



# THE HEALTH

a chro education series by the

# CARE REFORM

american health policy institute

# SPECTRUM

Part Two of Six

AMERICAN  
HEALTH  
POLICY  
INSTITUTE



*Employers and the US  
Health Care System*

## **II. ■ The Health Care Reform Spectrum** *PART TWO 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 CHROs, their teams, stakeholders, and the public 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.

**III. ■** *Spotlight:  
"Replace the ACA"*

**IV. ■** *Spotlight: "The  
Medicare  
for All Act"*

**V. ■** *Spotlight: "Medicare  
Extra for All"*

**VI. ■** *Implications for  
Employers*



# The Health Care Reform Spectrum

PART TWO of SIX

## Policy Makers Have Differing Visions of Health Care Reform

The US health care system is unique among industrialized nations in two ways: it does not provide universal coverage for all citizens, and access to coverage for nearly half is linked to employment. 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 US 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 US 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 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.

### *Texas v. Azar*

*In December 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.*

*You can read more about the case in our Brief [here](#).*

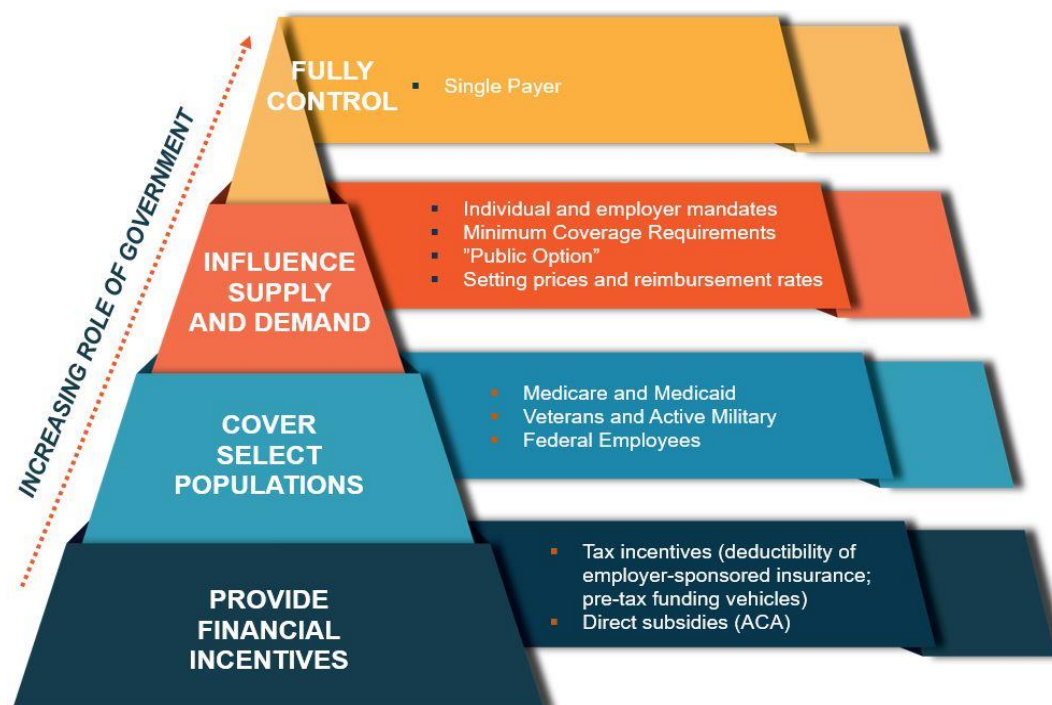
For Democrats, “Medicare for All” is emerging as a rallying cry for many - but there are significant differences between the moderate and progressive elements of the party as to what, exactly, such a plan would include. Some believe the only viable solution to the nation’s health care crisis is a complete 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).

This second installment in our series 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 US 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.<sup>i</sup>

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.<sup>ii</sup>

## 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.<sup>iii</sup> Members of the armed forces and their dependents receive coverage under the government-run TRICARE and VA programs, which cover almost 5% of Americans.<sup>iv</sup> In 2017, taxpayers paid \$114 billion in active duty and veterans' health care.<sup>v</sup>

### *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.<sup>vi</sup>

### *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.<sup>vii</sup>

*Almost **38%** of Americans receive health insurance provided directly by the government<sup>ix</sup>*

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. Nearly 40% of children in the US are covered by either Medicaid or CHIP.<sup>viii</sup> In 2017, Medicaid and CHIP cost taxpayers \$600 billion.<sup>ix</sup>

### ***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.<sup>x</sup>

## **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 mandate”); and the requirement that employers with more than 50 employees offer coverage that meets minimum standards (the “employer mandate”).

### ***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.*

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.<sup>xi</sup>

## 4. Government provides substantially all health insurance

As is in 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.

### *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*

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.

## Next Up: “Replace the ACA”

By evaluating potential future reforms using this framework, we hope to make it easier to evaluate the impact of various proposals on employers, moving beyond political rhetoric toward developing fact-based assessments.

The next piece in our series will analyze the major proposals being discussed to replace the key provisions of the ACA.



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## Endnotes

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<sup>i</sup> <https://home.treasury.gov/system/files/131/Tax-Expenditures-FY2020.pdf>

<sup>ii</sup> <https://www.cbo.gov/system/files?file=2018-06/53826-healthinsurancecoverage.pdf>

<sup>iii</sup> <https://galen.org/assets/Replacing-Empl-Spons-Insur-112618.pdf>

<sup>iv</sup> U.S. Census Bureau, Health Insurance Coverage in the United States: 2017, Table 1.

<sup>v</sup> National Health expenditures by Type of Expenditure and Program, National Health Expenditure Data, Table 19.

<sup>vi</sup> U.S. Census Bureau, Health Insurance Coverage in the United States: 2017, Table 1.

<sup>vii</sup> *Id.*

<sup>viii</sup> <https://familiesusa.org/product/children-health-insurance-program-chip>

<sup>ix</sup> National Health expenditures by Type of Expenditure and Program, National Health Expenditure Data, Table 19.

<sup>x</sup> [https://www.washingtonpost.com/news/powerpost/wp/2017/10/06/feds-pay-more-for-insurance-but-its-still-a-good-deal/?utm\\_term=.e80639cecf97](https://www.washingtonpost.com/news/powerpost/wp/2017/10/06/feds-pay-more-for-insurance-but-its-still-a-good-deal/?utm_term=.e80639cecf97)

<sup>xi</sup> National Health expenditures by Type of Expenditure and Program, National Health Expenditure Data, Table 19.