An Employee Benefit Professional's Perspective on Medicare for All

by **James L. McGee, CEBS** | *Transit Employees' Health & Welfare Fund*

My first exposure to my own health care coverage came as an apprentice with UA Local 520 in Harrisburg, Pennsylvania. I later became a trustee and secretary of the Plumbers and Pipefitters Local 520 Health & Welfare and Pension Plans, a Taft-Hartley multiemployer benefit plan. Since then, I have served in various consulting roles to Taft-Hartley, multiemployer, and collectively bargained health and pension plans.[1]

Those experiences may have blinded me somewhat to some of the inequities in our health care system. Multiemployer plans were designed to provide continuity of coverage for employees in industries characterized by temporary or seasonal employment: construction, entertainment, transportation and hospitality, for example. Employers pay into the fund for each hour worked, and the employee enjoys continuity of coverage during periods of brief unemployment between employers. The principle is that you pay while you are working so you have coverage when you are not.

It wasn't until I took my current job, executive director of the Transit Employees' Health & Welfare Fund in Washington, D.C., that my eyes were opened to a darker side of the status quo. Our plan has a generous continuation-of-benefits provision. Some employees on extended leave (illness or disability) can continue their benefits for up to three years by paying the same premium share (about 20%) that they were paying when they were actively working. But when you have no income, health care cannot be cheap enough. Before the Affordable Care Act (ACA), I would regularly encounter people who had to choose between rent and health care premiums and would drive to our office in their "home" to pay their health insurance premium.

Even with ACA, I still meet people who would rather make the difficult choices necessary to keep our coverage, coverage they know and are familiar with, than risk the uncertainties of exchange coverage.[2]

It was those experiences that pushed me to become an advocate for a more fundamental solution—Medicare for all, or single payer, and to join and later become a steering committee member of the Labor Campaign for Single Payer.

Transitioning to a Medicare-for-all system will, no doubt, be a big challenge. Yet few people seem to disagree that we would be better off had we started down that road initially.[3]

AT A GLANCE

- In the author's view, the current employment-based system for health insurance in the United States does not meet the criteria of the triple aim: (1) improving the individual experience of care, (2) improving the health of populations and (3) reducing the per capita costs of care for populations.
- A 2017 study comparing the U.S. health system with those of ten other advanced economies shows that the U.S. system ranked last in performance, despite spending significantly more than the other countries studied. Health care also costs significantly more in the U.S. when compared with other countries.
- The author argues that a Medicare-for-all system would address the challenges the U.S. health care system faces.

Many argue that we should build on what works. This article argues that what works best now is Medicare.

It is the objective of this article to demonstrate that the current employment-based system does not meet the criteria of health system performance as outlined in the triple aims originally developed by the Institute for Healthcare Improvement and described in Health Affairs in 2008.[4, 5]

As the authors describe it:

… the United States will not achieve high-value health care unless improvement initiatives pursue a broader system of linked goals. In the aggregate, we call those goals the "Triple Aim": [1]improving the individual experience of care; [2] improving the health of populations; and [3] reducing the per capita costs of care for populations.

The authors describe certain policy and market constraints in the U.S. that make it difficult to focus on all three goals simultaneously. The objective of the Triple Aim is not to be a guidepost for a comparison of national health systems but rather a tool to direct quality improvement initiatives within specific health systems. Nevertheless, it can be a useful guidepost to examine how the reliance on employment-based health care in the U.S. improves the experience of care, improves health and reduces costs.

The Experience of Care

The majority of people in the U.S. receive their health insurance coverage through their employer or the employment of a family member (parent or spouse usually). Estimates range from 153 million[6] to 181 million.[7] Max Baucus—former Democratic Senator from Montana, chairman of the powerful Senate Finance Committee and a key leader in the fight to enact the Affordable Care Act—described the employment-based system of health insurance in the U.S. as the "foundation" of American health care.

It is a wobbly foundation and getting wobblier.

One would expect that a system that covers the majority of people in the U.S. and is regarded as a "foundation" of American health care would compare favorably to public programs.

