



Opportunity Costs and Opportunities Lost

*Businesses Speak Out About the
U.S. Health Care System*

Ten Case Studies of Company Health Care Programs

Meena Seshamani

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the U.S. Health Care System**

*Ten Case Studies of Company
Health Care Programs*

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Executive Summary

Businesses are the backbone of the U.S. health insurance system, providing health benefits to nearly 175 million Americans¹ as part of workers' total remuneration. Yet, ever-escalating health care costs are placing a huge strain on employment-based health insurance while leaving nearly 45 million other Americans without any health insurance whatsoever.

Many companies are at a loss over what to do about rising health care costs for their own employees. Companies also now recognize that America's legions of uninsured must rely on expensive emergency care for their health needs, which in turn indirectly drives up the cost of health insurance for all company-based benefit plans.

Surveys of chief executives' views on the state of the U.S. health care system and interviews of individual CEOs in the mainstream press drive home both points. Yet little specific case study work has been conducted on companies' actual decision-making about health benefits. Unlike broad-based surveys or anecdotal evidence culled from the press, illustrative case studies can dive deeper into the health care experiences of individual businesses and the reasons why they choose to provide different kinds of health insurance or none at all.

The 10 case studies that constitute the bulk of this report provide key insights into the challenges facing employer-based health insurance. Through extensive interviews, these case studies highlight companies' decisions about how (or whether) to offer employee health care packages, and their strategies for determining how (or whether) to provide health benefits amid rising costs over time.

This paper examines 10 different kinds of businesses, including two large multinational corporations, two medium-sized companies, and six small businesses. These 10 businesses, based in different parts of the country, are engaged in manufacturing, technology development, retail sales and services, education, staffing, and the media. They include a local grocery store and a gift shop, a global technology manufacturer and a worldwide retail store operator.

Our case studies are not based on a large or nationally representative sample of businesses, yet they do provide valuable information about the intricacies of company decision-making on health care. Most importantly, they reveal in detail the views of individual company executives concerning health insurance for their own employees, for their business rivals both here and abroad, and for the broad U.S. labor pool.

Our interviews with the executives directly responsible for making health care decisions for their companies have produced information that generally track national survey data. Executives in our case studies and in national surveys understand that:

- A healthy workforce can lead to increased productivity and efficiency.
- Rising health care costs seriously strain employer-provided health care.
- Providing employee health benefits may strain U.S. businesses' global competitiveness.
- Uninsured Americans are a hidden cost in their own health care plans.

Our case studies boast rich details on all of these points, which in turn allow for more in-depth examinations of the motivations, successes, and challenges of American businesses in the provision of health benefits to their employees. Before we present them, however, we must first set the stage with an overview of the current state of the U.S. health care insurance system and how U.S. companies in general are coping with an increasingly dysfunctional system. That broader

analysis begins on page 5; our individual case studies begin on page 12.

These 10 case studies tell a compelling story of the strain experienced by businesses under the current health care system, and offer possibilities for reform. Among the experiences that can be drawn from this survey are:

Substantial resources are invested by businesses in deciding on a health plan. Many small business owners pay an external broker, while larger businesses employ staff to specifically handle such decisions.

All businesses, regardless of size, are dealing with rising health care costs. Some businesses have decided to forgo offering health insurance to their employees, while others have increased cost-sharing with their employees. Larger businesses engage in utilization management programs to control their health care spending, but medium- and small-sized businesses that offer health insurance often lack the time, resources, or expertise to engage in such management programs.

Health care costs, along with the resources invested in making decisions on health plans, affect business as a whole. Employment decisions, product pricing, investment in research and development, and other employee benefits are now weighed against the impact of rising health care costs.

Employee education presents a challenge for employers. Employees often do not appreciate health care benefits as part of their overall compensation, and are not always proactive participants in health care decisions.

High health care costs and the rising number of uninsured are two major areas for potential health care reform. Many businesses link these two problems because they realize that the uninsured ultimately generate higher health care costs through their inefficient use of the U.S. health care system—costs that are passed on to the insured.

A partnership between business and government is essential. Sustainable health reform will necessitate the involvement of all players, including the government, employers, providers, health plans, and patients.

All of the executives at the 10 businesses interviewed in these case studies recognize that the current U.S. health insurance system needs to be fixed. While there is no obvious consensus on what shape the reforms should take, what is evident to all of them is the need for a partnership between business and government. All of the executives recognize that sustainable health care reform is critical to their businesses' productivity and competitiveness and will require the involvement of the government, employers, health insurance plans, health care providers, and patients.

Introduction

The Crisis in Employer-Sponsored Health Insurance

As major providers of health insurance for Americans, employers are facing head-on the cost pressures of rising health care expenses. How they have dealt with this strain depends on the structure of their employee health insurance benefits, current recruiting needs, employee demands, and cost trends specific to their region or industry.

Rising health care costs

The United States spent \$2 trillion, or about \$6,697 per person, on health care in 2005, the last year for which complete data is available.² At 16 percent of gross domestic product, health care expenditures in the United States rank far above that of other developed countries, where on average 10 percent of GDP is spent on health care.^{3,4} Health spending in the United States rose 6.9 percent in 2005⁵ and is projected to continue to rise at a similar rate for the next decade.⁶

Employers, through their private insurance benefits, bear a large portion of this cost (see sidebar, page 6, for a history of employer-based health insurance in the United States). Employers paid \$559.6 billion for health benefits in 2004, which accounted for 43.2 percent of total benefits, up from 38 percent of total benefits in 2000 and 36.3 percent in 1990.⁷ Total benefits include required payments, such as Medicare, Social Security, and workers' compensation, as well as voluntary benefits, such as retirement packages and health insurance plans, which employers can actually control.

Voluntary health benefits, which alone cost \$482 billion, represented an even larger proportion of voluntary benefits—57.4 percent in 2004, up from 52.1 percent in 1990.⁸ Health care premiums increased 11.2 percent in 2004, 9.2 percent in 2005, and 7.7 percent in 2006, more than three times the 2.7 percent growth in workers' wages over the same period.^{9,10} In short, health care benefits are absorbing a larger portion of benefit package costs and total worker compensation as health care premiums continue to rise.

How are employers dealing with the strain?

Economic theory posits that if health insurance premiums go up, they will be passed along to workers in the form of lower wages, thereby keeping the overall wage/benefit package constant and limiting the effect on business competitiveness and profits.^{11,12} Employers, however, may be unable to pass along the increased insurance costs to workers because of workers' dislike of a decrease in their nominal wages, or the constraints imposed by bargaining processes, regulations, and policies.¹³

Empirical studies are inconclusive on whether costs actually get transferred to workers in the form of lower wages.^{14,15,16,17,18} Current news abounds, however, with stories of employers shifting the burden of health care costs to their employees and retirees in the form of higher deductibles, higher co-payments, and larger premium contributions.^{19,20,21,22}

In fact, average general plan deductibles for single coverage in preferred provider organizations increased from \$187 in 2000 to \$473 in 2006.^{23,24} Employees contributed on average \$627 towards their premiums for individual coverage

and \$2,973 towards family coverage in 2006, increases of \$293 and \$1,354 since 2000, respectively, though the proportion of total premiums paid by employees has stayed relatively constant to those paid by employers during that time frame.²⁵

Unfortunately, several empirical studies confirm that as health plans become more expensive and as employees pay increasingly larger premium contributions, they are more likely to opt out of coverage.^{26,27,28} One study predicts that if employee premium contributions were reduced to zero, an additional 1.4 million workers nationally would take up coverage.²⁹

The History of Employer-based Health Insurance

The employer-based health insurance system in the United States largely evolved through a patchwork of government and employer responses to hiring regulations, changing employment practices, and changing health care cost and delivery trends over the past 70 years.

Demand for health insurance increased in the United States in the 1930s to 1940s as health care costs rose with the advent of new medical technologies, and as patient care was increasingly delivered in a hospital setting instead of in patients' homes. Blue Cross insurance plans for hospital fees and Blue Shield insurance plans for physician fees emerged during the 1930s, when tough economic conditions made increasingly costly medical care unaffordable.

