



**CORPORATE SUPPORT FOR EMPLOYEE HEALTH INSURANCE
FOR FRANCHISES AND COMPANY OWNED NATIONAL CHAINS**

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Editor’s Note: This Sagamore Policy Paper is the seventh in a series of essays in support of Sagamore’s project on the Benefits Access Learning Cluster, an effort funded by the Charles Stewart Mott Foundation and managed by Senior Fellow April Kaplan. This particular report explores a policy option, currently under consideration, that would strengthen employer-based health insurance. In addition, it attempts to put into perspective the importance of employer-based health insurance and the positive role that businesses can play.

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INTRODUCTION

Health insurance is an important issue for everyone: for politicians, for families, for individuals, for businesses, for adults, and for children. It has become a major policy issue with a consensus that

everyone needs health insurance and that it must be accessible and affordable. There is not yet consensus about how this will be accomplished. In addition, there is a growing understanding that the lack of health insurance does not just hurt individuals. It hurts families, communities, and ultimately hurts everyone financially.

Health directly affects the ability of individuals to work. It also directly impacts the ability of their children to learn in school and to eventually become productive workers themselves.

- Lack of health insurance can lead to poor health. Many studies have shown that people who lack health insurance tend to forgo needed care until they become much sicker.
- Delayed health care can mean higher costs with high use of expensive emergency room service and can lead to very expensive chronic illness.
- Lack of health insurance can eventually harm an individual’s or family’s health and drives up health care costs for everyone else.

A recent *New York Times* editorial reported that the number of uninsured Americans has been rising; soaring

health care costs have driven up premiums; employers have scaled back or eliminated health benefits; and hard-pressed families have found themselves unable to purchase insurance at a reasonable price. The article stated that the main reason for the upsurge in uninsured Americans is that employment-based coverage continued to deteriorate. The writer reported that the number of uninsured Americans increased by 2.2 million, from 44.8 million in 2005 to 47.0 million in 2006.¹ While this was happening, Medicaid, the states' main public assistance health care program, had grown to about 16 percent of their budgets.

The growing number of uninsured, the overall impact on the nation's health, and the high cost of emergency care continue to garner national attention and strengthen the call for health care to be made available to all. There is not yet a consensus on how this will be accomplished nor how much support will be government's responsibility versus businesses' responsibility.

As the debate over health care intensifies, it is important to understand how and why employers are providing health insurance to employees.

Much attention is currently focused on the large number of uninsured individuals and families. This has led some to call for an expansion of government insurance (Medicaid/SCHIP) and implementation of a single payer system. Others are concerned that such an expansion would lead to

“crowd-out” and actually reduce the use of employer-based health insurance.

This paper does not attempt to provide a comprehensive solution to the problem of the uninsured. Rather, it explores a policy option, currently under consideration, that would strengthen employer-based health insurance. In addition, it tries to put into perspective the importance of employer-based health insurance and the positive role that businesses can play.

This paper will also attempt to increase the level of understanding by describing several different types and configurations of employers. It will show the major different types of choices of employee health insurance that are available and in use by these employers.

WHAT ARE THE MODELS FOR NATIONAL CHAINS?

Franchises

Franchisees are simply entrepreneurs who have chosen to purchase a “proven” brand and marketing system from a franchisor. They are also known as chain stores. In addition to the brand name or trademark, franchises have a business model and a proven track record. Thus, opening a franchise does not require the market research that a new business usually requires. Franchisers usually have a corporate organization that provides support services to the franchisee. They help the franchisee to establish and run the franchise according to the set business model.

The biggest advantage of franchising from a business perspective is that a

¹ “A Sobering Census Report: Bleak Findings on Health Insurance,” *New York Times*, 29 August 2007.

business can use other people's capital to expand rapidly.

There is tremendous diversity in the types of businesses that are franchises. The top ten (in terms of size) illustrate this.

The top 10 franchises for 2007:

1. Subway
2. Dunkin' Donuts
3. Jackson Hewitt Tax Service
4. 7-Eleven Inc.
5. UPS Store/Mail Boxes Etc.
6. Domino's Pizza LLC
7. Jiffy Lube Int'l. Inc.
8. Sonic Drive In Restaurants
9. McDonald's
10. Papa John's Int'l. Inc.

These have large operations with thousands of franchises in the U.S. and abroad. For instance: McDonald's Corporation, reported 31,062 units as of 31 March 2007; Subway Restaurants reported approximately 27,836; 7-Eleven operated, franchised, and licensed 32,711 stores at the end of June 2007.

Each franchise location is its own business. It also may surprise many that businesses such as those listed above, which are household names to most of us, generally fall into the "small business" category because they are franchised.

As small business owners, most franchise owners have a challenge of obtaining affordable health insurance policies for themselves and their

employees. Many franchise owners face the same insurance challenges as the independently-owned auto repair shop down the street. This paper explores some of the differences among franchises and how the franchise corporations may or may not be assisting the local franchisors. It will explore the challenges facing many franchisors in obtaining affordable group health insurance policies for their officers and employees.

Why Franchise?

Fred DeLuca, the founder of Subway, emphasized the following reasons²:

When the company first started it just had company-owned stores. DeLuca quickly saw that company-owned stores that were not close to company headquarters did not run as well. The management of these stores seemed less dedicated and less entrepreneurial. So he figured they needed to create a system in which all the stores would be like the ones close to company headquarters. DeLuca wanted managers to have the feeling of being very invested in the company's performance and of really caring about the company's success. He thought that the best way to make store managers really care about Subway's success, and have that kind of unique entrepreneurial spirit, was to franchise.

