

# **MANUFACTURERS ON THE FRONT LINES OF COMMUNITIES:** A Deep Commitment to Health Care

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## ABOUT

This paper builds on work initiated in 2020 in conjunction with Northwestern University's Feinberg School of Medicine and provides an overview of how manufacturers have been resilient and innovative in providing care that is accessible and affordable, places special attention on the management of chronic illnesses and is guided by sound data analysis. This work is the culmination of the review of academic research and a recent survey of more than 160 manufacturers, largely from small and medium-sized companies, and a series of in-depth interviews.

CHAIN CLAMPS AIR

# Manufacturers on the Front Lines of Communities: A Deep Commitment to Health Care

Manufacturers have a long-standing and proud commitment to providing quality health care to their employees and their dependents. While 99% offer health insurance coverage to their employees, manufacturers face continuing challenges in their efforts to deliver quality and affordable health care to worker populations and their families. The pandemic not only underscored the importance and necessity of health coverage, but also helped re-envision the future capabilities of health care through innovative delivery mechanisms like telemedicine, new therapies, a wider social acceptance of mental health care, new approaches to medical conditions and the numerous applications of treatments and technology like mRNA vaccines. Manufacturers are on the front lines of their communities across the nation, and delivery of health care is a critical, community-oriented undertaking that has stretched companies to their limits. Despite rising costs, hospital and provider consolidations, limited competition in insurance markets, less access to care in rural markets and an overall lack of transparency, manufacturers have risen to the challenge consistently to make it all work for their employees and families.

While manufacturers are committed to continuing to help improve health outcomes and well-being for the workforce, there is no supporting infrastructure for employers when it comes to the navigation of regulatory barriers, the transparency of decisions led by the management of health care providers and hospitals, the coordination of managing certain chronic conditions that disproportionately impact worker populations and the increasing lack of access to specialty care communities across the U.S. While the United States leads the world in medical innovation and has harnessed an unrivaled research ecosystem—especially as it relates to new therapies, treatments and medical devices—the delivery of health care is in need of serious reevaluation and restructuring that puts the patient first and reduces the waste that surrounds the system.

Many manufacturers have taken health care matters into their own hands. Manufacturers are health benefit designers, innovators and funders whose efforts are undermined frequently by the complexities, bureaucracy and ineffective design of the broader health care system. This paper—the first in a series—uses data and manufacturers' firsthand experience to articulate the challenges and opportunities ahead in this rapidly shifting system.

## Key Findings

- Designing health benefits is difficult and increasingly expensive, and the insurance system is not designed to meet the needs of many manufacturers. Yet, employer-sponsored health coverage is the most common type of health insurance in the U.S.
- Health care must be affordable for employees to take advantage of services beyond what an employer underwrites. Affordability is key for both employers and employees.
- Manufacturers strive to be forward thinking and utilize tools such as primary care to support early interventions and improve outcomes for employees.



## A Deep Commitment to Employer-Sponsored Health Care

Americans, and as this paper examines, manufacturing workers in particular, depend on and appreciate the health coverage their employers provide. In 2019, just under half of Americans (49.6%) received health insurance from their employer, and around two-thirds of those were covered “under self-insured arrangements where the employer, rather than the insurer, carried the financial risk for health care costs.”<sup>1</sup> This means that employers that design their own coverage plans play a significant role in the larger health care sector. However, manufacturers have felt that their role as health care benefit designer, innovator and funder has often taken a backseat to other health care forces at play. They are frustrated that the system has become so expensive and unresponsive to their needs that they have taken matters into their own hands by becoming more active players to drive needed changes.

Manufacturers are leaders among all private-sector employers and have one of the highest percentages of workers who are eligible for health benefits provided by their employer. Indeed, 91% of manufacturing employees were eligible for health insurance benefits in 2022, according to the Kaiser Family Foundation, which is much higher than the 78% average across all employer types. This significant rate of eligibility excludes part-time and other workers deemed by the employer as not eligible. Among the grouping of companies that identify as NAM members, 99% offer health benefits to employees, representing a higher-than-average sectoral commitment to health care.

Of those who are eligible, 81% of manufacturing employees participate in their employers’ plans (i.e., the take-up rate). State and local government (89%), transportation, communications and utilities (85%) and finance (83%) had slightly higher take-up rates in 2022. The average annual cost of a family health care plan for a family of four in manufacturing was \$21,852 in 2022,<sup>2</sup> and these costs are often a shared responsibility between employer and employee, with employers working hard to keep premiums stable for the plan beneficiaries.

In 2022, more than half (53.4%) of manufacturers surveyed listed health care and other benefits costs as one of the top sources of inflation, and they predicted that health insurance costs would rise more than 7.7% during the following year.<sup>3</sup> Such cost increases are evident across the health care industry, as seen in Figure 1, which shows the growth in premiums over decades. From 2017 to 2022, the average premium for single coverage rose 18%, while the average premium for family coverage grew 20%.<sup>4</sup> These increased costs are appearing in conjunction with increased inflation across all sectors. Figure 2 shows how premium increases since 2017 have outpaced inflation and remained just below growth in workers’ earnings.

<sup>1</sup> [https://journals.lww.com/joem/Fulltext/2022/03000/Employer\\_Led\\_Strategies\\_to\\_Improve\\_the\\_Value\\_of.6.aspx](https://journals.lww.com/joem/Fulltext/2022/03000/Employer_Led_Strategies_to_Improve_the_Value_of.6.aspx), 218.

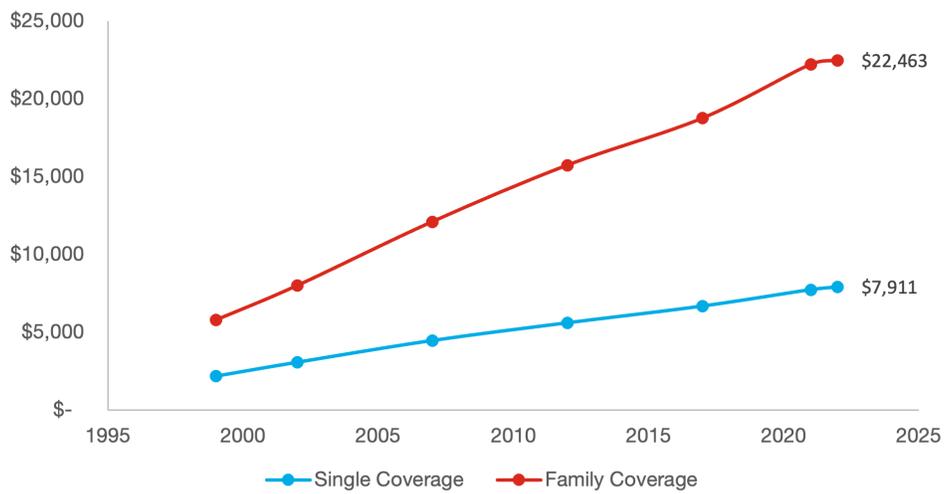
<sup>2</sup> <https://www.kff.org/report-section/ehbs-2022-section-1-cost-of-health-insurance/>.

<sup>3</sup> [https://www.nam.org/wp-content/uploads/2022/06/Manufacturers\\_Second\\_Quarter\\_Outlook\\_Survey\\_June\\_2022.pdf](https://www.nam.org/wp-content/uploads/2022/06/Manufacturers_Second_Quarter_Outlook_Survey_June_2022.pdf); and [https://www.nam.org/wp-content/uploads/2022/09/Manufacturers\\_Third\\_Quarter\\_Outlook\\_Survey\\_September\\_2022.pdf](https://www.nam.org/wp-content/uploads/2022/09/Manufacturers_Third_Quarter_Outlook_Survey_September_2022.pdf).

<sup>4</sup> <https://www.kff.org/report-section/ehbs-2022-section-1-cost-of-health-insurance/>.

