



# EMPLOYERS

a chro education series

# AND THE

by the

# U.S. HEALTH

american health policy institute

# CARE SYSTEM

Part One of Six



AMERICAN  
HEALTH  
POLICY  
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## ■ Employers and the U.S. Health Care System

*PART ONE of SIX*

**Nearly a 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 HR Policy Association members better understand the health care landscape and the prospects for change, we're launching a series of short papers that will discuss the various types of reform proposals being discussed among policy makers, political candidates and other key stakeholders.

### OBJECTIVES OF THE SERIES

We hope this CHRO Education Series will increase member awareness of the spectrum of potential future health care reforms that may be proposed over the next two years – and will help senior HR leaders assess the implications of various types of reform on their future business and talent strategies. We will also use these papers as the basis for follow up discussions with members in 2019 that will help shape the Association's work with policymakers.

II.

*The Health Care Reform Spectrum*

III.

*Spotlight: "Replace the ACA"*

IV.

*Spotlight: "The Medicare for All Act"*

V.

*Spotlight: "Medicare Extra for All"*

VI.

*Implications for Employers*





## Employers and the U.S. Health Care System

PART ONE of SIX

### 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<sup>ii</sup> 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.<sup>iii</sup> 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.<sup>iii</sup>

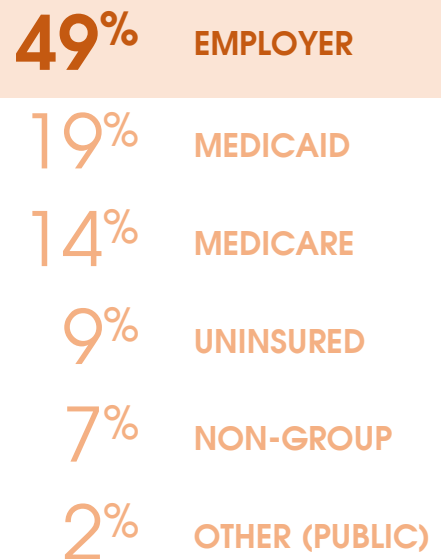
#### Origins of Employer-Sponsored Insurance in the U.S.

*During WWII, many workers were off fighting the war, which resulted in a severe labor shortage. The government worried that employers would continue raising salaries to attract employees and that inflation would rise at an unsustainable rate.*

*In response, President Roosevelt signed an executive order to freeze wages. Employers, searching for ways to attract new talent, began to offer health insurance as a benefit.*

[Read more here.](#)

#### Health Insurance Coverage of the Total Population



Source: Kaiser Family Foundation, 2018

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.<sup>iv</sup>

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.

### Rise in Non-Traditional Employment Arrangements

*With the rise of the gig economy and independent contractors, these workers are at a disadvantage when it comes to health benefits because they do not qualify for group health insurance.*

*A 2018 study by UpWork and The Freelancers Union indicated that over a third of the workforce is estimated to have freelanced in the past year. Freelancers are also more politically active, and 70% said 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 here.](#)*

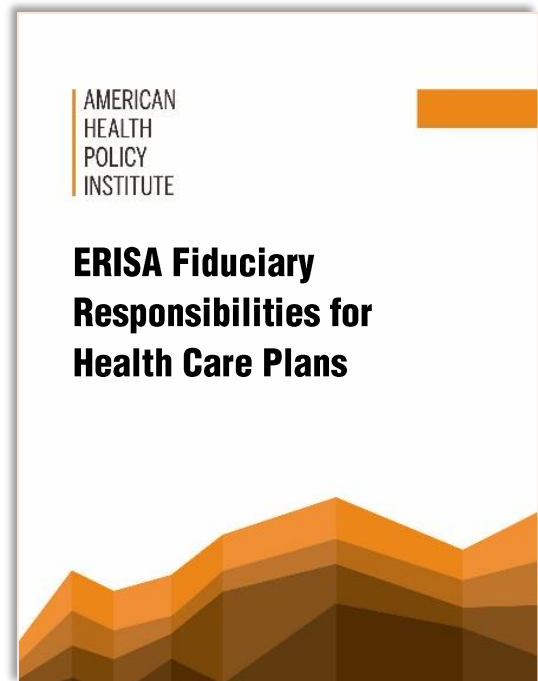
## Most Large Employers Remain Committed to Health Care Coverage

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.

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.”](#)



### Why Employers Offer Health Insurance

1. Keeps employees healthy and productive on the job
2. Adds to corporate ethos and a culture of health
3. Serves as a driving force in employee retention and is vital to securing a robust workforce
4. Employees appreciate, desire, and expect health insurance
5. Efficient way to administer health coverage to large numbers of people
6. 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 here.](#)

### 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 the HR Policy Association – have long defended this provision with policy makers at the federal level.*

*For more on ERISA preemption, see the Institute's 2017 Paper:*

**[The Need to Strengthen ERISA Preemption](#)**

The second major piece of legislation impacting employer funded health coverage is the **Affordable Care Act (ACA)**. The ACA impacts employers in the following ways:

- 1. 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.
- 2. 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 about the Cadillac Tax here.](#)*
- 3. Reporting Requirements:** Large employers must file an annual return.
- 4. 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-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 here.](#)*

## 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 new California Governor-elect) 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 9<sup>th</sup> 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 series.



