



A System Under Stress, Exacerbated:

The Employer-Sponsored Health Insurance System at a Crossroads

By Andrew Schwab, Director of Policy, Federal Affairs and Partnerships

September 2020

EXECUTIVE SUMMARY

- ★ America's health care debate historically has revolved around the future of government programs, their contraction, expansion, and cost. But the employer-sponsored insurance (ESI) market covers the most people and accounts for the greatest portion of health spending in the nation.
- ★ Moreover, employers are incentivized to provide insurance to their employees via the [single largest tax expenditure](#) worth over an estimated \$242 billion in 2019, according to the U.S. Department of the Treasury.
- ★ But this 75-year-old system is facing tremendous strain. As health care prices rise and the average annual cost of ESI family premiums surpassed \$20,000 in 2019, both public and private employers [have shifted](#) more costs onto employees, requiring them to pay higher premiums, and increasing both copays and untenable deductibles.
- ★ As a result, prior to the COVID-19 outbreak, states and companies across the country have pursued a wide range of cost control policies directly impacting the ESI market.
- ★ One of the consequences of the COVID-19 pandemic, however, is the tremendous number of people who are losing their jobs, and with that, their employer-sponsored health insurance coverage.

- ★ While COVID-19 has highlighted the potential for disruption that can occur when people lose their job and health care coverage simultaneously, this system has been under stress for many years.
- ★ As we head towards the end of 2020, the implications of the COVID-19 pandemic on the already-stressed ESI system continue to unfold in real time; More than 30 million people in America have lost their jobs and estimates show that between [12 million](#) and [27 million](#) people may have lost their health insurance.

Affordability and Growth Targets

- ★ To mitigate unsustainable costs, some states have taken steps to restrain increases in health care spending across payers and providers by creating cost growth targets.
- ★ Rhode Island leads the way, regulating its state insurance market to increase investment in primary care while keeping private insurance premiums stable. And they have accomplished this with a broad coalition of health care stakeholders.

States and the Private Sector Try Transparency, Negotiation, and Market Forces

- ★ Some states are trying to use their market power as employers to reduce health care costs for public employees and taxpayers; Montana has seen success at reducing costs through negotiation, while Colorado's legislature passed a law leading to greater transparency around the rates insurers negotiate with hospitals.

- ★ Companies with large revenues and big workforces have developed new benefit designs and Centers of Excellence (COE) to keep their employees healthy.
- ★ Executives see these efforts as recruitment and retention tools and important investments to ensure productivity.

States Can Lead the Way, but Federal Action Will be Necessary

- ★ Absent steps to limit costs, challenges facing the ESI market will grow more serious, with ramifications for both the private sector and governments at all levels as well as the nation's workers.
- ★ With jurisdiction over 61 percent of ESI-insured lives, the federal government is an integral part of this conversation.
- ★ Federal legislation and regulation are key components to relieving stress on the current system. Proposals considered in Washington, D.C. include: requiring more transparent hospital rates, ensuring transparent price negotiations between insurers and providers, and prohibiting "spread pricing" by pharmacy benefit managers.
- ★ In response to COVID-19, Congress and the Trump administration required insurance coverage of treatment and testing and gave providers access to funding to pay for care of those without any insurance.

INTRODUCTION

Our national health care debate has traditionally revolved around the status and future of government programs, including the critical importance of Medicare, the urgency of Medicaid, and the individual market of the

ESI provides **178 million people**, including dependents, with health coverage via their workplace.



55.1%
of all health coverage in 2018.

Affordable Care Act's exchanges. But most Americans rely on Employer Sponsored Health Insurance (ESI), which accounts for the single largest share of American health spending at [34 percent](#), or \$1.2 trillion in 2018. This paradigm was under stress before the COVID-19 pandemic hit the United States; unsustainable costs for small and large businesses alike and crippling out-of-pocket expenses for patients have increasingly forced those seeking medical care to ask the question, "can I afford to get care?" rather than, "how do I access the right care for me?" Now, in the midst of a historic pandemic, the deficiencies of this system are laying bare the interconnectivity between our personal access to affordable health care, our financial and job security and each other. More than 30 million people in America have lost their jobs, estimates show that between [12 million](#) and

Between 2008 and 2018, Americans earning just over \$64,000 per year, saw a 47 percent increase in the combined cost of premiums and deductibles.

