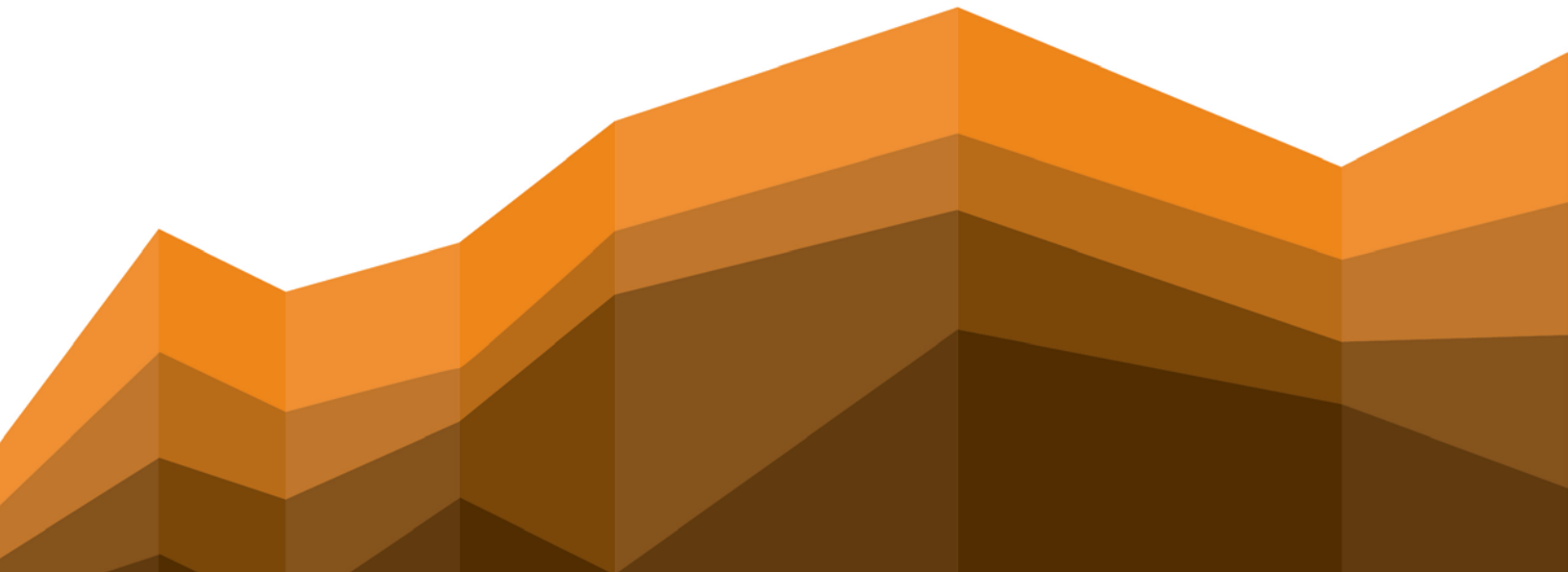


A Move to Single-Payer Health Care? Implications for Employer-Sponsored Care

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American Health Policy Institute (AHPI) is a non-partisan 501(c)(3) think tank, established to examine the impact of health policy on large employers, and to explore and propose policies that will help bolster the ability of large employers to provide quality, affordable health care to employees and their dependents. The Affordable Care Act has catalyzed a national debate about the future of health care in the United States, and AHPI serves to provide thought leadership grounded in the practical experience of America's largest employers. To learn more, visit americanhealthpolicy.org.

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Introduction

With Republicans struggling to come to a consensus or even a simple majority on health care reform, Democrats are looking to take advantage of what is now both a political and a policy opportunity. Based on recent rhetoric and emerging plans, it appears increasingly likely that Democrats will pursue a single-payer health care system as their solution to America's health care challenge. Most Democrats in the House of Representatives already support a single-payer solution,¹ and polls show that 60 percent of Americans believe it is the federal government's responsibility to guarantee health care coverage for all.² Although only 33 percent of Americans want a single-payer system, 52 percent of Democrats support it,³ and Democratic interest groups are already demanding that Democratic candidates support the concept as a condition for political and financial support.

