



# *HEALTH AND PRODUCTIVITY CHALLENGES FOR LOWER-INCOME WORKERS*

## HEALTH INSURANCE, PLAN DESIGN AND BARRIERS TO CARE

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### EXECUTIVE SUMMARY

Access to health services is an important determinant of a person's health. In the U.S., health insurance is the principal means of access to affordable care—though rising deductibles and out-of-pocket costs present a barrier to care for many enrollees. Lower-income employees may be at a particularly high risk of experiencing cost-related barriers to care. Even when they have employment-based health insurance, high-deductibles, coinsurance, and health care and prescription medication costs can often keep health care out of their reach.

Research shows that employers share some of the burden of illness when their workers cannot afford needed care. Foregone care results in lost work time and impaired job-performance—the value of which may negate savings from cost-sharing strategies. To explore the productivity losses that cost-related barriers to care can impose on employers, IBI analyzed the links between lower-income employees' health insurance, cost-related barriers to care, and illness-related absences from work. Summary findings for employees with family incomes above \$35,000 are also reported.

### Principal findings:

- From 2007 to 2017, two out of five lower-income employees (with annual family incomes less than \$35,000) were uninsured. Among the insured, one in six were enrolled in high-deductible plans (defined as greater than \$1,100 for a single person and \$2,200 for two or more enrollees in a plan). Half of insured lower-income employees did not have coverage for prescription medications.
- One in three lower-income employees experienced a cost-related barrier to care over the course of 12 months. Nearly one in four delayed needed care, compared to about one in five who could not afford medical care, and almost one in six who could not afford prescription medications. Only about one in 20 reported that they needed but could not afford mental health care.
- More than half of uninsured lower-income employees experienced a cost-related barrier to care, compared to about one fifth of insured lower-income employees.

- Compared to insured employees in plans with low deductibles, lower-income employees enrolled in high-deductible plans were 75% more likely to experience a cost-related barrier to care. Health savings accounts did not reduce the risk of experiencing cost-related barriers for employees with high-deductibles. However, flexible spending accounts and coverage for prescription medications were associated with reduced risk of experiencing cost-related barriers to care.
- On average, a lower-income employee who experienced a cost-related barrier to care had 1.9 more lost workdays per year than a lower-income employee who experienced no barriers to care—a 70% increase in lost work time from a baseline of 2.7 days.
- If only one in five lower-income employees had experienced a cost-related barrier to care—roughly the rate experienced by employees with low deductible insurance—there would have been 6% fewer lost workdays among this population. Lost workdays would have been 8% less if the overall rate of barriers was as low as that experienced by employees with low deductible insurance, coverage for prescriptions, and a flexible spending account (about 18% of whom experienced a barrier to care).
- While employees with incomes above \$35,000 experienced fewer barriers to care, the association with health insurance and plan design was stronger than was observed at lower income levels. Barriers to care had a similar impact on lost workdays across the income distribution.
- Given the limits of the survey data used for this analysis, the findings do not include information on disability leaves or losses from impaired job performance (i.e., presenteeism). The findings therefore represent a conservative estimate of the lost productivity associated with barriers to care. This implies a substantial business value for benefits policies that balance healthcare cost control against enrollees' access to cost-effective, timely and beneficial care.
- To help employers design benefits policies that balance the need to manage treatment costs against enrollees' access to cost-effective, timely and beneficial care, experts from the field of health and productivity recommend that employers develop a data-based understanding of their workers unmet needs for care, recognize the full financial impact of their cost-sharing strategies, leverage employee benefits to promote access, and prioritize prevention, healthy living and cost-effective care as the default options.

## Background

Access to health services is an important determinant of a person's health.<sup>1</sup> In the U.S., health insurance is the principal means of access to affordable care—though rising out-of-pocket costs present a barrier to care for many enrollees.<sup>2,3</sup>

Lower-income adults, who often do not receive health insurance through employment<sup>4</sup> and may not qualify for or enroll in government subsidized programs such as Medicaid,<sup>5</sup> may be at a particularly high risk of experiencing cost-related barriers to care.<sup>6</sup> Even for low-income Americans with employment-based insurance, high-deductibles, coinsurance, and health care and prescription medication costs can often keep health care out of their reach. In addition, lower-income workers spend a higher share of their income on premiums for employer sponsored health insurance.<sup>7-9</sup>

Given the well-established link between low socioeconomic status and poor health,<sup>10-12</sup> employers likely share some of the burden of illness when their lower-income workers experience cost-related barriers to care. Lower-income workers in employer-sponsored health plans have been shown to use fewer preventive services and more inpatient and emergency care than their higher-income peers.<sup>13</sup> A previous IBI review of the research literatures on cost-sharing, care utilization, and productivity concluded that some of the medical and pharmaceutical cost savings realized from high-deductible plans occurs because enrollees avoid beneficial and necessary care in addition to low-value care.<sup>14</sup> The avoidance of beneficial care may in turn lead to increased sick day and disability absences or impaired job-performance—the value of which may negate some health care savings.

Prioritizing preventive services and access to care may offer additional benefits for employers. When employees take appropriate absences when ill, recovery times are reduced and the spread of contagious diseases is prevented.<sup>15</sup> For those with chronic conditions, continuity of care reduces complications and decreases long-term expenditures.<sup>16</sup> Appropriate utilization of preventive health care services can improve employee physical and mental health which benefits employers by increasing retention and productivity while decreasing worker errors and on the job accidents.<sup>15</sup>

To explore how cost-related barriers to care can impose productivity losses on employers, we analyze 11 years' worth of employees' survey responses about their health insurance, cost-related barriers to care, and illness-related absences from work. Our analysis focuses on three main questions:

1. How many lower-income employees report cost-related barriers to care?
2. How does health insurance availability and plan design impact cost-related barriers to care?
3. How many illness-related absences are attributable to reported cost-related barriers to care?

While the main emphasis of this analysis is on lower-income employees, we also briefly compare these results with employees in higher income groups.

## Data

The National Health Interview Survey (NHIS)<sup>17</sup> is a cross-sectional survey of US households conducted by the National Center for Health Statistics, a division of the Centers for Disease Control and Prevention. The survey monitors trends in health, access to care and utilization. We used 11 years of pooled data between 2007-2017

provided by the University of Minnesota's Integrated Public Use Microdata Series (IPUMS)<sup>\*</sup> to obtain a sample of 180,738.

