Nearly one decade after the passage of the Affordable Care Act, health care continues to be a top issue among voters in the U.S., with the two major parties offering distinctly different visions of the direction of future reform. To help CHROs, their teams, stakeholders, and the public better understand the health care landscape and the prospects for change, the American Health Policy Institute examines the various types of reform proposals currently being discussed among policymakers, political candidates and other key stakeholders.

Objectives of the Discussion

We aim to increase awareness of the spectrum of potential future health care reforms that may be proposed over the next two years—and help senior HR leaders assess the implications of various types of reform on their future business and talent strategies. We will also use this information as the basis for follow-up discussions with members that will help shape the Association’s objectives.
I. EMPLOYERS AND THE U.S. HEALTH CARE SYSTEM

THE U.S. HEALTH CARE SYSTEM IS UNIQUE

The U.S. health care system is unique among industrialized nations in two important ways. First, the system does not provide for universal coverage for all citizens. Second, for most Americans, access to health care coverage is linked to employment.

The U.S. health care system is built on the concept of private sector competition, with government playing a more limited role compared to other developed nations. About half of Americans get coverage through their employment while roughly one third are covered by government plans. A small number (7%) purchase their own individual insurance policies, and about 9% remain uninsured.

The majority of insured Americans receive coverage through an employer-sponsored plan. Of 327 million Americans, nearly 160 million get coverage through employment.

The percentage of Americans with employer coverage reached 65.1% in 2009.1 That percentage declined over the last decade until turning upward again in 2018. Nearly 70% of private industry workers are now offered health care coverage from their employers—and among union members in the private sector, availability is almost universal at 94%. Slightly less than three quarters (72%) of private sector workers who are offered coverage actually opt to take it.iii

HEALTH INSURANCE COVERAGE OF THE TOTAL POPULATION

<table>
<thead>
<tr>
<th>Source: Kaiser Family Foundation, 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>EMPLOYER 49%</td>
</tr>
<tr>
<td>MEDICAID 19%</td>
</tr>
<tr>
<td>MEDICARE 14%</td>
</tr>
<tr>
<td>UNINSURED 9%</td>
</tr>
<tr>
<td>NON-GROUP 7%</td>
</tr>
<tr>
<td>OTHER (PUBLIC) 2%</td>
</tr>
</tbody>
</table>

ORIGINS OF EMPLOYER-SPONSORED INSURANCE IN THE U.S.

WWII resulted in a severe labor shortage. Employers increased salaries to attract workers. Worried that inflation would rise at an unsustainable rate, President Roosevelt froze wages. Employers, searching for ways to attract new talent, began to offer health insurance as a benefit.

Read more.
Coverage among large employers has remained steady over time, but smaller employers began to drop coverage at higher rates following the passage of the Affordable Care Act. The number of small firms offering health benefits to their workers dropped by 24% between 2012 and 2016.iv

As part-time and “gig economy” work increases, the percentage of working Americans receiving coverage connected to employment is likely to decrease—as many of these arrangements do not qualify for benefits coverage.

MOST LARGE EMPLOYERS REMAIN COMMITTED TO HEALTH CARE COVERAGE

While many small employers have stopped offering health care coverage, most large employers remain committed to this benefit as a key part of their total compensation package. Many are going further and linking coverage to creating a culture of wellness—a key addition to their employment value proposition. Other employers view coverage as a necessary part of a basic employment offer—not necessarily as a source of competitive advantage in attracting talent. A 2018 HR Policy survey shows that 71% of employees value their health benefits and it continues to be a key to their employment decisions ranking just behind compensation.

THE FEDERAL REGULATORY FRAMEWORK

Employers operate their plans under a well-established legal framework, the centerpiece of which is the Employee Retirement Income Security Act (ERISA). In addition to establishing the regulatory framework for benefit plans, one of ERISA’s most significant elements for employers is “ERISA preemption.” Practically speaking, ERISA preemption means that employer-sponsored health care plans that comply with ERISA’s provisions are relieved from the burden of complying with state and local laws that regulate insured health plans.

RISE IN NON-TRADITIONAL EMPLOYMENT ARRANGEMENTS

Non-traditional workers (gig economy, independent contractors) are at a disadvantage when it comes to health benefits because they do not qualify for group health insurance.

Over one third of the workforce is estimated to have freelanced in the past year. Freelancers are often more politically active; 70% say they would cross party lines to vote for those who support their interests. The number one public policy issue for freelancers? Access to affordable health care.

Read more.

THE IMPORTANCE OF ERISA PREEMPTION

If ERISA preemption were abolished, many employers could decide the burden of offering health care coverage is too great.

Employer groups—including HR Policy Association—have long defended this provision with policymakers at the federal level.

Read our piece on ERISA preemption: “The Need to Strengthen ERISA Preemption.”
ERISA imposes duties on employers who offer benefit plans to act in the best interests of their plan participants—which among other obligations, means employer sponsors must ensure that plan funds are spent responsibly. This can be a challenge in the health care arena, as companies don’t always have insight into the pricing and quality data of their administrators and providers. For more on this, see our piece “Erisa Fiduciary Responsibilities for Health Care Plans.”

THE AFFORDABLE CARE ACT

The second major piece of legislation, the Affordable Care Act (ACA,) impacts employers in the following ways:

- **Employer Mandate:** Large employers are subject to a payment if the employer does not offer affordable coverage that provides minimum value to its full-time employees and their dependents.

- **The Cadillac Tax:** While Congress has delayed the Cadillac Tax’s effective date to 2020, if implemented, the provision will impose a 40% tax on employer-sponsored health coverage that provides value in excess of certain dollar caps. Read more on the Cadillac Tax.

- **Reporting Requirements:** Large employers must file an annual return.

- **Provide a statement to each full-time employee**—reporting whether they offered health insurance, and if so, what health coverage they offered their employees.

In addition to complying with federal regulations under ERISA and the ACA, employers must also ensure that their benefit programs comply with federal tax law. Employee health benefits are tax-exempt, meaning that the amount an employer spends toward employee coverage is not considered taxable income to the employee. This tax-preferred treatment provides a financial incentive favoring employer-

**WHY EMPLOYERS OFFER HEALTH INSURANCE**

- Keeps employees healthy and productive on the job;
- Adds to corporate ethos and a culture of health;
- Serves as a driving force in employee retention and is vital to securing a robust workforce;
- Employees appreciate, desire, and expect health insurance;
- Efficient way to administer health coverage to large numbers of people; and
- Employers are in a position to seek financially sustainable rates, whereas they would have less control if they were to send employees to the exchanges.

Read more.
sponsored health care coverage. The tax code also regulates employer plans that allow employees to contribute pre-tax income to a health care savings account.

Read more about the benefits of the tax-preferred status of employer-sponsored health coverage.

**STATE-LEVEL ACTIVITY**

While employer self-funded health care plans are generally not required to comply with state laws, recent actions by states and local governments have threatened to erode or evade ERISA preemption. Examples include:

- **Healthy San Francisco:**
  Passed in 2006 with the support of then mayor and now California Governor Gavin Newsom, the “Healthy San Francisco” ordinance mandates that large businesses operating in the city either provide health coverage to their employees, pay into a citywide healthcare fund or contribute to their employees’ health savings accounts. The City of San Francisco was sued over the ordinance, but the 9th Circuit Court of Appeals upheld the law, and the U.S. Supreme Court refused to hear the case on appeal.

- **Michigan self-insurance claims act (since repealed):** In 2011, the State of Michigan passed a law requiring Third Party Administrators, insurance carriers and HMOs to charge and collect a 1 percent tax on health care claims paid for Michigan residents who received health-related services in Michigan. This law was repealed in 2018.

Also on the horizon is the potential for one or more states to bypass the federal process entirely and implement their own universal coverage requirement. Over a decade ago, Massachusetts enacted a law requiring residents to purchase health care coverage, and most employers to offer coverage. Since then, efforts to enact health care reform at the state level have taken place in several states, including Vermont, Colorado and California. We’ll examine these reform initiatives in more detail later in our paper.

**THE U.S. SYSTEM IS COSTLY**

Health care is one of the most important—and contentious—issues in the U.S. In the campaign leading up to the 2018 midterm elections, surveys indicated that health care was one of the top three issues of concern to voters. And the primary reason for this is cost. The cost of employer-sponsored health benefits is expected to grow to $15,000 per employee next year.