World War II, however, was the pivotal time when the growing health insurance market transformed into an employer-based health benefits structure. Wage and price controls imposed during the war limited employers' ability to attract scarce labor, so increasingly companies turned to benefits, including health insurance plans, as a way to compete for workers.

Specifically, the 1942 Stabilization Act limited wage increases but allowed employers to provide health and retirement benefits. As unions developed more power in collective bargaining, these benefits became a prime target for their negotiations.

Several other policy changes aided their cause. In 1945, the War Labor Board deemed that employers could not modify or

drop insurance plans during the life of a contract. In 1949, the National Labor Relations Board and ultimately the Supreme Court ruled that the term "wages" included both monetary compensation and benefits.

With the rise of unions and manufacturing jobs came the rise in employer-based health insurance. In 1940, 10 percent of employees were covered in this fashion, but by 1950 the number had increased to 50 percent.¹

Health benefits are now a highly coveted part of remuneration from employers. In 2005, 71 percent of workers had employment-based coverage.² Contributions towards health care insurance are deducted from pre-taxed income to provide an additional incentive for employers to provide health benefits. In a survey of employees, 60 percent said employment-based health benefits were the most important benefit they received, followed by retirement savings plans at 23 percent.

Moreover, 77 percent of employees said that they strongly consider benefits when deciding whether or not to accept a job offer.³ Health benefits also comprise a key component of labor negotiations. The director of collective bargaining for the AFL-CIO stated that health care was the "number-one issue" in most bargaining,⁴ and an informal survey of 21 union leaders found that all 21 considered health care to be a central issue in their contract negotiations.⁵

Because company-paid premiums are still on the rise, employers are using other strategies to deal with rising health care costs. Some have encouraged their low-wage workers who are eligible for public insurance, such as Medicaid and the State Children's Health Insurance Program, to enroll in this coverage. Some large employers are self-insured, operating their own health insurance programs to reduce administrative costs, or they have initiated health wellness programs to decrease the risk of developing disease and reduce future costs.³⁰

Consumer-directed, high-deductible plans—often known as Health Savings Accounts—provide another way to shift health care costs to employees.³¹ Large corporations have also dropped coverage for retirees; 35 percent of them now provide retiree health benefits, compared to 66 percent in 1988.³²

More disconcerting is the elimination of health benefits for employees, particularly by small businesses. The percentage of employers offering health insurance fell to 61 percent in 2006 from 69 percent in 2000. This drop stems almost completely from the small-business sector: from 2000 to 2006, the percentage of companies with 200 or more workers offering health benefits only dropped one percentage point, to 98 percent from 99 percent, while the percentage of small businesses offering coverage dropped 9 percentage points, to 60 percent from 69 percent.^{33,34}

Employers are also tightening eligibility requirements, for example by increasing waiting periods and restricting coverage to full-time or permanent employees.³⁵

The rise in the number of uninsured Americans over this same period—44.8 million in 2005³⁶ from 38.7 million

in 2000³⁷—is largely a result of these changes in employer-sponsored coverage.^{38,39} A study by the Kaiser Family Foundation estimates that half of the four-percentage-point decline in employer-provided health coverage among employees over the last five years is due to loss of employer sponsorship; another quarter is due to employees opting out of plans, and 14 percent is due to loss of eligibility.⁴⁰

Looking forward, one economic study predicts that if real per capita medical costs continue to increase at a rate of one to three percentage points per year, the number of uninsured will increase in a range of 1.9 million to 6.3 million by 2010.⁴¹ (See sidebar, page 9, on uninsured workers and employer-based health insurance.)

The importance of a healthy workforce

Given all these facts, should employers make the provision of health care benefits a priority? Clearly, providing health benefits is a way for businesses to attract and retain workers. But perhaps more importantly, several studies show a link between health and workplace productivity, whereby poor employee health leads to absenteeism and “presenteeism,” or the time at work where an employee does not function fully.

An analysis of Commonwealth Fund survey data in 2003 found that 72 percent of employees reported sick days or days when they could not concentrate because of illness. Interestingly, workers without paid time off to see a physician were more likely to have days with reduced productivity.

Generalizing the survey findings to a national level, the study estimated 407 million missed days of work and another 478 million days of reduced productivity

Numerous studies examining the effect of health promotion programs on absenteeism and health care costs have found that health promotion programs are associated with decreased absenteeism and decreased health expenditures.

due to ill health in one year. Using workers' average hourly wage and assuming that reduced productivity days were at half productivity, the authors of the study estimated that absenteeism and presenteeism led to a \$75 billion loss in productivity nationally over one year.⁴²

Another survey, the American Productivity Audit, asked employees how many hours over the prior two weeks they missed work or had reduced performance for a health reason. Using self-reported wages, the study estimated that national lost productivity for personal and family health reasons totaled \$225.8 billion per year. Of this, 71 percent stemmed from reduced performance.⁴³ Several studies have similarly evaluated the impact of individual chronic diseases on workplace productivity (See Table 1, page 10).

Moreover, numerous studies examining the effect of health promotion programs on absenteeism and health care costs have found that health promotion programs are associated with decreased absenteeism and decreased health expenditures. A review of these studies found that for every dollar spent on wellness programs, between \$2 and \$10 were saved on absenteeism and health care costs.⁴⁴

The programs of greatest value were for depression, back pain, smoking cessation, and influenza vaccination.⁴⁵ More rigorous controlled studies over a longer time frame, however, are needed to definitively prove a causal link.

Still, improving workforce health can be financially beneficial for employers by improving productivity and reducing absenc-

es, and can be potentially useful in reducing subsequent medical costs and worker turnover.⁴⁶ Some economists even suggest that productivity gains from reduced absenteeism will be larger than what is represented by missed hourly wages.

The reason: companies often cannot find a perfect substitute for the workers who are on sick leave. This is particularly true for small firms, which cannot afford to maintain a "reserve pool" of workers to replace those who are absent.⁴⁷

Beyond improved workplace productivity, there is also an inherent value to society in extending the length and quality of life. Several studies have attempted to quantify this value of a statistical life in dollar terms by looking at the "willingness to pay" to reduce risk, for example by extrapolating consumers' purchasing decisions for smoke detectors.⁴⁸ Estimates of the value of a statistical life in the economics literature range from \$1 million to \$9 million, with a value for each year of life gained at approximately \$100,000.⁴⁹

Applying this economic value to the health output of improved longevity, studies have estimated that a dollar spent on health care will return between \$1.10 and \$4.80 in health benefits, depending on the time frame and type of intervention examined.^{50,51,52} The cost per year of life gained, however, has increased dramatically over the decades. In the 1970s, increasing the life expectancy of newborns by one year cost on average \$7,400, compared to \$36,300 in the 1990s. For people aged 65, the cost per year of life gained was \$46,800 in the 1970s and \$145,000 in the 1990s.⁵³

Uninsured Workers

A prominent concern about the employer-based health insurance system from a public policy perspective is the growing number of employees who cannot access this system. Approximately half of the uninsured workers in 2002 worked for employers that did not offer any health benefits as of 2002, the last year for which national survey data is available.¹

The lack of health insurance coverage for employees is particularly pronounced for small businesses that may not be able to afford health care coverage for their employees because they lack the large risk pool and negotiating leverage of larger companies. In 2006, only 48 percent of companies with three to nine workers offered health benefits, compared with 92 percent of companies with 50 to 199 workers and 98 percent of companies with 200 or more workers.²

Companies with a significant part-time workforce or low-wage workforce are also less likely to offer benefits.³ Unionization increases the likelihood of health benefits as does working in the public sector. The type of work employees are engaged in also affects the likelihood of receiving health benefits; manufacturing companies are the most likely to offer benefits, agriculture and construction companies the least likely to do so.⁴

The percentage of employer-provided health care also varies by geographical region, with parts of Arizona, California, Florida, New Jersey, New Mexico, New York, and Texas ranking lowest. These parts of the country also tend to be areas with higher unemployment rates, a higher proportion of employees working at small firms, larger concentrations of immigrants, and a higher proportion of employees working at smaller firms.⁵

