Are Fortune 100 Companies Responsive To Chronically Ill Workers?

Benefits for persons with chronic illness are more generous in these firms than they are in the Medicare program.

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ABSTRACT: We conducted a survey of Fortune 100 companies to determine their response to the growing number of employees with chronic conditions. We found that although all companies cover some services that are particularly beneficial to persons with chronic conditions, gaps in coverage remain. We also found large variations in cost-sharing mechanisms, number of covered visits, and lifetime maximum benefit provisions, which are especially important to persons with chronic conditions. In general, for persons with chronic conditions the benefits offered by these Fortune 100 companies are superior to those offered by Medicare.

During the past two decades many employers have transformed their health benefit packages in response to their employees' demands and their own need to limit spending on health.[1] Large companies typically have been at the forefront of these benefit changes, which smaller companies have later adopted.[2] In this paper we examine how some Fortune 100 companies are structuring their benefit packages to meet the needs of a growing number of employees with chronic health conditions.

We focus on persons with chronic conditions because our own analysis of Medical Expenditure Panel Survey (MEPS) data from 1996 suggests that 47 percent of adults ages twenty-one to sixty-five had one or more chronic conditions and that these persons were responsible for more than three-quarters of health care spending in their age group.[3] Our analysis also shows that privately insured persons with chronic conditions spend more than twice as much out of pocket as do persons without chronic conditions, and persons

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with multiple chronic conditions, more than three times as much. During the next thirty years, as the baby boomers continue to age and medical progress prolongs life, the prevalence of chronic conditions is expected to rise further.[4] Employers may decide to respond by altering their benefit packages.

We conducted a survey of Fortune 100 companies to analyze (1) the degree to which their health insurance benefits, identified as key services for persons with chronic conditions, were offered by these companies; and (2) what benefit limitations, such as cost sharing or up-front benefit caps, were imposed to limit the use of the services covered. Our survey may provide a leading indicator of how well health benefits in employer-sponsored plans are reflecting the needs of a chronically ill population. It also serves as a comparison to the benefit package offered by Medicare and other insurers.

Data And Methods

■ **Defining chronic care services.** We used several sources of information to develop a list of medical- and health-related benefits that are most important for persons with chronic conditions. First, we identified seven organizations (Alzheimer's Association, American Academy of Pediatrics, American Diabetes Association, American Geriatrics Society, Family Voices, National Alliance for the Mentally Ill, and National Chronic Care Consortium) that represent providers, clinicians, and advocates for those with chronic conditions. Each organization was asked to identify the benefits deemed to be most important for its constituents. Second, we convened focus groups among a cross-section of Americans, including various groups with specific chronic conditions and caregivers. Third, we reviewed the academic literature on benefits design, focusing on the issues relevant to those with chronic conditions.[5] Finally, we examined the benefits (both mandated and optional) offered by state Medicaid programs and those offered by organizations such as the Program of All-Inclusive Care for the Elderly (PACE), social health maintenance organizations (HMOs), and others that offer services to persons with chronic conditions. We then developed a list of benefits particularly important to those with chronic conditions. We excluded services relevant for both acute and chronic conditions from this list.

■ **Verifying plan data.** We used *Fortune* magazine's list of the 100 companies with the highest revenues in 1999 as our sampling frame. Companies were asked to send their health care summary plan descriptions that were available to workers in the spring of 2000. For firms offering multiple plans, we requested information about those offered to salaried employees working at U.S. corporate headquarters. We then selected the plan with the widest and most flexible set

of benefits, regardless of premium. Information from each chosen plan was abstracted onto coding sheets. The abstracted data were sent to the director of human resources (or equivalent person in the company), who was asked to review our summary. We obtained responses from seventy-six companies of the Fortune 100 (a response rate of 76 percent).

Study Findings

■ **Types of plans.** Our analysis of the seventy-six plans shows that 12 percent were traditional indemnity plans, 24 percent were point-of-service (POS) plans, 57 percent were preferred provider organization (PPO) plans, and 7 percent were HMOs. A nationwide survey of employer-sponsored plans in 2000 found that the distribution nationwide was 8 percent traditional indemnity, 22 percent POS, 41 percent PPOs, and 29 percent HMOs.[6]

■ **Covered benefits useful to the chronically ill.** Exhibit 1 shows the list of benefits surveyed that are important for persons with chronic conditions and the percentage of firms that cover each one. Although all or nearly all companies offer some services, many of the companies place limitations on these benefits that can create a financial burden for persons with chronic conditions. The type of restriction varies by type of service.