Both employers and employees have shared in the increased costs; but over time, the percentage of total costs borne by employees has increased, as companies look for ways to manage their health care expense.
As part of the cost-sharing strategy, many employers have moved to “consumer directed” or “high deductible” health plans. Under these arrangements, employees typically pay lower monthly premiums, but must reach a much higher deductible before plan benefits are paid. These plans are based on the premise that putting more financial responsibility on employees would motivate them to be more effective health care consumers. Recent studies call into question whether that is happening. These studies suggest that employees participating in high deductible plans may, in fact, be delaying needed care due to out of pocket costs. Eighty-two percent of workers see their medical costs as the biggest challenge but only 25% rank contributing to a health savings account as a priority—below saving for retirement, paying for essential day-to-day living expenses and paying off debt.

In addition to working to create better health care consumers, some employers have attacked the cost question by trying to lower the price of care—by using their negotiating power to contract directly with providers, by creating centers of excellence, and by creating high performance networks. But implementing these types of actions typically requires the employer to have deep benefits expertise and resources—things that many mid-sized or small employers don’t have.
The escalation in costs has had a major financial impact on Americans. Medical costs are a common cause of bankruptcy for Americans—even those with insurance. Rising health care costs have also been linked to sluggish wage growth—as the money employers put into health benefits drives up labor costs and depresses increases in cash wages.

Why are health care costs so high in the U.S.? Recent evidence points to higher prices—not higher utilization. One study showed that the U.S. spent nearly twice as much as 10 high-income countries on medical care, but health care utilization did not differ substantially. Prices of pharmaceuticals, devices, and administrative costs proved to be the main cost drivers. Waste is also a key contributor to high costs, estimated at $750 billion per year.

Some observers also argue that the recent consolidation among health care providers contributes to higher prices.

**THE U.S. SYSTEM IS LARGE AND COMPLEX**

The U.S. health care system—those who provide care, manufacture drugs and devices, administer and pay claims, and provide consulting and other services—is large by any measure. Not only does it consume almost one-fifth of U.S. GDP, it’s the largest source of jobs and the second largest sector in the S&P 500.

**HOW THE STATE OF MONTANA ATTACKED THE COST OF CARE**

The head of Montana’s employee health plan made better deals with hospitals and drug benefits managers and saved the state’s plan from bankruptcy. She believes employers should be pushing back against the industry and demanding that it justify its costs. They should ask for itemized bills to determine how prices are set. And they should read the fine print in their contracts to weed out secret deals that work against them. This success story shows how a large employer leveraged its buying power to negotiate its own health care costs and saved money doing it.

**HOW BOEING USES DIRECT CONTRACTING TO FIGHT FOR VALUE**

Boeing has bypassed the health insurer to make its own direct contracts with health care systems in four states. Since 2015, Boeing has added more than 15,000 employees to direct contract plans, which the company calls its “Preferred Partnership” health plan. Boeing says that direct contracting has improved the quality of care provided to employees and has resulted in higher patient satisfaction.

Read more here.
# THE MAJOR PLAYERS

The health care sector is also very complex. The major players in the system include:

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patients who receive care</strong></td>
<td>While the patient is the consumer of care, most pay only a small percentage of the cost of care</td>
</tr>
<tr>
<td><strong>Providers who deliver health care services and products</strong></td>
<td><strong>Physicians</strong> – increasingly part of large groups, often part of hospital system</td>
</tr>
<tr>
<td></td>
<td><strong>Hospitals and other facilities</strong> – both non-profit and for-profit hospitals; increasing trend of consolidation</td>
</tr>
<tr>
<td></td>
<td><strong>Drug and device manufacturers</strong> – drug manufacturers are large, global, and largely for-profit entities</td>
</tr>
<tr>
<td><strong>Insurers that process payments for care</strong></td>
<td>The insurer market is dominated by few, large insurers – the five largest companies insure half of the population; the four largest control 80% of the private insurance market</td>
</tr>
<tr>
<td></td>
<td>Insurers play two roles: Providing actual insurance for individuals and groups – where the insurer bears the financial risk of loss; and acting as plan administrators (“Third Party Administrators”, or TPAs) for employers who retain the financial risk</td>
</tr>
<tr>
<td></td>
<td>60% of the revenue from the nation’s five biggest insurers come from plans funded by Medicare and Medicaid</td>
</tr>
<tr>
<td><strong>Consultants/brokers/intermediaries</strong></td>
<td>Firms that perform a variety of services that facilitate the delivery and/or administration of care. Pharmacy Benefit Managers (PBMs) and insurance brokers are two examples.</td>
</tr>
<tr>
<td><strong>Government</strong></td>
<td>Plays multiple roles: acts as payor (through Medicare and Medicaid), provider, and regulator</td>
</tr>
<tr>
<td><strong>Employers</strong></td>
<td>Pay the majority of health care costs for half of Americans</td>
</tr>
</tbody>
</table>
HOW PRICES ARE SET

The system is founded on the principle of private sector competition; as a result, except for government programs (Medicare and Medicaid) prices are set based on negotiation between providers and insurers. Insurers work to get the best prices they can using the negotiating leverage of being able to deliver a certain “volume” of business to providers. As a result, different insurers negotiate different prices with the same provider, because each party comes to the negotiation with more or less leverage.

And, providers and insurers strive to keep their financial arrangements secret—so that consumers and even employers (on whose behalf they are negotiating) don’t know what is actually paid. This lack of price transparency is a major cause of concern among employers, as it inhibits their ability to direct employees to the most efficient providers.

When the government is the one paying the bill, the situation is different. Medicare reimbursement prices are decided by the federal government for more than 7,000 services. These payments to hospitals and doctors are determined by a system called the Resource-Based Relative Value Update Scale (RBRVS). The RBRVS takes the average costs of providing services and adjusts the price to accommodate other provider expenses such as administrative costs and malpractice insurance.

Medicaid, on the other hand, is jointly funded by the federal and state governments and is run by the states. The states pay providers, and the federal government reimburses the states based on the Federal Medical Assistance Percentage, a yearly assessment of each state’s average individual income level. States with higher incomes receive fewer federal dollars, while states with lower incomes receive more.

THE ROLE OF PBMS

PBMs serve as a middle-man in the prescription drug supply chain. They administer prescription drug plans for self-insured employer plans, union plans, commercial health plans, Medicare Part D plans, managed Medicaid plans, state government plans, and others.

PBMs are controversial because they are often seen as one of the more opaque players in the health care supply chain. Only one-third of employers rate their PBM as “very trustworthy,” and half say that PBMs do not provide enough transparency into formularies—the list of prescription drugs covered by a drug insurance plan.

More information on PBMs.
Medicare typically pays health care providers higher rates than Medicaid. Over the past several years, Medicare has implemented new value-based payment models as opposed to traditional fee-for-service payments. This means that providers are paid more when patients have better outcomes. These experiments in payment models have the potential to drive changes throughout the entire health care system, which could drive efficiencies and lower costs.

The complexity created by multiple players and payment models means vast resources are needed just to administer the system – one of the key reasons the cost of health care in the U.S. is so high. The size, complexity, and variation in quality also make it very difficult to get the consensus needed to drive meaningful reform.

PRIVATE SECTOR RESPONSES

But while public policy reform has essentially stalled, private-sector led changes are disrupting the marketplace.

- **Consolidation**: Hospitals and physician groups are combining to create scale-driven efficiencies. At the same time, providers and insurers are combining to drive vertical integration. The recent combinations of Aetna with CVS and CIGNA with Express Scripts have the potential to transform the patient experience with the health care system.

- **Employer actions**: As noted above, there has been an increase in direct contracting with providers by large employers; employers are also leveraging their buying power to make changes to the system. Two prominent examples of this are the collaboration between Amazon, JP Morgan Chase and Berkshire Hathaway aimed at driving lower costs and better outcomes for their employees; and the Health Transformation Alliance, created by the HR Policy Association in 2016 and now operating as an independent cooperative working on behalf of employers to improve the health care system.

