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Cover Page Footnote

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Employee Health Benefits: Corporate Strategies for Cost Containment

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ABSTRACT

With health care costs increasing and a major portion of employee benefits attributable to health care, employers have turned their attention to a range of strategies for controlling costs. A typology of the employer role in employee health care is presented which suggests that cost containment strategies may bring increasing influence by the employer in the health care decisions of employees. Four roles for employers have been identified: (1) the Enabler, providing traditional health benefits, with increasing use of deductibles and copayments; (2) the Advocate, providing benefit and alternative delivery options (e.g., HMOs) with incentives for less costly choices; (3) the Mediator, providing programs which intervene in health care utilization decisions (e.g., second surgical opinions); and (4) the Provider, providing direct services at the workplace (e.g., screening and health promotion programs). Implications for employers, employees, and the health care system are raised.

Background

Employer payment for health insurance coverage is part of a trend underway since World War II toward fringe benefits. Historically, the provision of fringe benefits for employees was based on the premise that the employer had some social responsibility for the needs of workers outside the workplace, as well

as an obligation to adequately compensate them for services performed (Allen, 1969). With good paying jobs and economic prosperity, workers accepted non-wage benefits in lieu of higher salaries; unions bargained for these benefits; and employers viewed fringe benefits as a way of reducing wages while increasing productivity through the presumed effects of such benefits on workers. While the provision of specific benefits can vary, most employees today are given paid time off—vacations and holidays—and are covered by life and health insurance (U.S. Department of Labor, 1989).

The extent of health insurance coverage is seen in census data for 1987 which show that 71 percent of the insured population, 147 million persons, were covered by employee health care plans (Health Insurance Association of America, 1989). Despite an increase in the number of uninsured workers and a corresponding decrease in the number of persons with employment-related group health coverage since 1977 (Wilensky, et al., 1984), there is typically complete insurance for hospital care for most employees and their families. This evidence is confirmed by the Bureau of Labor Statistics annual national survey of firms with at least fifty employees in eight major industry categories; results indicate that 98 percent of employees with health care benefits were covered for hospital and medical expenses, x-ray and laboratory services, and mental health care (U.S. Department of Labor, 1989).

At the same time that health insurance has become a major fringe benefit, the costs of health care have risen dramatically. Total health care spending was more than \$500 billion in 1987, over 11 percent of GNP (Health Insurance Association of America, 1989). Employers are paying a larger proportion of employee benefits for health insurance coverage. A recent survey of over 1,600 employers indicated that average total medical costs per employee have risen from \$1,600 in 1984 to more than \$2,300 in 1988; 28 percent of the companies reported per employee costs of \$3,000 or more (Foster Higgins, 1988b). These costs comprise 9 percent of payroll, according to a U.S. Chamber of Commerce survey (Geisel, 1989).

Employer Responses

Coming to terms with these increasingly large expenditures, employers in business and industry have joined in organized attempts to contain health care costs and influence health policy and health services delivery. Since the early 1970s, the Health Task Force of the Business Roundtable has focused on issues related to health benefits coverage and design, and recommendations have been made for employers to control health care costs (The Business Roundtable, 1985). Meetings convened by the Center for Industry and Health Care of the Boston University Health Policy Institute and coalitions such as the New York

Business Group on Health, among others, have considered ways employers can help to improve the delivery of health care services while holding down costs. Private sector initiatives in health care have been the focus of several studies (cf. Friedland and Watt, 1983; Bergthold, 1988).

Coalitions of business and industry, formed to focus on health costs, benefits, and delivery issues (Goldbeck, 1984). Over 200 coalitions are estimated to be functioning (McLaughlin, et al., 1989) although only 125 responded to a recent coalition survey (Dunlop Group of Six, 1990). While most have undertaken cost management strategies, their structure and objectives may vary. McLaughlin, et al. (1989) propose two life-cycle models: a temporary employer-only coalition oriented to collective purchasing power, and a process-oriented broad-based coalition focused on education and working with other sectors (e.g., insurers, providers) to make the system more efficient.