## **SAMPLE**

Our eligibility criteria for this analysis is adults who are currently employed or who were employed within the previous 12 months and who were younger than age 65 (to exclude Medicare-eligible employees). We included respondents for whom we had valid health insurance plan design elements (described below) or who were uninsured.

## **FAMILY INCOME**

We measure total annual family income as a proxy for an employee's ability to pay for healthcare. The variable is recorded in four ordinal categories introduced in the 2007 survey year:

1. Less than \$35,000
2. \$35,000 to \$74,999
3. \$75,000 to \$99,999
4. \$100,000 or more

For the main analysis, we focus on approximately 50,000 employees with annual family incomes of less than \$35,000 (about 24% of the entire sample). Nearly two out of five employees in this group had incomes below the federal poverty level for their family size. Less than 1% of employees in higher income groups were below the federal poverty level.

## **ILLNESS-RELATED ABSENCES**

The survey includes a question asking, "During the past 12 months ... about how many days did you miss work at a job or business because of illness or injury (do not include maternity leave)?" Several survey validity studies indicate that a 12-month recall for self-reported illness absence is valid for research purposes.<sup>18-21</sup> To minimize the influence of outliers, we top-coded the maximum number of lost workdays at 90 days (the 99<sup>th</sup> percentile of all employed adults).

## **HEALTH INSURANCE**

The NHIS questionnaire includes several questions about respondents' health insurance coverage: self-purchased private insurance, employer-sponsored, and public programs such as Medicaid, Veterans Affairs, etc. Responses to these questions were used to create an indicator variable classifying a person as having coverage or no coverage. Figure 1 shows that about two in five lower-income employees were uninsured at the time they completed the survey.

## **PLAN DESIGN**

For respondents with health insurance, several questions are used to characterize different elements of their plan design. We focus on four elements that may influence the out-of-pocket costs of accessing care. Each element is coded as a dichotomous variable indicating whether it was included as part of their health insurance.

1. High-deductible: We use an NHIS-defined variable to indicate whether a person was enrolled in a plan with a high deductible. NHIS characterizes a high deductible as greater than \$1,100 for a single person

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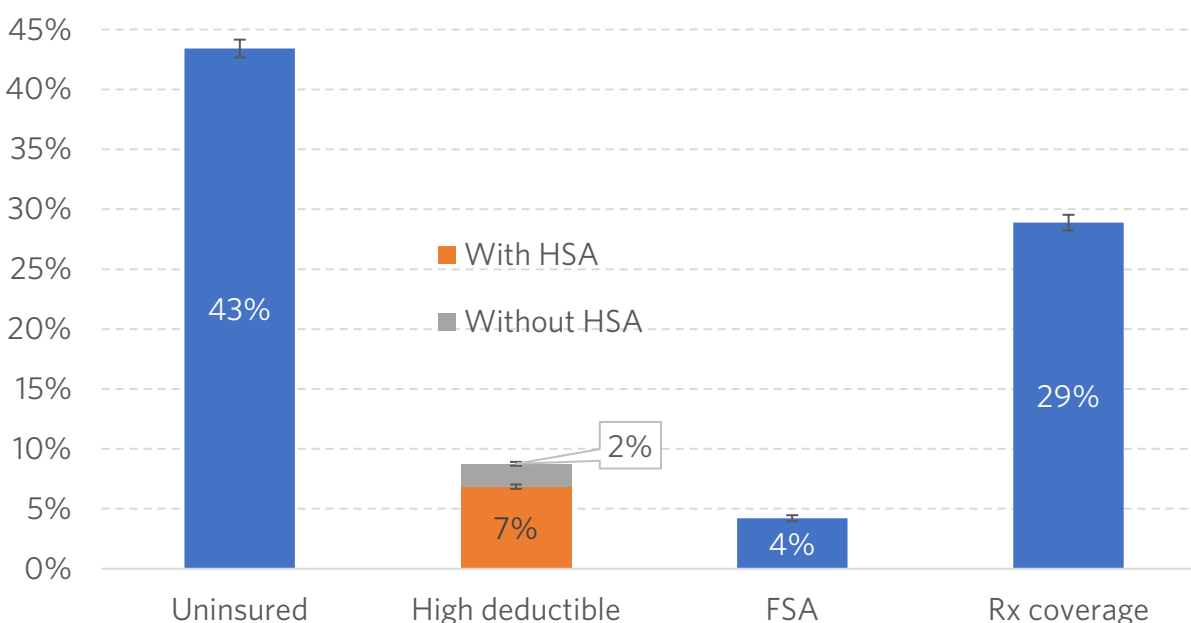
<sup>\*</sup> <https://www.ipums.org/index.shtml>

and \$2,200 for two or more enrollees in a plan. For simplicity, throughout this report we refer to persons without high deductibles as enrolled in “low-deductible” plans.

2. Health savings/reimbursement account: Persons enrolled in high-deductible plans were also asked if their plan included a health savings or health reimbursement account (HSA), described as “a special account or fund that can be used to pay for medical expenses” separate from a flexible spending account.
3. Flexible spending account: The variable indicates whether a person had a flexible spending account (FSA) to set aside pre-tax money to reimburse themselves for qualified out-of-pocket expenses for health care.
4. Coverage for prescription medications (Rx): The variable indicates whether a person’s health plan pays for any of the costs for medication prescribed by a doctor.

Figure 1 shows that about one in eleven lower-income employees had a high-deductible plan (one in six of insured employees), one in five of whom had an HSA (2% of all lower-income employees). One in 25 had an FSA, while less than one in three had coverage for prescription medications (about half of all insured lower-income employees).

**Figure 1: Summary of lower-income workers with health insurance and plan design elements**



Notes for Figure 1: The brackets indicate the 95% confidence interval (CI) around the percentages (see footnote\*).

## BARRIERS TO CARE

The survey contains four questions indicating whether in the prior 12 months a person experienced any cost-related barrier to receiving health care. Reported barriers are:

\* CI = confidence interval, the range within which we have 95% confidence of the “true” magnitude of the association.

1. Delayed seeking medical care due to worries about the cost (delayed care).
2. Needed, but did not get, medical care because they could not afford it (needed medical care).
3. Needed, but did not get, prescription medications because they could not afford it (needed Rx).
4. Needed, but did not get, mental health care or counseling because they could not afford it (needed mental health care).

