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Changing Attitudes Among Large Employers Towards Health Care Delivery: A 2017 Snapshot

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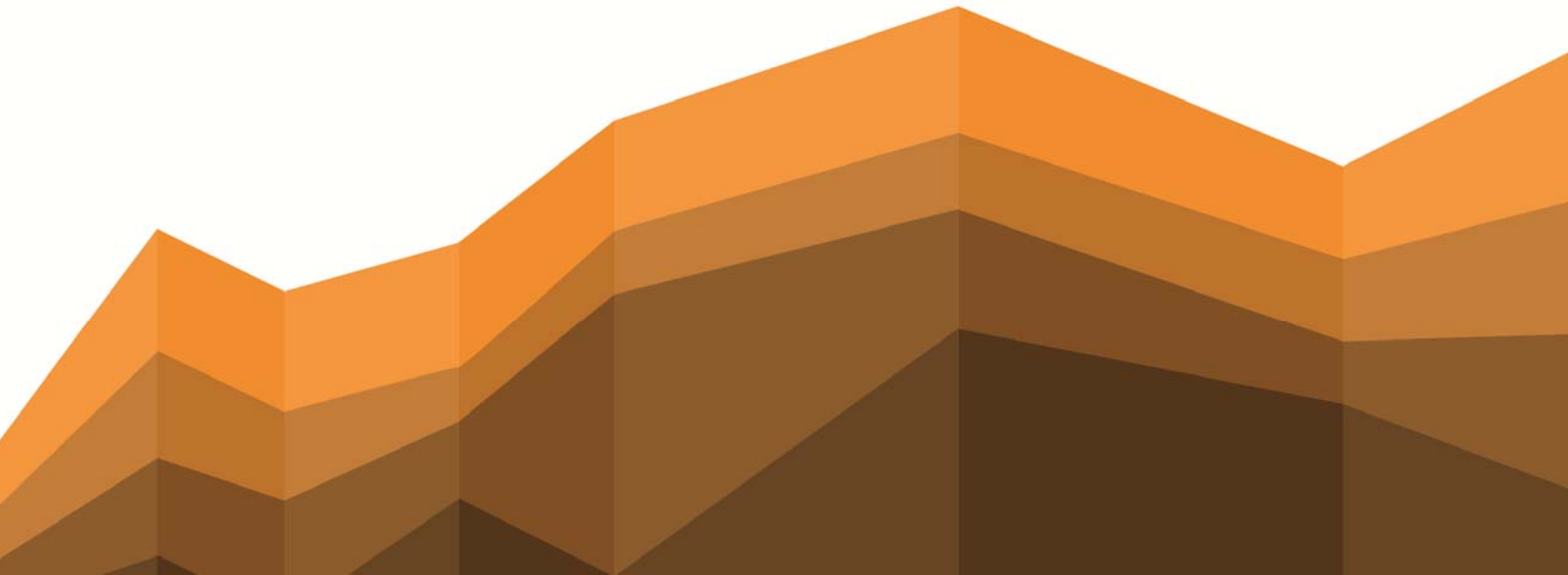

American Health Policy Institute (AHPI) is a non-partisan 501(c)(3) think tank, established to examine the impact of health policy on large employers, and to explore and propose policies that will help bolster the ability of large employers to provide quality, affordable health care to employees and their dependents. The Affordable Care Act has catalyzed a national debate about the future of health care in the United States, and AHPI serves to provide thought leadership grounded in the practical experience of America's largest employers. To learn more, visit americanhealthpolicy.org.

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Executive Summary

In February of 2017, as Congress began discussions of changes in health policy, HR Policy Association surveyed its nearly 400 members and then discussed the results of that survey at its March 2017 CHRO Summit. This paper compiles the results of that survey and the discussions that followed. It deserves careful consideration by policymakers. The members of HR Policy Association are Chief Human Resource Officers (CHROs) of large employers who provide health benefits to more than 9 percent of the private sector workforce in the United States and to over 20 million Americans. In 2015, large employers accounted for more than $395 billion in health care expenditures and provided coverage to 97.6 million Americans.[1]

For more than six decades, employer-provided care has been the backbone of the American health care system with employers providing its sustainability. Today, private sector employers spend more than $486.2 billion annually providing health care to employees, the dependents of their employees, and retirees.[2] They see healthy employees as essential to a productive and competitive workforce. In addition, most employers consider quality care as a key element of employee compensation packages as well as a tool to attract and retain a talented workforce. Employees, in turn, value the coverage they receive through their employer. Health insurance has been shown to be the benefit that employees value the most.[3] According to a study by the Employee Benefit Research Institute, one-half of those with employment-based health insurance coverage are extremely or very satisfied with their current plans, and 41 percent are somewhat satisfied.[4] Very few are dissatisfied.

