

Managing Costs, Managing Benefits: Employer Decisions in Local Health Care Markets

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Objectives. To better understand employer health benefit decision making, how employer health benefits strategies evolve over time, and the impact of employer decisions on local health care systems.

Data Sources/Study Setting. Data were collected as part of the Community Tracking Study (CTS), a longitudinal analysis of health system change in 12 randomly selected communities.

Study Design. This is an observational study with data collection over a six-year period.

Data Collection/Extraction Methods. The study used semistructured interviews with local respondents, combined with monitoring of local media, to track changes in health care systems over time and their impact on community residents. Interviewing began in 1996 and was carried out at two-year intervals, with a total of approximately 2,200 interviews. The interviews provided a variety of perspectives on employer decision making concerning health benefits; these perspectives were triangulated to reach conclusions.

Principal Findings. The tight labor market during the study period was the dominant consideration in employer decision making regarding health benefits. Employers, in managing employee compensation, made independent decisions in pursuit of individual goals, but these decisions were shaped by similar labor market conditions. As a result, within and across our study sites, employer decisions in aggregate had an important impact on local health care systems, although employers' more highly visible public efforts to bring about health system change often met with disappointing results.

Conclusions. General economic conditions in the 1990s had an important impact on the configuration of local health systems through their effect on employer decision making regarding health benefits offered to employees, and the responses of health plans and providers to those decisions.

Key Words. Employers, health benefits, labor markets, health plan, premiums

Results from surveys of employer health benefit offerings are reported on a regular basis in the popular press and, occasionally, academic journals (for example see *BNA's Health Care Policy Report* 2001; *Medical Benefits* 2001a; Reese 2001a; Brubaker 2001; *Medical Benefits* 2001b; Gabel et al. 2000; *BNA's*

Studies and Surveys 2000). These surveys provide useful information about the current state of health benefits and recent changes in coverage or out-of-pocket costs. Less is known, however, about how employers think strategically about health benefits, how employer health benefits strategies change over time, and how factors outside of the health care arena can influence employer strategies. These are important issues, given that virtually all firms with two hundred or more employees offer health insurance, and employers pay 85 percent of the premium for individual policies and 73 percent for family coverage (Gabel et al. 2001). Employment-based insurance affects 153 million workers and dependents, as well as five million early retirees in the United States (Gabel et al. 2001).

In this paper, we use interview data collected at multiple sites over six years to discuss two interrelated historical roles that employers have played in local health care systems, one relatively private and one typically very public. The private role involves the decisions of each individual firm in managing its health benefits. The public role focuses on the collaborative efforts of employers to accomplish their objectives in local health care systems.

EMPLOYER DECISIONS REGARDING HEALTH BENEFITS: DIFFERING PERSPECTIVES

The literature provides (at least) three distinct perspectives on employers and their health benefits decisions. These perspectives are not mutually exclusive, but they do emphasize different factors as being of primary importance in employer decision making. Together, they provide a framework that is useful for interpreting our empirical findings relative to the private and public roles of employers in local health care markets.

Health Benefits as Compensation

The first perspective emphasizes the role health benefits play in attracting and retaining workers, in the context of the employer's overall employee

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compensation strategy. This perspective is largely based on standard theories of labor and product markets. One prediction of these theories is that increases in health care costs will be borne largely by employees, in the form of lower wages (Morrisey 2001; Pauly 1997a, b). The net result is that total compensation remains largely unchanged, but workers receive more of that compensation in health benefits and less in wages. If the adjustment process occurs relatively quickly, increases in health care costs have only a minor, short-term negative impact on firm profits. (There is some empirical support for the predictions of this “economic model.” See, for instance, Woodbury 1983; Eberts and Stone 1985; Gruber and Krueger 1991; Gruber 1994; Blumberg 1999; and Jensen and Morrisey 2001.) Other recent studies by Levy and Feldman (2001) and Simon (2001) did not find supportive evidence. Another way of framing this perspective is that employer efforts to reduce coverage or implement other changes in the pursuit of cost control themselves have a cost. If employees perceive that these efforts diminish the value of health benefits, they may leave the employer unless compensation is increased in other areas. This suggests that employer efforts to contain health care costs will not cause profits to increase. Therefore, from this perspective, the key question for employers is how to package health benefits with other compensation in order to be successful in a competitive labor market.

