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Health Policy Reforms to Fit the Modern US Labor Force and Address Underlying Cost Drivers

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About the Author

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Executive Summary

The US labor market is shifting away from full-time, permanent jobs that offer employer-sponsored group health insurance. A key labor market trend is the large and growing proportion of employees working as contract workers, independent contractors, part-time and temporary workers, and members of the “gig economy” such as Uber and Lyft drivers. Another trend is the steady decline in the proportion of small employers offering health coverage. A third trend is the shifting of a substantial portion of the cost of employer coverage from the firm to the worker. Employees’ contributions to employer group health insurance have far outpaced the growth in their earnings, and this has led some workers to decline job-based coverage.

In addition, many workers are being displaced by technology. Finally, despite very tight labor markets in 2018, the labor force participation rate remains very low. Some of this reflects the retirement of baby boomers but another large chunk represents people in their prime working years (25-54) stuck outside the labor force, many of whom would like to work but face barriers to employment and are not prepared for the demands of a modern work force.

The US needs a viable source of nearly automatic health coverage for such workers. This paper makes the case for correcting problems with the Affordable Care Act (ACA) and building on it to move the US toward universal health coverage. Incremental progress toward universal coverage can be achieved without mandates on individuals and employers and without a single payer system. This is not to discredit those approaches, and the termination of the penalties for not having health coverage starting in January 2019 removes one of the important pillars of the ACA.

While the debate over mandates and Medicare for all continues, however, we need to find an analytically and politically viable approach to make health coverage available and affordable for millions of uninsured Americans. Most important, we need to fix and strengthen the ACA Marketplaces (Exchanges) and help people who are eligible for subsidized coverage but currently not participating obtain and retain it easily. We also need to avoid kicking people off Medicaid for whom, at least in the near-term, it is the only source of affordable health coverage.

Expanding health coverage will be more affordable if we address the fundamental cost drivers. These include: (1) the ongoing march of medical technology, bringing wondrous advances in patient care, but frequently without balancing such advances with the related risks and harms, or with the costs; (2) avoidable use of the ER and inpatient hospital admissions, for lack of the effective prevention and management of chronic medical conditions; (3) the very high prices of many health services and products; (4) our neglect of the strong forces outside of the medical system that drive people into it, such as poor housing, food insecurity, tobacco use, substance use disorders, and inadequate transportation; and (5) open-ended tax subsidies that are poorly targeted to need and discourage employees from being conscious of the quality of health care and cost when they select a health plan.

The following policy measures address these problems:

Improve the viability of ACA Marketplaces and the Individual Markets

1. Restore the ACA Cost Sharing Reduction (CSR) program.

2. Encourage more states to develop reinsurance programs and consider re-constituting a national approach.
3. Shore up and strengthen the ACA risk-adjustment program.
4. Extend eligibility for the ACA option of “catastrophic coverage” insurance plans from young adults under the age of 30 to all adults.
5. Avoid converting short-term, thin-benefit health insurance plans into multi-year plans.
6. Avoid proposals that would restore pre-ex exclusions, insurance rating based on health status and gender, and other insurance rules that encourage insurers to shun older and sicker patients or price them out of coverage.

Significantly Expand Automatic Enrollment Strategies to Insure More Americans

1. Federal and state governments create incentives for automatic enrollment in public programs.
2. States create incentives for employers to use auto-enrollment into their health benefit programs and develop approaches to broaden coverage that fit their own situations.

Continue to Reform Medicaid but Avoid Harsh Measures that Block or Drop Enrollment

1. Limit the use of work rules and create a broad range of acceptable community/work arrangements with phase-ins of requirements; work supports create a better path out of poverty than removing people from Medicaid who are going to have a hard time finding affordable private market alternatives.
2. Develop care plans for Medicaid enrollees with complex medical and social needs.

Address the Underlying Health Care Cost Drivers

1. Develop a new approach to health technology assessment.
2. Overhaul the incentives driving avoidable hospital use.
3. Develop new strategies to reduce high prices.
4. Address the social determinants of health.
5. Cap open-ended tax subsidies and re-deploy savings to help finance coverage for those with low incomes.

The shrill battle over the Affordable Care Act is keeping the country from a constructive debate over the best and most bipartisan ways to move in the direction of universal health coverage through incremental, substantial reforms while controlling health costs. We need a cease-fire in the battle over ACA, leading to a non-ideological blueprint for health reform. This report is designed to offer a menu of policy options in that spirit, and to highlight several promising reforms underway in Maryland.

Statement of the Problem

The U.S. labor market is undergoing important, long-term changes that are shifting large numbers of workers and their families away from traditional employer-sponsored health insurance. This trend highlights the importance of facilitating a seamless and nearly automatic transition for such workers to an alternative organized purchaser of affordable health care. The gradual decline in the proportion of people covered by employer health coverage over the past two decades has exacerbated this problem.

Millions of U.S. workers are in non-traditional work arrangements that are outside of the full-time, “permanent” jobs that for decades provided affordable employer-sponsored health coverage to employees and their families. Non-traditional work arrangements include part-time work among workers who want to work full-time, temporary jobs, contract jobs, independent contractors or freelancers, and those in the still small, but rapidly growing “gig economy” at places such as Uber and Lyft. Economists Lawrence Katz and Alan Krueger found that the percentage of workers in such alternative work arrangements rose from 10.1 percent in February 2005 to 15.8 percent in late 2015.¹ A study by the Office of Tax Analysis at the US Treasury Department found that almost 17 million self-employed workers represented 12 percent of all tax filers with earnings in 2014.²

These alternative work arrangements typically do not provide health coverage to workers. The Affordable Care Act’s (ACA) Marketplaces, sometimes called Exchanges, were intended to meet the needs of those stranded from group coverage. These Marketplaces, however, have been under siege by opponents of ACA (frequently called Obamacare) and enrollment can be daunting. More than half of the uninsured today are eligible for some type of subsidized coverage—public or private—but are not participating. The US needs a new approach to providing affordable coverage to those remaining uninsured who are eligible for coverage. We also need new strategies to help the uninsured who are not eligible for coverage—for example, poor and near-poor adults living in states that have not adopted the Medicaid expansion under ACA.

The underlying cost of health care is driven by such forces as our failure to evaluate fully new advanced medical technology (i.e. drugs, biotech products, medical devices) and develop coverage and reimbursement policies that reward the demonstration of superior value of some new technologies while collecting information about medical advances that have not yet proven such value to inform future coverage and payment decisions. Another important factor pushing up health spending is that the prices of many health care services and products are higher than necessary to provide Americans with top-quality health care at an affordable cost. Further, consolidation and market power across many sectors of our health system contribute to high prices.

In addition, open-ended tax subsidies inversely related to financial need discourage cost and value-related decisions by employees choosing health plans. Finally, the vast bulk of our spending is within the

¹ Lawrence F. Katz and Alan B. Krueger. The Rise and Nature of Alternative Work Arrangements in the United States, 1995-2015. https://krueger.princeton.edu/sites/default/files/akrueger/files/katz_krueger_cws_-_march_29_20165.pdf

² Emilie Jackson, Adam Looney, and Shanthi Ramnath. The Rise of Alternative Work Arrangements: Evidence and Implications for Tax Filing and Benefit Coverage. Office of Tax Analysis, US Department of Treasury. January 2017. <https://www.treasury.gov/resource-center/tax-policy/tax-analysis/Documents/WP-114.pdf>

walls of our medical system while there is ample evidence that well more than half, and perhaps as much as 80 percent of what determines the health of an individual arises from forces outside those walls.

Opponents of the ACA have implemented policy changes that mainly *shift costs from one set of Americans to another rather than lowering spending for all*. Our failure to address and check the underlying health care cost drivers leads to more and more individuals remaining uninsured because they cannot afford the cost of individually purchased health insurance. Others cannot afford their share of the cost of health plans offered by their employers. Spiraling health costs also lead some employers, particularly small firms, to avoid offering health coverage. For those firms that offer coverage, the high cost of health care increases their total employee compensation, and the cost of the resulting higher premiums is mostly shifted back to workers in the form of slower growth in earnings.

The twin challenges of making health coverage affordable for workers in a changing labor market and addressing the most important underlying factors driving up health care spending call for modernizing our policy toolkit to move the US toward universal health coverage at an affordable cost. There are no quick fixes. This quest is now a little more than a century old, and we need a bipartisan consensus on the best way forward. This report develops a menu of policy options and highlights some promising policy approaches underway in Maryland.

Intense fighting over ACA, with no viable alternative on the table today, is keeping us from seeking a new approach to health reform that corrects problems with the law and builds on its strengths. This can be done in a bipartisan way.

Background

In addition to the growth in the “alternative work force,” the proportion of small and medium-size firms offering health insurance has been falling. According to a study by the Kaiser Family Foundation, the proportion of employers with 3-49 employees who offered health insurance fell from 63 percent in 1999 to 54 percent in 2018. The proportion of firms with 50-99 workers that offered health insurance fell from 96 percent in 1999 to 89 percent in 2018. Among companies with 100 or more employees, the decline was very slight, from 98 percent in 1999 to 96 percent in 2018.³

From 1999 to 2015, workers’ contributions to family health coverage increased by 221 percent while workers’ earnings increased by only 56 percent. Since overall inflation increased by 42 percent over that period, workers’ real earnings grew very little while their contributions to family coverage soared.⁴ While 158 million US residents get coverage through employer-sponsored health insurance, this mainstay of health coverage over several decades should not be viewed as permanent or stable.

In addition, despite very low unemployment in the US in 2018, many working-age people remain stuck outside the work force. Frequently, they are unprepared for work although they would like to work; are too young for Medicare; are not poor enough for Medicaid; and cannot afford to buy health insurance on their own. Among the many causes of their predicaments are chronic physical conditions; mental

³ Kaiser Family Foundation. Employer Health Benefits 2018. Summary of Findings. p. 6.

<http://files.kff.org/attachment/Summary-of-Findings-Employer-Health-Benefits-2018>

⁴ Henry J. Kaiser Foundation. Recent Trends in Employer-Sponsored Health Insurance Premiums.