Despite a rising interest in the single-payer approach, it is still not clear what single-payer would mean for Americans. What are the potential implications for the U.S. health care system under a single-payer approach? Specifically, this paper will examine the impact a variety of single-payer options may have on employer-sponsored care, which currently covers 177 million people, the majority of the country.⁴

Previous proposals at both the state and the federal level can give us a sense of what a single-payer system might look like in the United States. In the 2009-2010 debates leading up to the passage of the Affordable Care Act (ACA), most analysts dismissed a single-payer system as not politically feasible in large part because it would be too disruptive to employer-provided health care benefits. Still, Vermont Senator Bernie Sanders made a case for single-payer, and unsuccessfully pushed to have a public option included in the ACA as an initial step towards a single-payer system.⁵ In September of 2017, Sanders revealed a "Medicare-for-All" bill, which would make it "unlawful" for employers to provide benefits for employees or dependents that duplicate the benefits provided under his bill.⁶ The bill received 16 co-sponsors. (We will examine the Sanders bill in a forthcoming analysis.)

In 2010, Vermont embarked on an effort to implement the first state-level single-payer health care system in the United States, but abandoned the effort in 2014 because it could not figure out how to finance the program without politically unacceptable tax increases on Vermont citizens and employers. In 2016, Colorado voters reviewed a ballot initiative that would have established a single-payer government-run health insurer, eliminated private health insurance in the state, and would be paid for with a 6.6 percent increase in employers' payroll taxes and a 3.3 percent increase in employees' payroll taxes. The initiative was rejected by 79 percent of Colorado voters.

Despite these setbacks for single-payer, California could emerge as the next frontier for single-payer health care in the U.S. On June 1, 2017, California's State Senate passed a single-payer bill called Healthy California without providing a way to pay for it. Shortly afterwards, Assembly Speaker Anthony Rendon said he would not bring the bill up for debate this year because it was "woefully incomplete," but left the door open to consider it next year if the State Senate can send the Assembly "workable legislation that addresses financing, delivery of care, and cost control."⁷

Ultimately, whether America transitions to a single-payer system largely depends on a variety of factors: not just the short-term politics, but also how we get there from here, the period of transition, and ultimately the cost. Moving over 70 percent of the U.S. adult population, many

of whom already receive better benefits via employer-sponsored care, to some kind of Medicare-for-All type system would be no small feat.⁸ Attempting to do this transition in a short period of time – just one year in a proposal by Michigan Representative John Conyers – could cause a serious shock to the health care system.⁹ Even a more gradual transition or moving to a system that is not entirely single-payer (perhaps allowing supplemental private insurance) raises many tough questions regarding both cost and logistics. Making a change to our health care system along single-payer lines will require extensive and detailed planning, since any one feature of the system or any one step of the process could have major repercussions for generations to come. It would also have to come to grips with resolving what to do with employer-sponsored care, which covers 61 percent of all Americans with health care benefits, the majority of whom are happy with their coverage.¹⁰

Going forward, Democrats who fail to support single-payer could find themselves facing primary challengers from the left. As Ben Tulchin, a pollster for Sen. Sanders' presidential campaign, put it, "Our view is that within the Democratic Party, this is fast-emerging as a litmus test."¹¹ This heavy emphasis on single-payer among Democrats means that a legislative initiative to institute single-payer could be as soon as one presidential election cycle away. Given this proximity, it's important to answer two key questions: what would the proposal look like, and what would it mean for health care in the U.S. We can't know these answers definitively, but we can look to the details, or lack thereof, of some of the most recent single-payer initiatives to get a better sense of what some future proposal's impact might be.

Comparison Chart: Single-Payer Proposal Details

	Approach	Costs/Taxes	Impact on ESI
Public Option in the ACA 2009-10	<ul style="list-style-type: none"> Rules for public and private insurers: Enrollees should be able to use public subsidies for coverage for all plans in the exchange at the same level Risk adjustment: Insurance plans should receive different amounts of payment from the exchange based on the health risks of enrollees 	<ul style="list-style-type: none"> Regional pricing: Differences in plan costs should be reflected in premiums 	<ul style="list-style-type: none"> Employer-sponsored insurance remains intact
Vermont's Green Mountain Care 2014	<ul style="list-style-type: none"> Military health care operates independently Some big companies pay directly for employees' care Medicare, Medicaid, and ACA would be separate unless granted waivers Individuals can purchase insurance in nearby states 	<ul style="list-style-type: none"> 11.5% payroll tax Up to a 9.5% premium assessment Would have received 94% actuarial value (up from 87%) Less federal funding than anticipated 	<ul style="list-style-type: none"> Multi-state businesses are exempt Local businesses had to provide single-payer plan, calling for a new payroll tax AND high premiums for workers Big businesses can instead pay directly for employees' care through "self-insurance"
ColoradoCare 2016	<ul style="list-style-type: none"> Over 100,000 people not covered by Medicare, Medicaid, or ACA Replaces and eliminates private or employer-sponsored coverage 	<ul style="list-style-type: none"> \$25 billion payroll tax (10%) \$8 billion deficit Unclear whether plan would have saved individuals money 	<ul style="list-style-type: none"> No more employer-sponsored care 10% payroll tax Individuals responsible for covering health care services until full implementation
Healthy California 2017	<ul style="list-style-type: none"> Completely replaces all private insurance Covers all residents regardless of age, employment, or immigration status No premiums, copayments, or deductibles Ability to see any health care provider without referral Covers any medically appropriate service 	<ul style="list-style-type: none"> \$400 billion total Expected savings of 18% totaling \$331 billion \$225 billion provided by redirecting funding from Medicare and Medi-Cal Remaining \$106 billion provided by two new taxes 2.3% gross receipts tax on businesses after first \$2 billion of revenue 80% of businesses pay nothing (small businesses) Medium-sized businesses effectively pay less than 1% tax rate. Sales tax increase of 2.3% which does not apply to housing, utilities, food for home, etc. 2% income tax credits for low-income families 	<ul style="list-style-type: none"> No more employer-sponsored care Projected savings for most businesses after taxes