Health Benefits as a Target for Cost Reduction

The first perspective raises the question of why employers would want to devote much managerial effort to containing premium increases. Yet, many employers clearly have devoted resources to this end over the years, suggesting that they hold a different view (Pauly 1997a, p. 19). Their perspective (which Pauly terms the “business model”) places emphasis on health benefits as a cost center within each firm to be monitored and aggressively managed. If an employer could cut expenditures for health benefits, or control their rate of increase, and its competitors in the product market could not, it could lower product prices, increasing market share and profits. These gains might be short term in nature if other firms have access to the same cost containment approaches, but nevertheless they may be worth pursuing. Labor market considerations are seen as important constraints on employer cost containment efforts, but the goal of cost control is paramount.

Health Benefits as Infrastructure

A third perspective on employer health benefits decision making emphasizes the number and strength of the constraints employers face in managing health benefits. Under this perspective, local health benefits managers may wish to manage health benefits to make them more attractive to potential employees, or to reduce costs, but they are severely constrained in doing so. For example, the policies and procedures in large firms may make health benefits decision making relatively inflexible and insensitive to local labor market conditions. Or, a highly structured collective bargaining process may tie the hands of health benefits managers who otherwise would pursue more aggressive management strategies. Faced with limited options, the primary goal of health benefits managers, under this perspective, is to minimize costs associated with benefits administration, as well as employee complaints that could reflect negatively on the managers' efforts.

DATA AND METHODS

We utilize data collected as part of the Community Tracking Study (CTS) to address our research questions. The CTS employs semistructured interviews, predominantly conducted in person during community visits by a research team, to collect data from respondents in twelve randomly selected communities (Boston, Cleveland, Greenville, Indianapolis, Lansing, Little Rock, Miami, northern New Jersey, Orange County, Phoenix, Seattle, and Syracuse). Media located in these communities were closely monitored to identify significant changes that occurred between community visits. We carried out our first round of interviewing in the fall of 1996 and the winter of 1997. Additional rounds of interviewing were completed at approximately two-year intervals, with the last community visited in the spring of 2001. There were 685 respondents in the first round of community visits, 606 in the second round, and 917 in the third. The general respondents included managers of local health care systems, health plans, and physician practices; public sector representatives; reporters; and civic leaders. Most were asked about employer activity and the influence of employers in local health care systems. Union officials, company human resource managers, health benefits consultants, and health insurance brokers were asked more detailed questions about employer health benefits, with more of these respondents interviewed during rounds one and three than in round two. Our analysis was based on medium to large employers (employed groups of five hundred or more members).

The interviews provide a variety of perspectives on employer decision making regarding health benefits, as well as the employer role and influence in local health care systems. These perspectives were corroborated across respondents within each site for consistency and accuracy. The longitudinal nature of the data was particularly valuable in identifying the shifting influences on employer decisions, and the changes over time in the impact of those decisions in local markets.

RESULTS: THE PRIVATE ROLE OF EMPLOYERS

Our findings, based on interviews over the six-year study period (and particularly interviews with human resource managers and health benefits consultants) suggest that each of the perspectives described above is important, to varying degrees, for understanding the decision making of individual employers regarding health benefits. For most health benefits managers, the challenge was to effectively balance the role of health benefits in competing for new workers and retaining existing ones; the pressures from top management to contain health care costs; and the impact of a wide range of constraints on their actions. During our study period, however, they clearly placed the greatest emphasis on managing health benefits in a manner that ensured the firm would be competitive in local labor markets. When employers pursued specific strategies to control premium increases, they did so with caution to avoid the appearance of a reduction in benefits, which would place the firm at a competitive disadvantage in hiring workers. Additionally, we found that the internal structure and policies of large, national firms played an important part in determining what options were available for local health benefits managers.

Employer Efforts to Manage Benefits

For the employers in our study that were not unionized, health benefit decisions were made as part of overall employee compensation strategies that could, and did, change over time. (For a discussion of a benefit trade-off in the context of a specific compensation negotiation, see Dresang 2001). When unions were involved, health benefits decisions were made as part of negotiations regarding wages, vacation policies, sick leave, retirement benefits, and numerous other issues. In either case, these strategies were strongly influenced by conditions in the labor market. For instance, in the second and third rounds of CTS interviews, it was common for employers to

state that they were not aggressively attempting to control or reverse premium increases through benefit redesign, because they feared this might limit their ability to attract new employees and retain existing ones. (General survey support for this observation is found in *Medicine and Health* 2001b, p. 3; also see Reese 2001c; and *BNA's Health Care Policy Report*, April 30, 2001).