<https://www.kff.org/slideshow/recent-trends-in-employer-sponsored-health-insurance-premiums/>

health and substance use disorders; current incarceration or past convictions that make getting a job very difficult; and caring for a family member with ongoing serious health conditions. Despite very tight labor markets (a 3.9 percent unemployment rate in December 2018), the labor force participation rate in the US in December 2018 was 63.1 percent,⁵ and has been stuck at about this level for a long period. This general level of participation approximates a previous low level in 1978, or forty years ago. The highest labor force participation rate of 67.3 percent occurred in January 2000.⁶

A good portion, perhaps as much as half, of the current low labor force participation rate involves the retirement of the Baby Boomer population. Yet, many people in the prime labor market age group (ages 25-54) are outside the labor force for reasons such as those cited above. The labor force participation rate of 25-54 year-old men, for example, has fallen from 91.1 percent in January 2008 to 88.8 percent in July 2018, a period of continuous job growth following the Great Recession.⁷

Restrictive immigration policies may also play a role. Setting aside the emotional and political debate surrounding immigration, it is important to concentrate on the implications of immigration for an adequate work force and strong economic growth. Immigration can help supplement the US-born work force in a period of an aging population, slow growth of the working-age population, and low labor force participation. Health care is filled with examples of this, in occupations such as nursing, home health aides, and personal care aides. A recent book by economist Paul Osterman documents the looming shortages of workers in such fields.⁸ It has been estimated that the presence of immigrant workers, both legal and illegal, already makes the GDP about 11 percent larger than it would be without them. An estimated 8 million unauthorized workers comprise 5 percent of the US work force and pay more than \$13 billion in payroll taxes.⁹

While the US continues to debate immigration policy, we should develop new policies to ensure that adults and children get access to health care regardless of immigration status. These people fill important roles in the economy, and it is important that they be healthy. This is good for our economy and good public health.

The Role of ACA Marketplaces and Uncertainty About Their Future

There are two ways for individuals to purchase health coverage on their own. First, they can go to what is called “the individual market” and select coverage from a choice of private health insurance plans. Second, they can enroll in Marketplaces established under ACA. Thirty-nine states use Federally Facilitated Marketplaces, while the other states and the District of Columbia operate their own. These Marketplaces are designed to provide a source of affordable health insurance for people in the types of alternative work arrangements described above, those in more traditional jobs where the employer does not offer coverage, and people unemployed or out of the labor force. More than 80 percent of participants in Marketplaces receive subsidies in the form of Advanced Premium Tax Credits, or APTC,

⁵ <https://www.bls.gov/news.release/empsit.t15.htm>

⁶ <https://tradingeconomics.com/united-states/labor-force-participation-rate>

⁷ <https://data.bls.gov/timeseries/LNS11300061>

⁸ Paul Osterman. *Who Will Care For Us? Long-Term Care and the Long-Term Care Workforce*. New York. Russell Sage Foundation. 2017. Osterman projects a shortfall of 3.77 million unpaid family and friend caregivers in 2030 and 11.1 million in 2040. He also projects a shortfall of about 151,000 paid direct care workers in 2030 and about 355,000 in 2040. pp. 169-170.

⁹ Joseph Minarik and Caroline Ferguson. *Immigration is best solution for shortage of workers*. The Hill. July 9, 2018.

scaled to their incomes. About one of twenty Americans purchase health coverage on their own in one of these two ways.

A combination of forces is threatening the viability of these Marketplaces. First, there were serious implementation problems in the initial roll-out, frustrating consumers who tried to enroll on line. Second, the population that enrolled in the Marketplaces were, on average, older and sicker than the overall population, forcing insurers to raise premiums substantially.

Although the Marketplaces face numerous threats, there is some indication that they are stabilizing. Premium increases vary substantially from state to state, but in many states, premium increases are more modest than in prior years, and in some states, premiums are lower in 2019 than in the prior year. Focusing on premiums for the second-lowest cost silver plan, Georgia will experience an increase of 10 percent in 2019 above the 2018 rate; Ohio an increase of 3 percent; New York, an increase of 15 percent; Minnesota, a decline of 8 percent; and New Mexico, a decline of 17 percent. Numerous states will see premium increases in single digits.¹⁰

The perspective of ACA opponents on ACA Market Regulations, Subsidies, and Marketplaces
ACA opponents argue that this law follows a type of “one-size-fits all” approach and denies consumers the opportunity to customize the type of health coverage they buy to fit their own needs. Younger and healthier consumers are forced, according to this line of thinking, to buy the insurance package with the ten “essential health benefits” that include some covered services that such people may feel they do not need to insure against—thus, they are forced to “over-insure.” This leads many such people to decide to remain uninsured when they might instead purchase a leaner benefit package. Further, ACA’s elimination of insurers’ ability to rate consumers based on their health status and the limitation on age rating to no more than three-to-one raises the cost to people in reasonably good health, relative to what we might think of as the “actuarial value” of their own insurance.

Thus, these opponents believe that insurance with leaner benefit packages that are not ACA-compliant should be readily available to people. If they qualify for subsidies based on income, they should be able to use those subsidies for a range of different insurance plans including plans previously limited to short-term coverage, e.g., three months, which they believe insurers should be able to offer for longer time periods; Association Health Plans (AHPs); and plans that omit some of the ACA essential benefits. Further, states should be able to apply for waivers from the federal government to return to insurance market practices outlawed or limited by ACA, including rating based on current health status (higher rates for people who were in the hospital at least once last year, for example, than for those who were not), and even the return of pre-existing condition exclusions. It should be noted that most opponents of ACA maintain they do not want to return to pre-existing condition exclusions, but the waiver flexibility contained in some federal government proposed regulations would permit states to ask for all these changes. An important feature of the opposition to ACA is that the law is alleged to be overly prescriptive and over-regulates health insurance markets.

¹⁰ Rabah Kamal, Cynthia Cox, Michelle Long, Ashley Semanshee, and Larry Levitt. Tracking 2019 Premium Changes on ACA Exchanges. Kaiser Family Foundation. October 11, 2018. <https://www.kff.org/private-insurance/issue-brief/tracking-2019-premium-changes-on-aca-exchanges/>

ACA opponents maintain that this alleged over-regulation is to blame for high premiums inside the Marketplaces and in the external markets where people buy coverage on their own. They maintain that if left alone, ACA will “implode” or “collapse under its own weight.”

The perspective taken in this paper

The viewpoint taken in this paper is that the approach favored by the opponents, as just explained, leads to cost-shifting and not real cost control. The combination of allowing people to customize their benefit package to include plans with very skimpy coverage will lower costs for one segment of Americans but will inevitably result in costs rising commensurately for another segment of Americans. In short, the opponents’ approach is a zero-sum game. I can only win if you lose, and vice versa. This runs counter to the very concept of health insurance. Large numbers of people are placed in a risk pool. Some will not need much health care in a given year, so they are “paying for” others who do. But later, as the people in good health grow older, or sooner if they are victims of accidents or a sudden illness, other people will pay for them.

This paper takes the position that the way to lower the cost of health care in the US is to address the underlying cost drivers, an approach that holds the promise of lowering premiums for all Americans, not just those fortunate enough at a given point in time to be in good health. The final section of this paper identifies some of the key underlying cost drivers and suggests some approaches to address them.

The main reason for the sharply higher Marketplace premiums is the all-out attack on ACA

The most important set of factors driving up premiums in ACA Marketplaces involves the relentless and repeated attacks from ACA opponents in both Congress and the Trump administration, and this threatens their viability. In September 2017 the Trump administration terminated reimbursement payments to insurers for cost sharing reduction (CSR) stipulated by ACA. CSR is available to Marketplace enrollees with incomes under 250 percent of the federal poverty line (FPL) to assist with their copayments, deductibles and coinsurance. Nevertheless, insurers are required by the ACA to offer these cost sharing reductions, and without the reimbursement expected from the federal government under the law, were forced to make additional, large premium increases. At least 47 State Insurance Commissioners either allowed insurers to raise premiums shortly before the administration terminated CSR payments, or allowed them to do so quickly after the termination of CSR.¹¹

Most consumers were shielded from the cost of CSR termination—instead, according to CBO, it was the American taxpayers and unsubsidized Marketplace participants who footed the bill as the premium subsidies “rode up” with rising premiums—the higher the premiums, the higher the federal subsidies.¹² The termination of CSR payments contributed to the process of “silver-loading,” under which most insurers packed CSR-related premium rate increases into silver-level health plans. ACA uses the premiums for silver-level plans to determine the size of federal subsidies for people with incomes below 400 percent of the FPL. When premiums for these silver plans rose sharply, federal subsidies went up commensurately. Some consumers switched from silver-level plans to zero-premium bronze-level plans

¹¹ Letter from CBO Director Keith Hall to the Honorable Mark Meadows. June 8, 2018.

¹² Keith Hall. Cost Sharing Reductions in CBO’s Spring 2018 Baseline. May 3, 2018.

<https://www.cbo.gov/publication/53799>

with limited to no cost-sharing such as copayments. But they face much higher deductibles when they go to get health services.¹³ These unexpected effects illustrate “the law of unexpected consequences.”

Health law expert Professor Timothy Jost explains that the Trump administration also effectively ended the ACA’s SHOP small business marketplace program. Further, it has tried to create an alternative individual health insurance market independent of the ACA by expanding the ability of Association Health Plans to cover individuals and small groups subject only to permissive large-group consumer protections. The Trump administration’s short-term, limited duration coverage rule permits the marketing of more plans completely free of all ACA insurance reforms. Recent rules allow states to alter essential benefit requirements, reduce transfers across insurers under the risk adjustment program, and diminish required insurer medical-loss ratios.¹⁴

Professor Jost notes that despite many efforts to undermine the ACA, the Trump administration has also taken steps that have helped stabilize ACA individual market coverage. The final rule issued by the Administration in Spring 2017 included several provisions, such as limiting the special enrollment period, that insurers argued would be market stabilizing. CMS has encouraged and now granted seven state innovation waivers to allow reinsurance programs that have the effect of reducing individual market premiums. The federal marketplace and call center operated effectively during the 2017 open enrollment period.¹⁵

Congress also pulled money out of the ACA Risk Corridor program that assisted insurers with medical claims above a pre-established target that resulted from paying for a disproportionate number of high-cost cases. The goal was to pay for this assistance largely with transfers, via HHS, from insurers with claims that were below pre-established targets. Under ACA, Congress appropriated funds to address the situation in which an insufficient number of insurers experienced lower-than-expected claims to fund the overage of insurers with higher-than-expected claims. This program was working in the 2014-2015 period. But it was essentially gutted by Congressional amendments to federal budget bills in 2015 and 2016 that removed almost all the federal funding. As in the case of renegeing on promised CSR payments, this failure to live up to commitments to insurers that were designed to stabilize the individual markets led to higher premium increases. Since almost all insurers got less healthy pools of enrollees than anticipated, there were little or no “surpluses” among some insurers to share with “deficits” faced by others. Thus, the removal of this backstop federal funding further hampered the viability of Marketplaces.¹⁶

¹³ Advisory Board. ‘Silver-loading’ helped save the ACA’s Exchanges in 2018. Now, the Trump administration may ban it. April 17, 2018. <https://www.advisory.com/daily-briefing/2018/04/17/exchanges-silver-load>

¹⁴ Timothy S. Jost. The Affordable Care Act Under the Trump Administration. The Commonwealth Fund. August 30, 2018.

