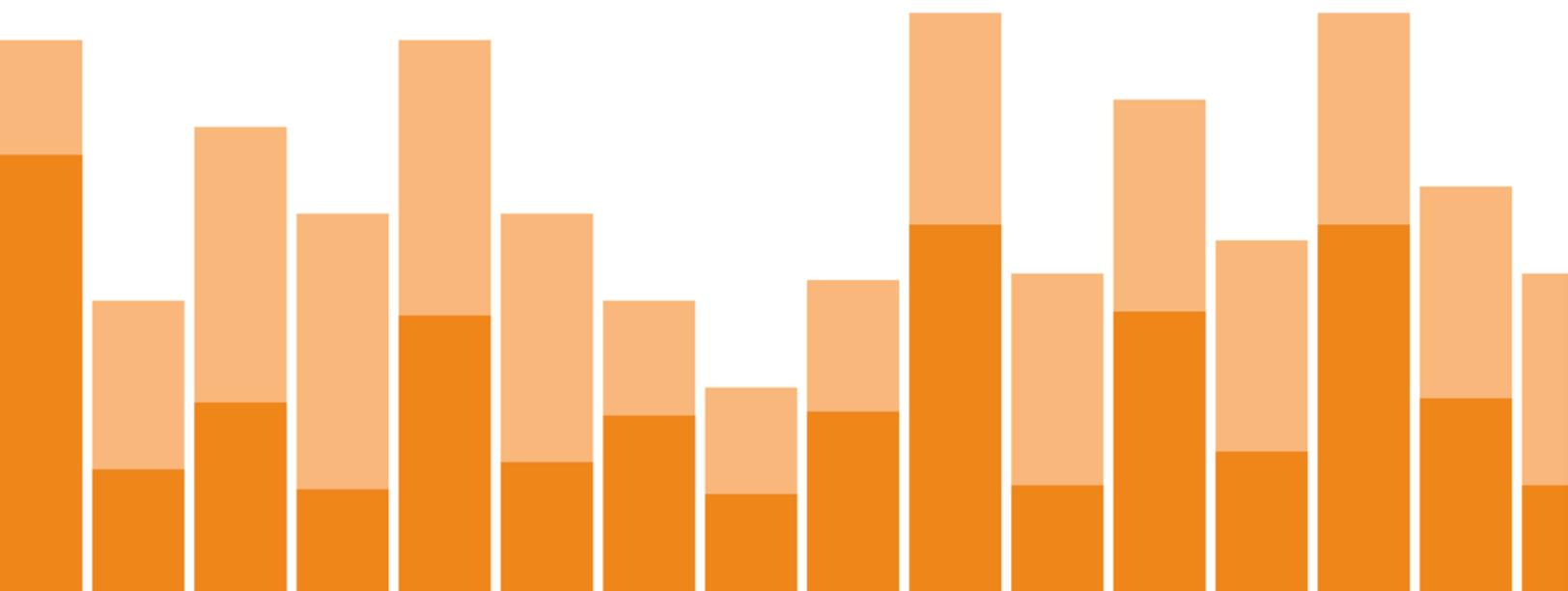


# **Towards a New Model of Health Care: Employer-Facilitated Care**

By Robert E. Andrews, Jeffrey C. McGuinness, and Tevi D. Troy





**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](http://americanhealthpolicy.org).



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“ Employer-provided health care in the United States is in critical condition and will not survive without major transformation.”