Are Franchises a low-road approach to managing employees?

Franchise jobs are often described in negative terms: high turnover, little training, and little or no employee

² Joshua Kurlantzick, "Growing Your Business Your Way," *Entrepreneur Magazine*, November 2003, Entrepreneur.com

involvement. Research suggests otherwise and has found that they tend to be more sophisticated than those of equivalent independent operators. Once industry, size, and other control variables are included in the analysis, franchise operations appear to offer better jobs with more sophisticated systems of employee management than similar non-franchise operations³.

Company-Owned Model

This is a common and well recognized model. Many businesses such as Wal-Mart, Walgreen's, and Starbucks own all of their stores.

The biggest advantage is that the company gets 100 percent of the revenues. A franchisor typically only receives a royalty that is generally limited to 4 percent to 10 percent of a unit's gross revenues.

The company-owned model has higher risk and requires capital.

Why Use the Company-Owned Model

Howard Schultz, the founder of Starbucks, emphasized the following advantages⁴:

Schultz believed very early on that people's interaction with the Starbucks experience was going to determine the success of the brand. He felt that the culture and values of how they related to customers would determine their

success. Schultz felt that this is reflected in how the company relates to its employees. He thought the best way to have those kinds of universal values was to build around company-owned stores and then to provide stock options to every employee and to give them a financial and psychological stake in the company. Furthermore, employees working directly for the company, argued Schultz, ensured the preservation of those corporate values. He also reported that Starbucks has the lowest employee turnover of any food and beverage company, which he attributed to the fact that employees believed they were dealing with a premium product and that it would have been hard to provide the level of sensitivity to customers and product knowledge if they franchised. Schultz concluded that one can be just as entrepreneurial and experimental in a company-owned model.

Using Both Models

Most franchisors use both models in a strategic way to get the best of both worlds. For instance, as of 2007, worldwide McDonald's claims 22,581 franchises and 8,190 company-owned restaurants. Some franchisors choose to own and operate in the best markets and franchise the secondary and tertiary markets. Others develop a company-owned presence in their core market place and franchise in more distance markets.

The variety of models results in a considerable variation how employer-based health insurance actually operates.

³ Peter Cappelli, "Are Franchises Bad Employers? A Closer Look at Burger Flippers and Other Low-paid Jobs," *Knowledge@Wharton*, 5 September 2007.

⁴ Kurlantzick, "Growing Your Business Your Way," *Entrepreneur Magazine*, November 2003, Entrepreneur.com

EMPLOYER-BASED HEALTH INSURANCE

It is important to understand the extent that employers use health insurance as a benefit for employees, why they used it and what are their current issues.

Overall, over 70 percent of employees have employer-based health insurance coverage.

According to CBO analysis of the Current Population Survey, private insurance coverage varies as family income increases from 50 percent of children in families with income between 100 and 200 percent of the poverty level to 95 percent among those over 400 percent.

In the United States, more than 45 million Americans are without health insurance. According to published analyses, more than 60 percent of uninsured Americans work for small businesses, which are defined as those with 50 or fewer employees.

Indeed, the number of full-time workers without health insurance rose from 20.8 million in 2005 to 22.0 million in 2006, presumably because either the employers or the workers or both found it too costly.

Why do Employers Offer Health Insurance?

Health insurance is one of the most desirable benefits that employers can offer employees.

Employee turn-over is a major problem. According to the National Restaurant Association, the median turnover rate for the quick-service segment in 2002 was 80 percent. This is an expense because

of the need to recruit and train new employees. The estimated cost of replacing an hourly employee is \$2,399, according to People Report's survey of 12,798 restaurants ranging from fine-dining to fast-food establishments.⁵

Many employers want to be well perceived by their employees and by the community. Sometimes employers do this on their own and at other times in response to criticism. Some have the attitude that they are taking care of their employees and their business by providing a health-care plan.

A People Report's survey of 70 chain restaurants found that from 2002 to 2003 the percentage of companies offering health insurance to part time workers rose from 48 percent to 60 percent, where it currently stands. Nearly 90 percent of full-time hourly workers are offered health insurance. The survey also showed that 41 percent of companies are offering domestic partner benefits.⁶

Health Insurance Options

Employers have many options. Before analyzing how employers are using health insurance, it is a good first step to understand what the options are and how they differ. This section describes the basic set of options. There are different costs and trade-offs. Employers make decisions based on what they want to

⁵ Todd Henneman, "Jack in the Box Tackles Turnover," *Business Opportunities Journal*, <http://www.boj.com/articles/franchise/jbx.htm> ; see also www.PeopleReport.com

⁶Shyam Patel, "Just Published People Report Survey of Unit Level Employment Practices Highlights Rapid Shifts in the Workforce," www.PeopleReport.com

achieve, how much they want to pay, and how they want to contain costs.

The majority of Americans get their health insurance coverage through an employer or through a government program.

Menu of Choices

There are several basic options for setting up a plan:

- A traditional indemnity plan, or fee for service

Employees choose their medical care provider; the insurance company either pays the provider directly or reimburses employees for covered amounts.

- Managed care

Two common forms of managed care are the Health Maintenance Organization (HMO) and the Preferred Provider Organization (PPO). An HMO has a prepaid amount (capitation) and limits enrollees to doctors employed by or under contract to the HMO. Under a PPO, there is a negotiated discount with the physicians and the hospitals. Members must choose doctors from a limited list and pay a set amount per office visit; the insurance company pays the balance.