■ **Cost sharing and other limitations.** *Prescription drugs.* Coverage of prescription drugs, for example, is a benefit upon which many

EXHIBIT 1
Percentage Of Fortune 100 Companies That Offer Benefits Important To Chronically Ill Persons, 2000

Benefit	Percent offering
Prescription drugs	100%
Mental health outpatient services	100
Mental health inpatient services	100
Home health care	100
Physical therapy	100
Durable medical equipment	100
Occupational therapy	99
Speech therapy	99
Skilled nursing facilities	99
Chiropractor	97
Family counseling	50
Dietitian-nutritionist	45
Medical social worker	37
Respite care	0
Personal care	0
Nonemergency transportation	0
Home modifications	0

SOURCE: Survey of Fortune 100 employer-sponsored health plans, 2000, Partnership for Solutions, Johns Hopkins University.
NOTE: N = 76.

"Drug coinsurance amounts among Fortune 100 firms are generally much lower than proposals for Medicare drug coverage."

companies have imposed restrictions. In the past decade the range of prescription drugs covered and spending for them have grown at annual rates that were much faster than the overall annual growth rate of private insurance.[7] To limit this rapidly growing portion of health care benefits, some employers use cost-sharing mechanisms, formularies, generic drugs, and other pharmacy management techniques. Our study of the Fortune 100 shows that 33 percent of firms require coinsurance for pharmaceuticals; 72 percent require copayments, and the mean copayment per prescription is $5 (Exhibit 2). Several studies have shown that the use of cost-sharing mechanisms such as copayments and coinsurance reduces the demand for prescription drugs.[8] Two studies found that the impact of such mechanisms seems to be more pronounced for medication used for chronic conditions.[9] This finding may be related to the more frequent use of pharmaceuticals by persons with chronic conditions.[10] For comparative purposes, it is important to note that the coinsurance amounts among Fortune 100 firms are generally much lower than what is being proposed in most legislative proposals for Medicare drug coverage.[11] All of the Fortune 100 companies use formularies: 72 percent use open formularies, and 28 percent use closed formularies.

Mental health care. All of the companies surveyed covered mental health care services, both outpatient and inpatient. Legislation passed in 1996 requires those employers who offer coverage for mental health care services to do so at parity with the rest of the health services offered.[12] This legislation has led some employers not to place limits on dollar amounts but rather to introduce other types of limitations such as the number of inpatient days and outpatient visits covered, to constrain the use of mental health care services.[13] Our survey shows that the majority of the companies impose limits on visits and inpatient days for mental health care services: 64 percent impose limits on the number of outpatient visits with a range of ten to ninety visits per year; 63 percent of the companies restrict the number of inpatient days with a range of 20 to 120 days (Exhibit 3).

The consequences for employers and employees of cost containment efforts related to mental health care coverage have been studied in various situations, and the conclusions are inconsistent. A nine-year follow-up study of health insurance coverage in a large corporation that changed from fee-for-service with a mental health carve-out to a comprehensive managed care program inclusive of

EXHIBIT 2
Coinsurance And Copayment Variations Among Fortune 100 Companies, 2000

Benefit/ coinsurance amount	Percent of firms requiring coinsurance	Copayment amount	Percent of firms requiring copayment
Prescription drugs	33%		72%
<20 percent	6	<$10	10
20 percent	22	$5–$10	59
>20 percent	5	>$10	3
Durable medical equipment	55		0
<20 percent	30	<$15	0
20 percent	25	$15–$20	0
>20 percent	0	>$20	0
Mental health outpatient	66		59
<20 percent	30	<$30	24
20 percent	30	$30–$50	30
>20 percent	6	>$50	5
Mental health inpatient	66		14
<20 percent	30	<$10	6
20 percent	30	$10–$15	7
>20 percent	6	>$15	1
Physical therapy	47		37
<20 percent	22	<$10	1
20 percent	25	$10–$15	34
>20 percent	0	>$15	2
Occupational therapy	47		37
<20 percent	22	<$10	1
20 percent	25	$10–$15	34
>20 percent	0	>$15	2
Speech therapy	47		37
<20 percent	22	<$10	1
20 percent	25	$10–$15	34
>20 percent	0	>$15	2
Skilled nursing	51		0
<20 percent	32	<$10	0
20 percent	18	$10–$15	0
>20 percent	1	>$15	0
Home health care	46		0
<20 percent	30	<$10	0
20 percent	16	$10–$15	0
>20 percent	0	>$15	0
Chiropractor	47		46
<20 percent	4	<$10	2
20 percent	20	$10–$15	43
>20 percent	23	>$15	1

