# Employer-Funded Health Care and Labor Markets: An Insider's View

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I am not here to defend employer-sponsored health care but rather to give an insider's view of several important issues related to the role of employers in the U.S. health care system. My perspective comes from my role over the past 10 years of being responsible for managing the health care costs of the General Electric Company (GE). These total about $2.5 billion annually and increase by a couple of hundred million dollars a year. Even for a firm like GE, that is serious money. The five issues that I will touch upon rarely make it into the literature about the impact of employer-funded health benefits on labor markets.

### Medical Innovations

An issue that I think merits more attention is the role of employer-based funding in supporting and enabling medical innovations. Although this relationship is not explicit, nor part of the original intent of the system, it is still the case that the unique funding and controls (or lack thereof) that characterize our system allow for unparalleled access to new technology. As much as employers are concerned about how much they spend on health care and how that impacts other business decisions, such as wage increases or the location of new facilities, it is also the case that one person's cost—or one company's cost—is another company's revenue. Any attack on health care costs engenders fierce resistance because of this cost-revenue relationship, and the resistance is intensified under circumstances in which a company is itself in the health care space or has important customers that are.



In our employer-based system, we expect the market to control costs in a manner that other countries handle by relying on central government-directed global budgeting. But as Alain Enthoven, Mark Pauly, and others have taught us, the market is particularly imperfect in health care, due to both price distortions and information asymmetry. It has been hoped that employers, as sponsors of health benefits, might view it to be in their interest to try to ameliorate these shortcomings. To the extent that we have tried, we have failed. As a result, the strong incentives for employees and providers to use more services has led us to our current state, in which the high-tech suppliers to the health care industry—pharmacy, device, and imaging companies—derive about 50 to 60 percent of their profits from the United States, despite the fact that our country represents only about 5 percent of the world's population. By way of full disclosure, although I do not work for the health care business at GE, and, in fact, frequently frustrate them with ventures like the Leapfrog Group,[1] GE does have a business in the health care technology field, and it is doing very well.

The Boston health care market provides a good illustration of the tension between costs and revenues. In the early 1990s, I was head of the Massachusetts Business Roundtable Health Care Subcommittee, where the number one issue was the high and rapidly accelerating cost of health care. The prevailing wisdom then, as now, was that the overabundance of expensive tertiary care beds in the Boston market is a major contributor to high health costs. You can imagine my surprise when, as a newcomer to this area, I found myself at the first meeting, chairing a subcommittee composed largely of the CEOs of these same academic medical centers and their suppliers. However, the experience provided a good education concerning the complexity of addressing costs in health care, as it turned out that health care was also the economic engine of the metropolitan area. Controlling health care costs without adversely impacting employment and overall economic growth is no easy matter.

Table 5.1, which Jeff Immelt, GE's CEO, and I put together, summarizes the situation as it plays out at GE. Jeff likes to call this "the perfect hedge": a $15 billion business growing at 10 percent a year alongside a corporate health care cost of $2.5 billion, also growing at 10 percent a year. Jeff likes to say that, unlike most of his competitors, at least GE has

**Table 5.1**
GE in Health Care: The Perfect Hedge

| Health Care Business | Corporate Health Care |
|---|---|
| $15 Billion in Revenue | $2.5 Billion in Cost |
| Growing at 10% | Growing at 10% |
| • Diagnostics | • Founder of the Leapfrog Group |
| • Services | • Fastest-Growing Expense |
| • Information Technology | • Driving "Consumerism" |

revenues from health care to "hedge" the several hundred million dollars of new spending that he knows he is going to have every year.

Although having employers as directly engaged in health care funding as they are is a historical accident, decoupling them will be no accident—it will probably take something like the Jaws of Life to pry those two apart.

**Labor Unions**

A second issue that I would like to address has to do with labor unions and what I believe is an underestimation of their impact. Although unionized workers represent less than 10 percent of the private labor market, their influence extends beyond their numbers, and it does so in at least two ways. The first way is through their continuing political clout. The Medicare Modernization Act (MMA),[2] passed a couple of years ago, includes a large employer subsidy for companies that continue to offer drug benefits for retirees. Though the government had its own reasons for the subsidy, namely, to give employers a reason to continue to offer retiree benefits, there was a time late in the development of the bill when no such subsidy existed. That an employer subsidy ultimately ended up in the bill was largely due to the successful lobbying efforts of businesses with very large union populations and very, very large retiree health obligations. If you look at the ripple effect of this subsidy on taxpayers, and how all employers covering retiree health care are benefiting from it, you can get a feel for how the impact of unionization is far greater than what you would expect from its 10 percent share of the labor market.



The second unappreciated fact is the amount of time companies spend on union avoidance. For the past several years, health care has been an issue of some tension between companies and their workforces. With increased cost sharing has come unhappier employees, and with unhappier employees comes the threat of unionization. To the extent that employers would rather not have unionized workforces, the time and resources spent on union avoidance subtract from resource allocation in areas more germane to the company's core products or services.

