American Healthcare Reform

by Lee Benham, Benham Insurance Associates, January 2018

History

Prior to World War II, most Americans paid for their own medical care directly to the provider, however in the 1930s, the Local Blue Cross insurance entities were created to offer guaranteed service for a fixed price, thus Individual Health Insurance market was born, back then health insurance really was insurance: the transferring of risk from and individual to a company for unforeseen illness/accidents that could not be personally financed by the insured. These plans provided coverage for major items like hospitalizations that people could not afford to pay for themselves. All other expenses were paid out-of-pocket directly to the service provider.

The Beginning of Employer Sponsored Health Insurance

After World War II, the United States government was concerned about post-war inflation. The U.S. Government had already witnessed the devastation that hyperinflation had brought to post World War I Germany. To stop the hyperinflation form accruing, the Government instituted wage and price controls during the war. Many labor groups did not like this and would come together to plan to strike. In order to avoid having the masses go on strike, the War Labor Board exempted **Employer-Sponsored** Health Insurance from wage controls and income tax.

This historical event created a tremendous tax advantage for Employer Sponsored Insurance over Individual Insurance and has driven the demand for employer-sponsored health insurance plans to this day. Employers receive a 100% tax deduction for premiums paid while the benefits employees receive are also exempt from federal, state, and city income tax. Financing Health Care through Employer Sponsored plans has imbedded the cost of Health Care into products and services making the United States the most expensive health care system in the world. No other county in the world finances healthcare through employer sponsored plans.

The proliferation of Employer Sponsored Insurance has also led to the majority of employees not understanding the true cost of insurance. Most employees do not understand that Employer Sponsored Insurance is in fact, part of their compensation package. Though employers send premiums to insurance companies on the employee's behalf, the employee is still paying 100% of the premium cost through compensation. The Employer receives the tax advantages of the arrangement while the employee who is trading the cash compensation has no ownership or choice in the plans selected. If the employee leaves the employer or become so sick they are no longer able to work and maintain eligibility, they lose the Employer Sponsored Insurance Plans.

Early Years

In the late 1940s, The U.S. Government tried to end the tax advantage status of Employer-Sponsored Insurance, however, the industry had already grown so popular with labor groups and they preferred the Employer-Sponsored health insurance model and fought to keep it. By the mid-

1960s, Employer-Provided health insurance had become imbedded into our culture. The employer model worked well until the early 1980's because costs remained relatively low and employee's usually stayed with the same company for most of their career.

Employer-Sponsored Health Insurance 1980's -90's

The Employer-Sponsored health insurance market began to have problems in the late 1980's and early 1990's. Insurers looking to maximize profits started aggressively using eligibility clauses and the 1974 ERISA laws to find ways to only insure the healthiest of groups. The escalating costs and restrictions started a slow migration for the self-employed and very small employer groups to once again look to the individual market for their health insurance needs. This Migration could have potentially devastated the Employer-Sponsored insurance market. To combat the migration in the 1990's, Insurance companies lobbied hard for new legislation called the National Association of Insurance Commissioners' (NAIC) "Small Employer Health Insurance Availability" Model Act. The effect of this legislation created another advantage to Employer-Sponsored Insurance Plans over Individual Insurance Plans. The NAIC Act made plans to small employers restricted "Guarantee Issue." This meant that small employers could still be turned down if they did not meet minimum participation requirements which were about 80% of eligible employees had to participate in the program and/or the minimum employer-contribution-to-premiums had to be 50% of the employee costs of the insurance. These groups were also experience rated so they could be charged more for claims.

While the NAIC Act did make health insurance more accessible to small businesses, it did not address the affordability and hyperinflation of the cost of health insurance. Still facing double-digit growth in health insurance premiums, many small employers either ceased offering health benefits or redesigned the plans with higher cost-sharing by employees. These annual benefit reductions coupled with double digit premium increases and increased cost-sharing by employees inevitably led to an on going version of adverse selection, a perpetual process referred to as the small employer-based health insurance death spiral.

