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### A Public Option for Employer Health Plans

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## A PUBLIC OPTION FOR EMPLOYER HEALTH PLANS

Allison K. Hoffman, Howell E. Jackson, and Amy B. Monahan\*

### Abstract

*Following the 2020 presidential election, health care reform discussions have centered on two competing proposals: Medicare for All and an individual public option (“Medicare for all who want it”). Interestingly, these two proposals take starkly different approaches to employer-provided health coverage, long the bedrock of the U.S. health care system and the stumbling block to many prior reform efforts. Medicare for All abolishes employer-provided coverage, while an individual public option leaves it untouched.*

*This Article proposes a novel solution that finds a middle ground between these two extremes: an employer public option. In contrast to the more familiar public option proposal, which would offer government sponsored health insurance directly to individuals, our plan creates a public option for employers, who can select a public plan—based on Medicare and altered to meet the needs of working populations—instead of a private health plan for their employees. Employer-based private health coverage is in decline and increasingly leaves workers vulnerable. Our proposal offers a gradual way to loosen reliance on this system.*

*We review the policy, regulatory, fiscal, and business arguments in favor of this form of public option, which we argue is less disruptive than Medicare for All but more impactful than an individual public option. Because employer take up would be gradual and voluntary, our plan has lower fiscal costs and should face less resistance from employees and vested interests than Medicare for All. Over time, if the plan meets employers’ and employees’ needs, more people would be covered by a public option, moving away from over-reliance on private employer plans and toward something akin to Medicare-for-Many in a less politically, legally, and fiscally fraught way.*

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## INTRODUCTION

When it comes to health policy, two opposing truths are evident. Fundamental change is needed and fundamental change is impossible. The Patient Protection and Affordable Care Act (ACA) addressed some major gaps in how Americans pay for health care. Perhaps its biggest accomplishment was to expand the Medicaid program, which provides medical care for lower-income individuals and families. The ACA's efforts to reform the private market, while remarkable politically, have had less impact. The ACA did little to lay the groundwork in the United States for the longer-term structures needed to pay for universal health care efficiently and equitably.

What this Article sets out to do is to build on existing policy ideas to offer a foundation for more productive and fundamental change in American health care financing while being cautious not to proceed at a pace or in a direction that is fiscally irresponsible, politically fraught, or simply impractical. We propose that employers be given the opportunity to provide health insurance coverage for their employees through a Medicare-based public health insurance option. Our proposal will disappoint those who would like to see a swift move to Medicare for All. Likewise, it entails more change than preferred by those who are used to, or profiting from, the current system. In other words, what we propose is probably not anyone's first choice. Yet, it offers transformative potential while avoiding unnecessary disruption, and the possibility of a consensus path forward on health care reform.

The 2020 Democratic primaries featured two major health policy reform ideas. Neither was universally satisfying and the contrast between the two proved divisive. Intriguingly, the two individuals who each represented one of these ideas are now President and Vice President of the United States.

The first idea was Medicare for All (MFA), endorsed by Vice President Kamala Harris, as well as Bernie Sanders and Elizabeth Warren. If designing from scratch today, this option that is closer to what exists in peer nations would most certainly produce a lower cost system with higher outcomes.<sup>1</sup> Yet, in moving towards a universal public program from today's status quo, MFA would inevitably dislocate people from familiar employer-sponsored health plans to which they are loyal, whether deservedly or not. MFA was accordingly demonized as antithetical to individual autonomy and free choice. It raised the specter of government overreach and evoked uncomfortable memories of President Obama's much repeated assurance that under the ACA people who like their health care could keep it.<sup>2</sup>

The price tag for MFA proved to be an equally substantial impediment. The cost of operating a fully implemented MFA program was estimated to run into the

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<sup>1</sup> Roosa Tikkanen & Melinda K. Abrams, *U.S. Health Care from a Global Perspective, 2019: Higher Spending, Worse Outcomes?*, Commonwealth Fund Issue Brief (Jan. 30, 2020), <https://www.commonwealthfund.org/publications/issue-briefs/2020/jan/us-health-care-global-perspective-2019> (“The U.S. spends more on health care as a share of the economy — nearly twice as much as the average OECD country — yet has the lowest life expectancy and highest suicide rates among the 11 nations.”).

<sup>2</sup> See Angie Drobic Holan, *Lie of the Year: ‘If You Like Your Health Care Plan, You Can Keep It,’* POLITIFACT.COM (Dec. 12, 2013), <https://www.politifact.com/article/2013/dec/12/lie-year-if-you-like-your-health-care-plan-keep-it/>.

trillions of dollars, necessitating a substantial increase in federal taxes. To be sure, comparative evidence suggests that a well-managed public health care financing system would reduce the overall health care spending in the United States.<sup>3</sup> Moreover, standard labor economics predicts that universal coverage could help workers by reducing the share of their compensation consumed by ever rising health care spending.<sup>4</sup> These defenses of MFA are, however, complicated and depend upon assumptions about market adjustments and economies of scale that are difficult to convey in academic seminars, much less presidential debates or twitter feeds. For many, the specter of higher taxes for MFA drowned out all else.

The second major health policy idea was incremental expansion, building on the successes of the ACA. This was the approach embraced by President Joe Biden, unsurprisingly in light of the role he played as Vice President when the ACA was signed into law. Although the details differed among candidates, the defining feature of most incremental reform plans was a public option based on Medicare. Mayor Pete Buttigieg aptly coined it “Medicare for all who want it.”<sup>5</sup> This approach leaves employer-based health plans largely untouched, while increasing offerings in the individual market. These public option proposals were targeted narrowly at the population most in need of coverage – the uninsured who are not offered employer-based coverage, who are ineligible for Medicaid, and who had not purchased coverage in the ACA’s reformed individual marketplaces. Most simply, the idea was that a public option, based on Medicare, would be added into those marketplaces and would compete with private plans already offered. In contrast to MFA, the main selling points were, first, that this approach retains a high degree of individual autonomy and, second, it massively reduced the fiscal costs to the federal government as compared to MFA proposals. Importantly, it also left the entrenched employer-based system untouched.

Yet, on the flipside, creating a public option for individuals would reach only a tiny fraction of the population.<sup>6</sup> This incremental building would not address structural problems in the system. It is a layer of plaster spread gingerly across a crumbling wall. Even though some public option proposals engage to a limited degree with employer-sponsored plans, none of the major versions advanced in the Democratic primaries envisioned any significant movement away from our reliance on traditional employer-provided health plans and toward a more streamlined healthcare financing system.

It is this feature of current public option proposals that motivated us to ask whether we can do better. Health policy experts in the U.S. have long lamented the

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<sup>3</sup> Tikkanen & Abrams, *supra* note 1.

<sup>4</sup> See, e.g., Lawrence H. Summers, *Some Simple Economics of Mandated Benefits*, 79 AM. ECON. REV. 177 (discussing the fungibility of compensation in cash and via benefits).

<sup>5</sup> Scott Simon & Heidi Glenn, ‘Just The Right Policy’: Pete Buttigieg ‘Medicare For All Who Want It’ Plan, NPR Morning Edition (Nov. 8, 2019) (interview with Pete Buttigieg regarding his health plan proposal during the 2019-2020 Democratic primaries).

<sup>6</sup> According to a review of the most prominent health care reforms of democratic presidential candidates updated in February 2020, the Biden public option proposal would have expanded coverage by only 15 to 20 million. See *Primary Care: Estimating Democratic Candidates’ Health Care Plans*, COMMITTEE FOR A RESPONSIBLE FEDERAL BUDGET, (Feb. 26, 2020), <http://www.crfb.org/papers/primary-care-estimating-democratic-candidates-health-plans>.

centrality of employer-sponsored health insurance as an accident of history that has become increasingly engrained over time, due to its favorable treatment by the tax code and a series of other policy decisions.<sup>7</sup>

Although having a connection between the workplace and health care is no global anomaly, the American way of tying health benefits to a job is unique and does not work well for many people, increasingly so as the gig economy grows. Employer-sponsored health insurance coverage has become less generous over time, leaving households vulnerable to unmanageable health care expenses, especially as this coverage comprises an increasing share of workers' total compensation.<sup>8</sup> And it has become a major stumbling block—we think the primary stumbling block—to more productive structural change, which is starkly needed now more than ever.

The United States has the most expensive, inefficient, and inequitable health care system among its OECD peer nations.<sup>9</sup> We spend twice as much as the average OECD nation and get worse outcomes than most on critical metrics, like life expectancy, chronic disease burden, and avoidable death.<sup>10</sup> What drives high healthcare spending is high prices (we use less care per capita than most other countries).<sup>11</sup> Prices are high because of a fragmented financing system and consolidation among providers, who at this point can all but set their reimbursement rates in negotiation with private payers, even the largest ones.<sup>12</sup>

The three of us (experts respectively in health law and policy; financial regulation, consumer protection, and federal budget policy; and employee benefits and tax law and policy) have come to believe that the necessary first step toward fixing how we pay for health care in the United States is to shift gradually away from a system of private employer-based health insurance. We think the best way to do that is to offer employers the opportunity to release themselves from the burden of designing and administering health care benefits for their employees through the creation of a different kind of public option that presents the opportunity for high-value coverage at a lower cost than the status quo.

In this Article, we make the case for a public option designed intentionally and primarily for employers as an alternative to private insurance plans for their employees. Employers could choose to enroll their workforce in a public plan, based on Medicare, instead of having to design and administer their own private plan. We advocate for focusing first on large employers in order to take advantage of these employers' relative expertise in health insurance and because such employers cover a majority of the individuals with employer-based coverage, making it easier to roll out and test a new approach.<sup>13</sup>

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<sup>7</sup> See Timothy Jost, *Access to Health Insurance and Health Benefits* in OXFORD HANDBOOK OF U.S. HEALTH LAW (I. Glenn Cohen, Allison K. Hoffman, and William M. Sage, eds. 2017).

<sup>8</sup> See Part I.C, *infra*.

<sup>9</sup> Tikkanen and Abrams, *supra* note 1.

<sup>10</sup> *Id.*

<sup>11</sup> *Id.* (showing lower rates of physician visits, similar hospitalization, but greater use of MRI scans per capita).

<sup>12</sup> See Part II.A, *infra*.

<sup>13</sup> In 2019, two thirds of private sector employees worked for firms with more than 100 employees with over 46 % at firms with over 1000 employer and a similar share of ESI coverage provided in these categories of firms. These estimates are derived from AGENCY FOR HEALTHCARE RESEARCH AND QUALITY, U.S. DEP'T OF HEALTH &

If even a handful of large employers chose to participate in a public option, it could provide valuable information about the benefits and costs savings possible from a national system of health care financing.<sup>14</sup> The experience gained through this transition – including understanding the number and type of employers that choose to opt into the public option – would offer compelling evidence on what might be the highest-value way to get employees health insurance, revealed through the voluntary, and hopefully educated, choices made by employers with substantial expertise in choosing health care plans.

If it works, gradually and organically, more employers—large and small—would opt in, eventually producing a less disjointed and expensive way of paying for and providing health care. While our approach would not likely result in Medicare for All, it might possibly deliver something like Medicare for Many More or Medicare for Most.

We present in this Article a basic concept for an employer-based public option. Arguments in favor are multi-faceted and compelling. Employers offer an efficient distribution channel to reach both the presently insured and also some of the remaining uninsured. According to recent estimates, 154.7 million non-elderly individuals had employer-sponsored health insurance as compared with 18.5 million with individual coverage<sup>15</sup> and roughly 29 million uninsured (the remainder of the population already has public coverage).<sup>16</sup> In other words, three times more people have coverage through an employer than the sum of current individual market enrollees and the uninsured. That means an employer public option has greater potential scale and, in turn, ability to streamline the overall financing system. It would likely also reduce the number of uninsured overall. Recent surveys reveal that now, unlike before the ACA, the majority of uninsured people are employed either full time or part time.<sup>17</sup> Some of these workers are offered workplace coverage that they cannot afford and others are not offered it at all. This segment will only grow as the gig economy and other forms of precarious work expand. A public option for employers can be tailored to incentivize employers to extend coverage to previously excluded workers and can subsidize low-income workers' share of the costs of coverage.

An employer public option also offers significant fiscal advantages. Current employer and employee contributions for employer-sponsored health insurance can

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HUM. SERV., *Medical Expenditure Panel Survey* (2018), [https://meps.ahrq.gov/mepsweb/data\\_stats/quick\\_tables\\_search.jsp?component=2&subcomponent=1&year=2018&tableSeries=-1&tableSubSeries=&searchText=&searchMethod=1](https://meps.ahrq.gov/mepsweb/data_stats/quick_tables_search.jsp?component=2&subcomponent=1&year=2018&tableSeries=-1&tableSubSeries=&searchText=&searchMethod=1); see also KAISER FAMILY FOUND., *EMPLOYER HEALTH BENEFITS: 2020 ANNUAL SURVEY* (2019), [files.kff.org/attachment/Report-Employer-Health-Benefits-Annual-Survey-2020](https://files.kff.org/attachment/Report-Employer-Health-Benefits-Annual-Survey-2020). [hereinafter KFF *Employer Health Benefits 2020*].

<sup>14</sup> For example, if one focuses on just the employees covered by the top ten ESI programs as reported on ERISA forms in 2018, covered employees total more than 4.2 million with covered household members no doubt a multiple of that number. The largest reporting plan – Walmart Inc. Associates' Health and Welfare Plan – reports over 1.5 million employees covered. Estimates derived from data downloaded from <https://freerisa.com/>.

<sup>15</sup> *Health Insurance Coverage of Nonelderly 0-64*, THE KAISER FAMILY FOUNDATION, <https://www.kff.org/other/state-indicator/nonelderly-0-64/?dataView=1&currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>, last visited Dec. 23, 2020.

<sup>16</sup> See Kaiser Family Found., *Issue Brief: Key Facts about the Uninsured* (Dec. 2019).

<sup>17</sup> See text accompanying notes 101-103, *infra*.

be retained—in whole or part—to finance a significant share of this form of public option. Indeed, if the cost savings of Medicare over private coverage are preserved even in part, employers and employees should both come out ahead financially. Perhaps even more important, the need for higher taxes to support this transition will be dramatically lower than those required under other leading reform proposals, as payments made to the Medicare system for this kind of public option would be accounted for as a voluntary exchange transaction – technically an offsetting government collection – and not a tax and spending program.

Employers would be free to choose whether or not to participate, as consistent with norms of autonomy as is the choice a company faces today when it decides whether to ship its goods with the U.S. Postal System as opposed to Federal Express or to prioritize employee travel by Amtrak rather than commercial airlines. Employers, especially large employers, are comparatively well equipped to evaluate the relative value of health plans, while taking into account their employees' needs and preferences. While a public option is usually touted on the grounds that private insurers “need real competition,”<sup>18</sup> competition works best when the consumers understand their choices. A mountain of evidence shows that individuals struggle to do so when making health insurance decisions.<sup>19</sup> Although not perfect, corporate human resources departments can better navigate alternatives.

There are good reasons to believe that many employers, both small and large, would choose to participate in a public option, even if there may be some initial hurdles to overcome. In many respects, it is anomalous that hundreds of thousands of employers must be in the business of providing and annually updating health insurance programs for their employees. Employers that choose to offer a group health plan in the current environment must manage health care costs that outpace inflation, and must do so within a highly regulated and complex legal environment. The possibility for relief from this financial and regulatory morass would motivate some employers to select a public option, so long as their employees were guaranteed high-quality coverage.

No doubt, the political lift will be herculean. Certain vested interests – most obviously providers and private health insurance companies – will resist an initiative of this sort intuiting, correctly, that it would mean lower reimbursement rates than they currently enjoy from private health plans. Medical providers, from hospitals to doctors to medical device and pharmaceutical companies, who gain great profit off the current system will fight against it. Even labor unions who might support the idea on a blank slate could resist it if they saw the effort as threatening the loss of bargained-for health benefits. But to the extent that there is political will to make progress on national health care reform, which will regardless of the specific policy platform see resistance from these same groups, a public option for employers should be seriously considered because it could spark more than just marginal improvements.

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<sup>18</sup> Press Release, JoeBiden.com, Biden-Sanders Unity Task Force Recommendations 31 (Aug. 2020), at <https://joebiden.com/wp-content/uploads/2020/08/UNITY-TASK-FORCE-RECOMMENDATIONS.pdf>

<sup>19</sup> See Part I.C., *infra*.