It doesn't. A 2002 article in *Health Affairs*[8] reported that:

> After differences in income, health status, and drug coverage were accounted for, respondents insured through the two main public insurance programs—elderly Medicare and Medicaid beneficiaries—were found to be more satisfied with their insurance than were those with employer coverage. Elderly Medicare beneficiaries were 2.7 times more likely than those with employer coverage were to rate their health insurance plan as "excellent," and Medicaid beneficiaries were 2.1 times more likely than those with employer coverage to do so.

Another study reported that 74% of citizens over 65 were satisfied with their health care system compared with 48% of those under 65.[9]

More recent studies show that it is not getting any better. Gallup tracks satisfaction with health care coverage. In 2015, satisfaction with Medicare and Medicaid was 77% and 75% respectively, compared with 69% for employer insurance and 71% for "union" insurance. The 2018 survey combined categories. Nevertheless, satisfaction with the public programs increased to 79% while satisfaction with employment-based coverage remained static at 70%.[10]

Another poll shows that health insurance companies rank in the bottom five industry categories in general consumer satisfaction, behind airlines but ahead of internet service providers.[11]

And dissatisfaction with the health care system seems unique to Americans. Repeated international comparisons show that people in the United States are more dissatisfied with their health care than the citizens of other nations. One study revealed that 89% of Americans surveyed wanted either "fundamental changes" or a "complete rebuild" of the health care system.

The same 1988 survey published in *Health Affairs* and replicated by the *Los Angeles Times* two years later showed that more than 60% of Americans preferred a Canadian-style health system.[12] The authors concluded that dissatisfaction in the U.S. resulted from sharply rising prices (in 1988) and the "inadequate financial protection provided by our health insurance system."

A study almost 30 years later attempted to dig deeper into the question as to why Americans were uniquely dissatisfied with their health care protection. It pointed to equity as a major concern—specifically the "variation in insurance cov-

erage and type in the United States" and "that variation's role in giving people security about being able to exercise health care preferences when needed." To put that into the terms of today's health care sound-bite debate, Americans seem to prefer a one-size-fits-all plan.

Improving Health

The subject of America's poor health care performance relative to the rest of the world has been cited so often that popular magazines use headlines like "What's Actually Wrong with the U.S. Health System?"[13] or "How Bad is U.S. Health Care?"[14] The latter concludes in the subhead, "It's the worst."

Just days after the election of Barack Obama in 2008, Senator Baucus released the Finance Committee's "Call to Action," outlining his principles for health care reform. In only the second paragraph of the 98-page report, he refers to the "poor quality of care received by patients in the U.S." The World Health Organization (WHO) reported in 2000 that the U.S. ranked 37th in health system performance,[15] a topic of considerable discussion during the debates leading up to ACA. WHO looked at the investment in health and health outcomes such as health improvement, reducing health disparities, protecting households from impoverishment and the provision of services. These criteria are not too dissimilar from the Triple Aim.

While the number "37" might have captured the imagination, it is much easier to understand that, despite spending more on health care than any other country, the U.S. is ranked 39th in infant mortality and 36th in life expectancy. And the U.S. is improving at a slower rate than other industrialized countries. In other words, the gap is widening over time.[16]

Even more disturbing is a more recent, and more probing, comparison of the U.S. health system with the health systems of ten other advanced economies on five dimensions of care. The study *Mirror, Mirror 2017* shows that the U.S. health care system performs dead last (11th) overall despite spending significantly more than all the other countries studied. It performed last compared with the other nations in health care outcomes, equity and access and next to last in administrative efficiency. Only in care process did it climb to the middle of the pack, where it ranked fifth.[17]

A more recent probe by the Kaiser Family Foundation reveals what the U.S. does better. While reporting similar results in the public health measures like overall mortality, premature deaths and admissions for preventable diseases, it also reveals that the U.S. performs well in very specific ways: lower mortality rates for cancer, fewer postoperative blood clots and sepsis, and lower 30-day mortality rates for heart attacks.[18] To this author, these revelations indicate that the U.S. does a good job at delivering *medical care*, a specific intervention to a specific set of symptoms. It does not do well delivering *health care*, ensuring that those interventions are timely, appropriate and effective and that they improve the health of the population.

