FOLLOW THE LEADERS:
HOW TO SUPPORT EMPLOYER HEALTH CARE INNOVATION
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According to the U.S. Census Bureau, more than 178 million Americans currently have employer-sponsored health insurance — more than half the country, surpassing Medicare and Medicaid and dwarfing the number of people covered in the individual market.

Despite employers playing such a significant role in the health care market, policy debates have too often ignored them, focusing instead on whether the states or the federal government should have a more direct role in providing health care coverage.

The American Benefits Council and Mercer, along with other stakeholders, have argued that employers are more than mere intermediaries. They play a critical role in the health care system, leveraging purchasing power, market efficiencies and plan design innovations to provide comprehensive health coverage at a fraction of the cost to government compared to federal programs.

Despite these successes, we are concerned that some policymakers subscribe to the myth that because health care is purchased with tax-free dollars, employers don’t feel the need to manage their own health care spending. That they don’t seek more cost-efficient health plans. That they don’t work to ensure quality of care. That they don’t innovate.

Employers have pioneered strategies that directly address the biggest cost drivers in the U.S. health care system: the relatively small number of high-cost claims that drive such a large percentage of spending, increasing unit prices resulting from marketplace consolidation, misplaced incentives, waste, inefficiency, uneven quality of care and lack of transparency. Many of these experiments have met with startling success and — if scaled and encouraged — have the potential to fundamentally improve health care for all Americans.

Even so, over the years, policymakers have erected barriers limiting the actions employers can take to control costs, improve quality and manage their populations. In many ways the deck is stacked against employers, given that the underlying health care system — dominated by the Medicare program — continues to misalign incentives and reward providers that pursue high volumes of services rather than high value. Congress and the executive branch have begun to chip away at this decades-old roadblock by implementing The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) and incentivizing alternative payment models, but more work remains. The next page provides a handful of suggestions about ways to make it easier for employers to continue providing affordable, quality coverage to over half the country and drive innovation that improves the health care system as a whole.
A health savings account (HSA) is a tax-exempt account that reimburses certain medical expenses. To make contributions into the account, the individual must be covered by a qualified high-deductible health plan (HDHP). Both employers and employees may contribute to an HSA.

HSAs have been used to help make health coverage more affordable, encourage a wiser consumption of health services and allow pre-tax spending on a wide range of qualified medical expenses. However, dated laws and regulations make it difficult for employers to include innovative reforms in HSA-eligible HDHPs. Congress and the executive branch should implement several policies to update HSAs to better align this increasingly popular plan design with innovative delivery system reforms. Some recommendations include:

**Update the definition of prevention to help Americans with chronic conditions:** Current law allows qualified HDHPs to offer certain preventive services on a pre-deductible basis. Internal Revenue Service (IRS) guidance narrowly defines “prevention” to include only primary prevention, and while this is important, primary prevention is a small component of total health care spending. By contrast, about 86% of our health care spending — now over $3.3 trillion and rising — goes toward care for patients suffering from chronic conditions, according to the U.S. Agency for Healthcare Research and Quality. If the IRS were to update its guidance to allow chronic disease prevention to be covered on a pre-deductible basis, this would give employers and health plans the ability to more effectively prevent the progression of chronic disease, leading to overall decreased health care spending and a better quality of life for employees. For example, some employers ensure enrollees with diabetes have access to insulin, test strips, annual eye exams and hemoglobin A1c testing without imposing cost-sharing. These designs increase patient compliance, which improves quality of life and productivity while also decreasing long-term health care spending. Unfortunately, IRS guidance prohibits employees enrolled in HSA-eligible HDHPs from receiving these high-value services on a pre-deductible basis.

The IRS should update its guidance to allow chronic disease prevention to be offered on a pre-deductible basis — and if it does not, Congress should pass legislation to allow this policy.

According to the U.S. Agency for Healthcare Research and Quality, about 86% of national health care spending — now over $3.3 trillion and rising — goes toward care for patients suffering from chronic conditions.
Make it easier for employers to offer onsite and near-site health clinics: Currently, employees enrolled in HSA-eligible HDHPs who receive medical care at onsite or near-site medical clinics must pay for services received at the onsite clinic if they have not met their deductible. This creates an unnecessary barrier to care and wraps employers in unnecessary red tape by forcing them to calculate fair market value and collect cost-sharing. Employers should be allowed to provide care at onsite and near-site medical clinics at low or no cost to employees enrolled in HSA-eligible HDHPs. With the US shortage of physicians expected to grow to 125,000 by 2025, changes may improve access (AAMC, 2008).