It has been argued that business leaders participated in these various organizations with the "expressed purpose of restructuring the health delivery system" (Leyerle, 1984). Their motivation includes increasing health care costs, the importance of health care as a fringe benefit, increasing liability for health and illness of employees under Federal legislation, and the need to collect and maintain employee health care data for planning health care programs and policies.

Another way employers have promoted change in the health care system is by influencing state health policy. A 1983-84 study (Bergthold, 1986) found that government and business partnerships designed to control health care costs occurred more frequently in states with high business activity. Most often, there was a statewide commission for cost containment (although not necessarily rate-setting programs), as well as more HMO and PPO development. Within companies, changes in health policies and programs have been influenced most by the chief executive officer, according to more than one-fourth of those surveyed in a study of Fortune 500 companies (Herzlinger and Schwartz, 1985). Yet, findings from an earlier study of sixty-nine large corporations indicated less concern with health care benefits and costs (Sapolsky, et al., 1981), contradicting much of the literature and suggesting that widespread interest among top management may be more recent.

Today, it appears that much of the employers' concern about health care costs is being focused on cost containment strategies in the workplace; these activities include restructuring health benefits and establishing programs intended to control utilization of health services. This paper addresses the complex and varied strategies employers are using in their efforts to control health care expenditures and to structure employee incentives to bring about savings. A typology of the employer's role is proposed to describe the range of cost containment strate-

gies and the extent of employer involvement in the health and medical care of employees.

Typology of Employers' Involvement in Employees' Health Care

The typology consists of four roles: enabler, advocate, mediator, and provider. This perspective suggests a continuum of increasing employer concern with both the delivery of health services for employees and the health of those employees in ways that may exert increasing influence on employee health care decisions (Barr, 1987). The roles are not mutually exclusive, and any particular employer might be described by more than one role at the same or different times.

Table 1
Typology of Employer Involvement in Employee
Health Care through Cost Containment Strategies

| EMPLOYER ROLE TYPE | EMPLOYEE HEALTH BENEFITS AND PROGRAMS | EMPLOYER CONTROL OVER UTILIZATION |
|-----------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| ENABLER | <ul style="list-style-type: none"> • health insurance coverage for hospitalization and medical services • copayment and deductibles | <ul style="list-style-type: none"> • traditionally, minimal • recently, indirect |
| ADVOCATE | <ul style="list-style-type: none"> • HMO options • PPO arrangements | <ul style="list-style-type: none"> • advise on selection • select those providers expected to control costs and utilization |
| MEDIATOR | <ul style="list-style-type: none"> • managed care programs: second surgical opinion preadmission testing length of stay review case management discharge management | <ul style="list-style-type: none"> • intervene to influence employee utilization decisions directly • influence provider utilization decisions indirectly |
| PROVIDER | <ul style="list-style-type: none"> • on-site health and medical services treatment (medication) diagnosis (screening, lab) prevention (health promotion/education) counseling (employee assistance program) | <ul style="list-style-type: none"> • direct delivery of services at the workplace |

In the ENABLER role, the employer makes available health benefits coverage for the employee, enabling workers to purchase health services and, thereby, enhancing access to care. The employer as ADVOCATE makes available alternative options for provider selection and the way health services are delivered and, at least implicitly, recommends these alternative sources of care or gives financial incentives to encourage choice of particular coverage options. As MEDIATOR, the employer makes available or requires specific managed care benefits and programs to intervene before or during utilization of services and potentially influence employee decision making. In the PROVIDER role, the employer makes available health services directly to the employee and is responsible for delivering care through medical and dental departments providing routine services and through special programs such as health screening.

ENABLER Role

The ENABLER is the traditional role of employers providing fringe benefits in the form of health insurance which enables the employee to pay for care. As noted above, the focus has been predominantly on hospital services, the most costly care. The underlying assumption for this employer role is that fringe benefits are a form of payment for work performed; there is an implicit exchange relationship between employer and employee. However, with increasing costs for health care coverage, this relationship is undergoing change.

