

Notes

Health Experts Consider a Post-ACA World

By Stephen Blakely, Employee Benefit Research Institute

A T A G L A N C E

With the election of President Donald Trump, no domestic policy is a bigger target for change than the Affordable Care Act (ACA), former President Obama's signature health insurance law. His very first executive order, signed within hours of being inaugurated, was aimed at rolling back parts of the ACA.

But how, exactly, is the law likely to change, and how will this fundamental policy shift affect the U.S. health care and health insurance systems? Those questions were explored by a panel of health and policy experts at the Employee Benefit Research Institute's (EBRI) 79th policy forum held in Washington last December, attended by more than one hundred people.

The short answer, as the new administration was taking shape: Nobody knows. But whether it's a "repeal and replace," as many congressional Republicans have advocated ever since the law was enacted in 2010, or "repeal and delay" or "partial repeal" or "repair" (as some are now suggesting) or just "repeal," it seems certain that change is on the way. Among the experts speaking at the EBRI policy forum:

- Leah Binder of the Leapfrog Group, representing medium-sized and large employers.
- Paul Fronstin, director of the Health Research and Education Program at EBRI.
- James Gelfand, senior vice president for health policy with the ERISA Industry Committee (representing the nation's largest employers).
- Robert Graboyes of the Mercatus Center at George Mason University.
- Kris Haltmeyer, vice president for policy at the Blue Cross/Blue Shield Association.
- Randy Hardock, a partner at the benefits law firm of Davis & Harman in Washington, DC, and a former Treasury Department official.
- Katherine Hayes, a Medicare/Medicaid/health reform specialist with the Bipartisan Policy Center.
- Tom Miller of the American Enterprise Institute.
- Carolyn Smith of Alston & Bird, who previously served on the staff of the Joint Committee on Taxation in Congress.
- Katy Spangler, senior vice president of health policy at the American Benefits Council, which represents large employers.
- Gene Steuerle, a tax expert at the Urban Institute.
- Jeanette Thornton, head of ACA policy development for America's Health Insurance Plans (AHIP).

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But how, exactly, is the law likely to change, and how will this fundamental policy shift affect the U.S. health care and health insurance systems?

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Some observers say there could be seismic effects on the financing and even the structure of health care and health insurance in America—and consequently on patients and health-care providers—depending on how quickly and how sweeping those changes are. Some also express the hope that this latest attempt to reconfigure the U.S. health care system will focus on controlling costs, rather than just coverage—the deliberately limited focus of the ACA.

"We don't know what's going to happen," said **Randy Hardock**, a partner at the benefits law firm of Davis & Harman in Washington, DC, and a former staffer with the Senate Finance Committee and Treasury Department official, but "if the [new] president goes out and says he wants it, there is no way it can be stopped. They [Congress] may modify it, they may be able to do some things to minimize the transitional damage and uncertainty, but it's happening."



Hardock also predicted that "once they pass repeal, they won't work on 'replace' for two or three years"—both because congressional Democrats will balk at cutting a deal with Republicans and because of the difficulty of finding new revenue if Republicans reduce the existing health insurance tax exclusion to pay for the loss of key revenue-producing provisions (notably the so-called "Cadillac tax" on high-value health plans) that were enacted to finance the ACA and keep it revenue-neutral. That could have major effects on the federal budget and on providers and patients.



Katy Spangler, senior vice president of health policy at the American Benefits Council, which represents large employers and strongly opposes the ACA's Cadillac tax on health plan sponsors, agreed Congress is likely to repeal the law. But she also predicted "they'll try to do pieces of replace along with repeal."

Republican leaders are planning to use a fast-track legislative procedure that ties ACA repeal to the so-called "budget reconciliation" process in Congress, which permits the Senate to pass a sweeping budget bill by a simple majority vote, thereby preventing Democrats from blocking the legislation with a filibuster; this is expected to happen soon. But given the parliamentary restrictions involved with reconciliation, that process would be

largely limited to only the financial aspects of the ACA and would not allow for a wholesale replacement—even if Republicans had one ready.

Given that the \$3.2 trillion health care industry accounts for about 18 percent of the Gross Domestic Product,¹ and the long lead time required by employers and providers to overhaul health plans, the prospect of a sudden change (whatever the policy) could prove chaotic. That, and the prospect of the federal government suddenly returning certain federal health insurance functions back to the states, has health plan sponsors and insurers worried.



