

The Views of Low-Income Employees Regarding Mandated Comprehensive Employee Benefits for the Sake of Health

KATHERIN A. ADIKES

National Institutes of Health, Bethesda, Maryland, USA

SARA C. HULL

National Institutes of Health, Bethesda, Maryland, USA

MARION DANIS

National Institutes of Health, Bethesda, Maryland, USA

Socioeconomic factors stand in the way of good health for low-income populations. We suggest that employee benefits might serve as a means of improving the health of low-wage earners. We convened groups of low-income earners to design hypothetical employee benefit packages. Qualitative analysis of group discussions regarding state-mandated benefits indicated that participants were interested in a great variety of benefits, beyond health care, that address socioeconomic determinants of health. Long-term financial and educational investments were of particular value. These results may facilitate the design of employee benefits that promote the health of low-income workers.

KEYWORDS *Public participation, socioeconomic factors, fringe benefits, inequality, insurance benefits, employees*

This article is not subject to U.S. copyright law.

Funding for this project was provided by the Department of Clinical Bioethics at the National Institutes of Health. The positions expressed in this paper do not represent the official views of the National Institutes of Health or the Department of Health and Human Services. The REACH tool was created through the joint work of the National Institutes of Health and the University of Michigan Center for Health Communications Research and copyrighted by the Board of Regents of the University of Michigan. The authors are grateful for the contributions of Lindsay Sabik and Frank Lovett to the development and implementation of the REACH exercise. They also wish to acknowledge the valuable input of Ezekiel Emanuel, Steven Pearson, and Carrie Thiessen.

Address correspondence to Katherin A. Adikes, BA, Department of Clinical Bioethics, Clinical Center, National Institutes of Health, Building 10, Room 1C118, 10 Center Drive MSC 1156, Bethesda, MD 20892-1156, USA. E-mail: kadikes@umich.edu

INTRODUCTION

Improving the health of low-income individuals requires interventions that go beyond increasing access to health care (Graham, 2004; Lurie, 2002; Solar, Irwin, & Vega, 2005). The Whitehall studies and the Black Report showed that even in populations that have universal access to health care, lower socioeconomic status (SES) is associated with poorer health (Marmot, 1978; Townsend & Davidson, 1992). In the U.S., resources remain concentrated in a health care system that fails to insure increasing numbers of low- and middle-income earners (Reinhardt, Hussey, & Anderson, 2004). Moreover, nonmedical programs to improve health often target higher income brackets (Graham, 2004). Inattention to the health of lower-SES populations derives not only from unequal distribution of resources but also from poor assessment of that population's needs (Alkire & Chen, 2004; *Lancet*, 2006).

The WHO Commission on the Social Determinants of Health recently reported a number of broad-based strategies to reverse such trends (WHO Commission, 2008). The commission considered conditions of work as one of the social determinants of health, and its framework for action included labor market policies that foster full and fair employment. In the context of this framework, modification of the employment benefits system is one approach to ameliorating the health of low-income earners that merits consideration. The employment benefits system has served as a major source of health insurance and an occasional provider of other benefits in the United States since World War II (Fronstin, 1998). The system capitalizes on the ability of the employer, as the benefit distributor, to reach many working age adults and identify the specific needs of employee communities (Chapman, 2004; Custer, Kahn III, & Wildsmith IV, 1999; Sorenson, Linnan, & Hunt, 2004; Thompson, Smith, & Bybee, 2005). However, as the rising costs of health insurance burden employers, the number of employees without access to important benefits continues to rise (Fronstin, 2005). Although larger businesses can often maintain benefits coverage without significant financial risk, the small businesses that employ most Americans today cannot (Chapman, 2004). Consequently, many low-income workers have lost access to the services that help promote good health (Gabel, Hurst, Whitmore, & Hoffman, 1999).

Notwithstanding these setbacks, employee benefits can be valuable investments for employers, generating long-term economic gains through the health and well-being of employees (Marmot, 2006). Several studies suggest that employer-provided health promotion programs reduce health care costs and absenteeism and increase productivity (Bly, Jones, & Richardson, 1986; Bowne, Russell, Morgan, Optenberg, & Clarke, 1984; Chen, 1988); even most small employers who offer benefits experience economic gains through health-related benefits (Fronstin, Helman, & Greenwald, 2003).

We conducted a study to determine low-income earners' priorities regarding employee benefits aimed at improving health (Danis et al., 2007).

Here we report a qualitative analysis to elucidate the reasoning of low-income earners as they participated in group deliberation about what employee benefits should be state-mandated for low-income employees.

METHODS

Study Design and Sample

Small groups of individuals were engaged in a hypothetical decision exercise using a computerized decision tool called the Reaching Economic Alternatives That Contribute to Health (REACH) exercise to engage low-income participants in the selection of employee benefits (Figure 1) (Danis et al., 2007). This exercise is a modification of an established computerized decision tool that allows small groups of individuals to select health insurance benefits (Danis, Benevides, Nowak, & Goold, 2005; Goold, Biddle, Klipp, Hall, & Danis, 2005).

The exercise allowed participants to spend a limited allotment of money in the form of markers to select employee benefits in four sequential rounds of hypothetical decision making: (1) individual selection of benefits for oneself, (2) smaller subgroup selection of benefits to be offered by a company, (3) whole-group selection of benefits that a state would require its employers to offer, and (4) a second individual selection of benefits for oneself. During the third round of whole-group decision making, each participant was asked to nominate an employee benefit and justify that nomination; groups then discussed the pros and cons of nominations and reached decisions either by consensus or by majority vote.