The ENABLER role is being modified in at least two ways: more employers are promoting individualized selection of benefits by employees, and they are requiring increased cost-sharing by employees. The first mechanism is intended to reduce unnecessary premiums through flexible benefits and "cafeteria plans" which allow employees to choose the benefits package (health insurance for dependents, pension plan, etc.) most suitable to his or her own needs and family circumstances (Fox, 1984a; Ellis, 1986). In a recent national survey of 793 firms with 1,000 or more employees (Foster Higgins, 1988a), 22 percent offered a choice in benefit levels including exchange for other nontaxable benefits, up from 18 percent in 1987. Employers are instituting such plans both to contain costs and meet the diverse needs of their workforces.

The other change in the ENABLER role is an attempt to influence employee utilization of services through cost-sharing for health care expenditures in the form of increased employee deductibles, copayments, and contributions to premiums (DiPrite, 1977; Fox, 1984a; The Business Roundtable, 1985; The Business Roundtable, 1987). In 1988, 51 percent of employees paid no contribution to premium; this is a decrease from 1985 when 61 percent of workers had benefits fully paid by the employer (U.S. Department of Labor, 1989). Most major medical plans require cost-sharing, and increasingly employees with basic

hospital coverage also must pay a deductible and coinsurance (Jensen, et al., 1987). In a survey of over 1600 employers, two-thirds required coinsurance for hospital inpatient services, and a majority (60 percent) reported increasing the amount of the deductible in the past ten years (Foster Higgins, 1988b). The trend toward self-insurance in companies is likely to reinforce these shifts because more self-insured plans require employee cost-sharing up front than do traditional insurers. The assumption is that employees use fewer and less costly services if faced with more out-of-pocket expenses (Herzlinger and Schwartz, 1985; Manning, et al., 1984).

These modifications in the ENABLER role are intended to hold down costs by tailoring benefits to employee perceived needs or by increasing employee payment for services. Yet, the coverage enables employees to select health benefits and services with relatively little direct influence from the employer, although the number and variety of options offered may enhance or restrict employee use of services. Further, it has been argued that in real dollar terms deductibles have not increased very much since 1981, and that limits on employees' out-of-pocket costs and increases in maximum benefits can help to minimize the effects of cost-sharing (Jensen, et al., 1987).

ADVOCATE Role

As the ADVOCATE for employees, the employer is in a position to negotiate health benefits coverage and to select and offer different health care delivery options. While federal legislation has thrust employers into this role, setting conditions under which the health maintenance organization (HMO) alternative must be offered, it is the employer who decides which ones to offer. To select health services alternatives, the employer must evaluate options including at least four types of HMO models (staff, group, independent practice association, and network), variations of the preferred provider (PPO) model, and numerous hybrid health care delivery and financing mechanisms with combinations of providers, covered services, and reimbursement schemes (Spies, et al., 1984).

Employer interest in the HMO movement has been evident since its beginning. A 1980 national survey of large corporate employers (Harris and Associates, 1982) found companies generally favorable to the HMO concept. Availability of the HMO option has expanded along with support for HMOs, both in attitudes among companies which offer HMOs and in the market penetration in these companies (Health Research Institute, 1986). Despite sustained growth nationally, companies vary in the extent of HMO coverage. According to industry surveys, 62 percent (Foster Higgins, 1989) to 70 percent (Hewitt Associates, 1989) of employers offer the HMO option. HMO enrollment is reported to be

19 percent of employees nationally (U.S. Department of Labor, 1989); 39 percent of eligible employees in smaller firms (less than 1,000) selected the HMO compared to 29 percent in larger firms (Foster Higgins, 1989).

A more recent option is the preferred provider organization (PPO), a strategy which includes financial incentives for the employee to choose specific providers recommended through the employer's health plan. Corporations may specify the components of the PPO plan to be offered, such as primary physicians as gatekeepers for specialists. Only 1 percent of employees nationally were covered by PPOs in 1986; by 1988, this figure had risen to 7 percent (U.S. Department of Labor, 1989). The percentage of employers offering a PPO has doubled from 15 percent in 1986 to 31 percent in 1989 (Foster Higgins, 1989).

