Corporate Attitudes toward Health Care Costs

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WITH THE GOVERNMENT STRAINING TO MEET its health benefit obligations to the poor and the elderly, it is not surprising that some policy analysts see the development of an alliance between business and government as the only effective means to control inflation in the health sector. Most Americans receive health benefits from their employers rather than from government (Carroll and Arnett, 1979). Rising health care costs, however, affect all purchasers of health care services. Government action alone has been unable to limit the growth in these costs. An aroused business community could make the difference if it added its purchasing power to that of government in an effort to discipline the utilization and pricing of health care services.

Businesses are certainly important purchasers of health care services, buying annually tens of billions of dollars worth of care on behalf of their employees. Many observers believe that firms, because of these expenditures, are a potential force for health sector reform (Council on Wage and Price Stability, 1976; Havighurst, 1978; Altman, 1978). The view they offer is that firms, especially the largest, are concerned about increases in health care costs; are seeking to improve

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the efficiency of health care services; are willing to use their influence to restrain the growth of duplicating medical facilities; are interested in exploring alternative modes for delivering care; and are ready to join with government in instituting reforms.

It is also not surprising that to realize this envisioned alliance between business and government some analysts are tempted to exaggerate its necessity and likelihood. There is no better example of this sin of exaggeration than the several versions of the auto makers' health care cost problem. One has General Motors buying more health insurance than it does steel; another attributes $2,000 of the price of a $5,500 Ford to the health care costs of the Ford employees (Iglehart, 1976; Cahill, 1979). If all 26 of the Blue Cross and Blue Shield associations from which General Motors buys health insurance are taken as one organization, then it is true that Blue Cross/Blue Shield is General Motors' largest supplier, much more important to their operations than U.S. Steel. But the 26 Blue Cross and Blue Shield associations are not one organization, and General Motors buys steel and steel products from more than 1,000 suppliers, U.S. Steel being only one of them. The $2,000 figure is the approximate annual cost of the health benefits of the average auto worker, not the price of health care in the average car. If we count all wages and benefits, each of its workers costs the auto manufacturers $30,000 a year. The auto workers' health benefit, generous as it may be, accounts for less than 7 percent of the total wage bill, a percentage not outrageously out of line with the experience in other heavy industries. The cost of health care included in the price of the average car ranges from $150 to $300, depending on model and manufacturer. As disappointing as this information may be to some, there is more steel than health care in American automobiles, even in the lighter weight cars now being produced (Zink, 1976b; 1978).

Still, one can be curious about the extent to which corporations are concerned about their health care costs and are willing to take action to control them. Even if firms are not overwhelmed by rising health costs, they might view these costs as a threat to their prosperity and be willing to join government in pursuing cost containment strategies. Perhaps there are particular containment strategies to which corporations are especially attracted and for which government might appropriately offer its assistance or collaboration.

To explore these topics, we interviewed executives in 69 firms

(Table 1). In each firm we sought and in most cases were able to obtain interviews with the chief executive officer or other board level officer, as well as with officials directly responsible for the management of the firm's employee benefit programs. Half of the firms were selected randomly from the various *Fortune* lists (the first 500 Industrials, the second 500 Industrials, the 50 largest Financial-diversified, Commercial banks, Life insurance, Retail, Transportation, and Utility firms). Only 9 firms (Table 2) refused to participate in the study, 3 of them still headed by their founders. In addition, we interviewed executives from major firms whose headquarters were either in cities that have a reputation for business involvement in health affairs (Minneapolis and Rochester), or representatives of industries in which there was widely reported special interest in health care costs (automotive and steel), managers from a sample of small firms located in the Boston area, senior representatives of major insurers selling group

TABLE 1
Firms Surveyed

Number of Firms	Industry	1979 Employment
2	Aerospace	178,000
2	Airline	110,800
3	Broadcasting/Publishing	38,800
4	Chemicals	188,600
6	Computers/Office equipment	652,000
4	Conglomerate	188,200
6	Consumer products	257,700
3	Electronics	407,000
6	Finance/Banking	86,400
3	Food products	221,000
4	Industrial products	105,300
3	Insurance	76,500
4	Metals	185,000
4	Motor vehicles/Parts	1,441,000
4	Pharmaceuticals/Scientific	53,700
3	Raw materials/Oils, Lumber, etc.	160,800
3	Retailing	580,000
2	Service	106,700
3	Utilities	1,015,600
69		6,053,100

TABLE 2
Firms That Refused to Participate in Survey

Number of Firms	Industry	1979 Employment
2	Chemicals	22,500
2	Consumer products	22,600
2	Finance/Banking	8,700
2	Industrial products	43,000
1	Pharmaceuticals/Scientific	49,000
9		145,800

policies, insurance brokers, health benefit consultants, knowledgeable and relevant state and local officials, representatives of health provider associations concerned about the topics we were exploring, labor union officials, and the federal officials responsible for the design of federal employee benefit programs. Approximately 250 individuals were interviewed in sessions ranging from one half to four hours. Because of the diversity of the sample and the complexity of the issues involved in the study we did not utilize a standardized questionnaire for interviews. Instead, we followed a topic guide, exploring specific topics in depth as was thought appropriate.

