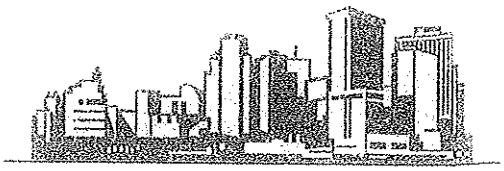
New York Hotel Trades Council
and
Hotel Association of NYC, Inc.



THE NEW YORK HOTEL TRADES COUNCIL
EMPLOYEE BENEFIT FUNDS
THE HOTEL ASSOCIATION OF NEW YORK CITY, INC.

FUND FACT SHEET

The New York Hotel Trades Council and Hotel Association of New York City, Inc. Employee Benefit Funds (the "Funds") are a group of Funds which provide benefits to employees and their families who work in the Hotel industry of N.Y.C. The benefits were established through collective bargaining between the New York Hotel and Motel Trades Council (the "union") and The Hotel Association of New York City, Inc. (the "employer" association). The "Funds" are comprised of the following:

- The New York Hotel Trades Council and Hotel Association of New York City, Inc. Health Benefits Fund ("Health Benefits Fund")
- The New York Hotel Trades Council and Hotel Association of New York City, Inc. Pension Fund ("Pension Fund")
- The New York Hotel Trades Council and Hotel Association of New York City, Inc. Pre-Paid Legal Fund ("Legal Fund")
- The New York Hotel Trades Council and Hotel Association of New York City, Inc. Training and Scholarship Fund ("Training and Scholarship")
- The New York Hotel Trades Council and Hotel Association of New York City, Inc. 401(k) Employee Savings Plan ("401(k)")

These Funds currently are providing these benefits to 29,000 active members and their families and 10,000 retirees. That is, nearly 86,000 participants.

Health Benefits Fund

This Fund provides the complete medical and dental benefits to eligible participants at no cost to them. The benefits include:

- Hospitalization
- Surgical benefits
- Anesthesia
- Obstetrical
- Diagnostic X-Ray and Lab
- Preventive Care
- Well Baby Care
- Emergency Care
- Health Center – (fully owned and operated complete ambulatory care centers with full range of specialists in Midtown Manhattan, Brooklyn, Queens and Harlem Health Centers)
- United HealthCare EPO Medical (for all eligible members living in Staten Island or outside N.Y.C.)

Health Benefits Fund (cont.)

- Dental (complete range of dental care , including oral surgery, provided through centers in Midtown Manhattan, Brooklyn, Queens and Harlem facility)
- Prescription drug program (provided through fully owned and operated pharmacies in Midtown, Brooklyn, Queens and Harlem facilities. There is a $5 co-pay for generic and $15 for brand name drugs on the Formulary)
- Optical (provided through General Vision Services)
- Members' Health Assistance (confidential consultative and crisis prevention assistance for emotional, alcohol and drug related problems)
- Disability (a benefit of 50% of pay up to $300 per week for active employees)
- Life and A.D.& D. ($10,000 benefit)

The annual cost of providing these benefits is currently $315,000,000 annually. This is completely funded through employer contributions from approximately 300 participating employers. The current negotiated contribution rate increased to 23% of gross wages on July 1, 2012. In addition, employers contribute $1.50 per member per month for optical benefits. The Fund's cost to provide all the benefits listed above is $412.98 for single members and $1,135.72 for family members. When excluding the benefits generally not covered by a Health Maintenance Organization (HMO), that is, dental, life, disability, vision and MHAP, the equivalent rate is $358.79 for a single member and $986.52 for family members. As a comparison the following are the New York State Department of Insurance published HMO rates for other plans in New York City:

Company	Single Rate	Family Rate
Health Benefits Fund	**$358.79**	**$ 986.52**
GHI	2,765.60	7,052.27
Aetna	1,320.00	4,091.00
Health Ins. Plan of NY	1,000.51	1,861.60
Oxford	1,385.39	4,260.07
Empire	1,533.76	4,754.66

At the core of the Health Benefits are our five Health Centers, which serve as family medical offices and provide many of the benefits to eligible participants as denoted above. For the year ended December 31, 2012 the centers had the following number of member encounters:

Service	Number of Member Encounters	
Medical	644,188	visits
Dental	193,168	visits
Pharmacy	553,426	prescriptions

Health Benefits Fund (cont.)

Currently this Fund has reserves for future benefits of $80,000,000, which represents 25% of the total annual expense. A joint industry and union committee oversees the management and investment of these assets. These reserves are handled by one active money manager and three additional "indexed" investment funds.

Pension Fund

This Fund provides a monthly pension benefit to over 10,000 hotel retirees. The current maximum pension benefit is $1,000 per month for 25 years of service and members eligible for this pension will now receive an additional one half credit for each year of service after 25 to 40. That is an additional $300 per month above the regular maximum pension for a member with forty years of service. Members are also eligible for an age and service pension, which is for those who have completed 25 years of service and are least 55 years of age. The current monthly Pension benefit paid to the 10,000 retirees is $6,100,000.

This Fund provides these benefits and funds future benefits through contributions by participating employers. The current contribution rate to this Fund is 9.00% of gross payroll. This results in total annual employer contributions of $127,000,000. This Fund currently has reserves for future benefits of over $1 billion, which are professionally managed by fourteen different money managers. The joint Board of Trustees take an active role in the policy making and oversight of the Fund.

Legal Fund

This Fund provides legal service to all active and retired members through a closed panel of attorneys throughout the Tri-State area. Covered matters include such things as consumer issues, closing on a home, wills, credit issues, landlord/tenant, immigration,
tax issues, divorce and child custody. Funding for this benefit is also through contributions by participating employers. The current contribution rate for this Fund is 0.5% of gross wages. This results in total annual employers contributions of $6,100,000. The total annual cost of this benefit is $4,380,000. The Board of Trustees of this Fund are active in the monitoring of this benefit.

Training and Scholarship Fund

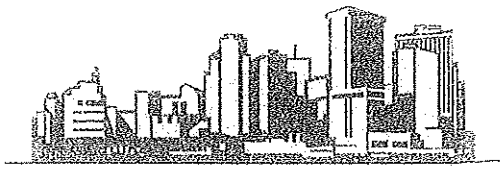
This Fund provides basic skills to the membership, that is, English as a second language, basic computers and G.E.D., through an arrangement with the N.Y.C. Board of Education. The Fund also offers classes in plumbing and sprinkler courses that provide the graduates with a certification in plumbing and standpipe. Other classes offered include: Banquet Server, A la Carte Server and Tournant. The training facility in Queens provides hands on training in a professional kitchen and working restaurant. The collective bargaining agreement provides that members are eligible to take a banquet server course, which will certify them, providing them the ability to be interviewed for any "B-List" opening in the banquet department of the hotel. The total annual cost of this benefit is $1,573,000. The current contribution rate is $1.50 per member per month.

Training and Scholarship Fund (cont.)

The Fund also provides scholarships to children of employees covered by the Industry Wide Agreement for college and trade school. The selection process is performed by an independent group of academics and guidance counselors from facilities of higher learning. Selection is based on both academic achievement and financial need. The scholarship award is $2,000 a year for all four years of education. That is $8,000 towards the cost of a four-year college degree. Last year the Fund awarded 36 of these scholarships ($288,000 in total awards). The current contribution rate for this benefit is $1.00 per member per month. This Fund's investment policies benefit levels and operations are monitored by the Board of Trustees.

401(k)

Effective July 1, 2001 employees working for employers who are signatories to the industry collective bargaining agreement were eligible to participate in a 401(k) plan. All contributions are voluntary by the employee. Employees can contribute up to 100% of their pre-tax wages to the annual I.R.S. maximum ($17,500 for 2012). Over 10,000 employees have enrolled in this benefit resulting in over $2,500,000 per month in wages being deferred. Participants have deferred over $225 million dollars in pre-tax wages into this fund since its inception. Employees can enroll twice a year on July 1 and January 1. They can change their contribution percent quarterly. The Fund has contracted with the Principal Group as the service provider. The Fund is administered by a professional staff and the Board of Trustees make all the policy decisions and monitor its operations.



THE NEW YORK HOTEL TRADES COUNCIL
EMPLOYEE BENEFIT FUNDS
THE HOTEL ASSOCIATION OF NEW YORK CITY, INC.

Health Benefits Fund History

The New York Hotel Trades Council and Hotel Association of New York City, Inc. Health Benefits Fund, Health Center, Inc. (HCI) has a proud history of over 60 years of continuous service. HCI's five Centers built and operated in accordance with Article 28 standards, exclusively serve unionized hotel and motel workers, their dependents and retirees pursuant to collective bargaining agreements between hotel employers in New York City and the Hotel Trades Council. In 2012, HCI served over 48,000 non-duplicated users and delivered more than 700,000 annual visits. HCI's pharmacies filled more than 600,000 prescriptions. As such, the HCI network of health centers is integral to the provision of needed health benefits to a significant population within New York City.

The New York Hotel Trades Council and Hotel Association of New York City, Inc. Health Center, Inc. (HCI) status as an Article 28 entity follows from its special statutory charter. In 1949 and again, in 1975, the New York State Legislature passed enabling legislation to authorize the creation of HCI as a New York not-for-corporation and to empower it to deliver "medical care, surgical care, optical and dental care," at one or more health centers, to unionized employees in the hotel trade, retired employees, their spouses and dependents

HCI's patient population consists of hotel workers and their dependents, a large number of whom are immigrants and/or minorities. However, as an ERISA-funded entity, HCI is restricted to serving eligible union members, retirees and their dependents. Accordingly, apart from a cost - reimbursement contract whereby the Centers for Medicare & Medicaid Services covers HCI's provision of Medicare Part B services to its Medicare-eligible retirees, and a Retiree Drug Subsidy (RDS) under Medicare Part D, HCI is not funded by or otherwise dependent on government insurance programs. As an ERISA-funded entity, HCI cannot serve the general public. HCI serves 86,000 eligible members, dependents and retirees from the five boroughs of New York City. Members typically seek care from the site nearest their residence, but may use any site, regardless of location. Overall, the eligible hotel union member population reflects that of New York City. It tends to be lower income, ethnically diverse, has a large proportion of immigrants, and single-parent families and has a higher rate of Ambulatory Care Sensitive Conditions (ACSC) than NY State as a whole.

HCI believes that its continued investment in technology will not only enhance the quality of clinical care, but will also help in containing costs. Over the past decade HCI has invested in

1) Pharmacy Robots: The Midtown, Harlem, and Queens site Pharmacies all utilize *ScriptPro 200* pharmacy dispensing robots. These state-of-the-art dispensing tools are faster and more accurate than human pharmacists. They contain multiple levels of quality assurance safety checks, and can produce many types of Utilization Management reports.
2) Digital Radiography: Digital Radiography, including mamography allows the transmission of radiographic images not only within each site but among the sites

and participating radiology offices as well. The ability to get stat reading of images as well as having multiple clinicians viewing the image will increase the quality of care. Image quality is improved; at the same time the new technology is environmentally friendly, eliminating the need for film developing chemistry.

3) Scheduling System: HCI has implemented the Cerner *Millennium* System. This is a state-of-the-art health services information system. The scheduling module, when integrated with the electronic medical record, will allow for automated recall of patients, the electronic transmission of physician orders to the appointment scheduler and the ability to automate patient reminders. Reports and data from *Millennium* will enhance Utilization Management activities.
4) Electronic Medical Record: HCI has a completely integrated and paperless electronic medical record , Cerner *Millennium Power Chart Office*, a state-of-the-art medical information system. This is an extremely powerful tool, enabling the HCI to improve the quality of medical documentation and Utilization Management, as well as doing long-term disease management studies and programs. In 2008, HCI began operating in a "paperless" environment with all Centers linked by a common electronic record, one of a very few ambulatory healthcare organizations to have an EMR, not associated with a hospital.

All sites participate in a program of Health Fairs and wellness events. These annual health awareness events are oriented toward the specific medical needs of the member population:

1) Women's Health Week, a full week, coinciding with Breast Cancer Awareness Month, focusing on mammography, smoking cessation and other women's health issues
2) Eat Well, Be Well, Feel Well , a full week cardiovascular event focusing on nutrition and exercise education and awareness
3) Seniors' Days , 3 days dedicated to preventive health education for the HCI's senior population
4) Kids' Days , three days focusing on child health issues such as nutrition, immunizations, exercise and safety
5) Men's Health Awareness Week , a full week, coinciding with Prostate Cancer Awareness week, oriented toward nutrition, cancer screening, smoking cessation and other men's health issues
6) Flu Vaccine Awareness , a three-month program offering and promoting the benefits of flu vaccination

The HCI constantly seeks to expand and improve its services in locations convenient to the membership. The HCI's ongoing Member Satisfaction Survey indicates the organization's success at meeting its goals. In a September 2012 survey, 97% of members indicated that they would recommend the HCI sites to their families and coworkers. This compares to a 65% overall level of satisfaction demonstrated by other health plans' members as reflected in the New York State HMO Report Card. The HCI's state-of-the-art care delivery system provides members with an outstanding caliber and experience of care at a cost to the Health benefits Fund of approximately 33% of the commercial HMO insurance rate.

As an organization HCI believes that our continued success will come from being proactive about health. It is a transformation from the past – focused on managing illness and costs- to something vastly different. HCI envisions health care designed around our members who have common, predictable health care needs, and creating a system that understands and manages the health risks and behaviors of our population.

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September 2012

The 14th annual Employer Health Benefits Survey by the Kaiser Family Foundation and Health Research & Education Trust was just released. I am enclosing a copy of the annual summary of Employer Health Benefits provided by Kaiser/HRET. The annual KFF report has become the occasion to measure our program against traditional employer based health benefits.

Employer-sponsored health insurance premiums for family coverage rose an average of 4% in 2012 and the average price for a family policy now exceeds $15,500 per year. This report is the latest warning that far more needs to be done to address the rising cost of healthcare. Since 2002, family premiums have increased from an average of $8,003 to $15,745 last year, a 97% total premium increase over the period. The average employee contribution for health benefits increased from $2,137 to $4,316 or an increase of 102%. With the rise in premiums, workers are now shouldering a greater burden of paying for those same benefits. Even this relatively modest premium increase in the context of a struggling recovery and weak economy makes the situation even more painful. The 4% increase in premium costs far outpaced both the 1.7 % increase in real wages and the 2.3 % rate of inflation for 2011.

The Health Benefit Fund has been extraordinarily successful in avoiding the trend of commercial insurance. Our members do not directly contribute to their employer based coverage for themselves or their dependents, nor do they face other costs such as co-payments, deductibles, co-insurance or maximums. The survey indicates that covered workers contribute an average of 18% of the premium for single coverage and 28% of the premium for family coverage. If we exclude hospital costs which are rising about 10% a year, the Health Benefits Fund's costs to provide a comprehensive benefit including medical, dental, prescription drug, optical and MHAP will increase by less than 2% this year.

Another way of looking at this is that the Fund's cost to provide all the benefits listed above including hospitalization is $412.98 for single members and $1,135.72 for families per month. When excluding the benefits not covered in the Kaiser Survey, that is dental, life insurance, disability insurance, vision and MHAP the equivalent rate would be $358.79 for single member and $986.52 for families. While the average annual health insurance premium is $15,745 for family coverage, more than 20% of workers are in plans costing in excess of $18,894. The Health Benefit Fund's plan costs $10,300 annually for a plan with far greater coverage, fewer exclusions and no participant costs other than the $5.00 and $15.00 copayments for the prescription drug benefit. Measured against commercial HMO rates here in New York, $866.63 a month for family coverage is about 1/3 the cost of the average commercial rate.