In preparation for the decision making processes, participants received written and verbal descriptions of (a) the socioeconomic factors that affect health and (b) the health-related impacts of each employee benefit included in the REACH exercise. They were reminded to consider the health-related effects of their choices but also informed that they could choose benefits for other reasons. To foster better-informed selections, participants were given health event "cards" following each of the first two rounds of decision making that described the health-related consequences of their choices. Trained facilitators guided the exercise. Materials were written to be understood at a 6th-grade reading level.

Group sessions were conducted at the National Institutes of Health in Bethesda, Maryland, between March and October 2005 with participants from the greater Washington, DC/Baltimore region who earned less than 3 times the national poverty threshold (under \$35,000 unless adjusted for multiple household members) (Thompson, 2003). Four hundred eight individuals participated in 52 group sessions ranging in size from 4 to 12 participants.

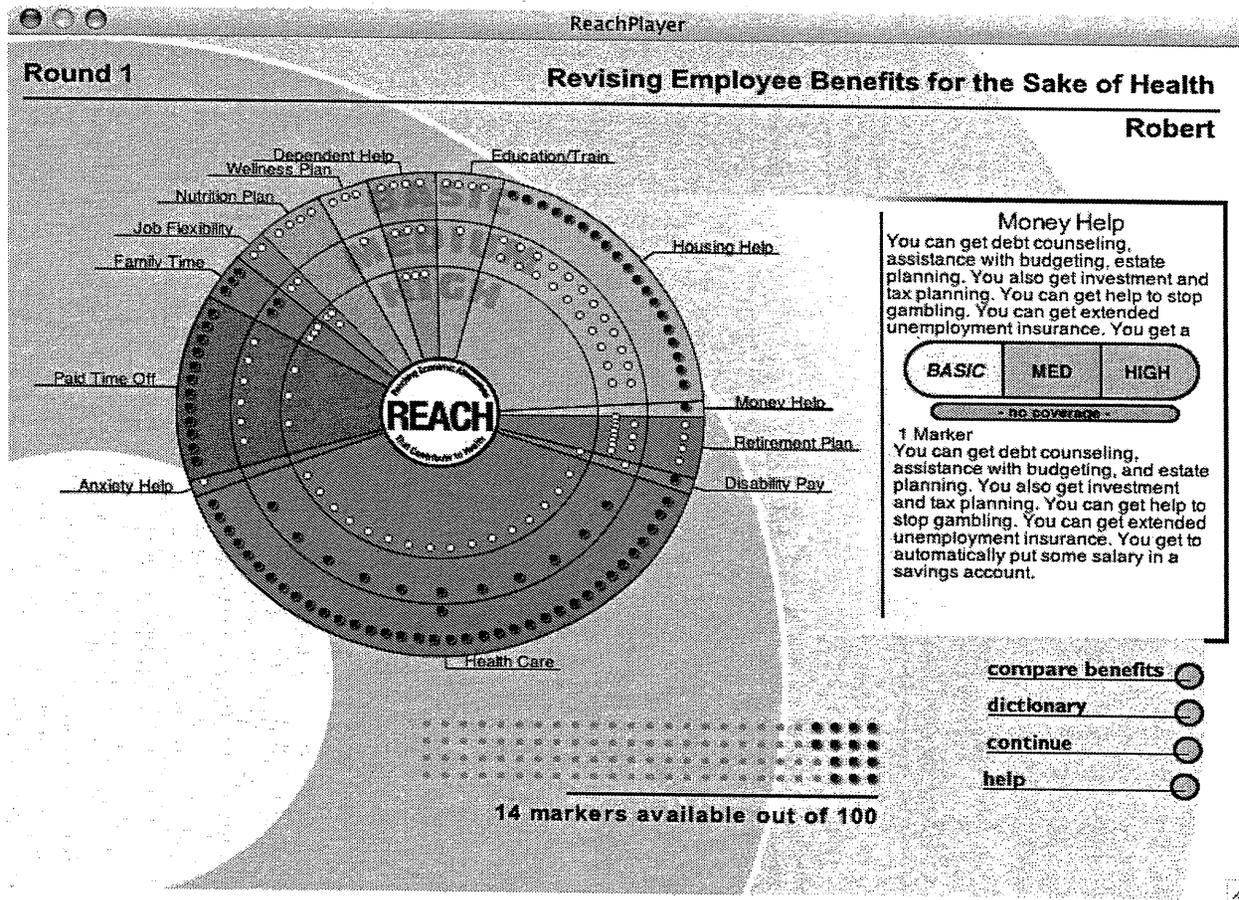


FIGURE 1 REACH exercise board.

Each participant was compensated \$75. The institutional review board of the National Institute of Mental Health approved the study.

Employee benefits included in the REACH exercise (Table 1) were based on both a survey of typical employee benefits by Marsh and Mercer Human Resource Consulting (MHRC, 2003c) and a literature review of employee benefits associated with a positive health impact. The actuarial costs of benefits, in up to three differing levels of expense (see Table 1), were estimated using the *Employers' Time-Off and Disability Programs Survey* (MHRC, 2003a), the *National Survey of Employer-Sponsored Health Plans* (MHRC, 2003b), and the *2003 Employee Benefits Study* (U.S. Chamber of Commerce, 2003). Costs were adjusted for inflation.