**Positive Impact on Employees**

In a health care system that is notoriously unresponsive and difficult to navigate, those employees lucky enough to obtain their insurance through midsize or large employers generally have a support system unknown in countries with more centralized systems. I do not know how many people remember the cover of *Newsweek* from November 8, 1999, but it showed a very frustrated-looking patient in a hospital gown and the headline: "HMO HELL." Employers know that unhappy employees are less productive; so, although managed care was saving them a lot of money, employers ultimately backed off because of this employee unhappiness. At GE, you could walk around any of our sites, and it seemed that at least half of the people were on the phone, either on hold with their HMOs or standing at the water cooler complaining about the call they had just finished. So, a major reason for the death of managed care was employee unhappiness. I think that you can read this phenomenon as evidence that "the market worked." It is unlikely that a government bureaucracy could be this responsive, this fast.

Another impact on employees is the fact that employers are beginning to believe in the connection between health and productivity. Although the literature is still immature, big-name companies like Johnson & Johnson and Procter & Gamble are starting to invest in health promotion. Although I will not go into this phenomenon any further today, I suspect that we will see a big increase in interest in this area in the near future.

**Catalyst for System Innovation**

Large employers have been a catalyst for system innovation. Although very few companies invest in a health care staff capable of creating these innovations, when successful efforts do occur, all employers (and their labor forces) benefit. One example of this is seen in the attempts to apply industrial quality approaches, like Continuous Quality Improvement or Six Sigma to health care. I do not know how many of you have heard of the Leapfrog Group (Galvin et al. 2005), but the mission of that group is to drive into health care the kind of transparency around product and service performance that exists in the majority of markets. In this case, it called for the public release of information around clinical hospital performance. The Leapfrog Group, which was founded in 2000, now comprises 175 companies, and the majority of hospitals publicly disclose information about their quality.

The Leapfrog Group started from an experience I had with an employee. As a physician working in industry, I get calls from employees looking for help with their medical problems. One such call was from an employee who needed heart bypass surgery. He said, "I have a surgeon who is in my parish who is a nice person, and someone in my neighborhood said they had had a really good experience with this surgeon at our local hospital. I have a date scheduled for my surgery. Am I doing the right thing?" I looked everywhere that I could think of for information on quality to try to help this employee, but I could not find the data about which doctors did this procedure the most, or who had the best outcomes. Since I am on the Yale faculty, I called a professor of medicine there who I knew had a contract to maintain data on clinical performance in Connecticut hospitals. I explained the situation to him and asked whether he could tell me what the morbidity and mortality data were. His answer was, "I have the data, but I can't tell you. I've signed contracts with the state medical and hospital associations committing me to silence." So I said, "That's a tough situation for me, because I'm trying to do the best for this employee. I'll tell you what. If I mention the three hospitals he could go to, would you cough once at the best, and twice at the next best?" And he did. The employee ended up changing hospitals to the one with the best performance; and, when I investigated further, it turned out that



the hospital he went to also had lower costs. So, the idea of demanding transparency has been driven by the private sector; and, as this initiative has taken off, we now see the Centers for Medicare & Medicaid Services in lockstep with this approach.

**Future Directions**

My final point has to do with the direction that employer-funded health care may take in the future. From an insider's point of view, the enthusiasm around high-deductible, or what are called "consumer-directed" plans, is palpable, and unlike anything I have seen since the excitement around managed care 15 years ago. I think that the piece, "Hello HSA, Goodbye HMO," (Boorady 2004) by one of the two or three most highly respected Wall Street health insurance analysts, Charles Boorady, which I have up as a slide, makes a persuasive case as to why the time may be right for this kind of product. The argument is that HSAs, or health savings accounts, are going to be to health care benefits what 401(k)s became on the retirement side, that is, a way of shifting from a defined benefit to a defined contribution model, a move that transfers much of the responsibility for decision-making from employer to employee. Although there are only a couple of million people covered by HSAs today, I think the prediction that 30 percent of the market will adopt this kind of product might not be too high. Since 160 million people get their insurance through employers, 30 percent of this number paying the first several thousand dollars of their health care bill out of pocket would mean a very big transition in both the delivery of health benefits and the flow of health dollars. Many of the dollars that in today's model flow from employer to health plan will, in the high-deductible model, flow from employee to provider.

The reason that I think HSAs may take off is because the product meets two major needs: ideologically, it appeals to those who believe that a rationalized health care system will never exist unless something is done about today's third-party payment and price distortions; and, practically, it might represent the first step in an eventual exit for employers from the burdens of administering health benefits in the way that they do today. Employers are interested in this kind of exit but they do not want to abandon their employees, and they do not want to lose valuable labor

to their competitors. HSAs may offer a way for employers to maintain competitive benefits, have better control of their health costs, and spend less administrative resources overall. HSAs would make health insurance more portable, which in turn would have a positive effect on labor markets. These plans will also impact providers; at the very least, they are likely to drive up the receivables of doctors and hospitals. I know that there is much controversy about this type of benefit design, and hopefully we can discuss it further.

## Notes

1. The Leapfrog Group aims to have information about the performance of hospitals and doctors made available to the public.
2. The full name is "The Medicare Prescription Drug, Improvement, and Modernization Act of 2003."

## References

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