Geographical areas with lower rates of employer coverage correlate with areas of high uninsured rates.⁶ Similarly, approximately half of the employees in firms with less than 25 employees had coverage from their own employers in 2005; another one-third were uninsured. And almost 30 percent of part-time workers and one-third of workers earning less than \$20,000 a year were uninsured in 2005, compared with less than 16 percent of full-time workers and 5 percent of workers earning \$75,000 or more.⁷

Employee insurance status is also affected by eligibility. In a 2002 survey, one-fifth of uninsured employees stated that they were employed by firms that offered health benefits but that they were not eligible for coverage. Of these, 44 percent were employed part-time, and another 42 percent had not completed a required waiting period of employment before being eligible for benefits,⁸ a restriction that is more frequent among lower wage workers.⁹

Even among employees with health insurance, coverage may not be adequate. One study estimated that almost 16 million people between the ages of 19 and 64 were under-insured in 2003, where under-insurance was defined as high medical cost exposure relative to income.* This led to a combined 35 percent of adults that were under-insured or uninsured.¹⁰

Aside from health insurance, there are other health-related benefits often provided by employers that the uninsured may not receive. Only 34 percent of uninsured employees get paid leave to see a physician and 29 percent get sick days, compared to 65 percent and 63 percent of insured employees respectively.¹¹

Lack of health insurance has been shown to have a dramatic impact on workers' access to health care and the quality of health care they receive. The uninsured are more than three times as likely to delay treatment for a serious illness than the insured, and twice as likely to skip medical treatment,¹² according to one recent study. Another report found that the under-insured are more than twice as likely to forgo medical care compared to the adequately insured.¹³

One-third of the uninsured were dissatisfied with the quality of care they received in 2003 and 41 percent were dissatisfied with their ability to get the latest medical treatments, compared to 11 percent and 15 percent of the insured, respectively.¹⁴ The uninsured tend to receive fewer preventive, diagnostic, and therapeutic services.¹⁵ Reduced access to needed health care and the lack of quality service translates into poorer health: studies report anywhere from a five percent to 20 percent reduction in mortality if the uninsured obtain insurance.¹⁶

* High medical cost exposure was defined as health plan deductibles accounting for 5 percent or more of income, medical expenses accounting for 10% or more of income, or medical expenses accounting for 5 percent or more of income for those below 200% of the federal poverty level.

How do employers make these decisions on health care provision?

How do businesses actually make their decisions on health care coverage? And what are the main challenges they experience as they try to provide coverage for their workers? Wide-ranging surveys provide some insight into this larger picture.

The recent Community Tracking Study, for example, conducted semi-structured interviews of medium-sized to large-sized employers that provide health benefits and found that maintaining competitiveness in labor markets and rising health care costs were their main challenges

with providing health insurance. Interestingly, the employers tailored benefits more based on employee preferences than cost control.⁵⁴

Similarly, a recent survey of small employers by the Employee Benefit Research Institute found that those that offer benefits do so because it helps with employee recruitment and retention, increases productivity, and is the “right thing to do.” Yet 25 percent of these small firms said they would change coverage and three percent said they would drop employee health coverage if health care costs rose by five percent. Employers who did not offer health benefits tended to have lower worker income and higher turnover.⁵⁵

TABLE 1: RECENT STUDIES ON THE IMPACT OF COMMON ILLNESSES ON WORKPLACE PRODUCTIVITY

DISEASE	STUDY	POPULATION	LOST PRODUCTIVITY	ASSOCIATED COST*
Allergy	Burton et al (2001) ¹	866 employees with or without allergies	10% loss in productivity when allergies are not treated.	\$65 per affected person per week
Arthritis	Burton et al (2006) ²	16,651 employees with or without arthritis	Physical work, time management, mental/ interpersonal activities, and overall output were significantly and negatively impacted by arthritis. Absenteeism was not measured.	\$1417 per affected person with arthritis per year
Depression	Stewart et al (2003) ³	28,902 employees in a national survey (American Productivity Audit)	People with depression had an additional 4.1 hours lost productive time per week, mostly from reduced performance.	\$35.0 billion per year nationally
Diabetes	Vijan et al (2004) ⁴	26 million people aged 51 to 61 (Health and Retirement Study)	People with diabetes had an additional 2.6 sick days per year, 3% were more likely to retire, 12% were more likely to not work. Presenteeism not measured.	\$10.6 billion lost income per year nationally
Gastroesophageal Reflux Disease	Wahlqvist et al (2006) ⁵	Systematic review	People with GERD had 6% to 42% loss in workplace productivity, mostly from presenteeism.	\$65 to \$449 per affected person per week
Ischemic Heart Disease	Guico-Pabia et al (2001) ⁶	380,625 people younger than 65 (National Health Interview Survey)	Workdays lost per IHD patient ranged from 6 to 26 depending on age and sex. Only 5% was from early mortality.	\$5449 per affected person per year
Influenza	Akazawa et al (2003) ⁷	7037 people aged 22 to 64 (Medical Expenditure Panel Survey)	People with influenza missed an average of 1.30 days from work in a year.	\$178 per affected person per year (1996)
Pain	Stewart et al (2003) ⁸	28,902 employees in a national survey (American Productivity Audit)	13% of those surveyed had on average a 4.6-hour loss in productive time per week from pain, including absenteeism and presenteeism.	\$69.4 billion per year nationally

* Cost in 2006 US Dollars, converted using Consumer Price Indices.

Another recent study, the National Survey on Small Businesses, found that cost was a large driver of health insurance decisions. Half of the companies that had switched health plans in the prior year stated cost as the reason. Seventy-two percent of companies that did not offer benefits cited high premiums as the reason, and 75 percent of firms that did not offer benefits said they would offer benefits if given a substantial tax credit.⁵⁶

A Robert Wood Johnson Foundation national survey of small-, medium-, and large-sized businesses found that health care cost increases are getting passed to employees in the form of increased

premium contributions and deductibles, and that 80 percent of businesses are concerned with the ability of employees to continue to afford those increases. The businesses surveyed also stated that the main problem in the future will be increased cost-shifting because of a larger uninsured population.⁵⁷

Small- and medium-sized businesses are addressing the challenge of rising health care costs by shopping around for lower-cost health insurance coverage, while larger businesses are limiting misuse of the health care system and lowering costs through wellness programs and employee financial incentives.⁵⁸

A recent survey of small employers by the Employee Benefit Research Institute found that those that offer benefits do so because it helps with employee recruitment and retention, increases productivity, and is the “right thing to do.”

The Case Studies

As the preceding review of the national data on health insurance coverage demonstrates, health care is clearly becoming more costly to businesses with employee-based health insurance programs. Yet, there are nuances related to the decision-making processes, the attitudes towards health benefits, and the impact of health benefits on other aspects of business that cannot be captured by such landscape surveys.

Several questions remain that individual case studies can illuminate. How does the offer of health benefits affect an employer's global competitiveness? What is the effect of devoting resources to managing health benefits on other aspects of business operations? What reforms do businesses see as necessary, and what role will businesses play in designing and implementing them?

Unlike broad-based surveys, illustrative case studies can dive deeper into the rationale and experience of an individual business to provide additional detail and insight into the challenges, implementation issues, and decision-making strategies when determining how (or whether) to provide health benefits. The value of a case study approach is to examine the intricacies of decision-making processes and attitudes, and enable businesses to share their experiences with their health benefits.

This paper examines 10 different kinds of businesses, including two large multinational corporations, two medium-sized operations and six small firms. These 10 businesses, based in different parts of the country, are engaged in manufacturing, technology development, retail sales and services, education, staffing, and the media. They include a local grocery store and a gift shop, a global technology manufacturer and a worldwide retail store operator.

Interview methodology

Data were gathered through structured interviews with four types of businesses:

1. Large corporations
2. Medium-sized businesses
3. Small businesses that provide health coverage for their employees
4. Small businesses that do not provide health coverage for their employees

The names of the companies and the executives in charge of making health benefit decisions at these companies have been kept confidential. Interviewees were provided with the opportunity to review a draft to check accuracy. The large businesses interviewed for this report were selected because of recent statements by their chief executives about the challenges of providing health benefits. The small- and medium-sized businesses were chosen for interview through contacts at various universities, congressional offices, and chambers of commerce.