TABLE 1 Definitions and Costs of Benefit Options

Type of coverage	Simple definition	Monthly per capita cost (\$)*		
		Basic	Medium	High
Anxiety help	Help to find treatment for personal problems	3	**	**
Dependent help	Help paying for dependent care	34	68	93
Disability pay	Insurance in case of illness or injury that prevents employee from working	11	16	22
Family time	Paid leave for care of sick family member and for childbirth	27	46	71
Health care	Health insurance	356	460	643
Housing help	Loans, grants, and other payments to help pay for housing	188	400	**
Job flexibility	Help paying for travel to work and for flexible working hours	18	39	70
Money help	Investment counseling and planning and extended unemployment	13	**	**
Nutrition plan	Inexpensive cafeteria at work and nutrition counseling	43	**	**
Paid vacation	Paid sick leave and other paid time off	113	170	203
Retirement plan	Money put into an account by your boss for retirement	35	144	**
Training/school	On-the-job training and mentoring and professional development program	38	46	**
Wellness plan	Healthy lifestyle programs, free vaccinations, and help to quit smoking	26	34	**
Extra pay	Taxable take-home pay	***		

Notes. *Monthly per capita costs of benefits have been determined as described in the methods. Dollar amounts shown here were rounded to the nearest multiple of \$9.67, which is the value of 1 marker. Benefits are represented on the REACH exercise board in the form of markers as shown in Figure 1. A more detailed explanation of actuarial calculations is included in a report prepared by Mercer and available on the REACH exercise CD from the Technology Transfer Office at the University of Michigan Office of Technology Transfer, 3003 S. State St. Suite 2071, Ann Arbor, MI 48109-1280, 734 763-0614.

**Indicates that the benefit is not offered at this level.

***Any amount of unused markers is left as extra take home pay.

Participants were given 100 markers that, in total, were equivalent in value to \$967/month or \$11,600/year, the average cost of employee benefits for employees earning \$25,000 who received employee benefits in 2004 (MHRC, 2003b). The 13 benefit categories had an estimated total value of \$21,344 per year. Therefore, the available markers allowed coverage of 54% of the available benefits.

Data Collection

The group discussions that occurred during the third round of decision making were audiotaped in their entirety, and every other tape (30 sessions) was selected for transcription. Pre-exercise questions were administered to ascertain participant sociodemographic characteristics, health insurance and costs, health risk factors, and self-rated health status.

Data Analysis

Thematic qualitative analysis was used to examine the reasoning expressed by study participants during the whole-group selection of employee benefits. The analysis highlighted (a) general themes underlying the rationale for state-mandated benefits and (b) the particular rationale for specific benefits. The accuracy of the transcriptions was verified against the tape recordings and uploaded into QSR N6 software for coding and analysis. One author identified the major themes discussed by participants. A codebook of seven index codes and additional subcodes was generated for each benefit category to reflect major themes (Table 2). All of the transcripts were coded by one author. Independent coding of transcripts by the two other authors established agreement about application of the codes. We counted the number of sessions in which each theme was discussed to calculate the frequency of major themes. Chi-square tests (SAS, version 9.1) were used to compare the sociodemographics and choices of the groups whose sessions were transcribed with those of the remaining 23 groups. Typical quotes are reported verbatim; additions are marked with brackets ([]) and deletions with ellipses (...).

RESULTS

Participant Characteristics

The mean age of the 408 participants was 39 years, and 61% were female (Table 3). Blacks made up 64% of participants, and 20% were White. While 78% were single, never married, separated, divorced, or widowed, 53% had dependents. Most (78%) had health insurance. The demographics (Table 3)

TABLE 2 Definitions for Coding Scheme

Themes	Description
1. Employee	
Health and wellness	Benefit is helpful to the employee for health-related outcomes.
Investment	Benefit is a good use of the employee's financial resources.
Unspecified	Benefit is helpful to the employee for unspecified reasons.
2. Others	
Community	Benefit is a community investment.
Family	Benefit is an investment for families.
Employer	Benefit is an investment for employers.
State	Benefit is an investment for the citizens of an entire state.
3. High priority	
Essential	Benefit is necessary to meet the basic needs of all employees.
Status quo inadequate	Benefit is necessary to replace inadequate programs.
Helps many	Benefit is important for it helps many people.
Frequency	Benefit is important because it is used frequently.
4. Low priority	
Uncertain	Benefit is a risky investment because it may not be useful.
Luxury	Benefit is excessive.
Helps few	Benefit is less important for it helps few people.
Alternatives exist	Benefit is not necessary because alternatives exist.
Design suggestion	Benefit, as described in this survey, is inadequate.
Unwanted	Benefit lacks value and is not wanted by participant.
5. Cost considerations	Benefit selection based on benefit cost or the limitations of REACH budget.
6. Responsibility	
State	Benefit should be provided through public programs.
Employer	Benefit should be provided through employers.
Employee	Benefit is a personal responsibility.
Past rules	Responsibility for benefit is set by precedent.
Other countries	Different bodies are responsible for benefits outside of the United States, and this influences participant views.
7. Personal input	
Control	Participant values the ability to select the benefits they receive.
Personal story	Participant discusses employment benefit in a personal story.

TABLE 3 Sociodemographic Characteristics of Participants

Characteristic	N	% or Mean
	236	
Age (years)		39.2
<20	3	1%
20 to 30	69	29%
31 to 40	48	20%
41 to 50	63	27%
51 to 60	44	19%
61 to 70	8	3%
>70	1	0.4%

(continued)

TABLE 3 (Continued)

Characteristic	N	% or Mean
Female	145	61%
Latino	11	5%
Race		
White	47	20%
Black or African American	152	64%
Other/unknown	37	16%
Insurance source		
No health insurance	56	24%
Employer, spouse/partner's or parent's employer	107	45%
Medicare/Medicaid/VA/military	59	25%
Student/other insurance	18	8%
Marital status		
Single or never married	137	58%
Separated/divorced/widowed	47	20%
Married or partnered	43	18%
Unknown	9	4%
Dependents		1.15
0	111	47%
1 to 3	96	41%
4 or more	20	8%
Unknown	9	4%
Out-of-pocket health expenses within last year		
\$0	29	12%
Less than \$500	90	38%
\$500 to less than \$2500	61	26%
\$2500 or more	23	10%
Not sure or unknown	33	14%
Educational attainment		
8th grade or less	1	0.42%
Some high school but did not graduate	6	3%
High school graduate or GED	49	21%
Some college or 2-year degree	81	34%
4-year college graduate	54	23%
Partial or completed graduate/professional degree	32	14%
Unknown	13	6%
Household Income		
\$0 to less than \$7500	17	7%
\$7500 to less than \$15000	41	17%
\$15000 to less than \$35000	117	50%
\$35000 to less than \$60000	46	19%
\$60000 or more	9	4%
Unknown	6	3%
Health status		
Excellent	47	20%
Very good	88	37%
Good	59	25%
Fair	31	13%
Poor	3	1%
Unknown	8	3%

of the participants in the sessions that were transcribed did not differ significantly from participants in the remaining groups.