We report the proportion reporting each of type of barrier in the results section. For the multivariate regression analysis, we created a dichotomous variable indicating that a person experienced “any barriers” if they responded affirmatively to at least one of the barrier questions.

### DEMOGRAPHIC AND EMPLOYMENT CONTROL VARIABLES

The statistical analyses (described below) employ estimation methods that control for the influence of factors associated with the main analytic variables. Demographic variables include age, sex, race and Hispanic ethnicity, marital status, and number of minor children in the household.

Work variables include whether a respondent’s occupation was “white collar” (e.g., management, engineering, medical and legal professionals) or “blue collar” (e.g., precision production, construction, maintenance)\*; usual hours worked per week, months worked in the prior year; and whether they had paid sick leave at their current job.

Importantly, because both care-seeking behavior (and therefore those most affected by issues accessing care) and illness-related lost workdays are a function of health status, the models include a categorical measure indicating overall health. The survey question asks respondents to rate their health as “poor,” “fair,” “good,” “very good,” or “excellent.” This question has been shown to have good reliability and validity for assessing physical and emotional health and predicting mortality and morbidity.<sup>22,23</sup> Since less than 1% of respondents rated their health as poor, we combine the categories “poor” and “fair.”

Summary statistics for the lower-income employee sample are provided in the Appendix.

## Statistical method

We estimate two multivariate regression models. The first uses logistic regression to model the probability that an employee experienced any cost-related barrier to care, as a function of their health insurance status and plan design elements. The model includes variables to control for overall health and demographic factors.

The second model uses negative binomial regression to estimate lost workdays as a function of any barriers to care, controlling for overall health, demographics, and work variables. The negative binomial approach models the probability of different counts of events—in this case, lost workdays. It is useful for the purposes of this report given that more than half of employees had no lost workdays. From the results of the regression analysis, we then estimate the average lost workdays based on the probabilities of each count.

All regression models and summary statistics are weighted to reflect the complex sampling design of the survey.

## Results

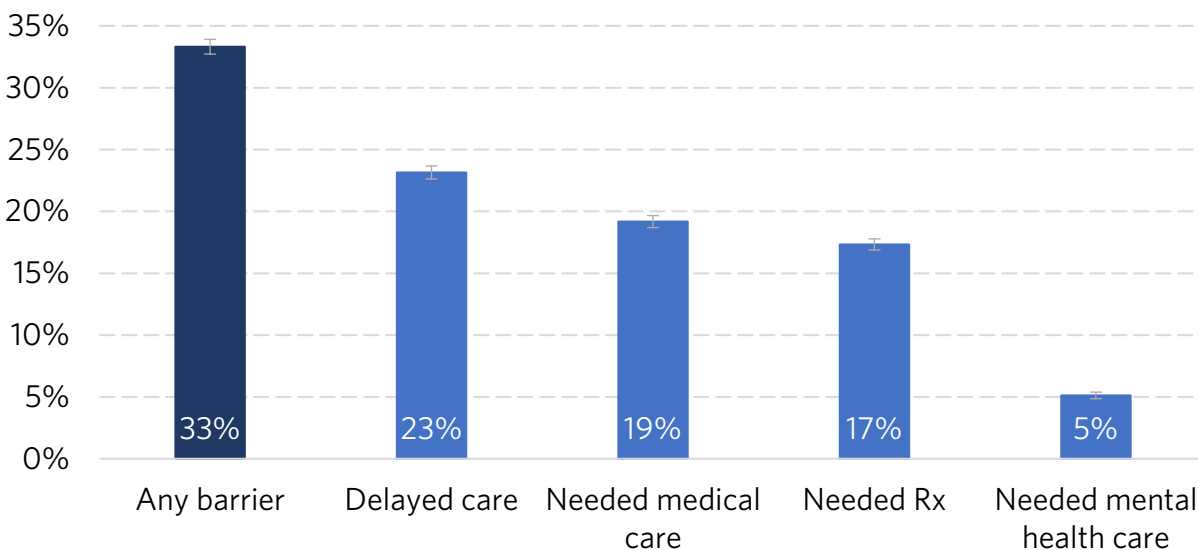
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\* For more information, see the IPUMS occupation coding guidelines, <https://usa.ipums.org/usa/volii/tocccode.shtml>

## HOW MANY LOWER-INCOME EMPLOYEES HAVE COST-RELATED BARRIERS TO CARE?

Figure 2 shows that one in three lower-income employees experienced a cost-related barrier to care in the prior 12 months. Nearly one in four delayed needed care, compared to about one in five who could not afford medical care, and almost one in six who could not afford prescription medications. Only about one in 20 reported that they could not afford needed mental health care.

**Figure 2: Percent of lower income employees experiencing cost-related barriers to care**



*Notes for Figure 2:* The brackets indicate the 95% CI around the percentages.

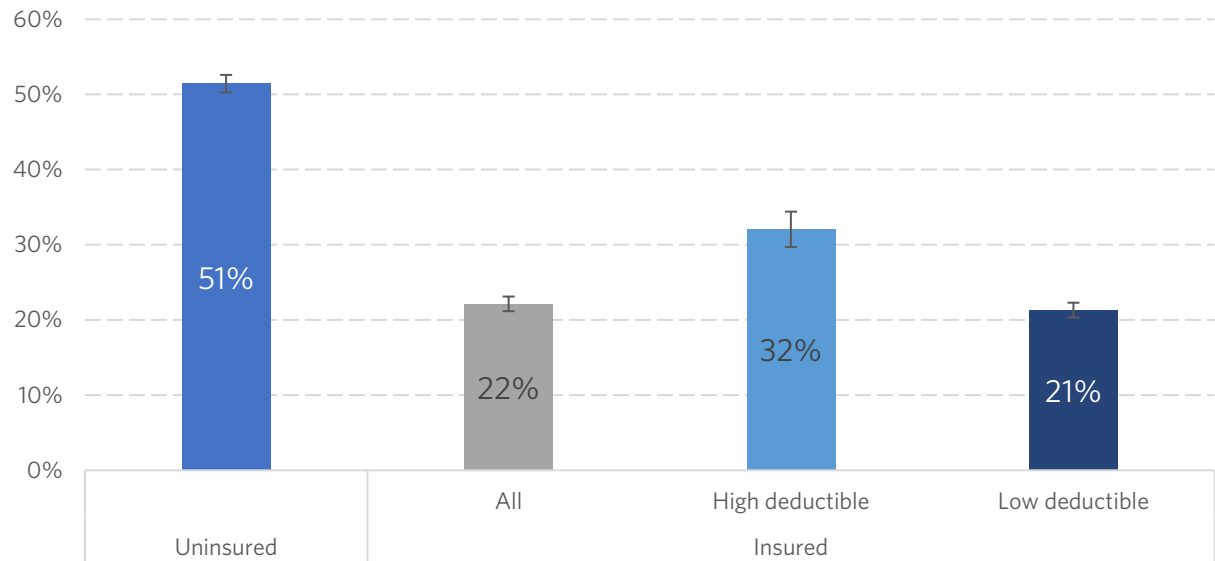
## HOW DOES HEALTH INSURANCE AND PLAN DESIGN IMPACT COST-RELATED BARRIERS TO CARE?