SOURCE: Survey of Fortune 100 employer-sponsored health plans, 2000, Partnership for Solutions, Johns Hopkins University.
NOTE: N = 76.

mental health found that the change led to a more than 40 percent decrease in mental health care costs.[14] Another study examined a large corporation that implemented cost containment by limiting access to mental health coverage and found that employees with mental health conditions fared worse, productivity declined, and

EXHIBIT 3
Limitations Of Benefits Among Fortune 100 Companies, 2000

Benefit	Percent of firms requiring this type of limitation	Benefit	Percent of firms requiring this type of limitation
Mental health outpatient visits per year	64%	Speech therapy visits per year	28%
<30	14	<20	4
30–50	41	20–60	17
>50	9	>60	7
Mental health inpatient days per year	63	Home health care days per year	43
<30	1	<100	9
30–60	55	100–120	37
>60	7	>120	11
Occupational therapy visits per year	46	Chiropractor visits per year	68
<60	11	<20	7
60	29	20–30	45
>60	6	>30	16
Physical therapy		Skilled nursing	
Sessions per episode	28	Days per episode	30
<60	4	<100	6
60	21	100–120	20
>60	3	>120	4
Sessions per year	22	Days per year	41
<60	8	<100	11
60	9	100–120	30
>60	5	>120	0

SOURCE: Survey of Fortune 100 employer-sponsored health plans, 2000, Partnership for Solutions, Johns Hopkins University.
NOTE: N = 76.

costs increased.[15] Some studies have found that increasing mental health coverage will raise insurance costs for all members and will lower rates of health insurance coverage in general among employees.[16] At the same time, studies suggest that there are potential improvements in productivity for employees who have access to coverage of mental health care.[17]

Skilled nursing/home care. Nearly all of the companies cover care in skilled nursing facilities. Coinsurance is required by 51 percent of the companies, and none require copayments (Exhibit 2). Thirty percent of companies placed limitations on the number of days per episode, with a range from 60 to 730 days; 41 percent of the companies imposed limitations on the number of days per year, with a range from 30 to 120 days (Exhibit 3). All companies surveyed offer home health care benefits; 46 percent impose coinsurance for the use of these services, and none require copayments (Exhibit 2). The most frequently used form of cap is limitations on the number of visits per year (Exhibit 3). In general, the coinsurance amounts and

"The higher out-of-pocket limit might be a financial burden; however, the higher lifetime maximum can be beneficial."

day limitations of home health care benefits of the Fortune 100 are lower than in Medicare.[18]

Other benefits. We found that nearly all companies offer other benefits such as coverage of physical, occupational, and speech therapies, but access to these services is frequently restricted to acute episodes and generally is not designed to provide the services needed by persons with chronic or congenital conditions. For instance, physical, occupational, and speech services are covered only as long as the treatment will help the person to recover functional or physical capacity or show clear signs of improvement in what is frequently called "a reasonable period of time." Current definitions of medical necessity often require that a service greatly improve a person's health status. However, for many persons with a chronic condition, certain medical services, therapies, and equipment can be needed to maintain their functional capacity, alleviate pain, or maintain quality of life without clear clinical improvement. When medical necessity is limited to those services that improve health status, persons with chronic conditions may be denied services that are vital to their functioning independently at home or contributing in the workplace. Telephone interviews with the directors of health benefits of the companies surveyed, however, suggest that some companies may be willing to cover these services for longer periods of time, but only on a case-by-case basis.

Three benefits are offered by some but not all companies: family counseling, dietitian-nutritionist services, and medical social worker. Several studies suggest that these benefits are important for persons with chronic conditions.[19] In discussions with the directors of medical benefits, we found that some of them cover medical social workers and dietitians in the context of home health care only. In our survey we explicitly differentiated the coverage of professional dietitian-nutritionist services and medical social workers from services covered by home health care. For family counseling, we looked for coverage of professional family group therapists that could address problems such as depression, anger, anxiety, panic attacks, chemical abuse or alcoholism, adolescent behavioral problems, sexual assault, childhood behavioral disorders, and coping with family members suffering from chronic conditions. These services were considered to be distinct from individual mental health coverage. More analysis is needed to determine why some companies offer

these benefits while others do not. Profitability, type of industry, and level of unionization are possible explanations.