Benefit Choices

All groups chose disability pay, health care, paid vacation, and a retirement plan (Table 4). More than half the groups included job flexibility, training/school, family time, dependent help, and anxiety help. Fewer than half the groups chose money help, a wellness plan, a nutrition plan, and housing help (Table 4). The choices of the groups whose sessions were transcribed did not differ significantly from those of the remaining groups.

Identification of Major Themes Underlying the Rationale for State-Mandated Benefits

The major themes identified in participant discussions concerned (a) benefits that help employees; (b) benefits that help others (community, family, employer, or state); (c) benefits that merit high priority; (d) benefits that are low-priority; (e) cost; (f) responsibility to provide benefits; and (g) the importance of personal input in benefit choices (Table 2).

EMPLOYEE NEEDS

Nearly every group focused on determining employees' needs and choosing benefits to meet those needs. The health and financial outcomes of benefit choices were considered to be of particular importance to employees in 67% and 97% of sessions, respectively. In 17% of sessions, participants justified

TABLE 4 Number of Groups Choosing Each Benefit

Levels chosen	Basic	Medium	High	Groups**
Disability pay	5	9	16	30 (100%)
Health care	2	18	10	30 (100)
Paid vacation	17	8	5	30 (100)
Retirement plan	14	16	*	30 (100)
Job flexibility	15	9	2	26 (87)
Training/school	3	20	*	23 (77)
Family time	11	10	1	22 (73)
Dependent help	14	3	4	21 (70)
Anxiety help	16	*	*	16 (53)
Money help	12	*	*	12 (40)
Wellness plan	7	1	*	8 (27)
Nutrition plan	5		*	5 (17)
Housing help	4	0	*	4 (13)

Notes. *Indicates that the benefit not available at this level.

**This column shows the number of groups ($n = 30$) that chose any level of the benefit with percentage of groups shown in parentheses.

the provision of a benefit for the general good of the employee without further specification (Table 5).

THE NEEDS OF OTHERS

After employee priorities, participants most often advocated for the selection of benefits that improve the family life of employees in 67% of sessions. In one-half of sessions, participants went further to emphasize the importance of employee benefit plans that address the diverse needs of a community, defined as social networks within businesses, surrounding neighborhoods, and society:

When you're looking at the state ... all ethnics, all, everybody, you're looking at everybody as a whole, not just individually. You've got single parents, married couples, White, Black, indifferent, foreign. Each one has particular needs.

Nearly one-half of groups worked to create benefit plans that would be good investments for employers, primarily by increasing employee productivity. Only 13% of groups anticipated the impact of benefits selection on the entire state: higher benefit mandates might lower statewide health care costs or compel employers to relocate to states with lower mandates.

HIGH-PRIORITY BENEFITS

Benefits were often given higher priority for helping *many* people:

The dependent help is going to help so many families and make so much more possible, you know, for so many more people, and hopefully, as a by-product, create [fewer] health problems in the community.

Decisions were based on how frequently a benefit would be used by employees in 37% of sessions. In most sessions, participants declared a need for a benefit to replace existing public or nonprofit programs that they found inadequate.

LOW-PRIORITY BENEFITS

In 90% of sessions, participants expressed doubts about the overall feasibility, effectiveness, or accessibility of one or more benefits: "You're saying grants and loans [for housing]. You know, people are looking at credit scores, so you might not be able to get that."

Some benefits were appealing but still rejected as excessive for an employee benefit plan. As such, housing help and vacation time were most often considered "luxuries" in one-third of groups. In most sessions, participants argued against benefits that might be available through existing programs:

TABLE 5 Frequency of Major Themes, Measured by Number of Sessions (*n* = 30)

Node	Anxiety	Dependent	Disability	Family time	Health care	House help	Job flex	Money help	Nutrition	Vacation	Retire plan	Training	Wellness	Total	%
Employee															
Health and wellness	7	0	0	2	5	6	2	1	3	5	0	3	12	20	67%
Investment	3	5	15	1	11	2	9	3	2	6	4	13	6	29	97%
Unspecified	0	1	0	0	0	1	1	0	2	0	0	2	0	5	17%
Others															
Community	7	1	3	1	0	1	3	1	2	1	0	2	1	15	50%
Employer	5	2	0	1	1	1	0	0	4	3	0	6	3	14	47%
Family	3	4	2	5	5	3	3	0	0	1	1	0	0	20	67%
State	0	1	0	0	1	0	1	0	0	0	0	1	1	4	13%
High priority															
Essential	7	11	12	8	21	8	2	5	0	17	16	8	0	28	93%
Status quo inadequate	1	4	4	3	6	8	1	1	1	3	6	4	1	21	70%
Helps many	9	17	6	2	11	12	9	5	3	6	5	7	2	28	93%
Frequency	1	0	2	1	5	1	0	0	0	0	4	0	4	11	37%
Low priority															
Uncertain	4	4	4	2	4	11	10	2	6	0	9	6	4	27	90%
Helps few	1	10	1	5	4	5	8	1	2	4	3	3	3	22	73%
Luxury	0	1	0	3	0	4	2	1	1	4	0	1	3	11	37%
Alternatives exist	4	7	4	4	6	12	3	4	3	5	6	9	8	27	90%
Design suggestion	1	0	1	2	5	3	1	1	0	1	4	3	1	15	50%
Unwanted	4	3	0	4	1	9	4	4	7	1	0	1	9	23	77%
Cost consideration	2	9	10	12	21	15	11	2	4	16	13	8	4	30	100%
Responsibility															
State	0	0	0	1	5	7	1	0	0	0	2	0	0	13	43%
Employee	7	5	0	0	8	7	7	4	6	0	9	3	4	26	87%
Employer	0	2	4	2	5	8	2	1	1	1	4	4	0	18	60%
Current policy	1	0	3	0	1	5	7	0	0	5	5	4	1	19	63%
Other countries	0	0	0	0	1	1	0	0	0	0	0	0	0	2	7%
Personal input															
Control	2	4	0	0	9	2	3	1	1	0	6	1	2	16	53%
Personal story	10	8	10	10	13	8	11	3	2	4	10	7	1	29	97%