At the time of this writing, the U.S. Congress and the newly elected Trump administration are seeking to make significant changes in health care policy through amendments to both the Affordable Care Act and the tax code. This is of great importance to CHROs because, as discussed in detail in a previous study published by the American Health Policy Institute, "The Cost of the Affordable Care Act to Large Employers," the passage of the ACA imposed new and additional costs on employers who offer health care to employees, and health care costs continue to rise on average 3.8 percent annually.[5]

This paper consists of three parts. It first discusses health care as a business challenge for larger employers. It then discusses the new directions in health care being considered by these employers, most of whom are self-insured. Third, the paper discusses the debate over changes in the Affordable Care Act and the reaction to it by CHROs.

The survey illustrates three longstanding concerns of large employers which have been intensified by the ACA debate, namely:

- The discussions of shifting greater regulatory power to the states at the expense of employers being able to operate uniform national plans across state lines, a change that has the potential of turning health care administration for multi-state employers into a nightmare;
- The lack of strong tools in regulatory policy providing purchasers and consumers of health care with the information they need to evaluate the quality, cost and effectiveness of the services being provided; and

- The attempts being made to limit the ability of employers to deduct the cost of providing health care benefits, a tax policy change that would substantially disrupt the system of health care utilized by over 170 million Americans.

However, there are new trends within the thinking of large employer CHROs which the 2017 survey unearthed, something not seen before to any great extent. First, large employers, companies who have been traditionally self-insured for decades, are now indicating strong interest in the individual market. If the individual market were to no longer have negative tax consequences, many employers have indicated that they would consider vouchering their employees into it. As Congress struggles with the ACA, trying to figure out how to deal with the risk pools in the ACA exchanges that are older and sicker than the population generally, it might want to look closely at this trend and consider changing tax policy to create a robust marketplace for the individual insurance.

Second, large employers historically have insisted on having strong control over the design of their health care plans to fit their needs. With current trends making it increasingly difficult for individual employers to have any influence over the vast health care marketplace, many large employers would like to consider for their active employees the kinds of simplified, limited option benefit plans common in the post-65 health care marketplace. They see greater standardization as having the potential to provide greater efficiencies in health care delivery and introduce more competition into the marketplace. Again, as Congress explores new directions in health care policy, this interest in simplified benefit plans deserves consideration by policymakers. And it also deserves consideration by those providing health care services to employers, namely carriers who serve as third party administrators, providers, PBMs and health care consultants.

Health Care as a Business Challenge for Self-Insured Employers

The cost of employer-provided care and the potential future directions of those costs remain one of the issues of greatest concern to the Chief Human Resource Officers of large companies. CHROs shoulder lead responsibility for health care policy and practice for their companies, and health plan strategies are among their higher priorities with health care as a top issue for most companies.

Chart 1: Since the ACA's passage, health care for our employees and their dependents has been among the top three business challenges our company has faced.

5%	Agree
58%	**A top issue, but not one of the top three**
35%	Disagree
2%	Neither agree nor disagree/not sure/no opinion

Of the several business challenges to CHROs with respect to heath care policy and practice, there are two that are particularly noteworthy—flexibility and transparency.

Flexibility

With health care costs constantly rising and CHROs being accountable for dealing with that rise, HR leaders have for years said that a key policy objective should be ensuring that they have the flexibility to design and adopt health care programs that best fit changing economic, regulatory and workplace realities. They believe they should be free from financial, regulatory or administrative incentives and disincentives that favor one type of health care approach over another.

Chart 2: Employers should have the flexibility to design healthcare programs that ensure a healthy workforce and enable access to affordable healthcare coverage in the way that best fits their business goals, company culture and talent needs. In determining the approach best suited to their needs, companies should be free from material financial, regulatory or administrative incentives or disincentives that favor one type of healthcare approach over another.

79%	**Agree**
2%	Disagree
16%	Neither agree nor disagree/not sure/no opinion
3%	Other

As part of this desire for flexibility, the overwhelming majority prefers a legal framework that supports the development of alternative approaches to employer funded and employer facilitated arrangements.

Chart 3: Policy makers should create a clear legal framework supporting the development of alternative approaches to employer funded and employer-facilitated arrangements.

