive contraction since the Great Depression. Throughout the past 20 years, employer-sponsored health insurance has been the dominant source of coverage for the nonelderly population, backed up, in various ways, by public policies designed to protect people who lose their jobs, primarily the Consolidated Omnibus Budget Reconciliation Act (COBRA), with some additional support from other federal legislation, including the Health Insurance Portability and Accountability Act (HIPAA), and by public programs that provide health coverage to low income populations, mainly Medicaid and the Children's Health Insurance Program (CHIP). During this same period, there have been significant changes in the design of health benefits and cost-sharing available in the group and individual insurance markets, as well as in public programs.

Recessions and Employment-Based Coverage

Unemployment data from the Bureau of Labor Statistics' Current Population Survey showed that the unemployment rate in the United States was 9.5 percent in June 2009, more than double the rate of 4.6 percent in June 2007.² The loss of jobs in the current recession, as in previous recessions and other, less profound economic downturns is clearly associated with reductions in health coverage. Analysis conducted for the Kaiser Family Foundation in 2002 showed that in the previous decade, including the recession in 2001, every percentage point increase in the unemployment



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Changes in Health Care Financing and Organization is a national program of the Robert Wood Johnson Foundation administered by AcademyHealth.

This issue brief is based on an invitational meeting convened in June 2009 by the Robert Wood Johnson Foundation's Changes in Health Care Financing and Organization (HCFO) initiative at AcademyHealth. The participants included experts from the research, policy, business and industry, health insurance fields and from public agencies. Michael Chernew, Ph.D., from Harvard Medical School, moderated the meeting.

rate leads to an increase of 0.5 percentage point in the nonelderly population without health insurance.³ The Urban Institute, in an analysis of more recent data, estimates that a 1.0 percentage point increase in the unemployment rate results in a 0.59 percentage point increase in the share of non-elderly adults without insurance.⁴

Recession leads almost immediately to loss of coverage for many individuals and their families who were insured through employer arrangements. While newly unemployed workers may be able to retain coverage temporarily,⁵ others will not qualify for or cannot afford continuation coverage under COBRA⁶ or other available programs. COBRA continuation coverage does not extend to employees enrolled in group insurance plans provided by employers with fewer than 20 employees, nor to those covered by employers who declare bankruptcy and discontinue all health plans.

Additional reductions in coverage are triggered by employers' needs to control benefit costs when the economy contracts. Economists argue that employee benefit costs are traded off against wages, so that decreasing benefits is not an effective way of limiting costs. But there are also real economic costs associated with the administration of benefits programs, and still other costs associated with cutting benefits, such as lower employee morale. While perceptions about the economics of employer-sponsored health benefits may differ, the outcome appears to be that most employers who have been able to offer health coverage are reluctant to eliminate health insurance benefits entirely, even during severe economic downturns. Research examining the relationships among economic cycles and costs of employee coverage in the late 1980s and early 1990s found that rather than dropping insurance benefits altogether, employers generally responded to the pressures of economic downturns by shifting premium costs to employees.⁷ Rates of employer-sponsored coverage did not, however, return to pre-recession levels in the recovery that followed the recession in the first part of

this decade. Analysis of declines in health coverage in the 1990s also found that the overall level of health coverage fell even when the economy was thriving, as a growing percentage of employees who could elect to receive benefits opted not to when their premium costs continued to increase.⁸

The 2008 Health Research & Education Trust (HRET) survey of employers found—even at the onset of what turned out to be a major recession—that among those firms offering health benefits, few reported that they were “very likely” to drop coverage or restrict employee eligibility in the coming year.⁹ More commonly, employers intended to find ways to reduce their costs by changing benefits and cost-sharing provisions. A survey of 438 employers conducted in March 2009 found, for example, that close to half were planning to make more cost-saving changes to health benefits than usual in response to economic conditions, including the adoption of consumer-driven plans (generally high-deductible plans with health savings accounts) or other high-deductible options, as well as tightening up on administrative costs, vendor payments, and dependent eligibility determinations.¹⁰