On average, the odds that an uninsured employee experienced a cost-related barrier to care were nearly four times as great as the odds that an employee with health insurance experienced a barrier (OR<sup>\*</sup>=3.75; CI<sup>†</sup>: 3.5 to 4.0). Converted to percentages, Figure 3 shows that our model estimates that more than half of uninsured lower-income employees experienced a barrier to care, compared to about one fifth of insured lower-income employees.

Compared to insured employees without high deductibles, employees enrolled in high deductible plans were 74% more likely to experience a cost-related barrier to care (OR=1.74; CI: 1.56 to 1.94). Figure 3 shows that this equates to about one in three high-deductible enrollees experiencing a cost related barrier to care, compared to one in five low deductible enrollees.

<sup>\*</sup> OR = odds ratio, a measure of the likelihood of an event occurring (in this case, a barrier care) relative to it not occurring. An OR above 1.0 indicates a higher likelihood of an event; an OR below 1.0 indicates a lower likelihood; an OR of exactly 1.0 indicates that there is no difference between the likelihood of an event occurring or not occurring.

Figure 3: Percent of low income employees with cost-related barriers to care



Notes for Figure 3: The brackets indicate the 95% CI around the percentages.

Our model indicates that other plan design elements (not shown) were associated with fewer reports of cost-related barriers to care. Particularly, employees with flexible spending accounts were significantly less likely to experience cost-related barriers to care (OR=0.87; CI: 0.76 to 0.99), as were employees with coverage for prescription medications—although not quite below the conventional 0.05 level of statistical significance ( $p = 0.055$ ; OR=0.92; CI: 0.85 to 1.00). By these estimates, about 18% (CI: 16% to 20%) of lower-income employees enrolled in a low deductible plan with coverage for prescriptions and a flexible spending account would experience a cost-related barrier to care. Health savings accounts did not significantly reduce the risk of cost-related barriers for employees with high-deductible plans.

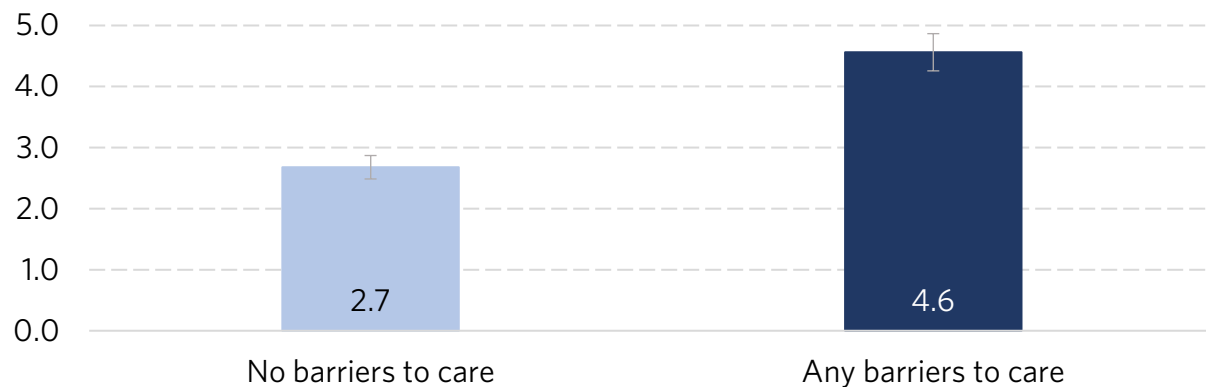
**HOW MANY ILLNESS-RELATED ABSENCES ARE ATTRIBUTABLE TO COST-RELATED BARRIERS TO CARE?**

Figure 4 shows lost workdays for employees with and without barriers to care. On average, experiencing a cost-related barrier to care is associated with a 70% increase in lost workdays compared to experiencing no barriers (1.9 additional days; CI: 1.6 to 2.2 days).

The model estimates that lower-income workers on average experienced 3.2 lost workdays per year (CI: 3.0 to 3.4 days)—considering that about 33% of employees experienced a barrier to care. If only one in five lower-income employees had experienced a cost-related barrier to care—roughly the rate experienced by employees with low deductible insurance—there would have been 6% fewer lost workdays among this population (from an average of 3.2 days to an average of about 3.0; CI: 2.8 to 3.2). Lost workdays would have been 8% less if the overall rate of barriers was as low as that experienced by employees with low deductible insurance, coverage for prescriptions, and a flexible spending account (about 18% of whom experienced a barrier to care).