TABLE: TYPES OF PAYMENT MODELS

<table>
<thead>
<tr>
<th>Payment Model</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fee-for-service</td>
<td>Provider is paid according to each service delivered</td>
</tr>
<tr>
<td>Value-based</td>
<td>Provider is paid according to patient outcomes</td>
</tr>
<tr>
<td>Accountable Care Organization (ACO)</td>
<td>Groups of providers share joint responsibility for cost and quality of care for a patient population</td>
</tr>
<tr>
<td>Bundled payment</td>
<td>Provider is paid according to the estimate of the total cost of all services provided for a particular health condition</td>
</tr>
</tbody>
</table>
II. THE HEALTH CARE REFORM SPECTRUM

POLICYMAKERS HAVE DIFFERING VISIONS OF HEALTH CARE REFORM

While most large employers remain committed to offering health care coverage, the growth of non-traditional employment relationships in the “gig economy” call into question the continued viability of a model based primarily on access through traditional employment. The U.S. system is also expensive and complex. Health care spending represents one-fifth of GDP, and the sector creates more jobs than any other; but the complexity and waste in the system are significant contributors to high and seemingly unsustainable costs. And while the U.S. is often praised for the quality of care available to its citizens, health outcomes for Americans fall short of those of other industrialized nations.

In light of the above, it’s not surprising that health care remains one of the country’s most significant public policy issues. During the 2018 midterm elections, health care was one of the top three issues among voters and it is shaping up to be a major issue in the 2020 election.

It’s also not surprising that Democrats and Republicans have very different visions of what direction health care reform should take in the future. While Republicans have largely abandoned prior calls to “repeal and replace” the Affordable Care Act (ACA), the Trump Administration declined to defend the ACA in a recent challenge in a Texas district court. Instead, the Administration has focused its efforts on taking actions to increase choice and competition.

TEXAS V. AZAR

In December of 2018, a Texas federal district court judge held that the ACA is unconstitutional. However, the judge stayed the decision pending appeal, so the ruling will not have an immediate impact for employers. Despite the stay, the ruling has turned up the political heat on health care reform.

Read more about the case.
and reduce benefit mandates and drug prices. For example, expanding access to short-term plans that do not meet the ACA’s minimum benefit requirements and reducing the penalty for the individual mandate have increased consumer choice for those who can’t afford expensive ACA plans. Overall, Republicans seek a future that encourages free market competition, discourages government mandates, favors individual choice, and gives more flexibility and control to the states.

For Democrats, “Medicare for All” is emerging as a rallying cry for many - but there are significant differences between the moderate and progressive elements of the party as to what, exactly, such a plan would include. Some believe the only viable solution to the nation’s health care crisis is a complete replacement of the current system with a government funded and controlled single-payer approach. Others, aware of the fact that nearly half of Americans have employer-based coverage and are happy with it, are advocating a “public option” approach, preserving employer-based plans, increasing subsidies in the individual market and allowing those without coverage to “buy-in” to a government program (such as Medicare).

The second chapter in this document presents a conceptual framework within which we can understand and evaluate proposals that are now (or will likely be) part of the coming discussions on health care reform among policy makers, think tanks and other stakeholders.
UNDERSTANDING REFORM PROPOSALS: THE ROLE OF GOVERNMENT

The health care industry is one of the most highly regulated in the U.S. economy, with government playing a significant role in virtually all aspects of how products and services are delivered. At the core of the national debate on health care reform is the question of who should pay.

To help explain and evaluate proposals to reform how health care is financed, we’ve focused on understanding the role government plays in how health insurance is designed, purchased and consumed. While this model is not meant to be an all-inclusive description of the many ways in which government impacts health insurance, we hope it explains the current landscape and facilitates a better understanding of proposals for change. The framework is presented in Figure 1. Our framework describes four major ways government plays a role in the market for health insurance.

1. Government provides financial incentives for the purchase of private health insurance

Today, government plays a significant role by providing financial incentives that encourage the private sector to provide health care coverage and individuals to purchase it. The primary way this is accomplished is through tax policy – specifically, the tax exclusion of employer contributions to health care insurance. This exclusion is the single largest under the tax code; according to the Joint Committee on Taxation, it cost the federal government $336.9 billion in 2018.16

Employers can provide tax-based financial incentives for employees to participate in their health care plans by allowing employee contributions to be made on a pre-tax basis; and by offering various forms of health savings accounts that allow for the payment of medical expenses with pre-tax dollars.

The government also provides financial incentives for the purchase of private insurance to certain lower income Americans. Under the ACA, low income Americans who do not qualify for Medicare or Medicaid (discussed below) can qualify for subsidies to purchase private insurance coverage on the public exchanges. These subsidies cost the federal government $49 billion in 2018.17

2. Government provides health insurance directly to select populations

Veterans and the Military

The federal government has provided health care coverage for veterans since the early days of the republic, and it remains a priority today. For 2019, Congress has approved a $50 billion for the Veterans Health Administration.18 Members of the armed forces and their dependents receive coverage under the government-run TRICARE and VA programs, which cover almost 5% of Americans.19 In 2017, taxpayers paid $114 billion in active duty and veterans’ health care.20

Elderly and Disabled Americans

With the creation of Medicare in 1965, the federal government expanded its footprint of health care coverage to a large population – the elderly and disabled Americans.
Medicare provides health care coverage to citizens age 65 and older, and to younger people who have become disabled. Medicare today covers over 17% of Americans. Low Income Americans and Children
Created in 1965 along with Medicare, Medicaid is a federal-state partnership that provides coverage to low income Americans. Medicaid is funded by both the federal and state governments and administered by the states. Eligibility for Medicaid was expanded significantly under the ACA, with the federal government covering the initial cost of the expansion. Following a 2012 Supreme Court ruling that allowed states to opt out of the ACA Medicaid expansion, several states declined to expand coverage. In the 2018 midterm elections, voters in three states (Utah, Nebraska and Idaho) passed ballot measures in favor of Medicaid expansion, bringing the total number of states to 37 (including the District of Columbia). Today, 19% of Americans are covered by Medicaid.

Almost 38% of Americans receive health insurance provided directly by the government

Four states—Arkansas, Indiana, Kentucky and New Hampshire—have received approval from the federal government for “work requirement demonstration projects.” These initiatives require Medicaid beneficiaries to work or be engaged in work-related activities in order to be eligible for coverage. Several other states are considering implementing these types of eligibility requirements. Children whose families do not have health insurance and who do not qualify for Medicaid are covered by the Children’s Health Insurance Program, or CHIP. Established in 1997, CHIP is funded by the federal government, and designed and administered by each state. It provides free and low-cost coverage for approximately 9 million children.

Federal Employees
Federal employees are covered by the Federal Employee Health Benefits Program, the nation’s largest employer-sponsored health plan. Over 8 million people are covered by the plan, which offers employees a choice of a range of private insurance plans from multiple insurance carriers.

Nearly 40% of children in the US are covered by either Medicaid or CHIP. In 2017, Medicaid and CHIP cost taxpayers $600 billion.

3. Government influences the supply and demand for health insurance

Government can influence the private market for health insurance by actions that impact the supply of and demand for coverage. The primary means of doing this is through regulation. Two notable examples of government regulation that impact supply and demand for health insurance are two provisions of the ACA: the requirement that every American have health care coverage (the “individual

21
22
23
24
25
mandate”); and the requirement that employers with more than 50 employees offer coverage that meets minimum standards (the “employer mandate”).

Government also impacts the private insurance market by regulating the products that can be sold. Both the federal and state governments play a role in regulating health insurance. Employer-sponsored plans are subject to the requirements of ERISA, while individual insurance policies are regulated by the states. The ACA established “minimum essential coverage” standards for insurance plans in order to satisfy the law’s individual mandate; these standards set a floor for coverage – and, according to critics, resulted in plans that offered coverage that many consumers didn’t need at a cost they couldn’t afford.

In addition to regulating supply and demand, government can impact the health care marketplace through its actions as a direct provider of health insurance. Because of the size of the population covered directly by government plans, for example, the federal government has significant power to set reimbursement rates for providers. For example, the 1992 Veterans Health Care Act set a ceiling on prices that manufacturers can charge the VA, the Department of Defense, the Public Health Service, and the Coast Guard. The price is based on the average sales price to purchasers outside the federal government. This market power would be further strengthened if Medicare (or another “public option”) was made available to non-elderly populations on a voluntary (or “buy-in”) basis. In 2017, Medicare cost taxpayers $705 billion.26

THE INDIVIDUAL MANDATE
Under the ACA, the individual mandate requires most citizens and legal residents to have health insurance – or pay a penalty tax. Congress repealed the penalty tax effective in 2019, but three states (New Jersey, Massachusetts and Vermont) and the District of Columbia have enacted individual mandate penalties.
4. Government provides substantially all health insurance

As is the case in some developed nations, government can exercise virtually complete control over the financing of health care by providing substantially all health care coverage to its citizens. In this type of system, private insurance that duplicates government-provided coverage is usually not allowed; but private plans that supplement government coverage are typically permitted. This type of scheme is a true “single-payer” system—where a single entity (the government) bears the financial risk for all (or virtually all) health care expenses.