84%	**Agree**
2%	Disagree
14%	Neither agree nor disagree/not sure/no opinion

Unfortunately, the passage of the ACA and the current regulatory structure that followed moved federal policy in the opposite direction. A major concern of employers, therefore, is whether Congress will continue that trend with the next iteration of the law, placing even more restrictions on employer efforts to cover their employees.

For example, there is considerable discussion at this time of shifting more responsibility for health care policy from the federal government to the states. Most large employers operate on a multi-state basis, and governors and state regulatory bodies in both blue and red states are proposing more localized control over employer health care programs. This creates a scenario in which large employers may have to abide by 50 different sets of regulatory requirements instead of utilizing the uniform benefit plans permitted by the Employment Retirement Income and Security Act (ERISA).

Chart 4: As Congress and the administration consider changes to the ACA, we need to get a sense of the issues of most concern to you. In the list below, please select the five issues of most concern.	
70%	Erosion or elimination of the tax-preferred treatment of health care
58%	Limitations one employer flexibly to design cost effective heath care
57%	Cost of prescription drugs
57%	Full repeal of the Excise (Cadillac) tax
49%	Congress enacting laws eroding the ability of multi-state employers to offer uniform benefit packages across the U.S.
43%	Lack of a clear path towards an efficient, affordable system of ensuring health care coverage for employees
39%	Lack of adequate mechanisms to force transparency

Transparency

After the restrictions on flexibility comes lack of transparency as a major employer concern. With only three percent of respondents disagreeing, 92 percent said that complete and transparent access to health care cost and quality data should be mandated so that a more competitive marketplace can be achieved. And 94 percent said that purchasers of health care, both corporate benefit managers and consumers, need greater insights into the relative cost and quality of the services and products available to them through the health care supply chain.

Chart 5: Mandate complete and transparent access to health care cost and quality data to create a competitive marketplace.	
92%	**Agree**
3%	Disagree
5%	Neither agree nor disagree/not sure/no opinion

Chart 6: Purchasers of health care, both corporate benefit managers and consumers, need greater insights into the relative cost and quality of services and products available to them through the health care supply chain.	
94%	**Agree**
5%	Satisfied with current levels of transparency
1%	Neither agree nor disagree/not sure/no opinion

These numbers, which indicate nearly uniform agreement among HR Policy members, are particularly noteworthy when it is remembered that 15 to 20 percent of all HR Policy members derive most or all their revenue from providing health care products and services.

Within the transparency discussion is the question of who should own and control the health care data generated by employers as they purchase and utilize health care products and services. Should the employers paying for the services own and control it, or should that control be exclusively in the hands of carriers, providers, PBMs and consultants? Here again, the strong majority is in favor of control being in the hands of the purchasers, not exclusively in the hands of the sellers.

Chart 7: Assuming all applicable patient confidentiality requirements are met, self-insured employers should have ownership and full access to their medical claims, administrative data, and other health data held by carriers, providers, PBMs, and consultants.	
71%	**Agree**
21%	Satisfied with current levels of transparency
8%	Neither agree nor disagree/not sure/no opinion

However, despite all the calls for greater transparency over the past 15 years, the trend has been in the opposite direction. Most contracts between employers and the providers of health care services have strict gag clauses limiting their ability to benchmark. These clauses are so restrictively written, in fact, that in most large employer health care services contracts, it is a violation to disclose even the language of the gag clause. In other words, the gag clauses have gag clauses. As a result, it is extremely difficult for employers to have an objective way of determining whether or not they are getting the best deal. This, in turn, raises questions regarding whether employers can adequately perform their fiduciary duties under ERISA if they are simply presented with an invoice with little ability to assess its merits. That may explain why when asked to list the issues of greatest concern as Congress and the administration consider changes to the ACA, one was the "lack of adequate mechanisms to force transparency." (See Chart 4.)

But what if employers were able to achieve the desired level of transparency. Would there be a material impact on their ability to control health care costs? Note that the level of transparency desired is not only having better information, but also being able to access it easily when making health care decisions. While 90 percent of respondents agreed that having such access would have an impact, only 31 percent were in full agreement that it would have a material impact on their costs while 59 percent agreed that it would constitute only an impact to some extent.