Reducing the Cost of Health Care

Much attention has also focused on how much health care costs in the U.S. compared with other countries. Health care in the U.S. costs twice as much as it does in the average European Union country and 50% more than in the next most expensive country; drugs are cheaper in other parts of the world; Americans pay more out of pocket than other countries; and the cost of health care for businesses increases faster than other costs of doing business and faster than general health care inflation, which itself increases faster than general inflation.[19]

Surveys indicate that few Americans are concerned about the cost of health care in the U.S. relative to that of other countries.[20] However, they are concerned about their own out-of-pocket expenses. A study by the Health Care Cost Institute reported, "Working Americans are using less care and paying significantly more."[21] The Employee Benefit Research Institute (EBRI) reported in 2018 that 47% of workers experienced an increase in their out-of-pocket expenses over the previous year.[22]

ACA has made health care coverage accessible to many who were unable to afford health care insurance or who were unable to purchase it at any price. But those gains were offset by deterioration in employer-sponsored health care. When ACA was passed in 2010, the uninsured rate was at 20%; by 2018 it had fallen to 12%. During that same period, the percentage of those who met the definition of *underinsured* rose from 16% to 23%, "with the great-

est increase occurring among those in employer plans."[23]

A report by the Economic Policy Institute describes the cost of employer-sponsored health care as the "canary in America's health care coal mine,"[24] referring to the increases to both employees and employers. But the report's assessment is not just a warning to the American health care system, it is a warning to the U.S. economy. The author argues that "excess cost growth" is eroding wages and standard of living for all Americans. People in the U.S. are not getting better health care protection for their money. Out-of-pocket health care expenses as a percentage of income has more than doubled in the past 20 years. There is also the issue of equity. Workers in firms with a higher number of low-wage workers pay more for health care both in absolute dollars and as a percentage of income.[25]

As discussed previously, American health outcomes fare poorly on most public health measures. Yet Americans actually use less health care than comparable countries. There are fewer physicians per capita and shorter hospital lengths of stay.[26]

Employer Efforts

It is fair to say that employers and plan sponsors have strived mightily against these trends. Some employers may experience savings relative to other employers, but their efforts have had little impact on overall trends, and an argument could be made that their efforts have contributed to the problem.

There is widespread agreement that what differentiates U.S. health care from other countries is the price we pay. It is not utilization, it is not demographic and it is not disease burden. The fragmented buying power of the tens of thousands of employers and plan sponsors cannot compete against the combined bargaining power of the hospital chains and large insurance companies. Government public plans have been much more effective at holding down cost increases than private plans.

The two main strategies that plan sponsors utilize to manage costs are steerage and cost shifting. *Steerage* takes the form of restricting access to providers based on cost and quality. Only 1% of employers are enrolled in traditional indemnity plans, while 44% are enrolled in preferred provider networks (PPOs), and another 26% are enrolled in health maintenance organizations (HMOs) or point-of-service (POS) plans. Each has its own variation on in-network and out-of-network plan designs. In its most extreme form, employers offer narrow networks and centers of excellence. Yet only 5% of large employers offer narrow networks and 16% offer centers of excellence.[27]

Much more widespread is *cost shifting*. Shifting an increasing portion of the cost of care onto patients is motivated, or at least justified, by the misguided theory of consumerism—the idea that when patients have "skin in the game" they will make more informed decisions. Consumers Union, a leading proponent of informed consumer choice, argues, "It's time to remove any implication that 'consumer driven health care' is consumer friendly."[28]

Consumers Union cites a statistic from a study by the Health Care Cost Institute[29] that only 7% of total health care spending was on "shoppable" services. The decisions that patients do make tend to be poor ones, scrimping on preventive services and in general using fewer services: fewer low-value services *and* fewer high-value services.