Like, if it were housing, I think the biggest problem is, people just don't know their rights, and they don't know what's available in this country.

In response, some participants recommended that employers distribute information about existing resources in lieu of providing programs.

Priority for a benefit was also decreased if participants felt it would not be equally accessible to all employees: "If you have a transportation system to take, you could use [job flexibility]. If you don't have it, you can't utilize it." Many participants also questioned the value of a benefit if it addressed rare or unpredictable needs, like illness: "Health care. How sick are we?"

In 50% of the sessions, participants commended the objective but disliked the design of a benefit as presented in the REACH exercise; most suggestions were directed at the design of health care benefits. In contrast, some benefits were simply "unwanted" because participants saw them as ineffective programs for low-income employees:

It's all over TV, "Eat more vegetables. Eat more fruit." I mean, they're just shoving it down your throat, and we're still eating our french fries and chicken with mambo sauce, okay. So, I think nutrition should be no coverage.

COST CONSIDERATIONS

Some participants were frustrated by resource constraints and felt the REACH budget forced them to compromise important values:

It's very exasperating. Because we made these decisions very deliberately and thinking them through, and so everything's important. But we can't have it all. . . . I'm taking this like it's going to happen . . . I'm feeling for some people out [there], that their life decisions depend on what we say here.

In nearly half of sessions, participants justified the selection of lower levels of various benefits in order to afford a more balanced and diverse plan:

I am drawn to this plan because I think that it doesn't make any real extreme choices. . . . I feel like making the plan for the high health care . . . is an extreme choice, and we [would be] forced to . . . make sacrifices in other areas by choosing the high health care plan.

In one-third of the sessions, participants chose lower levels of benefits so that they could take home more pay:

Well, I just want to say for the record that I would be willing to go to [lower] health care, just because I live check to check, and I need more money in my pocket.

Most groups complained that several benefits were too expensive given the budgetary constraints of the exercise.

RESPONSIBILITY

Participants lacked consensus on the appropriate party to hold responsible for certain benefits. In about one-quarter of sessions, participants held employees responsible for their own savings, housing, health, or anxiety; they viewed these issues as personal, to be resolved with resources dissociated from employment:

The majority of the health issues up here are personal issues that people need to take better care of themselves with their decision processes, their eating habits, their working habits, their working out habits.

Participants warned that benefits that give new responsibilities to employers or states may be infeasible or fail to pass "political muster":

The more things you're offering, I think the more people are going to say, "Oh, we can't do that." They're going to find reasons, realistic or not, [that] they can't do it or don't want to do it. You've got to find something you can sell ... knowing that not everybody votes, including many of the people these programs could benefit.

Only a few participants mentioned government-provided housing assistance and health insurance in Europe and Canada as models for alternatives to employee benefits in the U.S.

PERSONAL INPUT

In about half of the sessions, participants identified personal needs that made it important for employees to inform the design of the employee benefit plans they receive: "That's a one-on-one situation. There's no need to providing no super-high health care to somebody that's perfectly healthy, that eat health, that don't have no problems [*sic*]." Groups frequently shared stories about personal experiences with a benefit program to emphasize the importance that benefit.

Justification of Particular Employee Benefit Choices

We present some of the justifications for including (a) benefits that were selected by all groups; (b) those selected by over half the groups; and (c) those selected by fewer than half the groups.

BENEFITS CHOSEN BY EVERY GROUP

In justifying the inclusion of health insurance, participants told several stories about health care and considered it "beneficial for many people" more than any other benefit. Most stories recalled a personal need for health insurance or difficult experiences with the current system. Still, some participants were willing to take a lower level of health care in order to purchase a more balanced benefit plan:

If it was just health care and maybe one or two other things, yeah, go with the high. With the myriad of other things that will help that you could add with that medium or low health plan, like the family time and flex time, all this stuff that you could choose from. I think high would be a lot of wasted points. I would go with medium.

In 27% of sessions, participants held employees responsible for health care, primarily through personal health maintenance. They rarely considered the state an alternative provider, and the possibility of universal health insurance was mentioned in only 7% of sessions.

In justifying paid time off, participants *expected* sick leave and vacation time as an essential part of employee benefit packages: "Just to have vacation. Nobody's expected to work 52 weeks out of the year without a break. We have family. We have kids. Things come up—sickness, pregnancy." Paid vacation was among the benefits most frequently noted for positive health effects:

The people in Europe get a month off ... and our stress levels [are] higher and our health is suffering because of it. So the paid time off will definitely improve our health quality.... Although we [have] all the money, it seems we don't get enough time off.