The Employer-Based Health Insurance Death Spiral

A death spiral starts when an employee's cost to participate in the employer plan exceeds the employee's willingness to pay. (Insurance is transference of risk. when premiums and out of pocket costs rise to a point that it's not worth transferring the risk being insured) When this happens, the healthiest employees begin to drop off the employer plan in favor of more affordable individual policies. This causes the remaining small employer risk pool to become "sicker", resulting in higher insurance premiums on renewal the following year. Then, the process repeats. Again, the employer reduces benefits to maintain costs, more healthy employees drop off, and the rate goes up the following year. This death spiral perpetuates until the small business either: (1) cancels the plan; or (2) is unable to meet the minimum contribution requirements or minimum participation requirements set by the insurer, and the plan is canceled by the insurer. The Insurance Industry's main reason for supporting the Affordable Care Act is the instability it has caused the individual market. The ACA has driven individual Insurance premiums higher than most Employer sponsored plans, effetely killing off the completion and stopping the migration.

Rise of the Individual Health Insurance Market

Since the early part of the1980's, employer sponsored health insurance costs have been steadily increasing. In the early part of the1990's, several attempts were made by the states to make health insurance more affordable and accessible to small businesses, however, these efforts did nothing to slow the rising costs of health insurance.

By the 2000's, the employer sponsored health insurance death spiral started to accelerate. This was primarily caused by new legislation in 2005 that allowed companies to offer Premium Only (Health Reimbursement Arraignments, also known as HRA). This is where an employer could offer a fixed tax-free dollar amount to the employees and the employee would use that money to purchase an individual policy of their choice. The Affordable Care Act made using premium only HRA plans illegal and subject to a fine for being a non ACA compliant employer sponsored plan. However the Obama administration exempted congress from this change and it is why congress uses an premium HRA for its employees today. The average cost for a Family Employer Sponsored plan in 1999 was $5,884 per year. Today that cost has ballooned to $18,142 per year and is increasing at more than twice the rate of inflation.

The Cost of Health Insurance to Tax Payers

In 2016, the government spent $1.6 Trillion of the $3.3 trillion total spent on Health Care Programs. Tax payer costs are estimated to grow to $3 Trillion of the $5.5 Trillion total spent per year by 2025. This is not sustainable and is the #1 cause of our escalating debt. If we don't find a way to control these costs we will never be able to pay down our debt. The way to slow the out of control increases of health insurance programs is to offer an alternative to the way our government subsidies our current healthcare system. The government must offer a choice to individuals to either keep their traditional Defined Benefit program or voluntarily accepts a Defined Contribution program.

Government Current Defined Benefit Expenditures

Current Health Insurance plans are Defined Benefit Plans. Medicare, Medicaid, CHIP, Employer Sponsored, and ACA Tax Credits are all Defined Benefit Plans where premiums are paid for a specific set of covered supplies or services. The tax payer cost of these programs in 2016 (the latest information available) are as follows

- Medicare $672 Billion
- Medicaid $565 Billion
- CHIP $14.5 Billion
- Government Subsidies of Employer sponsored Insurance $280 Billion
- Government Contribution to Employer-Sponsored Insurance Premiums $36 Billion
- Retiree Drug Subsidy Payments to Employer Sponsored Insurance Plans $10 Billion
- ACA tax credits $36 Billion

Alternative Defined Contribution

On February 28th, 2017 President Trump's remarks to a Joint Session of Congress included, "We should help Americans purchase their own coverage through the use of tax credits and expanded Health Savings Accounts - but it must be the plan they want, not the plan forced on them by our government… We should give our great state governors the resources and flexibility they need with Medicaid to make sure no one is left out".

Instead of just paying premiums directly for insurance and/or healthcare programs the government would allow individuals to voluntary elect to claim tax a credit for the purchase of any Individual Medical (IM) product available in the States that the consumer lives in. Any unused tax credit that is not spent on insurance premiums, but would be rolled into the consumer's tax-free HSA. Tax credits would be age-based and not income based as follows:

- 0 – 4 years old $2,500 per year
- 4-29-years old $2,000 per year
- 30 – 39-years old $3,000 per year
- 40 – 49-years old $4,000 per year
- 50 – 59-years old $5,000 per year
- 60 - 69 years-old $6,000 per year
- 70-79 years old $7,000 per year
- 80 + Years old $8,000 per year

Age-based tax credits are advance-able and refundable which means everyone could participate.