Most covered workers also face additional plan costs when they use health care services. A large share of workers have a general annual deductible that must be met before all or most

services are reimbursed by the plan. Many workers face other types of cost sharing, such as copayments or coinsurance for office visits and hospitalizations. Other than the small co-payments on our two tiered prescription drug program, our members are not asked to share in the costs of their health care program.

Justice Holmes is quoted as saying; "It is not enough to do good it must also be perceived as doing good." Clearly our efforts are to provide the highest quality health benefits at the lowest possible cost. But this is insufficient if the people utilizing those services do not believe they are high quality. For more than a decade the Health Benefits Fund has been conducting patient satisfaction surveys. 10% of all patients to a Health Center in a month are surveyed as to their perception of the Health Center environment, the staff, and their care. For the month of September 2012, 99% of the HC respondents indicated they would recommend the Harlem Health Center to a family member or co-worker. This is the highest score a Health Center has ever received. I believe this indicates that our efforts at providing high quality services are appreciated by the membership at the same time we have been uniquely successful at controlling costs.

It has been two years since the signing of the Patient Protection and Affordable Care Act (ACA). Some of its mandates have already begun and others will be phased in beginning in 2014. While this is big news for most commercial carriers and their participants, it will have relatively little impact on our program. The Health Benefits Fund already has first day coverage and no waiting periods. We have never excluded pre-existing conditions. We have no annual or lifetime maximums. We had an in-patient psychiatric benefit before Mental Health Parity Legislation. Of some impact, we have reenrolled 1,485 dependents who are under 26 years of age and had previously "aged out" of our benefits. I think it is clear we were "ahead of the curve" when it came to plan design and high quality employee benefits.

The ACA pursued the path of considering a range of different approaches to controlling health care costs, from those that work on the demand side, such as the "Cadillac Tax", to those that work on the supply side, like innovative provider payment models, and to those that promote the type of evidence-based medicine that is key to ensuring cost effectiveness. Whether these policies by themselves can fully solve the long term health cost problem in the United States is extremely doubtful. They may however, provide a first step towards controlling costs and understanding what does and does not work. There can be no doubt that the Fund's health care delivery model has been a successful model in reducing the rate of annual healthcare cost increases. We started out as a lower cost plan and our cost increases are trending significantly lower than average, thus we will have an increasingly more favorable cost comparison to the national average in the years to come.

I envision a system of healthcare in which those who give care can boast about their work and those who receive care can feel total trust, confidence and comfort in the care they are receiving. I believe the New York Hotel Trades Council and the Hotel Association of New York City, Inc. can both look with pride at the system they have created and know that not only have they done good, but that it is perceived as good by stakeholders, providers and patients alike.

Dr. Robert H. Greenspan
Chief Executive Officer

THE KAISER FAMILY FOUNDATION AND HEALTH RESEARCH & EDUCATIONAL TRUST

$5,615 2012 Employer Health Benefits

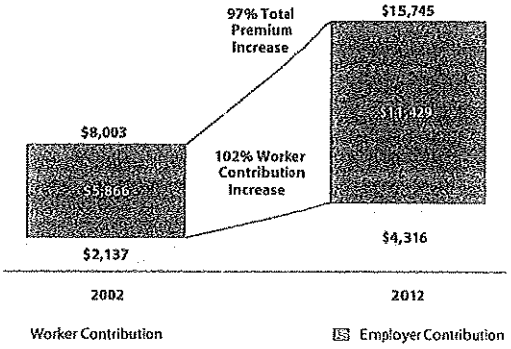
2012 Summary of Findings

Employer-sponsored insurance is the leading source of health insurance in America, covering about 149 million nonelderly people.[1] To provide current information about the nature of employer-sponsored health benefits, the Kaiser Family Foundation (Kaiser) and the Health Research & Educational Trust (HRET) conduct an annual national survey of nonfederal private and public employers with three or more workers. This is the fourteenth Kaiser/HRET survey and reflects health benefit information for 2012.

The key findings from the survey, conducted from January through May 2012, include modest increases in the average single and family insurance premiums and little change in the premium contributions and cost sharing that workers face since last year. Enrollment in high deductible plans with a savings option, such as a health savings account or health reimbursement arrangement, did not increase significantly over the previous year for the first time since 2009. The share of workers in a grandfathered health plan decreased significantly from the previous year to 48% of covered workers. Approximately 2.9 million adult children who were previously not eligible for benefits now have health insurance coverage through their parents due to the Affordable Care Act. In addition, the 2012 survey includes questions on employer wellness programs, including the percentage of plans with financial rewards or penalties for completing health programs or achieving biometric targets.

EXHIBIT A

Average Annual Health Insurance Premiums and Worker Contributions for Family Coverage, 2002–2012



Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2002–2012.

HEALTH INSURANCE PREMIUMS AND WORKER CONTRIBUTIONS

The average annual premiums for employer-sponsored health insurance in 2012 are $5,615 for single coverage and $15,745 for family coverage. Compared to 2011, the average premium for single coverage ($5,429) is 3% higher and the average premium for family coverage ($15,073) is 4% higher. Since 2002, average premiums for family coverage have increased 97% (Exhibit A). The growth in premiums has outpaced increases in both workers' wages (1.7% since 2011 and 33% since 2002) and inflation (2.3% since 2011 and 28% since 2002).[2]

The average premium for family coverage is lower for workers in small firms (3–199 workers) than for workers in large firms (200 or more workers) ($15,253 vs. $15,980). Average premiums for high-deductible health plans with a savings option (HDHP/SOs) are lower than the overall average for all plan types for both single and family coverage (Exhibit B), at $4,928 and $14,129, respectively. Average single and family premiums are higher in the Northeast and lower in the South when compared to the other regions.

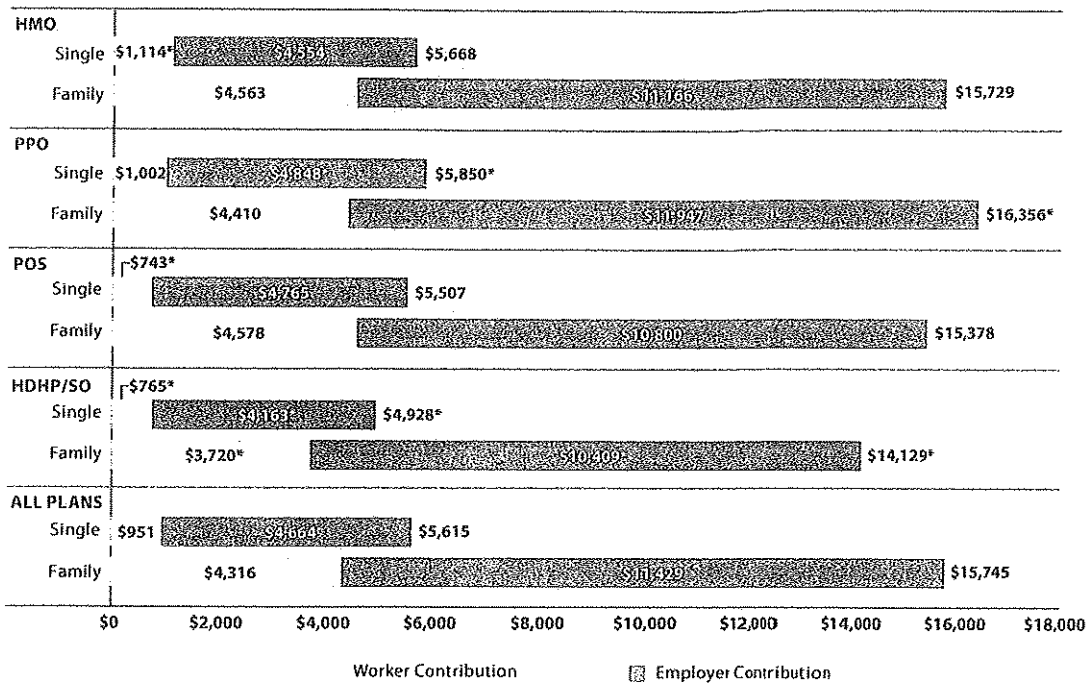
There is significant variation in the average annual premiums as a result of factors such as benefits, cost sharing, and geographical cost differences. Nineteen percent of covered workers are in plans with an annual total premium for family coverage of at least $18,894 (120% of the average family premium), while 20% of covered workers are in plans where the family premium is less than $12,596 (less than 80% of the average family premium). The distribution is similar around the average single premium (Exhibit C).

Covered workers contribute on average 18% of the premium for single coverage and 28% of the premium for family coverage, the same percentages they contributed in 2011 and relatively unchanged over the past decade. Workers in small firms (3–199 workers) contribute a lower average percentage for single coverage compared to workers in larger firms (16% vs. 18%), but a higher average percentage for family coverage (35% vs. 25%).

As with total premiums, the share of the premium contributed by workers varies considerably around these averages. For single coverage, 61% of covered workers are in plans that require them to make a contribution of less than or equal to a quarter of the total premium and 2% are in plans that require a contribution of more than half of the premium; while 16% are in plans that require no contribution at all. For family coverage, 43% of covered workers are in plans that require them to make a contribution of less than or equal to a quarter of the total premium and 14% are in plans that require more than half of the premium; only 6% are in plans that require no contribution for family coverage (Exhibit D).

EXHIBIT B

Average Annual Firm and Worker Premium Contributions and Total Premiums for Covered Workers for Single and Family Coverage, by Plan Type, 2012



* Estimate is statistically different from All Plans estimate by coverage type (p<.05).

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2012.

Looking at the dollar amounts that workers contribute, the average annual premium contributions in 2012 are $951 for single coverage and $4,316 for family coverage. Neither amount is a statistically significant increase over the 2011 values ($921 and $4,129, respectively). Workers in small firms (3–199 workers) have lower average contributions for single coverage than workers in larger firms ($848 vs. $1,001), but higher average contributions for family coverage ($5,134 vs. $3,926). Compared to the average worker contributions, workers in HDHP/SOs have lower average contributions for both single coverage and family coverage. Workers in HMOs have higher than average contributions for single coverage, while workers in POS plans face smaller contributions.

PLAN ENROLLMENT

Overall, PPOs are by far the most common plan type, enrolling 56% of covered workers. Nineteen percent of covered workers are enrolled in an HDHP/SO, 16% in an HMO, 9% in a POS plan, and less than 1% in a conventional plan (Exhibit E).

Enrollment in HDHP/SOs did not increase significantly in 2012 over the previous year, but over time it has risen to 19% of covered workers from just 8% in 2009 (Exhibit E). Enrollment distribution varies by firm size, with PPOs being relatively more popular among large firms (200 or more workers), and POS plans and HDHP/SOs being relatively more popular among smaller firms.

PLAN COST SHARING

Most covered workers face additional plan costs when they use health care services. A large share of workers in PPOs (77%) and POS plans (60%) have a general annual deductible for single coverage that must be met before all or most services are reimbursed by the plan. In contrast, only 30% of workers in HMOs have a general annual deductible. However, many workers with no general annual deductible still face other types of cost sharing when they use services, such as copayments or coinsurance for office visits and hospitalizations.

Among workers with a general annual deductible, the average deductible amount for single coverage is $733 for workers in PPOs, $691 for workers in HMOs, $1,014 for workers in POS plans, and $2,086 for workers in HDHP/SOs.[3] As in recent years, workers with single coverage in small firms (3–199 workers) have higher deductibles than workers in large firms (200 or more workers); for example, the average deductibles for single coverage in PPOs, the most common plan type, are $1,260 for workers in small firms (3–199 workers) compared to $563 for workers in larger firms. Overall, 34% of covered workers are in a plan with a deductible of at least $1,000 for single coverage, similar to the 31% reported in 2011, but up significantly from 22% in 2009 and just 10% in 2006 (Exhibit F). Covered workers in small firms remain more likely than covered workers in larger firms (49% vs. 26%) to be in plans with deductibles of at least $1,000.

The large majority of workers also has to pay a portion of the cost of physician office visits. Almost three in four covered workers (73%) pay a copayment (a fixed dollar amount) for office visits with a primary care physician or a specialist physician, in

EXHIBIT C

Distribution of Premiums for Single and Family Coverage Relative to the Average Annual Single or Family Premium, 2012

Note: The average annual premium is $5,615 for single coverage and $15,745 for family coverage. The premium distribution is relative to the average single or family premium. For example, $4,492 is 80% of the average single premium, $5,054 is 90% of the average single premium, $6,177 is 110% of the average single premium, and $6,738 is 120% of the average single premium. The same break points relative to the average are used for the distribution for family coverage.

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2012.

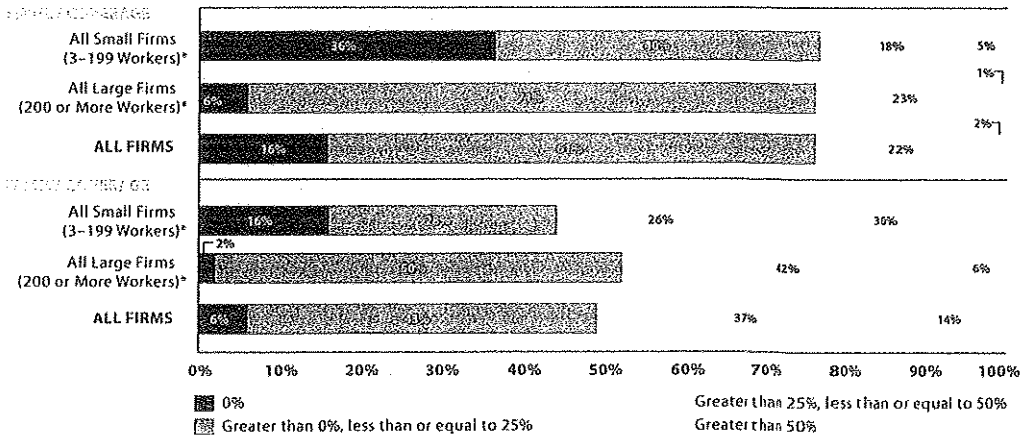
addition to any general annual deductible their plan may have. Smaller shares of workers pay coinsurance (a percentage of the covered amount) for primary care office visits (17%) or specialty care visits (19%). Most covered workers in HMOs, PPOs, and POS plans face copayments for physician office visits, while covered workers in HDHP/SOs are more likely to have coinsurance requirements or no cost sharing after the deductible is met. For in-network office visits, covered workers with a copayment pay an average of $23 for primary care and $33 for specialty care. For covered workers with coinsurance, the average coinsurance for office visits is 18% for primary care and 19% for specialty care. While the survey collects information only on in-network cost sharing, it is generally understood that out-of-network cost sharing is typically higher.

Fifty-eight percent of covered workers face copayments for emergency room (ER) visits and 22% pay coinsurance. The average copayment for ER visits is $118. For three in four workers (75%), cost sharing for ER visits is waived if the patient is admitted to the hospital.

Almost all covered workers (99%) have prescription drug coverage, and nearly all face cost sharing for their prescriptions. Over three-quarters (78%) of covered workers are in plans with three or more tiers of cost sharing, a figure that has increased tremendously in the past decade. Copayments are more common than coinsurance for each tier of cost sharing. Among workers with three-or-more tier plans, the average copayments in these plans are $10 for first-tier drugs, $29 for second-tier drugs, $51 for third-tier drugs, and $79 for fourth-tier drugs. These amounts are not significantly different

EXHIBIT D

Distribution of Percentage of Premium Paid by Covered Workers for Single and Family Coverage, by Firm Size, 2012



* Estimate is statistically different between All Small Firms and All Large Firms within coverage type (p<.05).