¹⁵ Timothy S. Jost. *Supra*.

¹⁶ The Risk Corridor program entails a complex formula to assist insurers (QHPs) with high medical claims. Total claims that fall within plus or minus 3% of targets have no adjustment. If insurers’ claims fall below the target by 3-8%, the insurer pays HHS 50% of the difference between actual claims and 97% of the target amount. If QHP claims fall below the target by greater than 8%, the insurer pays 2.5% of the target amount plus 80% of the difference between actual claims and 92% of the target. QHPs with claims exceeding target amounts by 3-8% get a payment equal to 50% of the excess of 103% of the target. QHPs exceeding the target by greater than 8% receive from HHS 2.5% of the target amount plus 80% of the amount greater than 80% of the target. See Cynthia Cox,

Other actions taken by the Trump administration and Congress are threatening the Marketplaces. The penalties related to the individual mandate are expiring in 2019 as a result of Congressional action. This will lead many younger and healthier individuals to remain on the sidelines of the health insurance system, raising premiums for others who cannot give up coverage because of serious and ongoing medical conditions. The Congressional Budget Office estimates that this repeal of the mandate's penalties will lead to a reduction of 4 million people with health insurance in 2019 and 13 million fewer insured people in 2027. Average premiums in the nongroup market would be about 10 percent higher in most years of the next decade as healthier people will be less likely to get health insurance.¹⁷

The open enrollment period was reduced from three months to six weeks for the Fall of 2017, and most of the funding for outreach and enrollment was eliminated.

A Promising Development

Under Section 1332 of ACA, states may apply for innovation waivers to alter key provisions of ACA. States may experiment with alternative ways of providing coverage and address insurance market problems. There are limits on states' flexibility. States must demonstrate that the innovation plan will provide coverage that is at least as comprehensive in covered benefits and at least as affordable as before, accounting for both premiums and cost sharing; the innovation plan must also cover at least as many people in the state as under the regular ACA and not increase the federal deficit. States may alter individual provisions of ACA or request an aggregate payment of what residents would otherwise have received in premium credits and cost sharing reductions, referred to as subsidy pass-through funding. States may not waive such ACA insurance market provisions as guaranteed issue, limits on age rating, and prohibitions on rating based on health status or gender.¹⁸

At the end of 2018, Oregon, Minnesota, Alaska, Hawaii, Maine, Wisconsin, and New Jersey have obtained federal government approval of their 1332 waiver applications. Maryland has an application pending with CMS. These states are using the waivers to establish reinsurance programs. This use of Section 1332 waivers is very promising. By providing federal and state funds for the cost of care for people with unusually high health expenditures in a given year, the reinsurance programs can help lower premiums for everyone else.

If these state reinsurance programs prove to be viable and effective, the U.S. should consider developing a national reinsurance program.

New Trump Administration 1332 Waiver Action runs counter to the ACA specifications

A very recent action from the Trump administration pertaining to Section 1332 was released on November 29, 2018. The administration permits states to request waivers for Account-Based Subsidies, among other new flexibility. Under this waiver concept, a state can direct public subsidies into a defined-contribution, consumer-directed account that an individual could use to pay for health insurance premiums or other health care expenses. The account could be funded with pass-through

Ashley Semanskee, Gary Claxton, and Larry Leavitt. Explaining Health Care Reform: Risk Adjustment, Reinsurance, and Risk Corridors. August 17, 2016.

¹⁷ Congressional Budget Office. Repealing the Individual Mandate: An Updated Estimate. November 2017. p. 1. <https://www.cbo.gov/system/files?file=115th-congress-2017-2018/reports/53300-individualmandate.pdf>

¹⁸ Kaiser Foundation. Tracking Section 1332 State Innovation Waivers. July 16, 2018. <https://www.kff.org/health-reform/fact-sheet/tracking-section-1332-state-innovation-waivers/>

funding made available from the Advanced Premium Tax Credit or the small business tax credit. The account could also allow individuals to aggregate funding from additional sources, including individual and employer contributions.¹⁹

Congressman Frank Pallone, Jr., then Ranking Member on the House Committee on Energy and Commerce and Congressman Richard Neal, then Ranking Member on the House Committee on Ways and Means wrote a letter dated November 29, 2018, to the Secretary of HHS and Secretary of the Treasury, the CMS Administrator, and the IRS Commissioner in which they state that the new regulations are “wholly inconsistent with Congressional intent” under Section 1332 of the Affordable Care Act. The letter states that “The new 2018 guidance allows states to simply show that a comparable number of residents have *access* to ‘meaningful’ coverage, regardless of whether they actually have it or not, thereby allowing the Secretary to approve waivers that do not provide coverage that is as affordable or as comprehensive as under the ACA. It also allows states to reduce coverage in the early years of the waiver, even though there is nothing in the statute that suggests that this type of loose interpretation was intended....Having access to coverage is not the same thing as having coverage, and the Administration’s attempt to read ‘access’ into the statute is transparently motivated by an ideological opposition to the benefits and protections afforded by the ACA.”²⁰

Premiums are quite high in the Marketplaces and the individual markets across the country. But it must be stressed that a whole series of recent federal government actions, taken together, have pushed up these premiums to higher and higher levels. Thus, it is not the case that “ACA is collapsing under its own weight.” It is more accurate to say that one important part of ACA (among many others that are working quite well) is in jeopardy primarily because it is under relentless attacks that are forcing premiums higher. The continuation of such attacks could lead to a “self-fulfilling prophecy.”

Pushing policies that would lure American’s into cheap, skimpy-benefit health coverage, or short-term coverage with pre-existing condition exclusions and no coverage for vital services such as prescription drugs or mental illness, is not the solution. It might help some workers and their families, e.g., those in seemingly perfect health, but at the cost of hurting others. This approach does not address the underlying cost drivers in health care, presented in the next section.

The Administration is also pushing for the flexibility to convert very short-term health insurance policies (e.g. three months), into semi-permanent or longer-term insurance. “Stop-gap” insurance plans are meant for such situations as a student who needs temporary coverage over the Summer and who is no longer eligible for parental coverage, or a person waiting to start a new job, or a person temporarily between jobs without access to COBRA. The Trump administration is enabling such very short-term health plans to be converted into year-long plans, that can be rolled over for additional years. This approach risks loading large numbers of American workers and their families into health plans that will

¹⁹ US Department of Health & Human Services, Centers for Medicare & Medicaid Services. Fact Sheet: State Empowerment and Relief Waiver Concepts. November 29, 2018. This new policy is found in Department of Health and Human Services and Department of the Treasury, *State Relief and Empowerment Waivers*, 83 Fed. Reg. 53575 (October 22, 2018).

²⁰ Letter from Congressman Frank Pallone Jr. and Congressman Richard E. Neal. November 29, 2018.

<https://democrats-energycommerce.house.gov/sites/democrats.energycommerce.house.gov/files/documents/Pallone%20Neal%20Letter%20re%20Section%201332.pdf>

typically not be there for them if they are really sick, need surgery, or are diagnosed with a serious illness.

An Urban Institute study estimates that the combination of the new rule allowing the extension of short-term plans to a period of up to 36 months, and then immediately re-enrolling, coupled with the repeal of the penalties associated with the individual mandate, will increase premiums in the Marketplaces by 18.3 percent in 2019 in the 42 states where such plans are allowed. These states may impose their own regulations on “short-term plans,” or ban them. But converting short-term health coverage with thin benefits into longer-term health plans does not lower health costs, as proponents claim. It merely further unravels the individual markets, and coupled with other attacks on ACA, will lead to a “death spiral” in these markets.

In December 2018 US District Judge Reed O’Connor made a ruling in litigation pursued by 20 State Attorneys General. O’Connor ruled that a decision by Congress in 2017 to eliminate the tax penalty for not complying with ACA’s individual mandate knocked the underpinnings of the ACA down, and that therefore the entire law must fall. The Judge did not issue an injunction to halt the implementation of the law. California Attorney General Xavier Becerra and 16 Democratic counterparts filed a legal brief asking Judge O’Connor to clarify that he intends for the ACA to remain in effect until appeals are completed. If that is not his intention, the motion asks for him to grant a stay.

The clear intent of Congress in the 2017 law was to change just this individual mandate feature of ACA and leave the rest of the law alone. This is a case of “severability” in which one change can be made in a law that does not ruin it or make it incapable of being effective and operational. As this paper argues throughout, while losing the penalties complicates the implementation of ACA, it in no way cripples the law irreparably. There are other policies, outlined here, that can help bring younger and healthier people into health coverage. The irony is that Judge O’Connor’s ruling is a classic case of “judicial overreach,” “judicial activism,” and “legislating from the bench,” precisely the type of ruling that conservatives have decried for decades. The appeals process bears watching even though the ruling is likely to be over-turned; but this is yet another attempt to destroy ACA without any viable alternative.

The Ingredients of Long-Term Reforms that Address the Changing U.S. Labor Force

A long-term plan for addressing the implications of a changing U.S. labor force for health coverage must include (1) access to affordable health insurance for all workers and their families, regardless of whether they are employed or self-employed, work part-time or full-time, are an employee or a contract worker, or in the “gig” economy; (2) full portability of that coverage across changes in the nature or location of their work; (3) new ways of automatically enrolling uninsured people eligible for health coverage but not participating, with an opportunity for them to opt out of such coverage; and (4) real cost management that addresses the underlying forces driving up health spending rather than simply shifting costs from one party to another.

Access to Affordable Health Coverage

Access to affordable health coverage requires the following elements:

1. An organized purchasing entity that provides affordable coverage for workers and their families who lack access to affordable employer-sponsored coverage and are not eligible for Medicare, Medicaid, CHIP, TriCare or other government-sponsored insurance coverage.
2. Insurance market rules that do not charge individuals higher premiums due to their medical history, including current pre-existing conditions, or gender; and some package of minimum essential health benefits that provides reasonably comprehensive coverage.
3. Access to public programs serving working-age individuals that is based on financial need and not on which state people live in or their family status.
4. Some type of access to affordable health care for all immigrants. This may be regular insurance coverage for documented, legal immigrants who are not yet citizens, and some alternative, insurance-like approach, or direct access to services, for undocumented immigrants. While including undocumented immigrants will be politically very controversial, it is good public health, particularly for challenges such as communicable diseases and disease outbreaks. *It is in no one's interest for people who are sick to be denied health care.*
5. A plan to automatically enroll people believed eligible for public programs or private coverage, with clear notification and full rights to opt out of coverage.