This Article is organized as follows. In Part I, we provide a brief overview of the U.S. health care finance system and review the leading proposals for health reform – Medicare for All and an individual public option. We then provide an overview of the current state of employer-provided coverage and its challenges. In Part II, we make the basic case for an employer public option and detail its key design features. We also consider in Part II the likelihood that employers will voluntarily choose to participate in such a public option. In Part III, we focus on the fiscal aspects of a public option for employers, comparing it to the widely publicized scoring estimates for prominent Medicare for All proposals as well as the more limited work that has been done on the budgetary scoring of other public option proposals. As explained in this section, the voluntary nature of a public option for employers has a dramatic impact on consequences of this proposal for the federal budget and elegantly internalizes the offsetting savings that employers and employees would enjoy by moving into the Medicare systems in this manner. We also offer in this section a brief analysis of why this kind of reform might be possible though a budget reconciliation bill that would only require a simple Senate majority.

## I. BACKGROUND ON U.S. HEALTHCARE FINANCE AND LEADING REFORM PROPOSALS

The United States is unique among nations when it comes to paying for health care, and not in a good way. Most OECD countries' systems for health care financing grew up in the early- to mid-20<sup>th</sup> century as medical care became more advanced and expensive.<sup>20</sup> In Europe, what emerged were public systems of health care finance in two forms, often characterized coarsely as Beveridge and Bismarkian systems.<sup>21</sup> The Beveridge approach was direct provision of health care by the government, as in England, where the government owns hospitals and employs medical professionals—aka “socialized medicine.” In Bismarkian systems, or social insurance, the government finances health care but the providers can be public or private. This is what traditional Medicare is in the United States. Even as countries developed variations on these themes, at their core, these systems embraced the idea that the government would take a central role in ensuring access to affordable health care for the entire population.

The U.S. charted a wholly different path, leading with private health insurance and facilitated by hospitals. As medical care became both more effective and expensive, hospitals feared unpaid bills if they relied on patients to pay cash for service, or having to confirm the financial solvency of every patient prior to providing care.<sup>22</sup> In response, first hospitals and later cities created pre-paid health care funds, such as the one established by Baylor University Hospital in the 1920s, which guaranteed people access to medical care up to a certain level, with pre-payment.<sup>23</sup> These types of hospital service plans spread and eventually evolved into Blue Cross. Within a short period, Blue Shield followed, offering a similar a

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<sup>20</sup> PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 237-240 (1982).

<sup>21</sup> T.R. REID, THE HEALING OF AMERICA, Ch. 2 (2009).

<sup>22</sup> STARR, *supra* note 20, at 295-96.

<sup>23</sup> *Id.* at 297-298.

structure for monthly prepayment of fees to groups of physicians in turn for guaranteed access of outpatient care.<sup>24</sup>

Then, in the mid 20<sup>th</sup> Century, employers grew as a source of health coverage in the U.S., coinciding with the moment that many other countries were doubling down on the government's role.<sup>25</sup> In the U.S., several public policies fostered the growth of employer-based coverage. A commonly-told story is that the trend is due to wage controls during the war, prompting employers to compensate with benefits instead of cash wages, but the growth in employer health plans was relatively small in this period as compared to the years prior and after the war.<sup>26</sup> More consistent with the timing of a major upsurge in adoption of ESI were a 1945 federal rule that required employers to leave wartime health benefits in place, a 1949 federal rule allowing unions to bargain collectively for health benefits, and most importantly a 1954 rule by the Internal Revenue Service excluding dollars spent on health benefits by employers and employees from taxation.<sup>27</sup> Because of this tax exemption, employer-provided health benefits are worth substantially more on an after-tax basis than an equivalent amount of cash compensation, creating a strong incentive for employers to offer such benefits. With all of these factors, ESI and the centrality of private insurance took hold.

The tax benefits associated with ESI continue to be an important driver of its primacy today, but other factors also contribute.<sup>28</sup> Before the ACA, markets for individually-purchased health insurance functioned poorly, allowing employers to offer their employees a benefit they could not get elsewhere. Large employers also benefit from natural risk pooling and economies of scale that make their administrative costs lower than either individual or small group coverage (although still higher than Medicare).<sup>29</sup>

While the ACA significantly improved the availability and affordability of coverage on the individual market, ESI has continued to be the dominant source of private coverage. Today, nearly 60% of all nonelderly Americans have insurance through an employer,<sup>30</sup> with Medicare providing the primary source of coverage for the elderly and individuals with disabilities and Medicaid providing the primary source of coverage for certain low-income and medically needy individuals. Across

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<sup>24</sup> *Id.* Unlike the private health insurance of today, the Blues embraced some of the solidaristic characteristics that define systems elsewhere in the world, like charging all members of a community the same rate for membership regardless of their personal characteristics or health status.

<sup>25</sup> In England, for example, during WWII the government built health infrastructure to deal with an unmet need for medical services and this infrastructure served as the beginning of the National Health Service, established at the end of the war. Donald W. Light, *Universal Health Care: Lessons From the British Experience*, 93 AM. J. PUB. HEALTH 25, 26 (2003).

<sup>26</sup> David Blumenthal, *Employer-Sponsored Health Insurance in the United States—Origins and Implications*, 355 NEW ENG. J. MED. 82, 83 (2006).

<sup>27</sup> *Id.* at 83: *see also* Jost, *supra* note 7.

<sup>28</sup> For an overview of the many advantages of ESI, see David A. Hyman & Mark Hall, *Two Cheers for Employment-Based Health Insurance*, 2 YALE J. HEALTH POL'Y, L. & ETHICS 23 (2001).

<sup>29</sup> *See* text accompanying notes 75-77, *infra*.

<sup>30</sup> KAISER FAMILY FOUND., HEALTH INSURANCE COVERAGE OF THE TOTAL POPULATION, <https://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D> (data reported as of 2019).

the entire U.S. population, 49.6% are covered by ESI, 5.9% by private individual market coverage, 19.8% by Medicaid, 14.2% by Medicare, and 1.4% through military coverage, with 9.2% remaining uninsured.<sup>31</sup>

Hundreds, or perhaps thousands, of proposals have promised to reform the dysfunctional health care financing system in the U.S. Many of these, dating back decades, have questioned whether employers should continue to play a fundamental role in health coverage.<sup>32</sup> We focus below on the two that have been most prominent in recent years – Medicare for All and an individual public option, the first of which abolishes the employer-based system and the latter of which leaves the employer-based system untouched. Because we believe that an employer public option provides an attractive path forward that avoids either extreme, we conclude this Part by focusing on the underappreciated challenges of employer-provided coverage and why what is often considered to be the highest-functioning piece of the U.S. health care system might be the best place to begin systemic reform.

### A. Medicare for All

Since its passage in 1965, some believed Medicare would eventually become the health insurance program for all Americans.<sup>33</sup> Momentum in this direction slowed right away with the simultaneous passage of Medicaid, a program that paid for the most vulnerable populations—children and pregnant women—and took the wind out of the sails of quick additional reforms that might have built on Medicare.<sup>34</sup>

Yet, the idea of building on Medicare has reemerged after a period of dormancy and in various forms. With Senator Bernie Sanders in 2016 and a longer bench of proponents in the 2020 Democratic primaries, including Senators Elizabeth Warren and Kamala Harris—the idea of Medicare for All (MFA) gained momentum. Most proposals lacked concrete details, but the basic idea was similar. Candidates argued to replace the dysfunctional way that we pay for medical care in the United States with a more efficient and equitable model available to all, or most, people.

Senator Bernie Sanders advanced the “purest” version of this idea, a single-payer public health insurance program that would cover everyone with automatic enrollment. He introduced the plan as a Senate bill<sup>35</sup> and as the basis of his health policy in his candidacy in the 2016 and 2020 Democratic primaries.<sup>36</sup> Following the

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<sup>31</sup> *Id.*

<sup>32</sup> *See, e.g.* INSTITUTE OF MEDICINE, EMPLOYMENT AND HEALTH BENEFITS: A CONNECTION AT RISK vii (Marilyn J. Field & Harold T. Shapiro eds, 1993) (“Unlike most National Research Council committees, however, this committee did not reach consensus on some central issues. For example, committee members could not agree on whether employment-based health benefits should be continued or abandoned . . .”).

<sup>33</sup> THEODORE R. MARMOR, POLITICS OF MEDICARE 173 (2d ed., 2000).

<sup>34</sup> *Id.* at 60.

<sup>35</sup> For most recent version, *see* Medicare for All Act of 2019, S.1129, 116<sup>th</sup> Cong., at <https://www.congress.gov/bill/116th-congress/senate-bill/1129/text?q=%7B%22search%22%3A%5B%22%5C%22medicare+for+all%5C%22%22%5D%7D&r=2&s=4>. The 2019 House version was sponsored by Representative Pramila Jayapal. Medicare for All Act of 2019, H.R.1384, 116<sup>th</sup> Cong., at <https://www.congress.gov/bill/116th-congress/house-bill/1384>.

<sup>36</sup> *Bernie Sanders on Healthcare*, FEELTHEBERN.ORG, <https://feelthebern.org/bernie-sanders-on-healthcare/> [<https://perma.cc/TGZ9-QPBV>], last visited Mar. 5, 2020 (stating Medicare for all “[c]overs primary and preventive

2016, election, more politicians began to follow in Senator Sanders’s footsteps. The Medicare for All Act of 2019 included fourteen co-sponsors, including prominent members such as Senators Harris, Leahy, Markey, and Warren.<sup>37</sup> Notable about Senator Sander’s version of Medicare for All are its ideological commitments and truly universal and comprehensive nature, which for many made it more symbolic than realistic.<sup>38</sup> This proposal came with a hefty price tag – with estimates from think tanks or academics ranging from about \$25 trillion to \$35 trillion in increased federal government costs or outlays over the ten-year period following a Medicare for All enactment.<sup>39</sup> Yet, many experts estimated that this plan that would leave no one uninsured or underinsured would result in little or no growth in total health care spending.<sup>40</sup>

As discussed further in Part III, because the federal government would pay a large part of the price tag through taxes, the fiscal case proved a major stumbling block. Sanders proposed a variety of mechanisms for progressive financing, including increased taxes that also provided his opponents fodder for attack.<sup>41</sup>

Notably, several candidates espoused the idea on the 2020 campaign trail during the Democratic primaries. One of the more intriguing policy aspects of these proposals arose when some candidates, including Senators Sanders, Warren, and Harris, introduced “phase-in” plans on how to transition from the current system to MFA.<sup>42</sup> Perhaps most relevant now are the details—albeit few—of Senator Harris’s plan.

After strong advocacy for MFA, Senator Harris pulled back slightly and acknowledged, rightly, that it is difficult to get from a deeply-embedded employer-based health insurance system to Medicare for All. Thus, she proposed a ten-year transition period, during which people who wanted to buy into Medicare more quickly could do so.<sup>43</sup> Harris’s transition period included some structural

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care, mental health care, reproductive care, vision, hearing and dental care, and prescription drugs, as well as long-term services for the disabled and elderly.”).

<sup>37</sup> Medicare for All Act of 2019, S.1129, 116<sup>th</sup> Cong., at <https://www.congress.gov/bill/116th-congress/senate-bill/1129/text?q=%7B%22search%22%3A%5B%22%5C%22medicare+for+all%5C%22%22%5D%7D&r=2&s=4>.

<sup>38</sup> These commitments included universal coverage; a short four-year transition period after which every American would be automatically enrolled; comprehensive benefits that reached well beyond what Medicare covers today, including dental and vision benefits, and long-term care; and no cost-sharing at the point of care, erasing the deductibles, co-payments, co-insurance, and balance billing that vex and financially strain many Americans. *Id.*

<sup>39</sup> *Choices for Financing Medicare for All*, COMMITTEE FOR A RESPONSIBLE FEDERAL BUDGET, <http://www.crfb.org/papers/choices-financing-medicare-all> (last visited June 12, 2020).

<sup>40</sup> See, e.g., Josh Katz et al., *Would ‘Medicare for All’ Save Billions or Cost Billions?*, N.Y. TIMES, Oct. 16, 2019.

<sup>41</sup> *How Does Bernie Pay for His Major Plans?*, BernieSanders.com, <https://berniesanders.com/issues/how-does-bernie-pay-his-major-plans/> [<https://perma.cc/J4BW-ZPX8>] (last visited Dec. 23, 2020).

<sup>42</sup> Elizabeth Warren, *My First Term Plan for Reducing Health Care Costs in America and Transitioning to Medicare for All*, ELIZABETHWARREN.COM, <https://elizabethwarren.com/plans/m4a-transition> [<https://perma.cc/L3LW-W4JJ>] (last visited Mar. 5, 2020) (detailing Warren’s plan for transitioning to Medicare for All, which included immediate and free coverage for children under age 18 and anyone earning under 200% of the federal poverty level).

<sup>43</sup> Kamala Harris, *My Plan for Medicare for All*, MEDIUM (July 29, 2019), <https://medium.com/@KamalaHarris/my-plan-for-medicare-for-all-7730370dd421> [<https://perma.cc/82EX-Q84G>]. The Sanders’s and Warren transition plans also allowed this individual opt-in.

characteristics to lubricate more fundamental long-term transformation, including automatically enrolling all newborns and uninsured people into the Medicare program.<sup>44</sup> Senator Harris stood by the eventual goal of MFA: “At the end of the ten-year transition, every American will be a part of this new Medicare system.”<sup>45</sup>

Although what we propose in this Article differs from Senator Harris’s transition plan, both recognize that a key to fundamental and necessary change is a more gradual shift away from our over reliance on employers as a locus of access to health insurance.

## **B. Fixing the ACA with an Individual Public Option**

The public option has been described by its proponents as simply one option among many, a public health insurance plan that would compete side-by-side with private plans. Presumably, if the public option offered a similar or better product for lower prices, people would choose it. As Jacob Hacker suggested: “public plan choice gives Americans the opportunity to choose for themselves how they value the strengths and weaknesses of a public, Medicare-based plan and competing private health plans.”<sup>46</sup>

Provoking some of the most heated moments in the primaries were debates between the MFA advocates and those candidates who preferred to build incrementally on the ACA with a public option. Most, including Vice President Joe Biden, still leaned on Medicare for their plans, but only to serve as the foundation for the public option to fill in the gaps the ACA left. Dozens of Congressional proposals envision a similar model.

What most defines the prominent public options plans is who makes the selection of the plan—the individual. These plans are built on individual choice and are sold as the epitome of autonomy, as Pete Buttigieg promoted it on the campaign trail: “Medicare for all Who Want It.”<sup>47</sup> Although the policy details have evolved from the initial conversations that took place prior to the passage of the ACA, the main contours remain and are similar among different plans. The public option is based on Medicare and is offered in the ACA exchanges, or marketplaces, where an individual, or in some cases a small business, could select it.

The Sanders-Biden Unity Task Force recommendations, which align fairly closely with what Vice President Biden proposed on the campaign trail, wrote:

Private insurers need real competition to ensure they have incentive to provide affordable, quality coverage to every American.

To achieve that objective, we will give all Americans the choice to select a high-quality, affordable public option through the Affordable Care Act marketplace. The public option will provide at least one plan choice without deductibles, will be administered by

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<sup>44</sup> *Id.*

<sup>45</sup> *Id.*

<sup>46</sup> Jacob S. Hacker, Institute for America’s Future, *The Case for Public Plan Choice in National Health Reform* 2 (2008).

<sup>47</sup> See Dylan Scott, *Pete Buttigieg’s Medicare-for-all-who-want-it plan, explained*, Vox.com (Sept. 19, 2019), at <https://www.vox.com/2019/9/19/20872881/pete-buttigieg-2020-medicare-for-all> (last accessed Feb. 15, 2021),

the traditional Medicare program, not private companies, and will cover all primary care without any copayments and control costs for other treatments by negotiating prices with doctors and hospitals, just like Medicare does on behalf of older people. The lowest-income Americans not eligible for Medicaid will be automatically enrolled in the public option at no cost to them, although they may choose to opt out at any time. Everyone will be eligible to choose the public option or another Affordable Care Act marketplace plan, even those who currently get insurance through their employers, because Democrats believe working people shouldn't be locked in to [sic.] expensive or insufficient health care plans when better options are available.<sup>48</sup>

This idea would improve the status quo. It would fill gaps left by the ACA, especially in those states that have chosen not to expand Medicaid, which perversely left some of the poorest people in the states uninsured when others earning just pennies more receive generous subsidies to buy private plans. Plus, in states where there are very few private insurers participating on the exchanges, there is evidence that a public option might help keep premium prices in check.<sup>49</sup> Various pieces of proposed legislation have included a similar public option, including eight of ten health reform bills proposed in Congress last session.<sup>50</sup>

Yet, the problem with these proposals is that they will almost certainly fail to catalyze more fundamental change. It is unlikely that this public option—even in the best-case scenario—will reach very many people. As of now, only six percent of the non-elderly population (just under 20 million people) have individual market coverage.<sup>51</sup> If every uninsured person were added to this market, it would grow to just under 50 million people.<sup>52</sup> By comparison, there are an estimated 156.5 million individuals with employment-based coverage,<sup>53</sup> and a further 26 million employees

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<sup>48</sup> Press Release, JoeBiden.com, Biden-Sanders Unity Task Force Recommendations 28 (Aug. 2020), at <https://joebiden.com/wp-content/uploads/2020/08/UNITY-TASK-FORCE-RECOMMENDATIONS.pdf>.