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2012.

from the amounts reported last year. HDHP/SOs have a somewhat different cost-sharing pattern for prescription drugs than other plan types: just 54% of covered workers are enrolled in a plan with three or more tiers of cost sharing, while 19% are in plans that pay 100% of prescription costs once the plan deductible is met, and 20% are in a plan with the same cost sharing for all prescription drugs.

In addition to any other cost sharing, 13% of covered workers with drug coverage also face a separate annual deductible for prescription drugs. For those with a separate drug deductible, the average amount is $145. Eleven percent of covered workers with drug coverage have a separate annual out-of-pocket limit that applies only to spending on prescription drugs, with an average limit of $1,722. The prevalence of these prescription drug deductibles and out-of-pocket limits has changed little over time.

Most workers also face additional cost sharing for a hospital admission or an outpatient surgery episode. After any general annual deductible, 58% of covered workers have coinsurance and 17% have a copayment for hospital admissions. Lower percentages have per day (per diem) payments (4%), a separate hospital deductible (3%), or both copayments and coinsurance (9%). The average coinsurance rate for hospital admissions is 18%, the average copayment is $263 per hospital admission, the average per diem charge is $221, and the average separate annual hospital deductible is $548. The cost sharing provisions for outpatient surgery are similar to those for hospital admissions, as most covered workers have either coinsurance (59%) or copayments (19%). For covered workers with cost sharing for each outpatient surgery episode, the average coinsurance is 18% and the average copayment is $127.

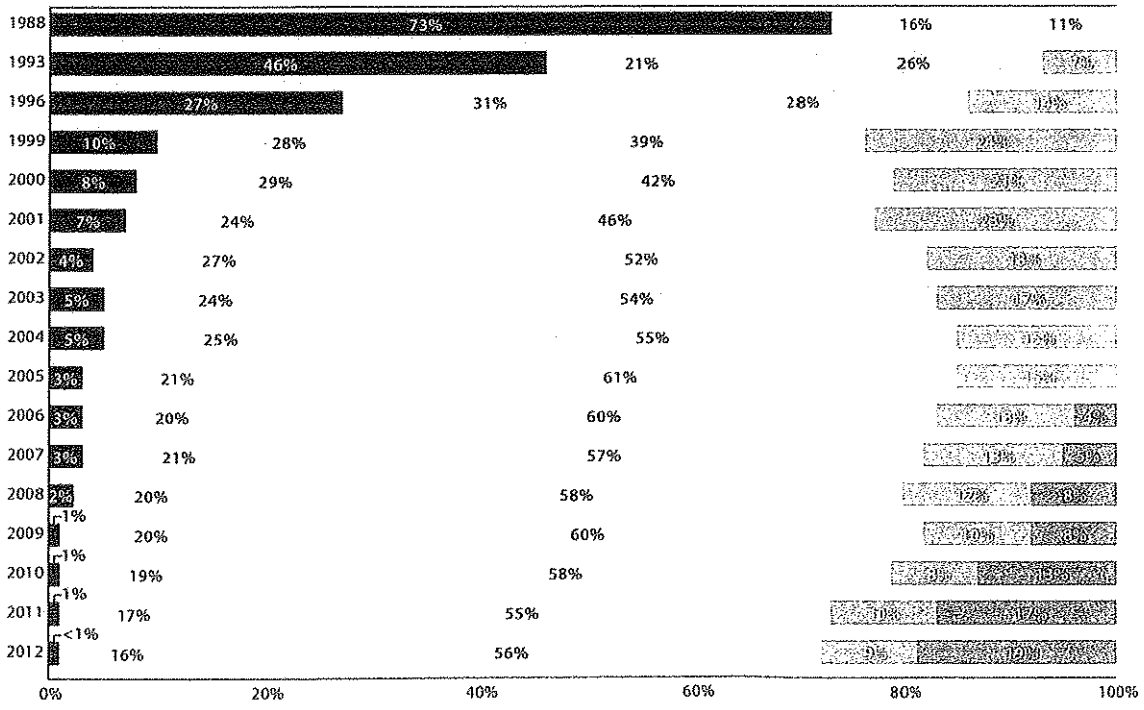
Most plans limit the amount of cost sharing workers must pay each year, generally referred to as an out-of-pocket maximum. Eighty-seven percent of covered workers have an out-of-pocket maximum for single coverage, but the actual dollar limits differ considerably. For example, among covered workers in plans that have an out-of-pocket maximum for single coverage, 41% are in plans with an annual out-of-pocket maximum of $3,000 or more, and 16% are in plans with an out-of-pocket maximum of less than $1,500. Even in plans with a specified out-of-pocket limit, not all spending is counted towards meeting the limit. For example, among workers in PPOs with an out-of-pocket maximum, 71% are in plans that do not count physician office visit copayments, 36% are in plans that do not count spending on the general annual deductible, and 80% are in plans that do not count prescription drug spending when determining if an enrollee has reached the out-of-pocket limit.

AVAILABILITY OF EMPLOYER-SPONSORED COVERAGE

Sixty-one percent of firms offer health benefits to their workers, similar to the percentage (60%) that offered last year (Exhibit G). The likelihood of offering health benefits differs significantly by size, with only 50% of employers with 3–9

EXHIBIT E

Distribution of Health Plan Enrollment for Covered Workers, by Plan Type, 1988–2012



Note: Information was not obtained for POS plans in 1988. A portion of the change in plan type enrollment for 2005 is likely attributable to incorporating more recent Census Bureau estimates of the number of state and local government workers and removing federal workers from the weights. See the Survey Design and Methods section from the 2005 Kaiser/HRET Survey of Employer-Sponsored Health Benefits for additional information.

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2012; KPMG Survey of Employer-Sponsored Health Benefits, 1993, 1996; The Health Insurance Association of America (HIAA), 1988.

workers offering coverage. Virtually all employers with 1,000 or more workers offer coverage to at least some of their employees.

Even in firms that offer health benefits, not all workers are covered. Some workers are not eligible to enroll as a result of waiting periods or minimum work-hour rules. Other workers do not enroll in coverage offered to them because of the cost of coverage or because they have access to coverage through a spouse. Among firms that offer coverage, an average of 77% of workers are eligible for the health benefits offered by their employer. Of those eligible, 81% take up their employer's coverage, resulting in 62% of workers in offering firms having coverage through their employer. Among both firms that offer and do not offer health benefits, 56% of workers are covered by health plans offered by their employer, similar to the percentage in 2011.

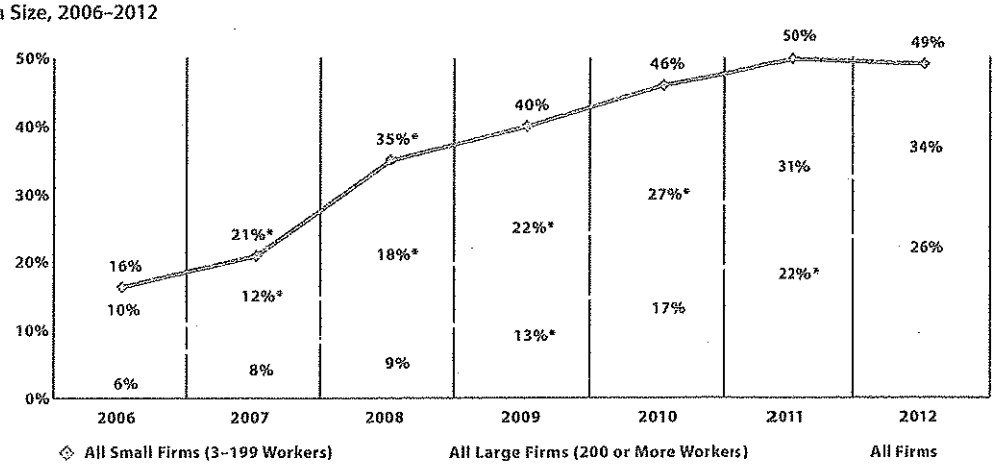
RETIREE COVERAGE

Twenty-five percent of large firms (200 or more workers) that offer health benefits offer retiree health benefits in 2012, similar to the percentage that did so in 2011. The offer rate has fallen slowly over time, with significantly fewer large employers offering retiree health benefits in 2012 than they did in years prior to 2007.

Among large firms (200 or more workers) that offer retiree health benefits, 88% offer health benefits to early retirees (workers retiring before age 65), 74% offer health benefits to Medicare-age retirees, and 5% offer a plan that covers exclusively prescription drugs.

EXHIBIT F

Percentage of Covered Workers Enrolled in a Plan with a General Annual Deductible of $1,000 or More for Single Coverage, By Firm Size, 2006–2012



* Estimate is statistically different from estimate for the previous year shown (p<.05).

Note: These estimates include workers enrolled in HDHP/SO and other plan types. Because we do not collect information on the attributes of conventional plans, to be conservative, we assumed that workers in conventional plans do not have a deductible of $1,000 or more. Because of the low enrollment in conventional plans, the impact of this assumption is minimal. Average general annual health plan deductibles for PPOs, POS plans, and HDHP/SOs are for in-network services.

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006–2012.

EXHIBIT G

Percentage of Firms Offering Health Benefits, by Firm Size, 1999-2012

FIRM SIZE	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
3–9 Workers	55%	57%	58%	58%	55%	52%	47%	49%	45%	50%	47%	59%*	48%*	50%
10–24 Workers	74	80	77	70*	76	74	72	73	76	78	72	76	71	73
25–49 Workers	88	91	90	87	84	87	87	87	83	90*	87	92	85*	87
50–199 Workers	97	97	96	95	95	92	93	92	94	94	95	95	93	94
All Small Firms (3–199 Workers)	65%	68%	67%	65%	65%	62%	59%	60%	59%	62%	59%	68%*	59%*	61%
All Large Firms (200 or More Workers)	99%	99%	99%	98%	97%	98%	97%	98%	99%	99%	98%	99%	99%	98%
ALL FIRMS	66%	68%	68%	66%	66%	63%	60%	61%	59%	63%	59%	69%*	60%*	61%

* Estimate is statistically different from estimate for the previous year shown (p<.05).

Note: As noted in the Survey Design and Methods section, estimates presented in this exhibit are based on the sample of both firms that completed the entire survey and those that answered just one question about whether they offer health benefits.

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999–2012.

WELLNESS

Employers continue to offer wellness and other programs as a benefit to their employees. These include offering their employees the opportunity to complete a health risk assessment and offering programs that help employees engage in healthier personal behavior. Some employers have begun to collect biometric information from employees (e.g., cholesterol levels, body mass index) and are using it as part of their wellness and health programs. Some larger employers also are offering on-site medical clinics to provide care for employees for work-related and non-work-related medical conditions.

Eighteen percent of employers offering health benefits ask employees to complete a health risk assessment. A health risk assessment includes questions about medical history, health status, and lifestyle and is designed to identify the health risks of the person being assessed. Large firms (200 or more workers) are more likely than smaller firms to ask employees to complete a risk assessment or appraisal (38% vs. 18%). Among these firms, 63% of large firms (200 or more workers) provide a financial incentive to employees to encourage them to complete the assessment (Exhibit H).

This year we asked firms who ask their employees to complete a health risk assessment if employees with an identified health risk factor face financial incentives or penalties for completing a wellness or health management program, or meeting biometric targets. Eleven percent of large firms reported that there are instances where an employee with an identified health risk factor is required to complete a wellness or health management program or activity in order to avoid a financial penalty, such as a higher premium contribution or higher patient cost sharing. Nine percent of large firms that ask employees to complete a health risk assessment report that employees are rewarded or penalized financially based on whether they meet specified biometric outcomes (not including smoking cessation), such as meeting a target body mass index (or BMI) or cholesterol level.

The majority of employers offering health benefits offers at least one of the following wellness programs in 2012 (63%): weight loss programs, gym membership discounts or on-site exercise facilities, biometric screening, smoking cessation programs, personal health coaching, classes in nutrition or healthy living, web-based resources for healthy living, or a wellness newsletter. This is similar to the percentage (65%) for 2011. Large firms (200 or more workers) are more likely to offer a wellness program than small firms (94% vs. 63%). When asked the primary reason for offering a wellness program, firms were most likely to respond that the wellness program was part of the health plan (37%) or was offered to improve employee health or reduce absenteeism (35%). Only 9 percent of employers offering these programs identified reducing health care costs as the primary reason for offering the program. When asked about the effectiveness of wellness programs, 73% of employers offering at least one of these wellness programs reported that wellness programs were effective in improving the health of their firm's employees, while 52% said that wellness programs were effective in reducing their firm's health care costs.[4]

Employers offer other health-related programs as well. Twenty-two percent of firms with 1,000 or more employees reported operating an on-site health clinic for their employees in at least one of their major locations. About three in four of these firms (76%) reported that employees could receive treatment for non-work-related conditions at the on-site clinic.

HEALTH REFORM

While many of the most significant provisions of the Patient Protection and Affordable Care Act (ACA) will not take effect until 2014, important provisions became effective in 2010 and others will take effect over the next few years. The 2012 survey asked employers about some of these early provisions.

Grandfathered Health Plans. The ACA exempts "grandfathered" health plans from a number of its provisions, such as the requirements to cover preventive benefits without cost sharing or to have an external appeals process. An employer-sponsored health plan can be grandfathered if it covered a worker when the ACA became law (March 23, 2010) and if the plan does not make significant changes that reduce benefits or increase employee costs.[5] Fifty-eight percent of firms had at least one grandfathered health plan in 2012,

EXHIBIT H

Percentage of Large Firms with Financial Penalties and/or Incentives for Employees Who Complete Wellness Programs or Meet Biometric Outcomes, 2012

	Large Firms (200 or More Workers)
Among firms offering health benefits:	
Firm asks employees to complete a health risk assessment:	38%
Among firms which ask employees to complete a health risk assessments:	
Firm offers financial incentives to complete a health risk assessment	63%
Employees with identified health risk factors have to complete a wellness program or face financial penalties	11%
Some employees are either rewarded or penalized based on whether they meet biometric outcomes	9%

Note: A health risk assessment or appraisal includes questions on medical history, health status, and lifestyle and is designed to identify the health risks of the person being assessed. Smoking cessation is not included as a biometric outcome. A lower percentage (18%) of small firms (3-199 workers) asks employees to complete a health risk assessment than larger firms (38%). The estimates for small firms which ask employees to complete a health risk assessment are not included due to the high standard errors.

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2012.

down from 72% in 2011. The percentage of firms with at least one grandfathered plan does not differ significantly between small (3–199 workers) and larger firms. In terms of enrollment, 48% of covered workers were in grandfathered health plans in 2012, down from 56% last year (Exhibit I).

Firms with plans that were not grandfathered were asked to respond to a list of potential reasons why each plan is not a grandfathered plan. Twenty-seven percent of covered workers are in plans that were not in effect when the ACA was enacted. Roughly similar percentages of workers are in plans where the deductibles or copayments (36%) or employee premium contributions (34%) changed more than was permitted for plans to maintain grandfathered status. The reasons plans were not grandfathered varied by firm size, with workers in small firms (3–199 workers) much more likely than workers in large firms to be in a new plan that was not in effect when the ACA was enacted (55% vs. 19%) and generally less likely to be affected by plan changes.[6]

Coverage for Adult Children to Age 26. The ACA requires firms offering health coverage to extend benefits to children of covered workers until the child reaches age 26. The child does not need to be a legal dependent, but until 2014, plans do not have to enroll children of employees if those children are offered employer-sponsored health coverage at their own job. The survey asked firms whether any adult children who would not have been eligible for the plan prior to the change in law were currently enrolled in health coverage under this provision. Twenty-nine percent of small firms (3–199 workers) and 90% of larger firms enrolled at least one adult child under this provision at the time of the survey. The numbers of children that enroll under this provision are closely related to the number of workers in the firm. Smaller firms (3–49 workers) on average enroll one to two adult children due to the provision, while the largest firms (5,000 or more workers) enroll an average of 478 adult children. In total, 2.9 million adult children are currently enrolled on their parent's coverage because of the ACA, 1.1 million at small firms (3–199 workers) and 1.8 million at larger firms.