We concentrated our attention on large firms because they are a significant factor in the market for private insurance and because, owing to their bureaucratic structure and public visibility, they are the business organizations most likely to work with government if a collaboration were established. The firms on the *Fortune* 500 lists, for example, employ nearly 30 percent of the labor force in the United States and generally offer the richest benefit packages to their workers. The firms we interviewed employ over 6,000,000 persons (or approximately 6 percent of the American labor force) and are responsible either partially or totally for the health care benefits of more than 12,000,000 individuals when retirees and dependents are also considered. In comparison, the total of federal beneficiaries, counting current employees, federal retirees, and dependents, is about 10,000,000. Because the interview information gathered was obtained with the promise of confidentiality, the specific firms visited will not be identified. (Tables 1 and 2 describe the type of industry and size of employment of the firms approached in the survey.) The references

to specific firms in this paper are taken from published sources and may or may not involve firms at which interviews were conducted. Our study of the federal government as employer will be reported separately.

Notwithstanding our efforts to be discreet, systematic, and comprehensive, we make no claim that the survey was scientific in the strictest sense of the term. For example, we did select some of the firms for interviews, not randomly, but rather because of their reputation or location. We also avoided the use of standardized questionnaires, thinking them too confining for the discussion we sought with senior executives. We are confident, however, that our exploration of the topics covered in the survey will stimulate others to attempt to apply more rigorous methodologies to the same issues.

Corporate Benefits

Before reporting our findings, it is useful to describe briefly the type of benefits the firms offer and the origin of employer-provided health care insurance. Health, of course, is only one of a number of benefits American employers offer their employees. Retirement income, vacations, insurance covering life, accidental death, short- and long-term disability, and income protection are among the more common benefits, in addition to medical service and hospitalization insurance. Increasingly, however, firms are adding dental care, vision services, matched savings, legal assistance, recreational services, and educational opportunities to the list. The range of possible benefits is enormous. Pace-setting firms, International Business Machines and Texas Instruments, for example, are said now to offer such unusual benefits as financial assistance for the care of the dependent with severe handicaps, and lump-sum payments to employees who adopt children; these firms also are thought to be considering sabbaticals for employees (Kneen, 1978; Matlock, 1980). One petroleum industry executive, commenting wryly on the trend, noted that it was possible to insure against everything including lunch; he ignored the fact that many large employers already subsidize the lunch of their executives and headquarters' staff, if not of all their employees.

The percentage of total compensation accounted for by benefits has been growing. In 1960 it was about 25 percent; today it is about

40 percent (Geisel, 1980). Table 3 summarizes the historical experience—although measurement problems and reporting variability cast doubt on the precise accuracy of the figures. This growth is largely attributed to favorable tax treatment of benefits, by which most benefits are not considered as taxable income for employees, and employers can claim them as a cost of business. Table 4 shows the distribution of costs by specific benefit. Vacation and retirement benefit costs exceed those of health care, but health care and disability costs are increasing most rapidly. The increases in disability costs are thought to be due to benefit expansion and changing employee attitudes toward work; the increases in health care cost are considered most likely to be due to inflation in the health sector rather than to increases in benefits or utilization.

The health care benefit is usually defined to include insurance coverage for hospitalization, medical, surgical, laboratory, and X-ray services, dental care, vision care, drug usage, mental health services, nursing and physical rehabilitation services, specialized services such as those for alcohol and drug dependence, and any direct care provided through clinics maintained by the employer. Normally excluded are income replacement and sick leave payments made directly to em-

TABLE 3
Employee Benefits as Percent of Total Payroll Costs, 1959–1979 (Panel of 182 Firms)

Year	Percent
1979	41.2
1977	39.9
1975	37.6
1973	35.1
1971	33.0
1969	31.0
1967	29.1
1965	27.1
1963	26.8
1961	25.8
1959	24.4

Source: Chamber of Commerce of the United States, *Employee Benefits 1979*, Table 19, p. 27. Washington, D.C., 1980.