Encourage employees to utilize Centers of Excellence (COE) programs: Many employers offer or plan to offer COE programs that incentivize employees to receive care from providers that attain high marks for the quality of care delivered and with whom employers are able to negotiate reasonable rates that keep costs in check. In many instances, employers will waive copays or deductibles entirely if the employee receives care from the COE. Unfortunately, waiving the deductible if the employee is enrolled in an HSA-eligible HDHP would disqualify any contributions made to the HSA, making the employee liable for taxes and fees on any contributions made. This imposes a barrier to these popular programs that should be eliminated by Congress or the executive branch.

OFFERINGS OF WORKSITE OR NEAR-SITE CLINICS FOR PRIMARY CARE SERVICES CONTINUE TO EDGE UPWARD

Among employers with 5,000 or more employees

Mercer National Survey of Employer-Sponsored Health Plans, 2017
Remove barriers to telemedicine and second-opinion services: Employers increasingly offer telemedicine and second-opinion services to their employees as one more avenue for increasing access and quality. Second-opinion services are a helpful tool for ensuring employees have the right diagnosis and the best treatment plan based on their personalized medical information. Currently, for employees enrolled in HSA-eligible HDHPs, these services cannot be offered outside the group health plan or they could disqualify the employee from making HSA contributions. If the services are offered as part of the group health plan, employers must charge employees to access the service if the employee has not met his or her deductible — many employers would prefer to offer these services without imposing cost sharing as a way to encourage this high-value venue for receiving care and ensuring a correct diagnosis and treatment plan. This barrier should be removed by Congress or the executive branch.

These are a handful of policy suggestions pertaining to HSAs. A full list can be found in the Council’s Magnifying a 2020 Vision: A Closer Look at Selected Approaches to Strengthen Employer-Sponsored Benefits.
When Americans obtain their health care coverage through an employer, the cost of that coverage is “excluded” from an employee’s taxable income.

This federal tax incentive, which encourages employers to offer health insurance coverage to their workers and encourages workers to sign up, has often been described as an “accident of history” — an inadvertent byproduct of World War II wage and price controls. In fact, these tax incentives have given rise to America’s enormously successful employer-sponsored health system, in which employers typically pay, on average, 82% of the cost of coverage. According to forthcoming research by the American Benefits Council, when the total amount employers paid for group health insurance in 2016 ($691.3 billion) is compared to the value of the tax expenditure that same year ($155.3 billion), we can calculate that employees received $4.45 worth of benefits for every dollar of forgone tax revenue — a more than four-to-one return on investment.

By assembling large groups that are not subject to the sort of adverse selection problems and higher administrative costs in the non-group market and engaging in innovative cost containment, employers are able to provide a better bargain for their workers than is likely to otherwise be available. Employer-provided health insurance is popular, affordable, high-quality coverage that leads to better health outcomes, lower costs and more satisfied and productive employees. Taxing these benefits could undermine the core of Americans’ health coverage system.

Fully and immediately repeal the so-called “Cadillac Tax” on employer-provided health coverage: Starting in 2022, the Affordable Care Act (ACA) will impose a 40% tax on employer-sponsored coverage that exceeds certain thresholds, projected to be $11,100 for employee-only coverage and $29,750 for family coverage. For millions of Americans who enjoy health insurance coverage through an employer, the mere threat of this tax has already resulted in reduced coverage and increased out-of-pocket costs.

Employers’ ability to alter benefit design to stay below the tax thresholds is constrained by the law’s benefit mandates, out-of-pocket limits and prohibitions on lifetime and annual dollar limits. Additionally, indexing the threshold limits based on changes to chained CPI-U will not be adequate to keep up with the cost of medical inflation. Historically, medical costs have increased at a much faster rate than general inflation, so the tax is expected to be imposed on many more plans each year.