Measuring the full extent of the current recession on insurance coverage is not possible in “real time.” Reductions in health insurance coverage lag behind job loss due to the temporary continuation of coverage available to some employees, and because changes in employer coverage are generally implemented in annual contracts. In addition, some people who lose employment-based coverage are able, after some lapse in coverage, to obtain new coverage from other sources, including public programs for low-income families or veterans, or to obtain coverage through a spouse, or through the individual market. The American Recovery and Reinvestment Act (ARRA) of 2009 (the “stimulus package”) provides a subsidy to unemployed workers eligible for COBRA, such that eligible individuals are required to pay only 35 percent of the premiums for COBRA, (rather than the usual 100 percent) as well as certain

state and local coverage continuation programs, for up to nine months. The effects of the subsidy on laid-off employees' election of COBRA benefits are not yet known. The 2009 *Spencer's Benefit Report* survey of employers found that, prior to the subsidies, fewer than one in five laid-off employees had elected COBRA coverage, primarily because the premium costs were too high.¹¹

The capacity of public programs—Medicaid and CHIP, Veterans Health Administration, the Indian Health Service, federally funded community health centers, and state and local programs—to fill in the gaps in coverage is limited. A study completed in early 2009 found that only 1 in 4 unemployed workers age 16 to 65 who had incomes below 200 percent of poverty received health coverage through Medicaid or other public programs.¹² With the additional federal funding provided in the 2009 CHIP reauthorization, some states expanded coverage for children or pregnant women. But other financially strapped states have been unable to come up with their share of the funds needed to expand CHIP coverage, and some, including California, have had to freeze CHIP eligibility.¹³ Pressure on public programs may not only restrict coverage and reduce benefits available to low-income unemployed families, but also add displaced public health workers and employees who administer the public programs to the unemployment rolls.

Determining the appropriate frames for comparison can be subjective. Is the relevant issue “What will happen to health coverage going forward, as the economy recovers?” or “How has insurance coverage changed in response to this recession compared to what might have been had the recession been less severe?” Significant numbers of laid-off workers were not covered by employer-sponsored plans. Employees in low-wage jobs, those working in small firms, and those in certain industries have been far more likely than others to have been uninsured when they lost their jobs. But this time, those los-

ing their jobs as the recession deepened have been working in industries or firms (for example, finance) that have generally provided generous health benefits. Retiree coverage could also be in play in some sectors of the economy. Shedding costs for retirees' health coverage or for Medicare supplemental coverage and/or prescription drug coverage could be important for firms facing bankruptcy.

Determining how economic recession affects insurance coverage therefore needs to take a variety of factors into account, including what types of jobs, with what levels and generosity of insurance benefits, are lost, and what other forms of coverage are available to different populations. The Urban Institute study includes separate estimates for children and non-elderly adults, broken down to show the interrelated effects on coverage generated by changes in enrollment in employer-sponsored coverage, Medicaid/CHIP, and non-group coverage. The study estimates that moving from the baseline rate of 4.6 percent unemployment in 2007 to a rate of 10 percent unemployment would result in 13.2 million fewer people with employer-sponsored health coverage, offset by an increase of 5.4 million enrolling in Medicaid and CHIP and 1.8 million in non-group coverage; altogether, about 5.8 million more non-elderly adults and children would become uninsured.¹⁴

Structural Trends

While employment-based health insurance is obviously strained by economic contractions, there are also broader factors shaping the scope of coverage of American workers and their families. Structural changes in insurance coverage and in the economy over time are particularly salient. First, while employer-sponsored coverage has maintained its dominant role in health coverage, the design and cost of employer-sponsored coverage has changed, leading to a decline in the rate at which employees are choosing, or are able, to take up insurance offers. Second, more people are finding work in jobs that are less likely to offer

comprehensive health benefits. Because coverage depends on where people find jobs as well as on whether those jobs include health insurance benefits, employer-sponsored coverage may be less secure over time.