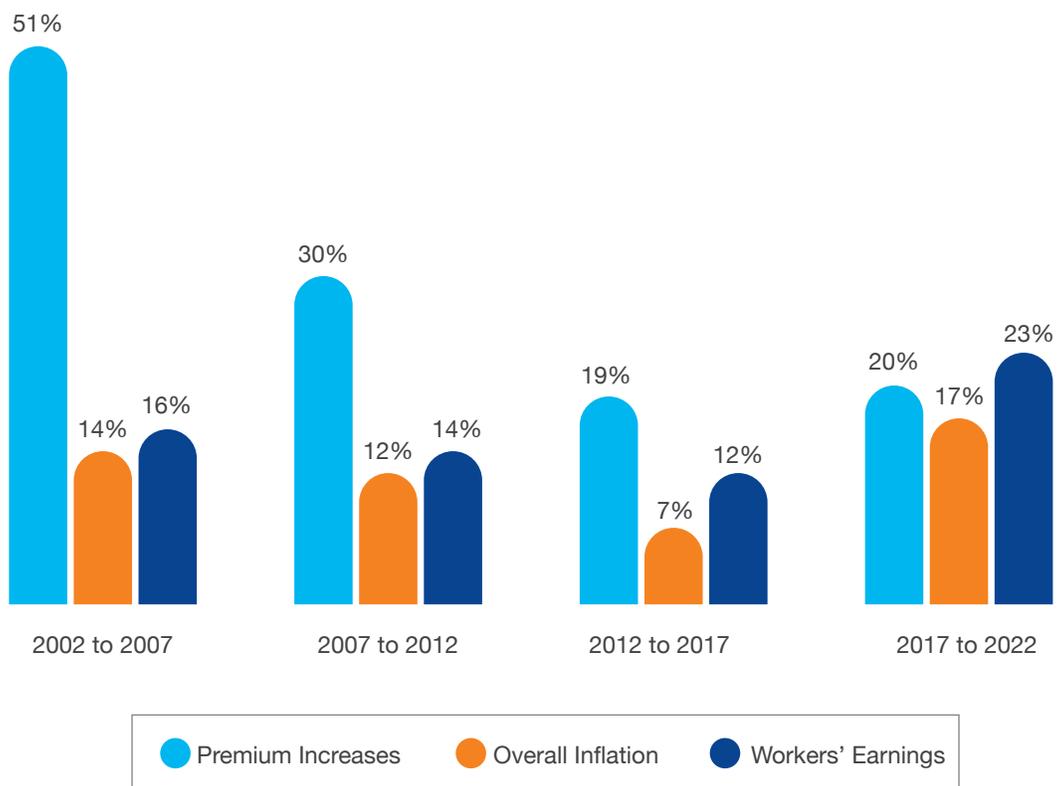
**Figure 1: Average Annual Premiums for Single and Family Coverage, All Industries, 1999–2022**

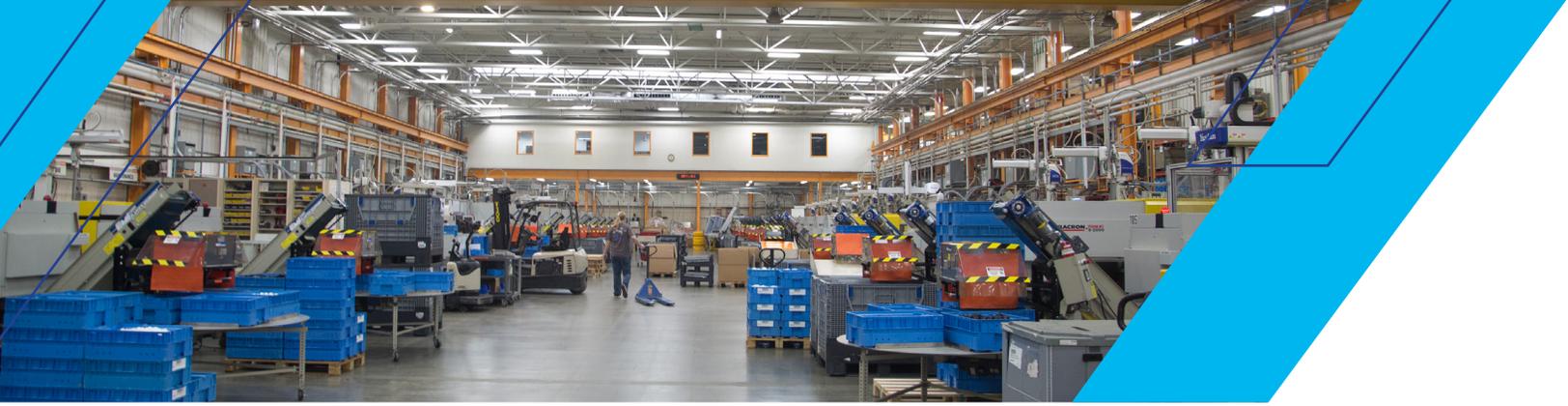
Source: Kaiser Family Foundation 2022 Employer Health Benefits Survey.



**Figure 2: Cumulative Premium Increases, Inflation and Earnings for Covered Workers with Family Coverage, 2002–2022**

Source: Kaiser Family Foundation 2022 Employer Health Benefits Survey.





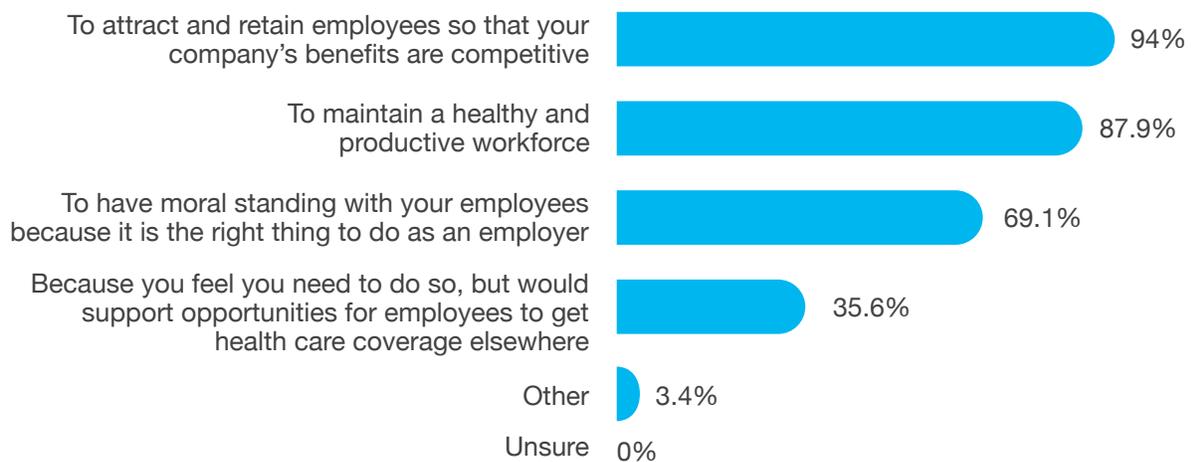
## Manufacturers and Health Care

Employers cite many reasons for providing insurance benefits (Figure 3). Survey participants said they offer health insurance to attract and retain employees so that their company’s benefits are competitive (93.9%), to maintain a healthy and productive workforce (87.9%) and to have moral standing with their employees because it is the right thing to do as an employer (69.1%).

Previous research by the Manufacturing Institute—the NAM’s workforce development and education affiliate—with support from Colonial Life on “The Manufacturing Experience: Compensation and Labor Market Competitiveness” confirmed that health insurance benefits were ranked second below only base hourly wage or salary level as a key benefit to attract talent.<sup>5</sup> This research recognizes that employers experience an enhanced financial benefit by offering coverage because it lowers overall medical costs, significantly increases productivity, lowers recruitment costs, raises retention rates and provides other tax benefits.