Each employer's perspective on how to structure health benefits depended on that employer's reading of the preferences of firm employees. (This reading sometimes was based on a survey of the firm's employees.) For instance, employers with younger work forces believed that other forms of compensation (e.g., on-site day care, wellness facilities, etc.) were more highly valued by their employees than traditional health benefits. Therefore, they devoted less time to fine-tuning health insurance coverages and sometimes did not offer retiree health benefits. In other instances, we found that employers, facing significant health plan premium increases, reduced other benefits in preference to reducing health benefits, because they believed that health benefits were more highly valued by employees.

These efforts on the part of health benefits managers were complicated by the fact that employees evaluated their health benefits along a variety of dimensions (Jensen 1986). With the advent of managed care organizations, employers offered their employees health benefit options that, in effect, combined delivery systems with insurance coverage. This meant that employees might value their benefit options not only in dollar terms but also based on the "nonpecuniary" characteristics of health plans, such as the physicians and other providers in the plan network, perceived quality of care, and ease of access (Jensen 1986).

Employer Efforts to Manage Costs

The attractiveness of managed care to employers, as clearly evident in our first round of interviews, was that it promised to create a competitive advantage for individual employers by reducing health benefits costs while maintaining or enhancing benefit coverage. Employers initially were pleased with the way in which managed care plans helped them to control their costs—their premiums were relatively flat year-to-year during the mid-1990s (Center for Studying Health System Change 2001b)—but then employers began to hear complaints from employees about plan restrictions on referrals, as well as the limited provider panels in some plans. In effect, the movement to managed care had devalued the health benefit, as perceived by some employees. Employers were faced with the choice of increasing wages to compensate for

lost value in the health benefits area or altering characteristics of plans to improve perceived value. The need to compete for labor tended to receive a higher priority than cost control. Health benefits managers reported pressure from top-level managers in the firm to respond to employee concerns quickly and meaningfully in order to mitigate workforce dissatisfaction, retain and attract employees, and maintain production in an expanding economy. They did so by pressuring health plans to expand provider networks; making only benefit changes that did not significantly reduce coverage; and pushing health plans to improve customer service.

Network Design. In response to employee complaints and concerns, during the mid-1990s the employers at our sites encouraged managed care plans to expand the number of providers in their networks. They also began replacing HMO options with point-of-service (POS) variants, and introduced preferred provider organization (PPO) alternatives to more restrictive forms of managed care. (In this respect, employer behavior at our sites was consistent with national trends [Heffler et al., 2001; Page 2001]). Employers recognized that POS and PPO plans increased employee costs at the point of service, but believed that most employees would prefer this to more restrictive forms of managed care.

Employers chose broader networks, despite the potential that this could result in premium increases, for two reasons. First, they believed that reverting to more tightly managed HMO products held little promise of cost savings (*BNA's Studies and Surveys* 2001a, b). National data indicate that the percent of workers with an HMO option continued to decline from 2000 to 2001 (*Medicine and Health* 2001b, p. 3). Second, and more importantly, all employers still faced tight labor markets and did not wish to take any steps that would be regarded by employees, or potential employees, as degrading the value of health benefits.

The concern of employers about maintaining attractive provider networks was particularly evident in several sites where employers voluntarily intervened in disputes between plans and providers, spurred by threats of network disruption. In a very few instances at the 12 study sites, providers even called on individual employers to play a direct role in their negotiations with health plans, asking employers to support demands for payment increases (Strunk, Devers, and Hurley 2001). Thus, the employer assumed the somewhat surprising position of opposing health plan efforts to contain health benefit costs. Clearly, a desire to preserve the perceived value of health benefits in a tight labor market motivated employer decision making in these situations.