*The Future of Employer-Sponsored Health Care: A Call to Action*  
March 2015

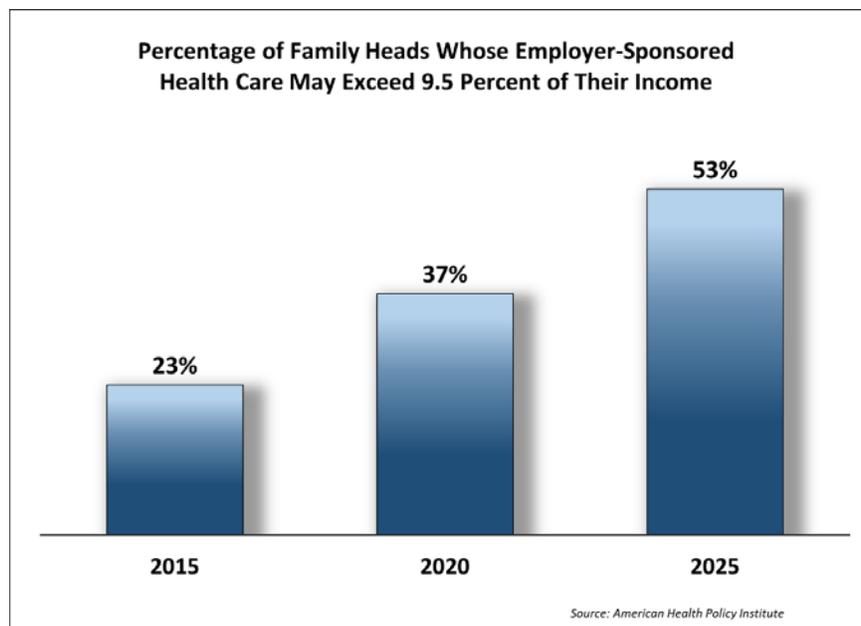


## The Challenge

Since World War II, employer-sponsored health insurance (ESI) has been the backbone of our health care system, providing reliable, affordable health coverage to a majority of Americans. Today, 54 percent of Americans, or about 169 million, get their health care from ESI. Unfortunately, however, this model is changing, and changing rapidly due to the continued rise of health care costs to unsustainable levels and the rapid consolidation of the health care industry. Engaging in a new, employer health care joint venture may be the solution to preventing employer plans, and the employees they cover, from being left behind.

Employers are on the front lines of tackling—and absorbing—some of the cost increases. Amidst the myriad health care challenges facing the nation, some of these costs have been passed on to employers, thus leaving over 13 million employees with employer based coverage—3.0 million with individual coverage and 10.4 million with family plans – facing the prospect of “unaffordable” health care. The Affordable Care Act (ACA) defines "unaffordable" health care costs as costs that consume more than 9.5 percent of a family's income. Although many observers contend that a much lower percentage would be more realistic, even the application of this steep measure of unaffordability shows how close many American families are to being unable to pay even for the health care they receive from their employer.

In 2015, 23 percent of American families were faced with health care coverage costs that exceeded 9.5 percent of their household income. Already by 2020, 37 percent of families will be burdened by unaffordable health care costs; and by year 2025, that proportion will grow to 53 percent.<sup>1</sup> Recognizing that this worsening trend cannot continue, and seeing firsthand the harm it is inflicting on working American families, employers are likely best positioned to change the trend in today’s environment—without relying on any political or regulatory action in Washington.