**Figure 3: “Why Do You Provide Health Care Benefits to Your Employees?”**

*Note: Respondents were able to check more than one response; therefore, responses exceed 100%.*



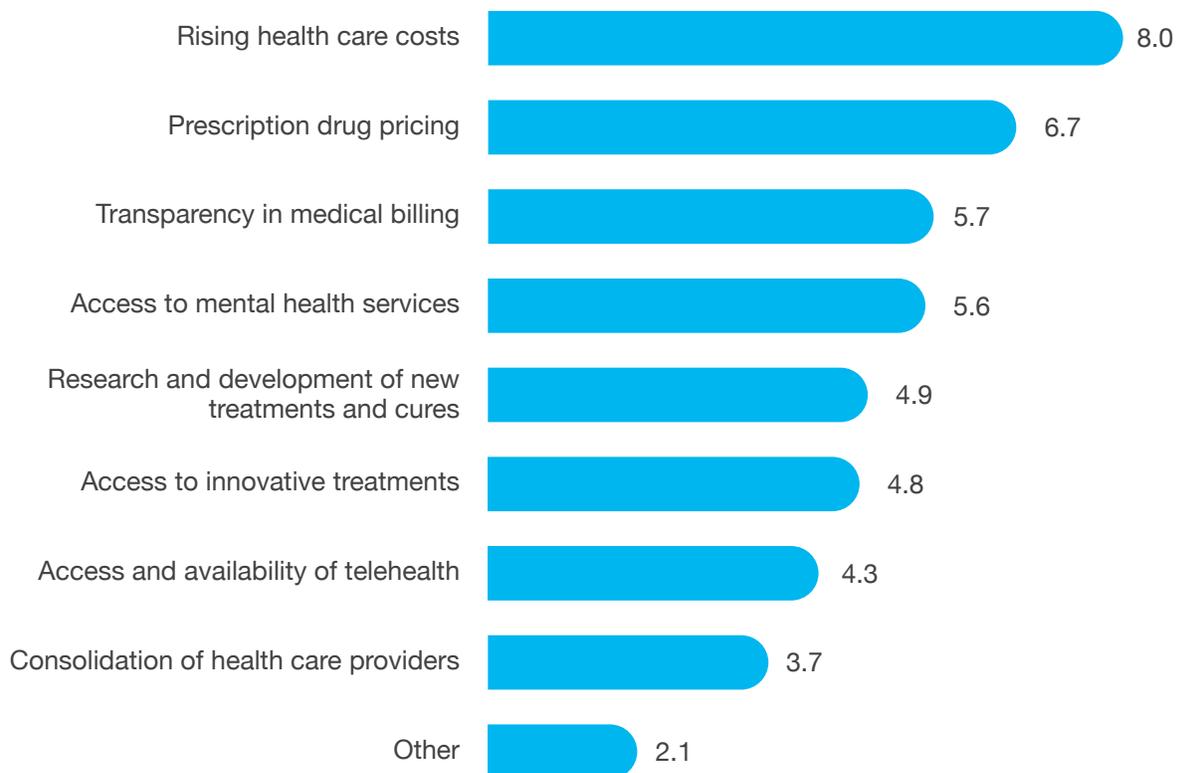
<sup>5</sup> <https://www.themanufacturinginstitute.org/wp-content/uploads/2022/05/Compensation-5-9-22.pdf>.

When asked about costs associated with offering health care to employees, 51.0% of survey participants stated health care was very expensive, with another 45.2% saying it was expensive. Only 3.8% called it affordable. Employers have experienced higher-than-usual costs in recent years due to the pandemic. In interviews, many said that their employees paused routine care in 2020 and then began to return to treatment and checkups at a heightened pace in 2021. While they report stabilization in 2022 that reflected limited utilization in 2021, employers saw spikes in costs as more people sought preventative care after pandemic-related delays.

Despite these cost increases, employers uniformly have reported a strong return on health investments, expecting a 42% return on investment in 2022, making employer-sponsored health care a highly valuable expenditure. Within the manufacturing sector, this data has been validated through anecdotal experiences gathered for this study. One interviewed company stated that by closely managing their own health coverage, an on-site clinic, they “see the cost savings and the increase in quality. As manufacturers, we are highly focused on the quality of the product we produce. For every dollar we spend, we save two.”

While manufacturers continue to offer health care and see a return on their investment despite rising costs, manufacturers believe Congress should play a role in curbing costs. The majority of respondents (68.3%) believe that health care should be a priority for Congress in 2023. As shown in Figure 4, top issues they felt needed to be addressed were rising costs, prices of prescription drugs, transparency in medical billing and access to mental health services.

**Figure 4: “What Health Care Challenges Should Policymakers Address in the New Congress?” (Average Ranking, with Higher Numbers Being More Important)**



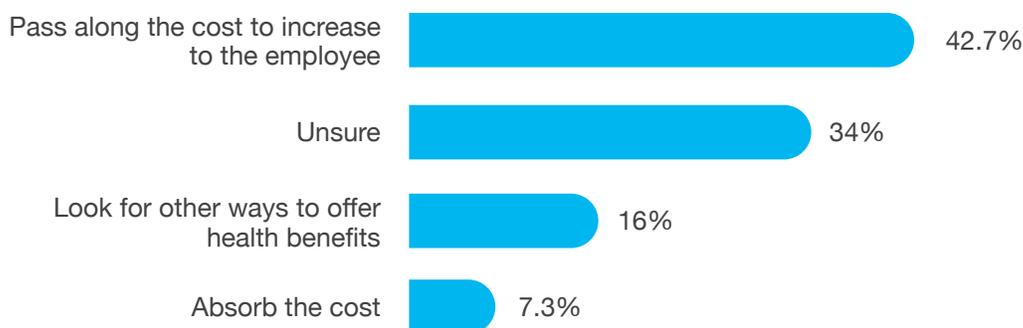
## Understanding the Tax Benefits of Employer-Sponsored Coverage

Health care coverage is a valuable employee benefit that is deducted from federal taxes, dollar for dollar. Both Republicans and Democrats in Congress have targeted this loss of federal revenue. One recent Congressional Budget Office proposal suggests a cap or outright elimination of the tax exclusion for employer-sponsored health insurance as a means to close the federal deficit.<sup>6</sup> Removing the tax exclusion for employer-sponsored health care would be extremely disruptive to the model and methods of providing health coverage to employees. Such an action could lead to fewer employers offering insurance to their employees due to the increased cost, burdens and lack of a meaningful incentive. Further, fewer employers offering health insurance to employees could lead to higher government costs elsewhere, as more individuals would be without employer-sponsored insurance and potentially forced to utilize other public health care options—the opposite of the intended outcome. And most concerning, fewer individuals with access to quality health care could decrease overall public health and wellness and lead to higher social and financial cost burdens

Tax incentives facilitate employer-sponsored health coverage and ultimately reward employers and employees simultaneously, which underlines the success of the employer-sponsored system. Companies with 100 or more employees derived around \$120 billion in tax benefits in 2022, and this number is set to grow.<sup>7</sup> For manufacturers, the tax benefits of providing employer-sponsored insurance account for about one-quarter of the return on investment in health care.

While many were unsure (34.0%), manufacturers surveyed stated that if health benefits were taxed, they would pass along any resulting cost increase to the employee (42.7%), look for other ways to offer health benefits (16.0%) or absorb the cost (7.3%) (Figure 5). When interviewed, manufacturers were in consensus: it would weaken their current plans because it would take away one critical financial incentive to offer health care.

**Figure 5: “If Health Benefits Were to Be Taxed, How Would Your Company Accommodate the Increase in Cost?”**



<sup>6</sup> <https://www.cbo.gov/system/files/2022-12/58164-budget-options-large-effects.pdf>, 36–37.