Because of the advance state deadlines for filing products and rates and for getting approval by state regulators, health plan sponsors and insurers must have their pending health insurance coverage plans ready no later than this April, said **Kris Haltmeyer**, vice president for policy at the Blue Cross/Blue Shield Association. If Congress is going to replace the ACA in time for health insurers to react, the new rules have to be clear and “everything has to occur really quickly,” he said.

“The industry is going to need to see stability that Congress will honor the commitments that have already been made for 2016 and 2017 for things that have already been priced and products that are out in the market,” he said. “We need that predictability going forward to see what the pathway is for the next two, three years, and have some idea of

what the replacement is as well.”

The EBRI forum focused on three key points: Strengths and weaknesses of the current U.S. health system; what panelists foresee happening this year; and what they expect for the future. A synopsis of the discussion follows. The full webcast of the event is online at <http://bit.ly/1gE99nX> (health section begins at 2:13:29).

Strengths & Weaknesses of the Current System

James Gelfand, senior vice president for health policy with the ERISA Industry Committee (representing the nation’s largest employers), noted that “for the 177 million people who have insurance through their employer and they have good insurance and surveys show that they’re happy with insurance, that part of the system works really great. Employers are the home of innovation and they invent things like wellness programs and care coordination, medication adherence programs, all the things that make health care cost less and serve patients better.” He expressed the hope that “we can preserve and not mess up that part of the system which works really well and people are happy with.”



He added that enactment of the ACA did not result in “the huge drop-off in employment-based coverage [following enactment of the ACA] that was necessarily predicted, although there may have been some and certainly that coverage has changed.”



Carolyn Smith of Alston & Bird, who previously served on the staff of the Joint Committee on Taxation in Congress, noted that the ACA “tried to deal with those people who were not covered, who were looking into the individual [health insurance] market.” As the Trump administration begins to grapple with health insurance issues, she added “we are, once again, looking at how you deal with those people, how do you arrange to have coverage so that people can have coverage, but yet let’s not try to fix what isn’t broken.”

In terms of positives, said **Katherine Hayes**, a Medicare/Medicaid/health reform specialist with the Bipartisan Policy Center, there is a slowing rate of per-capita cost growth in Medicare (the federal health care insurance program for people who are 65 or older, certain

people with disabilities, and people with End-Stage Renal Disease) and Medicaid (the federal-state health insurance program for low-income and needy individuals).

She also said “we’re seeing a greater shift toward *value*-based purchasing [of health care services], but a lot of folks are still in *volume*-based medicine, and it’s not going as fast as we’d like.”



On that point, **Leah Binder** of the Leapfrog Group, representing medium-sized and large employers, agreed that the ACA’s incentives to promote value-based health purchasing programs has been successful, noting that “it is originally a Republican idea.”

“Many of the payments in CMS [Centers for Medicare and Medicaid Services] are now tied to hospital performance on readmission rates and hospital-required conditions to reduce safety problems,” she said. “We’ve seen real improvements and there have been real changes in the hospital industry as a result of some of those provisions. I think they’re a good step in the right direction and hopefully those will continue in the next administration.”

Paul Fronstin, director of the Health Research and Education Program at EBRI, noted the ACA has not lived up to a couple of expectations, both for the good and for the bad. “There were some predictions that there’d be an erosion of coverage post ACA, and we haven’t seen that. There were also some predictions there would be an expansion because of the individual mandate, getting more workers to take coverage when it was offered and getting more employers to offer it, yet we haven’t seen that, either,” he said.



Clearly in the not-successful category, according to Blue Cross/Blue Shield’s Haltmeyer, is ACA’s attempt to stimulate health plan offerings among small employers, which historically have been far less likely than large employers to offer health coverage to their workers. “One area that hasn’t been stable has been the small-employer marketplace, we’ve seen about a 25 percent reduction in coverage among small employers over the last three years,” he said. “I think we’re going to have to reevaluate what set of reforms really makes sense for small employers as we think about health care reform,” Haltmeyer said.