Employer-sponsored coverage has, from one perspective, proven to be quite resilient. The percentage of employers offering health benefits has been relatively stable over the past decade; most large and medium-sized firms offer health benefits, and, even among small firms (fewer than 200 workers) the percentage offering health coverage has been relatively stable. HRET survey data show that in 1999, 99 percent of large firms and 65 percent of all small firms offered health benefits; in 2008, 99 percent of large firms and 62 percent of small firms offered benefits.¹⁵ Note, however, that there was a large fall in employer-sponsored insurance sponsorship rates, larger for small firms, between 2001 and 2005, and that over this period, low-income workers were more likely to lose employer-sponsored coverage than higher-income workers. The longer period, including both good and bad years, may average out coverage rates over the cycle.¹⁶

Nevertheless, in the face of rising health care costs, employers have continued to look for ways to redesign insurance coverage. Economic contractions may have increased the urgency of employers' cost containment efforts, and may have made it easier to overcome employee resistance to changes. But because health care costs have increased faster than wages or general inflation in good economic times as well as bad, changes in benefit design are not likely to be reversed when the economy turns around. For example, the recession in the early 1990s may have provided additional impetus to employer efforts to control costs by moving away from indemnity models to managed care plans. The recession in 2001 came on the heels of employers' retreat from managed care approaches that engendered public backlash; employers opted instead to increase

employee cost-sharing requirements. In the current recession, employers appear to be increasing their attention on consumer-driven options, but also on health promotion activities and other changes to benefits that might help to reduce utilization of health services.¹⁷ These emerging interests may also be reinforced by possible national health reform initiatives on health promotion and disease prevention. From the perspective of most employees, however, the most salient trend over the past decade has been an increase in the costs of premiums and growing levels of cost sharing, including higher copayments and coinsurance. In particular, more low-wage workers are opting not to take up coverage that is increasingly expensive.¹⁸

Because the costs borne by employees as well as the availability of coverage varies widely across regions, industries, and establishment size, longer-term changes in the economy are intertwined with changes in insurance design. More workers employed in low-wage, temporary, part-time work, and a shift to jobs in retail and service sectors industries may contribute to less affordable, less comprehensive employer-sponsored coverage for a growing segment of the working population. These shifts can be either cyclical or structural. Analysis of the Community Tracking Study (CTS), for example, found that economic cycles affect the "quality" of jobs, including whether they offer health insurance.¹⁹ Over the longer term, however, permanent shifts in the industrial base could change the dynamics of employment-based coverage. For example, the effects of a restructured auto industry, historically among the most important players in the employer-sponsored insurance market, could yield important insights.

Small firms also play a critical role in the longer-term structure of employment-based coverage. About half of all paid employees (across all industries) worked in enterprises with fewer than 500 employees (2006 data); about 18 percent worked in private sector enterprises with fewer than 20 employees.

In expanding as well as contracting economies, small employers are less able to find affordable coverage for employees and, in many cases, have limited resources to organize or manage health benefits or to subsidize benefit costs.²⁰ Small businesses also represent a “permanently changing” segment of the workforce. About 8 of 10 new establishments survive for a full year, and 2 in 3 survive two years, and less than half survive four years.²¹ The entry and exit of hundreds of thousands of new businesses each year,²² most of which begin with a very small number of employees,²³ also limit the ability of these establishments to provide stable coverage (and also greatly complicates the task of analyzing coverage trends).

The Economy, Health Providers, and Markets

The health care industry is a critical component of the national, and most regional and local economies in the United States. Cyclical economic contractions, innovations in medical technology, shifts in public policy, and local market factors can result in different, and sometimes contradictory, pressures on the supply and organization of health care delivery systems, suppliers, and practitioners.

Recession and Health Care Delivery

The effects of economic shifts include changes in the demand for (or access to) health care, but also organizations’ and practitioners’ own financial status. Reports from markets across the United States are describing a sort of perfect storm: falling revenues due to decreased demand for less non-urgent or elective care, more patients unable to pay their medical bills, significant losses in investment income, less charitable giving, and cuts in health care funding by states and localities.