<sup>7</sup> [https://www.uschamber.com/assets/documents/20220622\\_Chamber-of-Commerce\\_ESI-White-Paper\\_Final.pdf](https://www.uschamber.com/assets/documents/20220622_Chamber-of-Commerce_ESI-White-Paper_Final.pdf), 1.



## Stewardship

Manufacturers have a deep desire to care for their employees—a commitment that stretches beyond the workplace and extends to the well-being of their families. Throughout the interviews with company leaders, this sense of stewardship was reflected in manufacturers’ attempts to build comprehensive plans that best serve employee health and financial needs. The desire to educate employees on wellness practices, offer quality services and welcome feedback on their benefit plans demonstrates manufacturers’ stewardship when crafting health care benefits.

All interviewed companies are forward-thinking in their benefit formation and encourage early and preventative care. One company is guided by the idea that “all care is primary.” They design their plan so that all primary care is included at no co-pay to encourage all employees to seek preventative care early and have a full understanding of their health and wellness. Such a perspective is evidenced in the inclusion of yearly, mandatory physicals and one-on-one health evaluations. In these sessions, health care providers are able to monitor weight, do bloodwork and catch critical issues early. For one company, such interventions have been a gateway to offer more in-depth program support that brought diabetes and prediabetes down from their top three costs to outside the top 10—a major achievement.

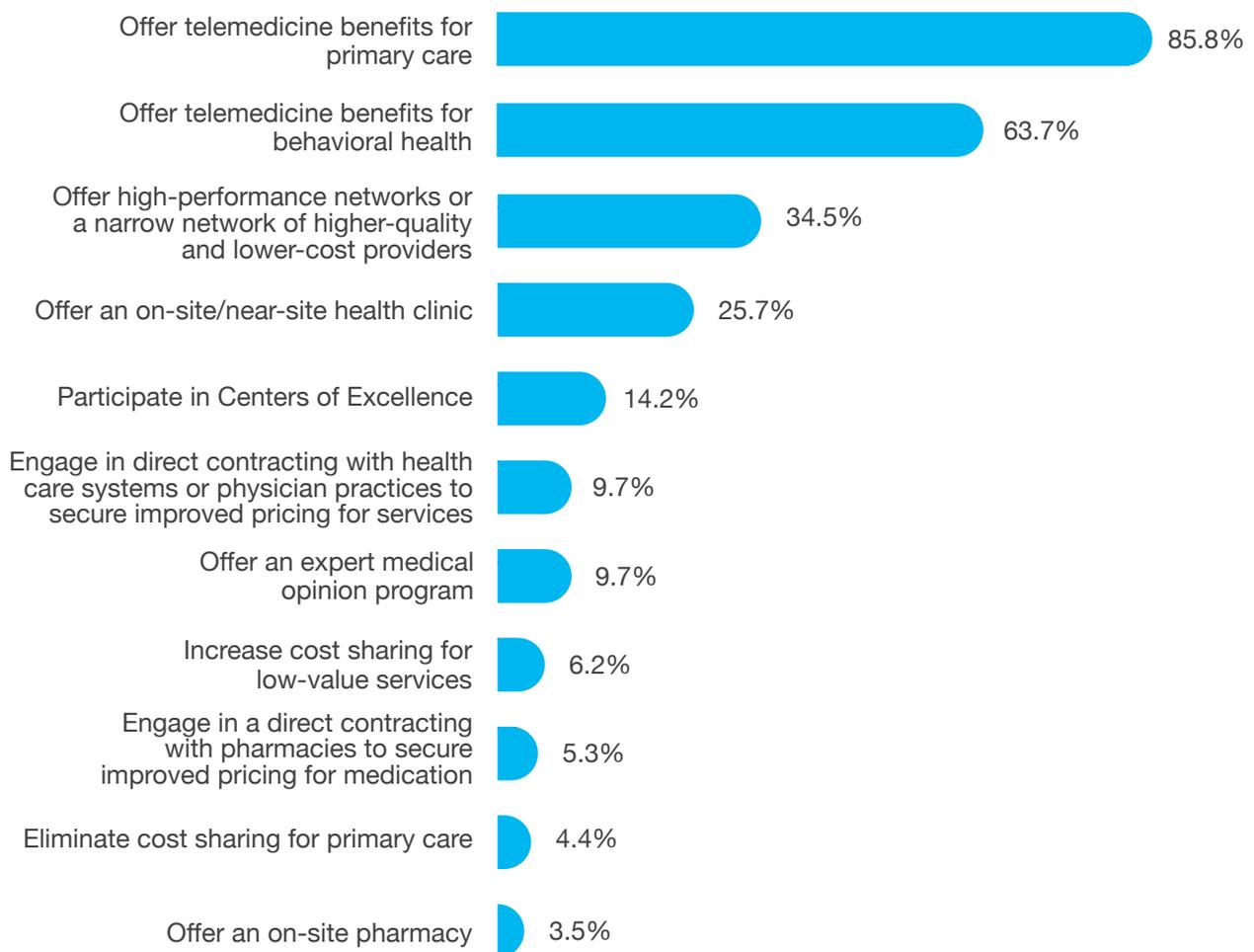


## Affordability

Manufacturers want to provide quality health care to their employees and need to do it at an affordable rate so employees can take advantage of the benefit. One interviewee said, “The best thing we can do is to find the most affordable solutions and treatments so that people do not opt out of treatment because feel like they can’t pay for it.” Companies have taken innovative steps to accomplish this goal. Figure 6 displays a few of the steps, including offering telemedicine benefits for primary care (85.8%) or behavioral health (63.7%), providing high-performance networks or a narrow network of higher-quality and lower-cost providers (34.5%) and participating in Centers of Excellence<sup>8</sup> (14.2%).

**Figure 6: “Does Your Company Use Any of the Following Strategies to Improve the Value of Health Spending?”**

*Note: Respondents were able to check more than one response; therefore, responses exceed 100%.*



<sup>8</sup> Defined as an arrangement where the company encourages employees to receive certain high-volume surgical procedures at providers nationally recognized for achieving high-quality outcomes. Providers may be located well outside the employees’ community, requiring significant travel. Reimbursement is often based on a bundled fee; typically, employee cost sharing is waived.

Crafting a health benefit plan that is affordable for both the employer and employee is an extremely challenging endeavor because it is time-consuming, requires resources and, ultimately, impacts lives. With those difficulties understood, manufacturers have taken innovative steps to make providing health care attainable. One company uses an outside vendor that does an additional layer of claims reviews to find things like duplicate billing and other small costs, resulting in added savings of about \$3 million to \$5 million dollars a year. These savings do not affect individuals' experience but decrease overall costs by eliminating waste. Others are increasingly depending on extensive direct contracting with specific providers or hospital systems to achieve the best price for the best service. For one company, this has led to a flat spending trend on certain procedures for the last 15 years without shifting any increased costs to workers. They have found that this approach leads to healthier outcomes because employees are more likely to pursue care.

Utilizing an outside contractor to review claims as well as direct contracting require employers to devote additional time and resources to providing health care to their employees. Health care benefits can be so cumbersome, one company mentioned they sought to retain transparency and control of the benefit by creating the smallest amount of distance between their employees and their care providers. This ultimately means taking control and providing a greater level of autonomy over certain decisions related to care and the cost of care. That can translate to individual companies eliminating the “middleman” by taking on a role of pharmacy benefit manager or negotiating a particular service, such as knee or hip replacements, with a health system that an insurer once accomplished as part of its network. Nearly 62% of manufacturers believe increased price transparency would result in lower health care costs and improved outcomes.