Consumers Union concludes that "Consumers should be empowered with timely, accurate and actionable information to help make decisions about their care." They also propose that "Efforts to address high prices and promote high-value care must have a strong provider-directed component, because providers direct treatment plans and steer almost all of our healthcare spending."[30] Such efforts must be moved upstream in the process of care.

My Experience

I see this in my role as a plan administrator and as a patient. One way that plan sponsors attempt to control costs is the use of pharmacy formularies, drug lists that determine which drugs are covered or not covered, and which drugs will be on a level two-, three- or four-tier copay. We offer three plans: two self-insured plans and one staff model HMO. In our self-insured plans, it is too often incumbent upon the patient to inform the doctor that a particular drug is not covered or on a higher tier copay and to ask the doctor for a different drug or to intercede with the pharmacy benefit manager (PBM) to get the drug covered. The patient is put in the middle.

We seldom hear complaints from participants enrolled in the staff model HMO that their doctor prescribed a drug that is not on the formulary. Why? Doctors in the self-insured plan deal with hundreds of different formularies and cannot be expected to know each and every patient's formulary. Doctors in the staff model know their formulary and know how to navigate the exception process. The cost and quality process is moved upstream—an important principle in all quality control initiatives.

I also experienced this comparison a personal level. Our plan recently adopted the patient-centered medical home (PCMH) model. The PCMH model, as the name might indicate, emphasizes primary care and provides various incentives to primary care physicians (PCPs) to manage care. One component is to offer incentives to PCPs to steer patients to more "cost-effective" providers among specialists, diagnostic centers, etc. I noticed a difference. Before the change, if my doctor would refer me to a specialist, I would be given a page with choices. After the change, I was offered a much shorter list, often with only one or two choices. The cost and quality control process had moved upstream to those who should be able to make more informed choices.

Why Medicare for All

Not all those who criticize the current health care system arrive at the conclusion that the U.S. should adopt a Medicare-for-all solution. It is fair to ask, why Medicare for all and not a more gradual or incremental approach?

One frequently hears advocates of reform echo the sentiments of former President Barack Obama, who noted that if the U.S. were designing a system "from scratch," a single payer, Medicare for all, model would be a logical choice.[31] They argue that making the change now to a single payer system would be too disruptive to those currently insured. Space does not permit a full discussion of the issues packed into that sentence.

Instead, I argue that there is no gradual way to move to Medicare for all. The current system is built on principles that are fundamentally different than those of Medicare for all. The status quo assumes that health care is a private good, something to be earned or purchased. Medicare for all assumes that health care is a public good, similar to education, highways and public safety.

The first approach emphasizes the roles of private markets in health care. Medicare for all attempts to mitigate or minimize the negative effects of markets in health care. Health care is not something that should be unaffordable; it should be afforded to us in the same way other public goods are available to us. Market-based reforms continually offer up the promise of competition in the health care market in the face of the realities of monopoly power in those same markets. The history of outrageous U.S. health care costs is clear proof of the failure of competition to win out over market power to set prices.

Some of that tension is captured by the former editor in chief of *Health IT Outcomes*, Ken Congdon, who wrote:

> Opponents of government-run healthcare are quick to tell horror stories of how this model will lead to federal "death panels" that decide when and how someone is treated and whether or not a patient lives or dies. As unsettling as this prospect is (although much of it is pure myth), I find the prospect of profit motive driving healthcare decisions to be even more frightening. There's big money to be made from those that are seriously ill. In my opinion, healthcare should focus on what's best for patients. It shouldn't be distracted or influenced by the desires and demands of investors. In a free market system, where's the incentive for a company or provider to cure cancer if doing so means it will most likely lose your most profitable consumers forever? Where's the incentive to lower costs in life and death instances where cost is no object? Healthcare is a difficult puzzle to solve. While I don't necessarily believe big government is the answer, neither is big business. We must work to find the balance between the two that works best for our country, our healthcare providers, and most importantly, the patients.[32]

Less radical proposals include the poorly defined "building on ACA" and various public option and Medicare buy-in ideas. The Partnership for America's Health Care Future, described as "a megacoalition of the health care industry devoted to killing single payer and public option proposals"[33] is an alliance of those who might have the most to lose in a Medi-

care-for-all system—insurance companies, the pharmaceutical industry and for-profit private hospitals. It routinely lumps together "moderate" proposals such as the public option or Medicare buy-in with Medicare for all. If you are going to face the same opposition with a more "moderate" proposal, why not strive for the more complete solution?