Ensuring Seamless and Portable Health Coverage When Workers Change Jobs or Lose Jobs, Experience Unemployment, or Leave the Labor Force

Contrary to the widespread notions expressed by opponents of ACA, the federally facilitated and state-operated Marketplaces are not “collapsing of their own weight” or “imploding.” In fact, despite the multi-faceted campaign by the Trump administration to unravel these Marketplaces, enrollment only slightly edged down from 12.2 million in 2017 to 11.8 million in 2018. These totals mask considerable variation across states. For example, in California, enrollment grew by 1.1 percent over this period while in Florida, enrollment surged by 11.4 percent. But in Pennsylvania enrollment fell by 1.2% and in Louisiana, it fell by 24.1 percent.²¹

The Congressional Budget Office concludes that “the market for nongroup health insurance is expected to be stable in most areas of the country over the decade, but that stability is fragile in some areas of the country. While all areas have at least one health plan in 2018, one quarter of enrollees have access to only one plan. Stability could be threatened if more health plans exit the markets than newly enter.”²²

Building on and Improving ACA

The US needs a two-pronged approach to shoring up and building on Marketplaces:

1. Supporting the Marketplaces now in place.
2. Making these Marketplaces automatically accessible to people who lose employer-sponsored coverage or eligibility for programs such as Medicaid and CHIP. “Churning” on and off these programs, particularly Medicaid, is very widespread, and frequently results in long periods of being uninsured for those leaving the programs.

²¹ <https://www.kff.org/health-reform/state-indicator/marketplace-enrollment-2017-2018/?currentTimeframe=0&sortModel=%7B%22collid%22:%22Location%22,%22sort%22:%22asc%22%7D>

²² Congressional Budget Office. Federal Subsidies for Health Insurance Coverage for People Under Age 65, 2018-2028. <https://www.cbo.gov/publication/53826#section2>

Supporting the Current Marketplaces

1. Congress could act to restore the cost sharing reduction subsidies that the Trump administration abruptly cancelled. This would alleviate the current situation in which insurers are required to offer the reduced cost sharing to people in households with incomes less than 250 percent of the FPL but do not get reimbursed for this by the federal government. Premiums would fall, or grow more slowly, when this unfair burden on insurers is lifted.
2. Congress should resuscitate a national version of the reinsurance program that was built into ACA for the first three years of the major ACA reforms, 2014-2016. Under this approach, after medical claims per individual reach a given threshold, called the “attachment point,” a large proportion of the cost of claims per individual would be paid for by the reinsurance plan either in full (a “catastrophic” coverage plan) or over a broad range (e.g. from a \$15,000 attachment point up to \$100,000). As explained below, Maryland is now implementing a new reinsurance program. As noted earlier, the Trump administration has been helpful in granting waivers to some states to establish such programs.
3. The federal government should continue the ACA risk-adjustment program. This initiative transfers a portion of funds received from insurers that enroll a relatively large proportion of low-risk individuals to insurers that enroll a relatively large proportion of high-risk individuals. This mechanism helps avoid a “death spiral,” under which insurers serving a disproportionately large number of people with complex medical needs must sharply raise premiums, thereby further discouraging future enrollment of healthier patients, which then leads to additional premium hikes. This situation is not sustainable.
4. States could be enabled by federal policy to let consumers of all ages receiving APTC tax credits enroll in “catastrophic coverage” plans. These plans feature high deductibles (up to a limit of \$7,350 in 2018) but provide full ACA essential benefits. In addition, such plans cover at least three primary care visits per year before the deductible is met, and as with other ACA-compliant plans, cover preventive care with no cost sharing, also before the deductible is met. Federal tax credits cannot currently be used with such plans, and only people under age 30 may enroll in them. Broadening participation in such high-deductible plans to include people 30 years of age and older would bring more healthy people into Exchanges and could improve the risk pool. The Trump administration should be open to this approach.
5. Congress should block proposals that would reimpose pre-existing condition exclusions from coverage and risk-rating of premiums based on such factors as health status and gender. Short-term plans with extremely limited coverage may remain for short-term purposes (e.g., up to three months of coverage) but could not be converted to long-term plans.
6. APTC subsidies should be limited to enrollment in Marketplace coverage that meets ACA requirements and not be made portable to skimpy-benefit or short-term plans.

Making Marketplaces Automatically Available to People Ineligible for Employer Coverage, Medicare, Medicaid, or CHIP

An effort to provide coverage for people in alternative work arrangements will be fostered by making enrollment in Marketplaces (or public programs if they are eligible but not now participating) as easy and simple as possible.

Enrollment in health insurance in the U.S. can be quite complicated and sometimes daunting. This illustrates a broader problem in the public/private U.S. social welfare system: the burden of entering

private coverage and public programs is placed almost entirely on the individual. It is as if the system is saying: It is up to you to find us and figure out how to get through the door and into our program. A bewildering array of forms and bureaucratic barriers may deter some who are eligible from participating, and others may believe that the cost to themselves is too high because they are unaware of public subsidies (e.g., the APTC credits used in Marketplaces to lower premiums). The sheer number of health plans available to consumers can be daunting. For example, in the Medicare Part D prescription drug program, potential enrollees may be offered thirty or more plans, which can be overwhelming.

Enrollee cost can also be a barrier to participation. Some ACA Marketplace plans (e.g., the bronze plans) may carry annual deductibles as high as \$5,000 to \$6,000 for an individual. A freelance artist or a handyman or furniture assembler using Task Rabbit to connect with customers may not be able to afford to self-pay over that large a range of spending.

In a twenty-first century economy, we should not be dependent upon people working their way through a bureaucracy to participate in health insurance. The alternative is to make it as easy as possible for people to join, even while ensuring that they are eligible.

This is not only the right thing to do, but also a smart investment: when people eligible for coverage remain on the sidelines, the rest of us end up paying for their health care in one way or another—through higher insurance premiums and/or higher taxes. Further, their health care ends up costing more than if they were insured, as they typically miss out on preventive care that frequently avoids illnesses and better manages them when they occur. Instead of an atmosphere of “just try to get in the door,” we should foster an atmosphere of “we have determined that you are eligible for coverage (private or public); of course, you are under no obligation to enroll, and you may opt out. But unless you do, we will enroll you easily.” Some refer to this approach as “passive enrollment.” Confidentiality and consumer choice of health plans would be ensured.

A key fact about the uninsured is that more than half of them (54 percent) are eligible for financial assistance to gain health coverage, either through Medicaid and CHIP (for near-poor and low/moderate income children) or subsidized Marketplace coverage. In 2016, of 27.5 million non-elderly uninsured people, 7.8 million were eligible for tax credits in Marketplaces; 2.7 million children were eligible for Medicaid or other public programs (e.g., CHIP); and 4.3 million adults were eligible for Medicaid or other public programs. This means that 14.8 million of the 27.5 million uninsured were eligible for subsidized coverage but not participating in it.²³ We have the tools to greatly increase participation in subsidized coverage among these groups.

Lessons from behavioral economics and neuroscience

Researchers in the fields of behavioral economics and neuroscience are teaching us that guiding people toward decisions that are in their own best interests, and the interests of society as well, and doing so with a light touch rather than mandates, can be helpful and applied to participation in both government programs and employer-sponsored benefits for workers. Professors Richard Thaler and Cass Sunstein

²³ Rachel Garfield, Anthony Damico, Kendal Orgera, Gary Claxton, and Larry Levitt. Estimates of Eligibility for ACA Coverage Among the Uninsured in 2016. Kaiser Family Foundation. June 19, 2018. <https://www.kff.org/uninsured/issue-brief/estimates-of-eligibility-for-aca-coverage-among-the-uninsured-in-2016/>

are two of the leading experts in this field. In their book, *Nudge: Improving Decisions About Health, Wealth, and Happiness*, Thaler and Sunstein explain how a modest reframing of government policies can yield excellent outcomes.²⁴

The authors introduce their readers to their concept of “libertarian paternalists,” which they note at first may seem to be a contradiction in terms but is actually not. Under libertarian paternalism, “choice architects” try to influence people’s behavior to make their lives longer, healthier, and happier. These architects steer but do not force people in directions that will improve their lives. But choices are not blocked or burdened. In their framework, a “nudge” is any aspect of choice architecture that alters behavior in predictable ways without forbidding alternatives or significantly changing economic incentives. Setting “default options” and other similar seemingly small menu-changing strategies can have huge positive effects on improving retirement savings and improving health.²⁵

Application to increasing the number of people with health insurance

There are numerous opportunities to apply the lessons of “the nudge” for automatic enrollment in health care. As noted by health policy analysts Stan Dorn, James Capretta, and Lanhee Chen, “Most people who remain uninsured today qualify for insurance, often at very low cost to themselves.”²⁶ They present ample evidence that automatic enrollment with opt out greatly increases participation in public programs in the US.

Dorn, Capretta, and Chen suggest an approach that should have considerable appeal among both liberals and conservatives—the federal government would establish an overall framework for auto enrollment but allow considerable latitude for states to experiment with alternative specific strategies to achieve frictionless enrollment into health insurance.

Seeking a compromise

We need a set of policies that strongly encourages people who are uninsured and eligible for some type of real health insurance, but not participating, to enroll. *The key feature is to make enrolling in such coverage the “default option,” and automatic, with a clear right for individuals to opt out. No mandates, no large federal bureaucracy.*

The concept is to identify people who are eligible for either public programs, such as Medicaid and CHIP, employer-sponsored coverage, or ACA Marketplaces, and enroll them based on clear information/data sources showing that they are eligible. These individuals must be notified about such enrollment immediately, and either grant permission or opt out. After reasonable attempts to notify people and offer them this choice, no response would be considered consent for that coverage period. No one is compelled to get coverage; yet, at the same time, people are not required to go through the cumbersome and frequently confusing process of filling out applications. This process is called “auto enrollment.”

²⁴ Richard H. Thaler and Cass R. Sunstein. *Nudge: Improving Decision-Making About Health, Wealth, and Happiness*. Penguin Books. 2009.

²⁵ Book Excerpt: *Nudge: Improving Decisions About Health, Wealth, and Happiness*. Milken Institute Review. Fourth Quarter 2008. <https://assets1c.milkeninstitute.org/assets/Publication/MIRReview/PDF/67-85mr40.pdf>

²⁶ Stan Dorn, James C. Capretta, and Lanhee J. Chen. Making Health Insurance Enrollment As Automatic As Possible (Part 2). May 3, *Health Affairs Blog*. 2018.