Chart 8: Our company believes that our employees and their dependents already possess sufficient information to ascertain the cost and quality of the healthcare they consume.	
17%	Agree
75%	**Disagree**
8%	Neither agree nor disagree/not sure/no opinion

Chart 9: If my company's employees had better information and a way that it could be easily accessed when making health care decisions, we believe it would have a material impact on health care costs.	
31%	Agree
59%	**Agree to some extent**
7%	Even if employees had good information and access, it would not have a material impact
1%	Disagree
3%	Neither agree nor disagree/not sure/no opinion

It seems, therefore, that employers believe that they aren't being given the information by the health care supply chain that they should be given regarding the underlying transactions making up their health care expenditures and the effectiveness of those expenditures. At the same time, they believe that even if they were given that information, their ability to use it effectively is limited. That may be why there is such strong interest in looking at alternative methods of delivering care, which brings us to the survey results discussed in the next section.

Alternative Directions in Health Care Sought by Large Employers

Congress is now struggling with how to change the Affordable Care Act to stabilize premiums and make the individual market more attractive to carriers and consumers. One of the reasons the ACA market is so challenged is that carriers offering health plans on the exchanges have found that those in the pool purchasing such care tend to be older and heavier users of health care than the general population.

For that reason, there has been discussion regarding how those pools could be broadened to attract younger, healthier people without having to impose unpopular mandates. It is worth noting that such people are already in the pools of employer self-insured plans and that employers who operate such plans have an excellent track record of getting people covered. At the same time, there appears to be a strong interest among employers in shifting employees from self-insured plans into the individual market. At this time, policymakers do not appear to be tying these two factors together as they explore changes in the Affordable Care Act.

Large Employers and the Individual Market

To illustrate the strong interest among large employers in alternatives beyond the self-insured market place, three data points deserve attention.

First, under current tax policy, there is the individual health care market and the group market, each of which is treated differently for tax purposes such that the benefits of the group market outweigh the benefits of the individual market. Self-insured employers are typically in the group market. Employers in that market can deduct the cost of providing health care to employees and their dependents as well as to retirees. Those receiving such care can do so without the contributions being treated as compensation and therefore taxable as income.

In contrast, those purchasing healthcare in the individual market outside the employment context do not have these same advantages. They pay the premiums without the ability to deduct the cost of those premiums.

It is interesting to note, therefore, that when the self-insured employers who make up HR Policy Association were asked whether tax policy should be changed so that there would be no differentiation between the individual and group markets, 85 percent agreed that tax policy should be changed to eliminate individual market disincentives. Only 2 percent disagreed. Why is there such overwhelming support for this change?

Chart 10: Preserve, extend, and equalize the tax-preferred status of all expenditures used for the purchase of health care coverage such that there is no differentiation between individual and group markets.	
85%	**Agree**
2%	Disagree
14%	Neither agree nor disagree/not sure/no opinion

Second, when asked whether policymakers should encourage and facilitate the development of a robust and competitive market for individual health care coverage, 91 percent responded in the affirmative. Again, why?

Chart 11: Encourage and facilitate the development of a robust and competitive market for individual health care coverage.	
91%	**Agree**
1%	Disagree
8%	Neither agree nor disagree/not sure/no opinion

Third, when asked if there were no difference in public policy between the cost of providing care through the company's self-insured plan and vouchering employees into the individual market, 48 percent—a plurality—responded that they would be interested in vouchering some or all their employees into the individual market.

Chart 12: If there were no difference between the cost of providing care through your company's self-insured plan and vouchering employees into the individual market, would you be interested in considering vouchering some or all of your employees into the individual market?	
48%	**Agree**
30%	No
23%	Not sure/no opinion

Further, a question was asked regarding the ACA exchange systems and health care funded by large employers. Asked what the reaction would be if Congress were to continue the ACA exchange system with lower income individuals receiving subsidized care on the exchanges and all penalties were removed such that employers could voucher some or all employees into the exchanges, would large employers be interested in considering such an option? Here, 53 percent said yes.

Chart 13: If Congress continues the ACA exchange system in which lower income people receive subsidized care on the exchanges, and if all penalties were removed such that you could voucher some or all of your employees into the exchanges, would you be interested in considering such an option?

53%	**Yes**
24%	No
24%	Not sure/no opinion

Now, in looking at all the questions regarding moving health care delivery beyond the traditional self-insured system, there appears to be as many as 30 percent of employers who say they would not be willing to do so. But that appears to be the ceiling. That means the strong majority of employers appears to be open to moving in new directions, and one that appears to be particularly attractive is shifting health care to the individual market.

The typical response by those resistant to the idea of employers being able to utilize the individual market and ACA exchanges has been to say that employers will simply voucher their sickest people into the exchanges. What is the evidence for this assertion? A more productive response would be to ask—what if employers were to put all their employees in the individual market? Would that have a positive impact on health care policy?