- Self-insurance

Some businesses self-insure. This is allowed under the Employee Retirement Income Security Act (ERISA). Employers using this often use an outside company for the paperwork and limit liability with “stop loss” insurance when claims exceed a certain amount.

- Medical savings accounts (MSAs)

MSAs are special savings accounts coupled with high-deductible insurance policies. They are funded with employees' pretax dollars and disbursements are tax-free if used for approved medical expenses. Unused funds can accumulate indefinitely and earn tax-free interest. MSAs can be used by self-employed individuals or by employees of a company with 50 or fewer employees.

Why are the choices important?

The different choices are important because, in the face of rising costs, many businesses have used them to control costs while maintaining at least some level of coverage for their employees.

The following web site provides detailed explanations about health insurance types and choices:

National Association of Health Insurance Underwriters:
www.nahu.org/consumer/guides.cfm

I. Individual Insurance

About five percent of Americans purchase private individual coverage and do not get their health insurance coverage through an employer or through a government program. Individual coverage is regulated differently by each state.

Individual health insurance can be sold to a single individual, to a parent and dependent children, or to a family.

Individual health insurance is very different than group health insurance, which is the primary type of insurance that is offered through an employer.

Benefits are generally less extensive and some benefits that may be considered "standard" in a group policy may not be included in an individual plan.

In most states you can be turned down for individual coverage if you have a very serious medical condition. Fortunately, most states have developed some way to provide uninsurable people with access to individual health insurance coverage. Thirty-three states provide coverage to medically uninsurable people through high-risk pools. Twelve states use other means of providing uninsurable people with access to individual coverage such as requiring that all individual health insurance companies issue individual policies regardless of health status. Five states still have no means of providing individual health insurance access to people with serious medical conditions.

There are a variety of policies which insurance companies offer on an individual basis. Common types of policies include:

1. Major Medical - provides coverage for doctor visits, surgery and hospitalization or ongoing illnesses
2. Hospital and Surgery - provides coverage solely related to hospital stays and surgical services
3. Hospital Confinement Indemnity - to pay a set amount for each day you are an "in-patient" at a hospital.
4. Health Maintenance Organizations (HMOs)
5. Specified Disease
6. Short-Term - typically a major medical policy but with coverage lasting only for a specified length of

time. Might be purchased to cover the time you are between jobs.

7. Accident Only - provides coverage for doctor visits, surgery and hospitalization resulting from an accident (no coverage for disease or illness).
8. Dental - provides coverage for costs associated with dentists and orthodontists.
9. Vision - provides coverage for sight correction.
10. Home-Health Care - care provided to enable you to remain in your home while receiving services which can range from assisted living (help around the house) to around-the-clock nursing with other health care providers on call.
11. Long -Term Care - coverage provided to individuals who otherwise would not be able to take care of themselves. A range of services from delivery of prepared meals, assistance with managing the residence, to stays in residential facilities. Often associated with long-term illness and the elderly.
12. Limited - Benefit - not very common, a bare-bones type of coverage intended to cover specific situations.

II. Group Insurance

The majority of Americans have group health insurance through their employer or the employer of a family member. Group insurance is regulated at the state level. Health insurance is issued differently for different types of employers and can vary significantly from state to state.

Group health insurance coverage is purchased by an employer for eligible employees and often their family members as a benefit of working for that company. The majority of Americans have group health insurance coverage through their employer or the employer of a family member.

Federal law mandates that no matter what pre-existing health conditions small employer group members may have, no small employer or an individual employee can be turned down by an insurance company for group coverage. In most states, small employer health insurance companies are allowed to look back at individual group applicants' medical histories for pre-existing conditions and may decide not to cover certain conditions for a specified period of time.

State laws determine how small group health insurance companies determine their initial premium rates for each company.

With large group health insurance contracts a health insurance company could reject an entire large employer group based on its claims history. No individual employee who is eligible for benefits can be excluded. If an insurance company issues a policy to a large employer, then all of its eligible employees must be issued coverage. This is a significant protection for employees.

Many employer-based health insurance plans are fully insured by a health insurance company. Under contract the employer pays the premiums for coverage, and the insurance company

assumes all claims risk. The states regulate fully insured group plans.

Most states require companies to have at least two employees to qualify for group coverage and often have specific and strict requirements to document that they actually are legitimate businesses.

What Types of Group Insurance are Available?

The primary advantage of group health insurance is its purchasing power. The insurance company is able to reduce the rate it charges to cover each individual. The group is in better position to bargain for additional benefits for its members.

There are a variety of types of group health insurance plans. The major distinction is how they are purchased. These include:

1. Fully Insured Employer Group - The employer contracts directly with the insurance company usually for major medical or health maintenance organization (HMO) coverage.
2. Small Employer Group - Insurance companies gather small employers from certain industry groups to form a larger group. The insurance company can then better predict the costs. This enables small employers to get coverage that is otherwise only available at a much higher rate. All the small employers get the same policy.
3. Large Employer Group – This is the same as a fully insured employer group with direct contract between the insurance company and the employer to provide individual certificates to covered employees.