This wide range of coverage options has given the health benefits manager new responsibilities vis-à-vis the employees (Fox, 1984b). As one manager remarked about the HMO offered by her company:

I used to make sure the benefits were paid; now, I have to make sure the services are provided and that the employee is satisfied. If they don't like something, they call me about it and expect me to take care of it. (Personal communication, 1985.)

Presumably, offering a choice and incentives for choosing less costly options engenders an implicit trust that the employer has investigated the options and is offering those which can be expected to provide high quality care as well as less costly services (Fox, 1984a). Employers' legal liability for selection of providers is being established as case law accumulates (New York Business Group on Health, 1990a). The utilization reviews required in most HMO and PPO plans recognize that efficiency includes both quality and cost.

Increasingly, employers and consumers are being urged to "buy right," a strategy on the part of the purchaser of health care benefits which rewards efficient providers (McClure, 1985). This strategy assumes an informed, aware consumer who must be able to identify more efficient providers, has an incentive to choose them over others, and will evaluate the different options before deciding about the purchase and utilization of health services. The employer as ADVOCATE can provide the necessary information to influence employee selection of options. Some evidence exists which suggests that employees do not necessarily choose the benefits option with the greatest coverage and that they are willing to forego some benefits to save on premium expenses, even when the additional benefits were a good buy (Farley and Wilensky, 1982; Feldman, et al., 1989). These findings and the literature on enrollee choice of HMO models (cf. Barr, et al., 1983) point to the importance of assessing the value of different options for employees.

MEDIATOR Role

In the new role as MEDIATOR for health and medical care, employers are offering, or even requiring, a variety of benefits and programs to intervene in the delivery of services by attempting to directly influence employee utilization decisions (Fox, 1984a), especially about hospitalization. As the focus shifts from cost control to cost management, specific strategies include: second surgical opinion; preadmission certification and preadmission testing; individualized management of complex or chronic cases; hospital review for length of stay and, in some cases, appropriateness of procedures; alternative services such as ambulatory surgery for specified procedures and home health care, hospice care, and long-term care as substitutes for hospitalization. These strategies include reviews of both medical decisions and benefit incentives.

The most widespread of these programmatic strategies for managed care are second surgical opinions, hospital preadmission certification and testing, and ambulatory surgery. Reports indicate that from 50 percent to 98 percent of companies surveyed pay for second opinions, and the proportion making second surgical opinions mandatory in order to receive full benefits is increasing (Chollet, 1984; Taylor, 1985; Johnson and Higgins, 1986; Health Research Institute, 1986; The Business Roundtable, 1987; Hewitt Associates, 1989). The U.S. Department of Labor (1989) found that payment for second surgical opinions increased from 50 percent of employees in 1985 to 59 percent in 1988. Of the more than 1,600 U.S. firms in the Foster Higgins (1988b) survey, 73 percent covered second surgical opinion; 68 percent included precertification of elective admissions; and 49 percent included concurrent review of hospital services. Similarly, another industry survey of nearly 1,000 companies of varying sizes found that 67 percent required hospital precertification (Hewitt Associates, 1989). In the U.S. Department of Labor (1989) study, 43 percent of the employees were covered by plans which included an incentive for prehospitalization testing. Incentives for ambulatory surgery include higher payments for use of outpatient rather than inpatient facilities. Such incentives were reported by nearly two-thirds of the companies in 1985 compared to only 27 percent in 1983 (Health Research Institute, 1986). Later reports indicated that 55 percent of the companies surveyed offered a financial incentive for outpatient surgery (Hewitt Associates, 1989), 71 percent encouraged using ambulatory surgery facilities (Mercer-Meidinger, 1985), and 86 percent offered coverage for ambulatory surgical centers (Johnson and Higgins, 1986). These varying estimates reflect, in part, different size companies and samples.

