HEALTH CARE AND INSURANCE

Genetic Testing: An Economic and Contractarian Analysis, by Alexander Tabarrok

Medical researchers are rapidly identifying the genetic causes of many diseases. Genetic tests can reveal an individual's probable health status many years in advance of sickness. Many fear that this will lead to genetic discrimination in the employment market and the health insurance market. Solutions such as consent laws are impractical and create adverse selection problems. A new form of insurance, genetic insurance, can eliminate these problems and allow everyone to be insured. It should be mandatory that every individual purchase genetic insurance before taking a genetic test. If the test came back positive, the individual would be paid a large sum of money to cover the expected cost of the disease. Those with negative results would lose their genetic insurance fee, but would gain the results of the test and lower health insurance premiums. This proposal requires that genetic testing be illegal unless genetic insurance is purchased. *Journal of Health Economics,* March 1994, 13(1): 75–91. (Reprinted with permission of ABI/Inform, copyright UMI.)

HEALTHCARE AND INSURANCE

Worker Demand for Health Insurance in the Non-Group Market, by Susan M. Marquis and Stephen H. Long

The present research examines decisions to purchase individual insurance by workers who do not have employment-based insurance. Using data from the Current Population Survey and the Survey of Income and Program Participation, coupled with prices for a standard insurance product in different markets, a price elasticity of –0.3 to –0.4 and an income elasticity of 0.15 are estimated. The estimate of the price response raises doubts that even substantial subsidies to the working uninsured would induce many of them to purchase coverage voluntarily. *Journal of Health Economics,* May 1995, 14(1): 47–63. (Reprinted with permission of ABI/Inform, copyright UMI.)

HEALTH CARE AND INSURANCE

Gainers and Losers Under a Tax-Based Health Care Reform Plan, by John F. Moeller

Currently, it appears that health care for the nonpoor and nonelderly in the United States will continue to be financed primarily through a private insurance market rather than a public insurance program. Even if this market-based system achieves maximum efficiency, a premium subsidy for low-income, non–Medicaid-eligible individuals likely will be required to make health insurance affordable for all Americans. There are advantages to carrying out that redistribution at the federal, rather than state or local level, possibly using credits or deductions within the federal personal income tax system. Which individuals decide to claim these tax credits or deductions, and how much the tax subsidies would have cost in 1993, are

examined. A tax on employer-provided health benefits finances the subsidy, and the characteristics of gainers and losers under the reform are analyzed. Data from the 1987 National Medical Expenditure Survey are used to develop a microsimulation model of the federal personal income tax system. *Inquiry,* Fall 1995, 32(3): 285–299. (Reprinted with permission of ABI/Inform, copyright UMI.)

HEALTHCARE AND INSURANCE

Employment-Based Health Insurance: Implications of the Sampling Unit for Policy Analysis, by Gary A. Zarkin, Steven A. Garfinkel, Francis J. Potter, and Jennifer J. McNeill

One of the least understood aspects of using employer data for the health reform debate concerns important differences between enterprise- and establishment-level surveys of employers. It is demonstrated that the choice of sampling unit affects the size of distribution of employees between large and small firms, as well as the estimated proportion of firms offering health insurance. Because health insurance decisions in multi-establishment enterprises generally are made for the entire enterprise rather than individual establishments, it is concluded that enterprise surveys are more appropriate for collecting information on the factors affecting the decision to provide health insurance coverage. Nevertheless, an establishment-level survey may be preferred for evaluating decisions made at the state, regional, or industry level. But establishment-level surveys will underestimate the impact of an employer mandate on the unit that ultimately makes the decision to offer health insurance—the enterprise. *Inquiry,* Fall 1995, 32(3): 310–319. (Reprinted with permission of ABI/Inform, copyright UMI.)

HEALTHCARE AND INSURANCE

How Adequate Are State Data to Support Health Reform or Monitor Health System Change? by Marsha Gold, Lauren Burnbauer, and Karyen Chu

Results of a 1994 telephone survey sponsored by the Robert Wood Johnson Foundation to obtain better information on state policy-makers' views of the quality of state-based health data and selected information on the actual data available are discussed. State policy-makers cannot identify easily who and how many are without health insurance coverage, nor do they know exactly how much money is spent in the state on health care and who spends it. They also cannot ascertain quality or consumers' satisfaction with health plans. Funding, lack of comparability across data sets, and the reluctance of providers and insurers to submit required data are perceived as barriers to improving data. Adopting realistic strategies to overcome these barriers may be crucial if states are to assume greater leadership in health policy and in monitoring health system performance. *Inquiry,* Winter 1995/1996, 32(4): 468–475. (Reprinted with permission of ABI/Inform, copyright UMI.)

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