**Figure 4: Lost workdays by report of cost-related barriers to care**



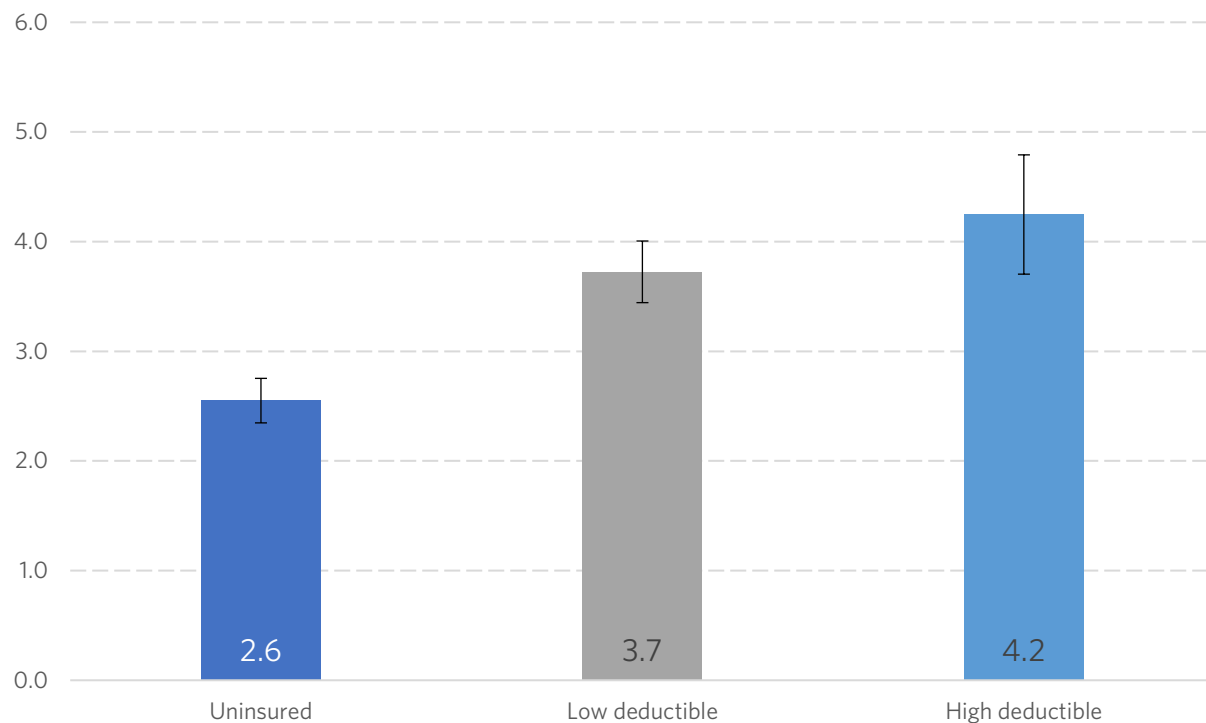
*Notes for Figure 4:* The brackets indicate the 95% CI around the estimate of lost workdays. Brackets for one category that overlapped with the estimate of lost workdays for the other category would indicate that the differences were not statistically significant.

Notably, enrollment in a high-deductible plan was associated with more lost workdays, even when holding constant factors such as barriers to care, age, health status, and paid sick leave benefits. Figure 5 shows that lower-income employees enrolled in high-deductible plans experienced 4.2 lost workdays per year on average (CI: 3.7 to 4.8 days), compared to 3.7 days for low-deductible enrollees (CI: 3.4 to 4.0 days)—a significant difference of half a day (CI: 0.1 to 1.0 days).

By contrast, uninsured employees experienced the fewest lost workdays on average. This partly reflects adjustments for their higher than average barriers to care. The remaining differences may be due to unobserved characteristics of the types of workplaces that make health insurance benefits available to lower-income employees, or unobserved characteristics of employees who decline to participate in health insurance benefits.

No other plan design element (FSAs, HSAs, and coverage for prescription medications) was significantly associated with lost workdays.

**Figure 5: Lost workdays by health insurance status**



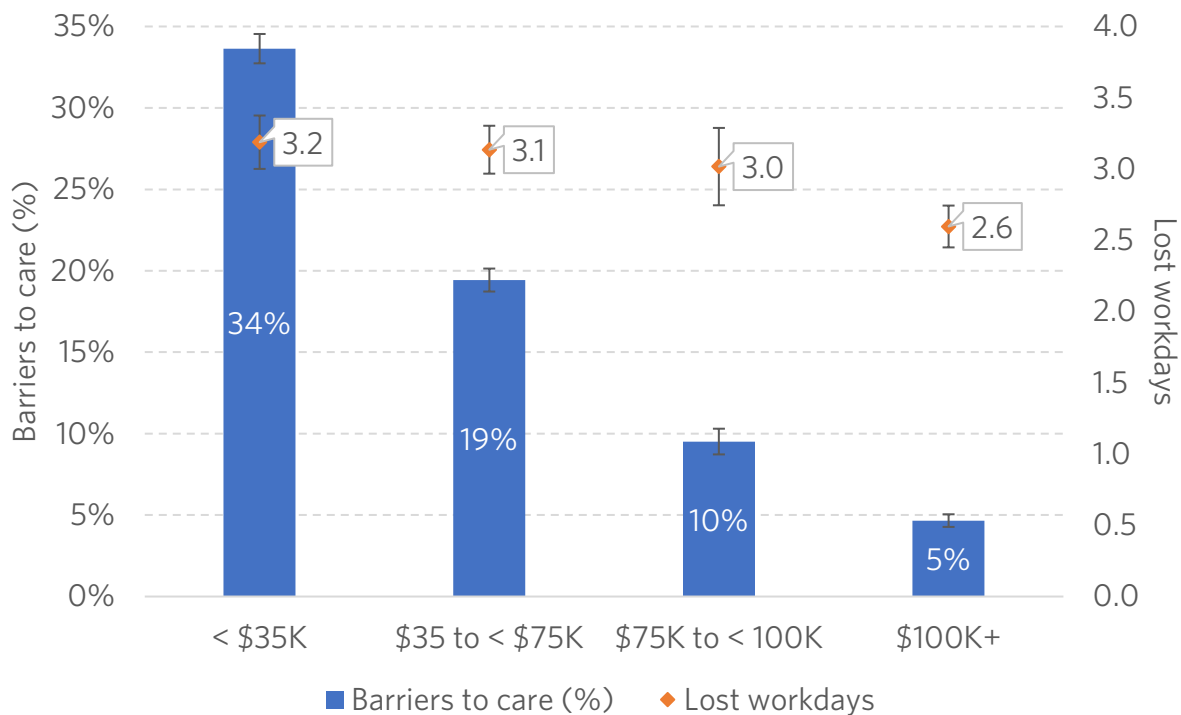
*Notes for Figure 5:* The brackets indicate the 95% CI around the estimate of lost workdays. Brackets for one category that overlapped with the estimate of lost workdays for the other category would indicate that the differences were not statistically significant.