Insurers are developing programs to help employers control costs (Anderson and Studnicki, 1985). Over three-fourths of Blue Cross and Blue Shield

plans offer "managed care" programs (Blue Cross and Blue Shield Association, 1986). A 1985 survey showed that the most frequent component of these programs is second surgical opinion, reported by 82 percent of the plans surveyed. Mandatory ambulatory surgery for certain procedures was reported by 62 percent of the plans, and preadmission testing was reported by half the plans. Over half (57 percent) included preadmission and/or concurrent length of stay assignment, and some included discharge planning and high claims case management, with components often tailored to specific employers. In each case, the managed care system is structured to intervene and potentially alter a course of care deemed inappropriate. For example, in the California preadmission review program, the

. . . cost-containment strategy relies on early intervention as an opportunity to evaluate more appropriate treatment alternatives before expenses are incurred. The second surgical opinion program screens certain elective surgical procedures to verify their medical necessity and to identify alternatives, when appropriate. (Health Care Management Systems, no date).

In some programs, the employee is free to make his or her own decision as long as the managed care procedures are followed, but others make approval a condition for full coverage and benefits. Penalties imposed on employees take the form of denial or reduction of benefit payments (either a flat fee or a percentage of costs). Alternatively, incentives, extended benefits, or bonuses may be offered for compliance with the elements of a managed care program. Some utilization incentives are financial; others are "red tape incentives" (McClure, 1985), such as requiring prior authorization for hospitalization and other reviews which may delay or discourage hospital admission.

With these programs, the employer has adopted an approach which requires a review mechanism before and, often, during a health care episode, thereby "mediating" between the employee and the provider of care—the physician or hospital. This strategy introduces a new dimension of employer/employee relations by placing the employer (or an agent of the employer) in the role of arbiter and advisor about specific medical care decisions. Awareness of the MEDIATOR role can be seen in American Telephone and Telegraph Company's program for preadmission review and mandatory second surgical opinion (Anonymus, 1986). The program seeks to build a "partnership" between employee and company to control medical expenses by managing health care costs, and a health services consumer advocate is available to act as an "intermediary" and help employees obtain and evaluate information.

PROVIDER Role

The most direct role for the employer in the health care of its employees is as the provider of services. Although this role is not a new one, it has been increasingly expanding to provide a broader range of services. R. J. Reynolds tobacco company built and operates a health plan for basic medical and dental care with hospital backup included in an HMO arrangement (Tudor, 1977). Nestle Enterprises, Inc. has recently opened a family medical clinic near its corporate headquarters to serve 7,300 employees, dependents, and retirees; intended to save on health costs for the company and improve access for employees, the clinic provides full primary care including x-rays, laboratory tests, and prescriptions (Schachner and Lenckus, 1990). Steelcase, Inc. has expanded its long-standing medical service to a "mini-hospital" center which treats 75 percent of employee health care needs (Soule, 1986). Other employers operate on-site medical departments to provide a range of services, with a few providing preventive dental care at work; company medical directors have expanded their efforts to address employee health care needs (Schofield and Egdahl, 1977; Friedland and Watt, 1983; Walsh, 1984; 1987).

Employee assistance programs (EAPs) provide counseling, primarily for alcoholism and drug abuse problems, to employees in two-thirds of Fortune 500 companies surveyed (Hollander and Lengermann, 1988) and nearly half (46 percent) of the companies in the Foster Higgins survey (1988b). One program includes preadmission testing provided at the worksite by Continental Illinois National Bank and Trust Company of Chicago for employees scheduled to enter area hospitals (Powills, 1985). Under the program, a technician comes to the bank several times a week to perform lab tests (e.g., throat cultures, EKGs, urinalysis, blood tests) following orders of the employees' physicians. Disability management programs provide on-site rehabilitation services following surgery or injury, as well as testing, tutoring, and rehabilitation counseling in the workplace (Anonymous, 1987). A growing number of companies provides prenatal care and education to avoid costly premature births. In addition to prenatal classes, First National Bank of Chicago provides weekly visits by an obstetrician/gynecologist to the worksite to perform prenatal exams and routine gynecological care (Swerdlin, 1989).