4. Health Maintenance Organization (HMO) – A group program, the organization provides a full range of medical services to participants who are called “enrollees.” Enrollees are assigned to or select a general practitioner from the organization who then refers the enrollee to a specialist when needed.
5. Self-Funded ERISA – This is available to large groups (usually an employer or union). The group creates the plan and pays the claims. Usually a third-party administrator handles the paperwork.
6. Association Group - Similar to a fully insured employer group, the distinction here is that instead of an employer, it is a different type of group, such as a credit card company offering insurance as a benefit to its cardholders or a church group offering insurance to its parishioners.
7. Preferred Provider Organization (PPO) – These are networks (doctors, hospitals, and other health care providers) that contract with health insurance companies.

ERISA

As described above, large employers may choose to fully or partially self-insure their group benefit plans. They set a pool of funds in reserve and assume the risk for health benefit claims. They also generally buy stop-loss insurance policy to protect against losses above a certain threshold. Self-funded plans are regulated federally by the Department of Labor under the Employee Retirement Income Security Act of 1974 (ERISA), so they are sometimes known as ERISA plans.

HSAs

Health Saving Accounts (HSAs) are another way of paying for medical care. As of 1 January 2004, almost anyone with a qualified high-deductible health plan can also have a Health Savings Account. They are available for both individuals and employers. Both of the high deductible plans can be set up entirely by the employee or by the employer. Regardless of who sets it up and contributes to it, it is the employee’s account even if the employee changes jobs or moves to a different state. It can be used to pay for deductible expenses and expenses not covered by the insurance plan. Unspent funds remain in the account until the employee spends them on medical care.

Limited Benefit

Policies with premiums as low as \$10 per week are used by an estimated 750,000 employees and families. Several major companies make them available to their employees. Coverage often pays only \$1,000 per year.

The existence of limited benefit policies underscores the importance of not only evaluating whether employers offer insurance, but also evaluating the type of insurance being offered, the employee premium, deductible, and coverage. Since this is a confusing and complex arena, there is a possibility that the employees will choose the lowest choice option only to learn the hard way that the policies do not cover very much. When companies offer many choices, including limited benefit policies, they should also ensure that their employees understand the benefits and limitations of the different plans.

Trade Associations

Many trade associations negotiate lower rates and improved coverage for all small employers in an entire association. This is one way that small businesses can offer choices that they ordinarily could not afford. Depending on the type of insurance offered, however, this may be quite limited. For instance, if they are offering employer group insurance, the largest pool will be at the state level and not at the national level because of the difference in state laws.

Legislative Efforts to Amend ERISA

Current law permits small businesses to form purchasing groups or associations to obtain health insurance; however, they must comply with each state's laws, regulations, and benefit mandates.

In other business areas, purchasing groups involve members in multiple states. If applied to health insurance this should allow them to pool and spread their risks. Insurance coverage and costs usually go down with a larger group, increasing their bargaining power and reducing their administrative costs, thus resulting in lower premiums and increased insurance options. However, the Employee Retirement and Income Security Act requirement to comply with each state's rules and laws, effectively limits the size of the group to the state level.

Legislation has been repeatedly introduced that would allow a single set of requirements and exempt some of the state insurance laws and oversight. An association would be able to offer one plan.

A recent Senate bill (S. 1955), known officially as the Health Insurance

Marketplace Modernization and Affordability Act of 2006, is commonly referred to as the Small Business Health Plan (SBHP) legislation. Prior House and Senate bills have been referred to as Association Health Plan (AHP) legislation. As with ERISA, the U.S. Department of Labor would oversee and administer the legislation. While there is interest in expanding health coverage and reducing costs, none of this legislation has passed.

There are critics and advocacy groups, such as the American Cancer Society, the American Diabetes Association, and the National Governors' Association, that oppose this legislation. They do not wish to bypass state benefit mandates. They are concerned that such policies would cover healthy individuals and bypass unhealthy individuals.

The legislation's supporters counter that federal laws provide sufficient protection and that this would actually spur competition and not hinder it. They point out that ERISA permits single employers and labor unions to "self-insure" and offer health benefits with exemption from state insurance laws. They claim that this leaves small businesses of many types at a competitive disadvantage.

This is a very good example of the complexity of the employer health insurance issue and a good example of how it polarizes the different stakeholders (employers, insurance companies, advocacy groups, states, and the federal government).

Medicaid and SCHIP

The Medicaid and State Children's Health Insurance Program (SCHIP) are

funded by the federal government and by states. Medicaid is available to families with income under 100 percent of the poverty limit. SCHIP is available primarily for children and has a higher eligibility limit which varies from state to state. Several states, like Wisconsin, have expanded SCHIP to cover working families, not just the children.

Medicaid and SCHIP are important considerations in any discussion of employer-based health insurance. For many individuals, these programs are a safety net and a work support. Federal law, for instance, allows transitional Medicaid benefits for TANF participants who have left cash assistance because they are working.

On the one hand, there is great concern that families and children have these programs as a safety net. Over the last several decades, eligibility has been expanding. On the other hand, there is great concern and controversy over companies that have large numbers of their employees who are using Medicaid and SCHIP for their health insurance rather than using employer-based health insurance.

Lack of Understanding

As with many government programs, there is often a lack of understanding about such programs by those who need them the most. One of the most common misunderstandings is that any income and especially work will disqualify a family from Medicaid and SCHIP. In fact, many children whose parents are working but do not have health care would be eligible for SCHIP. A recent story in the *New York Times* chronicled a family in North Carolina that piled up bills and skipped physical

exams and immunizations only to learn that most of those expenses would have been covered under SCHIP. The story reported that an estimated 30 percent of the children who are in similar situations have not been enrolled in SCHIP even though they are eligible⁷. There are many other barriers including language and a reluctance to go on “welfare.”