[27 million](#) people may have lost their health insurance at a time when everyone's health is more connected to our own than ever before. While it is estimated [79 percent](#) of jobless people will be eligible either for Medicaid or tax credits to purchase coverage [on the Affordable Care Act's exchanges](#), the remaining will become uninsured.

A SYSTEM UNDER STRESS BEFORE COVID-19

The employer insurance market, [developed during World War II](#), has been under stress for some time and, even prior to the COVID-19 outbreak, a [growing number of Americans](#) found their employer-based insurance options difficult to afford. In 2018, the number of people with private health plans [fell](#) and per person spending [grew](#) by 6.7 percent, the most of any stream of health coverage. Between 2008 and 2018, middle income Americans, those earning just over \$64,000 per year, saw a [47 percent increase](#) in the combined cost of premiums and deductibles. In fact, a rising number of employers are offering [supplemental insurance](#) just to cover the costs primary ESI does not.

For the first time, the 2019 average annual family premium in the employer market [exceeded](#) \$20,000 and per capita spending on private health insurance has grown [52.6 percent](#) over the past decade, more than twice Medicare's growth and four times the rate for Medicaid. Effects are wide ranging but are acutely felt among low-income individuals. According to the Congressional Budget Office (CBO), only [36 percent](#) of employees with salaries below 150 percent of the Federal Poverty Level (FPL) (\$18,735/year for an individual and \$38,625/year for a family of four) are estimated to have access to employer coverage while [90 percent](#) of those with incomes 400 percent of FPL (\$49,960/year for an individual and \$103,000/year for a family of four) or higher do. Responding to the increasing cost of coverage, employers have shifted more costs to their employees - for example, a general annual deductible has increased by [30 percent over the past decade, while the average deductible itself has doubled during the same time](#). This has led to many employees having coverage they [cannot afford to use](#). While some insurers have voluntarily categorized COVID-19 treatment as pre-deductible, [determining what constitutes](#) this type of service is not well defined and people may still face [significant out-of-pocket costs](#). Even the decision to enroll in an ESI plan offered by an employer is closely connected to income. Of those under 65 years old, 21 percent of those with income below 150 percent of FPL enroll in ESI, while 88 percent of those with income above 400 percent of FPL do. Federal policy in this area is also critical since employers are incentivized to provide ESI via the [single largest tax expenditure](#) worth over \$242 billion in 2019, according to the U.S. Department of the Treasury.



A COMPLEX LEGAL FRAMEWORK MAKES COORDINATED POLICY RESPONSES CHALLENGING

Regulation and potential reform of the ESI market is complicated by the jurisdictional split between the states and the federal government. While some employees receive ESI from health plans regulated by states, [61 percent](#) of American workers receive employer coverage via self-insured plans, where employers assume the financial risk for their employees' health expenses and pay for claims. Under the federal [Employee Retirement Income Security Act \(ERISA\)](#), enacted in 1974, these arrangements are outside the regulatory jurisdiction of states. As a response to escalating costs for both employers and employees, some states and well-known private companies have taken steps to reduce costs in certain areas of the employer market. These state and private initiatives offer roadmaps for federal policies to increase transparency and bring down costs.

As COVID-19 [ravages state revenue collections](#), states will be looking for ways to rein in the cost of not only Medicaid but also public employee benefits. States can look to pre-pandemic examples of efforts made by two states, Rhode Island and Montana, to attempt to reduce overall health care costs for public employees and residents. A third state, North Carolina, also attempted to reduce costs in its public employee health benefits program but the effort was unsuccessful. And Colorado has tried to bring greater transparency to the rates negotiated by private insurers and paid to hospitals.

RHODE ISLAND TAKES ON AFFORDABILITY IN THE COMMERCIAL INSURANCE MARKET

In 2010, the Rhode Island Office of the Health Insurance Commissioner adopted affordability standards for all commercial insurers offering fully insured products (i.e. insurance subject to state insurance regulation in addition to ERISA). The standards include:

- ★ Capping annual price inflation for inpatient and outpatient services at the Medicare price index, plus 1 percent;
- ★ Moving hospital payments to value-based arrangements, including performance-based contracts;



- ★ Increasing the share of spending on primary care by one percentage point per year between 2010 and 2014 and prohibiting consumer premium increases connected to these required investments.