A survey conducted by the American Academy of Family Physicians received only a very small number of responses from the 10,000 physicians polled, but among those who did respond, more than half reported seeing fewer patients

since the recession began.²⁴ A survey of community hospital CEOs fielded by the American Hospital Association (AHA) in March 2009 also reported that fewer patients were seeking inpatient and elective services.²⁵ At the same time, physicians and institutional providers report seeing more patients without insurance, or with inadequate insurance, who are unable to pay for their care.²⁶ Some providers have compensated for lost revenue by expanding their hours of operation.²⁷ Many, however, report that they are dealing with declining volume and lost revenues from unpaid bills by reducing services or cutting staff.²⁸ The AHA 2009 survey of community hospitals found that 9 in 10 had made some cuts in response to economic concerns, including reducing staff or administrative expenses, or reducing services. Many reported scaling back on capital improvements, including putting upgrades to clinical and information technology systems on hold.²⁹ Survey respondents also reported that physicians are increasingly seeking financial support such as opportunities for on-call pay or employment.³⁰

The effects of economic contractions can be hard to parse out because they run counter to the sustained growth in the health sector. Rather than an actual contraction, the recession may have resulted in a slower growth of health care-related jobs overall.³¹ Some of the fastest-growing employment in health care has been jobs such as therapists, aides, technicians, and personal care assistants, which are distributed throughout both the private and public sectors of the economy. Cost-cutting by hospitals or by public programs struggling with budget deficits could slow the growth of these jobs, but perhaps only temporarily.

At the same time, the recession has increased demand for care in community settings that provide subsidized or low-cost care. Many community health centers, for example, have reported a surge in the number of new uninsured people seeking care.³² Funding from the federal stimulus bill directed to community health centers

should help meet some of their growing needs, but at the same time cutbacks in state funding reduce resources for community health centers as well as safety net hospitals. Determining the net effect of the recession on health care jobs may therefore be difficult.

The recession has also created pressure on health care professionals to revise their career and retirement plans. There is some evidence that employment of registered nurses grows during economic downturns. A recent analysis suggested that concerns about family income, for example a spouse being laid off, lead nurses to reenter the job market.³³ There are also reports that nurses may be delaying retirement.³⁴ At the same time, retrenchment by health providers reduced the number of nursing job openings in some market segments.³⁵ In the Boston area, for example, staff reductions associated with a downturn in elective hospital admissions, combined with a growing number of nurses seeking to go back to work, resulted in a shortage of job openings for nurses for the first time in years.³⁶ Some analysts fear that the temporary rush into the labor market will be followed by mass exits when the economy recovers, intensifying a longer-standing nursing shortage.³⁷

This recession may also impact physicians more significantly than previous, less severe economic downturns. Physicians who have lost significant amounts of their investment portfolios may be postponing their retirement, either by continuing in their current practice longer than they had planned, or by establishing practice arrangements with hospitals or other provider groups. Physician leaders have also expressed concern that students seeking loans for medical school education might not be able to find them in the distressed credit market. In the short term, physicians’ need to remain in the workforce could possibly offset a predicted shortage of primary care doctors. But if older physicians are concerned about generating revenue to replace investment losses, and younger cohorts are saddled with excessive debt, economic incentives to prac-

tice in more lucrative subspecialties could become even more persuasive, further exacerbating the pressure on primary care.³⁸

Structural Trends

Over the longer term, factors such as a growing demand for health care, more formal or virtual integration of services delivery facilitated by health information technology, or substantive legislative reforms affecting the financing and regulation of health care could overwhelm the effects of economic cycles.

Two dominant trends—growth and consolidation—are likely to continue to reshape health care delivery, but reform legislation, related changes in federal investment in health information technology and health manpower, and provider payment could significantly affect the direction of changes. Horizontal and vertical integration of providers might be accelerated by recession, but the trend can also be seen as a response to longer term pressures. A surge in hospital mergers and acquisitions in the 1990s was driven by structural changes including technologies that moved services to outpatient settings. Consolidations provided hospital systems with an opportunity to enhance and better leverage their market positions.³⁹ Over time the prevalence of independent practitioners has also been declining. Data from the CTS shows that the percentage of primary care physicians in independent practices declined by 5 percentage points from 1996-97 to 2004-05, while the percentage of medical specialists and surgical specialists in independent practices declined 19 percentage points and 9 percentage points, respectively.⁴⁰ Much of the change is the result of physicians moving to mid-sized single specialty groups.⁴¹ Physician groups were also focused on increasing efficiency and containing costs before the onset of the credit crisis that ushered in the current recession.⁴²

Looking forward, major insurance and financing reforms could change the incentives driving provider restructuring in different sectors of the health industry.