<sup>49</sup> See Jon R. Gabel et al., *Competition and Premium Costs in Single-Insurer Marketplaces: A Study of Five Rural States*, THE COMMONWEALTH FUND, (Mar. 6, 2018), <https://www.commonwealthfund.org/publications/issue-briefs/2018/mar/competition-and-premium-costs-single-insurer-marketplaces-study> (showing that decreases in number of insurers in some states marketplaces led to relatively faster premium growth).

<sup>50</sup> Choose Medicare Act, S. 1261, H.R. 2463, 116<sup>th</sup> Cong. (2019); Medicare for America, H.R. 2452, 116<sup>th</sup> Cong. (2019); Medicare-X Choice Act of 2017, S.1970, 115<sup>th</sup> Cong. (2017); The CHOICE Act, H.R.2085, S.1033, 116<sup>th</sup> Cong. (2019) (sponsored by Representative Schakowsky and Senator Whitehouse to create a federal public plan option on the ACA marketplaces under existing procedures and rules); Keeping Health Insurance Affordable Act, S.3, 116<sup>th</sup> Cong. (2019) (sponsored by Senator Cardin to create a federal public option on ACA exchanges); Medicare at 50 Act, S.470, 116<sup>th</sup> Cong. (2019) (sponsored by Senator Debbie Stabenow and allows individual age 50 and older to opt into Medicare early); Medicare Buy-In and Health Care Stabilization Act of 2019, H.R.1346, 116<sup>th</sup> Cong. (2019) (sponsored by Representative Higgins to allow individuals age 50 and older to opt into Medicare); State Public Option Act, S.489, H.R.1277, 116<sup>th</sup> Cong. (2019) (co-sponsored by Senator Schatz and Representative Lujan to allow a state public option for Medicaid buy in).

<sup>51</sup> KAISER FAMILY FOUND., *supra* note 30.

<sup>52</sup> *Id.*

<sup>53</sup> Matthew Rae, Daniel McDermot, et al., *Long-Term Trends in Employer-Based Coverage*, PETERSON-KFF, HEALTH SYSTEM TRACKER.

(Apr. 3, 2020) <https://www.healthsystemtracker.org/brief/long-term-trends-in-employer-based-coverage/>.

who either are not offered coverage by their own firms or are offered and decline coverage. Even more, these proposals all rely on individuals identifying that the public option is better for them than the private plans offered in their state and selecting it. A mountain of evidence makes clear that individuals struggle to figure out what health plan is best for them and are resistant to change plans once they select them.<sup>54</sup> Even those who understand health insurance well struggle to differentiate and select among health plans, which should be unsurprising when considering the nature of health plan choice. At the most fundamental level, buying health insurance demands having preferences about things that most people have never experienced before, like hospitalization or cancer care, and weigh the risk of ever needing such care against spending on other goods and services.

Most people do not understand the basic features of health insurance plans that should shape their decisions—such as how much a plan costs, cost-sharing features, and what benefits are covered.<sup>55</sup>

Furthermore, choosing a health plan requires making calculations regarding deductibles, cost-sharing, and premiums that exceed many American’s literacy and numeracy skills.<sup>56</sup> In the end, there is a volume of empirical work illuminating the many ways that and reasons why individuals—regardless of education, income, or smarts—make poor choices among health plans.<sup>57</sup>

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<sup>54</sup> See Allison K. Hoffman, *Health Care’s Market Bureaucracy*, 66 UCLA L. REV. 1926, 1953-58 (2019) (citing studies showing the many ways in which people make poor health insurance choices, and why); Allison K. Hoffman, *The ACA’s Choice Problem*, 45 J. HEALTH POL., POL’Y, & L. 501, 504-506 (2020) (describing a selection of these studies).

<sup>55</sup> Deborah W. Garnick et al., *How Well Do Americans Understand their Health Coverage*, 12 HEALTH AFF. 204, 206 (1993) (finding that even though consumers largely understood whether their plans covered hospitalization or doctors’ visits, they underreported that their plans covered services including mental health, alcohol and drug abuse treatment, or prescription drug and over-reported that their plans covered long-term care). George Loewenstein et al., *Consumers’ Misunderstanding of Health Insurance*, 32 J. HEALTH ECON. 850, 855 (2013) (In a survey of insured adults, only 14 percent correctly answered four simple multiple-choice questions about cost-sharing features like a deductible or copayment.)

<sup>56</sup> Wendy Nelson et al., *Clinical Implications of Numeracy: Theory and Practice*, 35 ANN. BEHAV. MED. 261 (2008) (providing an overview of research on health numeracy and the clinical implications for patients); Ellen Peters & Irwin P. Levin, *Dissecting the Risky-Choice Framing Effect: Numeracy as an Individual-Difference Factor in Weighing Risky and Riskless Options*, 3 JUDGMENT & DECISION MAKING 435 (2008) (showing that lower levels of numeracy led to higher loss aversion). On health insurance literacy specifically, see, e.g., ZSOFIA PARRAGH & DEANNA OKRENT, HEALTH LITERACY AND HEALTH INSURANCE LITERACY: DO CONSUMERS KNOW WHAT THEY ARE BUYING (Alliance for Health Reform, Jan. 6, 2015), [http://www.allhealthpolicy.org/wp-content/uploads/2017/01/Health-Literacy-Toolkit\\_163.pdf](http://www.allhealthpolicy.org/wp-content/uploads/2017/01/Health-Literacy-Toolkit_163.pdf) (describing and summarizing studies on health insurance literacy).

<sup>57</sup> The many studies showing these problems span different insurance marketplaces that have plan choices, including employer, ACA, and Medicare Part D. See, e.g., Eric J. Johnson et al., *Can Consumers Make Affordable Care Affordable? The Value of Choice Architecture*, 8 PLOS ONE e81521. (showing in a simulated ACA model even odds that participants who passed a screening test for basic insurance literacy would select the better plan, and Wharton business school study participants got it wrong over one-quarter of the time); Anna D. Sinaiko & Richard A. Hirth, *Consumers, Health Insurance, and Dominated Choices*, 30 J. HEALTH ECON 450, 453 (2011) (showing among enrollees in the University of Michigan’s employee health plan, over one-third of workers selected a plan that was identical to another in every way except that it had a more restricted provider network, a plan known as a “dominated” plan because no one should choose such a plan in any circumstance); Jason Abaluck & Jonathan Gruber, *Heterogeneity in Choice Inconsistencies Among the Elderly: Evidence from Prescription Drug Plan Choice*, 101 AM. ECON. REV. 377, 379 (2011) (finding that 73 percent of Medicare Part D prescription drug program enrollees could have chosen a plan with lower premiums with no risk of spending more on prescription drugs over the course of the year.); Florian Heiss et al., *Plan Selection in Medicare Part D: Evidence from Administrative Data*,

The bottom line is that public option proposals focused on the individual market are unlikely to provide an incremental step towards more coherent and equitable health care financing. Competition in the individual health insurance market simply does not work as intended or predicted. Even if the public option were an obvious best alternative offered on the individual market, individuals would not necessarily select it. In turn, the public option would not exert competitive market pressure that some still predict and hope it might. That means that even if the public option were widely taken up by currently uninsured individuals, it would reach only a small subset of the population, while leaving the larger inequitable and confusing patchwork in place.

### **C. Employer-Sponsored Coverage as an Attractive Starting Point for Reform**

As discussed above, employers currently play a central role in providing health insurance, which at first blush makes targeting a public option and reforms at ESI seem potentially fraught. It is one of the more stable aspects of a healthcare financing system that has many more critical gaps to fix, including the fact that approximately ten percent of the population under age sixty-five is still uninsured.<sup>58</sup> Yet the fragmented employer-based system acts as a real impediment to any type of fundamental change to our system of healthcare finance. Without beginning to rethink employer-provided coverage, it is hard to imagine tackling fundamental issues such as cost containment and the provision of universal and equitable coverage.

There are of course several reasons why employers might prefer to remain at the center of the U.S. healthcare system. Large employers generally view health benefits as an important part of their strategy to recruit and retain workers, a position that is generally supported by employee surveys.<sup>59</sup> Some employers see keeping employees healthy as enhancing productivity and use health benefits to try to maintain a healthy workforce, including wellness programs, gym membership, and health coaching for chronic or serious conditions.<sup>60</sup> These factors make the current

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32 J. HEALTH ECON 1325, 1377-78 (2013) (estimating that only about 10 percent of Medicare Part D enrollees choose the least-expensive plan option); Vicki Fung et al., *Nearly One-Third of Enrollees in California's Individual Market Missed Opportunities to Receive Financial Assistance*, 36 HEALTH AFF. 21 (2017) (describing that a significant share of ACA enrollees choose plans with the lowest monthly premiums but that make them ineligible for cost-sharing reductions to help pay for out-of-pocket costs, likely leading to more spending over the year for many of them). When measured more subjectively, people fail to buy plans that align with their own stated preferences or needs. See, e.g., Saurabh Bhargava et al., *The Costs of Poor Health (Plan Choices) & Prescriptions for Reform*, 3 BEHAVIORAL SCI. & POL'Y 1, 7-8, 10 (2017) (simulating purchase on ACA exchanges, only one-third of respondents chose the cost-minimizing plan, based on their own anticipated medical care need) The authors of this study estimated that if all people buying plans on the ACA exchanges had similar error rates as the study population, "the result would be roughly \$7.1 billion of excess spending each year, borne by a population with low to moderate incomes." *Id.* at 10.

<sup>58</sup> KAISER FAMILY FOUND., *supra* note 30.

<sup>59</sup> See, e.g., America's Health Insurance Plans, *The Value of Employer-Provided Coverage* (2018) (reporting results of employee survey where 71% reported satisfaction with their employer's health plan. Forty-six percent of surveyed employees stated that their employer's health plan played a role in recruiting them, and 56% reported that the health plan has an impact on the employee's choice to stay in their current job).

<sup>60</sup> See Jeffrey Pfeffer et al., *Employers' Role in Employee Health: Why They Do What They Do*, 62 J. OCCUPATIONAL & ENVTL. MED. e601 (2020). *But see* Damon Jones et al., *What do Workplace Wellness Programs do? Evidence from the Illinois Workplace Wellness Study*, 134 Q.J. ECON 1747 (2019) (presenting the results of a

structure sticky, but not unyielding to change, as we explore in Part II.C addressing the many reasons why employers might want change. First, this subpart offers a quick landscape of the employer market and its challenges to illuminate why we think targeting a public option at that market is necessary.

### 1. The Evolving Picture of the Employer Market and Growing Costs

An estimated 156.5 million nonelderly individuals were enrolled in an employer plan in 2018 (58% of the nonelderly population and 49% of the total U.S. population).<sup>61</sup> Just over half of all private sector firms offer health insurance to some workers, but nearly all firms with more than 200 workers do so.<sup>62</sup> Seventy percent of workers covered by health insurance are employed at large firms.<sup>63</sup> This is why we think that large employers are a necessary locus for more fundamental, structural change.

Larger firms are more likely to offer better health insurance and to require employees to pay a lower share of costs, as compared to smaller firms. Large firm plans tend to have higher total premiums, due to the generosity of benefits, but lower employee premium contributions, lower deductibles, lower out-of-pocket maximums, and lower copays.<sup>64</sup>

Yet, regardless of size of firm, the cost of health benefits for employers has skyrocketed over the past two decades, far outpacing wage growth and inflation.<sup>65</sup> The average annual premiums in 2020 were \$7,470 for single coverage and \$21,342 for family coverage.<sup>66</sup> Employers have been paying more for coverage, with the average employer contribution increasing from \$1,878 in 1999 to \$6,227 in 2020 for single coverage and \$4,247 to \$15,754 for family coverage.<sup>67</sup> Employee contributions have also increased substantially, with required contributions for family coverage increasing 13% over the last five years and 40% over the last ten years.<sup>68</sup> Today, employees are required to contribute on average 17% of the premium for single coverage and 27% of the premium for family coverage.<sup>69</sup> Not surprisingly, firms with lower-wage workers have less generous benefits and greater worker contributions; for family coverage, these firms had an average family premium of \$19,332 in 2020, with workers contributions of \$7,226 (close to 40%). In addition to premiums, cost-sharing obligations are also considerable. In 2020, over half of all

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randomized controlled trial of a workplace wellness program, which found that such programs neither lower medical costs nor improve health outcomes or worker productivity).

<sup>61</sup> Matthew Rae, Daniel McDermot, et al., *Long-Term Trends in Employer-Based Coverage*, PETERSON-KFF, HEALTH SYSTEM TRACKER

(Apr. 3, 2020) <https://www.healthsystemtracker.org/brief/long-term-trends-in-employer-based-coverage/>.

<sup>62</sup> KFF Employer Health Benefits 2020, *supra* note 13, at 45.

<sup>63</sup> *Id.* at 25, Figure M.6.

<sup>64</sup> *Id.* at 41.

<sup>65</sup> *Id.* at 40, 42. Figure 1.10, Figure 1.12.

<sup>66</sup> *Id.* at 7.

<sup>67</sup> *Id.* at 83-84.

<sup>68</sup> *Id.* at 96.

<sup>69</sup> *Id.* at 82. Rates of employer subsidization vary based on firm size, particularly for family coverage. Large firms require employees to pay on average 24% of the cost of family coverage, while small firms require employees to pay 35% of the cost. *Id.*

covered workers were in plans with an average annual deductible of over \$1000.<sup>70</sup> When premiums and cost-sharing obligations are combined, employees on average pay 34% of total healthcare costs (20% premiums, 13% all other costs).<sup>71</sup>

Although most large employer plans offer a reasonable choice of providers, the breadth of choice has diminished over time as employers try to contain costs,<sup>72</sup> and will almost certainly continue to do so over time since limiting networks is the most feasible cost control mechanism under employers' control. Changes to benefits will be more likely to garner objections from employees. Large firm plans generally offer several options of plans but they have only small differences among them with respect to the treatments and services covered.<sup>73</sup> And employer plans have little control over the prices they pay for items and services, as discussed below. As a result, most ESI plans have some limits in the network of providers someone can see, or charge more for seeing doctors out of network.<sup>74</sup>

The overhead costs for plans vary significantly, although are difficult to estimate precisely because of the inconsistent and malleable ways that both private and public plans categorize various costs. One study reported that administrative expenses for small group health plans accounts for 25-27% of premiums, compared to 5-11% for large companies with self-insured health plans.<sup>75</sup> Another found that administrative expenses average 17% for private insurers.<sup>76</sup> In each case, the estimates for employer-provided plans tend to be higher than the 2-5% administrative overhead for Medicare and Medicaid.<sup>77</sup> And it is not clear whether these estimates sufficiently account for the in-house resources devoted to health plan administration, as discussed below.

## 2. The Administrative Costs and Challenges of Employer-Provided Health Coverage

In addition to the significant premium expense of employer-provided health plans, there are also less obvious costs and risks associated with such coverage from

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<sup>70</sup> *Id.* at 104.

<sup>71</sup> Matthew Rae, Rebecca Copeland & Cynthia Cox, *Tracking the Rise in Premium Contributions and Cost-Sharing for Families With Large Employer Coverage*, PETERSON-KFF: HEALTH SYSTEM TRACKER (Aug. 14, 2019) <https://www.healthsystemtracker.org/brief/tracking-the-rise-in-premium-contributions-and-cost-sharing-for-families-with-large-employer-coverage/>. As for prescription drug costs, the same report found that large employers end up paying 88.9% of the cost. *Id.*

<sup>72</sup> KFF Employer Health Benefits 2020, *supra* note 13, at 78, Fig. 5.1.

<sup>73</sup> DEP'T OF LABOR, SELECTED MEDICAL BENEFITS: A REPORT FROM THE DEPARTMENT OF LABOR TO THE DEPARTMENT OF HEALTH AND HUMAN SERVICES 5-36 (2011), <http://www.bls.gov/ncs/ebs/sp/selmedbensreport.pdf> 5-36.