In determining why there is such strong interest in the individual market among large employers, there are several factors deserving further analysis and discussion. For example, one characteristic of the individual market is that employers lose all control over plan design other than selecting an off-the shelf program that best fits their needs. Doesn't this willingness to accept a loss of control run counter to the desire for flexibility? Perhaps the flexibility large employers are looking for is the ability to shift from the self-insured to the individual market without either them or their employees suffering tax consequences. Further, why would employers being willing to give up that control? Is it because some feel they no longer have adequate resources or expertise, or both, to manage a complex health care benefit program? That doing so is beyond the company's core competency? Do some large employers view the significant consolidation in the health care supply chain as limiting their ability to control their health care destiny? Do they see a robust individual market as perhaps creating more competition? These are all questions deserving further discussion and consideration.

Simplified Benefit Plans

Connected with employer interest in the individual market is another trend revealed by the survey that deserves more study.

Over the years, companies have often said that maintaining control over their company's plan design was a way to ensure maintenance of the company's culture of care. Part of that culture is designing specific programs within the company's overall plan that meet specific employee needs and corporate objectives. The result is that, particularly for larger employers, each health program tends to be a one-off. Administrators must work with providers, PBMs and others to produce a unique structure to operationalize the one-off program. As can be expected, there is a cost for this customization. At the same time, administrators, providers and PBMs have said that customization to address company-specific needs overlooks an important fact. Specific needs found within a company aren't necessarily confined to just that company; rather, they often span the population. Care coordination, they would argue, should be community based, not company based. This means that if addressing specific needs could be aggregated across companies in a standardized way, then it may be possible to put more efficient and effective disease management programs into place. And who is in the best position to design specific disease management programs across the population? The company or the medical community?

For the above reasons, the response to one question in the survey is particularly fascinating and deserves considerable additional study. The survey asked how important it is for the organization to be able to control the plan design. It asked that question because of the experience of many companies who have moved their retirees into post-65 exchanges utilizing individual insurance policies. That environment has become stable and efficient from an administrative standpoint because of the limitation on plan designs imposed by the federal government. Medicare contracts with insurers to offer HMOs, Local PPOs, Regional PPOs, and PFFS, and creates strict standards for how such programs will be constructed.[6] Thus, there are only so many types of plans permitted, which means carriers must compete using a narrow range of options. Employers speak favorably regarding that development even though in the post-65 market, the ability of a company to do customization is limited.

In view of that favorable post-65 experience, the survey asked about a similar type of system for active employees, one that established that same kinds of standardized environments forcing carriers to compete using simplified plan designs potentially covering millions of employees. Would employers be interested in a simplified benefit plan option? Sixty four percent said yes. Only 13 percent of the respondents said no.

Chart 14: We are interested in learning how important it is for your organization to be able to control the plan design (*e.g.*, copays, deductibles, out-of-pocket limitations). We hear from member companies that they feel comfortable moving retirees into post-65 retiree exchanges because that environment has become stable and efficient from an administrative standpoint because of the limitations on plan designs. The federal government mandates specific plan designs in order to make healthcare shopping easier. If there were a similar system for active employees that established that same type of standardized environments, enabling carriers to offer cost-effective simplified plan designs potentially covering millions of employees, would you be interested in considering such an option?

64%	**Yes**
13%	No
24%	Not sure/no opinion

The survey also included a question on targeted disease management programs. We pointed out that health care experts said that if certain high cost health care claimants can be grouped in a targeted disease management program, the cost of their care can be substantially reduced. We asked that if tax and regulatory policy enabled a company to shift certain chronically ill employees out of your self-insured health plan into appropriate disease management programs funded by premiums without penalty, would it be interested in considering such an option? Sixty-one percent of the membership said yes, and only 13 percent said no.

Chart 15: Health care experts say that if certain high cost health care claimants can be grouped in a targeted disease management program, the cost of their care can be substantially reduced. If tax and regulatory policy enabled you to shift certain chronically ill employees out of your self-insured health plan into appropriate disease management programs funded by premiums without penalty, would you be interested in considering such an option?

61%	**Yes**
13%	No
26%	Not sure/no opinion

Having surveyed the HR Policy membership in depth on health care for nearly 20 years, this year's responses indicate a continuing strong interest in alternative health care delivery methods but with a greater openness to new ideas. Most HR Policy members have adopted high deductible consumer directed health care plans. Most have looked at private exchanges and found them wanting. At the time of this writing, there does not appear to be a fully evolved breakthrough program on the table. Therefore, we believe this interest in simplified benefit plans deserves much more study in the coming months to determine its potential for large employers.