TABLE 4
Average Employee Benefit Payments, by Type of Benefit, as Percent of Employee Payroll Costs, 1979 (922 Firms Reported)

Benefit	Percent of Payroll Costs
Social security taxes	5.8
Unemployment taxes	1.5
Workers' compensation	1.7
Pension costs	5.4
Life, health insurance	5.7
Long-term disability	0.3
Dental insurance	0.3
Discounts	0.1
Employee meals	0.1
Paid rest, lunch periods	3.5
Vacations	4.7
Holidays	3.2
Paid sick leave	1.2
Other leaves	0.4
Profit-sharing	1.4
Savings plans	0.7
Miscellaneous	0.6
	36.6

Source: Chamber of Commerce of the United States, *Employee Benefits 1979*, Table 4, p. 8. Washington, D.C., 1980.

ployees. As the specifics of the benefits are determined either unilaterally by firms, or jointly through negotiations with unions, subject only to minimal government regulation, there is great variation throughout the economy. Further variation occurs because firms differentiate among employee categories, provisions for dependent and retiree coverage, and requirements for employee cost-sharing in the form of deductibles, copayments, and coinsurance. There are literally hundreds of thousands of health benefit packages.

We do know through insurance surveys conducted by the government that over 80 percent of the work force has some private group protection against the costs of hospitalization and nearly as high a

percentage is protected against some medical and surgical expenses as well. The precise percentage of work force coverage is in doubt because of different methods of data collection. Lee (1979) cites an 80+ percentage and official reports listing over 90 percent. Skolnik (1976) cites a 70 percent figure. If consideration is limited to firms employing over 100 workers, the figures approach 100 percent coverage. For further discussion, see Sudovar and Feinstein (1979).

For much of the covered work force, this protection extends to dependents as well. Coverage is most extensive for acute illness and accidents. Less well protected are costs employees and their dependents may incur for other types of health care services such as outpatient services, drugs, and home nursing. But improvements are constantly being made in the range of benefits available to employees. Dental care insurance now covers 30 percent of the work force, up from 12.8 percent in 1975 (Shapiro, 1980). Some states—Massachusetts and Minnesota, for example—have begun to require employers to offer coverage for mental health care and substance abuse (alcohol and drug) treatments. Only part-time workers and those employed in industries dominated by very small firms are left behind in the trend to ever-increasing health care coverage (Congressional Budget Office, 1979).

The firms we studied rank among those that offer the broadest and deepest protection for their employees and the employees' dependents. A typical health benefit includes 365 days of protection against hospitalization, reimbursement for the usual and customary charges of physicians for medical and surgical services, 180 days of inpatient and up to $1,000 of outpatient mental health coverage, alcohol and drug rehabilitation care, scheduled dental coverage, and a limited amount of home nursing and physical therapy. All of the firms require employees to share in the cost, usually in the form of paying an annual deductible of $50 to $100 and 20 percent of medical charges. Most, however, pay the full premium for the employee and the employee's dependents. A 1979-1980 survey of 601 companies by Hays Associates indicates that 71 percent pay full cost for employees and 48 percent for employee dependents, up from 64 percent and 40 percent respectively in 1978-1979 (Shapiro, 1980). Many establish a stop loss of $1,000 or $2,000, after which the benefit plan will pay all costs incurred until the limit of coverage is reached (often as high as $500,000 or $1,000,000). Increasingly, supplemental coverage is

provided for retirees who receive Medicare benefits under Social Security.

Sometimes distinctions are made between executive level and other employees, the executives receiving free health insurance coverage and/or special benefits such as annual physical examinations or additional coverage when stationed abroad. More usually, the distinction made is between unionized and nonunionized employees. Benefit differences exist because those for unionized employees are framed in collective bargaining agreements, often on a plant-by-plant or craft-by-craft basis. As will be discussed more fully below, however, many firms with substantial numbers of unionized employees, or potentially subject to union organizing drives, follow carefully drawn strategies in which their nonunionized employees are provided with benefit improvements either in anticipation of or in keeping with union demands.

Unions clearly have played an important role in the development and expansion of employee benefits (Goldman, 1948). Historically, workers banded together not only to press wage demands, but also for common succor, providing aid to one another in time of personal illness or family distress. In the early twentieth century, major industrial employers sought to woo workers away from unions by offering similar assistance. Competition among employers and between employers and unions for the loyalties of workers led to an expansion of the number and types of benefits being offered. When unionization did occur or was maintained, benefits gradually became a subject of bargaining and part of the collective agreement.[1] The inability of unions to maintain the financial solvency of their programs, largely because of fluctuating membership, increased their willingness to accept employer-provided benefits. Union leaders are thought to favor benefit increases over additional wages, as bargaining for benefits is a complicated undertaking that adds to their power within the union (Greene, 1964; Swidinsky, 1971; Mabry, 1973).

Government also was instrumental in the growth of these benefits.

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[1] Fringe benefits became a legally inclusive element of collective bargaining in *Inland Steel Co. v. National Labor Relations Board* 170 F. 2d 247, September 23, 1948. Health benefits were specified as being included in the Inland case ruling in *W.W. Cross & Co., Inc. v. National Labor Relations Board* 174 F. 2d 875, May 24, 1949.