Public Option in the ACA

In the debate over the ACA in 2009, Sen. Sanders argued that any health legislation should have a “strong public option,”¹² and on July 30, 2017, he again called for “a Medicare-type public option available in every state in this country” for people that “don't like the private insurance that they're getting.”¹³ The most common type of public option discussed in the health care debate involves some expansion of existing government programs, like Medicare or Medicaid.¹⁴ This could involve lowering the eligibility age for Medicare to 55 and enabling people to enroll in the program if they do not have any ACA plans offered in their exchange, or if the ACA plans are unaffordable. Alternatively, Medicare or Medicaid eligibility could be expanded to cover anyone who does not have any ACA plans offered in their exchange or if the ACA plans are unaffordable. Dr. Helen Halpin, a professor at the U.C. Berkley School of Public Health, says this type of public option could help transition the U.S. to a single-payer program in the future.

Dr. Jacob Hacker, often referred to as the father of the public option, recently called for a national plan that would build on Medicare's existing infrastructure, with established systems for patient management and provider reimbursement.¹⁵ However, under his plan, the public option would be distinct from Medicare in several key respects. First, it would pay providers slightly more to incentivize them into the system. Second, it would cover a broader set of benefits, but public option enrollees would not have access to private Advantage Medicare plans. Finally, the public option should be priced so it breaks even nationally, and its premium should vary with the regional variation in Medicare reimbursement rates.

Proponents of a public option modeled after Medicare say it would increase coverage while lowering costs for consumers. The lower costs would be primarily due to the lower reimbursement rates Medicare and Medicaid pay to providers. Critics argue a public option would lead to reduced access to care, as physicians might be unwilling to accept the lower payments, and insurance companies would object to the unfair competition that would arise to the plans they currently offer on the ACA exchanges. There's also the question as to whether there should be one standard national plan, or if the states should design their own program and designate rates.

The next opportunity proponents will have to implement a public option could come after the next presidential election in 2020, and would most likely be attempted through the budget reconciliation process that only requires 51 votes in the Senate.

Vermont's Green Mountain Care

In 2011, Vermont Governor Peter Shumlin and the Vermont state legislature passed Act 48, which instructed the state government to implement the first state-level single-payer health care system in the United States (Green Mountain Care) provided the state could figure out how to finance the program.¹⁶ Under the Green Mountain Care plan, most private health insurance, including fully-insured employer-provided health care benefits, would have been replaced with a public-private single-payer system that would be financed through payroll taxes and would offer a generous standard benefit package (94 percent actuarial value). The Green Mountain Care plan would have replaced fully-insured employer-provided health care benefits with a 11.5 percent payroll tax and up to a 9.5 percent premium assessment for individuals and families depending on their income.¹⁷ Self-insured employers would not be taxed.