OTHER TOPICS

Pre-Tax Premium Contributions. Forty-one percent of small firms (3–199 workers) and 91% of larger firms have a plan under section 125 of the Internal Revenue Service Code (sometimes called a premium-only plan) to allow employees to use pre-tax dollars to pay for their share of health insurance premiums. These percentages are similar to 2010, the last time we asked about pre-tax contributions (40% and 90%).

Flexible Spending Accounts. Seventeen percent of small firms (3–199 workers) and 76% of larger firms offer employees the option of contributing to a flexible spending account (or FSA). FSAs permit employees to make pre-tax contributions that may be used during the year to pay for eligible medical expenses not covered by health insurance. These percentages are similar to 2010, the last time we asked about FSAs (12% and 74%).

Shopping for Coverage. Fifty-four percent of offering firms shopped for a new health plan or insurance carrier in the previous year. There was not a significant difference between small (3–199 workers) and larger firms in the likelihood of shopping for new coverage. Among firms that shopped, 18% changed carriers in the past year and 27% changed the type of health plan (e.g., HMO, PPO, POS or HDHP/SO) that they offer.

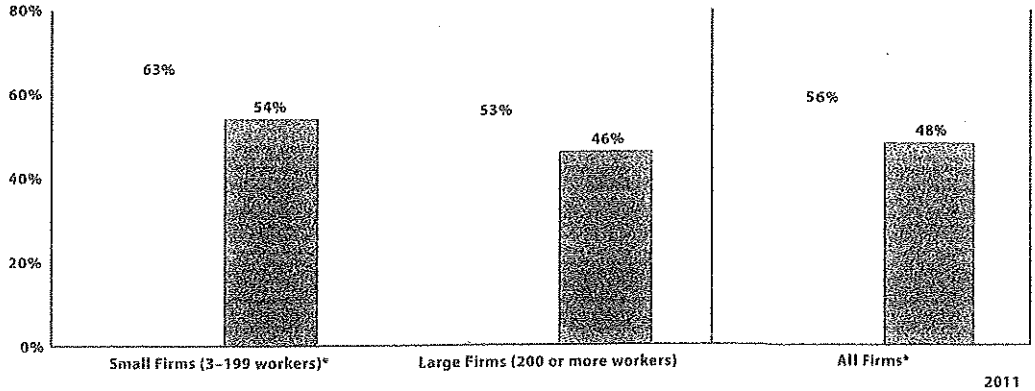
Stoploss Coverage. Most firms that have self-funded health plans purchase insurance, often called "stoploss" coverage, to limit the amount they may have to pay in claims either overall, or for any particular plan enrollee. Fifty-nine percent of workers in self-funded health plans are enrolled in plans covered by stoploss insurance. The average per employee claims cost at which stoploss insurance begins paying benefits is about $223,000.

CONCLUSION

In 2012, premiums increased moderately as the economy continued to recover slowly and utilization remained sluggish. The percentage of firms offering health insurance and the percentage of workers covered by health insurance remained steady. For the first time since 2009, the percentage of covered workers enrolled in high deductible health plans with a savings option did not increase significantly versus the previous year. Important differences remain in the health plans being offered at small and large firms, with covered workers

EXHIBIT I

Percentage of Covered Workers Enrolled in Plans Grandfathered under the Affordable Care Act (ACA), by Firm Size, 2011 and 2012



* Estimate is statistically different between 2011 and 2012 (p<.05).

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2011–2012.

facing larger premium contributions for family coverage and cost-sharing requirements at smaller firms.

A significant number of firms (18%) are asking their employees to complete a health risk assessment, with a share of employers levying financial penalties to certain workers who do not complete wellness programs or meet biometric outcomes.

Employers continue to implement the early provisions of the Affordable Care Act. Currently 2.9 million children are enrolled in a parent's employer-sponsored health plan as a result of the ACA. Less than half of covered workers are in grandfathered plans, a reduction from last year. The survey will continue to monitor employers' responses to health reform and other changes in the insurance market.

METHODOLOGY

The Kaiser Family Foundation/Health Research & Educational Trust 2012 Annual Employer Health Benefits Survey (Kaiser/HRET) reports findings from a telephone survey of 2,121 randomly selected public and private employers with three or more workers. Researchers at the Health Research & Educational Trust, NORC at the University of Chicago, and the Kaiser Family Foundation designed and analyzed the survey. National Research, LLC conducted the fieldwork between January and May 2012. In 2012 the overall response rate is 47%, which includes firms that offer and do not offer health benefits. Among firms that offer health benefits, the survey's response rate is also 47%.

From previous years' experience, we learned that firms that decline to participate in the study are less likely to offer health coverage. Therefore, we asked one question to all firms with which we made phone contact, but the firm declined to participate. The question was, "Does your company offer a health insurance program as a benefit to any of your employees?" A total of 3,326 firms responded to this question (including the 2,121 who responded to the full survey and 1,205 who responded to this one question). Their responses are included in our estimates of the percentage of firms offering health coverage. The response rate for this question is 73%. Since firms are selected randomly, it is possible to extrapolate from the sample to national, regional, industry, and firm size estimates using statistical weights. In calculating weights, we first determined the basic weight, then applied a nonresponse adjustment, and finally applied a post-stratification adjustment. We used the U.S. Census Bureau's Statistics of U.S. Businesses as the basis for the stratification and the post-stratification adjustment for firms in the private sector, and we used the Census of Governments as the basis for post-stratification for firms in the public sector. Some numbers in the exhibits in the report do not sum up to totals due to rounding effects, and, in a few cases, numbers from distribution exhibits referenced in the text may not add due to rounding effects. Unless otherwise noted, differences referred to in the text and exhibits use the 0.05 confidence level as the threshold for significance.

For more information on the survey methodology, please visit the Survey Design and Methods Section at http://ehbs.kff.org/.

[1] Kaiser Commission on Medicaid and the Uninsured. The Uninsured: A Primer. Kaiser Family Foundation. 2011 Oct. Available from: http://www.kff.org/uninsured/upload/7451-07.pdf. 56.2% of the non-elderly American population receives insurance coverage through an employer-sponsored plan.

[2] Kaiser/HRET surveys use the April-to-April time period. The inflation numbers are not seasonally adjusted. Bureau of Labor Statistics. Consumer Price Index, U.S. city average of annual inflation (April to April). [Internet]. Washington (DC): Department of Labor; 2012 [cited 2012 Aug 27]. Available from: http://data.bls.gov/timeseries/CUUR0000SA0?include_graphs=false&output_type=column&years_option=all_years10. Wage data are from the Bureau of Labor Statistics and based on the change in total average hourly earnings of production and nonsupervisory employees. Employment, hours, and earnings from the Current Employment Statistics survey [Internet]. Washington (DC): Department of Labor; 2012 [cited 2012 Aug 27]. Available from: http://data.bls.gov/timeseries/CES0500000008.

[3] The survey treats high-deductible plans that can be paired with a savings option as a distinct plan type – High-Deductible Health Plan with Savings Option (HDHP/SO) – even if the plan would otherwise be considered a PPO, HMO, POS plan, or conventional health plan. Specifically for the survey, HDHP/SOs are defined as (1) health plans with a deductible of at least $1,000 for single coverage and $2,000 for family coverage offered with an HRA (referred to as HDHP/HRAs); or (2) high-deductible health plans that meet the federal legal requirements to permit an enrollee to establish and contribute to an HSA (referred to as HSA-qualified HDHPs).

[4] Twelve percent of firms indicated that they did not know if wellness programs were effective in improving employees' health and 13% did not know if wellness programs were effective in reducing costs.

[5] *Federal Register*. Vol. 75, No 221, November 17, 2010, http://www.gpo.gov/fdsys/pkg/FR-2010-11-17/pdf/2010-28861.pdf.

[6] In 2012 and 2011 firms that indicate "other" were allowed to explain why the plan was no longer eligible. In 2011 firms that indicated that they changed carriers were recoded as having a new plan. Federal regulations now allow some firms that changed carriers to preserve their grandfather status, and therefore these firms were not recoded as new plans in 2012.

[7] *Federal Register*. Vol. 75, No 92, May 13, 2010, http://www.gpo.gov/fdsys/pkg/FR-2010-05-13/pdf/2010-11391.pdf.

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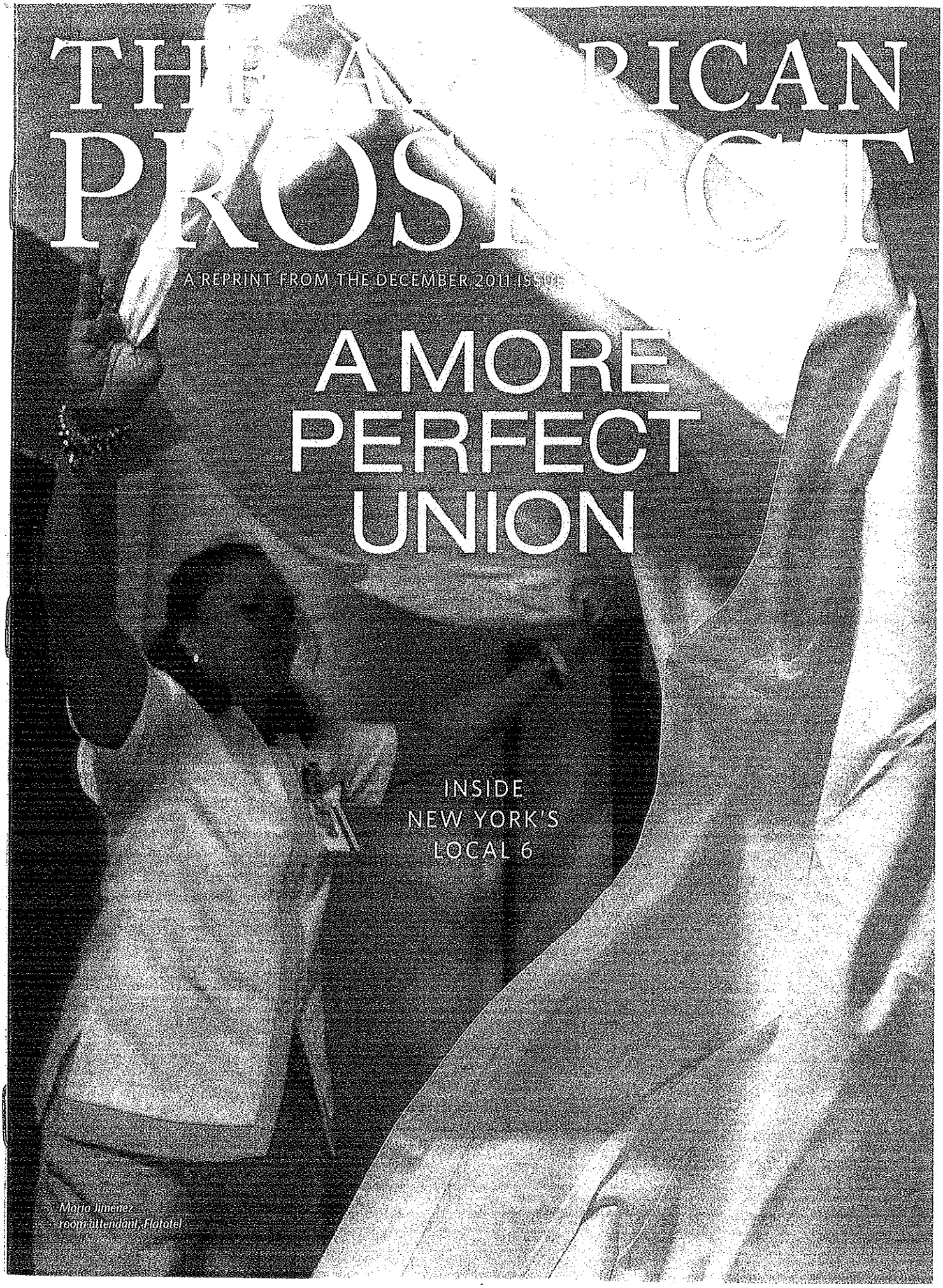
The full report of survey findings (#8345) is available on the Kaiser Family Foundation's website at www.kff.org.
This summary (#8346) is also available at www.kff.org.