<sup>74</sup> *Id.* at 77. Forty-seven percent of workers are in PPOs; 31% in HDHP/SOs; 13% in HMOs; 8% in POS plans; and 1% in conventional plans. The POS and conventional plans might compete on network, but all others have more network restrictions than Medicare does. Of firms with 5000 workers or more, the largest plan for 31% has a tiered provider network.

<sup>75</sup> A self-insured plan is one in which the employer retains responsibility for paying claims, often utilizing an insurance company only to provide administrative services.

<sup>76</sup> Emily Gee & Topher Spiro, *Excess Administrative Costs Burden the U.S. Health Care System*, CENTER FOR AMERICAN PROGRESS (Apr. 8, 2019), <https://www.americanprogress.org/issues/healthcare/reports/2019/04/08/468302/excess-administrative-costs-burden-u-s-health-care-system/>.

<sup>77</sup> *Id.*

the employer's perspective. In particular, offering a group health plan comes with significant plan design costs and challenges, compliance costs, and litigation risks. It is likely that at least some employers have become accustomed to these obligations and now have come to consider them among the costs of doing business. Yet, if offered the opportunity to relinquish them, we think many would do so gladly.

An employer that decides to offer a health plan to employees must begin by making various plan design decisions, such as eligibility terms, benefit design, cost-sharing structure, network breadth, and financing arrangement. For large employers, in-house benefits experts typically work with outside benefits consultants to make these decisions, while smaller employers may consult only an insurance broker.

Once these initial decisions are made, the employer must either purchase a group insurance policy or hire a third-party administrator (TPA) to administer the plan. That purchasing or hiring process is typically done through a request for proposals ("RFP") that solicits bids from interested parties. In fact, it is not unusual for a large employer to issue multiple RFPs to cover not only traditional medical benefits, but also separate RFPs for the plan's prescription drug benefit, specialty drug benefit, wellness program, COBRA administration, and data warehousing. Once bids are received, the employer must select a winner in each category and negotiate the final terms of the contracts.

If the employer wants to allow employees to pay for premiums on a pre-tax basis (as all should), the employer must establish a cafeteria plan under section 125 of the Internal Revenue Code to allow such contributions. Many employers also choose to offer a health care flexible spending account under their cafeteria plan, which allows employees to pay out-of-pocket medical expenses on a pre-tax basis, which typically requires yet another vendor.

After the plan has been designed and agreements with vendors are in place, the employer must administer an open enrollment process, informing eligible employees of their choices and allowing them to make an election within a specified window. Plus, they must establish technical processes to actually enroll the employee and family members in coverage and ensure the proper payroll deductions and plan contributions are made.

Following open enrollment, the plan must be administered on an ongoing basis. While the insurer or a third-party administrator is principally responsible for such administration, the tasks involved are significant. At a minimum, the insurer or TPA must process prior authorization requests, claims and appeals, and mid-year changes in enrollment. The insurer or TPA is also responsible for negotiating and maintaining a provider network and, as a practical matter, must have a call center for both participant and provider inquiries.

#### **a. Regulatory Burdens**

Once the plan is up and running, employers are faced with myriad legal requirements. The Employee Retirement Income Security Act of 1974, as amended (ERISA) is the federal statute that governs nearly all employer-provided health plans, other than those sponsored by churches or governments. Although ERISA was designed primarily with pension plans in mind, it imposes significant reporting and disclosure and claims and appeals procedures on health plans. ERISA also

incorporates federal requirements that provide the right for individuals covered by an employer health plan to continue their coverage for a specific period of time if they have a qualifying loss of coverage (known as “COBRA” continuation coverage), as well as various nondiscrimination requirements included in the Health Insurance Portability & Accountability Act (HIPAA) and a small number of mandated benefits.<sup>78</sup>

In addition to ERISA, the federal tax code also regulates employer-provided health plans. The tax code contains the so-called employer mandate, which subjects large employers to a financial penalty if they fail to offer an affordable group health plan.<sup>79</sup> The calculation of the credit is complicated, but it generally ranges from \$2,000 to \$3,000 per employee per year. There are regulations establishing when an employer is considered to offer a group health plan for these purposes, and when and to what extent that coverage is considered affordable for a particular employee.<sup>80</sup> The tax code also incorporates many of ERISA’s substantive group health plan requirements and the ACA’s health insurance reforms (such as prohibitions on pre-existing condition exclusions and lifetime and annual limits) and subjects plans that do not comply with such requirements to a \$100 per day per affected individual excise tax.<sup>81</sup> In addition, as mentioned above, in order to allow participants to pay premiums on a pre-tax basis, the employer must adopt a cafeteria plan administered in accordance with IRS guidance. For example, the cafeteria plan regulations dictate when a married employee who is getting a divorce may change their health plan election from family coverage to single employee coverage, or drop or add coverage altogether. Similarly detailed rules apply to health care flexible spending accounts, which may only be offered through a cafeteria plan.

Employers must also ensure compliance with several other federal laws that touch employer health plans, such as HIPAA’s privacy rules, the Americans with Disability Act (ADA), and the Family Medical Leave Act (FMLA). For employees who are Medicare-eligible, the employer or plan administrator must navigate Medicare Secondary Payer rules, which determine how benefit payments are coordinated between the employer plan and Medicare.

Some employer plans, if financed through an insurance contract rather than self-insured, are also subject to state laws. Such laws regulate not only the insurance company itself (through mechanisms such as capital reserve requirements), but can also have an impact on substantive features of the group contract, such as mandated benefits or dispute resolution mechanisms. For plans that self-insure but purchase stop loss coverage, state law can regulate the stop loss policy.

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<sup>78</sup> ERISA broadly preempts state laws that relate to employee benefit plans, other than those that regulate insurance, which creates an additional level of legal complexity that often results in litigation over what state laws are preempted and has produced an encyclopedic number of Supreme Court decisions. *See* 29 U.S.C. §1144(a).

<sup>79</sup> I.R.C. §4980H.

<sup>80</sup> Treas. Reg. §54.4980H-5. *See also* David Gamage, *Perverse Incentives Arising from the Tax Provisions of Healthcare Reform: Why Further Reforms are Needed to Prevent Avoidable Costs to Low- and Moderate-Income Workers*, 65 TAX L. REV. 669 (2012) (detailing some of the labor market distortions that are likely to result from the ACA’s tax provisions).

<sup>81</sup> I.R.C. § 4980D.

## **b. Claims Disputes and Litigation Risks**

In addition to the upfront plan design costs and ongoing compliance costs, employers that sponsor a group health plan also face risks related to claims disputes. Where a health plan denies a claim, the covered individual has the right to an internal appeal that is subject to detailed procedural requirements. In addition, as part of ACA reforms, nearly all employer plans now must offer participants the ability to appeal claims that are denied on the basis of clinical or scientific judgment to an independent medical expert. That independent review is conducted *de novo*, and is binding on the plan. If those appeals are unsuccessful, the covered individual has the right to file suit under ERISA to challenge the claim denial.<sup>82</sup>

While the financial impact of these claims disputes may be relatively limited,<sup>83</sup> these lawsuits can have a profound impact on the relationship between employer and employee. A dispute between an employer and employee about potentially life or death issues can irreparably harm the employment relationship with the affected employee and also damage morale within the broader employee community.

In addition to lawsuits brought by employees, employers that sponsor health plans sometimes find themselves as plaintiffs in lawsuits *against* employees to enforce plan reimbursement clauses. These clauses, common in employer health plans, require that covered individuals reimburse the plan for medical expenses if the plan paid for medical care and the employee later recovers against a third party in an action related to those medical expenses. For example, if an employee is injured in a car accident and receives a related settlement or judgment from a third-party, the health plan has a right to be reimbursed for the amount it spent to provide medical care to the employee as a result of the car accident. As with denied claims lawsuits, these reimbursement actions often damage the employer-employee relationship and have at times resulted in unfavorable media coverage of the employer.<sup>84</sup>

All told, designing and maintaining a group health plan is a significant and costly undertaking for large employers, over and above actual premium costs. While those efforts generally deliver a valued benefit, a public option that provides high value coverage without these burdens could prove very attractive to both employers and employees.

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<sup>82</sup> While claims that proceed to litigation pose relatively low financial risk, independent external review carries greater risk for a plan. In litigation, a court reviews a plan's decision under the highly deferential "arbitrary and capricious" standard of review. In external review, a qualified expert reviews the claim *de novo*, but only claims that involve the exercise of clinical or scientific judgment are eligible for external review.

<sup>83</sup> Punitive and extra-contractual damages are unavailable under ERISA which limits recoveries in successful appeals of benefit denials to the cost of the service at issue and plaintiff's attorneys fees.

<sup>84</sup> See, e.g., Andrew Clark, *Wal-Mart Drops Bid to Sue Brain-Damaged Former Shelf-Stacker*, THE GUARDIAN, April 2, 2008; Tara Parker-Pope, *Injured Woman Wins Wal-Mart Saga*, N.Y. TIMES, April 4, 2008; Andrew Wolfson, *Walmart Changed Policy After Claiming an Injured Worker's Settlement Became a PR Nightmare*, LOUISVILLE COURIER JOURNAL, April 5, 2018.

## II. OUR PROPOSAL: AN EMPLOYER PUBLIC HEALTH INSURANCE OPTION

We believe there is a better way forward than either Medicare for All or an individual public option. We propose a public option for employers, which would give employers a voluntary choice to offer Medicare-based public insurance coverage in lieu of traditional group coverage. We begin by making the basic case for an employer public option and then review key design features in detail. We conclude by examining the likelihood that the proposal would gain traction among employers and other stakeholders.

### A. The Basic Case for an Employer Public Option

If the ultimate goal of health care reform is to move toward universal and equitable coverage, we believe that providing employers with the ability to offer employees coverage through a Medicare-based public insurance program presents a meaningful and politically viable opportunity for reform. Specifically, an employer public option offers a path toward systemic reform, as well as direct benefits for both employers and employees, and it sheds the primary downsides of the two most prominent reform proposals. Unlike Medicare for All, a public option for employers would not force a shift to public coverage, yet it would have far more impact than an individual public option. Importantly, for those that favor Medicare for All as a long-term strategy, an employer public option would provide a potential transition to that end point. And an employer public option could be offered alongside an individual public option without harm to either strategy.

#### 1. The Ability to Achieve Systemic Change

##### a. Price Control and Provider Networks

An employer public option provides a mechanism to decrease the cost of care and its administrative expenses, increase the number of individuals with health insurance coverage, and deliver subsidies to low- and moderate-income individuals.

A key feature of an employer public option and its ability to bring about systemic change is the ability of the government to negotiate down prices. Medicare prices are on average one-half that of private health insurance plans.<sup>85</sup> Over the past decade, Medicare has controlled per enrollee spending much better than private health insurance.<sup>86</sup> Health spending growth has far outpaced growth of the economy, growing from just under seven percent of GDP in 1970 to nearly twenty percent now.<sup>87</sup> Even over the last decade, from 2008-2019, during a period when the rate of spending has slowed, private health insurance cumulative growth in per enrollee

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<sup>85</sup> Eric Lopez et al., Kaiser Family Foundation, *How Much More Than Medicare Do Private Insurers Pay? A Review of the Literature* (Apr. 15, 2020), at <https://www.kff.org/medicare/issue-brief/how-much-more-than-medicare-do-private-insurers-pay-a-review-of-the-literature/> (last accessed Feb. 15, 2020).

<sup>86</sup> Rabah Kamal et al., *How has U.S. spending on healthcare changed over time?*, PETERSON-KFF: HEALTH SYSTEM TRACKER (Dec. 23, 2020), <https://www.healthsystemtracker.org/chart-collection/u-s-spending-healthcare-changed-time/#item-start>.

<sup>87</sup> *Id.*

spending is over fifty percent, as compared to half that rate (just over twenty-six percent) for Medicare.<sup>88</sup>

During this same period, health care providers—including hospitals and physicians—have merged and become increasingly consolidated.<sup>89</sup> As a result, in many areas of the country providers have been able to demand higher prices for care with little effective resistance from private insurers and employers against these demands.<sup>90</sup> Even when Amazon, Berkshire Hathaway, and JPMorgan Chase joined together to attempt wield their collective power to improve employer-provided health care, they found that they lacked the market power to successfully negotiate prices down.<sup>91</sup> Large insurers might in some cases be able to push back on providers in market-based negotiations, but insurers have also become more consolidated over time and lack incentive to find the edge of negotiations when they can pass price increases off onto employers (and eventually employees).<sup>92</sup> Even when insurers push back, providers still often have the upper hand when they are critical to a local network, as in the case of “must-have” hospitals or large integrated networks of hospitals and physicians.<sup>93</sup>

Medicare, however, preserves a large, unrestricted network of providers despite lower reimbursement rates. It does so in part because of its scale, which translates to volume benefits to providers but also makes it difficult for large providers and hospitals to refuse to accept Medicare patients. It also does so by paying rates that make Medicare reimbursement acceptable for many providers, and not just when in mix with privately insured patients. Efficient hospitals were able, until recently, able to break even based on Medicare reimbursement rates.<sup>94</sup>

While setting reimbursement rates within an employer public option would be a delicate task, as we discuss in detail below, for now it is sufficient to note that a public option that uses Medicare’s rates and network as a starting point would be a viable mechanism for reducing the cost of care. In addition, a public option should also enjoy reduced administrative costs compared to current employer plans due to economies of scale and simplification.

For employees, an employer public option thus offers the possibility of lower health care costs delivered by a less restricted network of providers. If cost savings of public over private coverage are preserved even in part, savings should in theory translate into wage growth and increased employment, since we know that rising

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<sup>88</sup> *Id.*

<sup>89</sup> Martin Gaynor, *Examining the Impact of Health Care Consolidation*, Statement before the Committee on Energy and Commerce Oversight and Investigations Subcommittee U.S. House of Representatives 8-9 (Feb. 14, 2018), <https://docs.house.gov/meetings/IF/IF02/20180214/106855/HHRG-115-IF02-Wstate-GaynorM-20180214.pdf> (last accessed Feb. 15, 2021).

<sup>90</sup> *Id.*

<sup>91</sup> Sebastian Herrera & David Benoit, *Why the Amazon, JPMorgan, Berkshire Venture Collapsed: ‘Health Care Was Too Big a Problem,’* WALL ST. J., Jan. 7, 2021 (“Despite Amazon, JPMorgan and Berkshire’s collective size, they lacked scale to garner enough negotiating power with care providers”).

<sup>92</sup> Gaynor, *supra* note 89, at 9.

<sup>93</sup> See, e.g., Robert A Berenson et al., *Unchecked Provider Clout In California Foreshadows Challenges To Health Reform*, 29 HEALTH AFF. 699, 702 (2010) (“‘Must-have’ hospitals, by definition, have market leverage over health plans, because plans cannot plausibly threaten to exclude them.”).

<sup>94</sup> *Id.*

health care costs have done the inverse.<sup>95</sup> Despite economic growth, wages have stagnated since the 1970s and many attribute that stagnation in part to health care cost growth that has well exceeded inflation.<sup>96</sup>

### **b. Expanded Coverage, Especially for Low-Wage Workers**

An employer public option also presents an opportunity to meaningfully expand coverage to the currently uninsured, through a combination of lowering prices and increasing the availability of subsidies. As just described, the cost of coverage should decrease under the public option through a combination of lower reimbursement rates and lowered administrative expenses, which should in turn increase the number of employees who elect offered coverage. In addition, an employer public option would provide an opportunity to expand the subsidies currently available to low- and moderate-income individuals who purchase coverage on the individual market.

There are currently twenty-six million employees who either are not offered coverage by their own firms or are offered and decline coverage.<sup>97</sup> In 2019, only 57.9 percent of employees at large firms enrolled in employer sponsored health insurance.<sup>98</sup> Roughly twenty percent of employees were ineligible for ESI because of waiting periods or part-time/temporary work status.<sup>99</sup> Of those eligible for insurance, only seventy-six percent elected to purchase it.<sup>100</sup> Many of those declining to take up ESI offers likely obtained coverage elsewhere (often under the health plan of another family member or through public programs like Medicaid), but some no doubt turned down the coverage because of the cost or other considerations.