A single payer system does not necessarily mean that the health care providers are employed or owned by the government. Most single payer systems operate as a mixed public-private system—a system where there is a private sector providing at least some health care services, with the public sector responsible for financing those services. Among the most commonly cited single-payer systems are the United Kingdom, Canada, Denmark, Sweden, Spain, Australia, and Taiwan.

UNDERSTANDING OTHER HEALTH CARE SYSTEMS

To learn more about the health care systems of other industrialized nations, we recommend The Healing of America: A Global Quest for Better, Cheaper, and Fairer Health Care, by T. R. Reid.
III. SPOTLIGHT: REPLACE THE ACA

The cost of health care remains a top concern for voters, and it is sure to be a central issue on the policy agendas of presidential candidates as the 2020 elections near.

So far, we have looked at the unique role that employers play in U.S. health care and the problems that plague the system, including high costs and poor relative outcomes compared to other developed nations. Nearly a decade after passage of the ACA, these issues still prompt a continued call for reform. However, policymakers differ on which direction reform should take.

To understand and evaluate existing and future proposals for health care reform, it’s useful to focus on the different roles of government. As we explored earlier, government’s increasing role in health insurance can be described in four ways (although none of them are mutually exclusive):

- Provide financial incentives for the purchase of private insurance
- Provide direct coverage to specific populations (e.g., Medicare, Medicaid)
- Influence supply and demand for insurance, primarily through regulation
- Exert full control (single-payer)

Democrats have generally favored a greater role for government in health care focusing in particular on expansion of coverage (e.g., Medicare and Medicaid expansion), as well as regulations aimed at controlling costs. More recently, an increased number of Democrats have openly embraced the concept of a single-payer system. Republicans, for their part, have tended to espouse initiatives aimed at reducing government involvement believing that the free market can best ensure affordable health care for those who wish to purchase it. In chapter III of this document, we will examine the key elements of reforms being discussed by Republicans in Congress and by conservative thought leaders and policy experts.
HISTORY OF “REPEAL AND REPLACE”

In March 2010, the ACA was passed by Democrats on a party-line vote and signed into law by President Barack Obama. Since its passage, Republicans made it a campaign promise to repeal the law. But as 20 million more Americans gained coverage under the ACA—primarily through Medicaid expansion—the Republican party’s initial promise to simply “repeal” the ACA evolved to “repeal and replace” the law with market-based reforms.

However, Republicans failed to form a consensus around what health care reform should look like and were never able to coalesce around a specific replacement plan. This proved problematic when the Republican party maintained control of the House of Representatives and Senate and won the White House with the election of President Donald Trump in 2016.
On his first day in office, President Trump issued an executive order to “minimize the unwarranted economic and regulatory burdens” of the ACA, and tasked Congress with writing legislation to repeal and replace the law. Meanwhile, Republicans had to act quickly to put together a replacement plan for the ACA.

House Republicans introduced their first repeal-and-replace bill, the American Health Care Act (AHCA), in March 2017. The bill narrowly passed the House but died in the Senate. In June 2017, Senate Republicans released the Better Care Reconciliation Act; a revised version of this bill was voted down in July 2017, with the late Sen. John McCain (R-AZ) casting the decisive no vote. Finally, in September 2017, Republican Senators Lindsey Graham, Bill Cassidy, Dean Heller and Ron Johnson released an amendment to AHCA, the Graham-Cassidy-Heller-Johnson amendment, which again failed to garner enough votes in the Senate.

In December 2017, as part of the tax reform package, Congress amended the ACA’s unpopular individual mandate that required all Americans to purchase insurance by eliminating any financial penalty. But with gridlock in Congress on how to repeal and replace the law, Republicans’ biggest victory so far has been on the regulatory front. The Trump Administration has implemented regulatory changes to increase choices for Americans who can’t afford the cost of health care coverage on the individual market – costs driven higher by the benefit coverage mandates of the ACA. The administration has also issued guidance to give states more waiver flexibility to circumvent certain ACA regulations. For example, states can alter the ACA’s essential health benefit requirements, or use federal funding for premium tax credits to provide state-administered subsidies to individuals.

As more aspects of the law have been implemented over time, both the public and the insurance industry have adapted to the changes. Polls show that although most American voters viewed the ACA unfavorably between 2010 to 2017, this reversed in 2017, and a slim majority of Americans (53%) have since viewed the law favorably. This switch is likely in response to Republicans’ attempts to repeal the law, and also reflects the popularity of some aspects of the ACA, including protections for people with pre-existing conditions and the provision allowing adult children to stay on their parents’ health insurance plans until age 26.

Going forward, Republicans are expected to frame their approach to health care reform as plans to “increase choice and competition” or to “make health care more affordable and accessible,” rather than to “repeal and replace” the law.
PROPOSALS FOR REFORM

*Graham-Cassidy-Heller-Johnson Amendment (September 2017)*

The best way to anticipate what future Republican reform plans will look like is to analyze the most recent proposed GOP bill, the Graham-Cassidy amendment to the AHCA.

This bill would repeal key ACA provisions, including the individual and employer mandates, premium and cost-sharing subsidies, and the Medicaid expansion to able-bodied, childless adults.

It would instead create state block grants through the Market-based Health Care Grant Program, which would allow states to design their own reforms to expand health insurance coverage and reduce premiums. This would greatly increase the flexibility that states have in designing their Medicaid programs and in managing their individual markets and allow states to better target assistance to those in need. The block grant would replace Medicaid expansion and the current federal spending for premium and cost sharing subsidies. Federal Medicaid funding would be converted into a per capita allotment to limit federal spending on the program.

Graham-Cassidy would keep some of the ACA’s insurance market rules, such as the prohibition on denying coverage based on health status and the prohibition on excluding pre-existing conditions but would allow states to set their own covered benefit and rating rules for fully-insured plans under the block grant program. This means that states would be able to set their own rating rules for age and geographic location for the individual and small group markets. It would also encourage the use of Health Savings Accounts (HSAs) by increasing the annual contribution limits.  

Using the four-part framework chapter II of this document, the following chart shows how the Graham-Cassidy proposal would compare with the current state under the ACA.
<table>
<thead>
<tr>
<th>Role</th>
<th>Current State</th>
<th>Graham-Cassidy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial incentives</td>
<td>• Tax policy encourages ESI</td>
<td>• Maintain the tax-preferred treatment of ESI and repeal the Cadillac Tax on high value employer plans</td>
</tr>
<tr>
<td></td>
<td>• Subsidies for low income to purchase coverage on Exchanges</td>
<td>• Encourage use of Health Savings Accounts by increasing contribution limits</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Subsidies provided for low income people through block grants to the states</td>
</tr>
<tr>
<td>Direct coverage to select populations</td>
<td>• Medicaid/CHIP</td>
<td>• Repeal Medicaid expansion to able-bodied, childless adults</td>
</tr>
<tr>
<td></td>
<td>• Medicare</td>
<td>• Convert federal Medicaid funding to a per capita block grant and limit growth in federal Medicaid spending</td>
</tr>
<tr>
<td></td>
<td>• Veterans/Armed Forces</td>
<td>• No change to Medicare, Veterans, Federal employees</td>
</tr>
<tr>
<td></td>
<td>• Federal Employees</td>
<td></td>
</tr>
<tr>
<td>Influence Supply and Demand</td>
<td>• Employer mandate</td>
<td>• Repeal most ACA benefit mandates and premium and cost-sharing subsidies</td>
</tr>
<tr>
<td></td>
<td>• “Minimum Essential Coverage” standards</td>
<td>• Establish a new state block grant program to fund reforms designed by states</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Eliminate “Minimum Essential Coverage” standards</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Allow states to set market rules for coverage, such as premium rating based on age and geographic location, and permitting insurers to establish multiple risk pools</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Repeal employer mandate</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Repeal individual mandate</td>
</tr>
<tr>
<td>Fully control</td>
<td>n/a</td>
<td>n/a</td>
</tr>
</tbody>
</table>
Health Care Choices Proposal (June 2018)

After Congress failed to pass the Graham-Cassidy amendment, conservative health policy scholars, state leaders, and state-based advocacy organizations came together to write and release a new proposal for reform in June 2018: “The Health Care Choices proposal.” Like Graham-Cassidy, it would repeal some of the same ACA taxes, the minimum essential coverage rules, and increase HSA contribution limits. Although it has not yet been released in the form of proposed legislation, it could provide the basis for a future Republican effort to replace the ACA.