Special attention should be devoted to ensuring that people do not feel that they are being “railroaded” or pressured into coverage. There is a need to educate people about the value of health coverage but also to respect their individual rights to make independent decisions. We want to make it easy for people to enroll but also not make them feel that they are being pressured to enroll or that they are losing some degree of control over their personal decision-making. Of course, this is not the intent of auto-enrollment. This is a caveat on how it is implemented.

A complement to auto-enrollment could involve people using Smart Phone apps to enroll in coverage. For many people, particularly young adults, this is more in keeping with the way they lead their lives than filling out long forms either on paper or online. Thaler and Sunstein refer to themselves as “formophobics”—they really dislike filling out forms. Many people would agree.

When the Medicare Prescription Drug Benefit (Part D) was implemented in January 2006, the Centers for Medicare and Medicaid Services (CMS) enrolled 74 percent of eligible seniors in the Low-Income Subsidy (LIS) component of this program, which substantially lowers cost sharing for Medicare beneficiaries with low incomes—no action needed by the new enrollees. In contrast, only 14 percent of eligible people completed their LIS enrollment applications on their own. Auto-enrollment by the federal government was based on data matches made with state Medicaid programs and the federal Supplemental Security Income (SSI) program that provides cash assistance to low-income seniors. People participating in these programs have incomes low enough to qualify also for LIS. Thus, if a person is receiving SSI, for example, the federal government knows that person is also eligible for LIS even though the person is frequently unaware of this eligibility. This auto-enrollment continues and has led to a large proportion of eligible people receiving the financial help they need to obtain prescription drugs. Again, no one is *required* to do anything.

In a similar fashion, Louisiana auto-enrolled low-income people in Medicaid based on data showing that they were already enrolled in the Supplemental Nutrition Assistance Program (SNAP), formerly known as Food Stamps. Only 1 percent of people opted out, and many who had been uninsured and eligible for Medicaid came into the program. When a technical problem forced Louisiana to make people check a box to opt into Medicaid on their SNAP application, Medicaid enrollment fell by 62 percent.²⁷

We should start with the value that everyone should have health insurance. We do not have to do this all at once, and we need to fund it responsibly. But once we establish that value, policies like auto-enrollment become a tool to foster it.

Federal Framework, State Flexibility

The following steps could be taken by the federal government to enable and facilitate an auto-enrollment strategy:

1. States could be given the opportunity to base eligibility for federal financial assistance on prior year’s tax returns, eliminating the risk of the enrollee owing additional money at the end of the year. This would likely have to be accompanied by a requirement that taxpayers report a significant change in income during the year.²⁸

²⁷ Stan Dorn, James C. Capretta, and Lanhee J. Chen. Making Health Insurance Enrollment As Automatic As Possible (Part 1). May 3, *Health Affairs Blog*. 2018.

²⁸ This approach is used by Medicare Parts B and D to determine income-related premiums.

2. The federal government could authorize states to determine eligibility for premium tax credits used in Marketplaces based entirely on third-party data, without requiring consumer attestation.
3. The federal government could incorporate information about new recipients of employer-based coverage into the National Database of New Hires (NDNH) and make this data accessible for determining eligibility for subsidies and auto-enrollment.²⁹
4. Business leaders could be encouraged, instead of compelled, to use auto-enrollment in employer-sponsored coverage, and rewarded if they do so. One way to do this would be for states to offer a one-time, refundable tax credit to employers offering health coverage who initiate an auto-enrollment plan. The refundability feature means that employers who experience losses and have no income tax liability in a given year would still get the credit. Employers would have to show that they have implemented this approach in their companies and kept it in force for at least one year.

Maryland Proposed Legislation

In Maryland the Protect Maryland Health Care Act would use health insurance “down payments” by uninsured consumers to enroll in affordable coverage. The State would require people to obtain health insurance or pay a penalty but would make it easy to avoid the penalty by getting affordable insurance. On their state income tax returns, uninsured Maryland tax payers can ask for their information to be shared with the Maryland Health Benefits Exchange, which provides coverage that offers ACA premium tax credits for people with incomes between 100 percent and 400 percent of the FPL. Some will qualify for Medicaid and can be enrolled immediately. For others, the money they would have owed the state as a penalty can be converted ahead of time into a down payment to help them buy health insurance. Over 60,000 people in Maryland have access to this type of insurance and seem likely to get affordable coverage if this bill becomes law.³⁰

In effect, consumers in Maryland would “pre-pay” their insurance by using money they would have owed during the following year when they file their state income taxes. Lump-sum insurance payments during open season in one year are then subtracted from the amounts due on their forthcoming tax penalties. Such payments would enable insurers to receive monthly premium contributions, and consumers who dropped coverage during the year would be wasting money (the penalty would kick in). As Dorn explains, this creates a strong incentive not just to enroll in health coverage, but to keep it during the year. The “use it or lose it” approach embodied in this proposal provides a strong inducement for uninsured Marylanders to enroll in coverage.

According to Dorn, this bill has another attractive feature related to long-term health reform. A Families USA analysis of 2016 data from the American Community Survey, and premium information from the Maryland Health Benefits Exchange, indicates that more than two-thirds of the estimated 100,000 people who would purchase health coverage under the provisions of the Protect Maryland Health Care Act could purchase gold-level plans with deductibles of \$1,500 or less. Roughly two-thirds of this group

²⁹ Dorn, Capretta, and Chen. Part 1. Supra.

³⁰ Stan Dorn. The “Protect Maryland Health Care Act” Will Use Health Insurance Down Payments to Prevent Insurance Costs from Skyrocketing. Families USA. January 30, 2018. http://healthcareforall.com/wp-content/uploads/2018/02/Maryland-Insurance-Downpayment-Bill_Factsheet_013018.pdf

are adults under age 45, and 39 percent are under age 35. The addition of this relatively younger group of individuals to the Maryland Exchange could lower overall risk levels and unsubsidized premiums.³¹

All these options would bring affordable health insurance to people in alternative work arrangements.

Coverage for Immigrants

The most controversial part of a new approach to covering the uninsured is finding ways to make health care affordable for undocumented immigrants. Clearly, there is a very high level of controversy about what to do about undocumented immigrants. A full treatment of this complex and emotional subject is beyond the scope of this paper. Whatever course is taken on border security and a path to citizenship, *while undocumented immigrants are here, it is in everyone's interest that they have access to health care.* This may occur through both insurance-like arrangements and through providing direct access to health clinics, primary care practices, specialist physicians, prescription drugs, and other services. It may also occur through interventions that address the “social determinants of health,” discussed below.

Relating undocumented immigrants back to a key theme of this paper regarding the changing nature of the U.S. labor force, it is important to recognize, emotions and politics aside, that such immigrants have become a vital portion of the US work force. While a precise figure is difficult to calculate, it has been estimated that as many as 40 percent of U.S. construction workers are undocumented immigrants. The figure is likely at least that high among agricultural workers, and these immigrants are prevalent in other sectors of the economy. Given that some significant number of undocumented immigrants are likely to be an important part of our work life and society, it makes no sense to deny them health care. On a crowded subway car, a person who has tuberculosis or a severe bronchial infection who coughs on the individual next to him or her can damage that other person's health. From this public health perspective, it matters little what the transmitter of the infection's immigration status is—it is in everyone's interest to avoid this situation.

The possibility of a pandemic disease outbreak illustrates the importance of not allowing any segment of society to be without health care. The terrible flu pandemic that ran from January 1918 through December 1920 killed more than 50 million people worldwide.³² While we have vaccines and antibiotics today that did not exist a century ago, the Ebola virus and other disease outbreaks remind us of the importance of treating everyone affected and taking immediate steps to halt the spread of these deadly diseases. This could be hampered by having a substantial component of our population left outside of our health system.

Moreover, immigrants add substantially to the economy's productivity. When they are sick, productivity suffers, as it does when they pass on sickness to others.

The Medicaid Expansion under ACA

At the end of 2018, 33 states had adopted the ACA Medicaid Expansion, which was made optional for states by the June 2012 US Supreme Court decision. Virginia became the 33rd state to adopt the Expansion in June 2018, and in three more states—Utah, Nebraska, and Idaho--state ballot initiatives in November 2018 resulted in majorities in favor of the Expansion, making it likely to occur in 2019. Maine

³¹ Dorn, The “Protect Maryland Health Care Act” supra.

³² Catharine Paddock, Why the 1918 flu pandemic was so deadly? Research offers new clues. Medical News Today. April 29, 2014. <https://www.medicalnewstoday.com/articles/276060.php>

voters favored Medicaid Expansion in 2017, but it was held up by the Governor. The new Governor favors implementing the Expansion, and it is likely to occur in 2019. If these four states do implement the Expansion, this will bring the total to 37. Other states are considering this step.

Several states are seeking to include work requirements in their Medicaid programs or have already done so. These include Kentucky, Arkansas, Indiana, and Virginia. In Virginia, the work requirement is phased in over the first year, starting at 20 hours a month and increasing incrementally to 80 hours a month at the end of the year.

Some opponents of the Medicaid Expansion believe that Medicaid was intended for very vulnerable populations including poor elderly individuals, people who are blind or disabled, and very low-income parents and their children. The Medicaid Expansion without a work requirement, they contend, would provide coverage to non-disabled adults without dependent children who should be working and parents who are not extremely poor and could be working. Work requirements, with some exceptions for school, job training, family caregiving, and community service, will push these adults into the work force where they will hopefully either get employer-sponsored health coverage or be able to purchase coverage on their own.

Work Supports are a better policy than work requirements

The problem is that many people who are denied Medicaid coverage under the Expansion because of a work requirement would not be able in today's labor market to find jobs that provide employer-sponsored health coverage, nor could they afford to buy coverage on their own. Many who can find work will get jobs paying at or near the federal minimum wage, and many of these jobs will be part-time or temporary. Numerous jobs have irregular hours, leaving workers with insufficient earnings to pay their bills. Other people will enter the "gig economy," in many cases because they cannot find any other jobs.

Thus, the work requirements will thrust many low-income people into a labor market that leaves them without any affordable health insurance options. The requirements will "lock them out" of Medicaid for a substantial amount of time, so that they will fall back into the "coverage gap" under which they do not qualify for Medicaid but also do not qualify for ACA APTC tax credits because their incomes are below 100 percent of the federal poverty line. This is a Catch 22 that results from the fact that those who are promoting work requirements have an unrealistic view of the modern work force and its separation from job-based coverage for many workers in the alternative labor market.