Almost a decade later, Rhode Island has experienced:

- ★ An 8.1 percent per enrollee reduction in quarterly health care costs (equal to \$304 annually per enrollee);
- ★ Stable quality metrics with a significant reduction in low-value care, including decreased use of head imaging for uncomplicated headaches;
- ★ A decline in patient cost sharing, with an overall reduction in spending growth because of lower prices rather than reduced utilization; and
- ★ Evidence that price inflation targets, coupled with investments in primary care, “may effectively leverage state regulatory power to reduce health care costs, particularly in areas where the market power of providers is greater than that of insurers.”

*Source: [Health Care Spending Slowed After Rhode Island Applied Affordability Standards To Commercial Insurers](#) (Health Affairs, February 2019)

Rhode Island is now [further revising](#) their affordability standards to place additional downward pressure on costs. In late 2018, state officials convened a broad cross-section of health care stakeholders including hospitals, providers, and insurers to commit to - and sign - a [Compact to Reduce the Growth in Health Care Costs and State Health Care Spending](#). The Compact commits the state and stakeholders to a target health care inflation rate of 3.2 percent annually, and represents a rare political consensus between providers, insurers and hospitals. A state solution such as this proves progress can be made addressing consumer and employer concerns about cost, quality, and access, and that similar approaches may be possible at the federal level.

THE UNTAPPED NEGOTIATING POWER OF SELF-INSURED EMPLOYERS

Self-insured employers have a significant role to play in bringing down prices and premiums in the ESI market, but have [struggled](#) to use their market power to negotiate better payment rates with providers and stem escalating expenses. The State of Montana is one public employer that has taken matters into its own hands by using market clout to demand - and achieve - real savings.

Big Negotiations in Big Sky

In late 2014, Montana's [two-year outlook](#) for its self-funded health plan, which provides benefits to 30,000 employees and their dependents, was facing a projected [\\$9 million hole](#) in plan reserves; state leaders needed solutions. Charged with finding the answer was Montana's Health Care and Benefits Division Administrator, Marilyn Bartlett, who leveraged the opportunity to use the state's purchasing power to its advantage and negotiate contracts with all of the state's hospitals at a multiple of Medicare; she also wanted to contract with a new pharmacy benefits manager that would provide a transparent pharmacy benefit.

Administrator Bartlett assumed that since she ran a self-insured plan and paid each claim individually, she would have access to the costs of the procedures her plan was paying for. When she got deeper, she found a system paying different prices for the same procedures without regard to the cost, quality, or outcomes offered to her beneficiaries. In response, she negotiated contracts on all hospital services based on a percentage of Medicare in order to provide cost transparency and reduce plan expenses. In the first year, hospitals were paid an average of [23.4 percent of Medicare](#). Though certainly not lacking political friction, the negotiations set the stage for significant taxpayer savings leading to a positive reserve balance of [\\$112 million](#) without reducing benefits for enrollees.

Montana next turned its focus to the prices paid for public employees' prescription medication. The state of Ohio had recently announced it had overpaid [\\$208 million](#) annually for the drugs in its Medicaid program by allowing its pharmacy benefit manager (PBM) to keep the difference between the prices paid by the health plan and the amount remitted to the pharmacy. Even though Ohio focused on Medicaid, Bartlett knew Montana's employees would also benefit from eliminating this practice. Known as "the spread," this cost is often built into the fine print of contracts employers sign with PBMs. PBMs also keep additional rebates paid to them by drug manufacturers. Bartlett cancelled the deal with the state's PBM, replacing it with one that would commit to not taking any spread and would return all rebates received from drug manufacturers. In 2017, the state saved \$7.4 million by eliminating the spread, receiving 100 percent of the rebates, and implementing a retiree drug benefit similar to a Medicare Part D plan.

Trying in the Tar Heel State

In late 2018, North Carolina Treasurer Dale Folwell [proposed](#) a new provider reimbursement plan for the state's 720,000 public employees and their dependents. The Treasurer proposed paying the state's hospitals about 200 percent of Medicare rates and bringing new transparency to the costs incurred by state taxpayers when medical services are rendered. Like Montana, the Treasurer believed the people of the state should know the price and value of the medical costs they pay; ideally, standardization and payment system transparency would contribute to bringing down overall health costs. While opposition to Montana's proposal had been strong, it did not prove fatal as it did in North Carolina, a much bigger state covering over 20 times the number of people. Unfortunately, after several months and significant political opposition, Folwell's plan was put on hold.