Legislation and court rulings established the right of workers to organize collectively and to bargain for wages, working conditions, and benefits. During the Second World War the government, seeking to control wages and prices, but also wishing to avoid strikes, permitted substantial additions in so-called worker fringes (nonwage income increases including health care benefits). Favorable tax interpretations allowed these additions to occur without affecting tax liabilities of either worker or employer (Steuerle and Hoffman, 1979; Comanor, 1979; Congressional Budget Office, 1980; Greenspan and Vogel, 1980; Vogel, 1980).

Insurers too have aided the growth of benefits, first in demonstrating the wisdom of sharing risks and then in providing convenient and efficient management of benefit plans for employers preoccupied with their own businesses. The competition among insurers reduced the price of providing benefits and improved their design and acceptability. Experience-rating gave employers the feeling that they were controlling their benefit costs, or at least paying only for the costs for which their employees were responsible, while the use of usual and customary charges for reimbursement increased the satisfaction of employees and health care providers. Health insurance, it was said, initially was a loss leader by which insurers found an opportunity to sell additional types of group and business insurance.

The Favorite Benefit

Although unions now enroll only 20 percent of the national work force and are concentrated in a limited number of industries, they are never far from the thoughts of corporate executives. Most of the firms we studied have predominantly nonunion work forces and their executives want to keep it that way. Providing generous benefits is universally held to be an effective policy to reduce the attractiveness of unionization. Freeman and Medoff (1979) believe that the presence of unions increases spending on fringe benefits, especially health benefits, as unions respond more to the needs of the average worker than to the marginal worker. The average worker tends to be older, with more family responsibilities, than the marginal worker. Nonunion firms, they argue, respond more to the needs of the marginal worker whose needs act as a barometer of the current labor market. Where

unions exist, we found, the policy is often to isolate them by offering superior benefit packages to nonunionized employees. Firms seem quite willing to pay a premium, at least in terms of benefits, to retain the managerial freedom a nonunionized work force is perceived to give.

With rare exceptions, the benefit design and benefit management activities are assigned to the vice-president for personnel, human relations, or some similar category. This organizational location appears to reinforce the tendency to be generous with benefits, because the overriding concern is recruiting employees with scarce skills and maintaining work force morale. Although the assertion is never made that benefits attract potential employees, it is widely thought that comparatively inferior benefits are an impediment to recruitment and the retention of key employees (Greene, 1964). Given that there are usually several categories of workers in short supply, such as engineers or technicians (Rundle, 1980), and given that firms prefer to offer the same or similar benefits across their entire work force or at least broad segments of it, there seems to be an inherent upward pull in benefits through its assignment as a subordinate activity within the personnel function.

Benefit design begins with the identification of broad compensation goals. Invariably, the goals are derived from surveys of firms in the same industry or those who are said to be "peer firms" either because of their similarly structured work forces or because of their national standing. The goals take the form of corporate objective statements such as these: Our intention is to set our wages and salaries at the 75 percentile level of peer firms and our benefits at the 60 percentile level; or, We want to pay average wages and above-average benefits. For technologically based firms, the comparisons always involve Texas Instruments and IBM; for unionized firms, the comparisons involve settlements achieved by the auto makers and the United Autoworkers and the major steel companies and the United Steelworkers (Brown, 1979). Even firms that lack a technological orientation or a large unionized work force, retailers, for example, cannot completely ignore these pattern setters as they all worry about unionization and employ computer specialists, who are in short supply. Thus, major benefit improvements implemented by the nation's richest or most unionized firms diffuse throughout the economy by means of a chain of interfirm comparisons.

All the firms visited claimed also to be sensitive to the desires of their employees; many conducted periodic opinion surveys of workers and dependents to determine areas of benefit-related dissatisfaction. Complaints about poor benefit yields, or reports that friends and relatives are receiving better benefits such as dental care and drug coverage through other employers, become evidence for proposals to improve benefits. Given that the benefit staffs are designing their own benefits at the same time, there is a natural tendency to see benefit improvements in the most favorable light. Organizational self-interest works in the same direction; unless there are benefit improvements to be made, there is usually no need to support a staff to design benefits.

The survey evidence, however, shows clearly that, among available benefits, employees generally appreciate their health benefits most. Health benefits are viewed favorably throughout the age spectrum and among all classes of employees. Alone among benefits, they are used frequently by nearly all employees. (Disability, retirement, and death benefits, to be sure, are intended for limited use; not everyone saves money, or desires extra educational opportunities.) Not surprisingly, management is disposed to improve the health care benefit.