A more widespread effort by employers is the provision of preventive services through health promotion and wellness programs (Kiefhaber and Goldbeck, 1984). Such programs are intended to influence employees to change their lifestyles and adopt healthy behaviors (Conrad, 1987; Conrad and Walsh, 1989). Results of a national survey indicated that 65 percent of the over 1300 companies surveyed offered one or more wellness programs, such as health risk

assessment, stress management, hypertension screening, smoking cessation, exercise and weight-loss classes, and nutrition education (Fielding and Piserchia, 1989). A recent industry survey (Hewitt Associates, 1989) found that 80 percent of the companies sponsored at least one wellness program for their employees; most frequent were smoking cessation (63 percent), weight control (48 percent), cholesterol screening (45 percent), and stress management (44 percent). In the past five years, 1,500 employers representing 1,000,000 employees nationwide have joined Wellness Councils in 40 communities in 25 states to promote wellness at the worksite (Wellness Councils of America, 1990).

In the PROVIDER role, the employer determines not only what services will be offered but also how and by whom they will be delivered. On a continuum of involvement in employee health care decisions, this role has the potential for the most control by the employer (Green, 1988; Conrad and Walsh, 1989). It makes directly available services which are free or less expensive than in the community and structures incentives (including reduction of copayments, deductibles, or premiums) to encourage healthy behaviors and lifestyle changes (New York Business Group on Health, 1990b). As such, it may constitute a separate role of change agent (Warshaw, 1986).

Implications of the Role Typology

This review of strategies employers are using to control health care costs and the typology showing the roles of employers as they become increasingly involved in their employees' health and health care suggests several questions for consideration.

Which employers are likely to be in these different roles? Few studies report other than aggregate data about the respondents. Many surveys focus on larger firms and those likely to be more attuned to health care issues, so that results may overestimate the cost containment activity in business and industry (Jensen, et al., 1987). However, recent surveys of employee health benefits give some evidence about this question.

Foster Higgins & Co., a private benefits consulting firm, has conducted annual national surveys distributed through business coalitions to their membership. Although not randomly selected, the 1,500 to 2,000 responding organizations provide a description of firms most likely to be interested in cost containment and to be active in changing health benefits. Further, they include a broad representation of size (number of employees), type of industry, and region of the country. Relatively small employers with less than 500 employees accounted for well over one-third of the respondents, and 10 percent to 14 percent had 10,000 or more employees; the firms were predominantly in manufacturing (29% to 34%), with smaller proportions in technical/professional

services, financial services, health services, and other industries (Johnson and Higgins, 1986; Foster Higgins, 1988b).

The results for different categories of firms suggest some patterns of cost containment activity (Foster Higgins, 1988b). Both the ENABLER and MEDIATOR roles appeared to occur most often among companies in the south central region and in the transportation, financial, and energy industries. A larger proportion of firms in these categories required coinsurance, had increased the deductible, and included second surgical opinions. HMOs were offered by a larger proportion of firms in the Pacific region, where there has been greater availability of HMOs, and in the utilities, transportation, and communications industries, suggesting geographic location or characteristics of companies likely to be in the ADVOCATE role. Wellness, fitness, or health promotion programs, indicative of the PROVIDER role, were offered by a larger proportion of firms in the north central and Pacific regions and in the consumer products industry (Johnson Higgins, 1986). Because of the small number of firms in some of the industry categories, these data should be regarded as preliminary and suggestive of the need to examine these types of variables in future research. Although firms with the greatest number of employees were more likely to include some of the cost containment features, the only clear pattern by size is that companies with fewer than 500 employees were consistently least likely to do so.

The Bureau of Labor Statistics survey (U.S. Department of Labor, 1989) reported findings by employee category. Professional/administrative and technical/clerical workers were subject to more stringent incentives to control hospital use than production and service workers, although there was no difference in second surgical opinions, provided for 59 percent of all plan participants. The results suggest the possibility that companies with a predominantly production workforce may be found less often in the MEDIATOR role. These companies also may be more unionized, with the unions taking a MEDIATOR role in employee health issues.