The interviews were conducted based on a standard series of questions and were conducted over the phone. Data were collected in five main areas for the purposes of illustrating how these particular businesses have provided (or have not been able to provide) health benefits to their employees.

Profile of the company's health benefits

What is the general structure of their health benefits plan and how much do they spend on it? Do they employ wellness or disease-management programs? What aspects of their provision of health benefits or wellness programs have either achieved benefit goals or improved their business goals?

The decision-making process

How do they determine what services to provide? What resources are used for these decisions? Who makes the decision?

Challenges

What areas have they identified as challenging or in need of improvement? How have rising health care costs affected their ability to provide insurance? What changes have they made in response to these issues?

Broader Business Context

When allocating resources to health benefits, have other benefits been crowded out? How have health benefit costs affected the company's workforce policies for hiring, wages, and employee retention? Has the health benefits package affected pricing of their products or investment in research? Has their economic competitiveness been affected?

Broader health system context

What public policies are needed to improve the U.S. health care system and reduce companies' health care costs? What roles should employers and the federal government play in precipitating reform and operating within a reformed health care system?

To wrap up each interview, all of the businesses' executives were then asked to provide the single most important lesson that they have learned as providers of health benefits.

Large Businesses

Two large multinational businesses were interviewed. The first is a manufacturing and retailing company with a young workforce comprised of a sizable number of part-time employees. The second is a technology and manufacturing company with an older workforce comprised of both union and non-union employees and a retiree population that receives health benefits.

Both companies operate globally. Each has offices or branches internationally and engages in production and distribution across the globe. The two companies compete with rival global corporations in their respective product lines. (See Table 2, page 14)

Manufacturing/Retail Company

The decision-making process

Both national business norms and leadership principles underlie the health plan at this company, which prides itself on internal employee surveys that routinely rank the company’s health benefits as one of the top reasons why employees stay. The same health benefits and the same cost-sharing schedule are offered to anyone who works more than 20 hours per week, regardless of position.

The structure of the company’s health benefits plan is determined through national benchmarking, using well-known industry surveys and the company’s own research comparisons of broad industry, manufacturing, and retail competitors. Health benefits comprise the majority of the work of the director of benefits, though the company also utilizes an employee benefit consultant for strategic decision-making. The goal is to provide health benefits at an average level across industries—to be neither the richest plan nor the most restrictive plan.

The health plan in practice

The company is self-insured and pays 70 percent of employee and family coverage for anyone who works more than 20 hours per week. No retiree benefits are available. The company spent \$115 million on health care in 2005, the last year in which full data was available when our interviews were conducted. This \$115 million comprised 84 percent of employee benefits. The main drivers of health care costs, derived from claims data, are maternity, newborns, and musculoskeletal problems.

The company was approached two years ago by a local medical center comprised of a multi-specialty group practice, acute care hospital, and outpatient clinics, to see if there was an area in which they could all work together to improve the quality and cost of health care for the company’s employees. The company, the medical center, and the third party administrator for the health benefits plan decided to examine the management of musculoskeletal problems, and particu-

TABLE 2: PROFILES OF LARGE BUSINESSES INTERVIEWED

STATE	BUSINESS TYPE	PERSON INTERVIEWED	AVERAGE AGE	HEALTH PLAN DESCRIPTION	WELLNESS AND UTILIZATION MANAGEMENT PROGRAMS	\$ SPENT ON HEALTH CARE IN 2005	LESSON OFFERED
WA	Manufacturing/Retail	HR manager	20-55	Self-insured, pays 70% of employee and family coverage. No retiree benefits.	Programs for musculoskeletal problems and high-risk maternity; numerous wellness initiatives. Educational phone call to encourage efficient use of health system.	\$115 million; 84% of employee benefits	Health benefits key to employee loyalty and competitive business; Health system problems are complex and need all purchasers, providers, and health insurers involved in reform
NJ	Manufacturing/ Technology	VP of compensation and benefits; Director of health and insurance program	44	Primarily self-insured, pays 77% of employee and family premium. Pays approximately 80% of retiree premium (before 2000). Different plans for union workers.	Health resource program with employee health workshops, service that provides information on best practices and treatment options for acute and chronic illnesses.	\$448 million for employees and dependents, \$259 million for retirees; one-third of employee benefits.	The focus of health care reform should be on improving efficiency through information technology and disseminating best practice information.

larly lower back pain because it was one of the main drivers of health care costs.

Together, they developed a spine clinic where employees could receive a full workup and physical therapy in one visit. This program was found to reduce the time spent by the patient in the encounter stream, and also lessen associated anxiety and other mental health problems.

The company's next management initiative will focus on depression. The company chose depression because the health care management of this condition has not been well-studied, though depression has direct ties to numerous other medical conditions and symptoms. The company hopes that the proper identification and treatment of depression will have wide-ranging and long-lasting benefits for its employees.

In addition, the company has piloted various wellness programs, including one for nutrition and exercise, and one with WebMD to provide Internet-based health information to employees. The company believes these wellness programs are a key long-term solution to engaging their employees more directly in their own health maintenance.

Challenges

The rising cost of health care is the main challenge facing the company's benefits department. The department recently started a pilot project in which new enrollees receive a welcome phone call that educates them about their health benefits, appropriate use of the emergency room, availability of urgent care facilities, and the importance of establishing a primary care provider.

The benefits department recently hired a financial analyst to analyze their claims data for utilization and cost drivers, and identify areas for improvement. For example, the financial analyst is evaluating the effects of a high-risk maternity program provided by their third-party insurance administrator and has plans to examine regional variations in care provision. The ultimate goal is to have the data direct the company towards programs that can reduce waste, improve quality of care, and control costs.

Broader business context

The increasing cost of health care is never out of executives' minds when they assess the company's overall investments and expenditures. Health care comprises one part of overall operating costs, which in turn influences the company's investment decisions. Providing health benefits, however, has not changed the company's labor practices, in part because they are currently experiencing healthy revenue and profit growth.

Providing employer-based health care benefits is also important to the company's board of directors because of their views on corporate social responsibility. Board members believe it is in the interest of their company and society to provide good health benefits.

The company did not provide information on how the provision of health benefits may affect their competitiveness, research, or product pricing.

Broader health system context

The company's manager of public policy and government affairs identifies four broad principles in public policy that will affect the company's health care

decision-making: quality, access, technology, and lifetime solutions. The executive says the company does engage in healthy policy discussions in Washington, but adds that the company cannot rely on the government to supply the solution to these four issues.

Instead, the company does what it can on its own to improve the health care it provides to its employees, says the Director of Benefits, noting her participation in a regional health care alliance in which clinical improvement teams drawn from health care providers, purchasers, and health plans examine how to better manage a variety of health issues. The key to this work, adds the executive, is including all players in the health care arena in one forum.

The executive believes that the government needs to provide incentives for employers to provide and improve upon their health plans. Ultimately, the executive argues that it is the responsibility of employers and employees to be good users of the health care system.

Manufacturing/Technology Company

The decision-making process

This company views health care benefits as a way to attract and retain employees and to improve health status and workplace productivity. In determining benefits, the company uses a national database of 400 large companies, focusing on manufacturing, technology, and chemical industries, to benchmark its health benefits coverage, contributions, and per-capita costs. The company believes that health benefits are considered a business norm for large businesses, which is why the executives in charge of the health benefits program design them to enable

the company to compete for talent across all industries for certain skill sets.

The company's vice president of compensation and benefits and its director of the health and insurance program spend two to three months each year working intensely on their strategy, incorporating market trends, competitive practices, and internal data to determine the company's health plans. They also revisit and reevaluate their health benefits strategy year-round. They meet with the CEO several times a month in a "constant dialogue" to discuss how much they are going to provide in contributions, what health care initiatives they will pursue, and what will be the cost outlays and savings they expect.

The health plan in practice

The company is primarily self-insured (though union workers have different health benefits as specified in their contracts). The company pays approximately 75 percent of employee and dependent premiums for non-union employees, with contributions for unionized employees varying by contract. For those hired before 2000, the company also pays approximately 80 percent of retiree health premiums. These benefits are provided for anyone working more than 20 hours per week.