Colorado is part of a small but growing consensus that it is necessary not only to review insurance premiums...but also to ensure the insurer-negotiated rates with hospitals are affordable for consumers.

Bringing Clarity in Colorado

In the spring of 2019, Colorado enacted a bipartisan [bill](#) forming a [Primary Care Payment Reform Collaborative](#) to recommend targets for investments in primary care and giving their insurance commissioner authority to draft regulations related to the creation of an [affordability standard](#), both of which align with Rhode Island's approach. In December 2019, Insurance Commissioner Michael Conway [announced](#) he would release a rule related to the affordability standard requiring insurance companies to list their negotiated prices with hospitals as a percentage of what Medicare would pay for the same service. If the subsequent rates charged to consumers are deemed unaffordable, the insurance commissioner would have the authority to reject the plans from being offered to consumers. Like traditional health insurance premium rate review, Commissioner Conway said his goal is to "give the market more tools in order to more directly impact what they're being charged..."

This has been one of the first state-level efforts to bring transparency to the negotiations between insurance companies and hospitals. As a result, Colorado is part of a small but growing consensus that it is necessary not only to review insurance premiums, a long-established oversight practice, but also to ensure the insurer-negotiated rates with hospitals are affordable for consumers. While this effort has been put on [hold](#) during COVID-19, it is a hopeful development to strengthen what we know about how hospitals are reimbursed by private insurance companies and the extent to which this is an equal or unequal negotiating power dynamic.

INNOVATION AND MARKET CLOUT BY THE BIGGEST EMPLOYERS

Public employers are not the only organizations leveraging their negotiating power. Large employers are also taking matters into their own hands. While

SAVINGS RESULTS OUT OF MONTANA

- ★ In 2017, Montana saved \$7.4 million by eliminating the PBM spread and receiving 100 percent of the rebates.
- ★ Taxpayer savings leading to a positive reserve balance of \$112 million without reducing benefits for enrollees.

[Haven](#) (the partnership created by Amazon, Berkshire Hathaway and JPMorgan Chase to create better outcomes and lower costs in the ESI market, particularly for their employees) is known to many, other companies have also been experimenting with new health care models for their workforces.

Boeing & Cisco Experiment with Direct Contracting

Boeing, the aerospace giant and America's largest exporter, has over [130,000 employees](#) in all 50 states, which uniquely positions the company to demand lower prices and innovative arrangements for the health care of its workers. In 2015, Boeing began contracting directly with integrated health systems to provide care to its employees. Today, [15,000](#) Boeing employees utilize care through these arrangements. By eliminating the insurance middleman, Boeing is seeking improved quality, better coordination between primary care and behavioral health specialists, and lower costs. Like Medicare Advantage, providers are asked to take on greater accountability for the total cost of care; if the health systems do well, they share in the savings. Though the results of Boeing's arrangement are not yet available, it has the potential to save significant dollars.

Cisco has seen 10 percent lower costs for participants as compared to standard coverage.

Driven by the same goals, Cisco Systems has [contracted](#) with Stanford Health Medical System to provide not only health services to its employees but will also hold Stanford accountable for good results. Physicians will track a dozen health indicators to keep employees well. Provider's quality of care - from the clinical care provided to bedside manner - is evaluated by the employees. High-quality care and satisfactory experiences will result in bonuses to Stanford Health. To further coordinate care, Cisco embedded a general physician inside its headquarters. So far, the company has seen [10 percent lower costs](#) for participants in these efforts as compared to standard coverage.

Walmart Innovates, Keeps Employees Healthier, and Saves Millions of Dollars

1.5 million Americans [earn their living](#) at Walmart, affording the company incredible negotiating power with health care providers. Frustrated with rising costs and approaching the limits of their employees' ability to shoulder additional premium or deductible increases, Walmart started a [Centers of Excellence \(COE\)](#) program in 2013. Like Montana, Walmart is a self-insured employer and grew tired of having little visibility into what they paid for their employee's health care. For businesses, [wide price variation](#) and limited transparency make it difficult to budget for employee health care expenses.