## Findings for employees at other income levels

The findings of this analysis generally support the premise that both a lack of health insurance and high levels of cost-sharing impose cost-related barriers to care for lower-income employees—which has a detrimental impact on their productivity. Subsequent analyses of employees with family incomes above \$35,000 suggest that the links between health insurance, plan design, and cost-related barriers to care are stronger at higher income levels. While barriers to care had similar impacts on lost workdays across the income distribution, absences among higher-income employees may be especially costly to employers since wages reflect workers' value to the firm.

Figure 6 shows cost-related barriers to care and lost workdays after running the regression models for employees across income categories. On average, except for employees with family incomes of at least \$100,000, lost workdays do not differ significantly across groups. By contrast, cost-related barriers to care decline by about half with each increase in income category—from about one in three employees in the lowest income category to one in twenty employees in the highest income category.

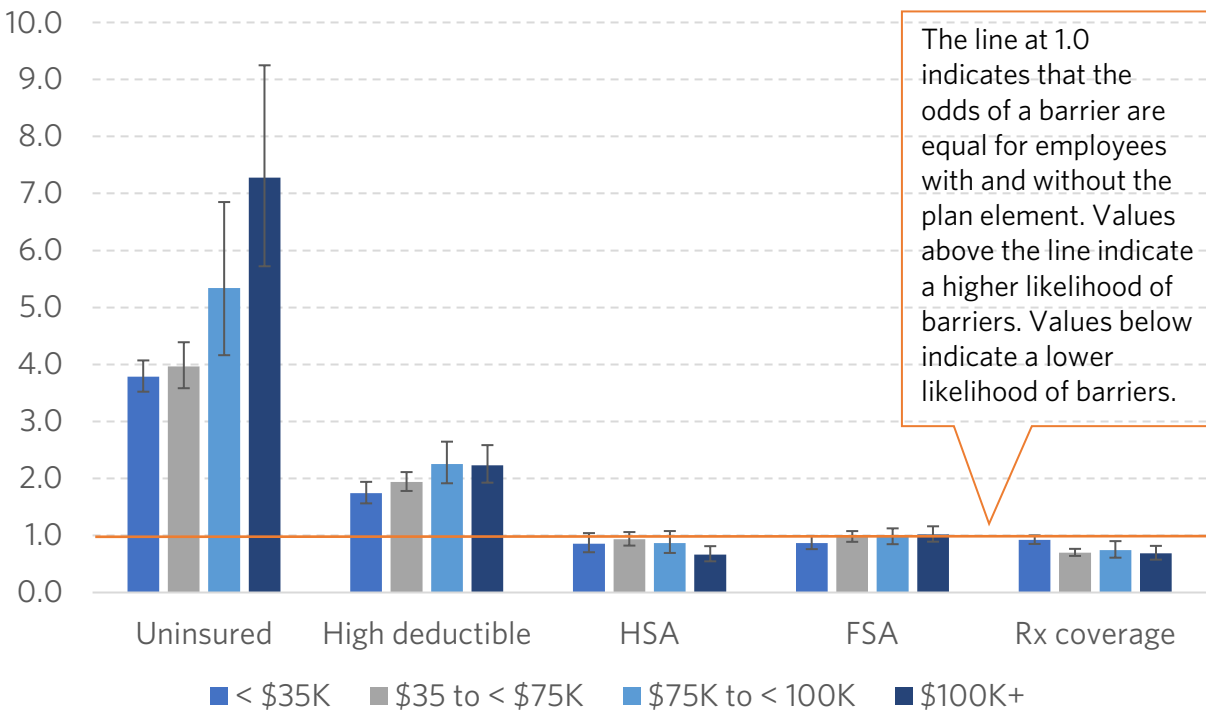
Figure 6: Summary outcomes by income level



Notes for Figure 6: The brackets indicate the 95% CI around the outcomes. Brackets for an income group that overlap with the outcome of another income group indicate that outcomes for those groups were not statistically significant.

Figure 7 shows that uninsurance and high-deductibles have stronger associations with cost-related barriers to care at incomes above \$75,000 than below \$75,000 (as indicated by the odds ratios). This is driven by the low number of higher-income employees reporting barriers to care (Figure 5), and the high proportion of those who report barriers to care being uninsured (one in four) or in high deductible plans (one in three). A much higher proportion of lower-income employees report barriers to care, but these barriers are less dependent upon plans and plan design elements (with the exception of FSAs) than those at higher incomes. For employees with family income of at least \$100,000, an HSA reduces some of the barriers associated with enrollment in a high-deductible plan. FSAs are unrelated to barriers for employees with family incomes above \$35,000, while coverage for prescription medicines reduces barriers for employees with family incomes above \$35,000.

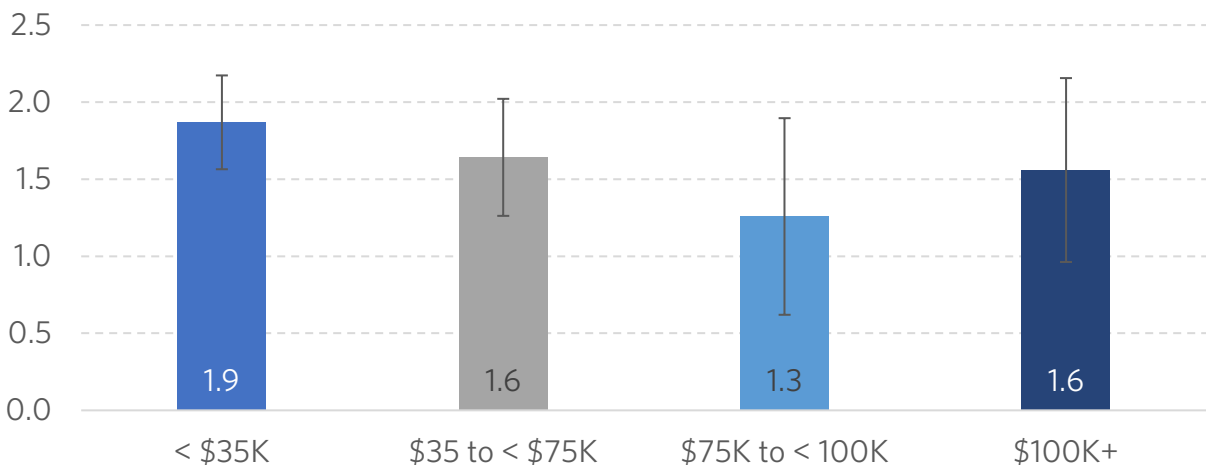
**Figure 7: Odds ratios of experiencing any barrier to care by income group**



*Notes for Figure 7:* The figure shows the predicted odds that an employee with an insurance plan element experienced any barrier to care, compared to an employee without that plan element. The brackets indicate the 95% CI around the log-odds. Brackets that overlap with the line at 1.0 indicate that the OR is not statistically significant. Brackets for an income group that overlap with the OR of another income group indicate that the OR for those groups are not statistically significant.