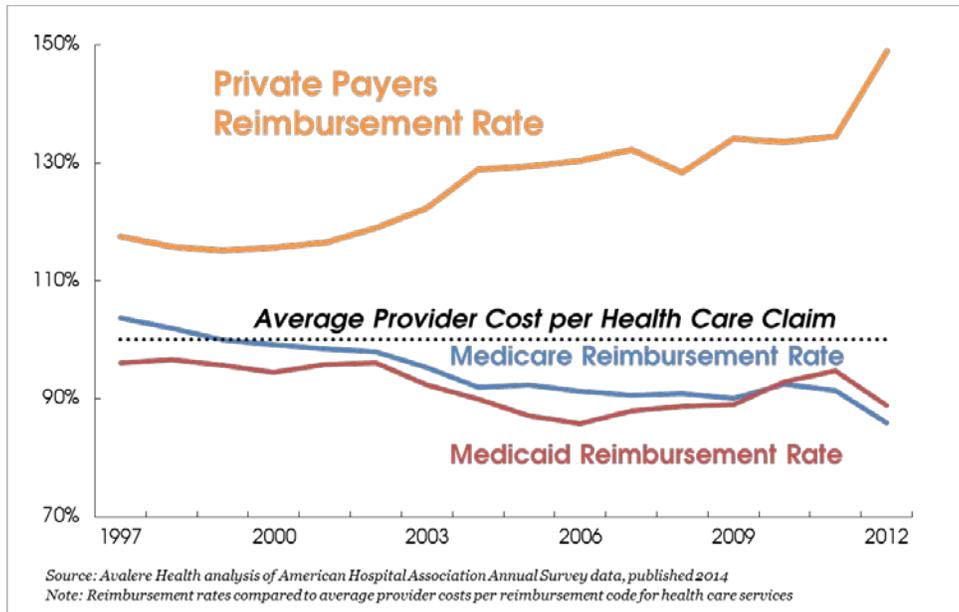


This relentless escalation in health care costs has set American employers and their employees on a course hurtling toward a wall of unaffordability, and correcting that course is not a matter of preference – it is a matter of necessity.<sup>2</sup> Since 1999, the overall rate of inflation has been 42 percent.<sup>3</sup> During the same period, workers’ weekly earnings increased 50 percent, while health care premiums for family coverage rose 191 percent, and worker contributions to premiums increased 213 percent.<sup>4</sup> From the worker’s perspective, health care premiums for employees have increased over four times more than worker earnings in this period.<sup>5</sup>

In addition to the troubling previous history of cost hikes, recent developments suggest that these hikes will continue, at perhaps even higher rates. The Affordable Care Act (ACA), passed in 2010, was intended to bend the cost-curve downward. But a recent Harvard study showed that insurers with higher numbers of customers in the ACA’s state exchanges raised their 2015 rates by 10 percentage points more than the average premium hikes – 23.9 percent versus 13.7 percent.<sup>6</sup> These increases come as no surprise to benefits managers or human resource executives: the current expectation is that health care costs will continue to rise at an average of almost 6 percent per year, every year, for the next 10 years.

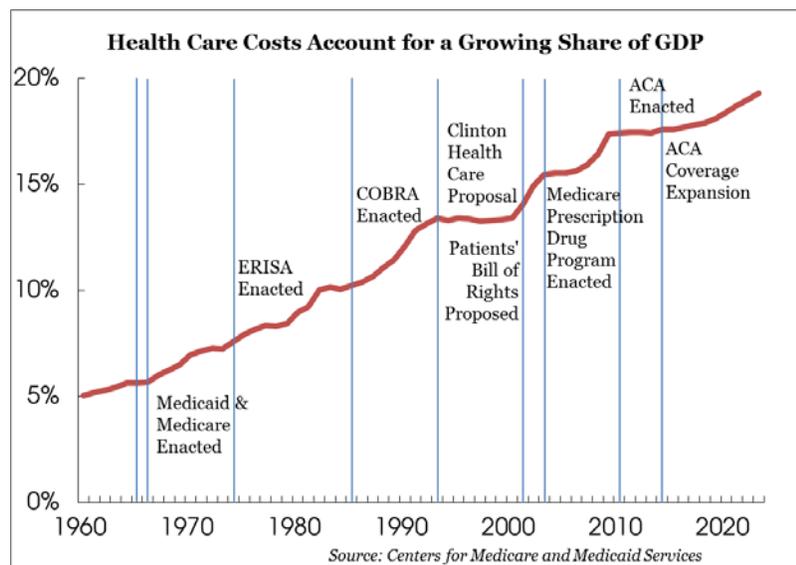
Because of these intense cost pressures, as well the ACA’s pending excise tax on high-cost plans, it is unclear how long ESI will continue as a feasible delivery model. The loss of ESI would constitute a big change, as America’s health care system as currently configured relies heavily on employers to pay for health care. While many large employers remain committed to continue providing health care to their employees, retirees, and dependents, some are considering coping with the cost challenge by moving from an employer-sponsored to an employer-facilitated health care model.

In looking to make this change, employers face some limits on both the industry and the government side of things. Government is already strapped for health care financing: Medicare currently has a \$28.5 trillion unfunded obligation,<sup>7</sup> and by 2030 the Medicare Hospital Insurance (HI) trust fund is depleted.<sup>8</sup> On the Medicaid side, expenditures will double over the next decade, rising from \$541 billion today to more than \$1 trillion annually by 2025.<sup>9</sup> As a result of these severe pressures, provider reimbursement levels from both Medicare and Medicaid are below cost, which means that providers charge privately insured patients in ESI programs more to make up for the shortfall. This cost-shift from government to employers means that government exacerbates, rather than alleviates, the problem of health care costs for employers. Employers and employees find themselves bearing the burden not only of their own health care, but also bearing the cost of subsidizing patients enrolled in government programs. The average cost per claim paid to providers by Medicare and Medicaid has flattened (or even dropped in some years), but claims paid by employers and employees have risen steadily.