This is another example of why this is such a difficult area to understand and to debate. There is a strong expectation that employers will provide or contribute towards health insurance. At the same time, there is a strong commitment that government health insurance will be available for children of low-income families. There is a tremendous amount at stake in this debate. At the center of the debate is the unsettled question of when government should step in and provide health care. While there is widespread agreement that everyone should have access to affordable health insurance, there is a lack of consensus about how this should be done and what government’s role should be.

Forces on States, Employers, and Employees

States

As a result of annual increases in the cost of health care, many state and local governments are looking at ways to shift this burden, at least for working people.

A recent survey done for Westchester County, New York, estimated that the lack of adequate employer-based health insurance cost the county between \$11.5

⁷ Kevin Sack, “Many Eligible for Child Health Plan Have No Idea,” *New York Times*, 22 August 2007.

million and \$34.5 million per year.⁸ Westchester County Executive Andy Spano stated: “As this report demonstrates, employers in significant numbers are having the best of both worlds: a healthy productive workforce, but no expense of paying for their health benefits.”

Some states have stepped up the pressure by publishing the names of companies with large numbers of employees who are receiving government health insurance. Perhaps the company most at the center of this pressure has been Wal-Mart because of its size and national presence. Wal-Mart has actually responded in a positive way to this pressure (see discussion in example section below).

There has been much legislation introduced with new employer requirements, although few of these have been enacted into law. Maryland would require employers to spend a percentage of their payroll on health insurance. Connecticut would require employers to provide coverage or pay into a state fund. New Jersey would restrict companies that could bid on state contracts to only those that provided health insurance for their workers. California would require employers to pay at least 80 percent of employee’s health insurance premiums.

Employers

It also is useful to look at this issue from the employer’s perspective. According

to its annual 2006 survey,⁹ the Kaiser Family Foundation and Health Research and Educational Trust (HRET) have findings that illustrate the pressures facing businesses.

1. Employer-sponsored health insurance provides coverage for over 155 million non-elderly in America.
2. Since the year 2000, health insurance premiums have grown by 87 percent, compared with cumulative inflation of 18 percent and cumulative wage growth of 20 percent.
3. Average annual premiums for employer-sponsored coverage are \$4,242 for single coverage and \$11,480 for family coverage.
4. Over 75 percent of covered workers with single coverage and over 90 percent of covered workers with family coverage make a contribution towards the total premium for their coverage. This amounts to approximately a 16 percent contribution for single coverage and 27 percent for family coverage.
5. Covered workers in small firms (i.e. 3–199 workers) on average make a significantly higher annual contribution towards single and family coverage than covered workers in larger firms (single: \$689 vs. \$515, family: \$3,550 vs. \$2,658).
6. Average annual deductibles for single coverage are \$352 for workers enrolled in HMOs; \$473 for workers enrolled in PPOs; \$553 for workers enrolled in POS plans. The annual deductibles for small firms are

⁸ Andrew F. Neuman (Senior Assistant to Westchester County, NY Executive Andrew J. Spano), “Medicaid: The Best Business Subsidy Your Tax Dollars Can Buy,” November 2006.

⁹ *The Kaiser/HRET Employer Health Benefits Survey*, Kaiser Family Foundation, September 2006.

substantially higher than for large firms.

7. The vast majority of covered workers face co-payments when they go to the doctor; most also face cost sharing for prescription drugs.
8. Sixty-one percent of firms offer health benefits to at least some of their employees. Since 2000, the percentage of firms offering health benefits has fallen from 69 percent. Over 90 percent of firms with over 50 employees offer health benefits while only 48 percent of the smallest firms offer them.
9. Sixty-seven percent of firms with relatively few part-time workers (less than 35 percent of workers work part-time) offer health benefits, compared with 44 percent of firms with a higher percentage of part-time workers.
10. Not all workers get covered. Some workers are not eligible to enroll as a result of waiting periods or minimum work-hour rules, and others choose not to enroll perhaps because they must pay a share of the premium or can get coverage through a spouse.
11. Seven percent of firms offering health benefits offered a High Deductible Health Plan with Savings Option (HDHP/SO) in 2006. On average, workers enrolled in an HDHP/HRA receive an annual employer contribution to their HRA of \$797 for single coverage and \$1,584 for family coverage.
12. Twenty-six percent of employers offering health benefits include one or more disease management programs in their largest health plan. Twenty-seven percent of employers offering health benefits offer one or

more wellness programs to their employees

13. Few employers report that they are very likely or somewhat likely to drop coverage (6 percent) or limit eligibility (6 percent) in the next year. More report that they are likely to increase what employees pay for coverage (49 percent), increase plan deductibles (39 percent), increase co-payments or coinsurance for office visits (39 percent), or increase worker payments for prescription drugs (39 percent).

Employees

It is evident that pressures are not only on states and on employers. They are also on the employees who often must pay part of the premium, co-payments and deductibles. Employees are also under pressure to make informed decisions. They often must decide on health care options, on when and how to get medical services, and most importantly about wellness and healthy practices.

Need for a Balanced Approach

It has become increasingly clear to us that any solutions to the health insurance crisis in this country (i.e. access, affordability, and cost) need to involve government, employers, and employees. Health care must be viewed as essential and valuable. All three parties have an interest and a stake. When all three have a stake in the outcome, there is a better chance that health and health care will be approached in ways that will hold costs down. This problem cannot be solved by government alone, by employers alone, or by employees alone. When things get out of balance, each party will operate from its own self-

interest, which we know is not the best for the whole country.