Example 1: A 30-year-old couple with 2 children over the age of 4 that has coverage through an Employer Sponsored plan could choose not to take the Employer Sponsored plan and instead receive $10,000 in tax credits to purchase individual insurance. If the family found an Individual Medical plan that met their needs for $6,000, then the $4,000 left over would be deposited into the families HSA Account.

Example 2: A 68-year-old person, newly eligible for Medicare, could choose not to enroll in Medicare and instead claim a $6,000 tax credit to purchase Individual Medical Insurance or enroll into Medicare and not claim a tax credit or could enroll into a Medicare MSA plan.

Example 3: A 30 year old Single parent with 2 kids over the age of 4 on Medicaid could choose instead to decline Medicaid and claim $7,000 in tax credits to purchase personal portable Individual insurance for themselves and the children.

Tax credits would grow each year by the Consumer Price Index plus 1% which is far less than the current Rate of Inflation of the Defined Benefit programs that have no caps.

If this system was in place today and everyone in America was on a defined contribution plan instead of a defined benefit plan the government would be paying the following:

- U.S. Population 0-4 years of age 20 Million. 20 x $2,500 = $50 Billion

- U.S. Population 5-29 years of age 107 Million. 107 x $2,000 = $214 Billion
- U.S. Population 30-39 years of age 42 Million 42 x $3,000 = $126 Billion
- U.S. Population 40-49 years of age 40 Million 40 x $4,000 = $160 Billion
- U.S. Population 50-59 years of age 43 Million 43 x $5,000 = $215 Billion
- U.S. Population 60-69 years of age 36 Million 36 x $6,000 = $216 Billion
- U.S. Population 70-79 years of age 20 Million 20 x $7,000 = $140 Billion
- U.S. Population 80 + years of age 11 Million 11 x $8,000= $88 Billion

Total government outlay 1.2 Trillion with a yearly cap of CPI plus 1% on increases vs the current 1.6 Trillion with no cap on increases.

High Risk Pools for Pre-existing Conditions

States would establish High Risk Pools (HRP) for affordable insurance for those with pre-existing conditions. States may add funds to their HRP as they did prior to the ACA. People with pre-existing conditions have three (3) funding sources for insurance:

1. Federal Age-based tax credits
2. States' funding of HRP with a 1-2% premium tax on each medical policy solid in their states
3. Consumers' personal premium payments

Benefit -1, Working Nebraska Families and the Cost of Insurance

For many, employer-based health insurance has become too expensive. For example, school teachers in Omaha typically have to pay $500 a month or $6,000 per year to add their families to the schools' health insurance. The age-based tax credits are generous enough that many families would have 100% of their health insurance paid plus receive $4,000 in their HSA if they choose a higher HSA deductible. This means an Omaha teacher would save $6,000 a year in premiums that they are currently spending plus the $4,000 HSA deposit for a total savings of $10,000 a year. Defined Contribution Plans enhances spendable income to the America's middle class families and working poor. Some families save even more. The current Obamacare price in Omaha for the lowest cost Silver Plan for a 60-year-old couple with Obamacare is $34,500 a year. This couple will get zero Obamacare income-based tax credit if they earn $65,000 a year. However, they would qualify for $12,000 in the age-based tax credit plan that would pay 100% of the cost of an Individual Medical product that is currently available in Nebraska. This couple would save $34,500 a year in premiums.

Benefit -2, The Price of Products and Services will Drop

The current cost of our products and services are higher because the high cost of employer-sponsored health insurance is embedded into their final cost. The Defined Contribution Plan will strip these high-embedded costs out of American products and will make our products and services more competitive in world markets. When products and services are lower for Americans their hard earned dollars will purchase more and last longer. When American products are more competitive the economy will grow accordingly.

Benefit -3, Local Taxes Will Drop

One of the biggest expenses for City, County and State Governments is the cost for employee health insurance. Defined Contribution Plan lifts the cost of employee insurance off the backs of local governments, which will allow all local taxes to be diminished.

Benefit -4, Older Workers Become Employable Again

Employer-based health insurance discriminates against older workers because their health insurance costs are more. Companies prefer the lower health insurance costs of younger workers so it is more difficult for employees over the age of 45 to find employment if they lose their job. Employers won't care about the age of an employee if the employee has his own health insurance with age-based tax credits. This change will help older workers find new employment.