THE AMERICAN PROSPECT

A REPRINT FROM THE DECEMBER 2011 ISSUE

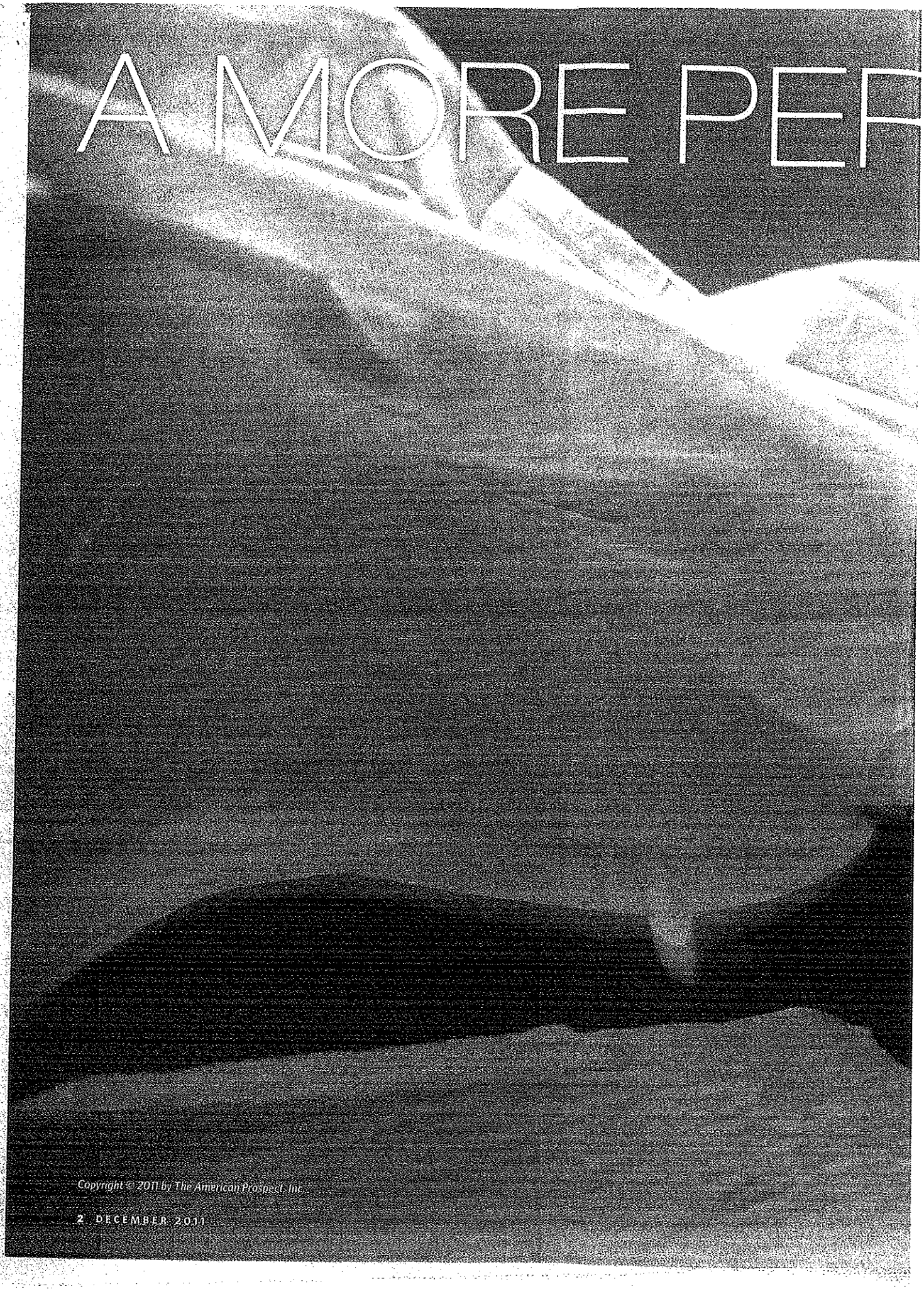
A MORE PERFECT UNION

INSIDE NEW YORK'S LOCAL 6



Maria Jimenez, room attendant, Flatotel

A MORE PER

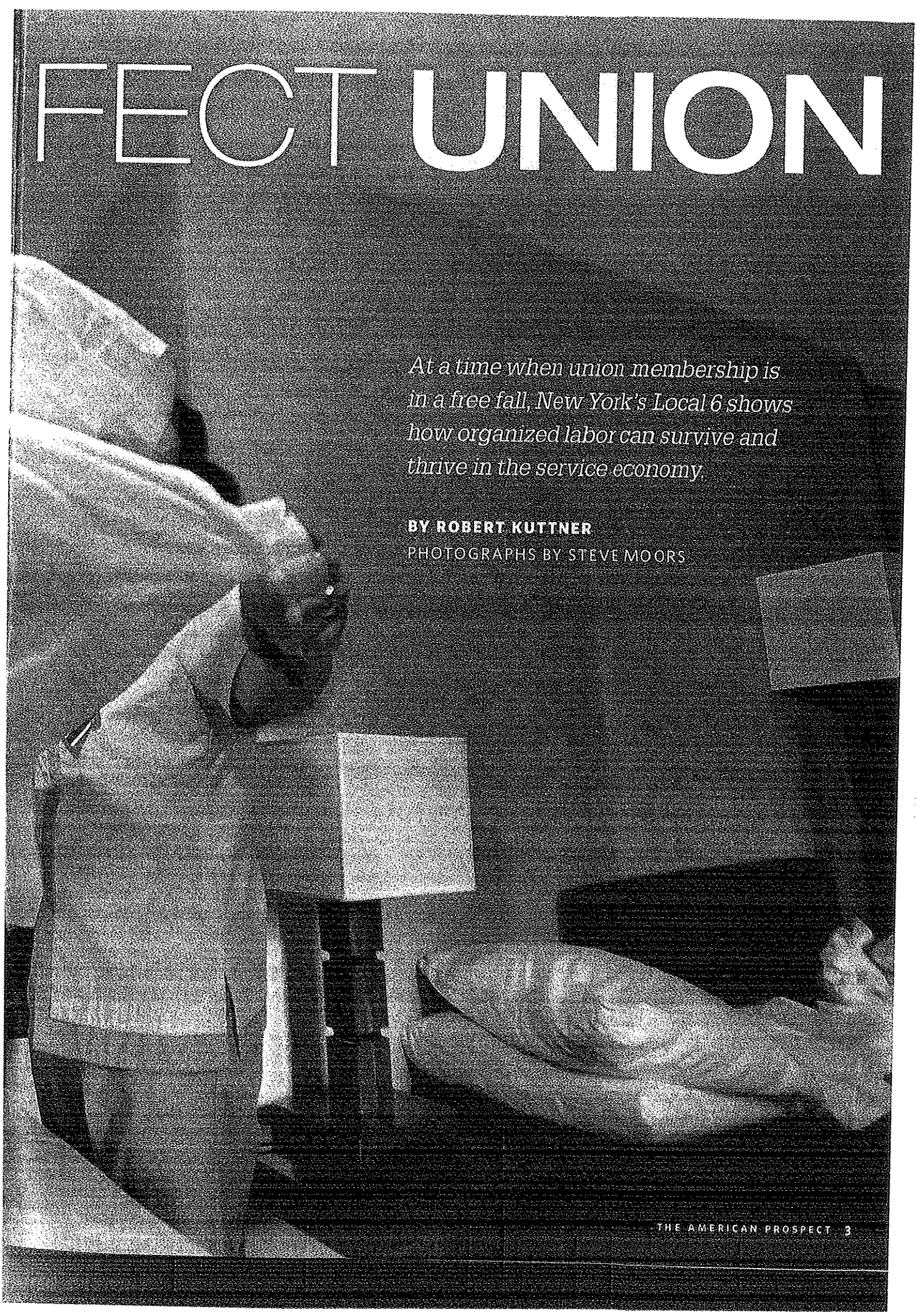


FECT UNION

At a time when union membership is in a free fall, New York's Local 6 shows how organized labor can survive and thrive in the service economy.

BY ROBERT KUTTNER

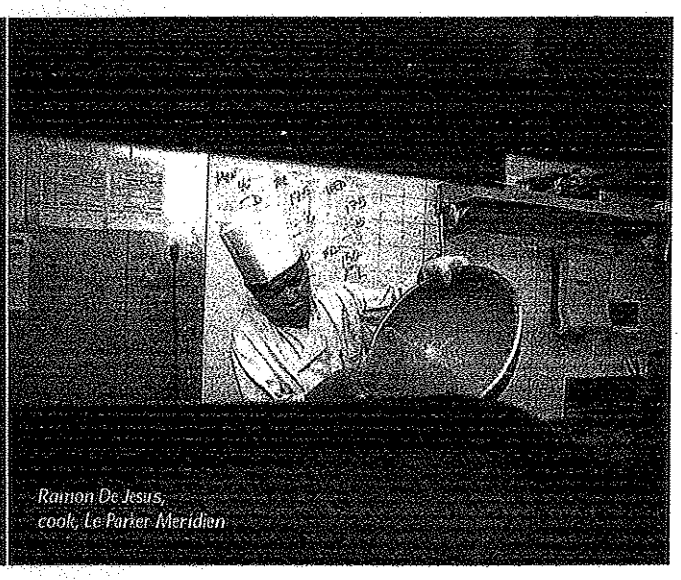
PHOTOGRAPHS BY STEVE MOORS



Emily Dopper and her boyfriend, Willem van Leeuwen, tourists from the Netherlands, were on their way to lunch at the Boathouse restaurant in New York's Central Park when they encountered the picket line. Clay Skaggs, a striking waiter, intercepted them. "We're asking you not to eat here," he said in a tone of polite explanation. "They practice sexual harassment, and they stole $3 million in wages over two years. They also got a C-rating on their health inspection."

Dopper looked dejected and unconvinced. "We came here to Central Park all the way from Europe," she said.

Maria Jimenez
room attendant, Flatotel



Ramon De Jesus,
cook, Le Parker Meridien

"There are lots of other great places nearby," Skaggs continued. He handed them a foldout flyer. One side featured a detailed map of the park and its myriad paths and attractions, displaying locations and write-ups of other restaurants and a big red circle with a slash around the Boathouse. On the other side was an explanation of the issues in the strike, with summaries in 19 languages. Adopting his best waiter's manner, Skaggs pointed out several eateries in and around the park. "Here's one of my favorites," he said. "It's a gourmet pushcart that has terrific pulled pork and jicama coleslaw. There are tables nearby."

The tourists exchanged a few words. "We are happy to help," van Leeuwen said. "We have an expression in Dutch. It means, when you team up, you are stronger." Off they walked.

In the six weeks of the strike by Local 6 of the hotel and restaurant workers' union, spanning the Boathouse's busiest season in August and September, restaurant traffic dwindled to a fraction of its usual level. The popular outdoor bar, usually five deep on a nice day, was all but empty. Meanwhile, the National Labor Relations Board (NLRB) was close to issuing a formal

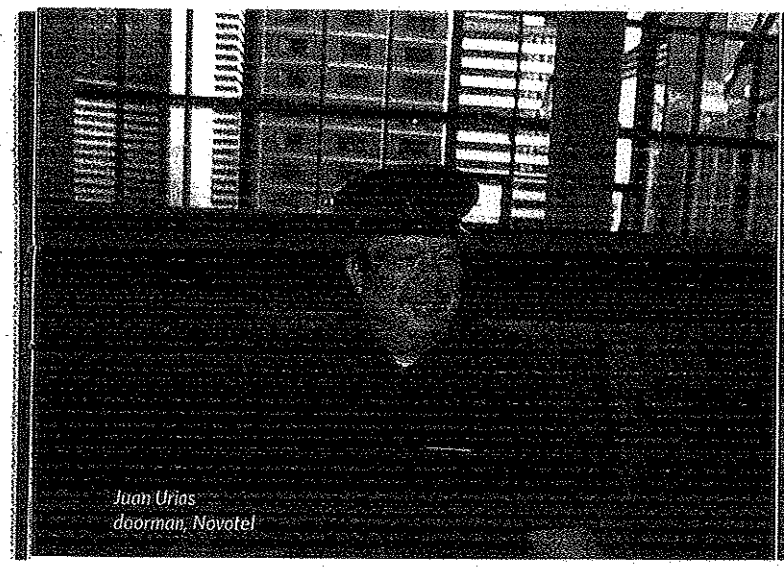
complaint against restaurateur Dean Poll citing a variety of infractions, including firing pro-union workers, stealing wages and tips, and several instances of sexual harassment. According to the union, the proprietor had ignored complaints when a manager pressured female workers to date him and when a banquet captain repeatedly stalked a waitress. Pregnant waitresses, the union charged, were given extra work to force them to quit. Employees also had long-standing frustrations about the low pay, the arbitrary layoffs and shift changes, the lack of bathroom facilities for workers, the shared changing room for male and female employees, and the refusal to grant sick days.

Local 6 had been working with Boathouse employees seeking a union for two years, waiting for the NLRB to act. Last spring, when several pro-union waiters were terminated with no explanation, a manager blandly explained that this was no big deal—the restaurant was making several decorative alterations, including replacing the chairs. This last straw gave the union its slogan for the strike: "We are not chairs."

Some 4,000 union members walked picket lines. The local printed 250,000 of the maps, which became popular with bus tour guides and pedicab drivers. The union used its contacts to discourage influential New Yorkers from holding events at the Boathouse. "Not a single elected official who we asked for support turned us down," says union president Peter Ward. Because the Boathouse is in Central Park, the City is Poll's landlord, and Deputy Mayor for Economic Development Robert Steel worked to bring about a settlement.

On September 22, facing escalating losses to his business, Poll caved. He signed a union contract giving workers raises averaging 30 percent to 40 percent as well as membership in the union's comprehensive health plan (see sidebar). Hourly pay for line cooks goes from $8 or $9 an hour to $16 an hour, and for grill cooks to $20. Dishwashers will go from earning minimum wage or slightly above to earning $13.50 an hour. Banquet waiters are guaranteed that gratuity charges will be passed along and will see their total hourly earnings rise to around $26. Eighteen workers illegally fired will be reinstated with full back pay. The union has been taking out Internet and print ads urging patrons to come back to the Boathouse. The new contract also requires the restaurant to display a prominent sign, "Union House." Workers also gain a range of due-process rights; they cannot be fired except for just cause, and for the first time, there are clear protections on scheduling and layoffs. (Poll declined comment.)

Union victories like the one at the Boathouse are rare.



Juan Urias
doorman, Novotel

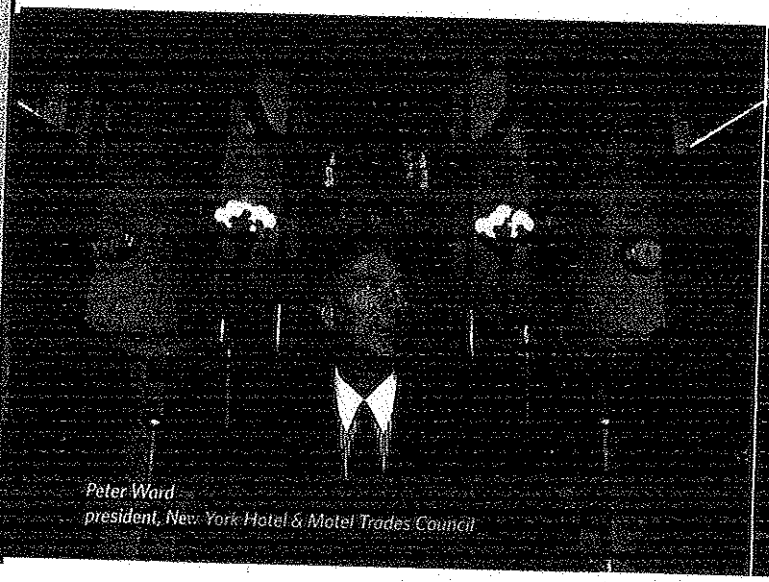
Jose Yanqui
steward, Le Parker Meridien

Almost everywhere else in the labor movement, the news is bleak. A three-decade assault on workers' right to organize has been worsened by high unemployment, outsourcing to low-wage nations, ever more aggressive anti-union tactics by management, and rising health-care costs—all of which make wage increases a distant memory. Today, collective bargaining is mostly about concessions, not new benefits, and collective bargaining itself is the exception, with union representation in the private sector down to just 7 percent of workers.

This reality, of course, makes New York's hotel union all the more remarkable. With some 23,000 members, Local 6 is by far the largest of the eight locals that make up the nearly 30,000-member New York Hotel and Motel Trades Council. Among the other locals in the council are the Operating Engineers and the Electricians, who represent specialized hotel employees. The council's master contract covers about 71 percent of hotel rooms in New York's five boroughs and nearly all large hotels in Manhattan. (Most freestanding unionized restaurants in New York are represented by another unit, Local 100.)

"Some people explain that it's more like

Local 6 members range from restaurant staff such as line cooks, dishwashers, waiters, bartenders, and busboys to desk clerks, bellmen, housekeepers, and unseen "back of the house" hotel staff like laundry workers. With wages and tips, a banquet waiter at a top hotel can command a six-figure income, but even the most humble jobs guarantee middle-class wages. A union housekeeper now gets more than $25 an hour, or about $50,000 a year, plus paid vacation, sick days, a pension, and the benefits of the union's health plan (which are paid for entirely by management). The heavily immigrant union—67 languages are spoken among the membership—runs continuing-education programs that range from English as a second language to culinary school.



Peter Ward
president, New York Hotel & Motel Trades Council

Jesus Fontanez, Joseph Massenat
room-service servers, Le Parker Meridien

Absent a union, the boss can fire for any reason or no reason at all. Management can be as arbitrary as it likes in assigning shifts, defining jobs, deciding whom to lay off and whom to call back. No formal process is required, and no explanation need be given. In a city with a large immigrant population at a time of high unemployment, there is a seemingly endless supply of workers willing to do casual jobs at low wages and fearful of being fired. All of which raises the $25-an-hour question. At a time when the strength of unions is dwindling, how does Local 6 do it?

THE UNION, FOUNDED IN 1938, has always had a tradition of militant rank-and-file involvement, according to Peter Ward, who has led Local 6 since 1995. He and organizing director Jim Donovan have been relentless in devising creative ways to involve hotel workers in the life of the local, so that "the union" is not an office across town but a membership highly engaged with defense of their rights.

Until the Hotel Trades Council made its breakthrough and signed union contracts with 62 New York Hotels by 1939, there had been failed attempts to organize a New York hotel union in 1934, 1929, 1918, 1912, and even an early effort in 1853. But this time, the unionists had the Roosevelt administration, the 1935 Wagner Act creating a legal right to organize or join a union, and the desire of hotelkeepers to avoid strife as they welcomed tourists to the New York World's Fair. But above all, the union had committed membership and shrewd leadership, under the legendary organizer Jay Rubin, the Hotel Trades Council's first president.