According to recent research by the Commonwealth Fund, the composition of uninsured Americans has shifted dramatically since 2010 so that a larger portion are now working uninsured.<sup>101</sup> Back when the ACA was enacted, fifty percent of working-age uninsured Americans were unemployed. By 2018, as a result of the ACA's expansion of coverage, only thirty-eight percent of the working-age

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<sup>95</sup> Katherine Baicker and Amitabh Chandra, *The Labor Market Effects of Rising Health Insurance Premiums*, 24 J. LABOR ECON. 609 (2006), at <https://www.journals.uchicago.edu/doi/abs/10.1086/505049?mobileUi=0&>. There are no guarantees, of course, that cost savings will reach workers' pockets, especially in industries where the balance of power between labor and employers has become lopsided. Eventually as Medicare covers more or most of the population, we would hope that workers experience an increase in wages, but these offsets are difficult to explain to the public and not guaranteed, which made the transition to MFA more challenging politically. Some experts propose attempting to legislate the return of such savings into workers pockets, but guaranteeing they remain there in the long-run equilibrium would be difficult. See Emmanuel Saez & Gabriel Zucman, *We Can Afford Medicare For All*, POLITICO (Nov. 25, 2019), <https://www.politico.com/news/agenda/2019/11/25/agenda-can-we-afford-medicare-for-all-071560>.

<sup>96</sup> Mark J. Warshawsky & Andrew G. Biggs, *Income Inequality and Risking Health-Care Costs*, WALL ST. J., Oct. 6, 2014, at <https://www.wsj.com/articles/mark-warshawsky-and-andrew-biggs-income-inequality-and-rising-health-care-costs-1412568847?wpsrc=nl-wonkbk&wpmm=1>.

<sup>97</sup> KFF Employer Health Benefits 2020, *supra* note 13, at 58.

<sup>98</sup> *Id.*

<sup>99</sup> *Id.*

<sup>100</sup> *Id.*

<sup>101</sup> Munira Z. Gunja & Sarah R. Collins, *Who Are the Remaining Uninsured, and Why Do They Lack Coverage?*, THE COMMONWEALTH FUND (August 2019), at 11, [https://www.commonwealthfund.org/sites/default/files/2019-08/Gunja\\_who\\_are\\_remaining\\_uninsured\\_sb.pdf](https://www.commonwealthfund.org/sites/default/files/2019-08/Gunja_who_are_remaining_uninsured_sb.pdf).

uninsured were unemployed. In contrast, the share of the uninsured who work full time has increased from thirty percent in 2010 to forty-two percent in 2018, while the share of those who work part-time stayed constant at nineteen percent during this period. Thus, in 2018, over sixty percent of the uninsured were employed. While more work needs to be done to understand exactly who are the working uninsured, the studies of Medicaid-eligible workers offer evidence of the labor attributes of low-wage workers without employer coverage. Nearly half of this population work at firms with more than 100 employees,<sup>102</sup> with heavy concentrations in the service sector and agriculture.<sup>103</sup>

Subsidies offered through an employer public option could improve rates of coverage among the low-wage working population. Under the current system, employees who are offered affordable and adequate coverage are ineligible for the premium tax credits that are available for exchange-based individual coverage. Yet, for many the cost of their share of employer coverage—without subsidies—is unaffordable. An employer public option offers an attractive mechanism for rationalizing current subsidy design. Our subsidy proposal, detailed in the next subpart, envisions providing the same subsidies to participants in an employer public option as those that are provided on the individual market.

### **c. Addressing Churn and Portability**

An employer public option, particularly if widely adopted, could also help address other systemic issues, such as churn between employer-provided coverage and Medicaid, and the care disruptions that often occur when individuals switch employment or lose jobs. Rather than falling out of private insurance coverage as they do today, workers covered by a public option could more easily and seamlessly retain their health care coverage if unemployed or moving between jobs.

For example, if an employer public option is offered alongside an individual public option, an individual who loses employer-provided coverage could seamlessly switch to individual coverage at subsidized rates, if applicable. Similarly, the employer public option could be a Medicaid coverage option that allows low-income individuals to retain their employer-provided coverage even when their income dips to Medicaid-eligibility levels.

## **2. Ability to Test Transition to a Single-Payer System**

One of the most significant benefits offered by an employer public option is the ability to enroll in short order large numbers of participants – significantly more than one primarily for individuals, particularly if large employers are targeted.<sup>104</sup> If just a small number of major employers elected to participate, hundreds of thousands of households would transition to the public option, providing a meaningful

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<sup>102</sup> ARE UNINSURED ADULTS WHO COULD GAIN MEDICAID COVERAGE WORKING?, THE KAISER COMMISSION ON MEDICAID AND THE UNINSURED (Kaiser Family Foundation, Feb. 2015), *available at* <http://files.kff.org/attachment/fact-sheet-are-uninsured-adults-who-could-gain-medicaid-coverage-working>

<sup>103</sup> *Id.*; Jennifer Tolbert, *What Issues Will Uninsured People Face with Testing and Treatment for COVID-19?*, KAISER FAMILY FOUNDATION (March 16, 2020), <https://www.kff.org/uninsured/fact-sheet/what-issues-will-uninsured-people-face-with-testing-and-treatment-for-covid-19/>.

<sup>104</sup> Linda J. Blumberg et al., Health Policy Center, *Estimating the Impact of a Public Option or Capping Provider Payment Rates* (Mar. 2020), at <https://www.urban.org/sites/default/files/2020/03/23/estimating-the-impact-of-a-public-option-or-capping-provider-payment-rates.pdf>

opportunity to collect data and to test the feasibility of expanding Medicare over time. It would also allow refinement over time in cooperation with sophisticated private industry partners. If several major employers make the leap and it works, it might persuade others that the benefits of their siloed private plans are not worth maintaining.

## **B. Design Features of an Employer Public Option**

For an employer public option to be successful – both in terms of providing valuable coverage to employees and facilitating structural reform – it must be carefully designed. The design details will, of course, determine whether an employer public option is politically feasible and also whether employers, especially large employers, can be enticed to give up current private coverage for a public alternative.

This section explores the key design features that will be necessary to navigate carefully to create a plausible policy and a competitive plan. Although we do not intend to solve all of these details perfectly here, we mention several that we think are the most important and explain their significance. We also describe how we would approach these design choices, recognizing that many readers might have different preferences, but proceeding under the assumption that there is value in setting forth a concrete proposal.

### **1. Voluntary Structure**

Critically, there would be no mandatory change in employer health care plans, which was a political stumbling block for Medicare for All in the Democratic primaries and in many previous health care reform efforts. Participation would be entirely voluntary on the part of employers, and would be subject to the same labor market pressures and cost concerns that currently inform their health plan decision-making. Indeed, large employers are the most sophisticated health finance decision makers in our current system.<sup>105</sup> Individuals would almost certainly be more receptive to a public option if selected and offered by their employers than if imposed on them by the government. They might still resist the initial switch, but that transition could be managed.

This voluntary feature is critical for two reasons. First, it insulates the approach from criticism that it infringes upon individual autonomy or market forces. Employers will only adopt a public option plan if they conclude that is it in their best interest or in the best interest of their employees to do so. Second, a public option for employers structured in this way would reduce the budgetary impact of expanding public coverage, as compared with either Medicare for All or even leading public options programs focused on individuals. Current employer and employee contributions to employer-sponsored health insurance could be retained—

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<sup>105</sup> Of course, employers do not always get it right. Some of the best research illuminating how employees make poor choices was made possible by their employers offering what are called “dominated” health plans. These plans are worse in than an alternative option for all possible enrollees in all possible scenarios. No employee should choose such plans and no wise employer should have it on the menu of options. One of the most well-known of these studies was conducted at University of Michigan, which one might think would have a sophisticated HR department. Sinaiko & Hirth, *supra* note 57. But compared to individuals navigating options, many employers, especially large ones, would be able to identify a public option that is better than what they offer privately.

in whole or in part—to finance an employer-based public option. We review the budgetary treatment of a public option for employers in Part III, but, for current purposes, it is sufficient to note that, from a fiscal perspective, a public option for employers has considerable advantages over other approaches.

## 2. Target Market

At least as an initial matter, we think the best policy target would be large employers, especially employers with more than 1000 employees. This would enable a smooth roll out to a meaningful number of people in a streamlined way. It would also allow partnering with a few large employers to test and refine the idea to demonstrate effectiveness and to refine policy details in the initial years of implementation.

Roughly 61.2 million or 46.6% of all private sector employees in the United States are located in these larger firms, as are a comparable percentage of employees covered by employer sponsored health insurance.<sup>106</sup> But even more important than gross numbers is efficiency in distribution. There are approximately twelve thousand firms with more than 1000 employees in the United States, implying an average of roughly six thousand employees per firm.<sup>107</sup> By way of contrast, according to Census data from 2017, there are nearly six million U.S. firms with fewer than 50 employees and more than five million of these have fewer than 20 employees.<sup>108</sup>

Another advantage of focusing on larger employers is that nearly all of these firms already offer health insurance to their employees, likely making them more receptive to a solution that could improve upon their status quo. Importantly, these firms already have the health insurance expertise to make informed decisions in this area, either through their own human resources staff or outside benefit consultants. To the extent that an employer public option offers a strong value proposition, large employers should be well equipped to evaluate the relevant data.

## 3. Exclusivity Requirements

Although it is possible to do otherwise, we recommend employers have to opt either to retain their private plan or to move all employees to the public option. Exclusivity would maximize equity and diminish adverse selection concerns—that employers would try to encourage employees with greater medical needs to choose the public option.<sup>109</sup> An exclusivity requirement would also lessen the need for

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<sup>106</sup> See AGENCY FOR HEALTHCARE RESEARCH AND QUALITY, U.S. DEP'T OF HEALTH & HUM. SERV., MEDICAL EXPENDITURE PANEL SURVEY (2019), [https://meps.ahrq.gov/data\\_stats/summ\\_tables/insr/national/series\\_1/2019/tia1.pdf](https://meps.ahrq.gov/data_stats/summ_tables/insr/national/series_1/2019/tia1.pdf).

<sup>107</sup> The MEPS data cited in the preceding footnotes reports on establishments rather than firms, but BLS data indicates that the number of large firms is on the order of the twelve thousand figure cited in the text. See U.S. BUREAU OF LABOR STATISTICS, DISTRIBUTION OF PRIVATE SECTOR FIRMS BY SIZE CLASS, [https://www.bls.gov/web/cewbd/table\\_g.txt](https://www.bls.gov/web/cewbd/table_g.txt). These figures are substantially consistent with more comprehensive Census Department data for 2017, which reports on both firms and establishments. See UNITED STATES CENSUS BUREAU, 2017 SUSB ANNUAL DATA TABLES BY ESTABLISHMENT INDUSTRY (Mar. 2020), <https://www.census.gov/data/tables/2017/econ/susb/2017-susb-annual.html>.

<sup>108</sup> *Id.*

<sup>109</sup> Amy Monahan & Daniel Schwarcz, *Will Employers Undermine Health Care Reform by Dumping Sick Employees?*, 97 VA. L. REV. 125 (2011).

complexities associated with experience-based pricing and similar safeguards. It would prevent redoubling the problems with individual-level health plan decision-making, as discussed above.

On the other hand, many employers today offer a range of health care plan options and some employers – especially larger employers—regard the ability to provide gold-plated health care plans as important tool in attracting top talent. Unions, as well, may object to a strict exclusivity requirement as reducing the potential scope of collective bargaining agreements. Fewer employers may thus choose a public option if it is the only plan they can offer.

In the end, we think employers should be required to adopt the public option as an exclusive base health care plan for all employees,<sup>110</sup> but could offer supplemental policies with more extensive benefits for all or some of their workforce, including, for example, those covered by collective bargaining agreements.

#### 4. Pricing and Financing of a Public Option Plan

The financial terms of the public option can benefit both employers and employees. An important question is how much of what is currently used to finance employer-sponsored health insurance could and should be captured to finance an employer-based public option. According to 2020 data, the average total annual premium for employer-provided health care coverage was \$21,342 for family coverage and \$7470 for single coverage.<sup>111</sup> On average, workers picked up eighteen percent of the premium for single coverage and thirty percent for family coverage. Plan details, of course, vary considerably across employers, with larger employers generally offering more generous benefits than smaller employers. Current cost structures could serve as a pricing benchmark and something close to current premiums for private insurance plans could potentially be available to finance an employer public option.

Although it is possible to use experience-based pricing—that is, pricing adjusted over time by employer based on its employees’ medical care costs—doing so would cut squarely against coverage and equity goals. Experience based pricing is consistent with current practices as most large employers (79.9%) self-insure their health care coverage,<sup>112</sup> and fully-insured policies for large employers are generally experience rated.<sup>113</sup> That said, if one goal is to encourage employers to adopt a

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<sup>110</sup> For current purposes, we leave to the side questions as to how define the boundaries of an employer in the case of affiliate firms or those organized as conglomerates engaged in substantially different lines of business.

<sup>111</sup> KFF Employer Health Benefits 2020, *supra* note 13, at 6.

<sup>112</sup> Authors calculations from [https://meps.ahrq.gov/data\\_stats/summ\\_tables/insr/national/series\\_1/2019/tia1.pdf](https://meps.ahrq.gov/data_stats/summ_tables/insr/national/series_1/2019/tia1.pdf) (Table I.A.2.a).

<sup>113</sup> Questions of experience rating interact with those addressed just below on whether employers must move all employees over to a public option, or are allowed to offer other plans as well. If the latter, experience rating may be advisable to combat employer sorting among plan choices. Among small employers, most only offer one plan, which eliminates concerns of employee sorting if that plan becomes the public option. Only 32.9% of employers with fewer than 50 employees have two or more plans. Authors calculations from [https://meps.ahrq.gov/data\\_stats/summ\\_tables/insr/national/series\\_1/2019/tia1.pdf](https://meps.ahrq.gov/data_stats/summ_tables/insr/national/series_1/2019/tia1.pdf) (Table I.A.2.d). On the other hand, a very high percentage – 88.2% -- of employers with more than 1000 employees offer two or more health care plans. *Id.*

public option for lower-wage workers with more costly health care needs, experience-rating would undermine that goal.<sup>114</sup>

### **5. Contributions from Employers & Employees**

Whatever the premiums in the public option plan, attention should also be given to how those costs are shared between employers and employees. Employer sponsored plans currently require different levels of employee contributions. One could imagine a public option for employers imposing a standard sharing arrangement for all participating employers (say, a 70/30 split that reflects something close to current practices for family coverage) or allowing employers to continue with whatever sharing arrangement they currently have with employees, or a transitional approach where employers are allowed to stay with current practices for some period of time, but gradually moving to a uniform approach.

Especially to the extent that a public option reduces costs of employer sponsored coverage, employers might attempt to capture that savings. Accordingly, some safeguards could ensure that premium sharing between employers and employees not be altered to redistribute the cost of health care coverage. While various approaches could work, one simple approach would be to require employers already providing ESI to maintain the current division of employer-employee contributions for some period of years. Employers offering ESI for the first time could be required to adopt industry average contribution rates, such as a 70/30 split. This approach would tolerate differences in employer-employee contributions among employers at least through some transitional period, but would ensure that employees share in any costs savings on overall premium payments.<sup>115</sup> Another approach, and the one we adopt for purposes of our subsidy proposal below, is to impose a fixed contribution percentage for all employers.

### **6. Incorporating ACA Subsidies**

To maximize enrollment of low-income workers, there is potential to incorporate ACA subsidies into employer coverage. While adding to fiscal costs, this feature might contribute substantially to the number of workers covered by an employer public option, especially among those who currently decline enrollment in

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<sup>114</sup> For employers with low-income and less-healthy workforces, experience-based pricing could disincentivize selecting an employer public option. In this context, pricing that is blind to employee health status could be seen as a positive rather than a negative because employees in greater need of medical care and less able to afford it will gain access. Cf. Deborah Stone, *Beyond Moral Hazard: Insurance as Moral Opportunity* in *EMBRACING RISK: THE CHANGING CULTURE OF INSURANCE AND RESPONSIBILITY* (Tom Baker & Jonathan Simon eds., 2002) (describing how increased use of medical care with insurance might indeed be a good thing since it could mean that people who previously needed care but did not receive it are able to do so without insurance). It might give employers with a less healthy workforce more chance to operate without shouldering an excessive share of health care costs of American workers. It might mean those workers get better benefits than they would otherwise. And it might mean that lower-paid workers are able to get better healthcare without seeing their wages stagnate. Plus, it might make sense that part of the cost of keeping higher-risk workforces healthy should be cross-subsidized.

<sup>115</sup> On this dimension, we diverge from proposals that anchor public option costs for employers to current premium levels, and anchor instead on current allocations of premium costs. We contemplate uniform pricing of public option plans for employers, with potential experience adjustments.