Retirement was also considered essential: "Everybody wants to retire and have ... money to retire.... You don't want to be retiring and still, like, struggling." Participants in nearly 50% of groups felt uncertainty for the future of retirement plans: "Retirement is so fundamental, and I think it's going to be a big crisis in the next few years." Even so, a few participants felt they could postpone saving for retirement to address immediate needs: "People that are kind of older need the retirement plan; people that's kind of younger need training and school [*sic*]."

In choosing retirement, most groups debated whether to select an investment plan or a pension plan, and while participants generally supported the concept of employer-distributed retirement plans, they frequently lacked trust in the employer to control their personal savings:

You're not guaranteed any retirement today. Your employers can take your money ... and end up filing bankruptcy, and the government

come[s] in and only give[s] you a minor fraction of what you've already paid into it.

Although all groups included the retirement benefit, participants in 8 of 30 sessions argued for taking personal responsibility for retirement investments: "We should be intelligent enough to manage that on our own. So, in a sense, I mean, all those points there for the pension, it could be handled on one's own."

BENEFITS CHOSEN BY A MAJORITY OF GROUPS

In justifying the selection of job flexibility, participants mentioned its financial value for employees. They appreciated coverage of work-related travel costs in 80% of groups. In 5 of 30 groups, participants even associated financial incentives to use public transportation with positive environmental impacts. Nearly 50% of groups expressed satisfaction with flexible hours, but some felt it placed an unnecessary burden on employers.

Not only viewed as a strong employee investment, training was the benefit most often valued for its potential to benefit employers:

The training is good because you can get a person that might not be good at that particular time when they sign up for a job, and with 2 or 4 weeks of training, they could be teaching someone else the job.

In 30% of groups, participants shared stories to demonstrate the impact of training programs; education was considered a method of career advancement and subsequent financial returns: "Because of my job, I was able to continue my education, and I got a better position at Wal-Mart and, plus, more benefits because I changed my position."

In 18 of 30 sessions, participants confirmed the importance of maternity leave, offered through family time: "It's important to me because somewhere down the line I will be a mother, and 3 months off to take care of my child is very important." Participants in one-third of the groups felt that the inclusion of additional caretaking days could restore or improve family values:

I like medium because it gives fathers a month of paid leave to take care of their children. . . . It just keeps in line with preserving the family, which is something that we've gotten pretty far away from nowadays.

However, when faced with budgetary constraints, participants often gave up a level of dependent help or family time to allow for other benefits: "I think mothers should be protected, especially single mothers. I don't think 3 months is very long—long enough, really . . . I'd like to up it, but I think that we can't afford it."

Most groups conveyed that dependent help was a good investment that would help many workers. They favored the child care programs offered at

the basic level: "I mean, I don't have any children, but I think, just out of the state and people, most people do. They need help . . . paying for child care." Stories of experiences as working caretakers usually entailed career sacrifices made in the absence of reliable child care: "Having had a number of friends [lose] their jobs because their child care wasn't up to what they could do for a job, I think [dependent care has] got to be something there."

Still, in 9 of 30 sessions, participants worried about mandating dependent help because many people do not have dependents: "I just don't see [dependent help] as important because everybody don't have children [*sic*]." Some held the working caretaker responsible for dependent care: "I don't think employers should really be responsible for your children, okay, because it's your children [*sic*]."

Anxiety help was among the benefits most often noted for health effects:

Well, it's a known fact that stress is also one of the leading causes of your medical conditions. So, stress bleeds into everything you got up there on that [REACH exercise board].

Participants considered the contributions that anxiety help could make to the workplace community in five sessions:

I think that it would alleviate major workplace problems, because—I don't know how it is for other people, but in my workplace people bring in, like, all kinds of personal issues that get in the way of everything.

Participants told personal stories that suggested a need for anxiety help, but they did not usually express familiarity with existing anxiety help programs. In 23% of groups, they viewed anxiety help as a personal responsibility, often suspecting that employer-provided anxiety help would inappropriately involve employers in personal issues:

I'd feel more comfortable going out to a shrink that's not connected to my job and saying, "I'm having problems. Can you help me?" As opposed to someone at my workplace who can spread my problems around.

Although it was a low-cost benefit, anxiety help was only selected by about half of groups.

BENEFITS CHOSEN BY FEWER THAN HALF OF GROUPS

Participants often acknowledged the potential for money help to improve the budgeting skills of individuals with debt. In 8 of 30 groups, they remarked on the value of unemployment insurance. Yet, despite this benefit's minimal cost, most groups rejected it. Some held employees responsible for their own money, and others suggested alternatives to employer-sponsored money

help: money management nonprofits, a good retirement plan, and self-taught personal finance.

The wellness program was the benefit most often associated with the prevention of medical conditions and reduction of health care costs:

If we focus on preventative health as opposed to post-health problems, then we would want to engage in things that would definitely prevent us from becoming unhealthy. And if there was some cost/benefit analysis, there's probably some idea that, by being a member at a gym ... there's reduced health care costs.

However, in 9 of 30 sessions, participants simply did not want a wellness plan: "It's not important to me, and we don't have that many markers available. We need to deal with what's important, and that's it." Many groups recommended existing alternatives to employer-sponsored wellness plans, including health insurance plans, community clinics, and magazines. Some participants disliked the implication of employer responsibility for wellness.

In 6 of 30 sessions, participants felt that employees ought to be responsible for their own nutrition, as well:

A counseling program to teach you how to eat healthy ... I wouldn't put my money into that because I read my own books, and I learn how to lose weight and how to handle my own ... food problems. Most people—I don't think most people need that.

Though a few groups discussed the need to address obesity problems, this benefit was viewed as unnecessary in 7 of 30 sessions: "That's common sense for most people. ... You can buy food at reduced costs in other places, you know."