Companies also promote and enable employees to save for health spending through health savings accounts and flexible spending accounts, which allow employees to set aside pretax earnings to be used for medical expenses. Each savings vehicle has its own set of benefits and restrictions. HSAs require enrollment in high-deductible health plans and have features that include savings that are pretax and permit year-over-year accumulated savings that can also be invested. These savings features serve as an important strategy to offset high, upfront out-of-pocket health care costs oftentimes associated with high-deductible health plans.

In a similar manner, FSAs also help employees saving for qualified medical expenses on a pretax basis. However, these savings vehicles are not paired with high-deductible health plans and offer a stand-alone savings mechanism regardless of the health plan. However, unlike HSAs, FSAs are “owned” by the employer and do not travel with the employee from job to job and cannot accumulate year-over-year. Further, there are savings limits to FSAs, and health spending must be achieved by certain deadlines. Of the manufacturers surveyed, 61.3% offered employees the ability to set aside pretax dollars for medical expenses in FSAs, and, of those that offer a high-deductible insurance plan, 56.7% also offer HSAs. As inflation increases health care costs, the limitations of both these accounts should be increased accordingly. Decades have passed since Congress established both types of savings vehicles, and it is time for Congress to reexamine the rules and find even more flexible and innovative ways to encourage saving for future health care expenses.



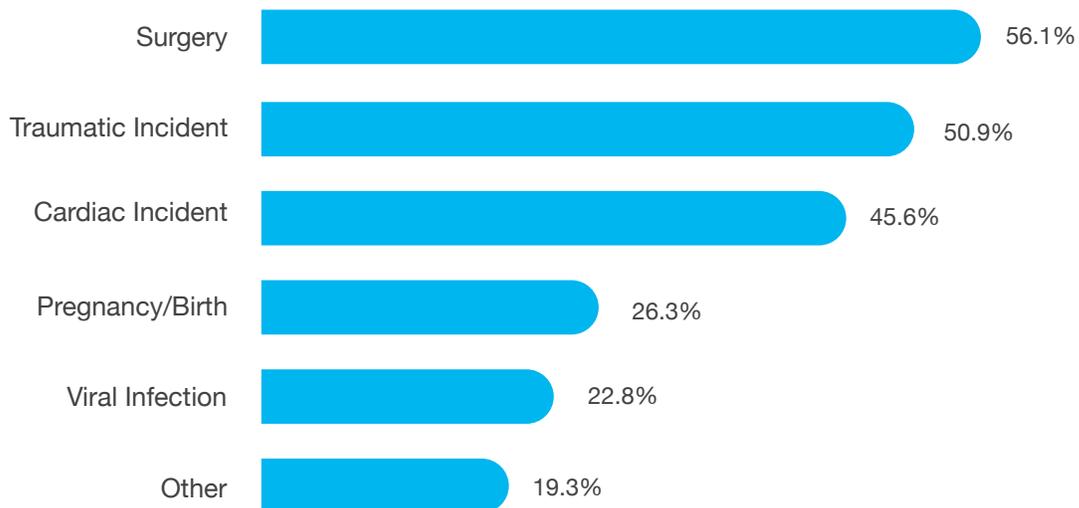


## Chronic Illness

Chronic conditions deeply affect both health care costs and workplace outputs. The most significant chronic health issues for manufacturers, in terms of cost and prevalence, are diabetes, heart disease, obesity, cancer and mental health. Nearly half (49.4%) of manufacturers cited the management of chronic conditions as a greater contributor to increases in premium costs when compared to single health events impacting individuals and/or families (35.9%). The most significant single health events, shown in Figure 8, for manufacturers are surgery (56.1%), traumatic incident (50.9%) and cardiac incident (45.6%). Even in the area of single health events, chronic conditions are still present and relevant, as nearly half (49.0%) of the single events reported are related to chronic conditions.

**Figure 8: “For Those Saying That Single Health Events Impacting Individuals and/or Families Were the Greatest Contributor to Increases in Health Care Premium Costs, Which Option Below Is the Greatest Contributor to That?”**

*Note: Respondents were able to check more than one response; therefore, responses exceed 100%.*



Because companies have expanded their workforces in the past years and because many employees skipped preventative care appointments during the pandemic, management of chronic conditions has increased in importance and urgency for many companies. One company cited an increase in expenditures related to chronic conditions due to the expansion of its labor force when the company began to employ people from other industries who previously did not have access to health benefits and therefore did not receive treatment or diagnosis for various conditions. Another company said, “We are catching up on things that people put off because of the pandemic. Those have elevated to some pretty serious conditions including cancer, diabetes, heart disease, etc. Then there are those who previously had basic muscular-skeletal issues who are now batching with providers.”

To manage these conditions and the associated costs, manufacturers invest a great deal of time, money and effort to ensure their employees have the care they need. One company waives co-pays and coinsurance for chronic condition medications and includes free, mandated on-site physicals. Others with on-site clinics and pharmacies are able to screen for breast and colon cancer and track their employees’ type I and II diabetes treatments. One company said, “Our wellness coach keeps track of those people and checks in with them on their dosages and makes sure they are completing their courses of medication.” Others use case management through their carrier and various point solutions, depending on the condition, particularly for diabetes and cancer. To encourage self-management of care, one company has been incentivizing participation by fully covering preventative options such as colonoscopies and mammograms—even before they were covered by law—and putting some cholesterol and other medications on their \$0 tier.

Health care providers have adjusted rapidly to continued crises in recent years and are still trying to understand how the pandemic will affect communities in the future. Since the first waves of COVID-19, researchers have been tracking increased instances of mental and behavioral health effects, including depression, substance abuse and interpersonal violence.<sup>9</sup> Those recovering from acute COVID have also reported depression and anxiety following treatment.<sup>10</sup> When asked about mental health concerns and benefits offered by their health plans, companies said that recent years have been a tipping point for the growth and utilization of mental health services. Many companies brought up the importance of mental health without being prompted, while few companies had listed mental health as a key chronic issue when this research first began three years ago.

One company reported that “mental health is our top issue, followed only by diabetes,” and another stated that “mental health could be the next pandemic.” They found that people are now more cognizant of anxiety and other mental health issues. While companies have been managing it with telemedicine and other tools, their behavioral health care usage has rapidly increased. Many struggle to locate enough providers to serve employees in their regions. One company combated lack of access by launching a mental health advocacy program with 600 advocates and expanded coverage for out-of-network services. Additionally, companies have greatly appreciated provider continuity and reciprocity across state borders for mental health care, which has been transformative in allowing more access for their employees.

Many companies also mentioned their desire to expand the resources available to prevent, diagnose and treat cancer. Some companies have begun to include mammograms and colonoscopies at their on-site clinics or for free on their benefit plans. Cancer treatments constituted a large part of their costs more recently, which many believed was related to lack of preventative medicine in 2020 and 2021.

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<sup>9</sup> <https://hub.jhu.edu/2020/11/10/covid-19-toll-on-mental-health/>.

<sup>10</sup> <https://www.hopkinsmedicine.org/health/conditions-and-diseases/coronavirus/covid-depression-and-anxiety>.



## Obesity Is Impacting the Workforce

The CDC cites obesity as a growing hindrance to a productive workforce.<sup>11</sup> Increasingly, policymakers, the medical community and employers are pressed to find new strategies to address the growing health challenge of this chronic condition. In Ohio alone, recent data points to 32,000 people who are not in the workforce due to obesity.<sup>12</sup>

Greater awareness of obesity and efforts to destigmatize the condition are helping to drive changes so that more treatments can become more widely acceptable and accessible, especially as alternatives to bariatric surgery are considered. Congress should recognize the toll obesity takes on individuals and families and support solutions that are designed to make a difference to people and their communities.