Enhanced Health Savings Accounts (HSA)

All Politicians agree on making HSAs bigger, better and bolder by increasing the amount that may be deposited each year. The maximum deposit would double so singles may deposit $6,900 and $13,300 for families. Employers may also choose to help fund HSA's. When employers pay employees in their paychecks they must pay payroll tax, workers' compensation and unemployment taxes. Employees must pay payroll tax, Federal and State Income tax in most States. When employers make HSA deposits to employees all of these costs are eliminated. HSAs are compensation without taxation. It's smart when employers and employees work together and cut the IRS out. HSAs earn interest or may be invested in mutual funds for the possibility of a higher return. HSAs turn high taxes and health insurance premiums into assets for employees.

Defined Contribution Medicaid Plan for States

States will educate the healthy Medicaid population about the benefits for them with age-based tax credits and HSA deposits. Education is the key. The Tax Payers save money when the Medicaid person chooses the age-based tax credits and the Insured has a much larger list of medical providers to choose from. The medical community will be pleased to receive higher reimbursement rates than what Medicaid offers. One Medicaid provider has seen their stock price jump from $6 a share in 2008 to $102 in 2017. That is a whopping 1,700% increase in less than 10 years yet they continue to raise prices. We want to get Medicaid back to its original goal of helping the truly needy and older citizens that require the help.

Defined Contribution for State High Risk Pools (HRP)

In addition to the Federal defined contribution the States would maintain a High Risk Pool (HRP) for those with pre-existing conditions. States will fund the program with a HRP Tax on all health insurance premiums in the State. The goal would be a 2% tax on all health insurance plans that are not permanent portable insurance plans like employer-sponsored health insurance and Short-Term-Medical (STM). The people on these insurance programs are more likely to use the services

of the HRP if they become too sick to work. The HRP Tax on personal, portable and permanent Individual Medical insurance would be reduced to 1% because these people are less likely to use the HRP.

Defined Contribution Plans for Young Families

The big question is: why spend the money that is growing tax free? Some people that spend $100 at the dentist don't have to spend the funds from their HSA. Instead they pay with a different VISA and save the dental receipt because they have the freedom to let the HSA funds continue to grow tax free and can reimburse themselves the $100 at time in the future. Some HSA clients today have over$150,000 in their HSA and have never taken any funds out so they can be used later in retirement.

Medicare

A brief look at Medicare milestones

The '60s

On July 30, 1965 President Lyndon B. Johnson made signed H.R. 6675 in Independence, Missouri. Former President Truman was issued the very first Medicare card during the ceremony. In 1965, the budget for Medicare was close to $10 billion and almost 19 million individuals signed up for Medicare during its first year. In 1966, Medicare's coverage took effect, as Americans age 65 and older were enrolled in Part A and millions of other seniors signed up for Part B. The life expectancy for men in 1965 was 66 years of age and women life expectancy was 73. Today males are 76 and females are 81 respectfully.

The '70s

In 1972, President Richard M. Nixon signed into law the first major change to Medicare. The legislation expanded coverage to include individuals under the age of 65 with long-term disabilities and individuals with end-stage renal disease (ERSD). People with disabilities have to wait up to two years for Medicare eligibility, but Americans with ESRD can get coverage as early as three months after they begin regular hospital dialysis treatments. This change added additional expenses that the original program was not designed to cover.

The ’80s

When Congress passed the Omnibus Reconciliation Act of 1980, it expanded home health services. The bill also brought Medigap otherwise called Medicare supplement insurance under federal regulations.

In 1982, hospice services for the terminally ill were added to a growing list of Medicare benefits. In 1988, Congress passed the Medicare Catastrophic Coverage Act, adding a true limit to the Medicare’s total out-of-pocket expenses for Part A and Part B, along with a limited prescription drug benefit. Most of the Catastrophic Care law was repealed less than a year later after opposition from senior groups over the program’s higher premiums.

The ’90s

New legislation required state Medicaid programs to cover premiums of the new Specified Low-Income Medicare Beneficiary (SLMB) eligibility group those eligible for Medicare with incomes between 100 and 120 percent of the federal poverty level.

Congress also passed the Qualified Individual (QI) programs and the remaining program (of two originally enacted) requires Medicaid to pay premiums (through a federal grant) for Part B members with incomes between 120 and 135 percent of poverty. The annual funding for QI is limited and once exhausted; beneficiaries are not entitled to receive the benefit although some states can provide it at their own expense. Unlike QMB and SLMB, the QI program must be reauthorized by Congress every few years, and states utualy do not take part in financing it.