But ultimately my endorsement of Medicare for all emerges from my experience of 30-plus years working in various capacities consulting to collectively bargained and multiemployer plans. Only a Medicare-for-all solution can address the two issues vexing both the American health care system and, specifically, employer-sponsored health care—cost and administrative complexity.

I have already described how employer-sponsored health care has failed to moderate health care increases, fails to deliver a product that satisfies its consumers and fails to deliver what it is supposed to deliver—a healthy population. Let me give a few examples of how administrative complexity contributes to those problems.

Open enrollments are an annual exercise in administrative confusion. Private and public employer plans are not alone in contributing to this mayhem. Medicare and the public exchanges now all have their versions of open enrollment. Each year, our plans must produce communication material, hold meetings, process enrollment changes and then deal with the inevitable mistakes that occur.

In the current system, open enrollments can make sense from a limited perspective, to reduce the probability that someone might wait until they need health care before they enroll. In that case, enrollment is an up-and-down decision—enroll or not enroll—and only makes sense in an environment that imposes an economic cost (premiums) for enrolling late. Thus, Medicare imposes a late-enrollment penalty for those who defer enrollment.

When our members come to our office to make plan changes, they generally have only one question—Is my doctor in the plan? In a national plan without restrictive networks, that is not a concern. One could liken our current system to requiring people to shop only in a specific shopping center for the next year. Stores in other places would be "out of network." That is not the choice consumers are interested in making.

It was mentioned previously how countless formularies can lead to confusion, administrative headaches and delays in care. But there is another consequence of our health care pharmacy maze that reveals how the system is focused on selling medical care rather than delivering health care. Our PBM was trying to upsell us on a product that made some sense. (Let's leave aside the issue of why a product that delivers health would be an "extra.") For a small per-member, per-month fee, those at risk for diabetes would be given free glucose monitors and test strips as well as access to a health coach. I asked how members would learn about this opportunity and was told that the PBM would reach out to members by phone. Wouldn't it make more sense, I asked, if the pharmacists could communicate this program when they delivered the prescription? I was informed that solution cannot work in a system with countless formularies and benefit designs. Pharmacists cannot be expected to know what might be available for each patient. But in a system with a uniform benefit design, such communication challenges would be greatly reduced.

Another feature of our decentralized employment-based system is that health care is a subject of collective bargaining. Certainly, that is an improvement over a system that allows employers to unilaterally make changes in health care benefits that can affect thousands of employees. In both scenarios it is disruptive. But too often collective bargaining disputes can spill into the public space when workers strike over health care benefits. Even short of that, disputes over health care can have an impact. During recent contract negotiations, our wellness team encountered a different pushback from workers: "How do you expect me to be thinking about diet and exercise when the employer wants to take away my health care?" If health care is removed as a major topic of bargaining, the workforce and the economy will benefit.

Conclusion

The current employment-based system does not meet the fundamental tests of health system performance as outlined by the Triple Aim. It does not improve the patient experience of care, improve the health of the population or

reduce the per capita cost of health care. The employment-based system has in fact added to costs by adding complexity to the system and failing to confront the monopoly power of the major health care economic stakeholders.

Medicare for all would address those issues. But beyond focusing on how the current system is broken, we also need to imagine a world where health care is taken for granted. Health care will no longer factor into decisions about where to work, how many hours to work, when to retire, or when to take off to care for a family member or return to school, whether to start a business or even to stay in a marriage relationship. It will increase worker mobility, employer agility and entrepreneurial creativity.

The real question should not be whether to make the change but how to make it and how to redesign the role of employee benefit professionals to focus efforts on employee health rather than employee medical care. BQ

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