EXAMPLES

The following are examples of how a variety of different companies are trying to deal with health insurance. It is interesting to juxtapose the interaction with government and with employees.

Innovative Practices

The following are examples of some of the many innovative practices that businesses are developing to improve health and reduce costs.

Intuit

This is the Silicon Valley software company known for its Quicken and TurboTax financial software. Intuit is taking an active interest in their employees as one way to reduce health costs and insurance premiums in the long run. It pays employees \$100 each for voluntarily filling out an online medical questionnaire that is intended to flag problems and suggest remedies. This information is then used to steer willing employees to remedies such as smoking reduction programs, which are also paid for by the company.

Costco

Costco is a discount retailer best known for high quantity consumer goods at low prices. It also has entered the insurance business. At the state level, Costco is combining numerous small businesses into one cost pool. It is doing this in Nevada, Oregon, Hawaii, Washington, and California. Most are businesses with fewer than five employees who previously did not have employer-based health insurance. By doing it at the state level, they conformed to each state's

group insurance regulations. By pooling multiple small businesses, they were able to secure better insurance rates and maintain low administrative costs. Rather than offering many different plans, they offer only one or two in every state. This is not a major profit area for them. Costco is doing this as a service because small businesses are among their primary customers. The net result is that Costco is helping many small businesses and helping their own business by serving their members.

Florida Power & Light (FPL) – Health Management Program¹⁰

Florida Power & Light Co. is located in Juno Beach, Florida. Since 1991, FPL has invested in a Health Management Program for its managers and employees. The investment has been small but the returns have been large. The fitness programs cost the company less than \$100 per employee. Since starting the program, FPL has seen a drop in insurance claims for cardiovascular disease, cerebral vascular disease, and some cancers. Its weight management program is helping workers control their diabetes.

Examples of Franchises and Company-Owned Chains

The following provide some examples of how a wide variety of different companies are dealing with health insurance

Dunkin' Donuts

Dunkin' Donuts, one of the nation's largest franchises, has no company-owned stores. It is one of the companies

¹⁰ Christine Larson, "When Your Boss Says Jump," *U.S. News and World Report*, 26 June 2006.

cited as having a large number of its employees on public health programs. Until recently, each franchise had to decide whether or not to offer health insurance. This was usually limited and/or expensive because each franchise did it on its own with a very small pool of employees.

Under ERISA and with approval from the U.S. Department of Labor, Dunkin' Donuts was able to offer its franchises a much lower cost group health insurance policy.¹¹ It did this by setting up a Distribution Center, which was wholly owned by the franchises. Under ERISA Section 3(5), the Distribution Center set up a health insurance plan to provide medical, surgical, or hospital benefits, or benefits in the event of sickness or accident to employees of Franchisees and of the Distribution Center and their dependents. Due to the much larger pool, the cost of insurance has been reduced.

Starbucks

As described above, Starbucks does not franchise its stores. They are all company-owned. Starbucks puts a high premium on its workforce and on presenting a high quality and consistent level of service everywhere. A high percentage of its workers are part-timers, yet it has consciously made a business decision that anyone working more than 20 hours a week is entitled to a reasonably priced health care insurance package that can also include dental and vision coverage. For the company's top-of-the-line health insurance, a part-time worker pays around \$800 annually. This

is much less than the thousands of dollars an individual policy would cost. While the company is concerned about the continual increase in health care costs, they are providing this benefit to attract the type of workforce that they want. This is very much related to their vision and business plan.

Domino's Pizza

Domino's Pizza consists of both company-owned units and franchised units, though most are franchised. Concerned about the increasing costs of employee benefit programs and health insurance premiums, Domino's established MaSSCorp as an association of the company's franchisees. MaSSCorp's mission is to provide cost saving and innovative employee benefit solutions for Domino's Pizza franchisees.

This is not an employer-based state regulated group insurance or ERISA regulated insurance. Rather it is low-cost, fixed amount individual insurance. Due to the large number of franchises, Domino's was able to negotiate the price.

A number of plans and options are available to the franchisees and the employees.

The Core plan pays 50 percent of the premium for the employee and allows buy-up options for higher levels of insurance; it allows employees to purchase coverage for additional family members. There is a Voluntary plan, which charges the employee 100 percent of the premium. A Dental/Vision plan also is available with a 100 percent employee premium.

¹¹ U.S. Department of Labor, Employee Benefits Security Administration, 31 August 2005, <http://www.dol.gov/ebsa/pdf/ao2005-20a.pdf>

While certainly very positive and undoubtedly for many more coverage than they had before, it is not a comprehensive major medical plan. When combined with a high deductible catastrophic plan, these options could provide a good choice for many employees.

Jack in the Box

Jack in the Box owns 78 percent of its 2,006 namesake restaurants and all of the JBX Grills, which are scheduled to expand into Central California, Idaho and Dallas.

The company is remaking itself by emphasizing premium food and superior guest service. It also has fundamentally changed its approach to health insurance.

In an internal study, the company found that the average tenure of those with health insurance was 15 years versus 1.5 years for those without it.

To reduce turnover, Jack in the Box has started offering medical, dental, and vision insurance in December 2006 to full- and part-time hourly employees at company-owned Jack in the Box and JBX Grill restaurants. The company pays a portion of the premiums for hourly employees who have at least one year of service.