The ’00s

Americans younger than age 65 with amyotrophic lateral sclerosis (ALS) are allowed to enroll in Medicare without a waiting period if approved for Social Security Disability Insurance (SSDI) income. (Most SSDI recipients have a 24-month waiting period for Medicare from when their disability cash benefits start.)

President George W. Bush signed into law the Medicare Prescription Drug Improvement and Modernization Act of 2003, adding an optional prescription drug benefit known as Part D and which is provided only by private insurers. Until this time, about 25 percent of those receiving Medicare coverage did not have a prescription drug plan.

> Because of the many changes and inflation of health care expenses Medicare has grown into a $672 billon program. The program is paying longer than originally designed because people are living longer and is covering more people than originally designed. Today the average cost per individual on Medicare is about $9,800 a year. The Average reimbursement amount that private companies receive

for Medicare Advantage plans is about $8,400 a year per individual. We need to transition more Medicare Eligible insureds to Medicare Advantage Plans, specifically Medicare Medical Savings Account (MSA) Plans. Insurance companies are not selling Medicare MSA plans because the insurance company by law must give a portion of the funds they receive directly to the insured to help cover out of pocket cost. Companies that offer Medicare Advantage Plans should also be required to offer a Medicare Advantage MSA. This will be the incentive that people will need to voluntarily transition away from traditional Medicare to Medicare Advantage.

What is a Medicare MSA Plan?

Medicare works with private insurance companies to offer you ways to get your health care coverage. These companies can choose to offer a consumer-directed Medicare Advantage Plans (or Medicare Part C). One such plan is a Medicare MSA Plan. These plans are similar to Health Savings Account Plans available outside of Medicare. You have flexibility in choosing your health care services and providers.

Medicare MSA Plans have two parts.

Medicare MSA Plans combine a high-deductible insurance plan with a medical savings account that you can use to pay for your health care costs.

1. High-deductible health plan: The first part is a special type of high-deductible Medicare Advantage Plan (Part C). The plan will only begin to cover your costs once you meet a high yearly deductible, which varies by plan.

2. Medical Savings Account (MSA): The second part is a special type of savings account. The Medicare MSA Plan deposits money into your account. You can choose to use money from this savings account to pay your health care costs before you meet the deductible.

3. Example: Insureds premium cost for the plan would be $0. The yearly deductible would be $2,500 then 100% coverage after the deductible. The Medicare MSA plan would deposit $1,250 the first of every year into the insureds MSA checking account. Plans like this were sold the first year the law was passed in 2005 but insurance companies only offered them for one year because they give too much money back to the individuals.

Steps to use a Medicare MSA Plan

1. Choose and join a high-deductible Medicare MSA Plan.

2. You set up an MSA with a bank the plan selects.

3. Medicare gives the plan an amount of money each year for your health care.

4. The plan deposits some money into your account.

5. You can use the money in your account to pay your health care costs, including health care costs that aren't covered by Medicare. When you use account money for Medicare-covered Part A and Part B services, it counts towards your plan's deductible.

6. If you use all of the money in your account and you have additional health care costs, you'll have to pay for your Medicare-covered services out-of-pocket until you reach your plan's deductible.

7. During the time you're paying out-of-pocket for services before the deductible is met, doctors and other providers can't charge you more than the Medicare-approved amount.

8. After you reach your deductible, your plan will cover your Medicare-covered services. Read information from the plan for details about out-of-pocket costs.

9. Money left in your account at the end of the year stays in the account, and may be used for health care costs in future years.

Prosperity for America

Lifting the cost of health insurance off the backs of American employers will make our economy soar like never before. America needs a salesman to sell the idea of American healthcare reform so our Nation can begin a healing process. Defined Contributions are exactly what the doctor ordered. America needs more options, more choices and more freedom, including age-based tax credits. Defined Contributions will empower America to save premiums, eliminate taxes and build wealth. Modernizing our inefficient healthcare system with American Healthcare Reform will make America great again.

Population by Age
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Government Costs
http://www.pnhp.org/news/2016/january/government-funds-nearly-two-thirds-of-us-health-care-costs-american-journal-of-pub
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