In fact, top executives are occasionally so sensitive to the morale aspects of the health benefit and the human needs it embodies that they are willing to break company rules in order to provide extra care and financial support for employees and their families. In one instance, a president of a firm told us that he ordered major dental work at company expense for several low-ranking employees even though the company lacked a dental plan. In another, the benefit manager of one of the nation's largest industrial firms told us that senior executives had granted extended coverage for the severely ill child of an employee whose care had exceeded the firm's maximum health benefit. And, in a third, the firm's personnel vice-president quietly maintained a fund from which he would reimburse employees for expenses denied or not fully paid by the firm's insurer. Other executives told us that their firms would never permit such practices; they admitted though that an accumulation of instances where needs were manifest would likely bring quick improvements in the firm's health benefit.

Several well-publicized labor disputes stand as reminders to executives who fail immediately to grasp the importance that workers place on health benefits. In 1976, Ford took a 4-week strike at the

behest of the industry in an attempt to achieve additional cost-sharing from the United Autoworkers (UAW) for the auto workers' health benefit (Weber, 1979). That strike ended without any concession by the UAW on this point. Since then, cost-sharing has not been a significant factor in the industry's labor negotiations. Instead, the industry's effort has been directed, but not very successfully, toward limiting increases in health-related benefits (Zink, 1978a). In 1977, the United Mine Workers struck the coal industry in order to regain health benefits lost in the bankruptcy of their own health fund (Derzon, 1977). More recently, both the oil refining and steel industries sought to limit the employer's share of health benefits; the oil refiners attempted to hold the employer's contribution to a fixed dollar amount, and the steel producer attempted to reinstitute cost-sharing. Neither succeeded. The oil refiners ended a 7-week strike by raising the contribution significantly. Steel producers, warned by the union that they would face the longest strike in the industry's history if they persevered, dropped the issue during contract-bargaining. Although it is clear that multiple issues are usually involved in labor negotiations, and that there is much posturing for the record and the press on both sides in such negotiations, it is also clear that tampering with health benefits is unprofitable.

But most of the firms we visited felt little impetus to seek changes in health benefits. For many, rapidly rising disability costs, or complaints from retirees about inadequate pension benefits, loomed as larger problems. Health care costs were growing, but often at or below national averages. Although benefit managers might be tempted to claim their good judgment as the cause, most attributed this apparent good fortune to the fact that their firms had long offered excellent benefits, and that large increases usually occur when extensive new opportunities are offered for service utilization. The firms had already given away the benefit and were pleased to learn that its costs simply kept pace with that of competitors and the rest of society. Top management rarely expressed a deep interest in health care costs, preferring instead to wonder only whether or not benefits were up to date with those of major rivals. Assured on this, they would concentrate on the central features of the business.

Only 4 of the firms had recently reduced a health care benefit, and 3 of them had offered their employees compensating increases in other benefits. Two were insurers seeking to sell their clients a health cost

containment package that included benefit redesign, and they felt compelled to accept it for themselves before facing customers. To pacify their employees, they asked for only nominal contributions, and increased life and disability benefits by more than comparative amounts. The third was a financial firm also in the business of health insurance and also willing to compensate its employees for the benefit retraction, this time with a dental plan.

Only an industrial equipment firm actually withdrew benefits. It required employees with dependents to contribute a greater share of the health benefit costs by paying an increased deductible. The change was made with great trepidation and was preceded by an internal publicity campaign that emphasized the effect of rising costs of health care premiums on the firm's profitability. When the change took place without significant protest, the publicity program was quickly dropped. No further benefit retractions are planned.

More commonly, firms were ready to increase health care benefits. Several retailers, recovering from poor earnings, felt that they had dropped too far behind their industry norms in providing benefits. One manufacturer, feeling the pressure of a local labor market, also wanted to increase benefits. Several conglomerates on our list were pursuing policies of offering comparable benefits throughout the firm and thus were in the process of improving the benefits for new acquisitions. A newspaper publisher saw the corporate mission as instituting decent benefits for the staff and printers of the several suburban and small-town papers it recently added to its holdings.

Although not entirely typical, one firm's behavior does demonstrate the problem the government faces in seeking an alliance with business in containing health care costs. Long a laggard in its industry, the firm recently became quite profitable. Much of its personnel effort is now devoted to compensating its employees for the many lean years. It has recognized the national inflation of health care costs and is ready to do something about the problem. Retirees' pension checks recently were accompanied by a note that read: "Due to rising health costs we have increased your supplemental health care benefit." Industry is not inclined to be tough on its retirees, employees, and dependents. After all, they are family. We discovered that there is much more paternalism in American industry than is commonly admitted.