The Health Care Choices proposal is different from Graham-Cassidy in that it does not convert federal Medicaid funding into a per capita cap. The proposal also addresses some of the roadblocks that Republicans faced in passing Graham-Cassidy. For example, many Republican senators in states that had expanded Medicaid did not like that Graham-Cassidy would decrease federal funding the most for states that had expanded Medicaid. The Health Care Choices Proposal would include a new formula to determine how much federal assistance each state receives based on current spending for ACA subsidies and Medicaid expansion.

Instead of the federal government giving tax credits to individuals, this money would go to the states in a block grant allocation. The block grant would provide a fixed amount of funding to each state, where at least 50% would be required to go toward supporting the purchase of private insurance, and another 50% would be required to provide coverage for those who are low-income. (These two categories would overlap.) A portion of the block grant would also be required to offset the costs of high-risk patients. Another feature of the Health Care Choices proposal is that any person on Medicaid would be permitted to use the value of that premium assistance for a private market plan if they so choose.

Between now and the 2020 election, we expect both Republicans and Democrats to refine their party positions on health care reform. Both sides will be gearing up for the next health care reform debate by deciding which plan to use should their party be in a position to pass legislation.
IV. SPOTLIGHT: THE MEDICARE FOR ALL ACT

**HERE WE EXAMINE THE OTHER END OF THE REFORM SPECTRUM—A VISION WHERE GOVERNMENT PLAYS A LEADING ROLE** in how individuals get health insurance by acting as the “single-payer” of health care for all citizens. In this model, the government is responsible for financing the health care services provided to individuals by both private and public providers. We’ll analyze this scenario by reviewing the provisions of the Medicare for All Act (S. 1804, 115th), which was introduced by Senator Bernie Sanders (I-VT) and has become a rallying cry for many progressive Democrats.

**HISTORY OF THE MEDICARE FOR ALL ACT**

When he introduced the Medicare for All Act in September 2017, Senator Sanders noted, “It has been the goal of Democrats since Franklin D. Roosevelt to create a universal health care system guaranteeing health care to all people.”

In the eight decades since the New Deal, however, Democrats’ attempts to transform America’s unique employment-based health care system have largely failed to generate any meaningful popular support, aside from Medicare and Medicaid. America’s private, employment-based system remains in place and is still popular among those with employer-sponsored coverage. In a March 2016 survey, 83% of respondents with employer-sponsored coverage rated their health insurance as excellent or good.

But in the decade since the 2008 financial crisis, public sentiment has begun to shift. Rising health care premiums and out-of-pocket costs have combined to make health care costs a top concern for many Americans.

**WHAT IS “SINGLE-PAYER HEALTH CARE”?**

In the current debate on health care reform, the term “single-payer” is used broadly to describe a variety of different systems. For our purposes, we define a single-payer system as one where costs for medically necessary services are paid by the government and private insurance that duplicates government coverage is not permitted; health care services are delivered by both public and private providers; enrollment is universal and automatic; and all medically necessary services are covered with little or no cost sharing by consumers.
While initially unpopular, the Affordable Care Act was viewed favorably by a slim majority of Americans for the first time in 2017. And public support for reform that goes beyond the ACA is growing. In several polls, a majority of Americans expressed support for a “Medicare for All” type program—however, support levels drop at the prospect of higher taxes to fund such a program, or when told that it would eliminate employer provided health care benefits.

While the Medicare for All Act has little chance of becoming law with Republicans in control of the Senate and the White House, debate over single payer is expected to be a top priority in the House of Representatives, governed by a new Democratic majority—78 of which are members of a Medicare for All caucus.

Hearings are expected in several House committees this year following Rep. Pramila Jayapal’s release of her Medicare for All Act (H.R.1384, 116th).

**MEDICARE FOR ALL: THE DETAILS**

The Medicare for All Act would represent the most sweeping reform of the U.S. health care system in history, creating a single government-run program that provides health care coverage to all U.S. residents. Private insurance coverage that duplicates government benefits—including employer plans—would not be permitted.

All U.S. residents would be eligible for coverage and would be enrolled at birth and provide life-time enrollment. The program would cover all medically-necessary services in 10 benefit categories, with no premiums, no deductibles and no co-pays. States may provide additional benefits at state expense. An exception to the no co-pay rule would be allowed for prescription drugs—to encourage the use of generics, a cost-sharing of up to $200 per year on drugs would be allowed.

Physicians and health care providers would be required to meet federal quality and performance standards to participate in the program. States would be permitted to set additional standards. They would be paid based on a fee schedule consistent with Medicare payment rates, within the context of an overall national budget for health care spending. The government would negotiate drug prices directly with pharmaceutical manufacturers. Balance billing would be prohibited; however providers would be permitted to enter into private contracts with patients subject to constraints imposed under current law.  

There would be a four-year transition to the new program. During the first year, eligibility for Medicare would be lowered to age 55 and benefits expanded to include dental, vision and hearing aids. Children up to age 18 would also be added. In the second year, eligibility would drop to age 45, and in the third year to age 35. By the fourth year, everyone would be covered.

Medicare for All would be far more comprehensive compared to the single-payer systems in other countries. For example, Medicare for All would cover dental and vision care, whereas the single-payer systems in Canada, the Netherlands, and
Australia do not cover these types of services.

Medicare for All would also not require any out-of-pocket payments for health care services apart from prescription drugs. There would be no copays to visit the doctor or the emergency room. Single-payer systems in other countries, on the other hand, do often require out-of-pocket payments for health care services. As such, the Medicare for All plan would stand alone among other single-payer systems.

Using the four-part framework from chapter II, the following chart shows how the Medicare for All Act would compare with the current state under the ACA.

<table>
<thead>
<tr>
<th>ROLE</th>
<th>CURRENT STATE</th>
<th>MEDICARE EXTRA FOR ALL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial incentives</td>
<td>• Tax policy encourages employer-sponsored health coverage</td>
<td>• Replace private insurance coverage, including employer-sponsored health coverage</td>
</tr>
<tr>
<td></td>
<td>• Subsidies for low income to purchase coverage on Exchanges</td>
<td>• Eliminates individual premiums, deductibles, and copays (exception: up to $200 per year cost sharing for prescription drugs)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Eliminates Exchanges</td>
</tr>
<tr>
<td>Direct coverage to select populations</td>
<td>• Medicaid/CHIP</td>
<td>• Replaces Medicare after a four-year phase in period</td>
</tr>
<tr>
<td></td>
<td>• Medicare</td>
<td>• Replaces Medicaid/Chip</td>
</tr>
<tr>
<td></td>
<td>• Veterans/Armed Forces</td>
<td>• (exception: Medicaid would continue to cover long-term services, supports)</td>
</tr>
<tr>
<td></td>
<td>• Federal Employees</td>
<td>• Veterans’ health programs would continue</td>
</tr>
<tr>
<td>Influence Supply and Demand</td>
<td>• Employer mandate</td>
<td>• Replaces private health coverage—including employer-sponsored health coverage, Federal Employees Health Benefits (FEHB), marketplace coverage, and TriCare—that duplicates government coverage</td>
</tr>
<tr>
<td></td>
<td>• “Minimum Essential Coverage” standards</td>
<td>• Government establishes fee scale for providers within a global health care budget</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Government negotiates prices directly with drug manufacturers</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Individuals and providers may enter private contracts for payment outside of the government program</td>
</tr>
<tr>
<td>Fully control</td>
<td>n/a</td>
<td>• Single government program where costs for medically necessary services (in 10 benefit categories including dental, hearing, and vision; provides coverage of reproductive health services) are paid by the government; services would be delivered by both public and private providers with scheduled payments to providers</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• States may provide additional benefits at state expense</td>
</tr>
</tbody>
</table>
OTHER SINGLE-PAYER REFORM PROPOSALS

In addition to the Medicare for All Act, there have been several proposals at the state level that would create a “single-payer” system on a smaller scale. While none of these proposals has been implemented, local experimentation has continued as reform at the federal level has stalled. Two proposals of interest are Vermont’s Green Mountain Care and Healthy California.