A key component of that study should involve carriers, providers, and PBMs to determine their level of interest in collaborating with employers to develop simplified benefit plans. It is axiomatic that with standardization comes greater efficiencies, and these efficiencies could lower the cost of health care and increase its effectiveness.

Drug Costs and Pharmaceutical Purchasing

When asked about the issues of greatest concern as amendments to the ACA were being considered, the cost of prescription drugs ranked the third highest. (See Chart 4.) We then followed with a question regarding how satisfied the company was with the PBM purchasing coalition it utilizes for procuring prescription drugs.

Only six percent said they were very satisfied and 46 percent said they were at least on the somewhat satisfied, meaning over half were on the somewhat satisfied side of the ledger. Eleven percent said they were dissatisfied. Thirty-six percent said that they did not participate in a purchasing coalition.

Chart 16: How satisfied are you with existing PBM purchasing coalitions that consultants sponsor?	
46%	**Somewhat satisfied**
36%	Our company does not participate in a PBM purchasing coalition
11%	Dissatisfied with current PBM purchasing coalition arrangements
6%	Very satisfied

Putting all this together would indicate that employers believe PBM coalitions as currently constituted may not be as effective as employers would like them to be in controlling the costs of prescription drugs and that employers, even when acting in concert with one another, have limited ability to control costs. One would think, therefore, that there would be a stronger correlation between concern over drug costs and the method being utilized to procure them.

CHROs and Reform of the Affordable Care Act

With Republicans now occupying the White House and holding the majority in the House and Senate, the interest in repealing and replacing the ACA is at the top of the party's political agenda. It is certainly the case that the ACA as currently written is not without its problems. However, the highly partisan political environment in which the federal government operates today makes reasoned policy making difficult. Large employers responsible for hundreds of billions in health care expenditures along with the health and well-being of their employees, therefore, are trying to figure out the best way to navigate this situation.

The Debate Over Repeal and Replace

Ever since passage of the Affordable Care Act, the Republican Party has campaigned on a platform of repealing and replacing the Affordable Care Act. In addition, some are simply calling for the repeal of the Act without a replacement. However, less than 10 percent of large employers believe that the ACA should be repealed and not replaced. The overwhelming majority believes the law should be changed to provide a more stable platform for covering the uninsured and the underinsured.

Chart 17: The ACA should be repealed and not replaced.	
9%	Agree
80%	**Disagree**
11%	Neither agree nor disagree/not sure/no opinion

Chart 18: The ACA should be changed to provide a more stable platform for covering the uninsured and the underinsured.	
87%	**Agree**
5%	Disagree
8%	Neither agree nor disagree/not sure/no opinion

There is also strong support for providing transitional relief as changes are made in the current ACA exchange system. When asked if Congress should move quickly to stabilize the marketplace and give carriers time to design and price their exchange offerings for 2018 while ACA replacement plans were developed, only nine percent of the respondents expressed opposition.

Chart 19: Enact quickly a package of ACA reforms that would stabilize the marketplace and give carriers time to design and price their ACA exchange offerings for 2018 while Republicans develop a plan to repair the ACA	
76%	**Support**
9%	Oppose
15%	Neither support nor oppose/no opinion

The Cost of Subsidized Care Under the ACA

Passage of the Affordable Care Act has resulted in health care coverage being extended to an additional 12 to 20 million people depending on how that figure is calculated. This means that any change in the ACA will likely need to keep this coverage in place; once people have a federal benefit or at least the promise of one, they tend to be highly resistant to it being taken away. Therefore, one of the key issues in the discussion of ACA reform is how will the coverage continuation for these 20 million persons be financed. Yet, while most people believe the uninsured need affordable coverage or access to affordable coverage, there is a significant debate over who should be required to pay the cost of that coverage.

For large self-insured employers, health care purchased by employers and employees includes a hidden "tax" for the uncompensated care or partially compensated care provided the uninsured, underinsured, and recipients of Medicare, Medicaid and other government health care programs. This "tax" is commonly referred to as "cost-shifting" or "cross-subsidization." While research on the existence of cost-shifting is mixed, the CBO concludes at most, a small fraction of Medicare's payment cuts is shifted to private payers. However, even a small percentage is equal to billions of dollars.[7] And anyone with any experience in the health care system knows that cost-shifting of uncompensated care is a matter of economic survival for health care institutions. Someone is paying the bill. Therefore, one question is the extent to which major purchasers of health care products and services should be involved in the development of solutions regarding who pays for the cost of providing care to the ACA 20 million.