Favorite Solutions

Those who specialize in advising firms on health benefits have a number of standard recommendations for ways to contain rising costs. Their favorites are: redesigning benefits to increase cost-sharing by employees (Di Prete, 1977); tightening of claims control (Tillotson and Rosala, 1978); promoting health maintenance organizations (*Washington Post,* 1978); and involving employers in attempts to limit the local supply of expensive health services (Goldbeck, 1977). Few corporations, however, find these recommendations congenial.

As we have reported, there is little inclination to require employees to absorb a greater share of their health care costs. The design of the dental benefit, the newest addition to the list of corporate benefits, appears to be the exception. Reluctant to take back benefits once given, corporations tend to be more careful in structuring new benefits. The standard dental benefit involves the use of a fee schedule that enumerates maximums for each procedure and a sliding copayment arrangement that favors preventive dental care over major reconstructive procedures. Some firms also require previous authorization for procedures priced over a certain amount. It would seem then that firms are likely to take a tougher stand toward health care costs.

But the dental benefit experience is deceptive. The firms recognize that there are important differences between medical and dental needs. Although medical care may involve the treatment of life-threatening conditions and the expenditure of prodigious sums, dental care almost always involves the provision of routine services and has predictable, limited costs. Dental care can often be delayed, without undue pain or aggravation of the condition, while approval for treatment is sought. The burdens placed on employees in the case of dental care, then, are modest when compared with what would be required if increased cost-sharing were required for medical care. Moreover, firms expect dental benefits to grow. One firm, when faced with the choice among what were described as Chevrolet, Buick, and Cadillac dental plans, picked the Buick. There was no point, we were told, in giving away everything at once. There had to be room for future benevolence.

There is a similar disinclination to implement tighter claims control. Firms fear disrupting employee relations by appearing suspicious or miserly when claims are filed. The prime concern in benefit admin-

istration appears to be to make certain that employees in time of need identify the benefit they receive with the corporation, rather than that they meet restricted access to these benefits. Thus, some firms use their own staffs to process claims instead of that of their insurer so as to heighten the firms' identification with the benefits.

The excuse firms often give for failing to use claims control as a mechanism to contain costs is that they lack the data necessary for action. Indeed, it was surprising at first to learn how little most firms know about the details of their claims experience. Some blamed their insurance carriers for this lack of information; others blamed competing priorities for the failure to obtain the data. The pattern of ignorance, however, was so universal as to belie any real intention to gather the data. Most firms, it seems, simply do not want to know what they would need to know to police the behavior of their employees and service providers.

To be sure, firms try to discourage fraud on the part of employees and health care providers and will act to protect themselves when flagrant patterns of abuse are uncovered. The existence of a claims-checking procedure, as innocuous as it might be, is thought to be a sufficient deterrent to fraud in most cases. Few firms, though, seem anxious to test the effectiveness of their current systems or to impose more stringent ones. The presence of a union only heightens their reluctance to get tough with their employees. The fear of bad publicity is the constraint on chasing providers.

There is considerable variation in the attitudes of corporations toward health maintenance organizations (HMOs). For some, HMOs are the answer to rising health costs and they do everything within their power to encourage their employees to enroll in these prepaid group practices. But, for most, HMOs are not viewed as the panacea advocates claim they are, but as having many faults.

To begin with, firms that are national in scope find it administratively inconvenient to deal with dozens of HMOs, each enrolling a small percentage of their work force. Their preference is for a national contract with one or two insurance firms to manage their entire health benefit package. To protect their employees from fraudulent or inadequate providers they feel compelled to investigate each HMO that seeks access to the firm's employees. This time-consuming process contrasts with the ease of signing a contract with one or another major insurer. With a major insurer there is a single price for the services

rendered, standard reporting forms, and a uniform set of benefits for the employees.

In addition, some executives remain skeptical about the savings HMOs are supposed to achieve. We witnessed, for example, an impromptu debate between officials of a firm that has 25 percent of its headquarters work force (several thousand workers) enrolled in 3 health maintenance organizations. The firm's chief medical director, an HMO advocate, praised the corporation's record in encouraging employees to enroll. The firm's insurance director, concerned about a rapidly rising Blue Cross rate, complained about HMOs' "skimming" (seeking out or attracting only the healthiest clients), and the fact that the firm's overall health insurance costs had increased rather than decreased despite their large HMO participation. No firm we visited could provide documented evidence of savings, though some still believed that savings would eventually be obtained.

Finally, no matter what the attitude toward HMOs, there is great reluctance to force employees to select one type of health service delivery system over another. We were constantly told that the employee's freedom of choice had to be protected. Since most managers are unlikely to sacrifice their relationship with particular providers, they cannot in good conscience attempt to direct the choice of the firm's employees. The potential, then, for the growth of independent practice associations (IPAs) is great, as this form of prepaid care does not restrict employee choice of physician as does the standard HMO format and thus is more compatible with the attitudes we found among executives.