Vermont’s Green Mountain Care

In 2011, Vermont became the first state to attempt the implementation of a single payer health care system called Green Mountain Care. Under the plan, most private health insurance would be replaced with a public-private single payer system financed through payroll taxes. The system was to be governed by an independent board consisting of payer representatives (employers, the state and families) and beneficiary representatives (patients and providers). However, the plan encountered both fiscal and political challenges and was abandoned in 2014.

Healthy California

In 2017, the California State Senate passed SB 562, the Healthy California Act, which would create a single payer system in the state. The plan would completely replace private insurance and would cover all residents. Under the plan, covered individuals would not have to pay premiums, copayments or deductibles; they would be able to see any provider without a referral, and would be able to get any medically appropriate service. While SB 562 was shelved by State Assembly Speaker Anthony Rendon, who claimed it was “woefully incomplete,” the issue is expected to get renewed attention with the election of Democrat Gavin Newsom as Governor. A supporter of SB 562 in the past, Newsom made health care a prominent issue in his campaign—and on his first day in office, announced plans to expand Medi-Cal (California’s version of Medicaid) to undocumented immigrants, impose a state-level individual mandate for coverage, and give the state power to negotiate drug prices.

NEXT UP: “MEDICARE EXTRA FOR ALL”

As the debate on health care reform continues, both Republicans and Democrats will work to refine their positions on the issue as large segments of the electorate continue to push for reform. Meanwhile, activity at the state and local level is also expected to increase, with governments experimenting with new ways of solving the health care crisis.

The next chapter will provide a deep dive look at the “Medicare Extra for All” proposal released by the Center for American Progress in 2018. Stopping short of a full single-payer approach, this proposal envisions preserving the private employer-based system while extending access to Medicare to all Americans.
HEALTH CARE REFORM ATTEMPTS IN THE U.S. SINCE MEDICARE AND MEDICAID

1974 Comprehensive Health Insurance Plan Act – Failed in Congress
- Employers mandated to purchase insurance for their employees
- Provided a federal health plan that any American could join by paying on a sliding scale based on income

1985 Consolidated Omnibus Budget Reconciliation Act (COBRA) – Enacted
- Amended ERISA to give employees the ability to continue health insurance coverage after leaving employment

1993 Health Security Act – Failed in Congress
- Mandated employers provide health insurance coverage to all of their employees
- Required each U.S. citizen and permanent resident alien to become enrolled in a qualified health plan
- Listed minimum coverage and maximum annual out-of-pocket expenses for each plan.

1997 Children’s Health Insurance Program (CHIP) – Enacted
- Like Medicaid, CHIP is jointly administered by federal and state governments
- Expanded coverage for uninsured children in low-income families with incomes that are too high to qualify for Medicaid

2001-2004 Patients’ Bill of Rights – Failed in Congress
- Established broad rights for patients regarding access to care, medical decision making, and recourse if denied care

2003 Medicare Prescription Drug, Improvement and Modernization Act – Enacted
- Created Medicare Part D prescription drug benefit
- Created Medicare Advantage plans—beneficiaries have choice of receiving Medicare benefits through private health insurance plans or through original Medicare Parts A and B

2010 Affordable Care Act – Enacted
- Required most Americans to have health insurance coverage or pay a penalty
- Required employers to offer coverage or pay a penalty
- Created state-based exchanges for the purchase of insurance, with income-based subsidies
- Expanded Medicaid eligibility
- Prohibited insurers from denying coverage based on pre-existing conditions
- Provided subsidies for large employers to discourage them from eliminating private prescription coverage to retired workers
- Prohibited the federal government from negotiating discounts with drug companies and prevents the government from establishing a formulary
WITH DEMOCRATS IN CONTROL OF THE HOUSE OF REPRESENTATIVES AND THE 2020 PRESIDENTIAL CAMPAIGN ALREADY UNDERWAY, health care is gaining increasing attention among policy makers in Washington and around the country. House Democratic leaders have announced hearings on health care reform, including the prospect of a “single-payer” system, while states explore ways of expanding access and controlling costs.

In chapters I and II, we examined the unique role employers play in the U.S. health care system, and framed the issue by looking at four ways government plays a role in health insurance:

- Provide financial incentives for the purchase of private insurance;
- Provide direct coverage to specific populations (e.g., Medicare, Medicaid);
- Influence supply and demand for insurance, primarily through regulation; and
- Exerts full control (single-payer).

In Part III, we looked at the key elements of reform proposals being discussed by Republicans in Congress, while in Part IV we examined the other end of the reform spectrum—where government plays the leading role in how individuals get health insurance by acting as the “single-payer” of health care for all citizens.

In this chapter, we’ll discuss the range of options that exist between replacing the ACA and moving toward a single-payer system. We’ll do this by taking a look at “Medicare Extra for All,” a reform proposal released in 2018 by the Center for American Progress. Medicare Extra for All is one of several potential reform proposals that would create a “public option” – a government-run plan that is made available to Americans as an alternative to existing private insurance.

THE CENTER FOR AMERICAN PROGRESS

The Center for American Progress (CAP) is a public policy research and advocacy organization which presents a progressive viewpoint on economic and social issues. The Medicare Extra for All proposal was released by CAP on February 22, 2018.

Read the full proposal here.
There are many variations of this basic concept of creating a public option for health care coverage; while we won’t cover them all in this paper, we’ll provide a basic overview of the key elements of CAP’s particular approach.

**MEDICARE EXTRA FOR ALL: THE DETAILS**

There is growing public support for offering Americans an option to “buy-in” to a government-run health plan such as Medicare. A recent poll\(^\text{38}\) by the Kaiser Family Foundation found that 74% of those surveyed would support a national government plan similar to Medicare that would be open to anyone but would allow them to keep their current coverage if they so prefer. Support among Democrats and Independents was strongest, but nearly half of Republicans (47%) also supported such a plan.

Support is even higher among Republicans (69%) when the plan is limited only to allowing those over age 50 to buy-in to Medicare. Medicare Extra for All (“Medicare Extra”) would create a new health plan available to all Americans\(^\text{39}\), regardless of income, age, health or insurance status. Individual premiums would vary by income, with caps ranging from 0% (for families with incomes less than 150% of the federal poverty level, or FPL) to 10% (for families above 500% of the FPL).

---

**WHAT IS A “PUBLIC OPTION?”**

While there are many potential ways to describe it, we define a “public option system” as one where a government-financed health plan would be offered to Americans as one of many options, competing with private health insurance plans.
Medicare Extra would not replace employer-sponsored insurance; employers would have the option to continue to offer coverage (subject to new standards) or provide financial support for their employees to get coverage under Medicare Extra. The preservation of employer-sponsored coverage is a key feature of Medicare Extra; in fact, under the proposal employer-sponsored plans are the only type of private insurance that is permitted to duplicate coverage provided by Medicare Extra. Private insurance companies would not be allowed to offer plans that duplicate Medicare Extra benefits, but they could offer “complementary” benefits.

The proposal acknowledges the popularity of employer-sponsored coverage and that most who get coverage from their employer are satisfied with it. However, it also points out that employer plans are becoming increasingly unaffordable and seeks to “balance the desire of most employees to keep their coverage with the need of many employees for a more affordable option.”

**Employer Options Under Medicare Extra**

Under the proposal, employers would have four options for providing health care coverage to their employees:

- **Continue to sponsor their own coverage.** Employers could continue to offer coverage, but it would need to provide an actuarial value of at least 80%, and employers would need to contribute at least 70% of the premium. Employers that choose this option would continue to benefit from the tax exclusion of premiums from income and payroll tax.

- **Sponsor Medicare Extra as a form of employer-sponsored insurance.** Employers would automatically enroll employees into Medicare Extra and would need to contribute at least 70% of the Medicare Extra premium. The tax benefit of employer-sponsored insurance would not apply to employer payments under this option.

- **Choose to make maintenance of effort payments.** Employers would make payments to Medicare Extra equal to their health spending in the year prior to the law’s enactment, subject to increases linked to consumer medical inflation rates. The tax benefit of employer-sponsored insurance would not apply to employer payments under this option.