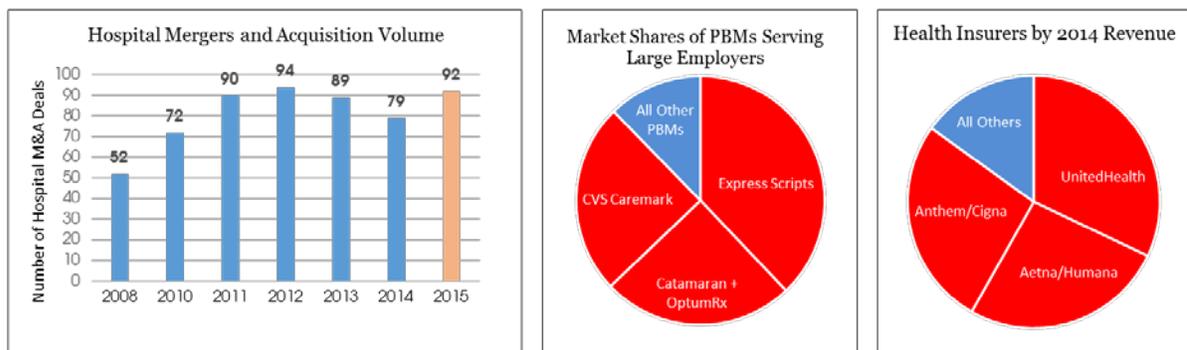
Furthermore, when the government does try to do something about overall health costs, the effect is often the opposite of what was intended. Throughout the last five decades, the federal government has attempted, in both Republican and Democratic administrations, to expand health care access, improve quality, and lower costs. Despite these repeated government efforts, health care costs as a share of GDP have only increased since government has expanded its role in health care (see Chart below). While prior government efforts to manage the cost of health care generally precede a period of increased health care spending, the Clinton health reform effort of the 1990s notably flattened spending, though it is important to note that the Clinton health effort did not pass and become law. The restraint in health care spending from 1993 to 1999 was largely driven by the private sector adopting managed-care strategies to control spending in ESI.

The lesson from these decades of both Democratic and Republican efforts is clear: Government solutions are unlikely to solve the health care cost problem. They have not done so in the past, and are unlikely to do so in the future.



The recent wave of consolidation among health care providers and insurers is creating new challenges for large employers as well. Employers provide health care for their employees as individual employers, but the various elements of the health care supply chain are in the process of consolidating into larger and larger entities. On the provider side, hospitals and physician practices are consolidating at an increasingly rapid pace. In 2015, 107 hospitals were going through mergers and acquisitions; in 2008, in contrast, only 52 were going through such deals. When it comes to pharmaceutical distribution, the three largest pharmacy benefit managers (PBMs) already control 87 percent of the large-employer market.

As consolidation continues, and assuming no major immediate changes occur in the health care marketplace, that number is likely to get even larger in the years ahead. Beyond just PBMs, consolidation in the insurance industry, and what impact it might have on premiums, is a concern as well. Given the planned mergers of Aetna and Humana, and Anthem and Cigna, only three carriers will soon have 85 percent of the large-employer market share. From the employer perspective, the elements of the supply chain are working together to secure more leverage, and the employers continue to purchase health services as lone actors, without consolidated marketplace advantages. As providers, PBMs and carriers rapidly accelerate their pace of consolidation, their market power dwarfs that of employers who stand alone in the marketplace.



## Envisioning the Employer-Facilitated Model

As a result of these challenges, U.S. employers are looking for creative means to improve the health of their employees and the families of those employees, generating sustainable long term savings. According to a study by the Employee Benefit Research Institute (EBRI), only 40 percent of employees want to continue along the same health care path they are on today.<sup>10</sup> However, 40 percent also want to be able to choose their health plan and are willing to provide additional resources, above what their employer pays, if necessary.<sup>11</sup> Another 20 percent want a lump sum payment from employers to allow them to pick their health coverage on their own.<sup>12</sup> What this means is that *60 percent of employees are looking for some new kind of way to get affordable health coverage.*<sup>13</sup> Another survey, of large employer Chief Human Resource Officers, found that while more than 90 percent of employers currently run employer-managed plans, almost 60 percent of them want – and expect – to shift away from this model by 2020, moving towards an employer-facilitated model.