Effective unions have long used shop stewards—regular workers who are available to listen to grievances and press complaints with managers. Local 6 takes the concept to a new level of sophistication and engagement. In New York's union hotels, shop stewards are called delegates. They and assistant delegates are elected directly by the membership at each hotel. Every job category has one or several delegates depending on the hotel's size.

Before the Flatotel on West 52nd Street was unionized in 2005, Ruth Cabrera, a Dominican-born mother of two from the Bronx, typically cleaned 20 rooms or suites per eight-hour shift. Since the hotel had many three-room apartments, her quota sometimes translated to as many as 37 actual rooms. When workers voted in the union, Cabrera's daily quota dropped to 12 actual rooms and her wages increased by about 40 percent.

Cabrera, who serves as a union delegate, works to settle disputes large and small. After guests checked out of a suite where they had stayed several nights, one of her co-workers found a stack of dollar-coins on a bedside table, which she took to be a tip. The guest later called in to say that she had left behind some coins that she had gotten from a local bank as a souvenir. Management accused the housekeeper of theft. "They wrote her up," Cabrera says. "They were going to fire

e think it's a charity. Others think it's a business. We have to e a political organization that works to get better contracts."

her." Cabrera persuaded the manager that the room attendant had a reasonable expectation that the money was left as a tip, and Cabrera and her co-worker went to the bank to replace the coins. The worker was not punished.

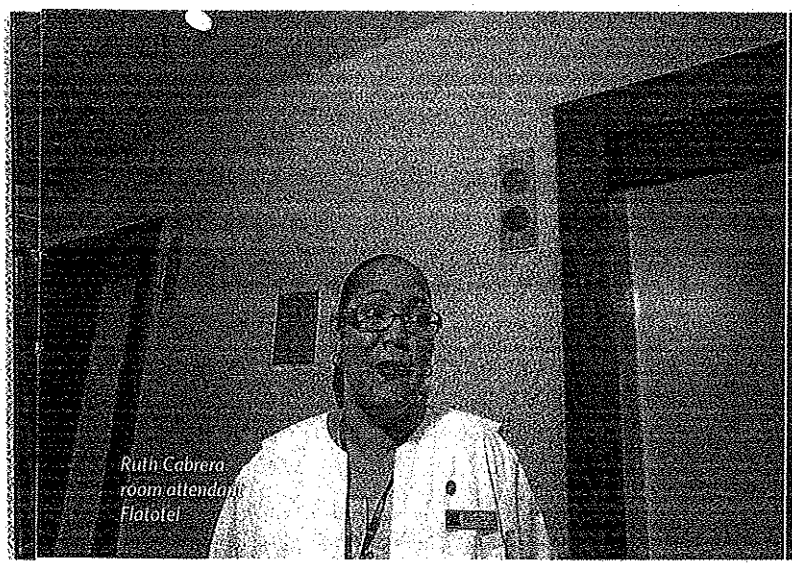
If a delegate cannot settle a dispute, it goes to the union business agent, a paid staffer who is responsible for several hotels. If there are still differences, the contract provides for binding arbitration. The union also has a tradition that it reserves for special occasions when it needs to make a point—the lobby meeting.

An epic case of the power of a lobby meeting occurred in 1997 at the ultra-luxury St. Regis hotel and created such turmoil that it made *The New York Times*. Three hostesses charged a maitre d' with repeated sexual harassment. They complained to management, but the celebrity chef at the hotel's famed Lespinasse restaurant, Gray Kunz, sided with the maitre d' and dismissed the claim. Senior management, evidently for fear of offending the chef, took no action. Most of the hotel staff showed up in the lobby in full view of the guests and demanded to meet with the general manager. The eventual settlement required management to fire the maitre d' and Kunz to read an apology to the workers in front of the entire staff. Chef Kunz was denied the authority to give orders to any staff except the cooks under his direct supervision.

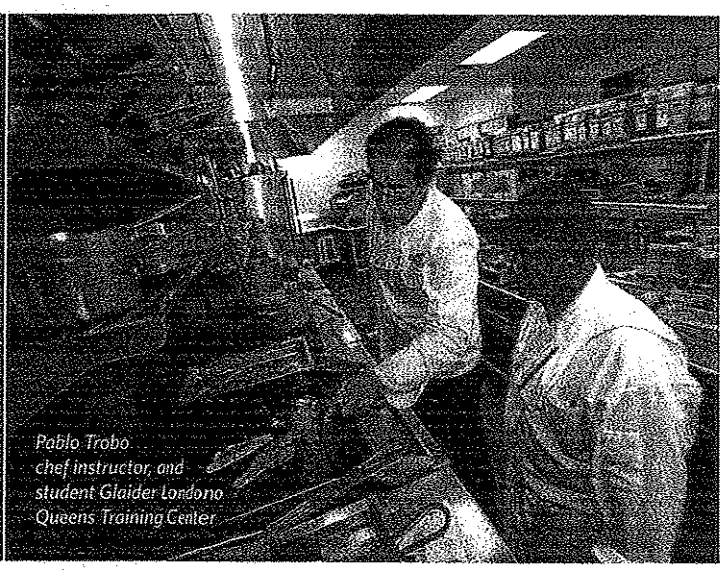
A lobby meeting is the union's equivalent of the famous distress call of the circus, "Hey, Rube," which brings performers running to help their mates. "Most workers just don't believe they can ever take on the boss," Donovan says. "Workers who put their jobs on the line to go on strike at a place like the Boathouse and trust their fellow workers not to sell them out are taking an incredible risk. When they win, it is absolutely transforming."

Because of the union's institutional power, however, the choreography of resolving disputes is mostly ritualized and peaceful. The contract spells out rights and responsibilities in detail, and the ultimate recourse to binding arbitration gives management an incentive to settle minor issues before they become major ones.

"Before the union, I stayed working one day until 2 A.M.," says Juan Urias, 56, a doorman at the Novotel, the site of a protracted organizing drive that the union finally won in 2005. "They owed me three hours overtime, and they wouldn't pay. I even complained to the NLRB. But the NLRB lady said, 'I can make them pay you for those three hours, but they will find a way to get rid of you.' So we decided to bring in the union." Since then, says Urias, who is also a union delegate, he hasn't lost a case involving a grievance.



Ruth Cabrera, room attendant, Flatotel



Pablo Trobo, chef instructor, and student Gleider Londono, Queens Training Center

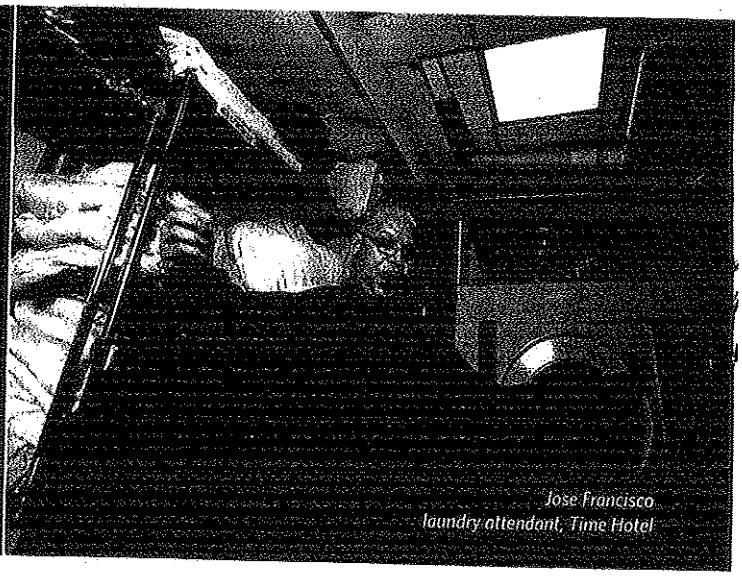
The union's citywide agreement with the hotel industry even includes the holy grail of union contracts—card-check neutrality. This means that if a hotel group, such as Hilton, Marriott, or Trump, has even one union contract in New York and decides to open, purchase, or manage another hotel in the city, it is bound by a neutrality clause. Management must allow the workers at the new hotel the right to choose a union (or not) based on an immediate count of who has signed union cards. Management has to provide the union with names and addresses of its employees and cannot campaign against the union. Under card check rules, Local 6 invariably wins certification by large margins.

THE JOURNALIST AND SOCIAL CRITIC Lincoln Steffens, after returning from a visit to Soviet Russia in 1919, embarrassed himself with a declaration often misquoted as "I have seen the future, and it works." Steffens actually said, "I have been over into the future, and it works." Either way, he got it wrong. After spending several weeks observing Local 6, I am tempted to write, I have seen the past, and it works.

"The number of guests fluctuates day to day. If managers reduce large numbers of workers to on-call status: 'We'll

Stepping into the world of Local 6 is like entering a time bubble. In the 1940s and 1950s, when government enforced the Wagner Act and unions represented one worker in three, management reluctantly concluded that unions were here to stay and that it was better to have good labor relations than endless conflict. Today, most corporations can break unions with impunity. Even under a Democratic administration, the backlog of complaints is so extensive that even workplaces with a large majority of employees wanting a union seldom get one. But in the New York hotel industry, the balance of power between labor and management is akin to what it was in 1949. So, for the most part, management wants to get along with the union, not destroy it. "I say I have the best job in the labor movement," says Richard Moroko, who became the union's legal counsel and vice president in 2002. "I'm actually negotiating for better wages and benefits."

Haniff Mohammad
freight-elevator operator, Salisbury Hotel



Jose Francisco
laundry attendant, Time Hotel

Peter Ward, who is 53 years old, is only the union's third president. He grew up in Brooklyn, and he speaks in the rich tones of outer-borough New York that also evoke the 1940s. After graduating from Sheepshead Bay High School and working as a waiter and a bartender, Ward found a salaried job at the union as a clerk. He was pressed into service in a fight with management seeking to oust a union at Downstate Medical Center in Brooklyn where Local 6 was helping another local ("I think they sent me because I could find my way to Brooklyn"). He was good at it and was moved from a desk job to organizing. In 1983, when he had already risen to business agent, Ward married the daughter of the union's then-president, Vito Pitta. Ward is described by colleagues as polite, tough, selfless, and brilliant.

"The union contract is vague in some areas, in a good way," Ward says. "There are hundreds of ad hoc settlements that modify contracts. For instance, let's say the hotel has renovated its rooms and the mattresses are heavier, and they agree to increased compensation or reduced workload. Everything is put in the database. The more we do this, the more we build credibility both with the rank and file and with management."

The master contract specifies not only that management must share all payroll and scheduling data but also that the information be provided electronically. The union database keeps all of these records and also has a searchable record of precedents from arbitrators' rulings.

In effect, the contract creates a local jurisprudence for workers and management with expedited remedies. Though all this may seem bureaucratic, it is the opposite. Worker and manager share a common interest in quick resolutions of problems. Because the union knows the contract well and has an engaged membership to be mobilized when necessary, most disputes are settled long before they get to either binding arbitration or lobby meetings.

What distinguishes a nonunion setting from a union one is not that a nonunion workplace is conflict-free. In the hotel industry, personnel conflicts—temperamental chefs, megalomaniac food and beverage managers, light-fingered bartenders, favoritism in hiring, scheduling and promotions based on friendships or sexual liaisons—are endemic. The difference is that in a union setting, ordinary workers have rights, and the inefficient, demoralizing petty corruption is more likely to be ferreted out, to the benefit of the company and employees alike.

"The union," says Mick Wannamaker, a veteran banquet waiter at Le Parker Meridien, "takes jobs and turns them into professions. It makes better managers out of management. The good ones get better—the bad ones don't survive."

The jointly sponsored health plan is an object of great pride to both union and management and helps cement cordial day-

s had their way, they would
l call you, day of, if we need you.'"

to-day relations on other fronts. "When Peter [Ward] and I sit across the bargaining table to negotiate contracts every five years, we are so-called antagonists," says Joseph Spinnato, who heads the Hotel Association of New York City. "But when we sit down as trustees of the health plan, we are on the same side."

THIS IS NOT TO SAY THAT ALL IS ROSY. The union narrowly averted a citywide strike in its last general contract bargaining, just before the recession, and will need all of its shrewdness and solidarity in negotiations next year.

As the hotel industry continues to evolve, the union has had to change with it. Two decades ago, large chains like Hilton and Marriott owned and managed the hotels that carried their brand. Then the stock market put pressure on hotel companies to increase earnings by selling off properties, which were tying up a lot of capital. Now, the property is typically owned by a third party and leased back, often as a real-estate investment trust (REIT) which can exploit tax advantages. The hotel may be "flagged" by one corporation as a Hyatt or a Sheraton and managed by another, such as Highgate or Interstate Management. The union has a binding contract with both the owner and the manager. Hotels are frequently bought and sold, and the contract follows the sale.

The same abuses keep repeating themselves, and the union has to respond with new forms of creativity. Two perennials are management thefts of wages and tips and efforts to turn permanent workers into temps. "The number of guests fluctuates day to day," Ward says, "so hotels have to fine-tune their staffing on a daily basis. If managers had their way, they would reduce large numbers of workers to on-call status: 'We'll call you, day of, if we need you.' But people need to be able to plan their lives, so there are rules that prevent that. They have to post schedules in advance. They are allowed layoffs for seasonal fluctuations but not day-to-day fluctuations. And they can't schedule overtime when people are on layoff. Many of our grievances involve scheduling." The union contract forces management to become more astute at planning and staffing, rather than just have employees bear all the cost and inconvenience of the ups and downs in bookings.

Then there is the chronic effort by hotels to purloin tips. "Food and beverage charges were traditionally the entire bills for banquets, and they included a charge for gratuities," Donovan explains. "Hotels began adding rental charges for the banquet room that were not subject to tips, as a way of diverting money from gratuities that banquet waiters were entitled to."

Tsultrim Sangmo
room attendant, Time Hotel

Kazi Housain
bartender, Hotel Plaza Athenee

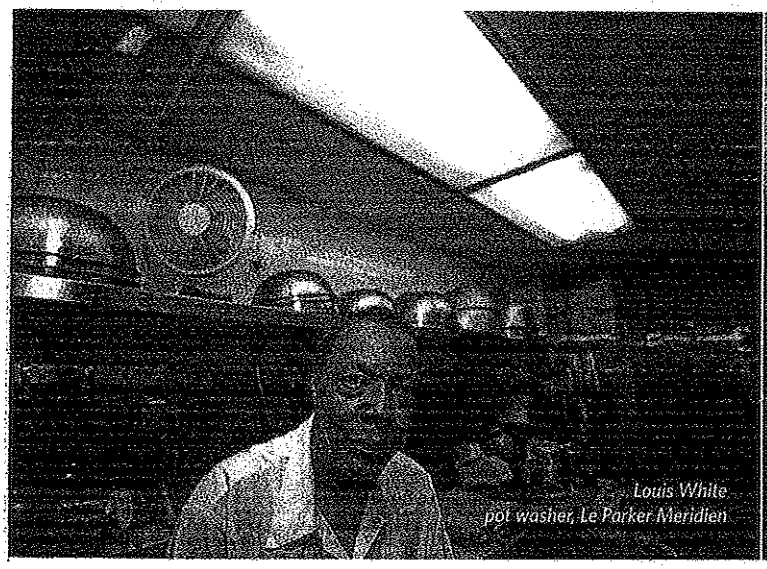
At the last contract negotiations in 2006, the union came armed with an electronic database and a PowerPoint showing how much money the managers had diverted in a variety of schemes to shortchange worker pay, and how many millions in back-pay claims were owed. "We've caught them stealing wages time and time again," Moroko says. "We were able to show that they were recidivists and that there was no incentive for them not to keep doing it. So we came up with a disincentive. They agreed to a 15 percent fine in addition to the back wages every time they're caught. The stealing has dramatically declined."