The evidence suggests that some employers are becoming "corporate rationalizers," Robert Alford's (1975) term for those interest groups in society that emphasize a more rational, efficient, cost conscious, and coordinated health care system. Indeed, employers may be taking the lead, along with government, in efforts to control health care costs and regulate the delivery of services to maintain quality of health care. Yet, the variations in adopting cost containment strategies suggest different sources of motivation arising both within and outside the organization. For some companies, the corporate culture may support a more active role for employers, for example, in the provision of wellness and health promotion programs which can convey more immediate and direct concern for the welfare of employees. Other companies may react to external pressures on

employers as major purchasers of health benefits to join in helping to reduce national health care expenditures. The similarity of programs, for example, the adoption of mandatory HMO enrollment for new employees in the airlines industry (Rundle, 1984), suggests that corporate response to rising health care costs may reflect uncertainties and contingencies in a particular field (DiMaggio and Powell, 1983).

How do cost containment strategies affect employer/employee relationships? The cost containment strategies reviewed suggest that the employer's role in employees' health care varies from enabler of health benefits to provider of direct health services, with the potential for increasing control over employee health care decisions. These expanded roles for employers raise questions about how employers can ensure that employees understand the options and choices offered and have the opportunity to make their own decisions about the extent of employers' responsibility for employee health, and about potential adverse effects of cost containment strategies.

As part of the ADVOCATE and MEDIATOR roles, some employers have adopted a consumerist perspective aimed at helping their employees become more informed health care consumers and active decision-makers in their own health care. Companies such as the American Telephone and Telegraph Company, Weyerhaeuser, Owens-Corning Fiberglass Corporation, and Quaker Oats provide information for employees to consider when making health care decisions and selecting available choices (Alexandre and Barter, 1985). One study identified 230 companies with "prudent purchase" programs intended to educate employees about health care benefits and alternatives, promote consumer responsibility, and motivate efficient use of the health care system (Stone, et al., 1985).

Cost-consciousness is applicable to several decision points: the choice of benefits coverage or health plan, the choice of specific provider, and the decision to use specific services (Wyszewianski, et al., 1982). While employers are structuring these decisions for their employees, they also may be shaping the decision making through the information they make available to employees. A recent study (Hibbard and Weeks, 1987) found that, contrary to expectations, exposing consumers to the costs of health insurance and services did not result in greater cost-consciousness by shopping for lower-cost services and more efficient health plans among most respondents.

An important issue is the extent to which structural incentives for cost containment, be it lower copayment for using preferred providers, or full benefits coverage for having a second surgical opinion, are directive or coercive (Stein, 1986). A positive perspective on this employer activity might suggest that business and industry, in their new roles vis-à-vis employees and health care, are

acting not only to lower their costs for health services; they also are promoting effective change in the way health care decisions are made and medical care is delivered. Perhaps because employees themselves are concerned about health care expenditures and confused over the proliferation of various service options, they may be more responsive to these employer initiatives. Surveys of 17,000 employees in 17 large corporations (EBPR Research Reports, 1985) found that 80 percent of the employees were willing to take a number of different actions to save money for themselves and their employers. These included preadmission testing, outpatient surgery, and obtaining second surgical opinions, all elements of the MEDIATOR role for employers. These programs may help individuals make sense of a potentially confusing health care system by providing information, perhaps where none was available. Programs such as second surgical opinions may function to "legitimize doubt" and help consumers make more informed decisions about surgery.

A more critical view concerns the employer's role as PROVIDER and suggests that the corporate sector may be adopting a "social control" stance through health promotion efforts (Kotarba, 1983; Becker, 1986; Conrad, 1987; Conrad and Walsh, 1989). According to Green (1988:479-80), observers have expressed concern about the thin line between employers' helping workers change unhealthy behaviors and attempting to control workers' behavior off the job through Employee Assistance Programs (EAPs) and wellness programs. Not only are such programs intended to contain health care costs and improve worker performance; they also may signify that it is appropriate for employers to be involved in the lives of their employees outside the worksite and that employees bear the responsibility for their own health, thus obscuring the employer's responsibility for a healthy workplace. Conrad and Walsh (1989) have similarly argued that these employer-sponsored programs signal a new corporate health ethic; while it has the potential for enhancing employee health, this ethic also extends the role of the corporation into the lives of employees outside the workplace and expands employer control over the structure of work.