In an employer-facilitated model, the employer would still play an integral role in providing health care benefits, but would not control all aspects of the provision of care. Employers would continue to help pay for it, and would also be involved in the big picture decisions about what kind of care they wish to provide, but they would have less involvement in the day to day management of health care. One way to do this is to place health care on a platform outside of the four walls of an individual company. In this model, employers and employees alike would have greater choice and flexibility when it comes to health care, but continue to benefit from the tax advantages granted to employer-sponsored care.

## **Achieving the Employer-Facilitated Model**

The first thing employers must determine in making the decision to move towards an employer-facilitated model is to articulate what they would want that model to look like. We have already seen some examples of employer-facilitated health care emerging, in the form of private exchanges, or greater movement towards defined contribution approaches. Unfortunately, these early attempts, while beneficial to some degree, have not yet solved the larger and admittedly difficult cost problems outlined above. Furthermore, they may take the employer too far out of the equation, in that they fail to maintain the levels of control that employers want to maintain even in the move to employer-facilitated care.

A successful model of employer-facilitated model can only be achieved through collaboration among employers. Success would be measured both in terms of bargaining power as well as desired outcomes—in terms of both cost and quality. Such a collaboration could allow employers to leverage the scale of many employees spread across a wide geographic area, but also allow them to reduce the administrative burden of managing the provision of health care as individual companies.

The benefits of employers coming together in such a fashion could be manifold, including the ability to speak with a collective voice, design their own solutions, empower their employees, gain access to insight-laden health care data, receive valuable insights from peers, and create an organization employers trust and control. Employers also want to be able to focus on what works for their companies and across their individual industries, and also to engage individual employees at their companies.

Employers have good reasons to pursue the goals in question. Speaking in one voice gives employers the ability to be heard above the din of those angling for a slice of the health care pie. Designing their own solutions means that employers would not be dependent on the existing offerings of the health care marketplace, but could let the market know exactly what it is that employers want and need. Empowering employees means that employees would be part of the solution and not an afterthought. Access to health care data would enable employers to make value-based decisions based on a fuller picture of what is happening in the health care marketplace. Gaining insight from peers means that human resource teams could share with one another effective strategies to lower costs and increase quality. Engaging employees will enable employers to modify and shape consumer behavior and bring about health outcomes. Finally, none of this will work without the organization being one that employers both trust and control, so they could devise solutions without fear of being poorly served or even misled. Successfully bringing together all of these elements is essential to the success of the organization, as these benefits will bring about health care synergies that do not exist in the current employer-sponsored model.

## **A New Approach: An Employer Health Care Joint Venture**

To meet all of these ambitious goals, and to do so effectively, necessitates a new and different way of approaching the challenge of employer-facilitated health care. Employers would have to be able to band together to take advantage of their combined marketing power, yet remain loosely affiliated enough that they could maintain their own systems and their own corporate cultures. One way to do this is to form a not-for-profit alliance among multiple companies.

Such an alliance could bring together a network of large employers in such a way as to deploy their large footprint in order to drive efficient, quality – and affordable – health care to foster a healthy, productive workforce. The legal entity driving this alliance would be a not-for-profit cooperative operating exclusively for the benefit of its members and their employees.

The value of such an organization would come from enabling employers to approach the health care marketplace together, not as a series of individual companies. Elements of the supply chain justify joining together for a number of reasons, including the ability to answer capital needs; to respond to payment changes under the ACA; to acquire better access to technology; to reduce costs via economies of scale; to enhance bargaining power; and to improve quality of care. All of these rationales would be applicable to an employer-based solution pursuing its own form of consolidation. Employers see the need to collaborate and want to benefit from acting in concert. As the health care transactions attorney Angela Humphreys put it, “we’re seeing significant implications from the Affordable Care Act take hold. Reforms like these are pushing providers to do more, better, for less – which in turn drives them to consolidate to become stronger in this new healthcare climate.”<sup>14</sup> The same pressures pushing the supply chain to band together are encouraging employers to act in similar ways as well.

In developing health care strategies collectively, companies would be able to accelerate innovation from a holistic perspective, looking at the entire health care marketplace, and adopting the best new technologies that the marketplace has to offer. Right now, individual large employers not only lack leverage, but they also lack the capacity to identify and integrate new and potentially transformative health care technologies. We are in the midst of a technological revolution in the health IT space, yet too many systems cannot benefit from it because they lack the capacity to take advantage of the revolution taking place all around them.