Only four groups selected housing help at the basic level, yet nearly 50% of groups noted that it is beneficial for many people. Participants associated good housing with safe environments, decreased risk of physical injury, and improved mental health: "People who have secure housing have a secure sense of everything else in their lives. ... It's a fundamental part. It's not even optional." A perceived lack of current housing assistance and concurrently high housing prices magnified its value:

And I don't think we focus enough on [housing] in this nation, making sure that the baseline for housing is not just like, "Here's a room. I know you're in the ghetto, and I know you're not going to make it out of here, but, you know, you've got somewhere to stay out of the rain."

Nevertheless, over one-third of groups expressed doubt that grants and loans would be justly awarded, and many suggested alternatives to employer-provided housing: government assistance, financial planning, bank loans,

and relocation to low-cost housing. Groups lacked consensus on the appropriate source for housing help. Some thought of housing as a personal responsibility:

If you got a halfway decent job, there's just some things that you work for. And [housing] should be one of them. And I just think the housing ... while it sounds good ... should be something that you should be doing. That's why you got that job, so you can get that house or apartment.

Others held the state responsible for fulfilling universal needs like shelter, but few argued for employer responsibility.

Ultimately, the high cost of housing help was a decisive factor in resolutions to forgo this benefit; the appeal of plans that offer many benefits usually outweighed priority for housing help.

DISCUSSION

The analysis reported here was intended to ascertain the views of low-income earners regarding what employee benefits ought to be state-mandated in order to improve the health status of this population. We found that every group chose disability pay, health insurance, paid vacation, and retirement plans. These benefits received praise as good financial investments and high-priority components of employee benefit plans.

In nearly half of sessions, participants expressed interest in balanced plans, and some found less conventional employee benefits appealing. For instance, dependent care and family time were often chosen to strengthen families, and several participants discussed the long-term outcomes of investments in employer-sponsored training. Though typically unfamiliar with job flexibility and anxiety assistance, many were attracted to the reduced transportation costs and help with anxiety that they offered. Groups regularly sacrificed high levels of more costly benefits, like health care, to include a wider range of benefits.

While many benefits were selected by only a small number of groups, they were nonetheless valued during group discussion: anxiety help for health and community gains; dependent care for addressing the needs of many people; and training as a good employee investment. Anxiety assistance, housing help, and wellness programs, among the benefits least often selected, were nevertheless widely praised for their possible health outcomes (Table 4). Discrepancies between preferences and final choices may reflect the view held by many participants that health maintenance was an important but *personal* responsibility to be fulfilled with resources and behaviors dissociated from employers.

Participants often thought that employees ought to be personally responsible for not only health maintenance but also housing, nutrition, retirement investments, anxiety help, and dependent care. Participants sometimes felt more comfortable with benefits that allowed only limited employer influence on personal issues, and some worried that the provision of certain benefits may compromise the financial viability of employers. Participants expressed concern for the financial and political hurdles that might complicate the launch of more innovative benefits.

Even though some participants hesitated to expand employer offerings, most accepted the general concept of employee benefits as a source of valuable services. Typical benefits like disability pay, health care, paid vacation, and retirement—benefits that did not require extreme changes to presumed current employee benefit standards—were often preferred. Nevertheless, additional benefits like anxiety help, dependent care, and training generally appealed to participants, and many groups expressed a willingness to choose lower levels of more expensive benefits to create a wider-ranging benefit plan for better financial outcomes, family relationships, and health.

Study Limitations

Participants occasionally based their comments on questionable information that was left uncorrected, as we did not want to interfere in discussions in a way that undermined the study's purpose. Only when a comment was obviously inaccurate would the facilitator interject a comment.

Participants in this study represent a particular region. Whether low-income earners living elsewhere would express the same priorities remains to be determined. Furthermore, this project solicits the opinions of employees exclusively. Consideration of the views of employers and political stakeholders will also be important. Finally, we offered one set of employee benefit options; ascertaining priorities for benefits with other characteristics may be useful.

Implications and Recommendations

Some policy makers may be skeptical about the ability of the public in general, or workers in particular, to prioritize employee benefits effectively and knowledgeably. This study begins to address this concern. We have created a structured opportunity, through a hypothetical exercise, to inform low-wage earners about the consequences of employee benefits and make choices within resource constraints. The reader can thus begin to assess the feasibility and merits of engaging the public in prioritizing benefits.

Including low-income individuals in resource allocation decisions can contribute to a just society that promotes health equality (Daniels, Kennedy,

& Kawachi, 1999). Participant comments affirmed their desire for involvement in these decisions. Their views, as expressed here, can contribute another perspective to the literature on employee benefits.

There is often a tendency to assign responsibility for health to individuals (Jiminez, 1997). The comments of many participants in this study suggest that low-income earners share the prevailing belief in personal responsibility for health and are eager to assume responsibility for health maintenance. Still, it can be argued that low-SES populations may lack the resources to fulfill this responsibility (Stell, 2002). More comprehensive and evenly distributed employee benefits may be one method of providing these resources.

Participants were receptive to wide-ranging employee benefits aimed at improving the socioeconomic determinants of health, and they were specifically attracted to those that were prudent financial investments. These findings suggest that employee benefits that go beyond health insurance coverage to provide low-income employees with financial and educational resources may be highly valued by low-income earners and allow them to share in activities that promote health.

Participants were aware of the constraints faced by employers who fund and supply certain benefits (Fronstin, 2005). Certainly the economic feasibility of the provision of health-promoting employee benefits by the diverse pool of U.S. employers requires analysis. Such analyses should take into account the utility of investments that foster a healthy workforce.