ESI for financial reasons or whom employers predict would do so and thus exclude from coverage.<sup>116</sup>

The ACA addressed the unaffordability of privately-financed coverage in two ways, through premium tax credits and cost-sharing subsidies. Premium costs for individual insurance policies purchased on ACA exchanges are subsidized for individuals with household income between 100% and 400% of the federal poverty level through refundable tax credits. These subsidies cover the difference between a specified percentage of household income and the cost of the “benchmark plan” available to the individual, on a sliding scale.<sup>117</sup> Individuals who are offered employer coverage that is considered affordable and adequate by the ACA are not, however, eligible for these subsidies. In effect this means that people offered coverage through work are rarely eligible for subsidies.

Even worse, the definition of what is “affordable” coverage under the ACA puts many families at a sharp disadvantage when a member of the family is offered coverage at work. The ACA provides that employer coverage is “affordable” when an employee’s required contribution is less than 9.78% of household income,<sup>118</sup> and adequate if the actuarial value of the plan is at least 60%. Regulations, however, base the affordability calculation solely on the required contribution for employee-only coverage, even if the employee desires family coverage.<sup>119</sup> For example, assume an employee is married with two minor children and has household income of \$65,500 per year. Her employer offers her health insurance where the required contribution for employee-only coverage is \$5,000, while the contribution for family coverage is \$10,000. Because the contribution for employee-only coverage is equal to 7.6% of the employee’s household income, the ACA deems that coverage affordable, even though family coverage would cost 15.3% of household income. Because the family is deemed to have “affordable” employer coverage under this test, no one in the family may receive a premium tax credit on the individual market. If this same family had not been offered employer coverage at all, they would have been eligible for a tax credit that would allow them to purchase subsidized silver-level coverage for the entire family with a household required contribution of \$5,456 annually.<sup>120</sup> As this example known as the “family glitch” illustrates, under the current system, individuals can be made *worse off* by being offered employer-

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<sup>116</sup> As ineligible workers are typically lower-paid, many employers may have rationally concluded that many of these individuals would not wish to participate in an employer-sponsored health care plan. But this calculation might change if ACA-style subsidies were available.

<sup>117</sup> I.R.C. § 36B. The benchmark plan is the second lowest-cost silver level plan available to the individual. *Id.* §36B(b)(3)(B). For example, an individual with household income equal to 150% of the federal poverty level would receive a credit equal to the difference between 4.12% of household income and the cost of the benchmark plan, while an individual with household income of 375% of federal poverty receives a credit equal to the difference between 9.78% of income and the cost of the benchmark plan. *See* Rev. Proc. 2019-29.

<sup>118</sup> The statute sets affordability at 9.5% of income, subject to future annual adjustments based on growth in income and growth in premiums. For 2020, affordability is set at 9.78% of income. Rev. Proc. 2019-29. Note that this calculation does not account for the part of health care costs that the employer funds. So with a typical 70/30 employer/employee split, affordability is measured only with respect to 30 percent employee contribution.

<sup>119</sup> Treas. Reg. §1.36B-2(c)(3)(v)(A)(1).

<sup>120</sup> This amount was calculated using an income of \$65,500 for a family of four, which is equal to 250% of the federal poverty level for 2021, and a resulting premium tax credit equal to the difference between the cost of silver coverage and 8.33% of income.

provided coverage because it causes them to lose premium subsidies that would otherwise be available to them based on their income level.

The second ACA mechanism to address the problem of unaffordability is cost-sharing subsidies that lower the out-of-pocket costs of receiving care once insured. These cost-sharing subsidies are available to individuals with household income between 100% and 250% of the federal poverty level, but only if they purchase silver-level coverage on an exchange.<sup>121</sup> As with the premium tax credits just described, these subsidies are unavailable to low- and moderate-income individuals who are offered affordable and adequate coverage by an employer. Because of this limitation on eligibility, low- and moderate-income individuals again may be made financially worse off by an offer of employer-provided coverage. The cost-sharing subsidies require insurers to lower out-of-pocket maximums<sup>122</sup> and increase the percentage of covered expenses on average paid by the insurer from the 70% generally required for silver-level coverage to at least 73% and in some cases as high as 94%. The threshold for “adequate” employer coverage, by contrast, requires the plan to pay, on average, only 60% of covered expenses. It is therefore possible that a low-income employee offered coverage by an employer could both pay more in health insurance premiums and receive much less generous coverage than would be available if the employer offered no coverage at all.

An employer public option presents an attractive mechanism to help address the shortcomings and distortions present in these two affordability tools. Specifically, the public option could provide premium subsidies that are consistent with those offered on the individual market and could feasibly calculate and implement the required employee contributions. In addition, the public option could vary cost-sharing schedules by income. For example, the public option might specify that individuals with income at or below 150% of federal poverty pay a \$5 copay for an office visit, moderate income enrollees pay \$15, and everyone else pays \$25. Implementing income-based cost-sharing schedules on the scale of a public option is much more efficient than every employer trying to do so.

While cost-sharing subsidies are relatively straight forward, premium subsidies are less so, and are worth a bit more discussion. There are many possible subsidy designs that could be implemented in conjunction with an employer public option, but we envision an approach that smooths subsidy design between employer and individually purchased coverage and allows employers a simplified method of satisfying the existing employer mandate. We present here one possible approach with these goals in mind.

In order to ensure that employer money stays in the system, the public option could specify a minimum required employer contribution percentage for all coverage tiers (employee-only, employee plus spouse, and family coverage, for

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<sup>121</sup> These cost-sharing subsidies are complicated because they require the insurer to reduce cost sharing to increase the actuarial value of the plan from 70% to between 73% and 94% for the individual, depending on income. It is up to the insurer how to adjust deductibles, coinsurance, and copays to hit the required actuarial values for the various income tiers.

<sup>122</sup> Individual marketplace plans can have an out-of-pocket maximum no higher than \$8,550 for individual coverage in 2021. Out-of-pocket maximums for those eligible for cost-sharing reductions can be no higher than \$2,850 to \$6,800 for an individual. Similar reductions apply to family level coverage.

example).<sup>123</sup> While setting a flat employer contribution percentage of, say, 70% of the cost of coverage—based on the average employer share of a family plan—may not perfectly capture existing employer contributions, it could likely get close in the aggregate and has the benefit of treating all employers equally. To prevent distortion between individual and employer market subsidies, we assume the same subsidy amount and structure would be available to employer public option participants as those in the individual market, with the public option calculating the available premium subsidies for potentially eligible participants, as the exchanges currently do for individually-purchased coverage. If premium subsidies continue to be based on the percentage of household income a family is required to pay for health insurance, the public option could gather the requisite income information and inform the employer of the required employee contribution amounts so that each eligible employee's payroll deduction reflects the subsidized cost of public option coverage. If the employee's household income is low, the federal subsidies might fully cover the employee's contribution and then could be applied to subsidize part of the employer's share as well, to create additional incentives for employers to extend coverage to their low-income employees. As with the current individual market subsidies, final subsidy amounts could be reconciled when an employee files his or her tax return for the year. Finally, because the current employer mandate is based on whether the employer offers full-time employees affordable coverage, employers participating in the public option could be deemed to satisfy the employer mandate without having to engage in any complicated calculations.<sup>124</sup>

Addressing the current shortcomings of the ACA's affordability tools through an employer public option has advantages over addressing them through either an individual public option or the current employer-based system. One frequently proposed solution to the subsidy problem is to change eligibility provisions so that anyone eligible on the basis of income can purchase a subsidized marketplace plan, irrespective of any available employer-provided coverage.<sup>125</sup> But that approach fails to capture current employer health care contributions, placing more burden on the government to fund the cost of coverage if someone opts for individual coverage and out of an employer plan. It also places a significant burden on low-income individuals, who must learn of individual market subsidies, decide if they are better off with those subsidies and an ACA plan versus employer subsidies and an ESI plan, and purchase such coverage. Harnessing the ability of employers, particularly large employers, to educate employees, facilitate enrollment, and subsidize coverage

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<sup>123</sup> As mentioned earlier, there may be value in allowing employers currently providing employer sponsored insurance to transition from current cost sharing arrangements to the fixed percentages assumed in the text. For simplicity, the example given above assumes uniform cost-sharing arrangements.

<sup>124</sup> While deeming the employer mandate satisfied is a straightforward regulatory simplification where the employer allows all employees to elect the public option, a more nuanced approach might be warranted where only certain employee segments are able to participate.

<sup>125</sup> Vice President Biden has proposed this type of universal subsidy availability, in addition to other changes to subsidy amounts and income limits. Cynthia Cox et al., Kaiser Family Foundation, *Affordability in the ACA Marketplace Under a Proposal Like Joe Biden's Health Plan*, at <https://www.kff.org/health-reform/issue-brief/affordability-in-the-aca-marketplace-under-a-proposal-like-joe-bidens-health-plan/> (In addition, Biden would allow workers with an offer of job-based coverage to enroll in Marketplace plans with subsidies if that would be a better deal. Under current law, employees qualify for Marketplace subsidies only if their employer's plan is deemed unaffordable or does not satisfy minimum coverage requirements.)(2020).

offers distinct advantages over solutions that rely on individual initiative. In addition, because large employers could add significant numbers of public option enrollees compared to an individually-focused solution, the problem of Medicaid churn could be much more broadly addressed.

It is even less plausible to address the current shortcomings through existing employer plans. Doing so would be difficult for a host of reasons, including the lack of standardization among employer plans and the need to have a sophisticated interface between employers and the government to advance premium tax credits. How would the government determine the correct level of subsidy, for example, if employer plans can differ fundamentally in their coverage terms and generosity? While income-based cost-sharing could perhaps be implemented within the current employer system, doing so would involve significant duplication of effort across thousands of plans.

To be clear, our proposed solutions do not address the universe of distortions and inequities caused by the current tax treatment of health insurance and medical expenses. While there are many, the best known and most expensive is the tax preference for employer-provided coverage, which is one of our largest tax expenditures, resulting in an estimated \$179.2 billion of forgone revenue in fiscal year 2021.<sup>126</sup> Because this subsidy takes the form of an exclusion from otherwise taxable income, the value of the subsidy varies with an individual's marginal tax rate, with the result that those in the highest tax brackets receive the greatest benefit (a structure commonly referred to in the tax literature as an "upside down" subsidy). Although we do not propose to take on this long-standing and long-criticized tax benefit as part of our public option proposal, we note that rationalizing premium tax credits and cost-sharing subsidies between the employer and individual markets would at least help offset the upside-down nature of other tax benefits for employer-provided coverage.

## 7. Network and Reimbursement Rates

A singular advantage the public option could have over existing employer plans is the ability to offer a broad, unrestricted provider network.<sup>127</sup> When Americans espouse their allegiance to health care choice, many likely care more about their choice of doctor than their choice of insurance plan. Most hospitals and many doctors accept reimbursement from Medicare, which means that someone who has

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<sup>126</sup> JOINT COMMITTEE ON TAXATION, ESTIMATE OF FEDERAL TAX EXPENDITURES FOR FISCAL YEARS 2020-2024 33(2020). By comparison, the cost of current exchange-based subsidies for health insurance is estimated to be 55.1 billion in fiscal year 2020. *Id.*

<sup>127</sup> A major political and technocratic question is whether the public option is based on traditional Medicare, which has an open network, or Medicare Advantage, Medicare plans operated by private insurers on behalf of Medicare that control costs in large part through narrow networks, like an HMO. While basing a public option on Medicare Advantage would be more appealing to the insurance industry because it would guarantee them a more substantive role in the future of health insurance, and greater excuse for retaining profits, enrollees might be worse off, certainly in terms of network and in other regards as well. See Amanda Starc, *Who Benefits from Medicare Advantage?* WHARTON PUBLIC POLICY INITIATIVE 1 (2014). See also CMA Staff, *CMA Alert*. CENTER FOR MEDICARE ADVOCACY (2017) (discussing gatekeeping requirements in MA plans for specialty care). The Unity Task Force has proposed an individual public option based on traditional Medicare, not Medicare Advantage, but the space between what is on the page in that proposal and what is feasible in Congress might prove formidable. Press Release, JoeBiden.com, Biden-Sanders Unity Task Force Recommendations 31 (Aug. 2020), at <https://joebiden.com/wp-content/uploads/2020/08/UNITY-TASK-FORCE-RECOMMENDATIONS.pdf>.

a public option based on Medicare—so long as provider participation is tied to Medicare participation—would have a broad choice of providers. Even though many employer plans have relatively broad networks, it is possible that as employers continue to work to control health care spending, more may turn to narrow networks, as the ACA individual plans have done. Even compared to the current baseline in employer plans, a shift to a public option will increase provider choice for many employees.

In the short term, however, some people may lose access to a provider who participates in their private plan but not in Medicare. Over time, if more large employers selected the public option, more and more providers would be forced to accept it for reimbursement, but that tipping point could take time.

One of the most complicated aspects of this proposal is how to set reimbursement rates to preserve and ensure a wide provider network. Although we do not begin to solve this aspect here, we note why we think it is feasible to move to a system with reimbursement based on and closer to Medicare rates than to private insurance rates. As noted above, providers participate in large numbers in the Medicare program both because of the volume benefits and because evidence suggests that Medicare rates were, until recently, sufficient that efficient hospitals could profit based on them.<sup>128</sup> In recent years, the rates have dipped slightly below break-even, but would require very little upward adjustment to enable profitability.<sup>129</sup> Reimbursement rates could be marked up considerably over Medicare rates to ensure adequate provider participation, while still offering cost savings as compared to current private reimbursement rates.

Over time, rates could be adjusted to ensure provider participation, especially by providers who are important to the large employer market. While a relatively modest transfer of employer-sponsored plan enrollment over to a public option with rates close to current Medicare reimbursement rates would not have a significant impact on hospital revenues, more substantial movements of coverage would. With such revenue decreases, even if many providers could operate more efficiently and maintain profitability, plan design would have to account for what levels of decreases are manageable operationally and, perhaps more important, politically. Employer-based public option plans could have a formula for reimbursement increases over time as the market share of those plans increased. Given existing inefficiencies, margins would not need to be fully equalized, but finding the right level of reimbursement that will maintain provider supply and trim spending will be one of the hardest aspects of this or any rate-based reform.

## **8. Benefits and Cost Sharing**

An employer public option needs to offer benefits that are comparable to the average large employer plan in order to viably compete with such plans. Even if using Medicare as a starting point, it would have to be modified somewhat for a working population and could be simplified as well. If rolled out in legislation that also creates a public option for the individual markets, the two programs should be

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<sup>128</sup> Lopez et al., *supra* note 85.

<sup>129</sup> *Id.*

aligned, both as a matter of equity and also to facilitate transitions between the two forms of public option when people face changing employment status.<sup>130</sup>

A public option for employers should, at a minimum, cover the treatments and services typically covered by typical large employer plans.<sup>131</sup> This was the same proxy used for setting essential health benefits for plans offered in the individual and small group markets.<sup>132</sup> While the employer public option may need a modest augmentation to include treatments and services that are not now covered by Medicare but are by employer plans, it should largely follow Medicare Coverage Determinations that determine when certain treatments are covered, based on what is considered reasonable and necessary, so as to not unnecessarily duplicate efforts.

Cost-sharing should be determined under the same principles. Medicare's complicated cost-sharing provisions that result in many enrollees purchasing supplemental coverage need not serve as the guide for the employer public option in the same way that it would not for an individual public option (and perhaps should be revisited for Medicare as well in the future).

Cost-sharing has at least two different components. The first is the overall level of cost-sharing within a plan, referred to as the plan's actuarial value. A plan's actuarial value represents the percentage of covered expenses paid by the plan for an average population. Among large employer plans, almost one-quarter have actuarial values in excess of 90%, with an average actuarial value above 80%.<sup>133</sup>

The second component is the cost-sharing design, which refers to how cost-sharing requirements are allocated among particular types of care or points of service. For example, will there be an annual deductible, or just co-pays and co-insurance? Will the copay for a specialist be higher than the copay for a general practitioner? Will treatments with a higher value be subject to lower cost-sharing requirements than those of lower value? Mapping these features to an employer plan benchmark is more difficult than overall actuarial value because there is significant variation among plans, and that variation is often based on plan type (e.g., an HMO is less likely to have an annual deductible than a PPO plan). The public option may present an opportunity to simplify cost-sharing based on the growing research that most people do not understand or act according to the complex financial incentives embedded in their plan structures.<sup>134</sup>

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<sup>130</sup> As discussed below, this alignment is especially important for gig economy workers who repeatedly transition between traditional employment and self-employment. See Part II.B.10, *infra*.

<sup>131</sup> For an overview of the benefits typically offered by large employer plans, see DEP'T OF LABOR, *supra* note **Error! Bookmark not defined.** (while it can be difficult to determine the precise contours of coverage under employer plans, most cover a broad range of medical services with substantial differences only in a few areas).