The joint venture would also be helpful in establishing rules and standards across participating companies. The alignment of consistent and rational standards would help align incentives among the participating pieces of the supply chain. In doing so, properly aligned incentives would not only reduce waste and increase efficiency, but would also bring about better outcomes.

Given these capabilities, a properly aligned joint venture could accomplish a number of transformative goals, including the ability to:

- Select opportunities for maximum initial impact;
- Define and set consistent standards for cost, quality, and access;
- Maintain needed flexibility across geographic areas and populations;
- Create competition among service providers who meet certain performance standards; and
- Negotiate template agreements that reset medical trend.

## **The Fundamental Difference**

The fundamental difference between prior employer coalition efforts and the proposed approach is that prior efforts have tended to be commodity purchasing plays or efforts to build and market a particular product. As such, they have not addressed the root causes of escalating health care costs – declining population health, an aging workforce, and massive inefficiencies in the existing health care system. This alternative approach, therefore, would not be a product employers could buy along with other health care products. It would instead represent a fundamental change in the way companies approach the health care supply chain: a strategic tool, not an off-the-shelf product. The entity would serve as an integral part of a company's benefits department and health strategy, attracting innovation, analyzing the latest data, and incorporating new medical network strategies based on the organization's collective leverage.

Another difference from previous efforts is that this entity is not at its heart just a purchasing organization. The new entity will indeed use its collective market power, but it would do so in order to shift the nature of employer-sponsored care from sick care to well care. This would not be Sam's Club using bulk purchasing to win discounts, but a fundamental rethinking of how to provide care. As a result of this transition to prevention and better health, worker populations would be healthier, and health challenges would be tackled on the front end, when they are cheaper, rather than after the worst and most costly symptoms have manifested.

In addition, the organization would also take a different approach to technology and in doing so help bring about a wellspring of innovation. Currently, employers hear of new technologies but have no means by which they can independently verify the technologies' value. Every assessor has a vested interest in promoting or discouraging new products. The body would have no such vested interests, meaning it could serve as a neutral arbiter of value. As a result, companies would be able to discover and identify the person with an app that really does work to help diabetics keep their blood sugar in check. Companies would benefit from the new innovation, and the diabetic would as well.

The organization's neutrality or lack of a vested interest would be helpful in another way as well. The not-for-profit aspect of the proposed model would enable it to avoid the conundrum of short-term profits versus long-term improvements in health. This would not be a for-profit venture required to report quarterly results to the market; it would instead be a market-based

solution reporting real-time progress on healthier outcomes to its members. It is the members who would be investing both time and resources to make the entity a success. Because of the not-for-profit structure, the members' time, resources and energy could be focused on their health care objectives, and not on marketplace or venture capital financial objectives. The organization would be a market-driven entity, playing within existing rules, and without seeking a taxpayer subsidy or regulatory break. By not seeking profits in and of itself, the collaborative organization would have added freedom to act in the best interest of its members, without regard for quarterly earnings figures or investor concerns. The organization would be accountable, but to its members, rather than investor shareholders.

## **The Approach in Action**

Some companies are already employing strategies along these lines, and some have yielded success in this arena. A growing number of self-insured employers, for example, are bypassing health plan administrators and contracting directly with health care providers. According to Aon Hewitt's "2014 Health Care Survey," 11 percent of employers are engaging in some form of direct health care provider and service contracting during this plan year, and 28 percent expect to do so in the next three to five years.<sup>15</sup> These numbers are likely to climb in the years to come as health care costs continue to rise.

Household name companies like GE, Walmart and Lowe's have seen cost savings in the millions with their direct-contracting plans. Instead of paying for premiums for their millions of employees, they have contracted directly with medical providers and arranged reduced rate contracts for both surgical and non-surgical services – allowing for a type of "medical tourism," where employees are encouraged to travel to secure cheaper medical services. Employers are even willing to absorb travel costs due to the contracted rates between the employer and medical provider. The employees themselves see an average savings of \$5,000 to \$12,000 as a result of being exempted from medical deductibles.