This tax will hurt Americans in a very inconsistent and inequitable way because, contrary to its nickname, the Cadillac Tax doesn’t simply tax luxurious health plans. It also affects ordinary plans that are expensive simply because they cover people with higher-than-average health costs, such as women, older and disabled workers, families with catastrophic health events and those who live in more costly areas.
COST DOES NOT EQUAL RICHNESS OF BENEFITS: DEMOGRAPHICS MATTER

Characteristics of large employers with plans that will reach versus won’t reach the Cadillac tax threshold in 2022:

<table>
<thead>
<tr>
<th></th>
<th>Will reach</th>
<th>Won’t reach</th>
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<tbody>
<tr>
<td>Older employees</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average age: 44</td>
<td></td>
<td>Average age: 42</td>
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<tr>
<td>More likely to offer coverage to part-time employees</td>
<td></td>
<td></td>
</tr>
<tr>
<td>63% offer</td>
<td>51% offer</td>
<td></td>
</tr>
<tr>
<td>More female employees</td>
<td></td>
<td></td>
</tr>
<tr>
<td>51% female</td>
<td>46% female</td>
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<tr>
<td>Plan values only</td>
<td></td>
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<tr>
<td>slightly richer</td>
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<tr>
<td>Average: 88%</td>
<td>Average: 86%</td>
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<tr>
<td>Higher rate of dependent coverage election</td>
<td></td>
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<tr>
<td>54% average rate</td>
<td>51% average rate</td>
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The Cadillac tax is more likely to penalize older workers, women, people with families, and employers who provide health benefits to part-time employees.

There is relatively little difference between the plan designs of those employers that will reach the threshold and those who won’t.

Estimates based on data from Mercer National Survey of Employer-Sponsored Health Plans 2017; premium trended at 4.7%, tax threshold trended at 2.75% in 2019 and 1.75% in future years.
Congress has twice delayed the tax by two years, so the original effective date of 2018 has been pushed to 2022. While these delays were helpful steps, Congress must fully repeal the Cadillac Tax to protect the coverage of 178 million Americans. The Council strongly supports the Middle Class Health Benefits Tax Repeal Act (S. 58, sponsored by Senators Dean Heller (R-NV) and Martin Heinrich (D-NM), and H.R. 173, sponsored by Representatives Mike Kelly (R-PA) and Joe Courtney (D-CT)), which would fully and immediately repeal the tax.

Reject new proposals to tax employees’ health benefits: Some policymakers in Congress have suggested replacing the Cadillac Tax with a tax on working Americans who have employer-provided health insurance. These proposals would tax health benefits provided by employers, meaning higher income and payroll taxes for millions of hardworking people.

“Capping” the employee tax exclusion — thereby subjecting the cost of employer-sponsored coverage above the cap to payroll and income taxes — constitutes a direct tax increase on employees and their health benefits. Such a proposal would be subject to many of the same flaws as the Cadillac Tax, disproportionately affecting employer plans in high-cost locations or with older workers, to name just two factors that affect health plan cost. In fact, capping the exclusion is essentially the Cadillac Tax under a different name.
EXPAND HEALTH REIMBURSEMENT ARRANGEMENTS (HRAs)

Employers are considering various strategies for health benefits design, including a “defined contribution” approach that would permit employees to purchase coverage from the individual market. Currently, IRS guidance prevents the use of HRAs, cafeteria plans or other tax-favored arrangements to purchase such coverage for employers with more than 50 employees.

The Department of Treasury and the IRS should update current guidance to permit employers to establish stand-alone HRAs (or similar, tax-favored accounts) that can be used to purchase individual coverage inside or outside the exchanges (both public and private). Employers and employees could share responsibility for funding these accounts. Amounts credited to these accounts could be used both to purchase qualifying coverage constituting “minimum essential coverage” and to pay for qualified health expenses. To avoid paying the employer mandate penalty, employers would need to make a contribution meeting the “affordability” test. “Double dipping,” in which employees receive employer money and an exchange subsidy, would be prohibited. Employees would not be permitted to cash out or use the funds for non-qualified health care expenses. To ensure a viable, individual insurance market, there must be adequate protections against adverse selection or risk segmentation.
Successful consumer-directed health plan designs, such as those incorporating HSAs and HRAs, are predicated on the availability and reliability of data showing the cost and quality of providers and services. Meaningful information on price and quality is often hard to capture, and adjusting for the clinical complexity of individual cases is difficult.