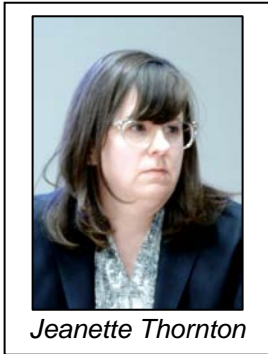
Hardock, of David & Harman, said the shift to consumer-directed health care was “a debatable success,” even though “the employer community has moved in that direction a great deal.”

What’s Likely This Year

Spangler, of the American Benefits Council, which has been among the leaders of the fight to repeal the so-called Cadillac tax on high-cost health plans, expects the new Trump administration will make that wish come true. But she’s also concerned that a wholesale reform of the federal tax code—another Republican priority—may hurt employment-based health plans by reducing current federal tax preferences for workers who take it.

“While we are very hopeful that the Cadillac tax would be fully and permanently repealed, we’re also nervous about proposals to cap or limit the employee exclusion or the employers’ deductibility, because of the impact that that would have on the folks that get that coverage,” Spangler said. She disputed the idea that such a move would decrease the cost of health care: “You’re really just shifting the costs” onto individuals.

Jeanette Thornton has led ACA policy development for America’s Health Insurance Plans (AHIP). She said a big concern of her organization is that “there could potentially be a lot of changes proposed very quickly in the new year” (using the budget reconciliation process in Congress), which would repeal the individual mandate (requiring most



Jeanette Thornton

individuals to either have health insurance or pay a penalty if they don't). This has the potential to be extremely disruptive of the health insurance industry if done suddenly, she said.

"One of the things that's really important is the transition, and a smooth transition. We have consumers who are enrolling right now during open enrollment, and we want to ensure that we have certainty and coverage for these individuals through the remainder of 2017," she said. "I think the individual market is really going to be the big focus coming up early in the year."

Consumer-Driven Health Plans

Smith, of Alston & Bird, predicted that "the consumer-driven model is going to be the core of what is envisioned." "This is nothing new from the Republicans—it has long been a focus of what they believe," she said. Republicans are also likely to propose a tax credit geared toward encouraging the individual market, purchasing a high-deductible plan, increasing contributions to health savings accounts (HSAs), and "providing something affordable," she said. "This is going to be the transition. This is going to be the model."

Gelfand, of the ERISA Industry Committee, noted that "high-deductible" and "affordable" may not be compatible. "Employers generally are very much in favor of moving in this direction and finding ways to make those plans work, but I think we also have to be real when we talk about this," Gelfand said. "The tens of millions of Americans who are living paycheck to paycheck, they're not putting any money into an HSA, okay? If you make \$10 an hour, you're not putting any money into an HSA."

He added: "We're talking about large institutions here and, yet, we're putting these individuals in charge and saying, 'All right, go get 'em, tiger. Go figure out how to make health care cheap.' Are those resources really, truly there? We have to really find a way to bridge these gaps, because just dumping everybody into high-deductible health plans and telling them, 'OK, now save money and then use that money well,' that's probably not going to work. We have to have some bridge to get there and to get people prepared to make those decisions and to get the information that they need."

Binder agreed that "we're still nowhere on being able to support consumers in making those direct-purchase decisions—it is extraordinarily difficult. Price transparency is nowhere." She also said HSAs "are not self-insurance vehicles—they are meant to be accounts that people use to spend money. They are very different from the insurance model, and they're meant to be different."

She predicted that the movement toward HSAs "is a shift that we're about to see in a very profound way in the next few months....the proposals on the table represent a shift from a reliance on health insurance as 'coverage that pays your bills as a consumer' to the notion that 'consumers pay their own bills in health care with insurance as a support for more catastrophic bills.'"

EBRI's Paul Fronstin noted that "we've already shifted" towards HSAs, which now represent a third of all private-sector health plans and even more if health reimbursement arrangements (HRAs) are counted; including high-deductible PPO and HMO plans with no savings or reimbursement account increases their market share to more than two-thirds of all private-sector health plans.

"So, we're already there with people having to take responsibility for those upfront expenses," he said.

Robert Graboyes of the Mercatus Center at George Mason University, who studies health innovation, agreed that a key element of the “consumerism” model (price transparency) largely does not exist. “One of the problems—I would say *the* problem—in the American health care is that a lot of the transparency mechanisms don't work very well because we've spent a century building in mandatory opaqueness, both in law and in tradition and in medical societies,” he said.



