

Dissertation Awards

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Labor Market Implications of Employer Provided
Health Insurance: Dissertation Summary

Kanika Kapur
Northwestern University

Labor Market Implications of Employer-Provided Health Insurance

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Employer-provided health insurance covers the majority of Americans under the age of 65. A beneficial aspect of employers providing health insurance is that the group to be insured is selected by a criterion other than the demand for health insurance. Hence, the problem of adverse selection is sidestepped. Recently, however, the disadvantages of the link between employment and health insurance, especially those pertaining to the labor market, have received a great deal of attention in academic and policy circles.

One problem with this system of employer-provided health insurance is that the strong link between employment and the provision of health insurance implies that if wages do not perfectly offset differences in the valuation of health insurance across jobs, individuals may not change jobs even when new jobs with higher match specific productivity are available. This phenomenon, called "job lock," may result in a welfare loss.

Another problem lies in the small-group market (typically, firms employing less than 25 persons) for health insurance, where the problem of adverse selection remains despite the link between employment and health insurance. Almost 60 percent of non-elderly adults without health insurance are employed. Nearly two-thirds of uninsured working adults are employed in small firms.

Small firms that provide health insurance to their employees struggle to find and keep affordable health insurance, because a single expensive illness or accident may lead to health insurance cancellations or prohibitive price increases. The impact of the small group health insurance market on small firm behavior is an area of much speculation but little research.

Despite the academic and policy interest in these problems with the system of employer-provided health insurance, the extent of the problems and the effect of the policy measures have not been fully established. The literature on job lock has reached no consensus on the importance of portability on job mobility. There is

little to no research examining how small firms are affected by aspects of the small group health insurance market. Furthermore, there is little research that evaluates the impact of recently enacted state-level health insurance legislation. This dissertation addresses this gap between policy and research.

The first chapter of this dissertation uses the National Medical Expenditure Survey (NMES) of 1987 to measure the importance of job lock. The economics literature has not reached a consensus on the severity of job lock. Studies using the NMES have found that job lock is responsible for a 25–30 percent reduction in job mobility—a large and significant effect. Other evidence, from the Panel Study of Income Dynamics and the Survey of Income and Program Participation, shows that job lock has an insignificant effect on job mobility for married men. However, these estimates are imprecise; hence, they are unable to reject the presence of large levels of job lock suggested by the studies using the NMES. This conflicting evidence from different data sources and empirical methodologies is puzzling for both researchers and policymakers. I use the NMES, which has yielded precise estimates of job lock, to answer the question "Is the conflicting evidence on job lock for married men a result of differences in the data or in the methodology?"

Ideally, to estimate job lock using the quasi-experimental difference-in-difference technique, the identification of job lock should be based on good proxies for family sickness and a relatively comparable job-locked experimental and non-locked control groups. The difference-in-difference estimator relies on the similarity of the experimental and control groups in order to identify the effect of interest from other exogenous influences. In most of the earlier work estimating job lock, insured persons form the experimental group and the uninsured form the control

Kanika Kapur received the Ph.D. degree from Northwestern University. Her dissertation advisor was Bruce Meyer.

group. However, the uninsured differ from the insured in terms of base levels of mobility and demographic and job characteristics; hence it is unlikely that the effect of exogenous influences on the insured group is equal to the effect of these influences on the uninsured group. The use of these groups to estimate job lock may yield inconsistent estimates.

I refine the difference-in-difference technique by creating more-comparable control and experimental groups and good proxies for family sickness. Job lock should be greater for workers who are sick or have sick family members because they are likely to face pre-existing condition exclusions if they change jobs. In addition, they are more likely to find factors such as waiting periods for coverage on a new job and lack of insurance during job search to be burdensome. I use previously unexploited, detailed data on medical conditions, health utilization, and medical expenses to proxy for sickness. To estimate find two groups which are comparable, one of which can be hypothesized to be more severely affected by job lock than the other, I turn to spousal health insurance. Individuals who have access to spousal health insurance (that is, their spouse holds employer-provided health insurance) in addition to their own employment-related health insurance are possibly already covered by their spouse's policy or may succeed in getting on a spouse's policy with loose rules, even if they do suffer from some pre-existing conditions. Therefore, individuals who have their own employer-provided health insurance but no spouse health insurance and have adverse family health conditions are the most likely to be job-locked.

Using this refined difference-in-difference approach, I find insignificant estimates of job lock, and the confidence intervals of these estimates exclude large levels of job lock. I find that the estimates of job lock have the wrong sign and are insignificant. Furthermore, the estimates are precise enough to exclude large levels of job lock from their confidence intervals. While these estimates are consistent with those from studies using the SIPP and the PSID, they are far smaller than the estimates using the NMES. To resolve this, I re-analyzed Madrian's 1994 finding of significant job lock using family size and pregnancy of spouse as job lock measures in the NMES. After correcting methodological problems and using better data to construct the job lock variables, job lock is insignificantly different from zero.