Adopt uniform, standardized quality measures:
Meaningful and uniform quality measures are at the foundation of value-based purchasing decisions. Adopting uniform quality measures, such as the measures defined by the Integrated Health Care Association and the Pacific Business Group on Health pertaining to commercial accountable care associations (ACOs), is a critical first step in untangling the health care cost and quality puzzle. As more large employers implement innovative payment reforms, such as direct contracting or creating an ACO, it would be incredibly helpful — if not vital — to have a uniform set of standardized quality measures. This would help achieve two policy goals:

- Standardized quality measures make it easier for providers participating in new payment programs to have one uniform set of measures on which to report. Some physicians have lamented being required to measure blood pressure three different ways for three different Medicare programs (measured one way for ACOs, another way for patient-centered medical homes, and yet another way for certain bundled payment programs). Providers are already being pulled in many directions and are pressed for time. Policymakers could ease the workload — while improving quality — by implementing a standardized measure set.

- Patients and employers would have an easier time identifying high-performing providers. If every program and provider necessitates its own set of measures, it quickly becomes impossible to compare providers. A uniform measure set — at a minimum, uniform across all Medicare payment programs and demonstrations — would help lay a strong foundation to achieving more meaningful payment reforms.

Uniformity in quality measures is essential. However, uniformity alone will not empower consumers to make smart health care decisions. Such measures must be meaningful to import value-based decisions into our health care system.
The employer shared responsibility provision of the ACA penalizes employers with 50 or more “full-time equivalent” employees who either do not offer coverage or do not offer coverage that meets minimum value and affordability standards.

As part of the tax bill enacted in December 2017, Congress repealed the ACA’s individual mandate penalties. It is essential that Congress also provide relief from the employer mandate penalties. The individual and employer requirements are directly linked. The statutory structure of the employer mandate makes clear that it was not simply a free-standing addition to a long list of provisions in the ACA but, rather, inextricably entwined with the individual mandate. The penalties are triggered when an employer has not offered a certain level of coverage and just one full-time employee receives a subsidy to purchase coverage in the insurance exchange. The employer mandate was intended to enable individuals to meet their legal obligation to have an established level of coverage — a legal obligation that no longer exists now that the individual mandate penalties have been repealed.

The vast majority of large employers offered coverage to their employees before the ACA was enacted and would continue to do so in the absence of an employer mandate. However, the final regulations implementing the employer mandate include many complex rules that present a significant challenge for employers. For example, the rules create a very difficult process for determining who is a full-time employee. The rules provide complicated methods for crediting hours of service, breaks in service and changes in employment status. Compliance with the mandate is extremely problematic, particularly with respect to employees who work a variable schedule (rather than a regular 30 or more hour/week schedule) as well as for temporary, seasonal or similar contingent workers. We strongly urge Congress to repeal the employer mandate to relieve administrative costs and burdens on employers that, collectively, serve to impede innovation rather than foster it.
Apart from repeal of the employer mandate, it is imperative that the onerous employer reporting requirements associated with it be simplified. This can be accomplished legislatively as well as with explicit direction to regulatory agencies, consistent with the executive branch’s directives to reduce regulatory burdens.

Specific ideas for relieving cost and administrative burdens and promoting regulatory flexibility regarding employer reporting requirements include:

1. Maintaining the relief from penalties for employers who make good faith efforts to comply with the information reporting requirements

2. Assisting employers with Social Security number reporting and verification rules

3. Providing relief from reporting deadlines, including allowing an automatic extension for the January 31 deadline to furnish statements to employees

4. Allowing reporting for employers on a controlled group basis

Additionally, last year, the IRS began enforcing the employer mandate by mailing Letter 226-J to employers, notifying them of proposed employer shared responsibility payments owed for calendar year 2015. Council members have many concerns about this process, including the short 30-day response time (from the date of the letter, including the time between sending and receipt of the letter); the potential for Letters 226-J to be delayed in reaching employers due to change of address, penalties triggered by systems errors; or mistakes due to the complexity of employer information reporting, particularly in 2015, the first year reporting was required.

Collectively, these complications demonstrate the need for very prompt action to make the reporting process more administrable.
Innovation in employer-sponsored health coverage thrives in an environment of regulatory certainty. This is due in large part to Congress’ wisdom more than 40 years ago when it enacted the Employee Retirement Income Security Act (ERISA), to include a provision that ensures ERISA plans are free from most state and local regulation. ERISA’s federal framework helps employers provide affordable and consistent health benefits to employees wherever they may live or work. Without ERISA uniformity, employers would have to comply with a patchwork of varying state laws and also would need to monitor and adapt to constant state-level changes.

Policymakers must ensure that future health reform proposals do not inadvertently weaken or circumvent ERISA and should consider advancing language strengthening ERISA uniformity to help ensure states cannot impose any requirements or taxes on self-funded employer-sponsored health plans.