A *New York Times* article (Kleinfeld, 1986) entitled, "When the Boss Becomes Your Doctor," argued that companies "have instituted health care programs that intrude on the traditional ways in which Americans tend to their illnesses." Critics, the author suggests, contend that rather than simply eliminating unnecessary procedures and lengthy hospital stays, these programs cut into some services that should be provided. Companies can exert their influence on employee health care decisions by refusing to pay for what are deemed "unwarranted" services, by incentives for alternative services, and by selecting HMO, PPO, or other plan coverage to offer employees. Little evidence is available to test these notions. However, case law is accumulating on the issue of the

extent of employers' liability for controlling employees' health care "choices" (New York Business Group on Health, 1990a). Employers in the future may be faced with liability for adverse effects of cost containment strategies which delay, deny, or modify treatment.

Increasingly, employers are expressing concern with the quality of care their employees receive. This emphasis can be seen in both the selection of alternative delivery systems in the ADVOCATE role and the managed care strategies which are part of the MEDIATOR role. In determining which HMOs and PPOs to offer, employers are looking at utilization data and practice patterns for providers and comparing them to others to determine cost savings as well as to examine quality of care. Similarly, managed care programs review the decisions of hospitals and physicians to hospitalize patients, to perform surgery on an inpatient or ambulatory basis or not at all, and to carry out certain tests.

These cost containment strategies may affect not only employees' decisions about the use of services but also patients' attitudes toward providers. The traditional patient-physician relationship has been eroding as a result of a number of factors (Haug and Lavin, 1983). By intervening in utilization decisions, employers may be contributing to this trend, especially if the reviews cast doubt on providers' recommendations, possibly weakening patient trust. By educating employees to be "prudent purchasers," the employer may be encouraging them to be more aggressive in questioning providers and more assertive toward the health care system. As benefits choices proliferate, employees may become more dependent on employers to sort through these options, make recommendations, and hear complaints about the way health services are delivered.

The expanding roles for employers outlined in the typology are dynamic and evolving. In the next several years, legislation and court decisions may make clearer how much latitude employers will have regarding their employees' health and health care. At the same time, the ways that employers are taking these roles may in turn exert changes on the health care environment.

Policy Issues

As these trends in employer initiated and sponsored health care continue, it will be important to assess the extent to which employers adopt cost containment and cost management strategies and to observe the patterns in employers' efforts as they respond to pressures to alter the structure of health benefits. The analysis of variations in the employer's role in employee health care highlights several key policy issues confronting employers:

- *How employers decide about employee health benefits*—the extent to which compensation decisions incorporate employee choice or become mechanisms for controlling employees; whether employers should be free to decide about the

availability and extent of benefits coverage for costly procedures (e.g., heart transplants) and catastrophic illnesses (e.g., cancer and AIDS); the patterns of growth and acceptance of cost containment strategies among employers;

- *External pressures on employers for cost containment*—the relationship between employers and insurers, including pressures to institute or change programs intended to control health care expenditures; the effects of federal and state mandated benefits (e.g., alcoholism and mental health), as well as employee selection and choice, on employer efforts to control costs; the ability of self-insured employers to offer benefits and control costs under exemptions of the ERISA laws which stipulate requirements for health plans; and

- *Employer responsibility to assess the effectiveness of cost control strategies*—whether cost containment programs are having the intended effects (e.g., second opinion programs reduce surgery without compromising health status); instituting evaluation research studies to assess the outcomes of managed care programs; and determining other effects of health care cost containment strategies on the company (e.g., reduce absenteeism, improve morale).

As employers become more involved in employee health care, an important focus for future study will be the shifting control structure in health care. The roles of employers and employees (including unions), as well as providers, insurers, and government should be examined to determine how their varying perspectives and incentives can be balanced to provide high quality care while controlling costs.

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