Figure 8 shows that for different income groups, on average, experiencing a cost-related barrier to care was associated with between 1.3 and 1.9 additional lost workdays compared to those experiencing no barriers to care. However, while the difference is statistically significant within each of the income groups, the associations between barriers and lost workdays were similar in magnitude across the different income groups. Put another way, barriers to care have the similar impact on lost workdays regardless of an employee's income.

**Figure 8: Additional lost workdays if any barrier to care, by income group**



*Notes for Figure 8:* The brackets indicate the 95% CI around the estimate of lost workdays. The overlaps between the brackets of each income group and the estimated lost workdays for the other groups indicate that the association between cost-related barriers to care and lost workdays was statistically similar across the income groups.

## Discussion

The results of this analysis are consistent with our hypothesis that for lower-income employees, having health insurance reduces barriers to care—which in turn reduces the number of days they miss from work due to illness. Given the limitations of the survey data used for this analysis, the findings do not include information on disability leaves or losses from impaired job performance (i.e., presenteeism). The findings therefore represent an underestimation of both lost productivity associated with barriers to care, and the business value of strategies to remove cost-related barriers to care.

Our findings are consistent with other studies showing that the uninsured have the hardest time paying medical bills,<sup>24</sup> and that access to care and cost are prevalent barriers to care in the lower-income workforce.<sup>25</sup> This implies that even though employers' compensation costs would increase from higher enrollments in their insurance plan, some of the costs of expanded benefits would be offset by improved productivity. This is especially true if an employee works as part of team or performs time-sensitive tasks—in which case losses from an absence may exceed the value of the absent worker's daily wages.<sup>26</sup>

The significant lost workday gap between enrollees in low- and high-deductible plans—along with the finding that uninsured employees have the fewest lost workdays on average—may be due to unmeasured factors that influence employees' access to (or preferences for) health insurance. The findings also suggest that while insurance is generally associated with reduced barriers and associated lost workdays, plans that reduce out-of-pocket expenses may produce greater productivity value.

While this analysis focused on deductible levels, FSAs, HSAs, and coverage for prescription medications, other workplace health and wellbeing benefits that increase access to care may similarly reduce illness-related lost workdays. Examples include resources to help employees find the lowest cost providers in their network or disease management programs to help chronically ill employees manage their conditions.

Lower-income workers face additional barriers to care that can be improved by policy and structural changes. Paid time off allows employees to seek care when necessary without incurring wage losses, which many cannot afford in addition to the cost of care.<sup>15,27</sup> In turn, allowing employees time off for doctor's appointments allows them to establish care with a primary care physician rather than turning to the emergency department when a health can no longer be ignored.<sup>28,29</sup> This further reduces health care expenditures and decreases wasteful and unnecessary spending.<sup>27,28</sup>

Importantly, this analysis found that the associations between insurance plan design, barriers to care, and lost workdays was not limited to lower-income employees, even though the burden to the lowest-income group may be greatest.<sup>24,30,31</sup> Even for employees with family incomes higher than \$100,000 per year, having insurance that limits out of pocket expenses was associated with fewer cost-related barriers to care and a reduction in lost workdays comparable to that observed for employees at lower incomes. Since absences among more highly paid employees represent greater productivity losses for employers, the reductions in barriers associated with lower deductibles, HSAs, and coverage for prescription medications may offset some of these benefit costs.

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## Guidance for Employers

Rising health care costs impact both insurance plan sponsors and patients. For this reason, employers will likely include some form of cost-sharing in their employee health benefits for the foreseeable future.

To help employers design benefits policies that balance the need to manage treatment costs against enrollees' access to cost-effective, timely and beneficial care, IBI sought input from experts at leading healthcare, benefits and absence management firms. A summary of their guidance follows.

In providing this guidance, we recognize that employers face practical limits on what they can accomplish on behalf of lower-income workers. Rather than a set of comprehensive, hard and fast rules, the suggestions are intended to generate discussions among internal stakeholders and external health and productivity partners. As always, employers are advised to design benefits that support their specific workforce and organizational goals and are consistent with their organizational culture.

### DEVELOP A DATA-DRIVEN VIEW OF UNMET NEEDS FOR CARE

Lower-income employees might have affordability issues in both participating in benefits or paying for care. Data in payroll, leave and healthcare systems<sup>6</sup> can help focus benefit strategies on the employees most at risk of barriers to care and illness-related lost work time.

- Use payroll records to assess how many employees fall into different wage or salary levels (i.e., the employee income distribution). Review the affordability of your health insurance premiums for employees at each wage/salary level and compare against the participation rates for eligible employees. Declining enrollment rates at lower wage bands may signal that employee contribution costs are placing insurance out of their reach.
- Analyze healthcare claims or survey data to understand the health risks of lower-income employees, their largest healthcare cost drivers, and how expanding access to preventive services could lower avoidable costs. Out-of-pocket costs can also serve as a baseline for the affordability of a plan to those employees who do not participate in health insurance—or those who may avoid seeking care due to costs.

### RECOGNIZE THE FULL FINANCIAL IMPACT OF COST-SHARING STRATEGIES

Savings from higher cost-sharing may in fact drive routine treatment expenses elsewhere, such as emergency room visits<sup>32-34</sup> and disability leaves. Strategies to improve the affordability of care for employees may increase expenses in the short-term, but ultimately lead to higher value for employers.

- Where possible, consider implementing employee premium contributions, co-pays and coinsurance on a sliding scale based on income.
- Determine feasible employee contributions to HSAs and FSAs to ensure that sufficient funds exist if a medical emergency occurs. Where necessary, consider making HSA contributions to cover the difference between employee contributions and deductible levels.