Of course, the attitudes of union leaders also have to be considered. In most cases they, too, resist attempts to restrict the choice of employees to particular types of delivery systems. The firms with the highest HMO penetration tended to be those with low union membership. It may be that the desire of union leaders to act as the negotiator for the specific benefits members receive is the inhibitor. At least, that is what several benefit managers suggested to us.

Corporations are also reluctant to participate in attempts to restrict the local availability of expensive health facilities. In most cases they feel that they lack the employment concentration to be a significant influence locally. And when they have such an employment concentration, they are reluctant to use the power it gives them to further their health benefit interests.

To be sure, there are glaring exceptions. In Rochester, New York, for example, a handful of major employers—Kodak, Xerox, Sybron—dominate the economic life of the city and are willing to use their resources to achieve such self-defined health goals as restricting the duplication of services and the growth in number of acute care beds (Sorensen and Saward, 1978). But the Rochester experience, as enticing as it may be for health policy analysts, can be duplicated in only a few locations across the country and raises important questions of equitable political representation and social justice. Most firms feel their political power is limited at the local level, and prefer to husband it for tax or zoning purposes, problems more central to the firm's financial condition.

There have been some experiments in training firm managers to improve the quality of their service on local hospital and health planning boards and in taking official stands against the expansion of particular health care institutions. But the fear of lawsuits, provider boycotts, and community backlashes against involvement in local decision-making serves as an important restraint on these activities. It is still less risky to appear as a community benefactor, donating to the local hospital building fund, than as an antagonist to community medical care ambitions.

A favorite example reinforcing this point is the story of the major industrial firm that decided it was not going to pay for chiropractic services. The staff work preceding the decision was impressive. So, too, was the flood of postcards from chiropractors to the president of the firm, promising him never to buy another one of the firm's products if the decision stood. Although chiropractors do not account for a significant share of the firm's market, the president was unwilling to jeopardize any sales for a small saving in benefit costs. Quickly the decision was reversed.

When firms are motivated to act they prefer to do it in concert with others. Thus, local health cost-control coalitions have been formed by firms in Westchester County/Fairfield County, Philadelphia, Chicago, and elsewhere (Government Research Corporation, 1979a, 1979b; Demkovich, 1980). Such coalitions are exploring the establishment of projects to control local hospital growth and develop outpatient and day surgery facilities. However, these coalitions are potentially quite unstable as their member firms are involved in different markets, jealous of their independence, and subject to changing

internal priorities. The least hint of bad publicity is certain to strain the coalition.

Actual Policies

Firms have taken some steps to control health care costs, but not the ones advanced by health policy analysts. Large firms know how to manage large amounts of money. As health care costs have risen, health benefits have come to involve large amounts of money. Not surprisingly, firms devote a lot of attention to being certain that the money set aside for health benefits is managed well.

Most major firms now self-insure (Egdahl and Walsh, 1979). This means that they carry their own risks for fluctuations in benefit costs. By doing so they avoid placing significant reserves in the hands of insurance firms and the 2 percent tax that states levy against insurance premiums. Insurance companies are usually retained to administer the benefits—to process claims, maintain records, issue reimbursement checks, and monitor relations with providers, tasks for which they are paid a negotiated fee. The benefit administrators, whoever they may be, draw funds to pay health care providers from the employer's account. Any reserves or claim set-asides are invested for the firm's own advantage (Herzlinger, 1978). The insurers find some comfort in the new arrangements as they no longer bear risks and can charge for each service (e.g., report) they provide their clients. They compete now on the efficiency and speed of their administrative services as well as their ability to calculate risks.

Even if firms do not formally self-insure, they can gain equivalent benefits by bargaining with their insurers. Minimum premiums and other devices guarantee that large firms do not lose the use of funds accrued for claims. Insistence on experience-rating even when dealing with HMOs and Blue Cross assures firms that their interests always are protected and their premium costs are kept to a minimum.

Firms have also begun to seek discounts from hospitals that are heavily used by their employees. The discounts are obtained in consideration for prompt payment and continued patronage. Another 2 to 5 percent of benefit costs can be saved in this manner. Discounts loom large in potential importance when one recognizes that hospitals often transfer losses on government clients to private payers. No longer

are the government and Blue Cross the only favored buyers of hospital services.

To most firms, however, health benefit costs are simply one small component of the wage bill. Seriously pressed, they do not look for significant savings by carefully managing benefits. Instead, they seek to trim labor costs as a whole by laying off workers and/or shifting to other businesses. The effects layoffs have on the availability of health insurance are discussed in Lee (1979).