For businesses, wide price variation and limited transparency make it difficult to budget for employee health care expenses.

In 2013, Walmart began their COE program focusing on common and expensive procedures with considerable variations in costs and outcomes. Heart and [spine](#) surgeries and hip and knee replacements met this criteria, with spine procedures being associated with the additional complexity of often being unnecessary. As profiled in the [Harvard Business Review](#), the bundled payments of Walmart's COEs "[turn] out to be a good indicator of the capabilities and character of a hospital and its providers; it shows that a provider is motivated and

RESULTS OF WALMART'S CENTERS OF EXCELLENCE



SPINE SURGERY

14% less hospital time

95% lower readmission than those who did not use a COE provider

.6% patients went to a skilled nursing facility compared to 4.9 percent of non-COE patients

JOINT REPLACEMENT SURGERY

32% less hospital time

70% less likely to be readmitted

0% need for a skilled nursing facility compared to 5 percent of non-COE patients

15% less overall cost than non-COE patients

*Source: [How Employers are Fixing Health Care](#)

able to integrate the work of a diverse clinical team around a patient's needs, align incentives to improve value, and track outcomes to inform continued improvement." Walmart requires substantial accountability for the providers who they contract with - if a patient has complications and must return to their provider within 30 days, the providers do not receive additional compensation for that care.

For more information on employer innovations in health benefits and explanations of the tools employers are using to manage their employee health benefit spend, [click here](#).

THE FEDERAL DEBATE BEFORE AND AFTER COVID-19

The federal government plays a critical role in the regulation and potential reform of the ESI market. Because of Congress's jurisdiction over ERISA, Washington has vast policy-making powers to increase transparency, limit bad practices driving up costs, and reorder market forces to operate more efficiently. States can only do so much, as they do not have jurisdiction over vast swaths of the ESI market; Washington must be involved.

Washington has vast policy making powers to increase transparency, limit bad practices driving up costs, and reorder market forces to operate more efficiently.

Prior to COVID-19, Congress engaged in a months-long debate regarding several proposals to eliminate surprise medical bills, a portion of which are generated from self-insured plans and governed by ERISA. But Congressional work extended beyond bad consumer billing practices and included several strong measures via the Senate HELP Committee. Title III of the [Lower Health Care Costs Act](#), sponsored by Senators Lamar Alexander (R-TN), Patty Murray (D-WA), and Joni Ernst (R-IA), is focused on "Improving Transparency in Health Care." Title III would remove gag clauses on price and quality data, allowing insurers and self-insured employers to see price and quality information (such as the data Montana demanded) and improving their leverage for negotiation. The HELP legislation also limits pharmacy benefit managers' ability to engage in spread pricing.

In late fall 2019, the Department of Health and Human Services (HHS) and Centers for Medicare and Medicaid Services (CMS) released [final and proposed rules](#) which would take significant steps forward on price transparency for hospitals, physicians and insurers. Both efforts aim to incentivize and ease informed consumer decision-making by improving the tools necessary to shop for health care services. The rules could also make it easier for self-insured employers to know what other, similar employers are paying when their employees receive health care services in the same market, offering further tools to employers to negotiate rates and increase competition.

The final rule requires, by January 2021, for hospitals to:

- ★ Make all standard charges public in a machine-readable online format;
- ★ Disclose consumer out-of-pocket costs before providing service, and;
- ★ Make available to consumers, researchers, employers and third-party developers the in-network negotiated rates with their network providers and historical payments of allowed amounts to out-of-network providers.

The reaction to these regulatory proposals has been [mixed](#), with some national employer groups split on the issue. The regulations are also being [litigated](#) by hospital groups which [argued](#) in court in early May that the HHS regulation exceeds the department's authority and violates the First Amendment by requiring hospitals to publicly post what they see as confidential information.

CONGRESS AND ESI DURING THE TIME OF COVID-19

To combat the pandemic, Congress has acted as it has during past crises by passing what are ostensibly emergency patches to the gaps in our employer-based system. These include [time limited](#) insurance enhancements to protect individuals and each other, more permanent insurance mandates requiring coverage for COVID-19 testing, coverage for a vaccine when available and a [provider relief fund](#) to help pay for COVID-19 treatment when patients are uninsured. For people with high deductible health plans, telehealth services must also be covered pre-deductible.