Benefits and financing for both Medicaid and Medicare would remain unchanged. However, both programs would be folded into the single claims administration and payment system, requiring federal waivers for both programs and creating a uniform payment scheme for providers.¹⁸ In addition, Vermonters would also still be able to purchase insurance in nearby states.¹⁹

The single-payer system would be governed by an independent board, consisting of both the “payers” of health care (employers, the state, and families) and the “beneficiaries” of a health system (patients and providers who receive payments) with some elements of the program’s administration run by private-sector organizations selected through competitive bidding. The annual benefit and payment update negotiations would be delegated to the board. However, companies with self-insured benefit plans would not be subject to the payroll tax.²⁰

A lack of federal funding was a challenge: the state government had expected \$267 million resulting from an ACA waiver, but would in reality only receive \$106 million. The state also expected to receive \$637 million in Medicaid funding, but in actuality would have received \$150 million less than that.²¹ The Green Mountain Care plan would have also been expensive. It required a 94 percent actuarial value level, significantly higher than the 87 percent actuarial value of the average private plan in Vermont.²² For a point of reference, the ACA “Gold” tier is 80 percent.²³ Vermont’s plan also faced opposition from insurance companies and hospitals, making its implementation more unlikely.²⁴ Insurers projected that the plan’s requirements would have driven them out of business. Hospitals objected to the fact that they would have received less reimbursement from the plan than from private insurers.

By 2014, Gov. Shumlin announced that Vermont would abandon the effort, as the state would be unable to afford Green Mountain Care.²⁵ The financial hurdles of implementation, combined with the opposition of interest groups and citizens derailed the plan. In pulling the plug on single-payer, though, Shumlin made clear that he was doing so to maintain the viability of single-payer plans passing in Vermont – and presumably elsewhere – in the future. As Shumlin stated in making his decision, “I am not going [to] undermine the hope of achieving critically important health care reforms for this state by pushing prematurely for single-payer when it is not the right time for Vermont.”²⁶

ColoradoCare

In 2016, Colorado voters were presented with a ballot initiative that would have established a single-payer government-run health insurer, eliminated private health insurance in the state, and would be paid for with a 6.6 percent increase in employers' payroll taxes and a 3.3 percent increase in employees' payroll taxes. Although the ballot initiative would not have prevented employers from offering health care benefits or people from purchasing private health insurance, it would have effectively taxed them out of existence.²⁷ Notably, the payroll tax would have applied to all employers in the state; both self-insured and fully-insured.

ColoradoCare would have insured the more than 100,000 Coloradans not covered by Medicare, Medicaid, or the ACA, while replacing private and employee-sponsored insurance and also taking control of the state’s Medicaid program.²⁸ The measure required a \$25 billion payroll tax to pay for it.²⁹ Even with the hefty tax, it would have created an \$8 billion deficit, according to the nonpartisan Colorado Health Institute.³⁰ The 10 percent payroll tax would have made Colorado’s tax bracket the highest in the country.³¹ There was also a dispute among

estimates as to whether citizens would end up paying more or less for insurance after the implementation of ColoradoCare.³²

Two major concerns were that the increased taxes would drive business out of the state and that the ColoradoCare board as structured would be too powerful. As written, the amendment would not have given voters the option to repeal the politically-appointed members of the interim board governing the program.³³ The amendment also lacked clarity as to who would select these board members.³⁴ There was also no requirement that members be health care experts added to the confusion.³⁵ Women's health groups worried that, without repeal, a 1984 law preventing the state from funding elective abortions would have denied women abortions under ColoradoCare.³⁶

Ultimately, the plan suffered a convincing political defeat, with about 80 percent of voters rejecting the ballot initiative.³⁷ Due to the array of forces against it, including some on the left, opponents outspent supporters by more than 5 to 1.³⁸ The most effective advertising highlighted the plan's increased taxes, effectively dooming the Colorado plan.³⁹

Healthy California

In June of 2017, the California State Senate passed Senate Bill 562, the Healthy California Act, which would create a single-payer health care system in California. Businesses would no longer be required to cover employees, and the plan would completely replace private insurance by covering all residents regardless of one's age, employment, or immigration status.⁴⁰ California residents would not have to pay any premiums, copayments, or deductibles; would be able to see any health care provider without a referral; and would be able to get any medically appropriate service.⁴¹

Insuring all California residents by extending coverage under the current system would cost about \$400 billion per year, which is about a 10 percent increase from the \$370 billion dollars California will spend on health insurance in 2017.⁴² The Healthy California plan, however, could save up to 18 percent of this \$400 billion total (or 8 percent of \$370 billion) to bring the total down to \$331 billion.⁴³ Under this plan, Medicare and Medi-Cal (California's Medicaid) funding would then redirect to Healthy California, providing \$225 billion of the \$331 billion needed.⁴⁴ This redirection of funds, however, would require waivers from the Trump administration, which seems unlikely to be given considering the proposed system's coverage of individuals regardless of immigration status.⁴⁵