REFERENCES

- Alkire, S., & Chen, L. (2004). Global health and moral values. *Lancet*, 364, 1069–1074.
- Bly, J. L., Jones, R. C., & Richardson, J. E. (1986). Impact of worksite health promotion on health care costs and utilization. Evaluation of Johnson & Johnson's Live for Life program. *Journal of the American Medical Association*, 256(23), 3235–3240.
- Bowne, D. W., Russell, M. L., Morgan, J. L., Optenberg, S. A., & Clarke, A. E. (1984). Reduced disability and health care costs in an industrial fitness program. *Journal of Occupational Medicine*, 26(11), 809–816.
- Chapman, L. S. (2004). Guidelines for health promotion in worksite settings. *American Journal of Health Promotion*, 18(4), 6–9.
- Chen, M. S. (1988). Wellness in the workplace: Beyond the point of no return. *Health Values*, 12(1), 16–22.
- Custer, W., Kahn III, C., & Wildsmith IV, T. (1999). Why we should keep the employment-based health insurance system. *Health Affairs*, 18(6), 115–123.
- Daniels, N., Kennedy, B., & Kawachi, I. (1999). Why justice is good for our health: The social determinants of health inequalities. *Daedalus*, 128(4), 215–252.
- Danis, M., Lovett, F., Sabik, L., Adikes, K., Cheng, G., & Aomo, T. (2007). Low-income employees choose employment benefits aimed at improving the socio-

- economic determinants of health. *American Journal of Public Health*, 97, 1650–1657.
- Danis, M., Benavides, E., Nowak, M., & Goold, S. (2005). Development and evaluation of a computer decision exercise for participation in insurance benefit planning. *Forum for Family and Consumer Issues*, 10, (2). Retrieved November 15, 2009, from <http://ncsu.edu/ffci/publications/2005/v10-n2-2005-october/ar-2-development.php>
- Fronstin, P. (1998). Features of employment-based health plans. *Employment Benefit Research Issue Brief*, 201, 1–27.
- Fronstin, P. (2005). Employment-based health benefits: Trends in access and coverage. *Employment Benefit Research Issue Brief*, 284, 1–27.
- Fronstin, P., Helman, R., & Greenwald, M. (2003). Small employers and health benefits: Findings from the 2002 small employer health benefits survey. *Employment Benefit Research Issue Brief*, 253, 1–21.
- Gabel, J., Hurst, K., Whitmore, H., & Hoffman, C. (1999). Trends: Class and benefits at the workplace. *Health Affairs*, 18(3), 161–166.
- Goold, S., Biddle, S., Klipp, G., Hall, C., & Danis, M. (2005). Choosing health plans all together: A deliberative exercise for allocating limited health care resources. *Journal of Health Politics, Policy, and Law*, 30, 563–601.
- Graham, H. (2004). Social determinants and their unequal distribution: Clarifying policy understandings. *The Milbank Quarterly*, 82(1), 101–124.
- Jiminez, M. (1997). Concepts of health and national health care policy: A view from American history. *The Social Service Review*, 71(1), 34–50.
- The Lancet. (2006). Where are all the philosophers when you need them? *The Lancet*, 368(9531), 175.
- Lurie, N. (2002). What the federal government can do about the nonmedical determinants of health. *Health Affairs*, 21(2), 94–106.
- Marmot, M. (1978). Employment grade and coronary heart disease in British civil servants. *Journal of Epidemiology & Community Health*, 32, 244–249.
- Marmot, M. (2006). Tackling social factors to improve health. *Bulletin of the World Health Organization*, 84(4), 267–268.
- Marsh and Mercer Human Resources Consulting. (2003a). *Employers' time-off and disability programs survey*. Louisville, KY: William M. Mercer, Inc., and Marsh USA.
- Marsh and Mercer Human Resources Consulting. (2003b). *National survey of employer-sponsored health plans*. Louisville, KY: William M. Mercer, Inc., and Marsh USA.
- Marsh and Mercer Human Resources Consulting. (2003c). *Spotlight on benefits: 2003 results*. Louisville, KY: William M. Mercer, Inc., and Marsh USA.
- Reinhardt, U. E., Hussey, P. S., & Anderson, G. F. (2004). U.S. health care spending in an international context: Why is U.S. spending so high, and can we afford it? *Health Affairs*, 23(3), 10–25.
- Solar, O., Irwin, A., & Vega, J. (2005). Towards a conceptual framework for analysis and action on the social determinants of health: Draft, Commission on Social Determinants of Health: WHO Health Equity Team. Geneva: World Health Organization.
- Sorensen, G., Linnan, L., & Hunt, M. (2004). Worksite-based research and initiatives to increase fruit and vegetable consumption. *Preventive Medicine*, 39, 94–100.

- Stell, L. (2002). Responsibility for health status. In R. Rhodes, M. Pabst Battin, & A. Silvers (Eds.), *Medicine and social justice: Essays on the distribution of health care* (pp. 405–425). Oxford: Oxford University Press.
- Thompson, S., Smith, B., & Bybee, R. (2005). Factors influencing participation in worksite wellness programs among minority and underserved populations. *Family & Community Health, 28*(3), 267–273.
- Thompson, T. (2003). *Annual update of the HHS poverty guidelines*. Washington, DC: U.S. Department of Health and Human Services.
- Townsend, P., & Davidson, N. (1992). The Black Report. In *Inequalities in health: The Black Report and the health divide* (2nd ed). London: Penguin Books.
- U.S. Chamber of Commerce. (2003). *2003 employee benefits study*. Washington, DC: U.S. Chamber of Commerce.
- WHO Commission on Social Determinants of Health. (2008). *Closing the gap in a generation: Health equity through action on the social determinants of health*. Retrieved December 27, 2008, from http://www.who.int/social_determinants/final_report/en/index.html.