<sup>11</sup> <https://www.cdc.gov/workplacehealthpromotion/model/evaluation/productivity.html>

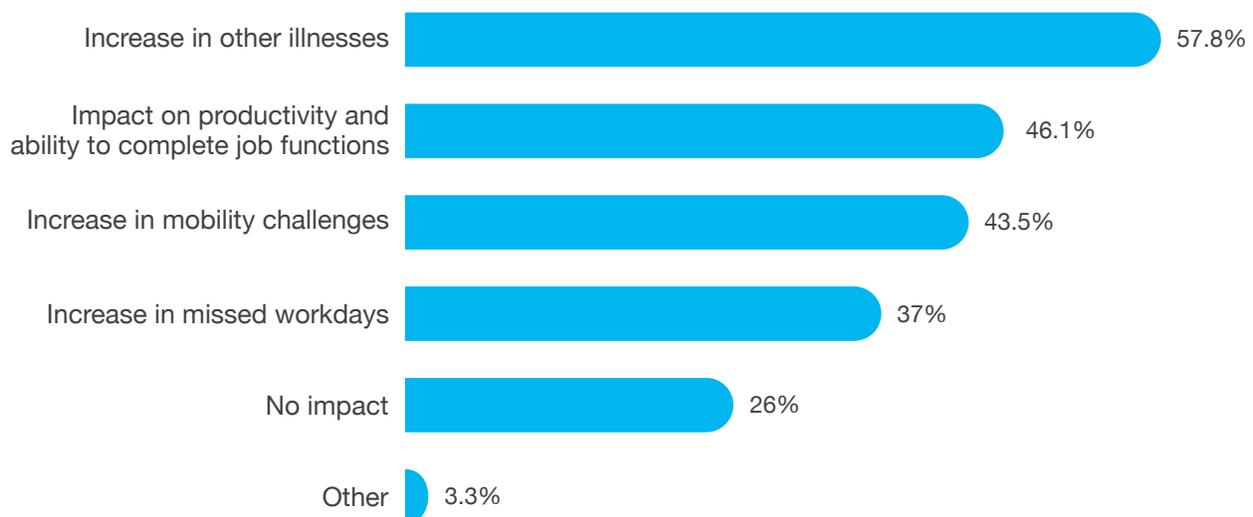
<sup>12</sup> <https://www.buckeyeinstitute.org/research/detail/new-buckeye-institute-research-more-than-32000-ohioans-working-if-obesity-were-eliminated>.

## The True Cost of Obesity in Manufacturing Workplace

Obesity is a persistent chronic issue in the American working population generally, and manufacturing companies are not exempt. While rates of obesity have plateaued since 2003, around two-thirds of U.S. adults are overweight or have obesity.<sup>13</sup> As shown in Figure 9, manufacturers note that obesity among the workforce raises the likelihood of other illnesses (57.8%). Obesity and excess body weight are associated with higher health care costs for adults—around \$2,000 more than costs of people in a healthy weight range. These additional costs account for \$170 billion to \$200 billion in annual spending in the U.S., making this disease a significant cost for employers.<sup>14</sup> One company stated that “losing weight is the biggest cost saver we have.” These health care costs compound with the indirect costs to productivity; 46.1% in the survey say obesity impacts productivity and the ability to complete job functions and increases mobility challenges in the workplace (43.5%). Moreover, employers have identified obesity and mental health as comorbidities and desire to treat them holistically.

**Figure 9: “In a Recent Manufacturing Survey, Respondents Cited Obesity as a Chronic Condition Affecting Their Workforce. How Does This Chronic Condition Affect Your Workplace Outputs?”**

*Note: Respondents were able to check more than one response; therefore, responses exceed 100%.*



There are increasing options for employers looking to manage obesity as a chronic condition. One way is by opting into covering anti-obesity drugs on drug benefit formularies. These drugs can result in a 15% to 20% reduction in weight in adults. Many of these drugs were developed for diabetes management and are currently in the process of FDA approval for obesity.<sup>15</sup> While prescription drugs are less invasive than surgical options, they are often not covered by insurance.<sup>16</sup> For employers designing their health care plans, research has found that cost-sharing for chronic illnesses, such as diabetes and obesity, can improve the value of employer health spending and can be done without major restructuring of contracts with providers.<sup>17</sup>

<sup>13</sup> <https://www.hsph.harvard.edu/obesity-prevention-source/obesity-trends-original/obesity-rates-worldwide/#:~:text=Roughly%20two%20out%20of%20three,in%20non%2DHispanic%20White%20adults.>

<sup>14</sup> [https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0247307.](https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0247307)

<sup>15</sup> [https://www.yalemedicine.org/news/new-medications-treat-obesity.](https://www.yalemedicine.org/news/new-medications-treat-obesity)

<sup>16</sup> [https://www.gao.gov/assets/710/700883.pdf.](https://www.gao.gov/assets/710/700883.pdf)

<sup>17</sup> [https://journals.lww.com/joem/Fulltext/2022/03000/Employer\\_Led\\_Strategies\\_to\\_Improve\\_the\\_Value\\_of.6.aspx](https://journals.lww.com/joem/Fulltext/2022/03000/Employer_Led_Strategies_to_Improve_the_Value_of.6.aspx), 221.

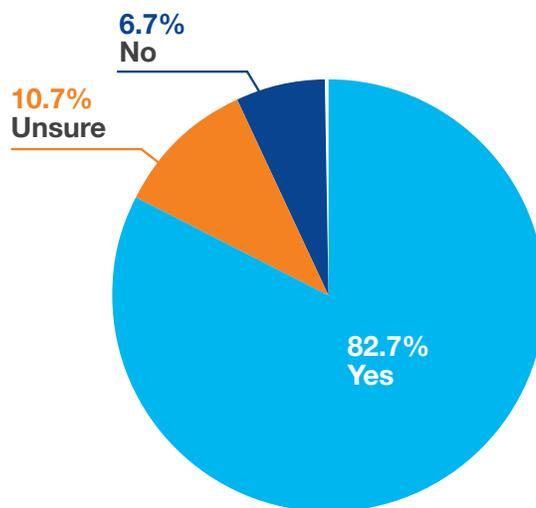


## On-Site and Near-Site Clinics

Consolidation is another point of concern for both manufacturers and policymakers. Hospital and university systems have purchased urgent cares, primary care providers and other health care delivery systems. In areas where hospitals and health coverage are consolidating, employers face higher prices and thus greater health insurance coverage costs. In regions monopolized by few health care options, prices are 12% higher than in markets with more than four rivals.<sup>18</sup> Additionally, rural areas tend to have less health care competition, and areas with less competition have fewer technologies, lower rankings and lower quality scores.<sup>19</sup> While one company had not seen problematic consolidation in urban areas, they said, “It is an issue in rural communities because people are having to travel large distances for care. We also see a decline in the quality of care as we lose experienced providers, especially in rural areas.”

Overwhelmingly, as shown in Figure 10, surveyed manufacturers report witnessing health care provider and hospital consolidation in their communities. While manufacturers might try to design plans to keep hospital care costs low, these efforts are limited in many areas because employers and providers have less market power than the consolidating hospital systems.<sup>20</sup> When interviewed, one company said that they had not experienced a scenario where alleged “new efficiencies” caused lower prices when a hospital system was consolidated.