Some benefits such as respite care, personal care, nonemergency transportation, and home modifications are not covered by any of the Fortune 100 firms we surveyed. Telephone interviews suggested great reluctance to add any of these benefits at the present time; however, some companies may provide them on a case-by-case basis.

Overall Plan Limitations

Health plan components other than those we studied may incorporate deductibles, overall out-of-pocket limits, and lifetime maximums. These provisions can also affect persons with chronic conditions.[20] We found that among the Fortune 100, the average deductible in traditional indemnity plans is $227 for individuals and $498 for families. In PPOs the average in-network deductibles are $261 for individuals and $639 for families; in POS plans, $225 for individuals and $449 for families. According to the Kaiser/HRET 2000 annual survey of employer health benefits, the average deductible in traditional indemnity plans nationwide is $239 for individuals and $545 for families. In PPOs the average in-network deductibles are $187 for individuals and $361 for families; in POS plans, $79 for individuals and $367 for families.[21] From this comparison we conclude that the Fortune 100 companies have higher PPO deductibles than do similar organizations nationwide but that deductibles for the other types of plans are similar to the nationwide average.

According to the latest data published by the U.S. Department of Labor (1995), our study found that the average individual out-of-pocket limit ($1,510) for the Fortune 100 companies surveyed was higher than the nationwide average ($1,358) for medium and large private firms in 1995; the mean family out-of-pocket limit ($3,122) in our surveyed companies also was higher than the average ($2,858) for medium and large firms. Thirty-six percent of Fortune 100 companies surveyed did not have a lifetime maximum benefit limit in 2000; 27 percent of all medium and large companies nationwide did not have one in 1995.[22] Of those Fortune 100 companies that specified a lifetime maximum dollar amount, the mean was $1,603,191. In 1995 nationwide only 9 percent of medium and large companies had lifetime maximum benefits over $1,000,000; 47 percent offered $1,000,000, and the rest specified lower amounts. This higher out-of-pocket limit among the Fortune 100 might represent a financial burden for those with chronic conditions; however, the higher lifetime maximum can be financially beneficial for the chronically ill.

From the available data, we did not observe differences in the characteristics of Fortune 100 companies that responded to our sur-

vey and those that did not. There were no statistically significant differences by profitability, sales, industry, or number of workers. Our selection of the most generous benefit package offered to employees may overestimate the benefits offered to all employees, especially union employees. The comparisons to Department of Labor data, however, suggest that this may not be a major difference.

THE FORTUNE 100 COMPANIES SURVEYED offer a wide range of benefits important to persons with chronic conditions and their families. However, not all Fortune 100 companies offer certain benefits, and none of them cover some services deemed critical to persons with chronic conditions. The imposition of cost-sharing mechanisms places potential access barriers and financial burdens on those with a continuing need for medical care. Persons with chronic conditions are much more likely to use medical services, so coinsurance, copayments, and lifetime maximum limits are of particular concern to them. In addition, medical necessity is frequently interpreted not to include services where improvement in the medical condition will not occur, something that happens frequently for those with chronic conditions.

The Medicare benefit package was modeled initially after the benefits offered by Blue Cross plans in 1965.[23] A comparison of Medicare benefits and Fortune 100 companies' benefits in 2000 shows that Medicare provides a less generous set of benefits than Fortune 100 companies for persons with chronic conditions. In particular, Medicare does not offer pharmacy benefits; offers more limited durable medical equipment, home health care, and skilled nursing benefits; and, in general, has greater cost-sharing provisions than most Fortune 100 companies do. Given the growing prevalence of chronic conditions in the United States, both private- and public-sector insurers will be challenged to respond to the needs of persons with chronic conditions and their families in the coming years.