Data from Arkansas, the first state in the nation to impose work and "community engagement" requirements on adults in Medicaid through Section 1115 waivers, show that this concern is real. As of November 1, 2018, the State reported that 12,277 people in Arkansas ages 30-49 had lost Medicaid coverage because they failed to report work hours online for three months in a row. Another 4,655 individuals lost Medicaid coverage for this reason as of December 1, 2018. The first group of people are locked out of Medicaid coverage until January 1, 2019, and the second group are locked out until February 1, 2019. Another 1,926 people have "two strikes against them," i.e., they had two months of non-compliance as of the beginning of December. This group was at risk of losing coverage on January

1, 2019.³³ On January 1, 2019 the work requirement will be extended to adults 19-29. While people can now use other ways to inform the state than reporting online, many are likely to lose coverage.

Further, many poor and near-poor adults have a constellation of chronic medical conditions including physical conditions and behavioral health conditions, and frequently both. The last thing we would want to do to such people is to make them ineligible for affordable health care. This will lead to worse health outcomes and greater health spending down the road. As noted earlier, if we place a value on moving toward universal health coverage, we do not want to be barring people with complex medical and social needs and low incomes from eligibility for subsidized coverage. Work supports, including transportation, child care, safe housing, and improved nutrition, represent a better approach than work requirements for this population. These work supports will help people get jobs without taking away their health coverage. This, in turn, will help lift them out of poverty and support them in today's modern and complex labor markets.

The relationship between labor markets and health coverage is a “two-way” street. The main thrust of this paper is on how trends in the labor market are leading more workers and their families to be without health coverage. In addition, however, trends in health coverage can influence the labor market. Thus, when firms decide to lower their health care spending by hiring more part-time workers, temporary workers, or contract workers, those decisions may lead to more such workers than if we had something much closer to a universal coverage system. Similarly, if states take actions that lead significant numbers of people to lose Medicaid coverage—*which was helping them stay on the job by covering the cost of their medications or making important screening tests available or helping a new mother get through post-partum depression and return to work*—this impacts the labor market. The sad irony of the work requirements is that over time, they are likely to make some potential workers into non-workers by removing important supportive services they need to stay active and work productively.

Thus, in some ways, health care policies may help foster the spread of the gig economy, the widespread use of contract workers, etc. Further, the long-term structural changes in the work force call for policies that involve work supports more than work requirements. The requirements of working in the modern labor force involve increasingly sophisticated computer science skills, educational attainment, training and re-training. Many workers are losing jobs, or unable to get them, because they lack such skills. Thus, forcing people into the labor force who are unprepared to get a job is not good economic policy. A better approach involves helping them learn new skills, overcome mental health and/or substance use disorders, and recover from accidents or manage chronic medical conditions. Having affordable health coverage is a vital component in meeting these goals. *Pulling health coverage and forcing people into a “sink or swim” situation seems like a backwards approach to moving people into the modern work force.* Further, when the next economic slowdown occurs, these problems will be worse. The slowdown will exacerbate the labor market changes and heighten the need to prepare people to find and retain a job.

The bottom line is that we do not need a “one size fits all” approach to providing affordable coverage to a highly varied and modern work force. We do need some broad federal government standards and

³³ Joan Alker. Arkansas Data are Clear—Trump's Medicaid Policy is a Dangerous Failure.” Georgetown Center for Children and Families. November 16, 2018. <https://ccf.georgetown.edu/2018/11/16/arkansas-data-are-clear-trumps-medicaid-policy-is-a-dangerous-failure/>. Updated by data from the Arkansas Works program through early December 2019.

guidelines, along with subsidies that are well targeted to financial need. Within that framework, considerable flexibility and variation across the states is advisable and will allow for experimentation in design and approach, with adaptations for state and local preferences in strategies. As we develop a policy agenda, it is critically important to shape policies both in Marketplaces and public programs that recognize the disconnect between the modern labor market and access to affordable health coverage and to make the distinction between addressing the underlying forces driving up health costs for all versus cost shifting from the young and healthy workers to older and sicker workers and their families.

[Maryland initiative to cover the uninsured](#)

Maryland is obtaining federal pass-through funding to partially finance a new Maryland Reinsurance program. That reinsurance waiver is scheduled to begin in 2019 and will be authorized through 2023. The plan will reimburse insurers for 80 percent of claims between an “attachment point” that is likely to be set at \$20,000 and a cap of \$250,000. The plan was submitted to CMS on May 31, 2018.³⁴ Maryland House Bill 1795 was signed into law on April 5, 2018. This new law establishes the Maryland reinsurance program, to be operated by the Maryland Health Benefit Exchange (MHBE), the state-operated ACA Marketplace.

The payment parameters can be adjusted as needed each year. The State believes that the reinsurance program *will lower premiums by about 30 percent in 2019 compared to what they would have been without the waiver*. The decreased premiums will help reduce federal outlays for the APTC tax credits used in the MHBE. Enrollment in the non-group market is expected to increase by 5.8 percent in 2019. Total program costs are anticipated to be \$462 million in 2019. Maryland House Bill 1782, signed into law on April 10, 2018, creates a 2.75 percent assessment on certain health insurance plans and Medicaid managed care organizations to help fund this new program.³⁵

Summary

The US needs a new approach to covering the uninsured. This approach recognizes that in a modern economy with workers changing jobs periodically, and sometimes changing careers, it is essential that health coverage be portable. In the “old economy,” many workers held the same job, frequently for the same company, through most or all their careers. A worker might have been with General Electric, General Motors, or Sears for three or more decades, advancing in pay and secure in benefits, including health coverage and a pension.

Today, pensions are received by a small minority of private-sector workers, replaced by Individual Retirement Accounts (IRAs), which are portable as workers change jobs, relocate, or start new careers. IRAs can be held and transported by workers from the traditional labor force to the “alternative labor force.” Yet, when employees make such job or career changes, they usually must check their health coverage at the door as they leave a job. If they can find new, affordable health insurance, the transition

³⁴ Kaiser Foundation. Tracking Section 1332 State Innovation Waivers. Maryland Section. p. 5. Supra. <https://www.marylandhbe.com/wp-rar20State%20Reinsurance%20Program%20-%20May%2031%202018.pdf>

³⁵ Maryland Health Benefits Exchange. Maryland 1332 State Innovation Waiver Application to Establish a State Reinsurance Program. May 31, 2018. https://www.marylandhbe.com/wp-content/uploads/2018/06/Final_Maryland%201332%20State%20Innovation%20Waiver%20to%20Establish%20a%20State%20Reinsurance%20Program%20-%20May%2031%202018.pdf

may mean that they must change physicians or other health care providers with whom they have longstanding relationships because their new plan does not include such providers in the network.

The US needs a national framework that allows for considerable state-by-state variation to provide health insurance coverage arrangements that can include all working families and those temporarily out of the work force, regardless of the nature of their work arrangements (assuming they are legal and not part of the “underground economy.”) An artist, a writer, a driver for Uber or Lyft, a yoga teacher, and a temporary worker in an office should all have access to affordable health coverage. Such coverage should be portable as these individuals move from one calling to another, relocate, and change their family status.

Many other countries make it easy and affordable for people in the alternative work force to obtain health insurance. In France, for example, a recent major revision of the health system has introduced the Protection Maladie Universelle (PUMA), which replaced the prior system called Couverture Maladie Universelle (CMU). The new PUMA system guarantees that all legal residents of France will be able to stay with their health insurance despite changes in their personal circumstances or loss of employment or business. Residents no longer need to apply yearly to renew their coverage, which lowers administrative costs. Freelancers and gig workers, along with other self-employed and unemployed people, can get coverage through the Regime Social des Independants (RSI) that provides comparable coverage to PUMA.³⁶

A Real Plan to Control the Growth of Health Spending

ACA makes progress toward cost control but does not take a bold new approach to addressing the underlying cost drivers. One cost control feature was repealed by Congress in February 2018 (the Independent Payment Advisory Board) and others delayed.

This section highlights five important forces that are driving up health spending and briefly describes policies that would address these forces. The premise here is that by lowering the cost of health care rather than shifting it, coverage will be more affordable, particularly for people outside the traditional labor force who do not have an employer or public program to pay for most of their health costs.

Improving Health Technology Assessment (HTA)

A major cost driver in the US health care system is the proliferation of advanced medical technology with scant regard for clinical standards of care and an approach that carefully weighs the important benefits of new technology with the risks/harms and costs. When a new technology emerges, it frequently sweeps across the population, applied to patients who are not adequately served by existing technology and really need this new advance, but also to patients whose medical needs *are* being met by services, procedures, and products already in use. The proliferation of advanced medical technology interacts with the growth in incomes, insurance coverage, and demographic trends (e.g., population aging) in a way that forms a major force underlying the growth in health care spending.³⁷

³⁶ https://www.expatica.com/fr/healthcare/Guide-to-health-insurance-in-France_108848.html

³⁷ An excellent explanation of how health care technology, the growth in incomes, demographic trends, and changes in insurance coverage interact to drive up health spending is found in Sheila Smith, Joseph P. Newhouse,

The US is frozen in old-fashioned approaches to health technology assessment (HTA). Public and private payers in the US use such criteria as “medical necessity,” court rulings, and so-called expert opinion to determine the appropriateness of care and to support coverage decisions.³⁸ Such concepts as medical necessity have been defined so broadly in practice that very few technologies fall outside of the definition.

Medicare covers anything “reasonable and necessary” without regard to the treatment’s comparative effectiveness or its cost in relationship to other treatments. “Medicare links reimbursement in one way or another to the underlying cost of providing services. Coverage is determined without any requirement for evidence demonstrating that the service is equally or more effective than other available options.³⁹”

Underlying this proliferation of technology is the fact that published prices are largely a fiction in the US health care system, because third-party payers negotiate the amounts they pay providers, and there are few consequences for either providers or patients of selecting a medical treatment that lacks a solid evidence base. A system for recognizing incremental value and pricing it accordingly would be a step forward.