In 2005, the company spent \$448 million on all employee health benefits (including those for unionized workers), which amounted to approximately one-third of employee benefits, and another \$259 million on union and non-union retiree health benefits. The main drivers of health care costs, derived from claims data, are acute illnesses and the chronically sick, who together comprise approximately 70 percent of the company's overall spending on health care.

Providing employer-based health care benefits is also important to the company's board of directors because of their views on corporate social responsibility.

A main focus of the company's health initiatives revolves around patient education. Says the vice president of compensation and benefits: "If you want to turn health care consumers really into consumers, you really need to engage them in a different way, because quite frankly they don't act like consumers in health care." Generally, the executive says, employers communicate with their employees once a year about health care, which is "typically with bad news."

Instead, he continues, it is important to establish a dialogue and a relationship with employees about health care. To achieve this goal, in 1999 the company rolled out a health resources program. Under the program, an employee with a diagnosis may call into the service, where he or she is put in touch with a research team (headed by a physician) that provides information on best practices, treatment options, and quality information on providers. The team then works with the employee to customize questions for a better dialogue with his or her physician.

Initially, participation rates in the program were low. To remedy this, in 2004, the company used employee focus groups to develop a series of workshops to educate employees on the rising costs of health care, variations in care, best practices, and the importance of playing a proactive role in health care. By empowering their employees in this manner, the company increased participation in the health resources program by 160 percent in just one year, with high satisfaction ratings from employees.

In 2004 and 2005, 900 participants used the program, of which 28 percent went through a treatment considered to be best practice, 23 percent changed doctors or sought a second opinion, 17 percent

reported they eliminated or minimized side effects, and 9 percent discontinued unnecessary or questionable treatment. Several employees also reported avoiding unnecessary surgical procedures. Overall, the new program saved the company approximately \$1 million, with an estimated three-to-one return on costs.

Based on these results, the company has now developed a similar program focusing on eight procedures with significant treatment variations, including certain types of back surgery, heart surgery, and knee and hip replacements. If a physician recommends one of these procedures, the employee qualifies for the program and receives \$500 into a health reimbursement account for participating.

Through the program, participants can ascertain whether the recommended surgical procedure is appropriate, and identify desirable providers based on quality information. The company has enrolled 150 participants in this new program since March of 2006.

In addition, the company provides so-called *Health Grades*, a product that enables employees to compare providers, and access to a Mayo Clinic online program for lifestyle changes, including smoking cessation and weight loss. The next step the company plans to take is to measure disability and productivity, to establish a more robust return on investment model for these health programs.

Challenges

The company's executives see rising health care costs as a primary challenge. They believe that rising costs are the result of new technologies and new prescription drugs, but also of uncompensated care of the uninsured getting shifted to the insured. The rise in costs

"If you want to turn health care consumers really into consumers, you really need to engage them in a different way, because quite frankly they don't act like consumers in health care."

has led the company to eliminate retiree medical benefits to anyone hired in the year 2000 or later.

In addition, the company has increased the employee share of health insurance premiums. Compared to full coverage in the 1990s, the company now covers 80 percent of the cost of health benefits, with a cap on total contributions, after which the employee bears all health care costs. Company executives say they are concerned that they are reaching a “flinch point” where they may not be able to shift costs further.

To meet future challenges, the company executives cite several areas where new technologies or new government action could improve upon their efforts to offer quality health care at a reasonable cost. First, they see a need for electronic medical records to provide better patient information and eliminate errors. Second, they believe there must be a national system to measure provider quality.

“Here we are, trying to provide the best available information to our employees to get them more engaged to manage their own care, but there is not the transparency [available from] the providers from a quality perspective,” says the vice president of compensation and benefits. He notes that different health plans measure quality differently, preventing a common definition of quality and causing employers to “lose credibility” when encouraging best-practice guidelines.

Third, they argue that financial incentives need to be aligned such that health care services compete on price as well as quality. Ideally, employees would be more sensitive to the price of health care without footing most of the bill.

Broader business context

Health benefits at the company comprise the largest piece of employee benefits, and the costs of these benefits are trending upwards at the fastest rate. These rising costs ultimately are reflected in the company’s earnings per share, which is how the company communicates its performance targets with its shareholders.

“If we are communicating to Wall Street our targets to increase earnings per share, but we have [a health care cost] increase of 4 cents per share, we have to find a way to get at that,” explains the vice president of benefits. He says that cost-shifting has ameliorated the earnings-per-share hit the company takes for rising health care costs, but he remains concerned that the company will eventually have to look to other programs to cut costs.

Moreover, the executive notes that rising health care costs have weakened the company’s global competitiveness, in part because employers abroad do not pay for their employees’ health care. “We are a global company, and we have business all over the world,” the vice president explains. “But manufacturing is being done cheaper in other parts of the world, and labor costs and health care [are] a big part of that.”

The constraint of high health care costs on the ability to compete globally is not limited to a particular industry either, the executive adds. “It has an impact on every U.S. company that’s working globally today,” he notes.

Broader health system context

The company executives believe that employers should continue to provide health insurance, and that employers can play a larger role in engaging employees to become more educated health care con-

“Here we are, trying to provide the best available information to our employees to get them more engaged to manage their own care, but there is not the transparency available from the providers from a quality perspective.”

sumers. “We have a captive audience to encourage healthy lifestyles [and] manage their diseases,” says the vice president of benefits. “You can’t miss the chance to educate the consumer. By giving people information, they are using that information and making better decisions about their care.”

The executive acknowledges, however, that the incentives to provide such programs are greater for large employers that self-insure, and less for small- or medium-sized employers who may not have the resources to develop such programs, and are often part of a larger risk pool with other businesses (thereby diluting any of their efforts to lower their premiums).

The two executives interviewed for this case study are also directly involved in policy. One sits on a steering committee for national quality standards through the Centers for Medicare and Medicaid Services, and the other participates in a customer advisory board that works with major health plans to pursue quality measurement.

More broadly, the company executives also believe that the government should

continue to finance Medicare, Medicaid, and health insurance for federal employees, and should play a role in addressing the issue of the uninsured. The two executives, however, do not have particular suggestions in this regard.

What they do emphasize is the role government should play in establishing national standards for quality, best-practice guidelines, and improved information technology, including electronic medical records. Rather than mandating benefits or coverage, the government should be an “enabler and advocate to help people better navigate the health care system and monitor performance,” says the vice president of benefits.

Medium-Sized Businesses

Two businesses were interviewed: a public school board in Wisconsin with 250 full-time employees whose benefits are negotiated through a teachers’ union contract, and a city newspaper in New Mexico with 250 mostly full-time employees that has utilized urgent care facilities to try to reign in health care costs (See Table 3 below).

TABLE 3: PROFILES OF MEDIUM-SIZED BUSINESSES INTERVIEWED

STATE	BUSINESS TYPE	PERSON INTERVIEWED	# EMPLOYEES	# FULL-TIME	AVERAGE AGE	# HEALTH PLANS	HEALTH PLAN DESCRIPTION	WELLNESS AND UTILIZATION MANAGEMENT PROGRAMS	\$ SPENT ON HEALTH CARE IN 2005	LESSON OFFERED
NM	Newspaper	Human resources employee	250	217	Wide range	1	PPO, pays 70% of employee and 50% of dependent premium.	Encourage use of urgent care facilities	\$700,000 annually, 80% of benefits	Need for universal health care
WI	Public school board	School board member	250	250	20–55	1	FFS, pays 100% of employee and family coverage. Pay 100% of retirees from 55–65.	Walking and organized exercise programs	\$2.5 million of \$16 million budget	High health care costs; need for universal health care

PPO = Preferred Provider Organization
FFS = Fee-for-Service

Public School Board

The decision-making process

Health benefits are essentially considered a requirement in any contract with the state teacher's union, and health premiums are negotiated as part of overall compensation. The school board pays 100 percent of the premium for a health plan provided by a statewide association of professional educators. Insurance agents are used by the school board to get quotes of comparable plans, which aid in the negotiation of the health plan premium.