Since Jack in the Box has such a high percentage of company-owned restaurants, this insurance coverage is available to a large number of employees.

To put this in perspective, 60 percent of the 230 fast-food restaurants surveyed by the National Restaurant Association offer partially paid health insurance to

hourly employees. One percent provides fully paid health insurance.

Jack in the Box had offered health insurance to hourly workers until 1991, when the company stopped extending the benefit to new crew members. Since then, the company has tracked the tenure of those with company health insurance and those who joined after 1991. The average tenure of those with health insurance was 15 years versus 1.5 years for those without it. Jack in the Box estimates that it costs \$1,000 to recruit and train each new employee and that its health care plan will pay for itself if the turnover decreases. Jack in the Box also wants to be perceived as a good corporate citizen and a good company.

Subway

Subway is the world's largest fast-food chain with over 21,000 restaurants located in the U.S alone. Sales in the U.S. totaled \$7.17 billion in 2005. All of its restaurants are franchises.

For corporate workers, the following benefits are offered:

- Medical and dental insurance
- Disability and life insurance
- Paid time off after completion of a 90-day orientation period

These benefits are contributory with the company and employee each paying 50 percent of the premiums.

Most of the Subway employees work for a franchise. It is up to each franchise to decide whether or not to offer health insurance. Some provide health insurance benefits while others do not.

7-Eleven

Most of the 7-Eleven stores are franchised.

At the corporate level, 7-Eleven offers health insurance benefits to its employees.

- For full-time employees and their eligible dependents, 7-Eleven offers a consumer driven health program through United Healthcare. Employees who elect medical coverage also are eligible for prescription drug coverage. A vision plan is available.
- For part-time employees, an affordable basic medical plan, which includes a limited prescription drug benefit plan, is available.

Employee benefits at franchise stores are governed by each franchisee's benefit package. Whether health care benefits are included is left to each franchise.

Wal-Mart

Wal-Mart, the nation's largest employer, does not franchise its stores. Given its place in the U.S. economy, Wal-Mart came under intense criticism from states and advocacy groups over the number of its employees who receive government health insurance. Some states have actually published the number of Wal-Mart employees that receive government insurance.

Wal-Mart's performance prior to this criticism was about the same as other retail employers. According to the Employee Benefit Research Institute only 45 percent of workers in the retail sector overall receive health coverage

from their employer. At the time, Wal-Mart was covering 48 percent of its employees. Wal-Mart stated that an additional 40 percent of their employees had health insurance through their spouse's employer, a parents' plan, or from retirement and Medicare programs. Still, 25 percent of employees were part-time and not eligible for health insurance for two years. About half of Wal-Mart's employees were opting out because of the cost.

It is likely that the widespread criticism of Wal-Mart and the public concern about the growing number of uninsured in the U.S. had an impact on the company. In October 2005, Wal-Mart announced that it was introducing a cheaper health insurance plan to make health insurance more affordable.

After implementing its new plan in 2006, Wal-Mart reported the following about employee (Associate) health insurance¹²:

- At a time when health insurance premiums for retail employees increased an average of 8.7 percent, the average Associate payroll deductions were 6 percent less overall in 2006 than in 2005.
- About 70,000 Associates who previously did not participate in Wal-Mart's health plans signed up for Wal-Mart benefits during 2006 benefits enrollment.
- Those who participate will pay a \$1,000 deductible, the maximum

¹² "What's the story about Wal-Mart health care benefits?" Wal-Mart brochure, July 2006, http://www.walmartfacts.com/FactSheets/832006_Health_Care.pdf

under Wal-Mart's insurance for 2005. Monthly premiums will be, on average, less than \$25 for an individual; \$37 for a single parent; and \$65 for a family. The \$11 premium for individuals will be available in a handful of areas.

- All eligible Associates can obtain medical coverage for about \$23 a month. They can add their children—no matter how many—for about \$15 more per month.
- As of January 2007, Associates in an HSA-Qualified Plan with a Health Savings Account will receive an up-front contribution from the company equal to 20 percent of their medical plan's deductible. That ranges between \$250 and \$1,200 annually that Associates can apply to health care expenses, depending on the chosen plan option. In 2007, there will be a matching plan that will add an additional company contribution up to \$1,200 to match dollars that employees put into the HAS account.
- All the plans provide major medical coverage with no lifetime maximum after one year of enrollment. That means Associates' medical coverage will not run out in their time of greatest need.
- Approximately 7 percent of surveyed Associates said they were on Medicaid before their hire date; however, 5 percent were on Medicaid after being hired. That rate drops to 3

percent after two years at Wal-Mart.

- Wal-Mart emphasizes that they help their Associates obtain private health insurance and that both full-time and part-time can become eligible for Wal-Mart's medical plans.
- Wal-Mart provides health insurance to about 1 million people: approximately 600,000 Associates and nearly 400,000 family members are enrolled in a Wal-Mart medical plan at any given time.

Frequently raised concerns about the plan focus on the high deductible. Some point out that the plan's \$1,000 deductible would be high for Wal-Mart workers, particularly older employees who are likely to visit doctors more often, and that the plan might not cover expensive treatments, particularly in its first year.

Deductibles are \$1,000 for a plan with a low premium, which does not include routine treatments such as flu shots and child vaccinations. Wal-Mart emphasizes that its health insurance provides protection for catastrophic health expenses such as cancer treatment.