Chart 20: How the nation addresses coverage for uninsured and the underinsured may be an important public policy issue, but it is not a discussion that large employers or their representatives such as HR Policy Association should be involved in.	
16%	Agree
77%	**Disagree**
6%	Neither agree nor disagree/not sure/no opinion

Chart 21: The employer community should take an active role in influencing the debate over how health care coverage is provided to the uninsured and the underinsured, including developing options for solutions and advocating them.	
80%	**Agree**
14%	Disagree
6%	Neither agree nor disagree/not sure/no opinion

Only a small percentage of these employers believe that they and their representatives should not be involved in this discussion. Rather, the overwhelming majority believes that the employer community should take an active role in influencing the debate over how health care coverage is provided to the uninsured and the underinsured, including developing options for solutions and advocating them.

Tax Policy and the Deductibility of Employer Provided Care

Of all the issues in play in the debate over repeal and replacement of the Affordable Care Act, there is none more important to large employers than tax policy. And as shown on Chart 4, erosion or elimination of the tax-preferred treatment of health care is the issue of greatest concern.

The initial drafts of the GOP repeal bill contained language limiting the ability of employers to deduct the cost of providing health care benefits to employees and their dependents and retirees. Strong resistance to this proposal resulted in this provision being removed from the GOP plan, but it could return in the coming debate over tax reform.

Regarding the 40 percent excise tax on high-cost employer health insurance plans, 95 percent of respondents support repeal of that tax while the same percentage supports expanding access to and permitting more liberal use of tax-free health savings accounts.

Chart 22: Repeal the Cadillac tax (a 40% excise tax on high-cost employer health insurance plans)	
95%	**Support**
2%	Oppose
4%	Neither agree nor disagree/not sure/no opinion

Chart 23: Expand access to and permit more liberal use of tax-free health savings accounts	
95%	**Support**
2%	Oppose
4%	Neither agree nor disagree/not sure/no opinion

Regulatory Policy

While large employers expressed strong views regarding tax policy and transparency, it was less passionate regarding regulatory policy. For example, when asked whether employers felt the ACA's provisions regulating employment-based health care were excessive and should be repealed, 69 percent agreed, but then 74 percent further agreed with the statement that while these provisions may be excessive, some regulation is necessary to ensure employees certain minimum levels of coverage.

Chart 24: The ACA's provisions regulating employment-based health care are excessive and should be repealed.	
69%	**Agree**
14%	Disagree
16%	Neither agree nor disagree/not sure/no opinion

Chart 25: While the ACA's provisions regulating employment-based health care may be excessive, some regulation is necessary to ensure employees certain minimum levels of coverage.	
74%	**Agree**
15%	Disagree
11%	Neither agree nor disagree/not sure/no opinion

There is also debate over the ACA's list of essential health benefits that must be provided and whether that requirement should be removed. Here, a majority of the membership (57 percent) said that they were willing to accept some level of minimum essential health benefit if employers were given greater flexibility. Only 24 percent of respondents supported their complete elimination.

Chart 26: Eliminate government health care mandated benefits, such as the ACA's ten "essential health benefits."	
57%	**Willing to accept some set of level of minimum essential health benefits, but ones giving employers greater flexibility**
24%	Support
13%	Oppose
5%	Neither support nor oppose/no opinion

Individual and Employer Mandates

For years, there has been a vigorous debate over whether individual Americans should be required to maintain a certain level of health insurance coverage. Those arguing in support of an individual mandate assert the following, saying that it:

- Is necessary to ensure younger healthier people are in the risk pools to cover a broad population;
- Reduces the cost of uncompensated care;
- Stabilizes and lowers premiums;
- Increases the percentage of small businesses offering coverage;
- Is an essential element if there is to be guaranteed coverage for pre-existing conditions and a death spiral is to be avoided;
- Must be required by law since someone must pay for each individual's health care and the individual should shoulder at least some of that burden; and
- Reduces shifting of the cost of uncompensated care by the supply chain to those who do pay for health care.

Those arguing against the individual mandate assert that the mandate is:

- An infringement on individual freedom, potentially unconstitutional;
- Administratively challenging, politically unsustainable, economically unnecessary, beyond the proper role of government;
- A requirement that cannot be effectively enforced;
- Bad economics—an inefficient way to finance health care; and
- Misdirected because the penalty finances government; it doesn't get paid to those providing uncompensated care.

It is well understood by employers that if care is uncompensated, the supply chain shifts part of its cost to those who do pay for health insurance. Therefore, when asked whether all Americans should be required to maintain a minimum level of health insurance, either through their employer or by purchasing an affordable package of care in the individual market, 66 percent of respondents agreed and only 20 percent disagreed.