The health plan in practice

The health plan is a fee-for-service plan in which employee and family benefits are fully covered by the board. Retiree medical benefits are covered from ages 55 to 65, at which point retirees are eligible for Medicare. Overall, the health plan accounts for \$2.5 million of the school board's \$16 million annual budget (which is 65 percent state funding and 35 percent local property taxes).

The main driver of health care costs is routine primary care, with some major family expenses including cancer, heart disease, and accidents. The school board has instituted workplace wellness initiatives centered on increasing physical activity, which the board member interviewed for this study believes has reduced absenteeism. The board member added, however, that they do not collect any data to determine the effect on health care usage or cost, and do not plan to do so.

Challenges

The main challenge that the school board faces is increasing health care costs. Already health care comprises more than 15 percent of a total \$16 million budget, and that does not consider dental insurance or social security, which are also

included in the total budget. "The more that gets put in the fringes, the less you see in salary increases," the board member explains. "Most people don't realize that compensation includes both."

The problem will only get worse. The school board's business administrator did an extrapolation based on current health care cost increases to project that in 2017, family health coverage will cost \$60,000 per employee—higher than the average wage at that time. "We are now at the tipping point," the board member says. "There is no way for the school to afford that without some kind of major revision in health care costs."

Compounded with the issue of high costs is unfunded care for retirees. Currently, teachers retire at 55, but are covered by the school health plan until they turn 65 and are eligible for Medicare.

The school board, however, only started to set aside funds for these costs three years ago. The estimated cost for retiree health benefits is \$290,000 per employee from the time they turn 55 to the time they are covered by Medicare. Overall, this adds up to a \$10 million liability that is currently unfunded.

Broader business context

The school board tends to hire more recent graduates with less experience because these new hires are less expensive and will work longer before retiring. Currently the school board is grappling with changing school programs as well, such as raising student activity fees, extracurricular fees, fees for field trips, and reducing school lunch subsidies. In the future, the school board may leave a position open after a teacher retires, in part because of high health care costs.

Broader health system context

The school board member emphasizes the problem of the uninsured as a prime cause of the district's rising health care costs, citing inefficient use of health care services and cost-shifting to the insured. "I don't think as a society we can afford 50 million uninsured people driving up the cost of service providers and insurance [premiums]," he explains. What is the solution? "There needs to be a uniform, national, universal health care system in which everyone is covered."

The board member argues that employers need to be at the table, playing a role in financing and determining how all Americans get health coverage. He believes such a system would include employer-based insurance (possibly with a mandate that employers provide health benefits), and government insurance for the unemployed.

Newspaper

The decision-making process

Health benefits are a key component of employee recruitment at this newspaper, which purchases its health insurance plan through a broker who gets a two percent commission. Each year, between November and January, the broker provides the newspaper's human resources manager with information on different plans, including costs, coverage, and accessibility to a physician network, and provides recommendations. February is then spent on enrollment materials and employee education. In all, health benefits management comprise a third of the human resources manager's job.

The health plan in practice

The newspaper uses a Preferred Provider Organization, or PPO, with 70 percent

of employees' premiums and 50 percent of dependents' premiums covered by the paper. Altogether, health benefits cost \$700,000 a year and represent 80 percent of total spending on employee benefits.

The main driver of health care costs is prescription drugs, followed by maternity care. While employees have expressed interest in workplace wellness programs, the newspaper has not yet developed any, largely because of a current outlay of funds to build a new printing plant.

Challenges

The main challenge facing the newspaper is rising health care costs. This year the company is considering whether to scale premium contributions based on salary and raise deductibles to be able to keep the same plan, which the human resources manager says provides a good physician network. The employer contribution for family coverage is now \$1,000 per month.

"The biggest challenge of all is selling it to employees when their salary raises are not large enough to afford all of that," says the HR manager, referring to the company's plans to scale premium contributions based on salary and raise deductibles. The HR manager adds that the small size of the newspaper increases their vulnerability in a year of large claims, because risk is pooled among a smaller number of employees. Therefore, they aim to keep the same carrier for multiple years so that more than one year of claims history is used to price premiums, preventing swings.

To try to curb costs, the newspaper encourages employees to use urgent care facilities instead of the emergency room. They also educate the employees as to

"I don't think as a society we can afford 50 million uninsured people driving up the cost of service providers and insurance premiums."

“People have to have access to care. They just do.”

the costs of various services, including laboratory and imaging, and provide information on the lower-cost facilities. The HR manager, however, feels that many of the employees do not want to be educated. “They just want to be taken care of,” she observes.

Broader business context

The HR manager says that rising health care costs have not crowded out other benefits, led to changes in labor practices, crimped the newspaper’s economic competitiveness, or led directly to price adjustments on its advertising rates. The manager adds, however, that operating costs as a whole—of which health care is a part—does determine pricing rates. Broader health system context

The HR manager believes that provision of health care is a social obligation that should not be on the backs of the employers. “People have to have access to care,” the manager says. “They just do.”

Yet she is not sure that the country is ready for a national, universal plan because she believes it will involve rationing of care. In the meantime, she says, tax credits could encourage employers to provide benefits for employees, adding that large malpractice awards, unnecessary end-of-life care, and expensive pharmaceuticals are other areas where the government could “get serious” to curb rising health care costs. She says that better preventive care and disease management are essential to keeping the population healthy and reducing costs.

Small Businesses

Four small businesses that offer health insurance and two small businesses that do not offer insurance were interviewed.

The industries in which these businesses are engaged include retail grocery and clothing, staffing and media consulting, and software development. These six businesses have been in operation anywhere from one to nearly 40 years, and are from different geographic regions of the U.S. The six companies also vary in the composition of full-time and part-time workers, from all full-time to nearly all part-time (See Table 4, page 23).

Among the four businesses that offer health benefits, health care costs range from one percent to 20 percent of operating costs. The two businesses that do not offer health benefits to their employees cite their operating costs as one reason for not doing so. The results of these interviews were compiled and are discussed below in aggregate in order to compare and contrast the decisions made about health benefits by these six small employers.

The decision-making process

All of the small businesses that offer benefits, except one, state that they do so to recruit employees. The owner of a media agency in North Carolina says that the first question she gets from a job applicant is whether there are health benefits. The owner of a gift shop in Wisconsin adds that she feels personally responsible for her employees. “Employees deserve benefits,” she explains. “You shouldn’t be in business for yourself if you can’t provide benefits for your employees. It is our responsibility.”

Yet employees do not always seek health benefits from these small businesses, notes the owner of an ethnic grocery store in Maryland. He says that initially he offered health benefits in an effort to care for his employees, but now approximately

30 percent of his employees opt out of health insurance for increased wages.

“The majority of the older workers we have don’t leave because they realize they may get sick, and they want the health care,” he explains. “The younger people, from my perspective, don’t think about tomorrow at all. They want money now. They don’t contribute to their retirement plan, and they opt out of health insurance. I perceive a change in mentality.”

All of the small businesses interviewed that do offer health insurance use insurance brokers to determine what kind of plan to provide. Reevaluation of plans occurs every year to every two or three years. The insurance brokers research and present data on insurance plans to

these businesses for a commission, ranging from three percent to five percent.

These small business owners say they must focus on health benefits several days a year to make decisions on insurance plans. The ethnic grocery store and media agency employ someone in personnel, either full-time or part-time, to interact with the health insurance broker and handle much of the decision making around health plans. This personnel employee is considered essential, as the owners of these companies believe they do not have the time or resources to deal with the intricate details of health plans themselves.