Wal-Mart is providing its employees with many choices for health insurance. In addition to major medical coverage with a high deductible, the company also provides limited benefit coverage and HSA accounts to help cover routine visits to the doctor and other costs not covered under the major medical policy.

Outreach

McDonald's

In Houston, Texas, several franchises participated in a community effort to enroll eligible children from the community in the SCHIP program. They set up a date and time (10:00 am to 2:00 pm) when parents could complete an application for SCHIP at participating McDonald's restaurants. This was done as a community outreach service to help inform families about the SCHIP program. McDonald's participated as one of the Children's Defense Fund "Back-to-School" Project partners.

60 Companies Promote Plan

In January 2005, 60 large employers, including General Electric, IBM, McDonald's, and Sears Roebuck joined together to sponsor an array of low-cost health insurance options to cover uninsured part-time and temporary workers, contractors, consultants and early retirees who typically are not eligible for employer health plans.¹³

These options, offered to part-time employees, are not intended to replace employer-paid health plans that are already in place for full-time workers.

The plans range widely in cost from \$5 a month for a card that provides users with discounts for doctors and pharmacies to more than \$300 a month for a high-deductible plan that covers major medical and hospital expenses. UnitedHealth Group will offer the four lowest-cost options in all 50 states. UnitedHealth and [Humana](#) will offer the medical policies in states where they

¹³ Milt Freudenheim, "60 Companies Plan to Sponsor Health Coverage for Uninsured," *New York Times*, 27 January 2005.

have been approved by regulators. [Cigna](#) will offer the program's major medical option in Arizona.

The employers are not paying for the insurance. They are creating a large pool of participants, which will lower the overall cost of the insurance.

It is noteworthy that a group of large employers decided to cooperate to address some of the issues with access and affordability to health insurance. They acknowledge that it does not solve all of the problems. But, it is a positive step. It also is significant that they have offered different types of insurance including group insurance that is regulated by states.

This demonstrates that employers are attuned to the issues and needs for health insurance and are taking positive steps to provide more access and affordability.

Use of Technology

One of the issues with health insurance and health issues is communication of information and choices to employees. Distance learning can be used as an effective tool by both government and employers to communicate this important but complex information. Fortunately web-based learning can be used as a very effective tool for franchises and other chains that are spread all over the country. Franchises such as Dunkin' Donuts and Subway are now using web-based learning as a cost-effective training tool.¹⁴ This technology could be used to

¹⁴ Julie Ritzer Ross, "Operators cite benefits of online training tools: lower costs and consistency of service named among chief advantages of Web-based learning," *Nation's Restaurant News*, 14 August 2006.

communicate health insurance options, wellness, and other health information to employees.

SUPPORT FOR EMPLOYER-BASED HEALTH INSURANCE

The number of uninsured Americans today stands at 45 million. Many of these uninsured Americans (60 percent or more, by some estimates) work for or depend on small employers who lack the ability to provide health benefits for their workers and their families.

CONCLUSION

This paper presented many different aspects of employer-based health care and focused on examples from employers with franchise or company-owned chain operations. The following conclusions are drawn about this very important issue:

- 1. There are a large number of choices.** Employers and employees need to understand the differences among the plans in order to make good choices. Some of the choices, such as group insurance, are regulated by each state; other choices are regulated by the U.S. Department of Labor while others like individual health insurance have little regulation. Due to the complexity of the choices, it is clear that education and understanding must be a priority at all levels – government, employers, and employees.
- 2. Franchises have multiple models.** Some companies allow the individual franchise unit to act independently like any other small business. As with any small business, providing employee

benefits including health care is completely up to the individual franchise owner. With other models, franchises are able to join together through associations to offer lower-cost health insurance options to their employees.

- 3. Small businesses are often not entirely alone.** At least at the state level, small businesses can often join together to form larger groups, which are eligible for lower health insurance prices.
- 4. Health insurance is not just a burden on businesses.** Many use it to compete with other businesses and to attract and maintain the best employees.
- 5. Limited-benefit programs can leave employees unprotected against major medical expenses.**
- 6. The struggle over the health care issue is complex and multi-faceted.** It is by no means a totally negative or bleak picture. There is growing evidence of innovation and an increased focus on wellness programs to improve health, reduce illness, and control costs.
- 7. It is a mistake to make blanket categorizations about franchises vs. company-owned chains.** Both can be innovative and both can offer good health insurance options to their employees.
- 8. Many companies, franchise, and corporations are approaching health insurance in a positive manner.** While health insurance is undeniably considered to be a burden, concerned businesses are not seeking to pass the cost of insurance off on the government or their employees, but rather are using

health insurance to attract and retain good employees

- 9. Businesses do respond in positive ways to public pressure about the need to provide employer-based health insurance.** Given the many choices now available, businesses can often take advantage of their ability to create a large pool of potentially insured and thus negotiate lower prices for insurance coverage.
- 10. Businesses do respond to cost pressures to adopt innovative approaches to health coverage.** Many businesses have decided to offer Health Saving Accounts, wellness programs, and other methods that help to reduce health care costs while at the same time providing health care coverage to their employees.
- 11. Improvements in health insurance will require the attention of all major partners.** Any efforts to address the matter of health insurance can not be handled by only one party, but must involve all parties, including government, employers, and employees. Each party has a stake. Each party has a responsibility. All must work together to achieve a balance and attain the ultimate goal of providing the best health care coverage for employees at the most reasonable costs.