As the exception to that rule, Graboyes highlighted the Surgery Center of Oklahoma, which lists on its website “to the penny” the cost of some 800 procedures. When patients cite those prices to doctors elsewhere charging vastly higher amounts, the high-priced doctors have been known to match the rates. Such clarity is needed throughout the health industry, he suggested: “The insurance plans we have, the laws we have, especially at the state level, many of the laws or regulations we have absolutely discourage this sort of openness, and the development of competitive markets. And they deprive people of the tools that can make it work like other markets do.”

Gene Steuerle, a budget and tax expert at the Urban Institute, who has “worked on a lot of health, tax, budget, and Social Security reforms” over the years, said “they all have one element in common—if you're on the inside, the numbers don't add up: The balance sheet is never complete.”



“Politically, of course, the politicians want to talk about winners and what they're going to do that's positive for people; but even if you're doing something good, you have to pay for it. And what politicians don't like to do is say who's going to be the loser. They want to hide who pays,” Steuerle said, adding: “Republicans are just as bad as Democrats, and they will be just as bad in this cycle as you've seen in any other cycle, and right now their numbers don't add up.”

“The first year of an administration, particularly for a party that's in power in both Congress and the presidency, they've got to do something their first year. They've got to deliver at least symbolically. They can't go through the first year and not deliver something like a tax cut or health reform. So there's a powerful, powerful political incentive that something significant be enacted.”

He described as the “original sin” of the American health care system is that “we bargain over what everybody else will pay....in economic terms that creates an infinite demand and infinite supply. You've got to empower somebody in the system to say no [to higher costs], and it's either individuals, it's an intermediary like an insurance company, or it's the government, through price control. Logically, it's got to be one of those.”

Steuerle said high-deductible health plans do let individuals “make decisions on some level,” but added: “It's not clear how much effect that has, because catastrophic expenses are still such a large portion of the total.” Also, that high-deductible plans are more likely to adversely affect low-income people than others. But whether it's high-deductible plans or insurance premium support in which employers provide a set amount and let their workers select a health plan, “they [reformers on both sides of the aisle] are trying to empower or make somebody in the system say ‘No,’ and I do think there will be some movement in that direction.”

Although the ACA focused on increasing health insurance coverage among Americans, he added that “we have to begin to shift our thinking beyond the issue of health coverage, which is very important, but that's not the only issue. If we're going to shift toward a model where consumers are out there purchasing directly, we have to start thinking about policies that make that work,” especially enabling price transparency.

The Politics of Repeal

Tom Miller, of the American Enterprise Institute, who described his job as “working on ACA demolition and replacement site preparation,” said congressional Republicans are “treading a narrow path” between simple repeal of the law and figuring out what to replace it with.

Beyond the political rhetoric, he said, there are serious legislative complications involving what budget reconciliation can and cannot do. “The sequencing, the timing, the transition, how you get a budget score, how you get a majority to hold together—those are substantial hurdles.”

“Trying to close that timing gap between ‘we repealed it’ and ‘we put something else in place’ is extremely, extremely difficult, and I would not count on much bipartisanship on that front,” Miller said.

One of the thorniest questions, he said, is how Republicans would keep their legislation budget-neutral, since repealing the ACA would also remove the tax increases (such as the Cadillac tax) that were enacted to finance the original law.

“Where are you going to get the money from? You’re going to get it out of Medicaid. It’s the only place to get it. So there’s going to be thinner benefits, less money going into that,” Miller said. That is certain to generate opposition from state governors, who would be under pressure to make up for reduced federal support. He also predicted Congress is very likely to continue to delay, if not repeal, implementation of the Cadillac tax on high-cost health plans. He added that the idea of replacing that lost tax revenue by capping or reducing the federal tax exclusion on employer-provided health insurance also lacks political support.



Katherine Hayes, of the Bipartisan Policy Center, predicted that the eight Republican senators who come up for re-election in 2018 will be the key decision-makers on ACA repeal and replace, since they stand to lose if there is chaos in the health insurance market as a result.

“The question becomes this core group of eight Republicans who are up for reelection. Some people are gambling on the fact that at the end of the day, this core group is going to be really worried about what is going to happen in the market, and they’re not going to be willing to play chicken and let everything collapse,” Hayes said.

