

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.)

HEALTH CARE 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.)

HEALTH CARE 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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