The *Harvard Business Review* recently highlighted Intel's Portland health collaborative. Intel had almost 40,000 covered lives in the Portland area, and used its large market share in that area to establish a Healthcare Marketplace Collaborative that aimed to change medical practices for six specific medical conditions. This venture was able to reduce waste and unnecessary care, and reduce the costs of three of the targeted medical conditions by 24 percent to 49 percent. The HMC showed the promise of a collaborative effort in a specific area where a company had a large number of covered lives, but it also showed that the leverage a company had was limited to narrow areas in which the company could exercise that leverage.

Some companies have been able to try the collaborative approach in more than one location. Boeing, Inc., took advantage of the fact that it had large employee populations in places like Washington and South Carolina to contract directly with local providers. This allowed them to combine low prices and superior service within a narrow network that worked for their organization. Again the approach was successful to a degree, but it was dependent on one company having a large workforce in a particular location or locations.

These modest examples of individual companies taking bold steps to determine their health care destinies are instructive and inspirational. But the capabilities of individual companies to create synergies and to shape the health care marketplace pale next to the potential of multiple companies banding together to use their collective leverage to create the future state of health care. A collective not-for-profit venture, with more companies, more lives, and a wider geographic distribution, would have a much greater ability to shape the health care marketplace according to participants' needs.

Furthermore, the promise of collaboration by employers through the not-for-profit approach extends beyond the near-term savings found via new negotiation dynamics. By generating data-driven definitions of quality and best practices and applying these standards across the marketplace, the alliance will accelerate the pace of innovations that produce better outcomes, which are the desired results: Type Two diabetics who no longer require amputations or suffer strokes. Asthmatics who literally breathe easier and live healthier and more productive lives. Breast cancer survivors who do not confront recurrences. The goal of the endeavor is not simply lower costs in the short run; it is healthier people and sustainable savings in the long run.

## **How to Proceed**

Building on these examples, the new organization could fairly quickly establish initiatives aimed at leveraging its members' buying power in areas such as setting up medical networks, pharmacy purchasing, data analytics, and consumer engagement. These initial initiatives could accelerate opportunities for saving and innovation that would have broader impacts as the collaborative ecosystem evolves. Successes in the areas of direct contracting, as well as data aggregation and analysis, wrapped with an interactive consumer interface, would both demonstrate the effectiveness of the model and open up pathways for additional initiatives to follow. As more members join, we would start to see cross-coalition collaboration, as the organization and its members align with other employer associations to gain even more leverage.

Once the initial phase is successful, we could see cascading benefits in other parts of the health ecosystem as well. The establishment of consistent quality measures across the ecosystem, for example, could solve the vexing problem of too many extant quality measures that are both redundant and not even measuring outcomes in a helpful or useful way. Payment reform is another promising area, as a not-for-profit entity entering the marketplace with millions of lives could both identify and adopt more effective payment reform methodologies, finally weaning the system away from fee for service and its perverse incentives in the area of health care.

Finally, a third area of promise is in the realm of new breakthrough technologies. More than \$6 billion a year is being invested in startups in the health care field. These innovators are bringing about all kinds of new technological miracles, but there are so many new products that large companies are often unable to incorporate or even identify the best ones. Benefit managers are too overwhelmed to listen to every new product pitch, and even when they do find products they want, their systems are insufficiently nimble to incorporate the new technologies. An employer-based not-for-profit organization, in contrast, would be far better suited to centrally and quickly identifying disruptive technologies that could bring positive change to the health care ecosystem in terms of improved quality and cost. Once identified, the organization could empower the integration of these new technologies by easily and seamlessly integrating new and cutting-edge service providers into the joint ecosystem.

## **The Collaborative Not-For-Profit Model**

In order to accomplish these worthy goals, the organization would operate as a not-for-profit cooperative. The official definition of a cooperative, as laid out in 1987 by the U.S. Department of Agriculture is as follows: “a user-owned, user-controlled business that distributes benefits on the basis of use.” Beyond the official definition, though, cooperatives tend to be innovators that come together to respond to market failure. The participants are often frustrated with the existing state of play, and they want to, indeed must, pool resources to respond to the challenges they collectively face. In doing so, and because of the frustrations of the market failures they are encountering, participants are also interested and willing to put in the time to work on governance of the organization. The demand for the organization tends to come from the members, and the members get to control the organization’s direction, structure, and strategic choices.