The two small businesses that do not offer health insurance—a software business in Oregon and a clothing store in

TABLE 4: PROFILES OF SMALL BUSINESSES INTERVIEWED

STATE	BUSINESS TYPE	# YEARS IN BUSINESS	# EMPLOYEES	# FULL-TIME	% MINORITY	AVERAGE AGE	# HEALTH PLANS	HEALTH PLAN DESCRIPTION	\$ SPENT ON HEALTH CARE IN 2005	LESSON OFFERED
MD	Ethnic grocery stores	42	64	55	99%	50% under 35	4	HMO, PPO. Pays 50% of employee coverage, no family, no retirees, no part-time.	\$151K, 1.6% of sales.	No political will to make changes.
NC	Clothing store	5	8	1 (owner)	15%	45-55	0	Individual plan for owner, FFS, \$5000 deductible, no preventive care.	\$6000, 5% of operating costs.	Health system is broken so people must fend for themselves.
NC	Media agency	20	10	10	10%	39	1	POS. pays 100% for employees, no families or retirees.	\$48,000, 15-20% of total operating costs, 60% of paid employee benefits.	Need to get all employers to provide some sort of health care.
NM	Staffing	30	23	22	35%	45	1	PPO, pays 82% of single coverage, 70% of family, no retirees, no part-time.	\$102K, approx half of benefits and 6% of operating costs.	Need for universal health care.
OR	Software	1	4	3	0%	29	0	NA	NA	The government can provide equal coverage less expensively.
WI	Gift shop	37	11	3	0%	20-30	1	HMO, pays 100% of single coverage, no family or retirees.	\$14,000, 1% of operating costs. The only employee benefit.	Employers must provide health insurance no matter what.

HMO = Health Maintenance Organization; PPO = Preferred Provider Organization; FFS = Fee-for-Service

North Carolina—cite just these types of management headaches as one reason why they do not offer coverage to their employees. “What I find really difficult about the whole health care insurance setup is that it’s really opaque, really difficult to get ‘apples-for-apples’ type comparisons or a really good sense of how covered am I,” explains the owner of the software business.

Small business owners all cite cost and affordability as primary considerations when deciding health benefits. When asked how he determines what health benefits to provide, the ethnic grocery store owner simply answers, “The most we can afford.”

The owner of the media agency adds: “We work with a broker that we have worked with for many years. On the first of the year we ask for an analysis on our plan and what the renewal would be and compare it to comparable plans, to determine what we can do to keep the rate as close to the prior year as possible.”

Cost is also a main factor for the two small business owners who do not offer benefits. The clothing store owner says that she chose to offer her employees higher wages instead, which she believes she can offer more consistently every week rather than try to figure out how to provide health benefits. “I didn’t want to take away their wages to pay for health benefits,” she says. “I couldn’t figure out how it would cost less than \$300 to 500 per month.”

The software business owner describes how the high cost of providing health insurance led him to ask his employees how much they actually wanted health coverage. “If we got to a level where that sort of cost was totally insignificant, we

could just throw it in and say, it doesn’t matter if you want it or not, we’ll pay it for you,” the owner explains. “But at the small business level, that money goes towards employees’ compensation, and they’re the best judge of how [the money] should be spent.”

The four small business owners who offer insurance differ on whether they look to their competition when making health plan decisions. The owner of a staffing agency in New Mexico explains: “Providing health benefits is a local business norm. We try to stay competitive with other businesses in town. If business is good, we tend to pay more, and if business is bad we tend to pay less. But we try to keep the level that we pay high enough so that people don’t drop coverage.”

The three other small business owners, however, say that they are in the minority of small businesses within their communities in North Carolina, Maryland, and Wisconsin who offer insurance. Consequently, they look more at their own finances (their overall operating costs and revenues) when making their decisions on what level of health benefits they can provide.

The software business owner who does not offer insurance says his decision is in fact based on the demands of his employees in Oregon. “I gave our employees an option of having insurance,” says the owner. “[One employee] already had insurance through her husband, and another wanted the extra paycheck and said she could sort out her own insurance.” The clothing store owner explains, “[Retail] is a business where people don’t expect to have benefits.” All of her employees except for one have coverage through a family member.

“What I find really difficult about the whole health care insurance setup is that it’s really opaque, really difficult to get ‘apples-for-apples’ type comparisons or a really good sense of how covered am I.”

Yet both of the business owners without health benefit programs for their employees expressed a desire to offer health coverage when they are more established and generate more revenue. The clothing store in North Carolina has been in operation for five years; the software business only one. If offered an affordable insurance product, both of these business owners say they would offer health benefits.

The health plans in practice

With one exception, the small businesses that offer health plans provide only one option, which is a managed care plan. The ethnic grocery store provides four plans through HMOs and PPOs. Among the four businesses, health benefits comprise approximately one to 20 percent of operating costs, and more than half of employee benefits.

These wide ranges are due to variations in the number of employees who use the health insurance, variations in the other operating costs of these businesses, and variations in other employee benefits provided. Yet there were no noticeable differences among the small businesses in terms of drivers of health care cost. All four employers cite routine care, such as prescription drugs, maternity, and family planning, and some catastrophic illnesses, such as cancer, heart attacks, and accidents, as major sources of health care costs.

No small businesses among those interviewed provide workplace wellness programs, with the exception of a flu vaccine program at the media agency. The most common reason given was that young, healthy employees often lack interest in wellness programs. The business owners also add that they do not have the resources to put programs in place for such a small number of people.

Challenges

The four small businesses that offer health insurance to their employees state that the main challenge regarding health benefits is increasing health care costs. All four say that employee cost-sharing has increased over time due to rising premiums; two of the four businesses state that health care coverage has decreased. As the owner of the staffing agency explains: “For small businesses it’s harder. The premiums are higher. It’s harder to get guaranteed coverage. You really don’t necessarily have a lot of [insurance] companies chasing after your business.”

The ethnic grocery store owner adds: “We used to provide 100 percent coverage for employee and family, but we now provide 50 percent employee and no family coverage. We have been reducing what we can cover because the costs are way out of proportion to what we make. We are working backwards.”

The owner of the media agency—who still pays 100 percent of employee premiums—predicts that “it really will reach a point where it is not affordable for us as a company to be able to pay 100 percent. We struggle with that every year. My CPA tells me that I shouldn’t be doing it, but it’s just something that I feel that I should be doing for my employees.” What has changed instead in her company’s health benefit plan is an increase in the deductible and exclusion of dental and eye care.

The owner of the other company that pays 100 percent of her employees’ premiums, the gift shop, faces a different challenge. Next year only one of her employees will need health care coverage, making her business ineligible for group insurance.

When asked how she will provide health benefits, she replies, “My insurance bro-

“Providing health benefits is a local business norm. We try to stay competitive with other businesses in town.”

ker will help me figure it out, because he does get paid for solving these problems.” She says that not providing coverage is not an option for her because providing health benefits is a central part of the way she wants to run her business.

Broader business context

While the small business owners could not quantify the exact strain on their profit margins from the cost of providing health benefits, all of them state that increases in health care costs, which they say range up to 14 percent a year, do strain their balance sheets. “If your monthly expenses increase but your revenue doesn’t increase,” explains the owner of the media agency. “Of course it impacts your bottom line.”

To cope with rising health care costs, two of the four business owners—the staffing agency and ethnic grocery store—have tried to charge more for their products. These two owners, however, feel that local competition limits the extent to which prices can be raised. “Some of our competitors don’t provide health insurance, so we have a five to six percent operating cost disadvantage,” explains the owner of the staffing agency.

The three businesses that offer additional employee benefits such as profit-sharing plans and 401(k) retirement contributions—the ethnic grocery store, media agency, and staffing agency—state that the amount of money going into these other benefits has decreased as a result of this financial strain. They add, however, that they cannot quantify the direct relationship of these cuts in other benefits to rising health care costs because other factors, including swings in revenue, come into play.

The owners of the ethnic grocery store, media agency, and staffing agency also feel they have not changed their hiring practices because of rising health care costs, while the owner of the gift shop says that she is more reluctant to hire part-time workers that do not otherwise have health benefits.

Broader health system context

All six small business owners interviewed believe that a main priority of health reform should be providing benefits to the uninsured. They all noted the “vicious cycle” of rising numbers of uninsured and rising health care costs.

“If everybody had insurance and were being taken care of, then medical costs will drop,” says the owner of the media agency. The uninsured, she says, “don’t go to the doctor until they are terribly sick and it costs a lot more to take care of them.”

Moreover, all six small business owners recognize that the cost of treating the uninsured results in higher premiums for the insured. Says the owner of the staffing agency: “Hospitals are taking care of the uninsured and have to raise what they charge the insured. This is what I am told every time I go to buy insurance.”