<sup>132</sup> 42 U.S.C. §18022.

<sup>133</sup> See Jon R. Gabel et al., *More Than Half of Individual Health Plans Offer Coverage that Falls Short of What Can be Sold Through Exchanges as of 2014*, 31 HEALTH AFF. 1339, 1342 (2012) (finding 41.2% of employer plans had actuarial values between 80 and 89%, while 23.9% had actuarial values that exceeded 90%).

<sup>134</sup> See e.g., Michael Chernew et al., *Are Health Care Services Shoppable? Evidence from the Consumption of Lower Limb MRI Scans*, NBER Paper No. 24869, at [https://www.nber.org/system/files/working\\_papers/w24869/w24869.pdf](https://www.nber.org/system/files/working_papers/w24869/w24869.pdf); Mary E. Reed et al., *In Consumer-Directed Health Plans, A Majority of Patients were Unaware of Free or Low-Cost Preventive Care*, 31 HEALTH AFF. 2641 (2012) (finding that a majority of enrollees were unaware that the deductible did not apply to certain high-value care, such as preventive office visits, medical tests, and screenings).

While mirroring the existing norms in the large employer market is likely a necessary condition to generate employer participation, there is also a case to be made for structuring the public option to be simpler than the norm, both in order to encourage participation and also to alleviate some of the burden employees have borne with recent increases in cost-sharing requirements.<sup>135</sup> That said, it might be unrealistic to expect an employer public option to be as generous as some of the best employer plans are today, but employers could choose to fill in the gaps through supplemental coverage or by increasing wages.

### **9. Communicating Benefits to Employees (and Employers)**

While it is important that the public option offer comparable benefits, it is just as important that those benefits be easily communicated to employees. Employees are much more likely to resist a plan change that they do not understand, and health plans are notoriously difficult for individuals to understand. Time and effort should be invested in the communications explaining the public option, and should include not only explanations of common coverage situations, but also a comparison to their current employer plan options. The ability to rely on employers as translators of the public option benefits is a major advantage as compared to an individual public option.

### **10. Designing for Portability and Integrating with Medicaid**

An employer public option could be designed to address two common issues in the current employer-based system: coverage disruptions that result from job change or job loss, and churn between employer-provided coverage and Medicaid.

Medicaid expansion, enacted by the ACA, was intended to provide universal coverage to families at or below 138% of the federal poverty level.<sup>136</sup> In those states that have elected to participate in the Medicaid expansion, the coverage is typically provided at very low or no cost to participants. Because eligibility to participate is tied to household income, many individuals churn between Medicaid eligibility and employer coverage, even within a single year, as wages and hours change. This churn is not only inefficient, but has been shown to result in significant care disruptions.<sup>137</sup>

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<sup>135</sup> As health care costs have outpaced inflation over the past several decades, many employers have managed this increase by moving employees onto high deductible health plans where they pay a higher share of medical care costs. From 2005 to 2020, the share of large firms offering a high-deductible health plan increased from 8% to 67% and the number of enrollees in such plans increased from 3% in 2006 to 33% in 2020. KFF Employer Health Benefits 2020, *supra* note 13, §8, Fig. 8.2 and 8.4.

<sup>136</sup> States, however, are not obligated to participate in this Medicaid expansion, and currently fourteen states leave this population uncovered. This expanded Medicaid coverage under the ACA is almost entirely funded by the federal government with very limited out of pocket expense for beneficiaries.

<sup>137</sup> Many individuals with low income cycle between employer-provided coverage and Medicaid as their income and therefore eligibility fluctuates throughout a year, in a process commonly referred to as “churn.” One study estimated that as many as half of adults with income below 200% of federal poverty will move between Medicaid and individual market subsidies in a given year, Benjamin D. Sommer & Sara Rosenbaum, *Issues in Health Reform: How Changes in Eligibility May Move Millions Back and Forth Between Medicaid and Insurance Exchanges*, 30 HEALTH AFF. 228 (2011), while a more recent study found that, in states that had expanded Medicaid, 13.7% of individuals with Medicaid coverage faced a coverage disruption over the course of a year. Anna L. Goldman & Benjamin D. Sommers, *Among Low-Income Adults Enrolled in Medicaid, Churning Decreased After the Affordable Care Act*, 39 HEALTH AFF. 85 (2020). In states that had not expanded Medicaid, 23.8% of Medicaid

An employer public option could improve continuity of coverage for low-income workers who currently churn between Medicaid and employer-provided coverage by specifying that the public option qualifies as Medicaid expansion coverage. If an employed individual's projected income falls below 138% of federal poverty, the individual and the employer would cease contributing to the cost of coverage, with the Medicaid program paying the full premium for the public option instead, enabling continuity of coverage through the employer plan. Reducing churn would dramatically reduce care disruptions for individuals who frequently change employment or whose income varies in an hourly job. As with premium tax credits and cost-sharing subsidies, addressing Medicaid churn through an employer public option provides a solution that private employer plans could not, because we could not, without further regulation, ensure that private employer plans offer the benefits and cost-sharing structures that would be appropriate for a Medicaid expansion population.

With respect to care disruptions caused by changes in employment, the employer public option again provides some unique solutions. The easiest scenario is for an employee who leaves one employer who has selected the public option to another who has also done so. This would be the ideal seamless transition between jobs with no change in benefits or network. What is less obvious is how to manage continuous coverage for individuals who leave a job and remain unemployed or begin work in one of the increasing number of gig-economy jobs without coverage. Ideally, an individual public option would be implemented alongside the employer public option, and they would offer identical or nearly-identical coverage and networks. If that were the case, an individual losing coverage through the employer public option could shift to the individual market public option, with relevant subsidies, and not face any care disruptions. The ability to move from employer coverage to nearly identical individual coverage at subsidized rates would offer a substantial improvement over the current system, which often results in dramatic shifts in coverage and providers for affected individuals, not to mention the sheer difficulty of navigating the relevant choices following a loss of job-based coverage.

## 11. Regulatory Relief

While employers play an important role in providing health insurance coverage to 154 million Americans,<sup>138</sup> they do so at a significant cost. As detailed in Part I.C.2, employers must navigate complex legal requirements and make significant financial and health policy decisions when offering a health plan to employees. A public option for employers offers the possibility of greatly simplifying the employer experience.

A key feature of a public option for employers should be to shift from the employer to the public option nearly all administrative tasks and legal responsibilities. In order to accomplish this simplified employer experience, ERISA

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recipients faced disruption. Churning is obviously inefficient, but it has also been shown to result in delayed medical care, lower utilization of preventive care, fewer prescription refills, and increased emergency department visits. *Id.*

<sup>138</sup> Kaiser Family Found., Health Insurance Coverage of Non-Elderly 0-64, <https://www.kff.org/other/state-indicator/nonelderly-0-64/?dataView=1&currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>.

should be amended to provide that employer participation in the public option does not create an employee benefit plan for purposes of ERISA, thereby relieving employers of all ERISA obligations with respect to public option participation. Once an employer elects to participate in the public option, its main responsibilities should be limited to facilitating employee enrollment, processing payroll contributions, and transmitting enrollment information to the public option. The public option would be responsible for reporting and disclosure, claims administration and appeals, and pursuit of reimbursement claims.

### C. Potential Interest in an Employer Public Option

Large employers may have the least incentive to move away from the status quo because—while burdensome—the coverage they provide is generous and highly valued by employees. Small employers would in many ways be a more obvious target for public option participation, given their well-known struggles to offer quality coverage at a competitive cost, but even a high level of participation by small firms is unlikely to generate meaningful public option enrollment since nearly three-quarters of workers are at large firms.<sup>139</sup> That said, there is reason to believe that some large employers might welcome the opportunity to relinquish the burden of running a mini health care operation with escalating costs, if there were a good enough alternative.

It is difficult to predict how employers of any size are likely to react to the availability of a public option, but it seems as if interest may be brewing.<sup>140</sup> There is significant evidence that small employers would in theory be amenable to Medicare opt in, but less evidence on large employers. One survey found that 64% of employers were interested in considering a simplified health plan design rather than the custom solutions created by many large firms, suggesting that a public option may appeal to those craving simplicity.<sup>141</sup> Another survey, conducted of companies mostly with 1,000 or more employees, reported that 34% indicated a Medicare public option could be a helpful reform, even if a majority were resistant to Medicare for All.<sup>142</sup> Recent polling by Data for Progress suggests a majority of likely voters supports an employer public option, which could influence employer receptivity.<sup>143</sup>

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<sup>139</sup> AGENCY FOR HEALTHCARE RESEARCH AND QUALITY, U.S. DEP'T OF HEALTH & HUM. SERV., MEDICAL EXPENDITURE PANEL SURVEY (2018), [https://www.meps.ahrq.gov/data\\_stats/summ\\_tables/insr/national/series\\_1/2019/tib1.pdf](https://www.meps.ahrq.gov/data_stats/summ_tables/insr/national/series_1/2019/tib1.pdf) (reporting 96 million works at firms with 50 or more employees out of 131 million total workers, or about 73%)

<sup>140</sup> See, e.g., Susannah Luthi, *Why Employers Are Flirting with the Public Option*, POLITICO (Feb. 8, 2020, 8:17 AM), <https://www.politico.com/news/2020/02/08/employers-health-care-public-option-112380>; Phil Galewitz, *Why Some CEOs Figure 'Medicare for All' is Good for Business*, KAISER HEALTH NEWS (June 7, 2019), <https://khn.org/news/a-large-employer-frames-the-medicare-for-all-debate/>.

<sup>141</sup> JEFFREY C. MCGUINNESS, AMERICAN HEALTH POLICY INSTITUTE, CHANGING ATTITUDES AMONG LARGE EMPLOYERS TOWARDS HEALTH CARE DELIVERY 9 (2017), [http://www.americanhealthpolicy.org/Content/documents/resources/Employer\\_Attitudes\\_Towards\\_HC\\_Delivery.pdf](http://www.americanhealthpolicy.org/Content/documents/resources/Employer_Attitudes_Towards_HC_Delivery.pdf).

<sup>142</sup> *Pulse of the Purchaser: Views on Affordability and Health Reforms*, NATIONAL ALLIANCE OF HEALTHCARE PURCHASER COALITIONS, <https://www.nationalalliancehealth.org/www/resources-new/pulse-of-the-purchaser> (last updated Feb. 2020).

<sup>143</sup> ETHAN WINTER AND JACOB S. HACKER, DATA FOR PROGRESS, VOTERS SUPPORT A PUBLIC OPTION FOR HEALTH INSURANCE 8 (October 2020), at <https://filesforprogress.org/memos/a-public-option-for-health-insurance.pdf>.

These polls are far from an accurate measure of demand, yet, conceptually even large employers might be inclined to consider a public option, especially with the right policy design and incentives. Over the past several decades as health care cost growth has exceeded inflation and legal compliance costs have increased, managing a health plan has become increasingly burdensome. Many large employers have had to redesign plans several times to deal with these costs increases, shuffling cost increases onto employees in the form of larger cost sharing, which can strain relationships with employees.

As illustration of employer frustration with the status quo, some of the largest employers—Amazon, Berkshire Hathaway, and JPMorgan Chase—joined forces to create a new venture, Haven Healthcare to attempt to fundamentally restructure how their collective employees get healthcare. They recruited Atul Gawande, a leading voice on healthcare innovation to run Haven.<sup>144</sup> Then, after a short period in this role, Gawande stepped back in May 2020, and the chief operating officer stepped down after nine months, suggesting some hurdles.<sup>145</sup> In January 2021, the whole enterprise folded.<sup>146</sup> Likewise, Walmart created Care Clinics for its employees that it is now rolling out to the broader public, whose impact remains to be seen.<sup>147</sup> Employers increasingly want better than the status quo, and most will struggle to invent it themselves.

If only a few large employers were to move their employees into a public option, it could create a cascading effect. The top twenty largest employers in 2018, including Walmart, Amazon, UPS, Kroger, Home Depot, alone employed on the order of ten million people.<sup>148</sup> If even just a few of them were to offer public coverage for employees and their dependents, the number of enrollees would add up quickly and would generate a strong incentive for regulators to focus attention on getting programmatic details right. Those early adopters could be partners to help monitor and refine the program in the first years.

A public option program could be designed with incentives to encourage large businesses to be early adopters to counterbalance inertial effects. For example, as discussed in Part II, participating employers would need to contribute to financing the public option. There could be lower contribution rates for employers who opt-in during the initial years, increasing every year thereafter up to a maximum amount.

Businesses that have not selected the public option might worry that the public plan with provider reimbursement closer to Medicare rates would translate into cost shifting onto them, where providers charge higher prices for private plans. Evidence suggests that such practices are possible, at least in some regions where providers

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<sup>144</sup> Atul Gawande, *A Message from Our Chairman*, HAVEN HEALTH CARE, <https://havenhealthcare.com/> [https://perma.cc/TLP5-T4FR] (last visited Dec. 23, 2020).

<sup>145</sup> Alia Paavola, *Haven Sees Exodus of Execs: 8 Things to Know*, BECKER'S HOSPITAL REVIEW (August 6, 2020), <https://www.beckershospitalreview.com/hospital-management-administration/haven-sees-exodus-of-execs-8-things-to-know.html>.

<sup>146</sup> Sebastian Herrera & Kimberly Chin, *Amazon, Berkshire Hathaway, JPMorgan End Health-Care Venture Haven*, WALL ST. J., Jan. 4, 2021.

<sup>147</sup> Elise Reuter, *Walmart Divulges Plans for 'Healthcare Supercenters'*, MEDCITYNEWS (Jun. 28, 2020), <https://medcitynews.com/2020/06/walmart-divulges-plans-for-healthcare-supercenters/>.

<sup>148</sup> [https://en.wikipedia.org/wiki/List\\_of\\_largest\\_United\\_States%E2%80%93based\\_employers\\_globally](https://en.wikipedia.org/wiki/List_of_largest_United_States%E2%80%93based_employers_globally).

have outsized bargaining power and seek to recapture any lost revenue when some share of their patient population shifts to a lower-reimbursing public option.<sup>149</sup> While this might cause employer opposition initially, it might also lead to the ultimate success of an employer public option as increasing numbers of employers decide the public option offers a viable mechanism for controlling costs.

The ACA likewise offers some reason to be circumspect about enthusiasm for plans to displace existing private employer coverage. As we saw with the small business health options program (“SHOP”) established by the ACA, rollout needs to be carefully managed to avoid early disasters, particularly of a technical nature. While SHOP held theoretical appeal – designed to offer a convenient method for small employers to shop for coverage and to offer a variety of coverage choices to employees – it fell far short in practice. Very few small employers chose to use the SHOP exchanges in the early years, with SHOP enrolling less than one percent of the small group market in 2016.<sup>150</sup> Today, SHOP exchanges barely exist.<sup>151</sup> While many factors contributed to the general failure of SHOP, early technical problems and broker opposition were key elements.<sup>152</sup>

Small employers may, based in part on the failure of SHOP, have little trust in federal solutions to health care. Yet if large employers were to get on board first with successful results, small employers might follow. Small employers have more reason than large employers to want to outsource health benefits and have more explicitly voiced their preference to do so through a public option.<sup>153</sup> Perhaps the key takeaway is that any employer public option—regardless of where it is offered—must roll out smoothly and strategically to overcome inertia and other barriers.

We also know from previous health care reform efforts that the support or opposition of insurers can be critical.<sup>154</sup> Efforts to create a public option in

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<sup>149</sup> See James Robinson, *Hospitals Respond to Medicare Payment Shortfalls by Both Shifting Costs and Cutting Them, Based on Market Concentration*, 30 HEALTH AFF. 1265 (2011).

<sup>150</sup> GAO, PRIVATE HEALTH INSURANCE: ENROLLMENT REMAINS CONCENTRATED AMONG FEW ISSUERS, INCLUDING IN EXCHANGES 30 (Mar. 2019).