Smith, of Alston & Bird, focused on “the interaction of federal and state law,” since states historically have been the primary regulators of health insurance. She noted that division has been impacted over the years, first by the ERISA pre-emption for self-funded private sector health plans, then the federal health portability and privacy law (HIPAA), and most recently by the ACA. Repealing the ACA would shift many regulatory responsibilities back to the states, some of which may be ill-prepared to assume the role, she said. Conflicts are likely for states (such as California) that have a lot of health insurance mandates and would want to regulate multi-state employers trying to avoid those mandates.

“One of the debates that hasn’t come to the public is, what is the role left for states? I think that’s going to be a complicating factor as we move forward,” Smith said.

Haltmeyer, of Blue Cross/Blue Shield, agreed, saying “it’s going to take a lot of work for states to become able to take back a lot of the [ACA] reforms,” such as high-risk pools. “We need to be really careful about making a smooth transition if there is going to be state reform, so that states have the time to enact the laws they need to and staff

up—and that will probably require a lot of federal support,” he said. “States don’t have the capability to do risk adjustment today—there’s no state that does risk adjustment. Most of them don’t have the capabilities to do a lot of the exchange functions.”

Graboyes, of George Mason University, noted that the Mercatus Center recently posted an online resource called the Health Care Openness and Access Project that enumerates state health laws and regulations and which states allow greater patient and provider flexibility. He said “states have an enormous amount of leeway” to support innovation in the delivery of health care.

As an example, he noted an inexpensive new FDA-approved device that fits on the back of a cell phone and, with artificial intelligence technology, allows individuals to give themselves an electrocardiogram and determine immediately whether or not they are suffering a cardiac emergency. He bought the \$100 device out of his own pocket and used it successfully when driving in a remote area to determine he was OK—not only protecting his health, but saving the \$3,000 cost and hours of time to have an EKG administered in a hospital.

“There are vast numbers of these technologies,” he said, but “our FDA approval system tremendously slows down the development of these things, the diffusion, the dissemination...It seems to be a sensible thing that Medicare or Blue Cross would buy things like this, but they don’t. We really need to look at the regulations that allow us to snip away chunks of cost piece by piece, because right now it’s death by a thousand cuts.”

Miller, of AEI, predicted that Congress has a political incentive to return health regulation to the states, since “that’s delegating the dirty work to the states—you assume they can do it without the proof they can actually do it, because it gets it out of Washington.”

He also said “we keep thinking about magic technology that can solve the delivery-system problem, and sometimes it can. But the magic technology we usually demand, it’s usually upper-middle-class voters who are asking for this, and it is cost-increasing technology, not cost-reducing technology...and then all the poor people who can’t afford it are stuck with that type of expensive system.”

He also predicted that congressional Republicans are likely to find out their perceived solution to health insurance problems may not be shared by the general public, especially concerning their preference for flat, fixed-dollar subsidies for health coverage. “We have a massive collision coming up where [lawmakers] think one thing and it does not square with where the public is,” Miller said. “That’s going to play out as far more difficult before the general public than it does within the Republican conference.”

Gelfand, who is not a fan of the ACA, praised the law for forcing some states (notably Maine) to reduce what he said were overly burdensome regulations. “One of the things that ACA really got right was they froze state mandates by saying that if you increase state mandates on insurance in the state, that cost is going to be shifted not onto the people paying for health insurance, but onto the government,” he said.

“It was one way of trying to get at this problem small employers especially have been complaining about for a very, very long time: If you’re in the wrong state, you’re screwed because health insurance just costs too much. Special interest on the state level is so, so much stronger than it’s been on the federal level,” he said.

He also expressed reservations about shifting to a more state-based regulatory process if the ACA is repealed, “because the state regimes have been a disaster...the individual market has always been the absolute worst place to get health insurance, and part of that is because of the overregulation and special interests involved.”

Steuerle predicted that within the next few years Congress “is not going to be able to avoid the issue” of high prescription drug prices. Because pharmaceutical companies largely can set their own prices, Steuerle said, “You [the

government] can't simultaneously give companies monopolies over prices and at the same time say you'll be willing to pay the market rate on that monopoly.... You either have to push in the form of regulating prices or you have to make competition much more viable."

To that point, Gelfand noted "there are dozens of states that are considering legislation to increase the barriers" to using less expensive "bio-similar" drugs to more expensive biologic drugs—an example of how on the state level "the special interests can just go haywire."