- **Make aggregated payments in lieu of premium contributions.** Employers could make simpler aggregated payments to Medicare Extra in amounts ranging from 0% to 8% of payroll, depending on employer size. The tax benefit of employer-sponsored insurance would not apply to employer payments under this option.

Small employers (fewer than 100 FTEs) would not need to make any
payments at all, nor would they be required to offer coverage or sponsor Medicare Extra. This means that 98% of all U.S. firms that employ one-third of all workers would not need to make any payments at all.  

**Employee Choice Under Medicare Extra**

Under the proposal, employees would have the option to enroll in either their employer-sponsored plan or Medicare Extra. If they did not make a choice, employers would automatically enroll them in the employer plan.

If employees choose Medicare Extra, employers would contribute the same amount to Medicare Extra as they would contribute to their own coverage. The tax benefit for employer-sponsored insurance would not apply to these employer-paid premiums.

**Controlling Costs Under Medicare Extra**

**Reimbursement Rates and Payment Reform**

In an effort to lower costs, provider payment rates under Medicare Extra would reflect an average of rates under Medicare, Medicaid and commercial insurance, minus a percentage. Medicare Extra would also increase rates paid for primary care relative to specialty care.

Under the proposal, “the benefits of Medicare Extra rates would extend to employer-sponsored insurance and significantly lower premiums.” Out of network providers would be prohibited from charging more than Medicare Extra rates.

Medicare Extra would reform the payment and delivery system by paying hospitals for a bundle of services. It would also make “site-neutral” payments -- the same payment for the same service regardless of where it takes place.

**Direct Negotiation**

Medicare Extra would seek to control costs by directly negotiating prices for prescription drugs, medical devices, and durable medical equipment.

**Leveraging Medicare Advantage: Medicare Choice**

Medicare Extra would leverage the success of the Medicare Advantage program, which provides a choice of plans to seniors. Medicare Advantage plans currently account for approximately 34% of total Medicare enrollment.

Medicare Advantage would be reconstituted as Medicare Choice and be made available to all Medicare Extra enrollees. Medicare Extra would solicit bids from insurance plans; the payments to the plans would equal the average bid (but would be no more than 95% of the Medicare Extra premium). Consumers who select a plan that costs less than the average bid would receive a rebate for the difference; those who choose a more expensive plan would pay the difference.
Transition to Medicare Extra

The Medicare Extra proposal envisions an 8-year transition period before the program would be fully implemented. In the first year, a “public option” would be offered in any county that was not served by at least one insurer in the individual market.

By year four, auto-enrollment would begin with those in individual market, the uninsured, newborns, and those turning age 65. Individuals in employer plans and in the current Medicare system would have the option to enroll, and small employers could sponsor Medicare Extra for their employees.

In year six, Medicaid/CHIP beneficiaries would be automatically enrolled, and by year eight large employers could sponsor Medicare Extra for all employees.

Using the four-part framework from chapter II, the following chart shows how Medicare Extra would compare with the current state under the ACA.
OTHER “PUBLIC OPTION” APPROACHES

While the Medicare Extra proposal has not been translated into actual legislation, there were several bills introduced in the 115th Congress (2017-2018) (See Table 1, below), and one in the current Congress would implement a similar public option approach. These bills are summarized below.

Public Plan Option

Three bills would create a public option similar to Medicare Extra but would differ in one important respect - they would offer the public option on the existing ACA exchanges and would compete with individual private plans. Existing subsidies could be used to purchase coverage, and all three plans would seek to lower costs by leveraging Medicare payment rates and by negotiating drug prices directly with manufacturers.

“Buy-In” for Older Americans

Three bills would take a more limited approach than Medicare Extra, allowing older Americans to “buy in” to Medicare at either age 50 or 55. All would allow exchange subsidies to be used to purchase coverage, and one (H.R. 3748) would allow those eligible for employer coverage to buy in and would allow employers to contribute to the cost of coverage.

State Medicaid “Buy-In”

The “State Public Option Act” would allow states to create a Medicaid “buy in” option that would be offered via the exchanges and allow ACA subsidies. The plan would cap premiums at 9.5% of income and enhance Medicaid reimbursement rates by referencing Medicaid as a floor.

As momentum builds in Washington for a renewed debate around health care reform, innovations at the state level could provide a “laboratory” for experimentation on ways to address America’s health care challenges.

IS THIS THE YEAR OF “MEDICAID BUY-IN”?

According to a Pew Stateline report, at least 10 states are considering allowing residents to “buy-in” to Medicaid. Legislation has been introduced in eight states; and in Nevada, a Medicaid buy-in was passed by the legislature in 2017 but vetoed by Governor Sandoval.

Read more about state Medicaid buy-in options here and here.

PUBLIC PLAN OPTIONS

H.R. 635 / S. 194, CHOICE Act
Rep. Schakowsky (D-IL), Sen. Whitehouse (D-RI)

Rep. Higgins (D-NY), Sen. Bennett (D-CO)

H.R. 6117 / S. 2708 Choose Medicare Act
Rep. Richmond (D-LA), Sen. Merkley (D-OR)

OLDER AMERICAN BUY-INS

S. 1742 Medicare at 55 Act
S. 470 Medicare at 50 Act
(introduced in February 2019)

H.R. 3748 Medicare Buy-In and Health Care Stabilization Act of 2017
Rep. Higgins (D-NY)

STATE MEDICAID BUY-IN

H.R. 4129 / S. 2001 State Public Option Act
Rep. Lujan (D-NM), Schatz (D-HI)
VI. IMPLICATIONS FOR EMPLOYERS

With the 2020 Presidential Election Approaching, momentum is building in Washington D.C. around a renewed debate on federal health care reform. Additionally, state-based policy innovations are providing a laboratory for experimentation to address the nation’s health care challenges at the state level.

In this paper, we have looked at the role that employers play as one of the many players in our large, complex, and costly health care system.

Employers provide health care coverage for nearly half of the nation’s insured population. This should be a top consideration for policymakers when making any changes to the system—particularly since most large employers remain committed to offering health coverage, and most employees are happy with the coverage they receive.

We have evaluated proposals using the “Health Care Reform Spectrum” showing how each proposal ranks on increasing government control:

- Provides financial incentives for the purchase of private insurance;
- Provides direct coverage to specific populations (e.g., Medicare, Medicaid);
- Influences supply and demand for insurance, primarily through regulation; and
- Exerts full control (single-payer).

In the paper, we’ve spotlighted three proposals along the reform continuum that are likely to be pushed in Congress and/or serve as the basis for plans endorsed by future presidential nominees. These include:

- Replacing the ACA: The Graham-Cassidy bill/Health Care Choices Proposal;
- Single-Payer: Sen. Sanders (I-VT) Medicare for All Act; and
- Public Option: Medicare Extra for All by the Center for American Progress.

Each proposal has different implications for employers, which we will summarize in this final chapter. The purpose of this paper is to recap the spotlighted reform proposals and specifically examine their impact on employers.
TOP CONCERNS OF EMPLOYERS PROVIDING HEALTH BENEFITS

Employers will evaluate health care reform proposals according to how they will impact their business processes, their financials, and their employees. They will also judge a proposal according to how it addresses concerns currently facing employer-sponsored health insurance (ESI).

These include:

- **Rising costs**: Medical expenses for employers are projected to increase 6 percent this year. The cost increase has moderated compared to previous years but is still increasing faster than inflation. Since 2008, general annual deductibles for covered workers have increased eight times as fast as wages.

- **Lack of price transparency**: Leads to a lack of consumerism and employee engagement.

- **Policy issues**: These include repealing the Cadillac tax, preserving the tax treatment of ESI, protecting ERISA preemption, and liberalizing Health Savings Account (HSA) rules and contribution limits.

- **The evolving workforce**: Employers are concerned with the ability of the current system to accommodate changing workforce and the rise of non-traditional employment arrangements.

“REPLACE THE ACA”

To anticipate what future Republican reform plans will look like, we analyzed the last GOP health care reform bill which was brought to a vote but did not pass, the Graham-Cassidy amendment to the American Health Care Act (AHCA).

**Provisions**

Graham-Cassidy contains a number of provisions that would impact employers. First, it would repeal the Cadillac Tax and maintain the tax-preferred treatment of ESI. It would also repeal the Affordable Care Act’s (ACA) employer mandate and encourage the use of HSAs by increasing contribution limits.