“It is less about public policy and more about social justice,” explains the clothing store owner. “I would not say that I am in the lower part of the pyramid in terms of economic power, but I have very little power over my health. People lower in the pyramid than me don’t have the ability to look into alternatives for very expensive health care or insurance, and we are living in a culture that promotes disregard for the people who are less well-off than you are.”

“The uninsured don’t go to the doctor until they are terribly sick and it costs a lot more to take care of them.”

The six small business owners differed, however, when asked how to provide coverage for uninsured Americans. Three owners—the ethnic grocery store, media agency, and software business—feel that employers should take responsibility for providing health benefits. But they believe they should get help to do so through new incentives, such as small business tax credits or through government efforts to simplify the health insurance plan selection process.

These three business owners also believe that the government could provide health benefits for the unemployed, or provide catastrophic insurance of last resort for those who reach the lifetime cap on their insurance policies. In addition, the operators of the ethnic grocery store and software business see an employer mandate—a requirement that all employers provide health coverage—as a possible solution.

“Right now, some of us by conscience or desire want to provide health insurance for people,” explains the ethnic grocery store owner. “Since it is not an obligation, a lot of people are making more profit and not providing [coverage]. The excuse I hear from insurance companies is that people are not insured, [thus] raising costs to us. If everybody had to pay, we would all benefit.”

The software business owner suggests that the government develop a required framework for universal, basic coverage. Employers and employees could then decide if they want additional benefits at additional cost.

Yet the remaining three small business owners—the clothing store, staffing agency, and gift shop—feel that the employment-based insurance structure

is not a logical solution. They cite the increasing numbers of independent and small businesses that can’t afford to offer benefits, and early retirees who don’t have a source of coverage until they are 65 years old.

Instead, they feel a government-based health insurance plan may be more appropriate. “As a small business person,” explains the clothing store owner, “it is out of the realm of possibility for me to do much to take care of the big picture of my employees’ health. I think that it is the responsibility of the community or the government to set up the system.”

Adds the staffing agency owner: “In today’s world, I’m not sure it makes sense to have health care connected to employment. There are so many independent contractors, small businesses, and early retirees, [that] there are a lot of people that are not connected to a company anymore.”

Four of the six businesses interviewed felt that while health care reform is often discussed, meaningful health care solutions will not emerge soon from the government. “I think the system is so broken, it’s going to take someone to jump up and down on the land politically, and I don’t think anyone is going to do it,” says the ethnic grocery store owner. The clothing store owner adds, “We are not on a course where I think it will happen. The voice of the people who need it to happen are disenfranchised.”

The software business owner is even more explicit. “We need to radically overhaul the entire thing, we can’t go for piecemeal changes anymore,” he says. “I think [health care] will continue to be a large part of the national debate, but I don’t see a solution emerging in the next 10 years.”

“We need to radically overhaul the entire thing, we can’t go for piecemeal changes anymore,”

Discussion

The businesses interviewed for this paper do not constitute a nationally representative sample, yet together they tell a compelling story of the strains felt by an increasingly expensive and disjointed health care system. Businesses are increasingly shifting costs to employees in the form of larger employee premium contributions, larger co-payments, and larger deductibles, or decreasing coverage for dependents and retirees.

Larger businesses engage in wellness programs to reduce costs, and even utilization management programs based on claims data analysis in the attempt to reduce waste and improve efficiency. Most of the small- and medium-sized businesses, however, are unable to offer these types of programs to help reduce costs.

Health care costs can also affect business as a whole. Some businesses surveyed in this paper speak in global terms, while others can pinpoint particular programs that are affected, including profit-sharing and pension plans, which receive less money when rising health care costs cut into profits. Two of the businesses describe potential changes in employment patterns, where they look to hire younger employees, or employees who have other avenues for health insurance. The pricing of companies' products can be affected, too.

The overall effect on these companies' local market competitiveness is mixed, depending in part on whether these businesses think that their competition provides health benefits. Yet underlying the pressures felt by these businesses is the belief among all but the smallest employers interviewed that they must provide some kind of health insurance to remain competitive. The reason: employ-

ee recruitment is a primary motivation for offering health benefits, in spite of the substantial resources invested in deciding on a health plan and the complexity of the health insurance market.

To provide insurance, small businesses use insurance brokers while the larger businesses employ a staff member who handles such decisions. In both cases, health care comprises a substantial portion of the job of a benefits manager. Some large businesses also hire external consultants and data analysts to examine strategy and make plan choices.

Surprisingly, employee education presents a primary challenge for employers. Several businesses, large and small, comment that employees do not necessarily appreciate the high cost of their benefits as a portion of their overall compensation package. Moreover, there is a pervasive lack of participation among employees in their own health care decisions, making it difficult to engage them in cost and quality comparisons to ultimately improve care.

What reforms are needed? These ten businesses identify two problems: the uninsured and rising health care costs. While the two are related, the large businesses seem to focus on improving efficiency and reducing costs, while small businesses focus on decreasing the number of the uninsured.

Not surprisingly, there was no consensus on the role of employers versus the government in solving these issues. Some believe that employers should have the responsibility to provide health benefits for employees and, in the case of large businesses, to employ utilization management programs to rein in costs. They express a distrust of the government as being able to provide efficient, high qual-

ity care. Others, particularly some small businesses, believe that the role of providing health benefits should be relegated to the government.

These businesses present several ideas for business and government to work together. While employers may retain the responsibility of choosing and purchasing health plans for their employees, actions that the government may take to enable improved coverage include simplifying the health insurance market, providing tax credits for small busi-

nesses to cover their employees, creating government mandates for employers to cover their employees, and providing health insurance for the unemployed or under-employed.

Another avenue that some of these businesses suggested for the government to take to improve health care coverage is to increase efficiency and quality of care, through best practice guidelines, uniform quality measures, and standardized health information technology.

Conclusion

What reforms should be made?

Several surveys have asked Americans what reforms could help in the face of the stresses on our nation's health care system. One survey found that Americans are most concerned about affordability; 55 percent of respondents said that "slowing the rising costs of medical care" should be a priority in Congress, compared with 38 percent who selected "improved access to health insurance," and 25 percent who selected "structuring Medicare payments to reward quality."⁵⁹ Another survey found that 85 percent of employees believe that there should be some sort of mandate for employers to provide health benefits.⁶⁰

Only two employer surveys, however, have examined employer views on health care reforms; both examined reforms to decrease the number of the uninsured. A Robert Wood Johnson Foundation survey asked businesses to rank reforms from a list they provided, based on whether the reforms would help to increase the number of Americans with health care coverage "a lot, some, not too much, or not at all."

The businesses most frequently ranked group insurance purchasing for small businesses and tax incentives for small businesses as reforms that would help "a lot" (53 percent and 41 percent, respectively). These rankings, however, were also influenced by employer size. While more than half of small businesses felt these reforms would help "a lot," just over one-third of large businesses thought so.⁶¹

Another national survey of small businesses found that 89 percent favored small business tax credits for health care purchasing, 75 percent favored tax deductions and/or financial assistance for individuals to purchase health insurance on their own, and 67 percent favored expanding government programs for low-income people.⁶²

This paper examines the health care crisis in this country from the direct perspective of ten businesses. All of the businesses interviewed, large and small, feel the strain of rising health care costs. The eight companies that provide health benefits to their employees invest money and time in the selection and provision of insurance plans—resources that are not available for other business activities.

Many of these businesses, particularly the small businesses, have decreased coverage to their employees over time or have had other benefits such as profit-sharing plans squeezed. Larger businesses have turned to disease management and other utilization management programs to try to make the system more efficient, but small businesses are often unable to take matters into their own hands. Most of the ten businesses also recognize that employees need to become more active participants, to attain efficient, high quality health care.

All employers interviewed in these case studies recognize that the system needs to be fixed. While there is no obvious consensus on what shape those reforms should take, what is evident is that a partnership between business and government is essential. Almost all of the businesses interviewed for this paper believe that sustainable health reform will necessitate the involvement of all players, including the government, employers, providers, health plans, and patients.

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ENDNOTES—Table One: Recent Studies on the Impact of Common Illnesses on Workplace Productivity

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