Although the neutrality card-check provision in the master contract makes it relatively easy for the union to organize newly built or purchased hotels operated by established management companies, the new wave of independent boutique hotels provides a fresh challenge. Last year, the union organized an average of one new hotel a month, and nearly all of these were based on card checks and management neutrality, according to Moroko. But independently owned hotels not bound by neutrality card check often put up the same

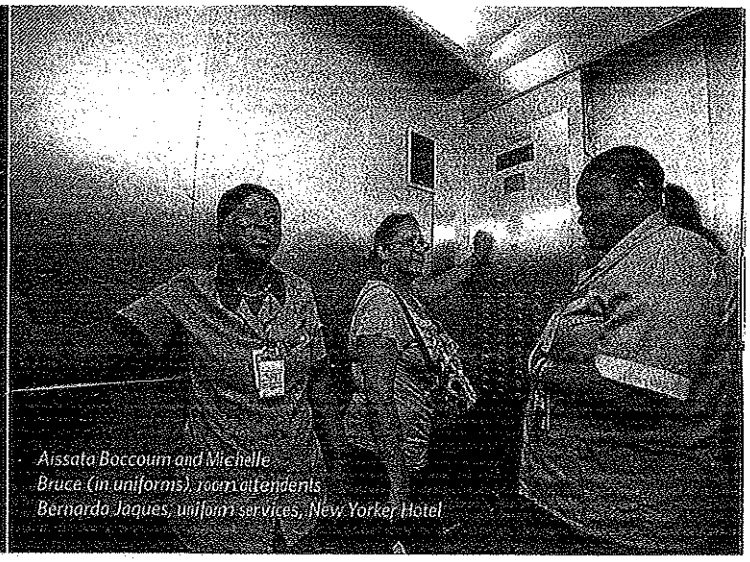
"The union takes jobs and turns them into professions. It of management. The good ones get better—the bad ones

resistance to unionization as nonunion employers everywhere.

The union has limited resources to organize hotels in the face of management resistance and has to carefully choose its battles. When a worker at a nonunion hotel contacts Local 6 for help, Jim Donovan says he begins by asking, "Why do you want a union? What do you think the union does? There are a lot of misconceptions. Some people think it's a charity. Others think it's a business. We have to explain that it's more like a political organization that works to get better contracts. We explain that we want more workers to be organized because your hotel with its low wages and standards is a threat to our union and its good standards. We explain that we have limited staff, and we have to invest our members' resources wisely,



Louis White, pot washer, Le Parker Meridien



Aissata Baccoum and Michelle Bruce (in uniforms), room attendants; Bernardo Jaques, uniform services, New Yorker Hotel

and you need to convince us that you are serious. How many people do you have who you can trust? What's going on that has people upset? We let people know the risks they will be taking."

With fewer than 20 paid organizers, the union can handle only one or two "bottom up" organizing drives at a time. For the past several months, nearly all were working on the Boathouse campaign. Others are assigned to work with existing members, to make sure that the rank and file stay informed and mobilized.

One of the union's newer innovations is the Hotel Employees Action Teams, or HEAT. Through HEAT, the union's members become more involved in local politics, working to elect supportive public officials. At a time when political campaigning is often reduced to writing checks, HEAT is one of the remaining sources of on-the-ground campaigners knocking on their neighbors' doors. "They punch above their weight," says Dan Cantor, executive director of New York's Working Families Party. "Every mayoral candidate is seeking their support." The union's former political director, Neal Kwatra, 37, is now chief of staff to New York's progressive new state attorney general, Eric Schneiderman. Savvy New Yorkers say this was less a reward for the union's support than a recognition of Kwatra's sheer talent. According to *Crain's New York Business*, no fan of unions, Kwatra helped turn the hotel union's members "into some of the most sought-after ground troops in any campaign in the state."

The union's political alliances pay dividends. A union with well placed friends sends a signal to developers that it's better to work with the union than against it. A developer seeking to open a new hotel may not want to bargain with the union, but the project must run a gauntlet of zoning approvals, permits, community-planning meetings—all of which can make the developer's life easy or miserable. The REIT that holds the real estate may be partly owned by another union's pension fund, which can also encourage the owner to agree to card check.

New York, to be sure, is hospitable territory compared to much of the country. When the hotel union prevailed in its last citywide strike, in 1985, even the mercurial Mayor Ed Koch was an ally, refusing to cross picket lines. In that respect, you might say that Local 6 was born on third base, but you'd be mostly wrong.

It's true that it's easier to organize a hotel than a shoe factory, because the union's members operate in full view of the customers, and a hotel seeking to avoid a union can't move to China. Also, unlike the autoworkers' union, the hotel union is not constrained to keep wages low for reasons of international competition. New York is a tourist destination, and its hotels will charge whatever the traffic will bear. Union hotels simply capture more of those profits for their members.

But despite its affiliation with a strong and creative national hotel union, UNITE HERE, Local 6 is the exception even in the hotel industry. Most good-sized cities have largely nonunion hotels, with dismal wages and no worker rights, and the same

makes better managers out don't survive."

chains that get along with Local 6 in New York resist elsewhere. San Francisco, Las Vegas, and New York are heavily unionized, while hotels in Chicago, Los Angeles, Boston, and Washington, D.C., are partly unionized. But if organizing hotel workers were a cakewalk, they'd be unionized everywhere in America, and they're not. The service sector today should be more amenable to unionization than manufacturing, yet service industries are mostly—and viciously—nonunion.

IN THE END, THIS STORY IS ALL ABOUT POWER, and power used responsibly. At Local 6, three generations of union leaders have continued to build on the power bequeathed to them by their predecessors, not for their own personal gain but for their membership. Union leaders do not double dip by collecting extra pay as pension- or health-fund trustees; union officers and delegates are democratically elected, and the delegates work as volunteers for no fees. Local 6 also has been corruption-free. (The union's second president, Sicilian-born Vito Pitta, in a case of mistaken identity, was once indicted by then–U.S. Attorney Rudy Giuliani in a roundup of suspected mobsters. When the judge reviewed the total absence of evidence, Pitta's case was severed from the others and all charges against him dropped.) The union keeps finding new ways to mobilize the membership, and success builds on success. The union's members have friends and relatives working in nonunion establishments and know the value of what they've got.

The union is the face of immigrant New York. Its largest ethnic group is Hispanic, from more than a dozen countries, but the union also has thousands of African, Asian, and African American members. You might think this ethnic fragmentation would be a huge obstacle, but networking among immigrants turns out to be a source of strength. The leadership training that produces good union activists also translates to community leadership, and community leaders often turn out to be union leaders. For example, New York's growing Tibetan community has found work in several major hotels, and some 500 Tibetans are union members. Tsultrim Sangmo, a room attendant at Time Hotel, is also a leading Tibetan human-rights activist and a much-admired community leader. When she volunteered for picket duty at the Boathouse, Tibetan workers were astonished and treated her like a celebrity.

In his classic work, *The Populist Moment,* on the transformative effect that occurs when ordinary people realize that they can change power relations in their lives, the historian Lawrence Goodwyn writes that "mass resignation"—the premise that things can never be changed—is culturally programmed, disabling democratic possibility, but that a "movement culture ... once attained ... opens up new vistas of social possibility." Goodwyn was writing of the populist revolt of the 1880s and 1890s, but he could have been describing Local 6.

Camille Cadet
head cook, employee cafeteria

Jose Class
guest services, Le Parker Meridien

It has become conventional for conservative and "third way" commentators to contend that the labor movement may have made sense back in the 1930s when most Americans had lousy jobs and did manual labor but that in today's knowledge economy, unions are an anachronism. This conceit is now as embarrassing as Lincoln Steffens's.

Recently, the Census Bureau reported that since the start of the financial collapse, median household incomes have declined by 10 percent. The American economy is in its own time bubble that looks increasingly like the 1930s, in every respect but the strength of the union movement. The Local 6 story suggests that in the enduring struggle of ordinary workers for fair treatment and a fair share of the national product, unions are not only more necessary than ever but still possible. ◙

A MODEL OF **HEALTH**

Members of Local 6 have some of the best—and most cost-effective—care in the country.

In 2005, when Local 6 won its first union contract at the boutique Time Hotel on West 49th Street, Angel Aybar, then a 21-year-old room attendant responsible for checking, cleaning, and restocking minibars, not only got a raise from $10 to $16.50 an hour; he became a member of a uniquely effective health plan. The New York hotel workers' plan provides comprehensive coverage at its own health centers, including full dental and optical care, with no deductibles or co-pays and a core philosophy that emphasizes primary care, wellness, and prevention. Aybar even credits the health plan for his marriage.

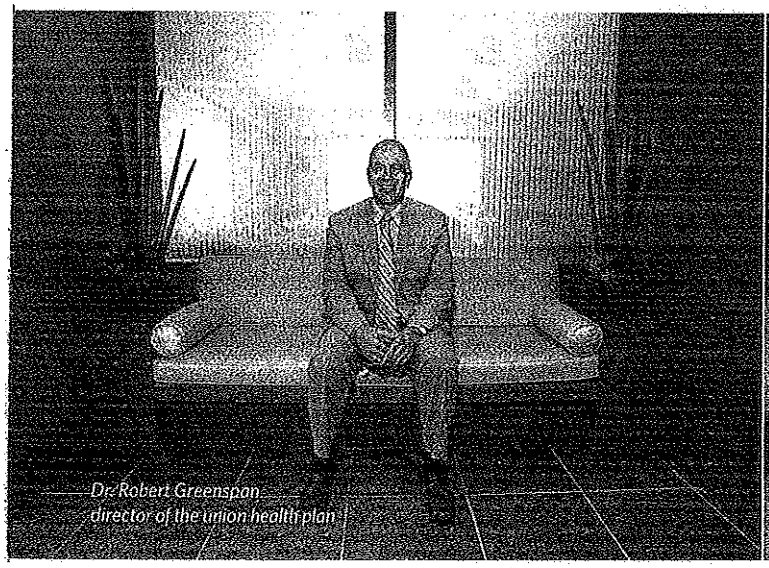
"My wife and I had been sweethearts since junior high," Aybar says. "She was working, and they were taking over $100 a month out of her paycheck for her health insurance. I guess it's not very romantic of me to say this, but it was the union health plan that pushed us over the edge to get married. She was getting chronic headaches. They kept telling her it was just stress. Her first visit to the union plan, they did an MRI and found a small tumor. They treated it, and she's fine. Now we have a two-year-old son. I would do anything for this union, just because of the health care. It lets me sleep at night."

The plan may well be the best in the nation at providing so much coverage while effectively constraining costs. All doctors are salaried, with general practitioners being paid slightly more than specialists, in order to reward primary care. The scale for GPs ranges from $85 to $115 an hour, or around $200,000 a year or more. The plan has no trouble enlisting good doctors, since the conditions of medical practice elsewhere have been deteriorating under relentless pressure from insurers to cut costs and justify their medical decisions. "I see about 35 patients a day, and nobody is breathing down my neck," says Dr. Andrew Sinesi, a pediatrician who practices at the plan's Queens health center. "I have all the time I need."

In the office of Dr. Robert Greenspan, who has headed the plan for 12 years, hangs the official charter signed by New York Governor Thomas E. Dewey in 1949 authorizing Local 6 to operate the nation's first medical practice run by a union. From a small clinic on Manhattan's West Side, the plan has grown into five comprehensive health centers, serving approximately 88,000 hotel workers, their family members, and union retirees. Even those who've been laid off keep their health coverage. The plan boasts New York's highest rate of patient satisfaction. In the most recent survey of patients, more than 93 percent said they would recommend the facility. The typical HMO in New York scores around 65 percent. "Our holy trinity," Greenspan says, "is increase the quality of care, raise patient satisfaction, improve efficiency."

The health center on 125th Street in Central Harlem is a $35 million state-of-the-art facility on five floors that opened in 2003 and now serves about 800 patients a day. The patient record-keeping system is 100 percent computerized. Digital radiography is standardized so that X-rays and scans are available to any office in the system. Lab reports show up in the doctor's computer inbox within hours of being ordered or almost instantly in emergencies.

The Queens, Harlem, and Midtown centers use pharmacy robots. The prescription goes from the doctor's computer to the pharmacy on the health center's ground floor, where the robot fills it from bins of the 200 most commonly prescribed drugs. A computer screen then displays the name of the drug, a picture of the drug, and any red flags based on the patient's medical record or other prescriptions. A human pharmacist reviews the screen, checks the pills in the bottle against the picture



Dr. Robert Greenspan, director of the union health plan

Priscila Perez, laundry attendant, Time Hotel

and the doctor's order, caps it, and signs off on it. By the time the patient comes down from his appointment, the prescription is ready to be picked up.

The plan's sole out-of-pocket charge is for drugs. While ordinary prescriptions require a modest co-pay of $5 or $15 for non-generics, the charge is eliminated for patients on long-term treatments, such as for high blood pressure. "Bob [Greenspan] experimented with free drugs for patients who are chronically ill," says union president Peter Ward. "He found that this dramatically reduced visits to the ER; there were fewer catastrophic events. So now, we waive all co-pays for patients on long-term drug therapy."

Before joining the union plan, Tsultrim Sangmo, a room attendant at the Time Hotel, had out-of-pocket charges of close to $100 a week. "My husband has diabetes," she says. "We had a Blue Cross Blue Shield PPO. It was $20 to come in for the test and another $20 to come back and get the results, and the medication was more expenses."

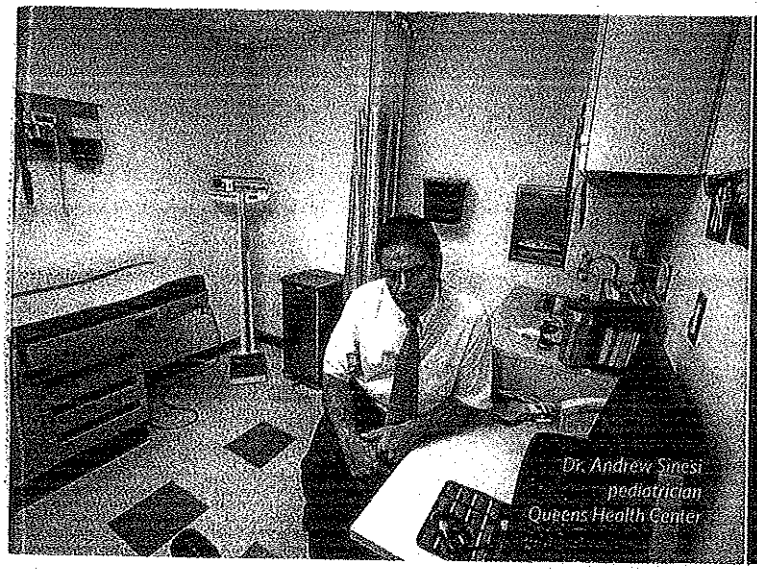
"The difference isn't just financial—it's philosophical," Greenspan says. "We want you to come in. We want unlimited access to primary care. It pays off over the long term. All of the co-pays and deductibles do the opposite of what is claimed. They don't assure that scarce medical resources are used as efficiently as possible or deter excessive use. They are simply barriers to care. People say, 'Maybe it will clear up by itself, so I won't see the doctor,' or 'I'll stretch out the medicine supply by taking less than the prescribed dose.' All you are doing is inducing people not to be compliant with the medical program. Then you wonder why costs keep going up—it's because people get sicker, and their eventual treatment is more expensive. We do just the opposite."