Chart 27: All Americans should be required to maintain a minimum level of health insurance, either through their employer or by purchasing an affordable package of care in the individual market.	
66%	**Agree**
20%	Disagree
14%	Neither agree nor disagree/not sure/no opinion

Asked whether provisions in ACA repeal/replace bills that would eliminate the individual mandate should be either supported or opposed, 52 percent said they were opposed and 34 percent its elimination should be supported.

Chart 28: Eliminate the individual mandate which requires all citizens to maintain health insurance.	
34%	Support
52%	**Oppose**
14%	Neither agree nor disagree/not sure/no opinion

There is another way to look this issue, one providing some equivalency. We asked if Americans are not required to maintain a minimum level of health insurance, should employers should not be required to provide it? Sixty percent agreed and 21 percent disagreed. In other words, if there is to be an employer mandate, then there should be an individual mandate. And if there is no individual mandate, then there should be no employer mandate nor the complex regulatory scheme the ACA mandates.

Chart 29: If Americans are not required to maintain a minimum level of health insurance, then employers should not be required to provide health insurance to their employees and the dependents of their employees.	
60%	**Agree**
21%	Disagree
19%	Neither agree nor disagree/not sure/no opinion

Conclusion

With health care policy front page news, it should be noted that the federal government is not the only institution taking a hard look at the subject and deciding whether changes are merited. Large employers who provide health care benefits to millions of Americans are also re-examining current delivery systems, and the 2017 CHRO Survey conducted by HR Policy Association reveals significant changes in thinking among HR leaders that deserve consideration by policy makers.

While the self-insured group marketplace has been the primary method utilized by large employers to deliver health care for decades, there is now strong interest in the potential of the individual marketplace if policy makers were to eliminate its disincentives. Further, for more than 10 years, employers have been shifting their post-65 retiree populations into exchanges that are heavily regulated by the federal government as a supplement to Medicare. Employers have found that the limited plan options permitted by the government in this area has resulted in both standardization and vigorous competition among carriers. That may be one reason why employers are expressing an interest in simplified benefit plans for active employees, the theory being that with standardization comes efficiencies and more affordability.

At the same time, the debate over how the Affordable Care Act should be changed is raising concerns among employers. One is whether the uniform benefit plans permitted by ERISA will be harmed. Depending on how individual states might be given the power to set local standards, uniform plans could be eroded, creating an administrative nightmare for multi-state employers. Further, the desire for greater transparency of health care cost and quality data continues to grow, but nothing in the proposals to date indicates a desire by policymakers to address that issue. Finally, employers are particularly concerned with the discussions that have occurred over the past few years regarding reducing or removing the deductibility of corporate health care expenses under the tax code as a means of raising revenue for the federal government. Because over 170 million Americans depend on employer-provided care, large employers believe policymakers should be focused on removing burdens and disincentives, not creating new ones that could disadvantage such care.

Endnotes

[1] American Health Policy Institute estimate for employers with 200 or more employees. Based on National Health Expenditure data (Tables 22 and 24), Census Bureau (County Business Pattern data, Small employer size file), Bureau of Labor Statistics (Household survey, Wage and salary workers), and Kaiser Family Foundation (Employer Health Benefits 2016 Survey, Exhibit 3.1).

[2] National Health Expenditure Data, Center for Medicare and Medicaid Services, National Health Expenditures by Type of Sponsor, 2015, see Table 24, available at https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nationalhealthaccountshistorical.html.

[3] Employee Benefits Study: Which Job Perks are Most Important to Employees? Fractl. See http://www.frac.tl/employee-benefits-study/

[4] Fronstin, Paul. Views on Employment-based Health Benefits: Findings from the 2015 Health and Voluntary Workplace Benefits Survey. Employee Benefit Research Institute. See https://www.ebri.org/pdf/notespdf/EBRI_Notes_03_Mar16.WBS-rev.pdf.

[5] Bureau of Labor Statistics Consumer Price Index, CPI Databases, All Urban Consumers, Medical Care. See https://www.bls.gov/cpi/data.htm.

[6] Medicare Advantage Fact Sheet. Kaiser Family Foundation. May 11, 2016. See http://kff.org/medicare/fact-sheet/medicare-advantage/.

[7] CBO's Analysis of Financial Pressures Facing Hospitals Identifies Need for Additional Research on Hospitals' Productivity and Responses. Congressional Budget Office. September 8, 2016. See https://www.cbo.gov/publication/51920.