**Figure 10: “In Recent Years, Consolidation Has Occurred in the Health Care Industry. Hospital and University Systems Have Purchased Urgent Cares, Primary Care Providers and Other Health Care Delivery Systems. In Your Geographic Area, Is Consolidation Occurring?”**

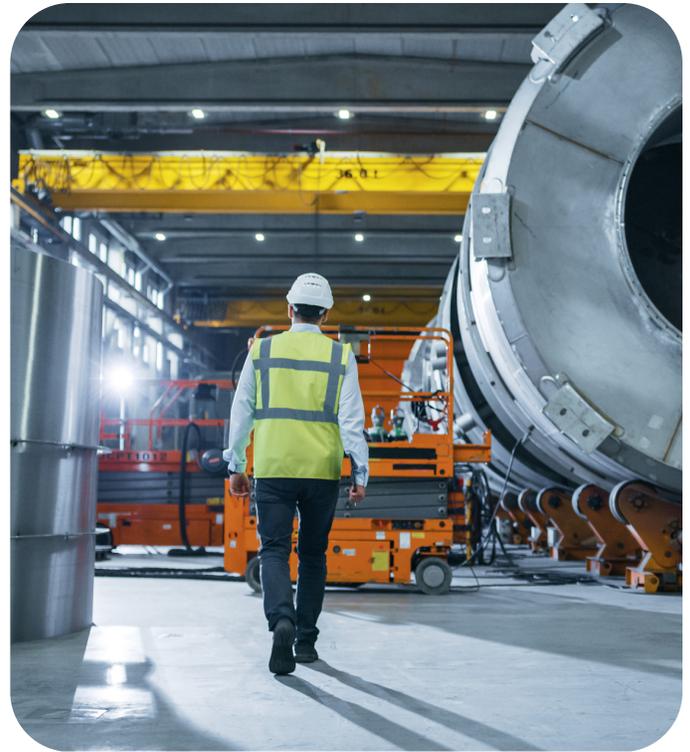


<sup>18</sup> [https://www.nber.org/system/files/working\\_papers/w21815/w21815.pdf](https://www.nber.org/system/files/working_papers/w21815/w21815.pdf); 17.

<sup>19</sup> *Ibid.*, 37.

<sup>20</sup> <https://www.kff.org/health-costs/issue-brief/what-we-know-about-provider-consolidation/>.

One way of dealing with the rising prices of consolidation and promoting more accessible care is to establish near- or on-site health clinics for employees and their dependents. An interviewed company found that on-site medical facilities help to prevent increased costs from consolidation, and their on-site clinics help to lower costs for their users and for the entire community. Given the size of their operation, they are helping to mitigate supply and demand shocks. Manufacturers that have made this investment are able to bring better care to their employees, thus making it easier to track and manage chronic conditions, ensure employees' families remain healthy and catch potentially catastrophic diagnoses early. One such company's clinic numbers have steadily risen, and more people are using the clinic as they start to bring their children and dependents in for primary and preventative care where they can see a doctor or nurse practitioner in about five minutes.



While this is an incredible investment for employers, such sites can remove many obstacles, such as time and travel, to getting health care.<sup>21</sup> One study found that more than one-third of large employers (more than 5,000 employees) had opened such clinic options and found they were a valuable addition to their health care plans, especially for the cost-effective management of basic and chronic health problems.<sup>22</sup> To overcome the large investment burden, an interviewee recommended that smaller companies set up co-ops to get the critical mass of patients needed to make it work financially. Once the program is off the ground, they recommend then selling access to clinic resources to those outside of the organization. However, the administration of on-site clinics can be difficult for companies that use a consumer directed health plan. Employers have to charge a fair market value for certain services to ensure that employees maintain their HSA eligibility.

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<sup>21</sup> [https://journals.lww.com/joem/Fulltext/2022/03000/Employer\\_Led\\_Strategies\\_to\\_Improve\\_the\\_Value\\_of.6.aspx](https://journals.lww.com/joem/Fulltext/2022/03000/Employer_Led_Strategies_to_Improve_the_Value_of.6.aspx), 223.

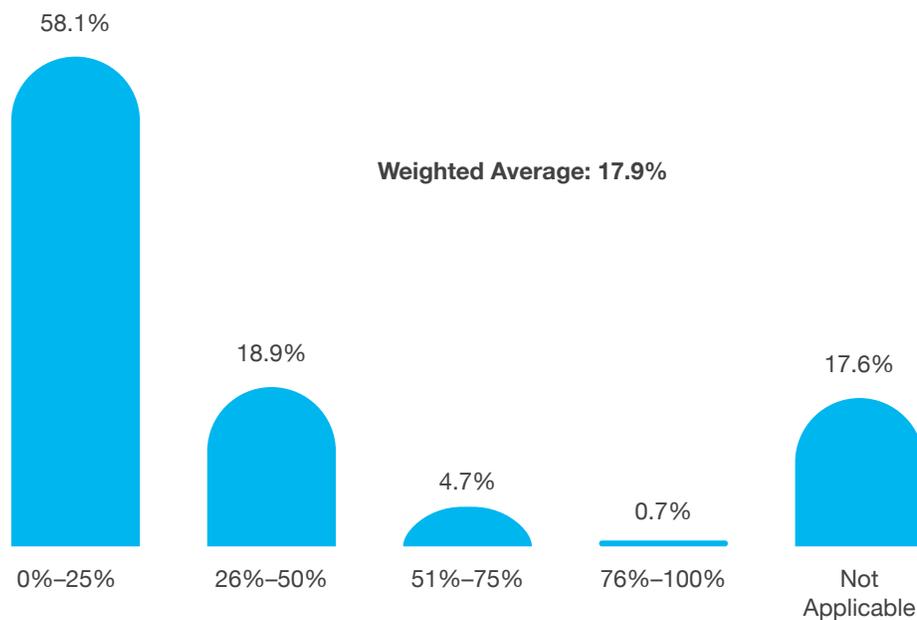
<sup>22</sup> <https://pubmed.ncbi.nlm.nih.gov/30883308/>.



## Outcomes of Telehealth

Telemedicine is another opportunity to offer quality health care, both physical and mental, in response to consolidation and other access challenges. This strategy preexisted the pandemic but grew as in-person medical treatment paused, and researchers have been interested to see how popular and effective telemedicine will be in the long-term.<sup>23</sup> As shown in Figure 11, up to 25% of surveyed companies report that around a quarter of their employees use telemedicine services. Almost all of the companies offered coverage for telehealth services pre-COVID, and several had expanded their coverage to include mental health services. This expansion occurred due to demand from employees and their dependents. Respondents reported that employees expressed high satisfaction with the benefit as a means to lower health care costs (70.0%), and the companies intend to retain coverage for telehealth services in the future and are looking for ways to expand usage.

**Figure 11: “If You Offer Telemedicine as a Health Benefit, What Percentage of Your Workforce Utilizes It?”**



Most of the companies surveyed for this paper saw a dramatic uptick in telehealth usage, with one stating, “There was a 500% increase in telemedicine utilization. It has gone down a bit, but it is still increased from before in terms of both mental health and primary care.” They see this as part of a slow but long-term movement toward both reference-based pricing, where an employer sets a price for a procedure rather than negotiating the price with providers, and increased virtual care that will dramatically reduce costs for employers and thus bring more affordability for employees and higher levels of insured individuals overall.

<sup>23</sup> [https://journals.lww.com/joem/Fulltext/2022/03000/Employer\\_Led\\_Strategies\\_to\\_Improve\\_the\\_Value\\_of.6.aspx](https://journals.lww.com/joem/Fulltext/2022/03000/Employer_Led_Strategies_to_Improve_the_Value_of.6.aspx), 223.

Another company noted that increased usage and access to telehealth services expanded the quality available to their employees, especially in rural areas, stating, “The more we can steer people toward virtual, the better their coverage is going to be.” Nevertheless, they hope to see improvement in the online experience in mental health care because there is still a fear that the quality is not as good as in-person services, though they have not found that to be the case. Overall, manufacturers view the utilization and increased access to online health care as a gateway for telehealth and look forward to the industry continuing to evolve to meet the needs of their patients and provide high-quality, efficient services.





## Data and Health

Better and more transparent data can help empower employers to provide the highest quality and cost-effective health care plans and employees to make informed decisions about how to best use their coverage to maintain their health. Claims data provide valuable information to employers and the federal agencies responsible for managing multiple health coverage programs. All of the companies interviewed for this project spoke about the importance of data collection and analysis in their health benefit decision-making processes.