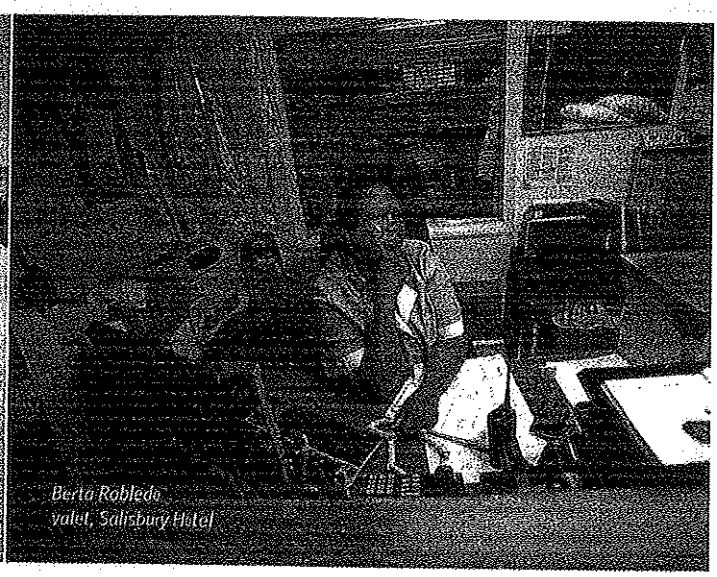
The plan has extensive patient-education programs on wellness and nutrition. It sponsors health fairs every year, one each for men, women, children, and seniors. "Sometimes, it's hard to get men to come in when the highlight of the visit is a prostate exam," Greenspan says. "We market this to wives. 'When was the last time your husband came in for a check-up?' And we have a language bank. There are medical professionals at our centers who can speak 45 languages."

Since the 1970s, the plan has reported to a joint labor-management committee co-chaired by Ward and his management counterpart, Joseph Spinnato, the longtime president of the Hotel Association of New York City, who takes great pride in the plan. "I could not duplicate this on the private market for anything like what we pay," he says. "When you measure it against what our member hotels pay to cover their nonunion employees and what they get, there is simply no comparison." Stephen Steinbrecher, legal counsel to the Hotel Association, says what's obvious: "The union has been very astute at marketing the plan as a benefit of membership."

Last year, the hotel workers' health plan cost $411.24 a month for an individual and $1,027.56 for an average family. By comparison, Healthfirst, the cheapest HMO in New York City, cost roughly three times as much—$1,116 a month for an individual and $3,316 for a family—while it excluded many services offered by the union such as dental and optical care and piled on deductibles and co-pays. Factoring in benefits not provided by other plans, the typical commercial insurance package costs about four times as much as the hotel workers' plan.

Insurance costs generally are increasing at 9 percent to 10 percent a year, according to the Kaiser Foundation. By contrast, the costs of the hotel workers' plan have been increasing at about 1 percent a year for the outpatient services that it provides directly and about 10 percent per year for inpatient services that are contracted with area hospitals. So the plan's overall costs have been going up at about 3.5 percent a year. Under the union contract, the health plan gets a budget increase that parallels the annual workers' raise, which just happens to be 3.5 percent. Thus, workers get their raise and the plan covers its costs; in some years, it banks a surplus,


Dr. Andrew Sinesi
pediatrician
Queens Health Center


Berta Robledo
valet, Salisbury Hotel

leaving enough money for capital improvements like the pharmacy robot and even for additional services. "We recently added fertility benefits," Greenspan says.

How can this possibly be? Are Local 6 members, on average, healthier? No, they are slightly more at risk since many come from immigrant backgrounds where they did not get good care earlier in their lives, Ward says. Are doctors inferior? Not at all, says Greenspan, and the figures on patient-health outcomes bear him out. Does the plan cut corners on services? No, it's the commercial plans that create incentives to deny care.

So why is the plan virtually unknown in the health-policy debate? For one thing, the union has emphasized publicizing the plan among New York hotel workers, and Greenspan has focused on improving care for members, not crusading for national reform.

Except for single-payer advocates, reformers have pursued cost-effective care *within* the context of an insurance-dominated system—something of a fool's errand—whereas the hotel workers' plan begins by dispensing with third-party insurers. To review all the ways that the hotel workers' plan delivers better care more cost-effectively is to appreciate the vast inefficiency in the rest of America's health system—and to see that cost-containment gurus are mostly looking in the wrong places for efficiencies.

For starters, by dispensing with insurance-company middlemen, the plan eliminates a whole layer of costs. A doctor treats the patient according to his or her best medical judgment. There is no army of staffers dealing with patient billing, claims, and insurance reimbursement; no arguing with insurance-company case reviewers.

Second, doctors are all on salary. So there is no incentive to undertreat or overtreat.

Further, the plan's core principle is unlimited access to primary care, with all of the prevention and early-detection benefits that approach brings. In most systems, specialists drive costs.

By dispensing with insurance plan eliminates a whole laye

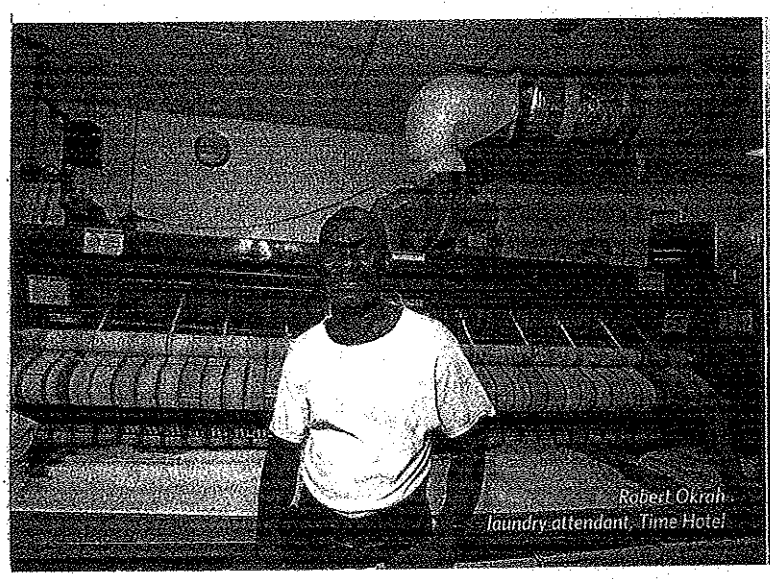
"We don't waste specialists on routine cases," Greenspan says. "We do want specialists to see appropriate cases, which is both more cost effective and more professionally challenging to the physician."

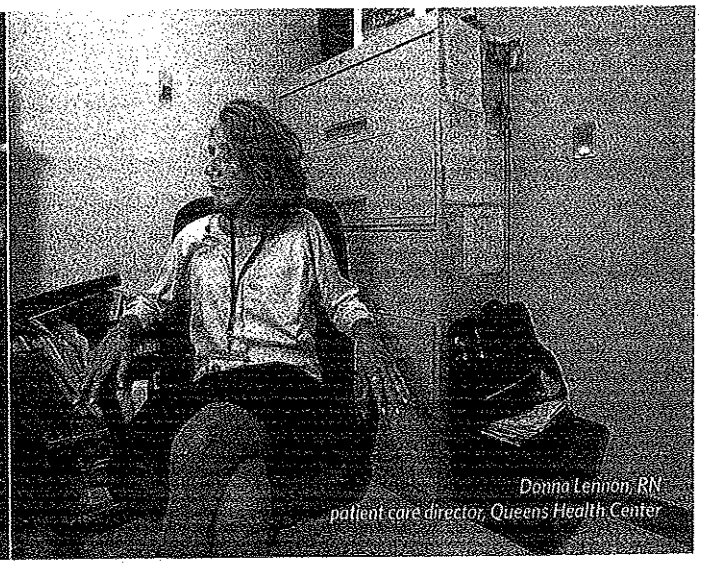
At the union health centers, if a primary-care doctor notices a suspicious-looking skin lesion, a dermatologist can be pulled in on the spot for what the staff calls a "drive-by consultation." If follow-up with a specialist is needed, it will be scheduled. In a conventional insurance plan, the doctor makes a referral to a specialist, who usually requires one visit for the initial exam and another for any treatment, all of which adds cost.

As Donna Lennon, the registered nurse who directs patient-care delivery, explains, the typical patient of the union health center stays with the plan 14 years. For commercial plans, the average is less than two years. "We have a lot more continuity, and doctors know their patients better," she says. That also means that doctors can carry a slightly larger caseload, because less time is spent getting up to speed on a constantly revolving group of patients.

The union, which knows something about negotiating, engages in hard bargaining with all of its vendors, from drug manufacturers to hospitals, and is relentless about eliminating middlemen. Most conventional health plans use "pharmacy benefit managers" who negotiate with drug companies on the plan's behalf and, of course, take a cut for themselves. The union negotiates directly. It also dispenses with cadres of consultants, from human-resource departments to utilization reviewers and behavioral-health companies, all of which add costs under the guise of shaving costs.

In New York, some medical specialists in high demand have market power to raise prices. "Have you heard the term, RAPER?" Greenspan


Robert Okrah, laundry attendant, Time Hotel


Donna Lennon, RN, patient care director, Queens Health Center

company middlemen, the hotel workers' union health-care of costs, leaving more money for patients.

asks. "It stands for Radiologists, Anesthesiologists, Pathologists, and ER doctors." Most New York hospitals now contract out these services to specialists' groups who charge whatever the market will bear. In recent bargaining with one of its hospitals over a proposed rate increase, the hotel workers were told that the increase partly reflected higher charges billed by anesthesiologists. Greenspan requested the hospital to push back. Not our problem, the hospital contended; we don't control these costs. "We told them, OK, next week our members stop using your hospital," Greenspan says. The costs came down.

Are there any negatives? Some might say that one negative is that members must use the plan's primary-care doctors and specialists. They can't pay extra and go "out of network" unless they choose to bear all the cost. For well-to-do people with unlimited private resources, the ability to track down the best specialist in the world is an important optional feature of a health plan. But the union's 93 percent satisfaction rate suggests that this is not an issue if the quality of care is high to begin with. In America's health system, unreliable care and demands for illusory "freedom of choice" feed on each other.

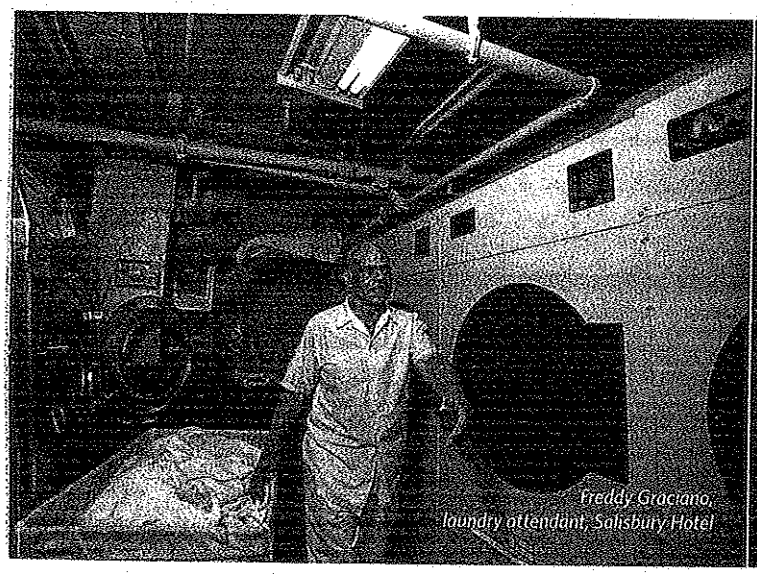
There is a lot of nonsense in health-policy debates about the costs of unnecessary care and the benefits of promoting "Chevrolet" policies rather than "Cadillac" policies. But on closer inspection, many of the supposed Chevys have high deductibles and co-pays or cover "catastrophic" events only and stint on prevention. They produce illusory savings by discouraging necessary care or shifting costs to patients. The hotel workers' plan, by contrast, is an efficient Lexus at the price of a Honda Civic.

The hotel workers' health plan does have some close cousins. The first wave of prepaid group health plans in the late 1930s and early 1940s used salaried doctors. Some of their nonprofit successors, such as Kaiser, share many of the New York plan's efficiencies. A few other unions still run their own clinics, though none are as comprehensive as the hotel workers'. America's highest-quality freestanding health centers such as the Cleveland Clinic and the Mayo Clinic also use salaried doctors.

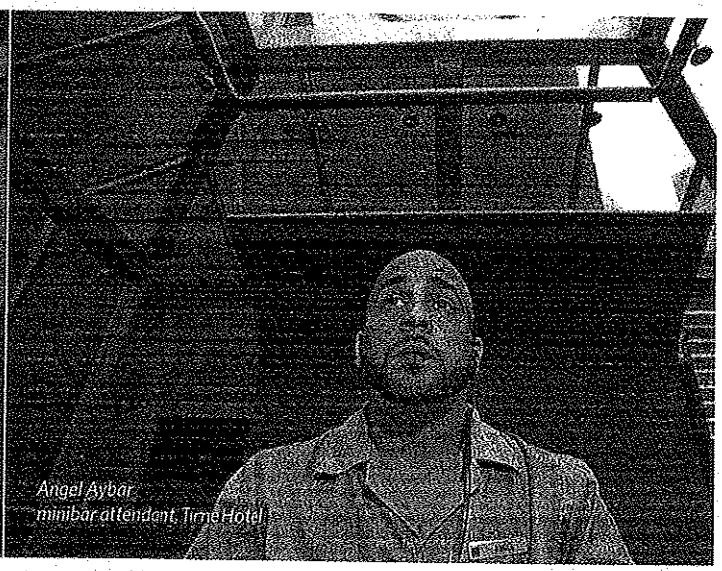
Although a single-payer system has been the prime goal of reformers, Dr. Arnold Relman, the former editor of *The New England Journal of Medicine*, has long argued that the system of delivery is at least as important as the system of payment. "In a staff-model nonprofit system," he says, "the overhead costs are minimized, and the plan and the doctors are on the same side. They both want to provide good quality care. In a conventional system, insurers and physicians are adversaries."

The hotel workers' health model should be at the center of the national health-policy debate, since it squares the circle of restraining costs while improving rather than cutting care. The obstacles to this brand of reform are, of course, political. All of the middlemen that the union health plan excludes, beginning with the insurance industry, have immense political power. That's why the Obama administration opted to work with, rather than against, insurers in the Affordable Care Act. One provision of the act does recognize and promote salaried nonprofit group plans, but then buries them under regulations to determine which qualify for official recognition and subsidy.

At some point, the public must realize that the choice is drastic reform or drastic cuts. More than any other in America, the hotel workers' plan points the way to an efficient and humane system of health care. —*ROBERT KUTTNER*



Freddy Graciano, laundry attendant, Salisbury Hotel



Angel Aybar minibar attendant, Time Hotel

To the members of the Hotel Trades Council and Local 6,

Enclosed is a reprint of two feature articles from last month's issue of *The American Prospect* magazine, which I believe will be of interest and pride to our members.

The first article, "A More Perfect Union," is a report on Local 6 and the Hotel Trades Council written by the respected journalist, Robert Kuttner. The second article describes our union's industry-wide health-benefit plan and is titled "A Model of Health."

Please note that the second article contains one quote, attributed to me, inaccurately indicating that the benefit funds "waive all co-pays for patients on long-term drug therapy." To be precise, co-payments are waived for many therapies such as HIV/Aids, chemotherapy, and asthma, but other chronic conditions do require a $5 or $15 co-payment.

I hope you enjoy both articles.

In Solidarity,
Peter Ward