Significant increases in coverage of previously uninsured or underinsured populations could reshape the demand for services. Changes in insurance regulation, along with payment reforms, could shift the incentives that drive providers' decisions about where and when they want to work. Comprehensive coverage reforms could lead to restructuring the roles of safety net providers and a redistribution of uncompensated care funding to a broader set of providers. Other reforms designed to promote the effectiveness and quality of health care, including increased funding and technical assistance for the implementation of health information and clinical management systems, could accelerate movement of independent practitioners into integrated systems. How structural changes will play out across different markets and what these might mean for the delivery of care for different populations will present very difficult challenges to the research community.

The Economy and Population Health

Although economic factors clearly affect the use of health services and health outcomes, the interactions among access, health-related behavior, and use of health services can be difficult to sort out. Variation in demographic and other factors across regions and markets make measuring the effects of economic forces even more difficult.

Recessions, Health Utilization, and Outcomes

Unemployment, lower income, or losing insurance coverage in economic downturns can result in reduced access to health services. Economic uncertainty itself also affects people's behavior, including how they spend money on health care and on other commodities or activities that can affect their health and health outcomes. Various reports suggest that the current recession is leading some to forego not just elective surgery and preventive screenings, but also basic care for acute and chronic conditions.

One privately-funded panel survey of more than 100,000 households found a marked increase in the percentage of households reporting that they had deferred (delayed or cancelled) health visits in early 2009, compared to 2006. The most commonly deferred care was physician visits (54.7 percent); followed by imaging procedures (8 percent), non-elective procedures (6.2 percent), and lab or diagnostic tests (5.7 percent). Deferring care was most prominent in lower-income households, but occurred across all income and age cohorts.⁴³ A survey of employees who were [still] employed and insured through employer-sponsored or union-sponsored plans found evidence that the recession was taking a toll on employees' physical and emotional health: 27 percent reported that they had chosen not to receive health care treatment to save money on coinsurance or copayments, 20 percent had skipped taking medications at the prescribed dosage, 17 percent were splitting drug dosages to make them last longer, and 40 percent said their mental health/stress/anxiety levels had become worse since the economic downturn.⁴⁴

Available evidence regarding the immediate versus longer-term effects of economic downturns and recovery on population health is somewhat ambiguous, however. For example, there is some evidence that economic pressure may lead more women to seek reproductive services, and, in particular, long-term contraception, and abortions.⁴⁵ At the same time, there is some evidence suggesting that, at least in previous recessions, decreased access to or use of prenatal services has been associated with a higher incident of adverse pregnancy outcomes such as anemia and low-birth weight infants in some low-income populations.⁴⁶ More recently, researchers have focused attention on an apparent link between recessions, reduced industrial pollution, lower levels of particulates in the atmosphere, and lower rates of infant mortality.⁴⁷

A body of economic research focused more broadly on the effects of economic cycles on health perhaps raises as many questions as it answers. A number of studies have found that health outcomes, as measured by mortality rates, are counter-cyclical, that is, mortality rates are worse (higher) when the economy gets better.⁴⁸ Explanations for this phenomenon generally focus on factors that could increase mortality in active economies, such as more deaths from traffic accidents because more people are commuting to work or taking vacations; more industrial production, increasing pollution as well as the probability of accidents; more cardiovascular illness related to work-related stress; or, changes in behavior during recessions that could reduce mortality rates, such as being more careful about eating, exercise, alcohol use, etc. when money is tight.