While, on the whole, job lock does not have a significant impact on job mobility, it may effect certain subgroups of working individuals more than others. I examine this proposition in the second chapter of the

dissertation. Since large firms tend to have generous health insurance policies with limited pre-existing condition clauses, job lock may not be a significant concern for individuals considering a move to a large firm. However, for individuals considering a move to a small firm, strict pre-existing condition clauses may be a significant deterrent to mobility. Furthermore, if small-firm policies are less generous than large-firm policies, non-portability would be more of a deterrent to job transitions to small firms for individuals who were employed in large firms (as opposed to those employed in small firms). Since most job transitions are from large firms to large firms, the overall measure of job lock discussed above may mask these important differences in transitions. Using the NMES, I estimate the magnitude of job lock for individual considering a move to a small firm and find that small-firm job lock is important for individuals with medical conditions that would lead to the denial of coverage by small-group insurers. This finding suggests that legislation aimed at reducing the problems with the small-firm market may reduce job lock.

In the third chapter, I examine how the small-group health insurance market influences small-firm employment. The difficulties faced by small firms in obtaining health insurance for their employees have been widely documented. Only about one-third of firms with fewer than 50 employees, and one-quarter of firms with fewer than 10 employees, offer health insurance as a fringe benefit. The small firms that do provide health insurance to their employees are in a precarious position. Insurance companies, wary of the possibility of adverse selection, calculate premiums on a yearly basis as the expected value of health care utilization. Hence, a single high-cost incident during the year could lead to a substantial surcharge on the premiums for all members in the firm. Alternatively, the insurance company could refuse to write a policy for the high-risk individuals in the group, and in extreme cases could refuse to insure the entire group. Small firms could respond to the inadequacy and unpredictability of their potential group health insurance policies by maintaining a work force that has a low expected utilization of health care services. Assuming that firms are unable to perfectly tailor individual wages to health insurance costs, small firms may screen out employees with high expected health costs in order to keep premium variability in check.

There has been little previous empirical work that uses detailed health data to examine such employment screening. Using the NMES data, I construct health measures based on the Office of Technological

Assessment's 1988 classification of 45 common medical conditions into three categories according to the underwriting behavior of individual and small-group insurance companies. Medical conditions are classified as those leading to outright denial of coverage, those leading to exclusion restrictions, and those leading to higher premiums.

I find small firms that offer health insurance are more likely to screen out workers with families that have conditions that lead to higher premiums. These workers are 65 percent less likely to be hired in small firms with insurance and 30 percent more likely to be laid off from small firms with insurance relative to large firms with insurance. However, small firms are no more likely than large firms to screen out workers who have families with conditions leading to denial of coverage or exclusion restrictions, since these conditions do not add to their medical claims. These results suggest that the link between small-firm health insurance and employment may lead to employment distortions and inefficiency. Therefore, small-group health insurance reform that reduces pre-existing condition limitations and regulates the pricing of small firm policies may be warranted.

In the last chapter, I study the impact of state small-group health insurance reforms on job mobility and employment outcomes, focusing on three types of reforms aimed to ensure the following. First, small firms that want health insurance coverage are accepted and renewed by insurers. Second, when an individual changes jobs, waiting periods for coverage and pre-existing condition exclusions are short or non-existent. Third, premiums are based on only certain allowable rating factors (such as age or family size and not on factors such as health status) and premium rate variations are limited. These laws generally apply to employer-sponsored health insurance plans covering 2–50 workers.

I address two main questions. First, have portability reforms aimed to facilitate job transitions and reduce job lock increased job mobility? Second, by limiting the use of health status in premium setting, have rating reforms increased the proportion of individuals with adverse health characteristics in insured small firms, and thereby reduced employment distortion in small firms? I develop a simple theoretical model which shows that contrary to common belief, portability reforms have an ambiguous effect on job mobility. Another interesting theoretical implication, possibly

unforeseen by policymakers, is that while rating reforms reduce small-firm health insurance costs for the sick, and thereby increase small-firm hiring of the sick, rating reforms increase health insurance costs for older individuals and therefore reduce small-firm hiring for the old. This is due to the fact that age is positively correlated with sickness, and rating reforms restrict the use of sickness in setting premiums, resulting in greater weight on age in premium setting.

The empirical analysis uses March Current Population Survey data from 1991–1997. My results suggest that rating reforms increase relative job mobility and small-firm employment opportunities of individuals who have disabled family members. Therefore, by reducing the cost of health insurance for sick individuals in small firms, rating reforms may reduce employment distortions due to the small-group health insurance market. On the other hand, rating reforms result in the setting of premiums on the basis of demographic factors such as age that are highly correlated with health status, hence these reforms decrease small-firm employment opportunities for older individuals. Therefore, rating reforms must be judged, at least partly, on the basis of whether this redistribution of health insurance costs from the sick to the old enhances welfare.

The impact of portability reform, which was introduced to reduce job lock, is somewhat mixed. Portability increases job mobility for insurance holders, suggesting that it reduces job lock. However, portability unaccompanied by rating reform reduces the proportion of insured small-firm new hires with family disabilities. This suggests that by increasing the cost of health insurance, portability may have a negative impact on individuals who have adverse health characteristics. By implementing both portability and rating laws at the same time, most states have balanced the negative effects of portability on individuals with adverse health characteristics with the positive effects of the rating laws. The impact of the small group portability reform serves as an important indicator of the expected effect of Health Insurance Portability and Accountability Act (HIPAA) that was signed into law in August 1996. This federal legislation mandates portability without any accompanying restriction on premium rating. The experience from the small-group health insurance reform suggests that HIPAA may have a negative impact on the employment opportunities of individuals with adverse health characteristics.