## LEVERAGE A SPECTRUM OF EMPLOYEE BENEFITS TO PROMOTE ACCESS TO CARE

Employee benefits that are designed to complement one another may help remove barriers related to the costs of care—but also barriers imposed by work schedules and other logistical challenges. Using a variety of resources can help ensure that employees have access to care when they need it—and provides a backstop if their need for care becomes critical.

- On-site clinics and telehealth services can bridge gaps in access to care—particularly for employees who live in areas with a shortage of primary care physicians or after-hours care options, or those who face transportation or scheduling difficulties.
- Allowing short intervals of paid time off during working hours or granting a half-day each year for an annual check-up can facilitate the scheduling of provider appointments when offices are generally open—potentially avoiding higher-cost, after hours care in emergency settings. Communicate with managers responsible for approving employee requests for time off to ensure that they understand the big-picture intent of the policies.
- Transportation supports such as shuttle services or reimbursements for public transit or rideshare costs to and from healthcare appointments may also remove care barriers for employees without private transportation options and reduce time away from work.
- In times of severe need, benefits such as short-term disability (STD), long-term disability (LTD), accidental injury, hospital, or critical illness insurance allow employees to access necessary medical care and recover from an episode of illness or injury without incurring severe financial hardships. Recognize, however, that lower-income workers often decline voluntary benefits. This means that communicating the value of income protection benefits in cases of injury or illness is critical.
- Financial wellness education and savings support can help employees with limited resources develop manageable budgets that include savings for health-related emergencies. Programs such as interest-free health care loans and reimbursements for certain non-medical health devices (such as air conditioners for employees or family members with asthma) could also ease the burden of costly conditions.

## PRIORITIZE PREVENTION, HEALTHY LIVING AND COST-EFFECTIVE CARE AS THE DEFAULT CHOICES

Encouraging employees to seek preventive care can minimize the needs for more expensive care and may decrease overall health care spending. Helping them understand their health risks and the availability of lifestyle and care management resources can support their efforts to engage in healthy behaviors.<sup>35-37</sup>

- Make every effort to ensure that employees and dependents understand which preventive services (such as vaccinations and screenings) are either free or low-cost under their plan.\*
- Periodic education on less costly care alternatives for obtaining care—for example, utilizing urgent care centers rather than the Emergency Department after hours, understanding which providers are in-network—can help employees make better care decisions.
- Free, annual onsite biometric screenings or confidential health risk assessments can give employees insights into their health risks. Continuous education on the long-term impact of unhealthy behaviors such as lack of sleep, poor diet, lack of exercise, smoking, and excessive alcohol consumption should

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\* At the same time, work with providers, insurers and third-party administrators to ensure that services are classified and coded appropriately for payment as preventive.

include a focus on how these impact families' out-of-pocket costs—and how following guidance to adopt healthier habits can save employees money.

- Worksite disease and care management programs offer a convenient way to provide information, care resources, and social support for employees with serious chronic conditions (such as diabetes).
- Lifestyle management programs focused on stress management, nutrition, and fitness can encourage healthier behaviors. These can be particularly effective for employees struggling with multiple chronic conditions, including mental and behavioral health issues. Subsidized gym memberships, on-site fitness facilities and healthy options in cafeterias can also help reinforce the importance of a healthy lifestyle.



## Appendix

### SUMMARY STATISTICS FOR LOWER-INCOME EMPLOYEE SAMPLE (N=51875)

		N	Weighted Proportion (%)	Confidence Interval
<b>Year</b>				
	2007	4,207	9.84%	(9.39, 10.29)
	2008	3,663	9.45%	(8.99, 9.91)
	2009	4,906	9.82%	(9.40, 10.24)
	2010	4,811	9.91%	(9.52, 10.30)
	2011	5,655	9.68%	(9.35, 10.02)
	2012	5,993	9.84%	(9.50, 10.19)
	2013	5,679	9.27%	(8.93, 9.60)
	2014	5,511	8.67%	(8.31, 9.03)
	2015	4,581	8.05%	(7.74, 8.36)
	2016	3,901	7.98%	(7.54, 8.43)
	2017	2,968	7.49%	(6.98, 8.00)
<b>Sex</b>				
	Men	23,114	49.00%	(48.4, 49.61)
	Women	28,761	51.00%	(50.39, 51.6)
<b>Age</b>				
	18-25	11,188	25.46%	(24.67, 26.24)
	26-34	13,211	24.68%	(24.14, 25.21)
	35-49	15,652	29.28%	(28.67, 29.90)
	50-64	11,824	20.58%	(20.06, 21.11)
<b>Health status</b>				
	Excellent	13,080	25.82%	(25.24, 26.40)
	Very Good	16,012	30.79%	(30.25, 31.32)
	Good	16,255	31.24%	(30.66, 31.82)
	Fair/Poor	6,508	12.15%	(11.76, 12.54)
<b>Occupation</b>				
	White collar	1,349	27.69%	(27.08, 28.31)
	Blue collar	36,704	72.31%	(71.69, 72.92)
<b>Race/Ethnicity</b>				
	Non-Hispanic White	23,434	50.50%	(49.46, 51.54)
	Non-Hispanic Black	10,828	18.77%	(18.02, 19.53)
	Hispanic	14,381	25.14%	(24.19, 26.08)
	Other	3,232	5.59%	(5.21, 5.98)

	N	Weighted Proportion (%)	Confidence Interval
<b>Insurance Coverage</b>	29,512	56.12%	(55.38, 56.86)
<b>Plan Design</b>			
HDHP	4,740	8.68%	(8.34, 9.03)
HSA with HDHP	10,50	21.79%	(20.18, 23.39)
FSA	2,261	4.22%	(3.97, 4.47)
Rx Coverage	15,282	28.65%	(28.00, 29.29)
<b>Paid Sick Leave</b>	16,418	30.10%	(29.55, 30.66)

#### FULL SAMPLE BY INCOME CATEGORY

	N	Weighted Proportion (%)	Confidence Interval
\$0 - \$34,999	51,875	23.98%	(23.5, 24.46)
\$35,000-\$74,999	53,929	32.61%	(32.2, 33.02)
\$75,000-\$99,999	20,572	14.43%	(14.14, 14.72)
\$100,000 and over	36,795	28.98%	(28.36, 29.6)

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