In a paradigm in which access to health care is essential not just to individuals but to each of us, relying on structures which tie financial protection from unanticipated health care costs to employment puts individuals, businesses and our society at risk.

The House of Representatives has passed legislation to allow [individuals eligible](#) for Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage to maintain their employer-sponsored coverage after a layoff, reduction in hours or furlough without having to pay premiums through January 2021. This provision would go further than one [enacted](#) during the 2008 financial crisis which subsidized up to 65 percent of COBRA coverage for unemployed people. While it is critical to ensure continuity of coverage in an unprecedented crisis, these are short-term patches on a system under stress that is being asked to do more than it ever has before.

An Alternative View Beyond Cost and Towards Negotiation Clout

Sabrina Corlette of the [Georgetown Center on Health Insurance Reforms](#) in a Health Affairs article entitled, [I've Been Calling For Greater Private Insurance Coverage Of COVID-19 Testing. I've Been Wrong](#), argues we need a federal "testing and vaccination fund" to adequately reimburse providers for testing services based on Medicare rates and financed by an assessment on insurers, employers and taxpayers. Much like the negotiation power utilized by Marilyn Bartlett, Corlette says a single entity pushing towards a fair price for all Americans to pay for an eventual vaccine rather than multiple payers doing so will save not only money but will ensure as many people as possible receive the vaccine regardless of ability to pay in order to protect us all.



LESSONS FOR THE FUTURE FROM STATES AND EMPLOYERS

Rhode Island placed controls on the payments insurers would make to providers, targeting overpayment at hospitals and increasing spending on primary care. The [Compact](#) agreed to by the state's various health care players shows when all stakeholders and their various competing constituencies are brought to the table from the outset, compromise is possible. Montana used their negotiating power to reduce costs, though North Carolina's pursuit of a similar approach highlighted the obstacles ahead for the states that follow in their footsteps. Colorado is actively pushing to ensure rates negotiated between insurers and hospitals are affordable and transparent. And Boeing, Cisco, and Walmart are creating new models of care delivery - including contracting with providers directly and building internal quality review mechanisms - to improve outcomes and reduce costs.

The Challenges Ahead

By focusing only on existing government programs, our national health care debate too often ignores the way most Americans access our health system. Through an anomaly of World War II, our employer-based health insurance system is fundamental to both our economy and the way we pay for and access health care when we need it. This intersection of economics, health care, and employment make it politically challenging for elected or appointed government officials to propose, let alone implement, big changes to these existing arrangements.

In addition to cost pressures, the COVID-19 pandemic has exposed and exacerbated underlying structural challenges associated with the connection of jobs and health coverage. In a paradigm in which access to health care is essential not just to individuals but to each of us, relying on structures which tie financial protection from unanticipated health care costs to employment puts individuals, businesses and our society at risk. That is why employers are a key component of how we will bridge the distance between

employment, economic downturns and pandemic response. One Dallas-based [small business](#) owner [praises](#) the COVID-19 related price transparency required by recovery legislation but calls for it to be extended more broadly to insert more predictability into the budgets of these organizations.

The tax expenditure incentivizing ESI and access to health care being linked to employment should be more prominent in our national health care conversation; the convergence both of a deadly pandemic and historically high unemployment has pushed that debate forward. Elected and appointed officials as well as thought leaders across the ideological spectrum need to develop proposals which take into consideration the totality of our health care system as it is, including the ESI market, regardless of its historic oddity. Any plans to improve health care access and affordability need to consider the millions of people whose health care coverage remains linked to their job but for whom, even with coverage, find it difficult to afford and employers find challenging to provide. That is why the fierce political

battles over transparency and negotiation fought in Montana and North Carolina may be harbingers of what is coming in the broader ESI market, even if it is often overlooked in our national health care discourse.

The tax expenditure incentivizing ESI and access to health care being linked to employment should be more prominent in our national health care conversation; the convergence both of a deadly pandemic and historically high unemployment has pushed that debate forward.

We would like to thank and acknowledge those who reviewed this brief and offered their feedback and expertise. We appreciate and are thankful for the assistance of:

Marilyn Bartlett, CPA, CMA, CFM
Paul Fronstin, PhD

Bill Kramer, MBA
Megan McCarthy-Alfano

Joshua Sharfstein, MD
Janet Weiner, PhD/MPH