An employer health care non-profit entity would therefore be operated in such a way as to benefit members, not create profits. It would be an organization of members, by members, and for the benefit of members. Members would elect the Board of Directors, have a role in staffing the organization, and in general have as much voice or involvement as they chose to have. Importantly, they would be shielded from liability by the cooperative, and would have protection from anti-trust laws.

The concept is not risk free. To succeed, the organization would have to maintain the cohesion in the face of status quo forces seeking to prevent change. Some members of the supply chain would likely view the organization as a significant opportunity while others may resist it because the entity by its very nature, would disrupt existing practices, relationships, and corporate cultures. Yet while the risks are there for all to see, so are the potential benefits, and they are far greater than the risks and more attainable than previously believed possible. What we do know for certain, is that the existing system is not sustainable and must be changed.

## **Conclusion**

The fundamental question regarding the establishment of a large-employer not-for-profit venture should not be “Can the model work?” but rather “How soon can it start benefiting my company and my employees?” The need is clearly there, as employer-sponsored health care is facing significant challenges and long-term unsustainability. The desire is there, as employers are looking for a new path forward in how best to provide health care to their employees, and it is clear that help is not coming from other quarters. The approach is there, as consolidation is already taking place throughout the health care industry, and preliminary efforts at collective employer action have yielded promising results. All that employers need to do to make it happen is to band together and help reshape the health care marketplace, and to do so in a way that works for them.

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- <sup>1</sup> Tevi D. Troy and D. Mark Wilson, “The Affordability of Employer Sponsored Care and the ACA Exchange Health Care Plans,” American Health Policy Institute, February 2015.
- <sup>2</sup> Tevi D. Troy and D. Mark Wilson, “Hitting the Wall: When Health Care Costs are No Longer Manageable, American Health Policy Institute,” June 2015.
- <sup>3</sup> Bureau of Labor Statistics, Consumer Price Index, <http://www.bls.gov/cpi/data.htm>
- <sup>4</sup> Bureau of Labor Statistics, Current Employment Statistics, Average Weekly Earnings of Production and Nonsupervisory Employees, <http://www.bls.gov/ces/data.htm>; and The Kaiser Family Foundation and Health Research & Educational Trust, Employer Health Benefits 2014 Annual Survey, Exhibit 6.4, <http://files.kff.org/attachment/2014-employer-health-benefits-survey-full-report>
- <sup>5</sup> The Kaiser Family Foundation and Health Research & Educational Trust, Employer Health Benefits 2014 Annual Survey, <http://files.kff.org/attachment/2014-employer-health-benefits-survey-full-report>
- <sup>6</sup> Wang E, Gee G. Larger Issuers, Larger Premium Increases: Health insurance issuer competition post-ACA. Technology Science. 2015081104. August 11, 2015. <http://techscience.org/a/2015081104>
- <sup>7</sup> 2014 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, July 28, 2014, Table V.F2.
- <sup>8</sup> 2014 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, July 28, 2014, Table III.B5 and pg. 7.
- <sup>9</sup> National Health Expenditure Projections, extrapolated out to 2025.
- <sup>10</sup> Paul Fronstin and Ruth Helman, Views on Employment-Based Health Benefits: Findings from the 2014 Health and Voluntary Workplace Benefits Survey, Employee Benefit Research Institute, Notes Vol. 36, No.2, February 2015.
- <sup>11</sup> *Id.*
- <sup>12</sup> *Id.*
- <sup>13</sup> *Id.*
- <sup>14</sup> [Brian Ahier](https://www.linkedin.com/pulse/20140703003521-36418825-consolidation-expected-to-increase-for-hospitals-it-companies?trk=hb_ntf_MEGAPHONE_ARTICLE_POST), “Consolidation Expected to Increase for Hospitals, IT Companies,” *Pulse*, July 3, 2014. [https://www.linkedin.com/pulse/20140703003521-36418825-consolidation-expected-to-increase-for-hospitals-it-companies?trk=hb\\_ntf\\_MEGAPHONE\\_ARTICLE\\_POST](https://www.linkedin.com/pulse/20140703003521-36418825-consolidation-expected-to-increase-for-hospitals-it-companies?trk=hb_ntf_MEGAPHONE_ARTICLE_POST)
- <sup>15</sup> Aon Hewitt, 2014 Health Care Survey, <http://www.aon.com/attachments/human-capital-consulting/2014-Aon-Health-Care-Survey.pdf>.