## 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.<sup>iv</sup> 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.<sup>v</sup>

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.

### Health Care Costs Grow Far Faster Than Wages

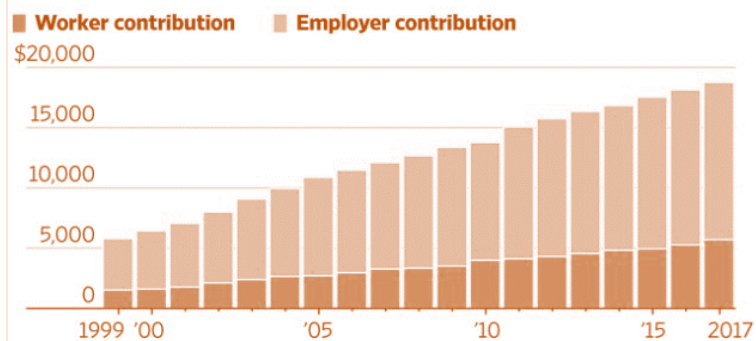
*Between 2008 and 2018, general inflation increased 17%, while workers' wages increased 26%. Over the same period, health care premiums for family coverage increased 55%, while deductibles for individual plans increased 212%.<sup>vi</sup>*

### Health Care Costs Steadily Increasing for Employers

*For employers, health care costs have increased on average 5 to 6% annually,<sup>vii</sup> and health care benefits represent 7.5% of total compensation costs.<sup>viii</sup>*

### Getting Covered

Average annual worker and employer contributions to premiums for family health coverage:



Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

THE WALL STREET JOURNAL.

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.<sup>ix</sup> 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.<sup>x</sup>

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

## 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.*

[Read more here.](#)

## 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.](#)

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.<sup>xi</sup> 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.<sup>xii</sup>

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.<sup>xiii</sup> Waste is also a key contributor to high costs, estimated at \$750 billion per year.<sup>xiv</sup>

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<sup>xv</sup> and the second largest sector in the S&P 500<sup>xvi</sup>.

## The Major Players

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

<b>PATIENTS WHO RECEIVE CARE</b>	While the patient is the consumer of care, most pay only a small percentage of the cost of care
<b>PROVIDERS WHO DELIVER HEALTH CARE SERVICES AND PRODUCTS</b>	<p><b>PHYSICIANS</b> – increasingly part of large groups, often part of hospital system</p> <p><b>HOSPITALS AND OTHER FACILITIES</b> – both non-profit and for-profit hospitals; increasing trend of consolidation</p> <p><b>DRUG AND DEVICE MANUFACTURERS</b> – drug manufacturers are large, global, and largely for-profit entities</p>
<b>INSURERS THAT PROCESS PAYMENTS FOR CARE</b>	<p>The insurer market is dominated by few, large insurers – the five largest companies insure half of the population;<sup>xvii</sup> the four largest control 80% of the private insurance market<sup>xviii</sup></p> <p>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</p> <p>60% of the revenue from the nation's five biggest insurers come from plans funded by Medicare and Medicaid<sup>xix</sup></p>
<b>CONSULTANTS/ BROKERS/ INTERMEDIARIES</b>	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.
<b>GOVERNMENT</b>	Plays multiple roles: acts as payor (through Medicare and Medicaid), provider, and regulator
<b>EMPLOYERS</b>	Pay the majority of health care costs for half of Americans

## The Role of PBMs

*PBMs play a significant role in the health care supply chain by serving 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 most 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.*

*[You can find more information on PBMs here.](#)*

## 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

## Types of Payment Models

***Fee-for-service:*** Provider is paid according to each service delivered

***Value-based:*** Provider is paid according to patient outcomes

***Accountable Care Organization (ACO):*** Groups of providers share joint responsibility for cost and quality of care for a patient population

***Bundled payment:*** Provider is paid according to the estimate of the total cost of all services provided for a particular health condition

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.

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<sup>xx</sup>. 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.

## Next Up: The Health Care Reform Spectrum

The next piece in our series will present a framework for understanding emerging health care reform initiatives.

<sup>i</sup> Health Insurance Coverage of the Total Population. <https://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>  
<sup>iii</sup> <https://www.wsj.com/articles/share-of-u-s-employees-offered-health-care-through-work-rises-1532112860>

- iv <https://www.kff.org/health-costs/report/2017-employer-health-benefits-survey/view/print/>
- ii <https://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>
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