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NOTES

1. See J.C. Cantor et al., "Business Leaders' Views on American Health Care," *Health Affairs* (Spring 1991): 98–105; J.B. Christianson, "The Role of Employers in Community Health Care Systems," *Health Affairs* (July/Aug 1998): 158–164; J.R. Gabel, "Job-Based Health Insurance, 1977–1998: The Accidental System under Scrutiny," *Health Affairs* (Nov/Dec 1999): 62–74; J. Piacentini and T. Cerino, eds., *EBRI Databook on Employee Benefits* (Washington: Employee Benefit Research Institute, 1990), 5–34; and K. Thorpe, "The Health System in Transition: Care, Cost, and Coverage," *Journal of Health Politics, Policy and Law* 22, no. 2 (1997): 339–361.
2. See T. Bodenheimer and K. Sullivan, "How Large Employers Are Shaping the

Health Care Marketplace" (Part One of Two), *New England Journal of Medicine* (2 April 1998): 1003–1007; R. Fernandopulle and D. Chin, "Private Initiatives," in *Health Care Policy,* ed. D. Calkins, R. Fernandopulle, and B. Marino (Cambridge: Blackwell Science, 1995), 219–229; H. Darling, "Employers and Managed Care: What Are the Early Returns?" *Health Affairs* (Winter 1991): 147–160; and D. McDermott, "Small Business Leaders' Viewpoints on Health Care Insurance: A Marketing and Social Perspective," *Health Marketing Quarterly* 7, no. 1–2 (1990): 169–175.

3. We examined data from the 1996 Medical Expenditure Panel Survey (MEPS) to estimate the prevalence of persons with chronic conditions and the costs they incur. We used Rounds 1, 2, and 3 of the survey, and each of the 22,061 persons participating in the study was assigned a weight based upon sociodemographic characteristics, to develop a nationally representative estimate for the civilian noninstitutionalized U.S. population in 1996. A definition of *chronic condition* was created, and the age group 18–64 was analyzed. The percentage of costs attributable to persons with chronic conditions in this age group also was analyzed.
4. P. Jozan, "The Epidemiological Future," *Health Policy* 11, no. 2 (1991): 87.
5. L.A. Bergthold, "Benefit Design Choices under Managed Competition," *Health Affairs* (Supplement 1993): 99–109; A.K. Biddle et al., "The Health Insurance Puzzle: A New Approach to Assessing Patient Coverage Preferences," *Journal of Community Health* 23, no. 3 (1998): 181–194; B. Booske, F. Sainfort, and A. Hundt, "Eliciting Consumer Preferences for Health Plans," *Health Services Research* (October 1999): 839–854; W.S. Custer, "Employer Health Care Plan Design and Its Effect on Plan Costs," *Inquiry* 28, no. 1 (1991): 81–86; A.E. Dembe, "Preserving Workers' Compensation Benefits in a Managed Health Care Environment," *Journal of Public Health Policy* 19, no. 2 (1998): 200–218; J.D. Loeser et al., "Incentive Effects of Workers' Compensation Benefits: A Literature Synthesis," *Medical Care Research and Review* 52, no. 1 (1995): 34–59; R. Frank, T. McGuire, and D. Salkever, "Benefit Flexibility, Cost Shifting, and Mandated Mental Health Coverage," *Journal of Mental Health Administration* 18, no. 3 (1991): 264–271; M. Gold, "Health Maintenance Organizations: Structure, Performance, and Current Issues for Employee Health Benefits Design," *Journal of Occupational Medicine* 33, no. 3 (1991): 288–296; and K. Wells, "Mental Health Parity Compliance: Legal Requirements and Benefit Design Options," *Behavioral Healthcare Tomorrow* 6, no. 4 (1997): 34–38.
6. J. Gabel et al., *Employer Health Benefits: 2000 Annual Survey* (Menlo Park, Calif.: Kaiser Family Foundation, and Chicago: Health Research and Educational Trust, 2000).
7. Pharmaceutical Research and Manufacturers of America, *Industry Profile* (Washington: PhRMA, 1998).
8. B. Harris et al., "The Effect of Drug Co-Payments on Utilization and Cost of Pharmaceuticals in a Health Maintenance Organization," *Medical Care* 28, no. 10 (1990): 907–917; A. Leibowitz, W.G. Manning, and J.P. Newhouse, "The Demand for Prescription Drugs as a Function of Cost-Sharing," *Social Science and Medicine* 21, no. 10 (1985): 1063–1069; A.A. Nelson et al., "The Effect of a Medicaid Drug Copayment Program on the Utilization and Cost of Prescription Services," *Medical Care* 22, no. 8 (1984): 724–735; and D. Smith, "The Effects of Copayments and Generic Substitution on the Use and Costs of Prescription Drugs," *Inquiry* 30, no. 2 (1993): 189–198.
9. C.E. Reeder and A.A. Nelson, "The Differential Impact of Co-payment on Drug Use in a Medicaid Population," *Inquiry* 22, no. 4 (1985): 396–403; and Nelson et al., "The Effect of a Medicaid Drug Copayment Program."
10. E.P. Steinberg et al., "Beyond Survey Data: A Claims-Based Analysis of Drug