Benefit Design. As employers moved from traditional insurance to managed care in the early 1990s, benefit coverage typically increased. However, when employers moved to plans with larger networks and fewer restrictions during the mid-1990s, cost-sharing at the point of service became increasingly common. Employees could reduce these payments if they remained in the plan's (now larger) network. And, to further ameliorate employee concerns, some employers offered employees access to discounted providers for uncovered services or discounted health club memberships, while others included coverage for "lifestyle" drugs that were highly valued by some employees. Again, the intent was that employee evaluations of their health benefits would not decline, and might possibly improve.

During our second round of site visits, in 1998–1999, many respondents predicted that employers would begin to limit benefits, and possibly move back to more restrictive forms of managed care, when projected premium increases took hold. However, we did not find any major benefit restrictions when we conducted our third round of data collection. By 2000, it was relatively common for employers to have adopted a three-tiered pharmaceutical benefit structure (Center for Studying Health System Change 2001a) and/or to have increased copays for physician office visits (as also reported by Gabel et al. 2000). However, in general, health benefits for employees remained relatively unchanged (Trude et al. 2002). The reason for the absence of more aggressive employer efforts to contain costs, according to respondents, was again the constraint on employer decision making that was imposed by tight local labor markets.

Quality Issues. The consensus of interview respondents in 1998 and 2000 was that employers were more interested in quality of customer service than clinical quality. Based on 33 interviews with large employers, Hibbard et al. (1997) also reported that, in the mid-1990s, measures of clinical quality were not generally used in employer decisions to offer health plans. And, Maxwell et al. (2001) noted that only a third of Fortune 500 firms used quality standards in purchasing health benefits. (For further discussion, see *Health Care Financing Organization News and Progress* 1997a). Some employers at the study sites expressed substantial dissatisfaction with the customer service provided by health plans to their employees. When large employers introduced incentives for improved service quality into contracts with health plans, their employees reported that, with some exceptions, these efforts had minimal effect.

The emphasis of employers on service quality, as opposed to medical care quality, is readily understood in the context of the need to compete for labor. Service quality is easily observed and evaluated by employees, and

therefore likely to affect employee perceptions of the value of their health benefits. Also, by expanding the provider networks offered by contracting health plans, employers in effect shifted the responsibility for selecting “quality providers” back to their employees.

Limits on Health Benefits Decision Making

Our interviews documented important institutional considerations within firms that affected the decision making of health benefits managers in the study sites. Most importantly, the largest private employers in our study markets typically had their headquarters elsewhere, with compensation strategies set by corporate headquarters. It was normal for these large, self-insured national employers to have an “administrative services” contract with a national health plan, and for the plan to offer a PPO or point-of-service product design with a geographically dispersed provider network to facilitate employee access. Over the six study years, large, highly visible employers in virtually every study community merged or were acquired, with their health benefits decision making shifting to national headquarters. The observation of one respondent that “we’re a branch office town” could apply equally well to most of our study sites. In some sites (e.g., Cleveland, Boston), local health care systems were among the largest remaining private employers with local headquarters.

The large, multisite corporations whose headquarters remained in our study communities typically had a strong preference for a common set of benefits for employees, irrespective of where the employees were located, to ensure benefits equity and reduce administrative costs. Even though these companies were headquartered locally, their health benefit strategies were not particularly sensitive to the characteristics of local health care systems. The functions of local health benefits managers became primarily operational, rather than strategic. They distributed information about benefit options, managed enrollment, and responded to employee complaints.

Health benefits managers that engaged in bargaining with unions over health benefits experienced a different set of constraints. For instance, unions viewed benefit redesigns that eliminated plans as “takeaways,” and therefore strongly opposed them in negotiations over benefits.

THE PUBLIC ROLE OF EMPLOYERS

There is a substantial literature regarding the efforts of employers to take collective action on health care issues in local communities (see, for instance

Mintz 1995; Brown 1993; Martin 1993, 1995; *Health Care Financing and Organization News and Progress* 1997b). In his dissection of the experience of employers in their “public role” during the late 1980s and early 1990s, Pauly (1997a) argues that employers are likely to gain little from some types of collective, public activities. For example, if employers participated in a community health care coalition that was successful in controlling their health benefits costs or improving quality, all employers would gain. There would be no competitive advantage in hiring labor gained by any single employer through participation. Pauly concludes that “the basic message, regrettably, is that saving health care costs for everyone in town will not add to the bottom line” (p. 153). For any individual employer “the best coalition is one that excludes other employers who hire the same kinds of workers you do but that includes enough employers who hire in other labor markets to have some influence on providers” (Pauly 1997a, p. 153). These observations arguably were supported by the generally disappointing impact of “community coalitions” in that time period, as well as the difficulties faced by employer health care purchasing coalitions in sustaining their effectiveness over time. The experience of employers in our study sites from 1995 to 2000 was similar; furthermore, the willingness or ability of employers to engage in cooperative activities related to purchasing, data gathering and dissemination, or political action appeared to decline over the study period.