One company has an internal data analytics team that does nothing but health care analytics to track programs, model potential design changes and make sure those changes have not had unintended negative consequences. They take pride in using their claims data to eliminate wasteful spending. Similarly, another company is looking for ways to use data to improve the health outcome of all, noting that “just saving money is not as important as improving health outcomes. We need to identify metrics to evaluate the tracking of chronic conditions and metrics to see if we are improving outcomes for the entire population, not just the sick population.” To overcome this challenge, many companies have brought on third-party health care consultants to review data and manage individual profiles and health plans.

When developing plans, companies also found it important to adhere to their established goals, not just the review of the data. In turn, any changes should be accompanied by adequate information and education. One company said that they were very direct with employees about why they were making changes, like raising out-of-pocket maximums, noting, “It has been important to pick philosophies and stick to them—then describe the why behind it. That is an example of taking the data, knowing we must make a change and making the change in a way that reinvests in us and our values.” This company and others are committed to giving their employees the right tools to make good health care decisions, using private services or in-house data. Another company has been trying to get the right data at the point of care for common scenarios so that employees have the information they need to ask their doctor the right questions and select the right service.

Despite companies’ best intentions, the greatest barrier to creating data-driven health plans and advocating for well-informed benefit usage is the lack of transparency in health care data and in the health care industry in general. While some have been encouraged by the transparency measures that have already been put in place by Congress, it is not yet enough. One company said that “looking at newly available price data has been advantageous, but it has also been painstaking to get all the data, not just the pieces that are comparable.” This company and others want to see regulations that make data more easily consumed by benefit providers. Additionally, manufacturers would benefit from a more common approach to defining quality so that they know how and where their employees can get the best treatment. On this topic, one company said, “The root cost problem is not having a common quality methodology system for health care, so we have a fragmented way to measure quality. We need a public–private partnership with a range of stakeholders to define a consistent way to measure quality.”

Beyond just quality, manufacturers worry about the sheer mass of unknowns when it comes to pricing, especially in pharmacy benefit management programs. Again and again, companies referred to PBM structures as “black boxes” for both pricing and coverage. When interviewed, a company said, “There are behind-the-scenes administrative fees that do not factor into the reimbursement. The sheer lack of transparency makes it impossible to know what you are getting. We are going through an audit with an outside company to better understand how that works.”

## Pharmacy Benefit Managers Under Scrutiny

The pharmaceutical distribution system in the United States is the safest in the world, yet it is the most complex with little visibility into its workings. The pharmacy benefit system is opaque, and a misaligned structure of incentives has evolved over time that relates to negotiations and payments within the supply chain.

When PBMs were first established in the 1960s and 1970s to help manage the cost of prescription drugs, the intentions were simple and directed around the design of prescription drug formularies (the lists that determine what drugs insurance covers and at what level). The goal of helping to manage prescription drug spending has remained consistent since the inception of PBMs. However, the business model has evolved over the past 50-plus years so that now only a few entities control more than 75% of the prescription drug market that patients access through their private insurance or Medicare and Medicaid plans. The PBMs exert further control now by steering business to specific pharmacy networks.

Today, PBMs work between pharmaceutical manufacturers and insurance plans, and they are coming under increased scrutiny for multiple reasons: rising prescription drug costs, their concentrated market power, their ties to the insurance industry and their links to pharmacy networks where there is a connected business interest. For example, the three largest PBMs are subsidiaries of larger health care companies, which raises questions about their ability to act as neutral intermediaries.

Amid these changes, little attention has been paid to the impacts of rising prescription drug costs on the employers that sponsor health plans and the patients who are facing increasing out-of-pocket costs at the pharmacy counter. In June 2022, the Federal Trade Commission launched a significant inquiry into the business practices of six PBMs, but as of May 2023, the results had not yet been finalized or released.

In the meantime, Congress is considering various legislative solutions to address PBM rebate, fee and payment structures. It has become increasingly clear that PBMs are not consistently passing on manufacturer rebates, reimbursements and other savings to employers and patients. Policymakers are focusing on providing increased transparency so that employers and patients alike have more visibility into the health care supply chain and PBMs’ practices—all in an effort to lower costs.

The kind of detailed data analysis approach manufacturers use requires a complementary regulatory system that leverages and exchanges standardized data to drive the health care system’s continuous improvements and innovations in medical research and care delivery. This lack of available data that manufacturers need access to could further aid innovation and help solve some of the most pressing medical and fiscal challenges. To unleash a new wave of consumer-driven health care innovation and enhance the patient-provider experience, we need a revised privacy quality framework that recognizes the strengths of the Health Insurance Portability and Accountability Act and includes opportunities for better information sharing for health care coordination.



## Policy Objectives

Despite the many challenges and strains facing the health care system, the United States is a nation that prides itself on first-class, best-in-the-world medical care. Our institutions, public and private, continue to lead the world on patient care, lifesaving treatments and medical research. We must uphold those successes while seeking to control or lower the cost of health care through market-oriented approaches. Employers are leading a great deal of innovation in health care delivery, and those positive developments must be allowed to flourish. Policies that continue to promote innovation and are in step with the next generation of health care delivery must be encouraged.

Based on the findings of this paper, lawmakers and manufacturers must be aware of the following:

- Designing health benefits is difficult and increasingly expensive for employers. To combat the high prices associated with providing benefits, tax benefits to employers offering health insurance must stay intact. Reducing or removing this benefit would negatively impact the landscape of employer-sponsored coverage.
- Health care must be affordable for employees to take advantage of services beyond what an employer underwrites. Congress should consider ways to make health care more affordable for employees and employers, looking at HSA and FSA rules as well as pharmacy benefit managers and their opaque business practices to lower health care costs.
- Manufacturers strive to be forward thinking and utilize tools such as primary care to support early interventions and improve outcomes for employees. Early intervention can reduce future costs, as chronic conditions ranging from diabetes to cancer and mental health contribute to costly premiums. It is necessary to develop ways to incentivize primary care. Early intervention through primary care can lead to early detection of chronic conditions and reduce the associated risks and cost if they do occur.

In assessing any policy proposals affecting employer-sponsored coverage, the following considerations must remain top of mind:

- Manufacturers believe that the values that have made America exceptional—free enterprise, competitiveness, individual liberty and equal opportunity—must guide any process to simplify health care and achieve lower medical costs. Effective solutions will require reasonable, market-oriented approaches. The public and private sectors should work in collaboration to lower costs, address chronic conditions that pose serious public health risks and reduce ongoing access challenges for the uninsured. Drawing on the expertise of the private sector, the government should recognize that employers have an incentive and deep commitment to designing health care plans that improve outcomes while increasing the value and quality of the coverage provided.

- Consider the Hippocratic Oath: “First, do no harm.” Approximately 99% of NAM member companies offer health benefits to attract and retain talent, to maintain a healthy workforce and because they believe it is the right thing to do for their employees. Manufacturers continue to develop and lead private-sector solutions to offer benefits that are more flexible, innovative, efficient and attractive to employees—more so than what the federal government is prepared to offer the public.
- Rising health care expenditures are a top business challenge. Cost shifting will result if a public option is implemented because provider networks will seek to recoup the lower reimbursement rates paid by the federal government. The only target to close financial gaps will be individuals covered by and paying for private insurance. Such burdens will conflict with your committees’ goals of health care that is simpler and affordable.
- The innovation ecosystem found in the United States is unique and part of what makes our nation a world leader in research and development. Our medical innovations—pharmaceuticals and medical devices in particular—are possible because of a policy environment and business environment that enable unparalleled investments, research and manufacturing here in the U.S. Advances in medical innovation require major up-front private-sector investments far beyond what any government alone can provide. If we maintain this welcoming business environment, innovation will improve and continue growing.





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