Policies to evaluate new technology and use it efficiently

The US needs a new way to tie coverage and reimbursement decisions to the clinical effectiveness of new treatments and products. Steven Pearson and Peter Bach have proposed a three-tier approach to reimbursement under Medicare, and this could also be used by other payers. In the first tier, if a new treatment or product has demonstrated superior clinical effectiveness, and/or fewer adverse side effects, the usual Medicare pricing based on existing formulas would be used. Under the second tier, if the evidence shows comparable clinical effectiveness and significant adverse side effects, then payment would equal that of the equally effective alternative. Under the third tier, where there is insufficient evidence to judge comparative clinical effectiveness, dynamic pricing would be used. This means that payment would be based on existing formulas for three years, after which a redetermination would be made. At that time, if superior clinical effectiveness of the three-year-old treatment is demonstrated, payment under the temporary favorable terms to the innovator would be maintained. But if there is still insufficient evidence, payment would move to the price of the most relevant care option.⁴⁰

This approach recognizes that some treatments and services provide more benefits than others, a few provide no clinical benefits at all, and many generate serious risks to patients. The benefits of new technology are often wonderful and frequently life-saving. But we must also factor in the cost and the risks to make informed decisions on how this technology is deployed and reimbursed.

and Mark S. Freeland, “Income, Insurance, and Technology: Why Does Health Spending Outpace Economic Growth?” *Health Affairs* September/October 2009. 28-5:1276-1284.

<http://content.healthaffairs.org/content/28/5/1276/T1.large.jpg>

³⁸ Mark Gibson, Aasta Thielke, and Pam Curtis. “Health Technology Assessment as a Cost Containment Strategy.” Paper Prepared for the Partnership for Sustainable Health Care. May 2012.

³⁹ Steven D. Pearson and Peter B. Bach. How Medicare could use comparative effectiveness research in deciding on new coverage and reimbursement. *Health Affairs* October 2010. Vol. 29, No. 10.

<https://www.healthaffairs.org/doi/10.1377/hlthaff.2010.0623>

⁴⁰ Pearson and Bach. *Supra*.

This is not rationing or blocking innovative technology from the market. It is a recognition of the need for a clinical evidence base and the introduction of flexible reimbursement based on that evidence.

Reducing avoidable utilization

Public and private insurers in the US routinely pay for the consequences of neglecting patients' chronic medical conditions such as diabetes, asthma, and hypertension. Many people also have under-managed heart disease and pulmonary conditions. Patients with severe depression, psychosis, and bipolar disorders are often under-served and end up with frequent visits to the ER and multiple inpatient hospital admissions. Substance use disorders abound, and the availability of qualified treatment centers cannot keep up with the need for treatment. The opioid crisis is growing rapidly, claiming 72,000 lives in the US in 2017, with over 80,000 deaths expected in 2018.

Maryland is a National Leader in New Approaches to Cost Control and Quality Improvement

In Maryland, 14 percent of people in fee-for-service Medicare (over 90% of Medicare enrollees in Maryland) have *six or more chronic conditions*. This group of people accounted for 48 percent of spending for the fee-for-service Medicare population in Maryland. Moreover, prior to the start of the new version of the All-Payer model in 2014, hospital readmissions were at or above the national average. After hospital discharges, patients in Maryland and around the country too frequently "fall over a cliff" for lack of follow-up care. They fail to see a physician in the critical weeks after discharge, lack home visits, and lack the necessary understanding of danger signals.

Maryland is a leader in addressing the problem of avoidable use of ERs and hospitals. In 2014, Maryland entered into a five-year agreement with the Centers on Medicare and Medicaid Services (CMS) to extend and build on the State's four-decade old All-Payer Model. Under the new approach, Maryland placed all the states' acute care hospitals under global budgets. The revenue caps for hospitals put in place in this agreement made important changes in hospital incentives. The old system featured a cap on per capita cost per hospital discharge, but placed hospitals at no risk for high rates of admission and readmission, and at no risk for sharply rising hospital outpatient care. The old incentives rewarded higher volume of care and did not adequately reward improvements in quality of care and patient safety. It also regulated hospitals only and did not involve aligning the incentives of physicians, providers of post-acute and long-term care, and other medical services.

In contrast, the new Model put an annual ceiling of 3.58 percent on the growth of total hospital spending per capita. This rate derived from the 10-year compound average annual growth of the Maryland gross state product, plus an adjustment for population growth. Maryland also committed to CMS that cumulative Medicare per beneficiary total hospital cost growth in the state over five years would be at least \$330 million less than the national Medicare per capita total hospital cost growth over five years. In addition, Maryland committed to reducing the aggregate Medicare 30-day unadjusted, all-cause, all-site hospital readmission rate over five years to the national average or below; and an annual reduction of 6.89 percent in Potentially Preventable Conditions (PCCs) over five years, amounting to a cumulative 30 percent reduction over five years.⁴¹

Maryland has met all these targets. Cumulative savings at the end of 2017, the fourth of the five years, were \$916 million, compared to the \$330 million promised over five years (5.63 percent below national

⁴¹ Health Services Cost Review Commission: Report to the Governor, FY 2016.
<http://www.hsrc.state.md.us/Documents/pdr/ar/Gov-Report-FY2016-102516.pdf>

average growth since 2013). All-Payer hospital revenue growth per capita, promised to be less than 3.58 percent per year, was held to 1.47 percent in 2014, 2.31 percent in 2015, 0.8 percent in 2016, and 3.54 percent in 2017. All-Payer Quality Improvement reductions in potentially preventable conditions (PPCs), promised to be at least 30 percent over five years, was 53 percent after four years (end of 2017). Maryland moved from exceeding the national average in hospital readmissions in 2013 to a readmission rate that was 0.19 percent lower than the national average at the end of 2017.⁴²

Maryland hospitals now have an incentive to invest in and collaborate with those entities trying to manage chronic illnesses in the community to help avoid the type of flare-ups and complications that frequently drive residents into the ER and hospital admissions.

The second phase of the All-Payer Model

The second phase of the All-Payer Model covers the eight-year period from 2019 through 2026. This new phase features a Total Cost of Care (TCOC) Model under which Maryland has committed to go beyond generating hospital savings and improved hospital quality to generate comparable results in physician care, post-acute care, and long-term care. Under the new agreement with CMS, Maryland has committed to producing \$120 million in savings to Medicare in 2019 and cumulative savings of \$1 billion over the 2019-2023 period.⁴³

Supporting Primary Care Practices

An important feature of the new phase of the All-Payer Model is primary care practice transformation. Under the traditional model, primary care physicians spend a small amount of time with a large number of patients, with all work done in the office during normal business hours. Neither doctors nor patients are pleased with such arrangements; there is scant time for the physician to get the full picture of a patient's needs, which frequently go beyond physical conditions to involve behavioral health problems and social needs that adversely affect health.

The traditional fee-for-service payment system discourages innovations in care delivery. The new Primary Care Model (MDPCP) begins in January 2019 and will enable Maryland to transition away from encouraging more services and higher costs to rewarding efficiency, value, and better health outcomes.⁴⁴

⁴² Maryland Health Services Cost Review Commission. All-Payer Model Results, CY 2014-2017.

<http://hscrc.state.md.us/Documents/Modernization/Updated%20APM%20results%20through%20PY4.pdf>

⁴³ If annual Medicare savings in 2019 or 2020 exceed annual savings targets, CMS will add one-half of the difference between actual Medicare savings for that year and the annual target for that year to the Annual Medicare Savings for the subsequent year, so that the State gets partial credit for exceeding the targeted savings. The TCOC model features "guardrails" that limit "over-runs." During the performance period, Medicare TCOC per beneficiary must not exceed the growth of national Medicare TCOC by more than 1 percent in any given year and must not exceed the growth rate in national Medicare TCOC by any amount for two or more consecutive years. Maryland Total Cost of Care Model State Agreement. July 9, 2018.

<http://hscrc.state.md.us/Documents/Modernization/TCOC-State-Agreement-CMMI-FINAL-Signed-07092018.pdf>

⁴⁴ Maryland Health Services Cost Review Commission. Summary of the Maryland Primary Care Program. June 2018. <https://health.maryland.gov/mdpcp/Pages/home.aspx>

Under practice transformation, regional entities called Care Transformation Organizations (CTOs) will provide support via care management personnel, infrastructure, and technical assistance. The CTOs will generate economies of scale to provide services that many practices would otherwise find challenging financially and operationally to provide on their own. This includes helping primary care practices obtain the help of care managers, pharmacists, behavioral health counseling, social services, community health workers, and health education. A new Learning System will assist practices entering the program to meet the specific requirements of being designated as advanced primary care practices.⁴⁵

CTOs will help primary care practices work with the Chesapeake Regional Information System for our Patients (CRISP) to offer practices on-site assistance in how to provide, receive and use data from CRISP, Maryland's Health Information Exchange. This could include real-time alerts when a patient in the practice is in the ER or is admitted to a hospital.

Physician payment reform will reinforce the new practice model. CMS will provide funding directly to Practices and CTOs. The funding can include Care Management Fees, Performance Based Incentives Payments, and a lump-sum bonus payment.⁴⁶

The combination of this support for practices, care management fees, and risk/reward payment arrangements is intended align physician incentives with hospital incentives.⁴⁷

US prices are high for virtually all services

The US health care system has very high prices for a wide range of health services and products.⁴⁸

Policies to Reduce Prices

Reference pricing

In some parts of the US, certain insurers, health plans, and self-insured employers are turning to "reference pricing." Under reference pricing, the employer or insurer establishes a price cap for a certain health care treatment based on a combination of price, quality, and perhaps geographic location. Patients who want to pay more to see a higher-cost provider may, of course, do so, but they would pay the full amount of the extra charges over the reference price.⁴⁹ Quality must also be factored in so that this is not a policy of "buying cheap." Rather, it is a policy of "buying smart." If one surgeon, for example, has at least as good a record on quality, outcomes, and patient safety as another, but the other one charges two, three or even eight times as much for the same treatment or procedure, the payer would provide generous coverage for the former, but would not "ride up" to pay the high-cost provider on a comparable basis.

⁴⁵ HSCRC. Summary of the Maryland Primary Care Program. Supra.

⁴⁶ HSCRC. Summary of the Maryland Primary Care Program. Supra.

⁴⁷ Maryland Total Cost of Care Model State Agreement. July 9, 2018.

<http://hscrc.state.md.us/Documents/Modernization/TCOC-State-Agreement-CMMI-FINAL-Signed-07092018.pdf>

⁴⁸ Data from the International Federation of Health Plans show that in 2015, the average cost of an appendectomy was \$15,930 in the US, compared to \$6,040 in Switzerland and \$6,199 in New Zealand. For CT scans of the abdomen, the average cost in the US was \$844 in the US and \$383 in Switzerland. (Ashish K. Jha. US Health Care Spending: International Context, National Trend, and Getting to High-Value Care. October 16, 2018.

<https://www.mass.gov/files/documents/2018/10/16/Ashish%20Jha.pdf>

⁴⁹ James C. Robinson and Kimberly MacPherson. "Payers Test Reference Pricing and Centers of Excellence to Steer Patients to Low-Price and High-Quality Providers." *Health Affairs* September 2012 31:9:2028-2036.