Research examining some of these possible explanations again presents a complex picture. A review of studies examining the effects of physician strikes shows that mortality rates go down when elective surgeries are less available.⁴⁹ But while some research has linked recessions to lower mortality rates for cardiovascular disease, economic downturns have also been linked to markedly higher rates of cancer deaths and homicides, and to a wide range of psychiatric disorders, as well as alcohol and substance abuse.⁵⁰ Although researchers have suggested that people may be more careful about diet and lifestyle when they are worried about money, there is also some evidence that the opposite may occur as well. A survey conducted by the American Heart Association in March 2009 found that about a third of respondents had made changes over the preceding 6 months that could have negative health consequences, including delaying preventive care appointments, not taking medications, or skipping dental appointments; 42 percent said they planned to make changes in the coming months that could be detrimental to their health, such as buying fewer fruits and vegetables.⁵¹ Research examining the effects of a recession

in the early 1900s found that higher rates of cardiovascular disease contributed to a 15 month shorter lifespan for those born during the recession compared to people born into a healthier economy. Although the applicability of these findings in the very different environment of the 21st century is questionable, more current work relating birth weight to economic conditions suggests that many unanswered questions remain about the effect of suboptimal conditions on early childhood development and longer-term health outcomes.⁵²

Structural Changes

The demand for health care and the benefits it brings have continued, rarely abated, over the past half century. The demand for health care is expected to continue to increase, accounting for a significantly larger proportion of the national economy.⁵³ But as the importance of health care and its costs has grown, systemic problems affecting different subgroups of the population have become intertwined with the economic forces affecting access, costs, and outcomes. Data from the National Health Interview Survey from 1997 through 2008 show a generally increasing trend in the percentage of people who reported that they failed to receive needed medical care due to cost over the course of the year. Failing to get care was more prevalent among those aged 18-64, and higher among Hispanic and non-Hispanic black persons. The percentage of people reporting that they had a regular place to go for medical care generally decreased, as did the percentage of people who said they had excellent or very good health. A variety of factors are increasing the need for health care. For example, the prevalence of obesity among U.S. adults aged 20 and older has generally increased over time, from 19.4 percent in 1997 to 27.6 percent in the last quarter of 2008.⁵⁴

Major reforms to the current system that would ensure that most Americans would have comprehensive health insurance,

and be able to retain it even when there are major economic contractions, would almost certainly moderate the variability of health care access and utilization over economic cycles. Delivery system reforms, such as investments in primary care, health information systems, or evidence-based clinical management systems could also help address systemic problems associated with accessing needed health care.

Looking Ahead

To understand the effects of economic shifts, it is critical to sort out cyclical effects of the economy on health coverage, utilization, and the structure and efficiency of health care delivery from longer term structural changes. Some changes to the employment base—such as bankruptcies or reductions in force that also eliminate employees' access to health coverage, or cuts in employer investments in insurance—may turn around as the economy cycles back up. Other effects of downturns, or adjustments in the structure of employment during recoveries, may involve changes not likely to be reversed, or may affect the trajectory of longer term trends, or perhaps move health care in entirely new directions. Changes in insurance coverage or in provider organization may also affect different segments of the population differently, contributing to longer term effects on health outcomes. The analytical challenges arising from this complexity are exacerbated by the lack of data needed to understand how insurance coverage, financial access to care, and the use of health services changes over the course of economic cycles among different populations.

While there is a vast body of research to support future analysis of economic forces on health care and health, the breadth of changes that could be set in motion by comprehensive reform legislation will add complexity. It will be important to understand, for example, how reforms might affect providers' ability to meet the demands of a better-insured population, including decisions about health profes-

sionals' and provider organizations' market participation; how changes in insurance regulation and enrollment in private and public insurance plans affects the distribution of insurance risk; how different insurance plans or care delivery systems are able to work with health practitioners and with consumers to improve the efficiency and quality of care delivery; and how well changes driven by the reforms actually work to improve health care access, efficiencies, and outcomes.

The current literature also demonstrates the limitations of efforts, drawn from assorted analyses of a very complex puzzle, to understand of how economic forces effect health care access, utilization, quality, and costs. To evaluate reforms, or to understand the full impact of failing to make changes to the health care coverage and delivery systems, researchers will need to draw on more complete data than is now readily available. This would include data that link people, their employers, their insurance coverage, their health care utilization, costs, and health outcomes, and how these interrelated factors change over time and across different populations.

About the Author

Jill Bernstein, Ph.D., is a consultant working with the Changes in Health Care Financing and Organization (HCFO) initiative.