Use and Spending by the Elderly," *Health Affairs* (Mar/Apr 2000): 198–211.
11. Congressional Budget Office, *Analysis of the President's Budgetary Proposals for Fiscal Year 2001* (Washington: CBO, 2000).
12. J.A. Penz, "Mental Health Parity Act of 1996: Summary of the Interim Rules Relating to Group Health Plans," *Employee Benefits Journal* 23, no. 2 (1998): 14–17; and L.R. Pelletier, "Update on Mental Health Parity," *Journal of Child and Adolescent Psychiatric Nursing* 11, no. 4 (1998): 159–160.
13. D. Mechanic, "Emerging Trends in Mental Health Policy and Practice," *Health Affairs* (Nov/Dec 1998): 82–98.
14. W. Goldman, J. McCulloch, and R. Sturm, "Costs and Use of Mental Health Services Before and After Managed Care," *Health Affairs* (Mar/Apr 1998): 40–52.
15. R.A. Rosenheck et al., "Effect of Declining Mental Health Service Use on Employees of a Large Corporation," *Health Affairs* (Sep/Oct 1999): 193–203.
16. P. Fronstin, *Issues in Mental Health Care Benefits: The Costs of Mental Health Parity,* EBRI Issue Brief no. 182 (Washington: EBRI, 1997).
17. C.S. Dewa and E. Lin, "Chronic Physical Illness, Psychiatric Disorder, and Disability in the Workplace," *Social Science and Medicine* 51, no. 1 (2000): 41–50; and L.S. Goldman, N.H. Nielsen and C.H. Champion, "Awareness, Diagnosis, and Treatment of Depression," *Journal of General Internal Medicine* 14, no. 9 (1999): 569–580.
18. Medicare requires a copayment of $97 per day for days 21–100, and all costs in the benefit period beyond the 100th day. Health Care Financing Administration, *Your Medicare Benefits 2000: Your Health Care Coverage under Part A (Hospital Insurance) and Part B (Medical Insurance) Including Preventive Services* (Baltimore: HCFA, 2000).
19. S. Kirk, "Families' Experiences of Caring at Home for a Technology-Dependent Child: A Review of the Literature," *Child Care, Health, and Development* 24, no. 2 (1998): 101–114; M. Jellinek et al., "The Need for Multidisciplinary Training in Counseling the Medically Ill: Report of the Training Committee of the Linda Pollin Foundation," *General Hospital Psychiatry* 14, no. 6 (Supplement 1992): 3–10; R.G. Knight et al., "A Meta-Analytic Review of Interventions for Caregiver Distress: Recommendations for Future Research," *Gerontologist* 33, no. 2 (1993): 240–248; E. Lipkin, "New Strategies for the Treatment of Type Two Diabetes," *Journal of the American Dietetic Association* (March 1999): 329–334; D. McCarron et al., "Comprehensive Nutrition Plan Improves Cardiovascular Risk Factors in Essential Hypertension," *American Journal of Hypertension* (January 1998): 31–40; and L.S. Sommers et al., "Physician, Nurse, and Social Worker Collaboration in Primary Care for Seniors," *Archives of Internal Medicine* 160, no. 12 (2000): 1825–1833.
20. For instance, high out-of-pocket costs may induce patients to "extend" their medications, as suggested in a study on drug coverage and hypertension. J. Blustein, "Drug Coverage and Drug Purchases by Medicare Beneficiaries with Hypertension," *Health Affairs* (Mar/Apr 2000): 219–230. Also see Steinberg et al., "Beyond Survey Data"; and G. Simon, M. Vonkorff, and M. Durham, "Predictors of Outpatient Mental Health Utilization by Primary Care Patients in a Health Maintenance Organization," *American Journal of Psychiatry* 151, no. 6 (1994): 908–913.
21. The figure for individual deductibles for POS plans was reported only with data from small firms in this survey. Gabel et al., *Employer Health Benefits.*
22. P. Fronstin, *Features of Employment-Based Health Plans,* EBRI Issue Brief no. 201 (Washington: EBRI, 1998).
23. T.R. Marmor, *The Politics of Medicare* (Chicago: Aldine Publications, 1973).