Cleveland provides a relevant example. There, a cooperative effort on the part of employers and hospitals was initiated in 1988 to develop hospital quality of care and cost measures (Cleveland Health Quality Choice [CHQC]). Cost measures were not developed until after our first site visit, and their addition proved extremely controversial. By our third visit, CHQC had disbanded, with key hospitals no longer willing to participate. According to some respondents, this was due to a failure of employers to use the data generated by CHQC in their purchasing decisions. Consolidation among hospitals may have made comparative data less useful to employers. Also, employee demand for broad networks reduced the likelihood that, in a tight labor market, noncooperative or low scoring hospitals would be excluded from health plan networks offered by employers.

In Lansing, the Capital Area Health Alliance (CAHA), with purchasers constituting 60 percent of voting membership, was formed in 1993 to promote high quality care at a reasonable cost. By our second site visit, stung by controversy generated by the release of a report comparing local hospitals, CAHA had shifted its focus to the promotion of wellness activities and

improvement of access to services for specific community groups. The State of Michigan, a large local employer, withdrew from CAHA. A separate cooperative effort of the three largest purchasers in Lansing—the State, Michigan State University, and General Motors—was attempted, but was disbanded in 1998, apparently due to differences in the health benefits priorities of the three participants.

In Syracuse, an employer purchasing coalition was under development at the time of our first site visit. By the third visit, it was clear that participation on the part of large employers would not meet coalition expectations. In Indianapolis, two employer groups merged to form the Indiana Employers Quality Health Alliance, which consisted of 20 employers representing approximately eighty thousand employees. At the time of our third site visit, the Alliance had issued a request-for-proposals to pilot a group purchasing effort, but respondents in Indianapolis suggested it was too early to judge its effectiveness. Coalitions operating in Phoenix and in Miami had disbanded prior to our first site visits.

Respondents offered a variety of opinions concerning why employer efforts to work cooperatively to purchase from health plans, evaluate hospitals, or collect and disseminate information to consumers proved so difficult. One view was that the largest employers in communities often saw little benefit to participation in employer coalitions, believing that they had enough leverage on their own to accomplish their purchasing objectives, and little to gain from coordinating or compromising with other employers. A second perspective was that several features of the general environment for purchasers during the study period discouraged collaborative efforts. First, in the early part of the study period, premiums were relatively flat, so employers may have seen little to be gained from pooling their purchasing power in negotiations with health plans. Second, the tight labor market made employers leery of participating in any collaborative endeavor that could alter their existing health benefits coverage, as this could be perceived as a benefit “takeaway” by employees. Certainly, offering the same benefits as other coalition members competing in the same labor market did not create a competitive advantage for participating employers. Third, at almost all of the study sites, consolidation at both the health plan and the provider levels occurred during the study period. In smaller sites, the result was that employees expected virtually all providers to be in every health plan network. Employers believed that, absent any real ability to shift patients among providers by switching health plans, and given a diminishing number of plan options, the potential gains from collaborative efforts would not outweigh the costs of participation.

DISCUSSION

We found that all three perspectives on employer health benefits decision making were useful in understanding employer strategies and actions. However, our data clearly underscore that labor market considerations were of primary importance for employer health benefits decision making during the study period. At the time the CTS was initiated, employers were acutely conscious of “managed care backlash,” particularly its potential to disrupt their efforts to enroll increasing numbers of employees in managed care plans. Their sensitivity to this issue was heightened by what was perceived, even as early as 1996, as a tight labor market at some sites. The need to compete for workers with other employers in the community, and sometimes nationally, and the importance of maintaining competitive benefits, including health benefits, was a consistent theme across all of the study sites and across employers of all types. Employers were hesitant to pursue cost containment strategies that might diminish the value of health benefits in the eyes of employees, because this could require an increase in wages or other benefits or, absent an increase, result in a competitive disadvantage in attracting workers. In the early part of our study period (1996–1997), employer concerns over the tight labor market influenced the way in which they responded to employee concerns about managed care; in the latter part of the study period (2000–2001), it influenced their response to rising premiums.