Endnotes

1 NBER defines recession as “a significant decline in economic activity spread across the economy, lasting more than a few months, normally visible in real GDP, real income, employment, industrial production, and wholesale-retail sales.” NBER. “Business Cycle Expansions and Contractions.” www.nber.org/cycles/ (Accessed 6/17/09). Under the NBER definition, “Contractions (recessions) start at the peak of a business cycle and end at the trough.”

2 “The Employment Situation: June 2009,” *News*, United States Department of Labor, Bureau of Labor Statistics, July 2, 2009; also see www.bls.gov/news.release/empsit.nr0.htm; Labor Force Statistics from the Current Population Survey, at http://data.bls.gov/PDQ/servlet/SurveyOutputServlet?data_tool=latest_numbers&series_id=LNS14000000

3 Gruber, J. and L. Levitt. “Rising Unemployment and the Uninsured,” Publication #6011, Kaiser Family Foundation, January 2002.

4 Holahan, J. and A.B. Garrett. “Rising Unemployment, Medicaid and the Uninsured,” Publication #7850, Kaiser Commission on Medicaid and the Uninsured, Henry J. Kaiser Family Foundation, January 2009.

5 Generally, COBRA (The Consolidated Omnibus Budget Reconciliation Act of 1986) coverage provides a maximum continuation period of 18 months, with additional coverage of up to 36 months for certain qualified beneficiaries (spouses or dependent children).

6 One estimate showed that in 2008, the national average cost of maintaining COBRA coverage for a single individual would be about one third of his or her unemployment insurance check. (“Squeezed! Caught between Unemployment Benefits and Health Care Costs,” *Families USA*, January 2009.)

7 Gruber and McKnight analysis covering 1982-1996, for example, found a 10 percentage point increase in the unemployment rate was associated with roughly a 1.2 to 1.7 percentage point decrease in the probability that the employer would cover the full cost of employees’ insurance costs (Gruber, J. and R. McKnight. “Why Did Employee Health Insurance Contributions Rise?” NBER Working Paper 8878, National Bureau of Economic Research, April 2002.

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11 *Ibid.*

12 “Unemployed and Uninsured in America,” *Special Report*, *Families USA*, February 2009. Also see www.familiesusa.org/assets/pdfs/unemployed-and-uninsured.pdf.

13 Sack, K. “Defying Slump, 13 States Insure More Children” *New York Times*, July 19, 2009.

14 Holahan, J. and B. Garrett. *Op Cit.*

15 “Employee Health Benefits 2008 Annual Survey.” *Op Cit.*

16 Clemens-Cope, L. and B. Garrett, “Changes in Employer-Sponsored Health Insurance Sponsorship, Eligibility, and Participation: 2001 to 2005,” *Issue Paper*, Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation, December 2006. Also see www.urban.org/publications/411619.html

17 Claxton, G. et al. “Health Benefits in 2008: Premiums Moderately Higher, While Enrollment in Consumer-Directed Plans Rise in Small Firms,” *Health Affairs*, Vol. 27, No. 6, November/December 2008, pp. w492-502.

18 Cunningham P., et al. “The Fraying Link between Work and Health Insurance: Trends in Employer-Sponsored Insurance for Employees, 2000-2007,” *Issue Paper*, Kaiser Family Foundation, November 2008.

19 Reschovsky, J. et al. “Why Employer-Sponsored Insurance Coverage Changed, 1997-2003,” *Health Affairs*, Vol. 25, No. 3, May/June 2006, pp. 774-82.

20 Bureau of Labor Statistics data show that in 2007, the average cost to employers in private industry for health insurance benefits was lower, both in average amount and as a proportion of total compensation in small versus larger establishments. In establishments with fewer than 50 employees, employers’ costs for health insurance averaged \$1.20, or 5.7 percent of hourly labor costs, while in establishments with over 500 workers, health benefit costs were \$2.88, or 7.9 percent of labor costs. (“Health Benefit Costs and Establishment Size,” *The Editor’s Desk*, United States Department of Labor, Bureau of Labor Statistics, March 2007. Also see www.bls.gov/opub/med/2007/jun/wk3/art05.htm.)

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