Many firms sought to emphasize this point by underlining the role that business strategy plays in controlling benefit costs, to which we have already alluded in the discussion of compensation goals. Another aspect of the business strategy is selecting carefully the areas for investment. Several firms, burdened with what they thought were expensive union settlements, told us that future growth was to be limited to businesses in which the work forces were unorganized and largely part-time. Others stressed plans to close factories in urban areas where labor costs were high, and shift production to lower-cost rural areas or abroad. Rather than focusing on a small component of the wage bill—health benefits—these firms preferred to stress ways to reduce overall labor costs.

Still other firms reported to us that labor costs, in whole or in part, are not important to them. In their industries, profits depend on raw material prices or the pace of technological advancement. As long as these crucial aspects of the business were properly managed, the costs of increased health benefits could easily be recovered through increased prices on the products.

It was largely these firms that seem most interested in health promotion and programs for modification of lifestyles. Although some references were made to the potential of preventive health efforts to reduce future health care costs, most executives knew that these claims were as yet unproven. Instead, preventive health was viewed as simply another benefit and a popular one at that. Their work forces tend to be professional and middle class. Providing employees with well-equipped gyms, time off for jogging, and guidance on good nutrition and weight loss fits perfectly with the values prevailing among these workers.

Of course, it is possible to take these programs to an extreme. The capacity of chief executives in some corporations to impose their whims on the organization appears near boundless. Thus, we find headquarters staffs entering teams in local marathons and enduring noontime ses-

sions of Alcoholics Anonymous just because the boss is a reformed fatty or an alcoholic.

Nevertheless, there is no doubt of the popularity of preventive health programs as additional employee benefits (Kaplan, 1980). And if the claims made for these prevention programs by their advocates even partially materialize, then the future medical costs of many corporations may decline. Certainly many benefit managers recognize the potential savings accruable to corporations by reductions in time lost and in the frequency of early death due to common illnesses and inadequate physical conditioning. These savings, however, may only mean additional costs for the government as it is the government and not the corporation that bears the burden for most of the care of the elderly (and the poor and the unemployed as well) in our society.

Conclusions

We found in our interviews that corporations were neither greatly concerned nor strongly motivated to do much about their health benefit costs. In our view, the opportunity for a close collaboration between business and government to contain health care costs simply does not seem to exist. To be sure, firms are no longer totally passive about health care costs; continual expenditure increases could provoke stronger action than what we have observed. However, firms are not now nor are they likely to be the force for system reform that some have imagined.

Major corporations are under no illusion that they can do much individually to alter their health benefit costs. The benefits have long since been given to employees and cannot now be called back without risking more employee dissatisfaction than most of these firms appear willing to tolerate. Moreover, once the benefits are established, the level of costs the corporation will incur is largely determined outside the firm by health care providers, physicians, and hospitals interacting in the overall health care system. The firm's ability to influence the system is not thought to be great. The political risks of attempting anything ambitious is believed to outweigh any savings the firm might achieve. Collaborative action tends to be limited by the least-willing participant.

Firms also believe that none of the proposed solutions, including some that they favor and have implemented, is likely to be very

efficacious. Self-insurance, HMOs, and second-opinion programs are viewed as producing marginal savings. Even proposals to eliminate the tax advantages are greeted unenthusiastically, as it is thought that compensatory wage increases would have to be provided if the proposals were adopted.

Benefits are provided because many workers want them. The level of benefits provided depends on the market conditions in the industry in which the firm operates and the nature of its work force (i.e., its age, sex, and location). Competition for key categories of employees and the threat of unionization spread benefit increases throughout the economy. For most of the firms we interviewed the key benefit issue is whether or not the employees are satisfied, not why the benefit costs are high. Until the benefit function is transferred to the jurisdiction of corporate financial managers, who naturally view every expenditure with a jaundiced eye, it will be considered largely as an adjunct to employee recruitment and retention activities.

Although government may be concerned with rising health care costs, we think most major corporations are not. Health benefits for the poor and the elderly account for nearly 10 percent of the federal budget and have recently been growing at twice the rate of other expenditures. In contrast, employee health benefits account for 2 or 3 percent of corporate expenditures and are growing less rapidly than many other business costs.

Doing absolutely everything it is advised to do to control health care costs, a company might be able to save 0.1 percent of total expenditures if it is fortunate. The equivalent managerial energy expended on activities more central to the business is almost always seen as more productive and certainly as less disruptive of corporate routines. Government not only uses a different calculus, but also has a larger health care cost problem.

This difference in perspective was dramatically shown in the stand the Business Roundtable (1979), the organization of America's major corporations, and its health care spin-off, the Washington Business Group on Health (1977), took on the Carter administration's Hospital Cost Containment proposal. Both groups opposed the bill, not just because they believed it would be ineffective, but also because they were opposed to any increase in governmental regulatory authority, regardless of the intended purpose. Although government has to place priority on controlling health costs, major corporations do not. They apparently perceive that there are greater evils to be combated.

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