Two new proposed taxes could potentially pay for the remaining \$106 billion. One would be a 2.3 percent gross receipts tax on businesses after the first \$2 million of revenue, which means that 80 percent of businesses (small businesses) would pay nothing, and medium-sized businesses would effectively pay a less than 1 percent tax rate.⁴⁶ The other would be a 2.3 percent sales tax increase that would exclude certain costs including housing, utilities, and food for the home. A 2 percent income tax credit would be given to low-income families to balance against this sales tax.⁴⁷ The results would be that most families save money, with middle-income families spending 2.6-9.1 percent less on health care.⁴⁸ Proponents projected that businesses would save as well: small businesses that provide health care for their employees would save 22 percent as part of payroll; medium-sized businesses would save an average of 6.8-13.4 percent; and most large businesses would save an average of 0.6-5 percent.⁴⁹ Of course, it's important to remember that some businesses might reduce employment because of the payroll tax.

Healthy California's advocates claim it addresses the issue of funding universal coverage while saving most families and the vast majority of businesses money, even after the introduction of significant new taxes.⁵⁰ They argue that this plan would have left the majority of businesses spending less, since smaller businesses would not have to pay the tax, and employers would no longer have to provide insurance for their employees.⁵¹ Still, even if they are right, and assuming the legislation does advance, additional obstacles to Healthy California exist. The Trump administration might not approve waivers to redirect Medicare and Medicaid funds to the new system.⁵² In addition, cost containment is a perennial problem, and the proposal could also allow doctors to continue providing service on a fee-for-service basis.⁵³

Getting people to support these new taxes in one of the most heavily taxed states in the country, however, might prove too difficult.⁵⁴ Although 56 percent of California likely voters are in favor of single-payer health care, only 43 percent are in favor if that system requires raising taxes.⁵⁵ Another cause for concern is the bill's mandate that health care providers be reimbursed on a "fee-for-service basis unless and until another payment methodology is established by the [Healthy California] board."⁵⁶ Fee-for-service along with the ability to see any health care provider without a referral would make containing costs difficult. However, the savings from a single-payer system might sufficiently offset these costs.

Conclusion: What Would Single-Payer Mean for Employer-Sponsored Care?

A truly single-payer health care system would mean no more employer-sponsored health insurance; employers would be completely rid of this responsibility, and there would be no more entanglement between the two separate spheres of employment and health care. However, even as a national single-payer system is gaining popularity, especially among Democrats, a *truly* single-payer framework seems the most unlikely form to be implemented. The federal government would be taking on the responsibility of providing health care to all Americans, a change so drastic with consequences ultimately so uncertain that it seems unlikely to win a majority of votes in Congress, especially considering how politically unfeasible it has proven on a much smaller scale even in very liberal states like Vermont.

More plausible forms of a single-payer system could involve a public option that would compete with private insurers to cover those without employer-sponsored coverage who don't qualify for Medicaid, or perhaps a single-payer system that covers everyone at a lower level but allows for supplemental private insurance that could still be provided through employers. A public option would likely result in heavy regulation of private employer-sponsored health insurance in an attempt to level the playing field between public and private options in market competition. Additional corporate taxes to pay for such a system are a likely component as well. On the other hand, employer-sponsored supplemental private insurance might operate much the same way from the employer perspective, which could have the benefit of relieving employers of some of the burden.

If single-payer, in any form, gets to the implementation stage in the U.S., the effects on employers ultimately depend on the details of funding. In a system that is not truly single-payer like Vermont's proposed Green Mountain Care, not all employers were required to participate in the system, which meant that the burden of financing the system was not evenly distributed and some businesses would have had to shoulder an 11.5 percent payroll tax. In a truly single-payer

system like the Healthy California Act, mandatory participation of all in the system and the redirecting of funds from Medicare and Medicaid would further diversify the burden of financing the system. The sales tax would take the place of the cost of premiums, copayments, and deductibles, thus saving most families money in direct out of pocket health care costs; the gross receipts tax would take the place of paying for employees' insurance. By further distancing individuals from the cost of health care, though, this full dollar coverage approach would remove an important check on health care prices, meaning that costs could potentially go up even faster in this new system.

Since a single-payer system has yet to be implemented even on a state scale in the U.S., it is ultimately unclear as to what it would mean for employer-sponsored health insurance. There are many ways in which it could place an excessive and damaging financial burden upon employers. In addition, removing cost-sharing from individuals, while potentially popular, could have a deleterious impact on health care prices. On the positive side from the employer perspective, a single-payer system has the potential to relieve employers of the administrative responsibility of providing health care while also saving them money. As with so many other aspects of complex health care policy, the true impact will depend on the details of the proposal.

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<http://khn.org/news/californias-new-single-payer-proposal-embraces-some-costly-old-ways/>