The bill would also establish a new state block grant program to fund reforms designed by states. It would allow states to set market rules for coverage, such as premium rating based on age and geographic location, and permitting insurers to establish multiple risk pools.

It also would repeal most ACA benefit mandates and eliminate Minimum Essential Coverage standards—though the vast majority of large employer-sponsored plans already met these requirements prior to passage of the ACA.

TOP CONCERNS OF CHROS AND THEIR TEAMS

Read more on the state of employer-sponsored health care here.
Considerations

Graham-Cassidy would not have dramatically changed ESI as we know it, but instead would have made more changes to Medicaid and the individual market.

It is important, however, to understand how these changes would indirectly affect employers. Reforms strengthening the individual market could give employees another alternative to ESI. Moreover, giving more authority to states could result in a patchwork of state schemes, potentially creating significant complexity for employers and adding to their administrative costs.

For example, if a state were to expand Medicaid eligibility to cover more low-income Americans, more low-wage part-time and full-time employees could opt-out of employer offered coverage and enroll in the newly expanded Medicaid program. While this could directly reduce employer health care costs, it is unclear what impact it would have on employer risk pools, which may increase costs in other ways.

While Graham-Cassidy is no longer being considered by Republicans in Congress, it is instructive to look at it when anticipating what type of plan Republicans might set forth as an alternative to Democrats’ reform proposals in 2020.

The Trump Administration has said that it will not support an appeal of a district court decision, Texas v. Azar, which would result in a full repeal of the ACA. Yet, as of now, it is unclear what the Republicans’ ACA alternative will be.

SINGLE-PAYER

The Medicare for All Act would drastically impact employers by significantly changing the role of employers’ involvement in their employees’ health.

Provisions

Medicare for All would replace all private insurance coverage, including ESI, that duplicates newly-created government-sponsored coverage. Employees would lose the employer coverage that they overwhelmingly like and appreciate.

Medicare for All would provide universal health care coverage for all Americans and replace the current Medicare program after a four-year phase in period. By providing universal coverage, the plan would provide greater flexibility to employees who want to retire or work part time, since they would not be compelled to stay in the workforce to maintain health insurance.

Individuals and providers would be allowed to enter private contracts for payment outside of the government program, meaning that employers would be permitted to provide supplemental benefits so long as they do not duplicate Medicare for All coverage.

Considerations

While one might assume that under Medicare for All employers would no longer play a role in their employees’ health, this is not necessarily true.
Regardless of who pays for health care coverage, employers have a vested interest in maintaining the health of their workforce. The presence of supplemental health plans and workplace wellness programs in some countries with single-payer systems is evidence of this.

Employers and human resources professionals will still play a key role in the well-being of employees—since better health outcomes improve productivity and can contribute to a positive work environment. However, employers would lose the financial leverage they have now of offering discounts on employee contributions to encourage employees to participate.

Since health insurance would be provided by the government, it would be portable, allowing employees to keep the same coverage when switching jobs. It would also provide coverage for employees who want to retire but haven’t yet due the current limited options for pre-65 retirees.

In a single-payer system, the government would set prices for health care services at a lower rate than what private payers currently pay. It is unknown what this would mean for health care providers, many of which currently rely on payments from private insurance companies to offset lower payments received by Medicare and Medicaid.

PUBLIC OPTION

The Center for American Progress’ “Medicare Extra for All” is one example of a proposal that creates a “public option”—a government-run plan available to all American citizens—while preserving ESI.

While the Medicare Extra proposal has not been translated into legislative language, there are several other bills that have been introduced in Congress and at the state level that would implement a similar public option approach while maintaining private insurance.

Provisions

Medicare Extra: Medicare Extra would preserve ESI and its current favorable tax treatment but would eliminate all other private insurance that duplicates Medicare Extra coverage.

Employers would have the option to sponsor Medicare Extra and employees would have the option to choose Medicare Extra over their employer coverage. If an employer chooses to continue sponsoring its own plans for employees, those plans would be required to deliver 80% actuarial value and employers must pay 70% of premiums to hold down costs for employees.

If an employer were to opt that all employees receive Medicare Extra coverage, the public plan would set caps on individual premiums based on income.
**Medicare Buy-In for Older Americans:** More limited in scope, current Medicare buy-in bills would allow a buy-in to the existing Medicare program at either age 50 or 55. Only one bill, H.R. 3748, would permit those eligible for employer coverage to buy in—and would allow employers to contribute to the cost of coverage.

**State Medicaid Buy-In:** At least ten states are considering ways to allow residents to buy in to Medicaid, and eight states have introduced legislation.

**Public Plan on Exchanges:** Bills offering a public option on the existing ACA exchanges would compete with individual private plans and allow ACA subsidies to be used to purchase coverage.

**Considerations**

Like the Medicare for All Act, a public option could alleviate the “job lock” problem that employees wishing to retire before age 65 face by providing an affordable public plan to purchase. It could also provide an affordable option for non-traditional employees such as independent contractors.

These proposals could give employers the flexibility to decide what is best for their business and employees.

However, state-based public option bills could create a patchwork of state schemes that employers would need to comply with. The unknown is how the costs of what an employer is currently paying would compare to the new scheme.

It is expected that the presence of a government-run public option would mean some downward pressure on health care prices. However, it is uncertain whether providers and insurers would shift costs to private plans, including employer-sponsored plans.

**CONCLUSION**

Understanding how these proposals will affect ESI will better help senior HR leaders assess the implications of various types of reform on their future business and talent strategies. We hope this paper has increased awareness of the spectrum of potential future health care reforms that will be considered over the next two years.
### Table I:

<table>
<thead>
<tr>
<th>EMPLOYER CONCERN</th>
<th>“REPLACE THE ACA”</th>
<th>SINGLE-PAYER</th>
<th>PUBLIC OPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rising Costs</td>
<td>Removing regulations and allowing states to set market rules for coverage could reduce costs by giving access to more affordable insurance plan options</td>
<td>Would constrain costs by setting a national budget for health care spending and establishing provider reimbursement rates; government would negotiate drug prices</td>
<td>Provider payment rates in Medicare Extra would reflect an average of rates under Medicare, Medicaid, and commercial insurance; government would negotiate drug prices</td>
</tr>
<tr>
<td>Lack of Price Transparency</td>
<td>Does not address</td>
<td>No need for price transparency when prices are fixed</td>
<td>Unknown</td>
</tr>
<tr>
<td>Policy Issues</td>
<td>Repeal Cadillac Tax, maintain tax-preferred treatment of ESI, repeal employer mandate, increase HSA contribution limits</td>
<td>Tax treatment and ERISA issues eliminated, but new costs imposed on employers to fund single-payer system</td>
<td>Maintains tax-preferred treatment of ESI</td>
</tr>
<tr>
<td>The Evolving Workforce</td>
<td>Strengthening the individual market would provide more options for non-traditional workers</td>
<td>Single-payer would address uncovered population, eliminate job lock</td>
<td>Public option would address uncovered population, eliminate job lock</td>
</tr>
</tbody>
</table>


ENDNOTES

1 https://www2.census.gov/programs-surveys/demo/tables/health-insurance/time-series/original/orghiisst1.txt
11 https://jamanetwork.com/journals/jama/article-abstract/2674671
15 https://www.investopedia.com/articles/personal-finance/080615/6-reasons-healthcare-so-expensive-us.asp
19 U.S. Census Bureau, Health Insurance Coverage in the United States: 2017, Table 1.
20 National Health expenditures by Type of Expenditure and Program, National Health Expenditure Data, Table 19.
21 U.S. Census Bureau, Health Insurance Coverage in the United States: 2017, Table 1.
22 Id.
23 https://familiesusa.org/product/children-health-insurance-program-chip
24 National Health expenditures by Type of Expenditure and Program, National Health Expenditure Data, Table 19.
26 National Health expenditures by Type of Expenditure and Program, National Health Expenditure Data, Table 19.
The Center for American Progress Medicare Extra for All proposal is predicated on the passage of comprehensive immigration reform as coverage is limited to individuals “lawfully residing” in the United States.

Under the Center for American Progress (CAP) proposal, the only alternative that does not require the value of healthcare coverage to be included in an employee’s taxable income is where the employer offers an appropriate level of healthcare coverage to all employees and does not offer Medicare Extra as an option to employees.

The value of the healthcare coverage provided would be taxable income to the employee.

The value of the healthcare coverage provided would be taxable income to the employee.