Graboyes suggested the United States should learn from the European Union's system of drug approval, which brings new pharmaceuticals to market much faster and more effectively. The U.S. system is "slowing down the development of drugs that can indeed bring costs down and improve health," he said.

The Future

Fronstin predicted that congressional Republicans will use the budget reconciliation process "as much as possible" to repeal the ACA, and that "we won't get a replacement bill at the same time, with one exception—for the Cadillac tax, which will be handled through tax reform legislation."

Spangler speculated that a Republican ACA-repeal bill that was passed by Congress last year included an expansion of Medicaid through block grants to the states. That measure was vetoed by President Obama but is likely to be the model they follow in 2017.

Concerning that legislation, Smith noted "no one really paid much attention at the time because it was symbolic, everybody knew it was going to be vetoed but it's a model of what they're thinking now." Not only had it cleared Senate rules and could be added to a budget reconciliation bill but it "basically got rid of pretty much all the ACA taxes that were there," and Medicaid expansion. Importantly, it left in the ACA market reforms, such as protection for patients with pre-existing conditions. "I think it's not sustainable to just get rid of the taxes and things without having a replacement and keeping those market reforms there," she said.

Thornton noted that "there are a lot of challenges if you go ahead and you repeal even with the transition and don't provide signals to the market about what the health insurance industry is going to look like, because, you know, benefits, networks, all these big changes that people are talking about, they take time." She added: "We've really been stressing the need to have some certainty, some rules of the road to understand what the market is going to transition to, so we can be prepared and make those changes."

Gelfand noted that "everything that [Republicans] suggest is going to be compared to the ACA," since it is the law of the land right now. That will be especially true regarding funding mechanisms for the ACA, which was financed by taxes on pharmaceutical manufacturers, medical device companies, insurance companies and hospitals and executive compensation. "What are the optics of saying we're going to get rid of all that, and finance health reform just with a tax on working families?" he said. Age-based tax credits, which Republicans appear to be embracing, are unlikely to maintain the ACA's level of health coverage and is not something that "actually can work in the real world."

Binder said Republicans will lose the health care debate if they "repeal Obamacare and replace it with Obamacare lite" that focuses just on tweaking health care coverage without addressing health care quality. "The Obama administration did not put the priority on improving care, the main focus was on improving coverage. They figured they'd deal with quality later, and later has come. Costs are growing and quality is not where it should be."

Noting estimates that one-third of health care costs are wasted, and 1 in 4 patients are harmed by the health care system, Binder asked: "When are we going to address that? The same old arguments are not going to improve things."

Graboyes criticized the health care pricing in the United States, describing it as “an opaque system where everything is discounts under the table.” Steuerle predicted that a powerful budget constraint would be to force hospitals to pay for readmissions. “If there’s no budget constraint in the system you can design the best idea in the world; but without a budget constraint, why adopt it?” he said.

During the question-and-answer session, one audience member described major health care reform legislation as a massive but likely futile effort, “sort of like invading Russia in winter. Napoleon did it, the Kaiser did it, Hitler did it, and people just kept doing it with the same result. And now the Republicans are invading Russia all over again.”

Steuerle noted that health costs “are still rising quite rapidly,” but because of Medicare—not Obamacare. With the sharply rising projected costs for Social Security and Medicare, he said, along with interest on the national debt, “basically all the revenue growth in the economy is committed to retirement and health—everything is going for retirement and health and interest. What we’re doing is crimping on education, on infrastructure, on basic government services. Everywhere else in the system is really taking it on the chin if we don’t tackle those problems [retirement and health programs] together.”

Graboyes credited increasing longevity in the United States—along with the failure of retirement policy to account for that change—for much of the financial stress currently being experienced.

“Our institutions for both retirement and health care were designed in a period where you were going to retirement and you were going to die fairly quickly thereafter. And if that were still true, we wouldn’t need to have most of this discussion today, because both retirement and health care systems would still be in pretty good shape financially,” he said. “We have never quite absorbed the fact that reality is gone, that we do live to our 90s, and that the old institutions we designed really aren’t up to snuff for handling that. And until we really internalize that, we’re not going to fix either of these.”

Endnote

¹ Centers for Medicare and Medicaid Services, <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html>

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