Reference pricing is a response to the situation where price differentials are as high as 5 to 1 or even 10 to 1 in the price of the same procedure in the same market area (e.g., for colonoscopies and for knee and hip replacements), with no evidence that the highest-priced providers offer better quality of care and that their patients experience fewer complications.

A CalPERS demonstration of reference pricing in pharmaceuticals within therapeutic classes of drugs found a savings of \$30.25 per prescription and an annual savings of \$15.7 million.⁵⁰

Centers of Excellence

Another approach used by some US purchasers to achieve long-term savings is “Centers of Excellence.” Under this strategy, patients are directed to hospitals that provide high-quality care and are willing to discount their prices in exchange for a higher volume of patients. Purchasers select a single hospital or just a few hospitals for high-cost and very complex medical procedures, and patients who require these procedures are directed to these centers unless emergency conditions or other mitigating factors make that infeasible. Centers of Excellence are best used for certain highly complex procedures, such as an organ transplant, or as a supplement to the broader provider network, with patients receiving lower cost-sharing for selecting the Center of Excellence.⁵¹

Anti-Trust Enforcement

The US also needs to strengthen anti-trust enforcement in the health care sector. Consolidation of market power has been unfolding in many subsectors of the health care industry for years. There are some beneficial effects. These include the possibility of improved quality of care, as newly formed larger entities can compile and analyze data on quality of care and patient safety across a broader patient population. Efficiencies in service provision may also occur, as larger provider delivery systems have more leverage over suppliers (in the case of hospitals, for example, suppliers of medical devices, surgical instruments, imaging equipment, and basic supplies).

A substantial body of research, however, shows that market power in the hospital sector leads to higher prices. Professor James Robinson employed a multivariate statistical method to evaluate the association between hospital market concentration, prices, and profits for commercially insured patients.⁵² This study found that hospitals in concentrated markets charged \$4,561 to \$13,690 more per patient across six cardiac and orthopedic surgical procedures than hospitals in non-concentrated markets. After adjusting the figures to account for patient and hospital characteristics, Robinson found that hospital prices for patients in concentrated markets were higher than hospital prices for otherwise comparable patients in competitive markets by 25.1% for coronary angioplasty, 13.0% for cardiac rhythm management (CRM) device insertion, 19.2% for total knee replacement, 24.1% for total hip replacement, 19.3% for lumbar spine fusion, and 22.7% for cervical spine fusion. Contribution margins were higher in concentrated than in competitive hospital markets by \$5,259 for angioplasty, \$3,417 for

⁵⁰ CalPERS Pension and Health Benefits Committee, Agenda Item 6. April 12, 2017.

<https://www.calpers.ca.gov/docs/board-agendas/201804/pension/item-6-a.pdf>

⁵¹ Robinson, JC. Hospital market concentration, pricing, and profitability in orthopedic surgery and interventional cardiology. *Am J Manag Care* 2011 Jun 1; 17(6 Spec No):e241-8.

⁵² Robinson analyzed data for patients admitted to 61 hospitals for six prominent and high-volume cardiac and orthopedic surgery procedures. The data encompass 27 markets spanning eight different states, and is based on The Dartmouth Atlas, which assigned 306 hospitals to US markets. The eight states represented are concentrated in the west and southeast. The 27 markets range from a low of just two hospitals to a high of 92, with an overall average of 15.6 hospitals per market.

CRM device insertion, \$4,123 for total knee replacement, \$5,889 for total hip replacement, \$7,931 for lumbar spine fusion, and \$4,663 for cervical spine fusion. Robinson concludes that hospitals in concentrated markets charge significantly higher prices and earn significantly higher margins than do hospitals in competitive markets.⁵³

Effective anti-trust policy would require evidence that mergers and acquisitions would not hamper competition and would not lead to substantially higher prices, prior to federal government approval.

Addressing the Social Determinants of Health

The US needs to redirect resources from the types of excessive health care spending described earlier to high-value investments designed to keep people out of the health care system where possible. This can be done through clinical and community-based prevention strategies with a solid evidence base along with investments in both the social environment and the built environment.⁵⁴

Trust for America's Health, in partnership with the Urban Institute, the New York Academy of Medicine, the Robert Wood Johnson Foundation, the California Endowment, and the Prevention Institute, conducted research on the amount of health care savings that would accrue if we invested more in disease prevention, specifically by funding proven community-based programs. The investigation evaluated 84 research studies and focused on prevention programs that do not require medical treatment, programs that target communities rather than individuals, and evidence-based programs that have been shown to reduce disease through improving physical activity and nutrition and preventing tobacco use in communities. The study found that in California, an investment of \$10 per person per year in proven community-based programs to increase physical activity, improve nutrition, and prevent smoking and other tobacco use could save California more than \$1.7 billion in annual health care costs within five years. This is a return of \$4.80 for every \$1 invested. In ten to twenty years, the savings could grow to more than \$1.9 billion annually, which would yield a return of \$5.40 for each \$1 invested.⁵⁵

Providing universal coverage for tobacco cessation services results in substantial health benefits and has a favorable impact on the economy. An analysis of the health impact of adding tobacco cessation service benefits to Medicare and Medicaid found that 615,000 beneficiaries would stop smoking, 560,000 smoking-related deaths would be prevented, and up to \$1.2 billion would be saved over ten years.⁵⁶

⁵³ Robinson, JC. Hospital market concentration, pricing, and profitability in orthopedic surgery and interventional cardiology. *Am J Manag Care* 2011 Jun 1; 17(6 Spec No):e241-8. In another study, Professor Leemore Dafny at Northwestern University studied 97 hospital mergers over a decade-long period and estimated the impact of those mergers on the prices of nearby "rival hospitals." Dafny found that hospitals increase prices by roughly 40% following the merger of nearby rivals. Under one specification of her model, the price increase averaged 46% while in another specification of the model, the increase was 35%. Leemore S. Dafny. "Estimation and Identification of Merger Effects: An Application to Hospital Mergers. National Bureau of Economic Research: Working Paper 11673. http://www.kellogg.northwestern.edu/faculty/dafny/Personal/Documents/Publications/2_Dafny_Identification%20and%20Estimation%20of%20Merger%20Effects_2009.pdf

⁵⁴ Jack Meyer. *Investing in Public Health: A Life Cycle Approach*. Xlibris Press. April 2014.

⁵⁵ Trust for America's Health. *Prevention for a Healthier America: Investments in Disease Prevention Yield Significant Savings, Stronger Communities*. February 2009.

⁵⁶ Campaign for Tobacco-Free Kids. *Medicaid and Medicare Costs & Savings from Covering Tobacco Cessation*. <http://www.tobaccofreekids.org/research/factsheets/pdf/0192.pdf>

Addressing the social determinants of health can have a positive impact on labor force participation and success in the labor market. For example, many lower-income people could work if they had transportation to get to a job. Particularly in rural areas and small towns, there is no public transportation available. People may not have a car, or their car may need repair, and they cannot afford to spend \$1,000 or more to fix it. Similarly, people who do not have a fixed address or a Smart Phone may never receive the notices about a state-imposed work/community engagement requirement, with the result that they are dropped from Medicaid for not responding. Good nutrition can also promote success in school and work.

Modifying the Tax Treatment of Health Insurance

Employees may exclude from income and payroll tax liability under current law the full value of their employers' contribution to their health insurance. This is a huge tax subsidy that is very poorly targeted to financial need—the higher the household income (and thus the higher the marginal tax rate), the greater the value of the subsidy, and vice versa. The great bulk of this subsidy goes to middle- and upper-income people.

A 2018 Congressional Budget Office report indicates that this subsidy will lead to a federal government revenue loss of well over \$250 billion in 2018. The cumulative revenue loss over the 2019-2028 period is projected to be \$3.7 trillion.⁵⁷

In addition to being poorly targeted to need and very costly, the tax exclusion of employer contributions to health coverage creates strong incentives for workers to opt for the most expensive health insurance plans when their employers offer them a choice, which almost certainly increases utilization of health services. The federal subsidies “ride up” with higher premiums, shielding workers from the true cost.

Most economists have called for some type of cap on this exclusion for decades. This is usually coupled with the idea of using the revenue gain from the cap to help finance health coverage for our lowest-income residents, many of whom were excluded from public coverage because they did not have a dependent child in the household or because the eligibility standards for Medicaid set by the state where they reside are so low that even their very modest incomes exceeded those standards.

ACA addressed this inequity through both the Medicaid expansion, making every household with an income below 138 percent of poverty eligible for Medicaid, regardless of family configuration and location, and placing a cap on the tax exclusion subsidy originally scheduled to take effect in 2018. Later Congressional action pushed this implementation date to 2020. The cap was set under the 2010 ACA law at what was then a very high level of insurance cost—\$27,500 a year for family coverage and \$10,200 for individual coverage. The cap would grow in line with overall inflation, not medical cost inflation, so that it would be likely to capture more revenue over time. There would be a 40 percent federal excise tax on the amount of employer-sponsored health plan premiums that exceed these caps.

Policy Initiative

This cap on the open-ended tax exclusion should be implemented on schedule in 2020. It will bring in new federal revenue, some of which could be redirected to shoring up federal financing of subsidies to

⁵⁷ Congressional Budget Office. Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2018-2028. May 2018. p. 2. <https://www.cbo.gov/system/files?file=2018-06/53826-healthinsurancecoverage.pdf>

assist low-income people obtain affordable health coverage. In addition, the cap should create incentives for employees to select a plan that provides them with good value for money.

Conclusion

The US needs a new approach to health insurance coverage and health care cost control that reflects the modern labor force and addresses the underlying cost drivers in health care. Health coverage should be available, understandable, affordable, and portable for all US residents. We can fix the problems by reinforcing and building on the Affordable Care Act to move the nation toward universal coverage in a mixed, public/private system.

Progress with cost control will require that we move away from cost-shifting from one party to another and focus on the underlying forces pushing up health spending. These include a new and flexible approach to assessing advanced medical technology, new initiatives to reduce avoidable ER use and hospital admissions and readmissions, strong incentives to lower prices, a multi-front effort to address the social determinants of health, and federal tax policy reforms that better target health-related tax subsidies to financial need and create incentives for US employees to get the best value for their health-care dollar.

The shrill battle over the Affordable Care Act is keeping the country from a constructive debate over the best and most bipartisan ways to move toward universal health coverage through incremental, substantial reforms while controlling health costs. It is time to move beyond the battle over ACA and develop a non-ideological blueprint for health reform.