A second important finding of our study is cautionary in nature. Most interview respondents across the study sites saw employers as relatively passive purchasers of health benefits during the study period, reflecting the fact that they did not pursue aggressive cost containment strategies by themselves or collaboratively. And, where coalitions were present, the results of their efforts were frequently disappointing. Consequently, it was easy for respondents to conclude that employers had little impact on local health care markets. However, our conclusions caution against judging the impact of employers based only on their highly visible, public efforts to stimulate change or the aggressiveness of their individual efforts to control health benefits costs. To do so overlooks the strong likelihood that individual employers, acting independently in their attempt to compete for labor, collectively had an important impact on the organization of health care delivery in their communities. Health plans responded to employer demands by offering products with larger provider networks and more out-of-network options. It could be argued that consolidation of providers in most of the study sites occurred in part to exploit this situation. A few of our respondents recognized

this. For example, one respondent in Orange County characterized purchasers as “driving the market,” but not through collective action. A Little Rock respondent suggested that employers influenced the market quietly through their contracting and benefits decisions.

If the health benefits decisions of employers, shaped by the need to compete for workers in a tight labor market, did ultimately create, or contribute to, an environment in local health care markets that supported provider consolidation, we think this has important implications for understanding health systems change. It suggests that the impact of general economic conditions, not just conditions in the various markets for health care goods and services, must be considered in any attempt to understand health systems change and to formulate intelligent public policy relating to evolving health care systems. In our study sites, a strong economy, with all of its benefits to consumers, may well have precipitated an unanticipated chain of events in which employers played a critical role, creating important public policy issues concerning consolidation and the market power of providers in communities. History suggests that “undoing” consolidation in local health care markets will be difficult, if indeed it is viewed as a suitable policy objective.

Next Steps for Employers

In our last round of interviews, many large employers speculated that they would change their compensation strategies if double-digit premium increases continued at the same time that the overall economy weakened. In particular, general layoffs would be expected to exert downward pressure on compensation, allowing employers to respond to increases in health care costs by reducing other forms of compensation (e.g., wages), shifting a larger share of health insurance premiums to employees, or increasing copayments and deductibles (see *BNA's Studies and Surveys* 2001a; *Medical Benefits* 2001c; *Medical Benefits* 2001e; also, in Seattle, Boeing announced [April 2001] that, for the first time, some union members would be charged monthly premiums for one of the company's four health plan options [Nyhan 2001]). In light of the increased consolidation of local providers and rising drug prices, health benefits managers did not expect to be able to improve their companies' bottom lines by squeezing inefficiencies out of the managed care plans in their communities, nor did they think that these plans could successfully restrain future premium increases. The views of many benefits managers likely are represented by one Boston respondent who stated that health insurance is now a “losing proposition” for employers: employees complain that there are not

enough plan choices, that the benefit design is wrong, and that costs are too high, while not appreciating how much the employer is contributing toward those costs. One “exit strategy” mentioned by some health benefits consultants would position the employer primarily as a financier, with employees assuming more decision-making responsibility and sharing more of the costs. (For a general discussion of this issue, see Silow-Carroll et al. 2001). Robinson (2001) describes this as a “trend...to offer information, options, and partial financial support, but to otherwise get out of the decision-making position” (p. 2623). Under this strategy, the implicit hope of employers would be that their employees valued greater decision-making autonomy sufficiently to compensate for assuming a greater share of health benefits costs. New, defined contribution (or “consumer driven”) health insurance options (Christianson, Parente, and Taylor 2002; Reese 2001a; Parrish 2001) could facilitate this change. However, the CTS findings to date suggest that employers will move cautiously in adopting these options, as long as labor markets remain competitive. (This is consistent with the hesitancy expressed by employers in several surveys. For instance, see *Managed Care Week* 2000; *Medicine and Health* 2001a; *Medical Benefits* 2001d; Reese 2001b). We saw little movement in this direction among employers at the time of our last round of interviews, but heard considerable speculation that matters could change rapidly if double-digit premium increases persisted and labor markets loosened significantly.

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