<sup>151</sup> In 2017, CMS announced that effective January 1, 2018, the federal government would no longer handle SHOP functions for states that chose not to operate their own SHOP exchanges. *SHOP Marketplace Enrollment as of January 2017*, CMS (May 15, 2017), <https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/SHOP-Marketplace-Enrollment-Data.pdf>; Timothy Jost, *CMS Announces Plans to Effectively End the SHOP Exchange*, HEALTH AFFAIRS BLOG (May 15, 2017), <https://www.healthaffairs.org/doi/10.1377/hblog20170515.060112/full/>. As of 2020, only ten states and the District of Columbia maintain any type of SHOP platform. *Id.*

<sup>152</sup> RHETT BUTTLE ET AL., THE COMMONWEALTH FUND, SMALL-BUSINESS OWNERS’ VIEWS ON HEALTH COVERAGE AND COSTS 4 (2019) (69% reporting they rely on a broker to choose a health plan), [https://www.commonwealthfund.org/sites/default/files/2019-09/Buttle\\_small\\_business\\_owners\\_survey\\_ib.pdf](https://www.commonwealthfund.org/sites/default/files/2019-09/Buttle_small_business_owners_survey_ib.pdf). Marshall Allen, *Insurers Hand Out Cash and Gifts to Sway Brokers Who Sell Employer Health Plans*, NPR (Feb. 20, 2019, 5:01 AM), <https://www.npr.org/sections/health-shots/2019/02/20/694719998/insurers-hand-out-cash-and-gifts-to-sway-brokers-who-sell-employer-health-plans>.

<sup>153</sup> See, e.g., Press Release, Hunter Railey, Colorado Director for Small Business Majority, New Report on Public Option Opens the Door for More Healthcare Choices for Colorado Small Businesses (Nov. 15, 2019), <https://smallbusinessmajority.org/press-release/new-report-public-option-opens-door-more-healthcare-choices-colorado-small-businesses> (small business majority in Colorado voicing support for public option based on Medicare)

<sup>154</sup> Shefali Luthra, *Insurers Sank Connecticut’s ‘Public Option.’ Would a National Version Survive?*, KAISER HEALTH NEWS (Mar. 4, 2020), <https://khn.org/news/connecticut-public-option-battle-insurers-pushback-federal-health-care-reform2/>.

Connecticut were defeated in part because of opposition by Cigna and Aetna, two of the state's top employers and the state's largest insurance companies.<sup>155</sup> Yet, if a federal public option focused on the largest employers, insurance opposition might be reduced. Most of the largest employers self-insure,<sup>156</sup> which reduces the role for insurance companies to that of a third-party administrator. While insurers are paid a per capita monthly fee for such administrative work, it is likely a less profitable sector than insurance, which allows the insurer to keep at least a certain percentage of "experience gains."<sup>157</sup> Because a public option targeted to large employers is less threatening to an insurer's profit centers, it is possible that their opposition will be lower. Of course, to the extent that a public option involves an explicit role for private insurers as third-party administrators, resistance might be lower still. That said, it would be naïve to expect insurers to embrace an idea that would eventually erode much of their business and profits.

There are also, however, reasons to be optimistic. Some large employers may support the idea and get behind it politically. Labor unions may support an employer-based public option at greater levels than Medicare for All. During the leadup to the ACA, major labor unions publicly supported the inclusion of an individual public option.<sup>158</sup> With respect to Medicare for All, some unions support it on the basis that it would allow unions to focus more intently on other bargaining issues such as wages, while other unions oppose it because they do not want to give up their bargained-for health benefits.<sup>159</sup> In part, the opposition is based on the fact that some union plans are more generous than Medicare.<sup>160</sup>

President Biden explicitly promised during his campaign that, "If you have a generous union-backed plan and you have given up union wages to get that plan, you can keep it."<sup>161</sup> A key advantage of a public option for employers is that it allows union plans to stay in place. Indeed, if health benefits are subject to a collective bargaining agreement they would remain unchanged under this proposal. The decision of an employer to offer the public option to union employees would be subject to future bargaining upon expiration of the current labor agreement, and

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<sup>155</sup> *Id.*

<sup>156</sup> KFF Health Benefits 2020, *supra* note 13, at 161. Ninety-two percent of firms with 1000 or more workers self-insure. *Id.* at 162, Fig. 10.2.

<sup>157</sup> While there is almost no publicly available information on the relative profitability of insured lines of business compared to administrative-only contracts, basic economic principles would suggest that insurers could charge a risk premium for taking on the uncertainty of medical expenses in a fully insured arrangement. Some support for this position can be seen in health insurers' security filings. *See, e.g.*, CVS Health Corp. Annual Report (Form 10-K) 31 (Feb. 18, 2020) ("Our Insured Health Care Benefits products that involve greater potential risk generally tend to be more profitable than our [administrative services contract] products").

<sup>158</sup> Helen A. Halpin & Peter Harbage, *The Origins and Demise of the Public Option*, 29 HEALTH AFF. 1117 (2010).

<sup>159</sup> Ian Kellgreen & Alice Miranda Ollstein, Labor's Civil War Over 'Medicare for All' Threatens its 2020 Clout, POLITICO, Feb. 18, 2020; Amanda Becker, Democrats' Medicare for All Must Consider Union-won Plans: AFL-CIO, REUTERS (Aug. 29, 2019), <https://www.reuters.com/article/us-usa-election-healthcare/democrats-medicare-for-all-plans-must-consider-union-negotiated-health-plans-afl-cio-chief-idUSKCN1VJ268>; Matt Pearce, Candidates' Talk of 'Medicare for All' Makes Some Unions Nervous. Here's Why, LA TIMES (Dec. 23, 2019), <https://www.latimes.com/politics/story/2019-12-23/why-some-unions-are-nervous-about-medicare-for-all>.

<sup>160</sup> Kellgreen & Ollstein, *supra* note 153.

<sup>161</sup> *Id.*

could easily accommodate differing union preferences in a way that Medicare for All could not. This flexibility may allow greater union support for a public option for employers than is possible for other reform proposals under serious consideration.

### **III. FISCAL IMPLICATIONS: SCORING AN EMPLOYER PUBLIC OPTION**

We turn now to the fiscal implications of an employer public option. From this perspective, the employer public option has a much smaller footprint than MFA, while still catalyzing structural improvement to healthcare financing. We start with a short primer on the basic principles of federal budgeting for exchange transactions as opposed to direct government spending. We next show how those principles have been applied to the scoring of Medicare for All proposals as well as some of the more prominent public options. We then describe how an employer public option would likely be scored, contrasting that approach with other leading health reform plans. Finally, we conclude by examining the likelihood that an employer public option could be established through budget reconciliation.

#### **A. A Short Primer on Federal Budgeting for Exchange Transactions**

Our current system for accounting for the federal budget was set forth by the President’s Commission on Budget Concepts in 1967.<sup>162</sup> One of the controversial budgetary issues of the day was how the federal budget should account for the many instances in which governmental entities interacted with the general public through market-like transactions, ranging from concession stands at the Smithsonian Museum to operations at national parks where visitors paid an entrance fee to the many different areas, from flood insurance to land leasing programs, where members of the public chose to make payments to government entities in exchange for goods or services. Since all involved payment to a government entity, would all of those receipts be considered comparable to federal taxes and therefore included in government revenues for purposes of budgetary aggregates or should receipts of this sort be treated differently for the purposes of the federal budget? To address these questions, the Commission’s report included a chapter on “Offsetting Receipts Against Expenditures” and specified:

“For purposes of summary budget totals, receipts from activities which are essentially governmental in character, involving regulation or compulsion, should be reported as receipts. But receipts associated with activities which are operated as business-type enterprises, or which are market-oriented in character, should be included as offsets to expenditures to which they relate.”<sup>163</sup>

As the report explained, when dealing with “enterprise-type” government activities, net costs to the government – that is expenditures less offsetting receipts

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<sup>162</sup> See M. Rodgers & D. Sullivan, H.L.S., Reconsidering the President’s Commission on Budget Concepts of 1967: Budget Policy Briefing Paper No. 30 (May 10, 2006), [http://www.law.harvard.edu/faculty/hjackson/President\\_Commission\\_30.pdf](http://www.law.harvard.edu/faculty/hjackson/President_Commission_30.pdf).

<sup>163</sup> See REPORT OF THE PRESIDENT’S COMMISSION ON BUDGET CONCEPTS 65 (Oct. 1967).

– is the relevant measure of public support and thus inclusion in budgetary aggregates. And as long as the underlying transactions were voluntary in nature and subject to market discipline, incorporating gross revenues and receipts into budgetary aggregates would give “an exaggerated view of the Government’s role in the economy.”<sup>164</sup> In recognition that the overall size of the operation of government enterprises remains a topic of public interest, the Commission proposed that the appropriate approach was to include supplemental information on total revenues and expenditures in supporting budgetary documents, but to include only net expenditures into budgetary aggregates, such as total government revenues and spending.

The approach laid out in 1967 remains the practice today. In the Analytical Perspectives section of Office and Management and Budget’s most recent budget documents, the budget office invoked the work of the President’s Commission and offered a similar justification for this aspect of budgetary practice:

Most of the funds collected through offsetting collections and offsetting receipts from the public arise from business-like transactions with the public. Unlike governmental receipts, which are derived from the Government’s exercise of its sovereign power, these offsetting collections and offsetting receipts arise primarily from voluntary payments from the public for goods or services provided by the Government. They are classified as offsets to outlays for the cost of producing the goods or services for sale, rather than as governmental receipts. These activities include the sale of postage stamps, land, timber, and electricity; charging fees for services provided to the public (e.g., admission to national parks); *and collecting premiums for health care benefits (e.g., Medicare Parts B and D)*. As described above, treating offsetting collections and offsetting receipts as offsets to outlays ensures the budgetary totals represent governmental rather than market activity.<sup>165</sup>

As this excerpt helpfully notes, premiums for Medicare programs are one enumerated example of offsets in the current federal budget, as are comparable charges for federal flood insurance and a host of other market based transactions with government entities.<sup>166</sup> Although these premiums reflect private payments to government entities, they are not counted as government revenues or taxes in budgetary aggregates.<sup>167</sup> This approach accurately makes these programs look less

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<sup>164</sup> *Id.* at 64.

<sup>165</sup> OFFICE OF MANAGEMENT AND BUDGET, *Chapter 12: Offsetting Collections and Offsetting Receipts*, in ANALYTICAL PERSPECTIVES 141 (2020), [https://www.whitehouse.gov/wp-content/uploads/2020/02/ap\\_12\\_offsetting\\_fy21.pdf](https://www.whitehouse.gov/wp-content/uploads/2020/02/ap_12_offsetting_fy21.pdf) (emphasis added).

<sup>166</sup> Reliance on voluntarily paid premiums to cover a good portion of for what become Medicare Part B along with its budgetary implications was a crucial step in the passage of the original Medicare legislation back in 1965. See THEODORE R. MARMOR, *THE POLITICS OF MEDICARE*, 2d (1973); Julian E. Zelizer, *How Medicare Was Made*, THE NEW YORKER (Feb. 15, 2015). See generally Eric M. Patashnik & Julian E. Zelizer, *Paying for Medicare: Benefits, Budgets, and Wilbur Mills’s Policy Legacy*, 26 J. HEALTH POLITICS, POLICY & LAW 7 (2001).

<sup>167</sup> One additional refinement with respect to offsetting payments is their relationship to the law of appropriations. Here, there are two basic approaches: offsetting collections and offsetting receipts, and the distinction is important in terms of whether the payment generates “budget authority” on the part of the receiving entity. The difference is explained in the following excerpt from the GAO’s Principles of Appropriations:

[W]e discuss two types of collections that may be received by the government: offsetting collections and offsetting receipts. Offsetting collections are collections authorized by law to be credited to appropriation or fund expenditure accounts. Generally, offsetting collections are collections resulting from business-type or market-oriented activities, such as the sale of goods or services to the public, and intragovernmental transactions. For

expensive as a fiscal matter: were the CBO to score a public option for employers for purposes of estimating its impact on the federal deficit or spending aggregates, employer contributions and the costs they cover would not be included, making legislative passage far more likely.

## **B. An Overview of Scoring Estimates for Medicare for All & Prominent Public Option Plans**

Public debates over the cost of MFA as well as prominent public option plans illustrate how these scoring conventions play out in practice and were detrimental to MFA proposals. Table One below reproduces a chart from a recent Committee for Responsible Federal Budget paper titled “Primary Care: Estimating Democratic Candidates’ Health Plans (Feb. 26, 2020). The table focuses on the central estimates for four different plans: Vice President Biden’s and Mayor Peter Buttigieg’s public option plans and then two MFA plans, Senator Sanders’s and Senator Warren’s. The chart breaks down effects into four components: increased federal costs for expanded and improved coverage, assumed savings from programmatic changes, direct offsets (from tax feedback effects and direct taxes), and indirect offsets from tax and spending adjustments in other areas. It presents the ten year fiscal impacts of the four proposals.

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example, the Secretary of the Interior is authorized to collect recreation fees from visitors to national parks. These fees are available for expenditure without further appropriation by Congress. 16 U.S.C. § 6806.

Laws authorizing offsetting collections make them available for obligation to meet the account’s purpose without further congressional action. Accordingly, because the receiving agency has the authority to obligate and expend offsetting collections, offsetting collections constitute budget authority.<sup>4</sup> Furthermore, as discussed earlier in this chapter, an appropriation is authority to incur obligations and to make payments from the Treasury for specified purposes. Thus, offsetting collections are an appropriation and are subject to the fiscal laws governing appropriated funds. B-230110, Apr. 11, 1988; 63 Comp. Gen. 285 (1984).

In contrast, offsetting receipts are collections that cannot be obligated and expended without further congressional action. Offsetting receipts are not available to an agency unless Congress appropriates them.<sup>5</sup> Offsetting receipts are not available to the receiving agency for obligation; accordingly, offsetting receipts do not constitute budget authority. An example of offsetting receipts is the motor vehicle and engine compliance program fee collected by EPA. These fees are deposited into the Environmental Services Special Fund but are not available to EPA without further appropriation. 42 U.S.C. § 7552.

*See* GAO OFFICE OF GENERAL COUNSEL, PRINCIPLES OF APPROPRIATIONS, ch. 2, at 2-6 (4<sup>th</sup> ed. 2016) (GAO-16-464SP). While the classification of offsets as either collections or receipts is a matter that would ordinarily be specified in enabling legislation, the more common practice for insurance premiums would be to denominate such payments as offsetting collections, that is, as creating budget authority. That is our assumption for purposes of this White Paper.

Central Estimates of the Ten-Year Fiscal Impact of Candidates' Health Proposals				
Proposals	Biden	Buttigieg	Sanders	Warren
Health Care Coverage Expansion	-\$1.7 trillion	-\$1.6 trillion	-\$29.0 trillion	-\$29.0 trillion
Long-Term Care Coverage Expansion	-\$0.35 trillion	-\$0.5 trillion	-\$4.5 trillion	-\$4.5 trillion
Maintenance of Effort Payments	N/A	N/A	\$3.1 trillion	\$3.1 trillion
Other Spending Increases	-\$0.2 trillion	-\$0.75 trillion	-\$0.2 trillion	-\$1.35 trillion
<b>Subtotal</b>	<b>-\$2.25 trillion</b>	<b>-\$2.85 trillion</b>	<b>-\$30.6 trillion</b>	<b>-\$31.75 trillion</b>
Prescription Drug Savings	\$0.4 trillion	\$0.75 trillion	\$1.7 trillion	\$1.7 trillion
Other Health Savings	\$0.05 trillion	\$0.45 trillion	N/A	\$2.5 trillion
Cap Health Cost Growth	N/A	N/A	N/A	\$0.5 trillion
<b>Subtotal</b>	<b>\$0.45 trillion</b>	<b>\$1.2 trillion</b>	<b>\$1.7 trillion</b>	<b>\$4.7 trillion</b>
Tax Feedback/Other Health Revenue	\$0.35 trillion	\$0.4 trillion	\$3.0 trillion	\$1.5 trillion
Employer Contributions/Taxes	N/A	N/A	\$5.2 trillion	\$12.7 trillion
Worker Contributions/Taxes	N/A	N/A	\$4.0 trillion	N/A
<b>Subtotal</b>	<b>\$0.35 trillion</b>	<b>\$0.4 trillion</b>	<b>\$12.2 trillion</b>	<b>\$14.2 trillion</b>
Individual Income Tax Increases	\$0.1 trillion	N/A	\$1.1 trillion	N/A
Capital and Wealth Tax Increases	\$0.55 trillion	N/A	\$1.55 trillion	\$1.5 trillion
Business Tax Increase	N/A	\$1.7 trillion	\$1.2 trillion	\$2.75 trillion
Other Taxes and Spending Cuts	N/A	N/A	N/A	\$2.5 trillion
<b>Subtotal</b>	<b>\$0.65 trillion</b>	<b>\$1.7 trillion</b>	<b>\$3.75 trillion</b>	<b>\$6.75 trillion</b>
<b>Net Fiscal Impact</b>	<b>-\$800 billion</b>	<b>\$450 billion</b>	<b>-\$12.95 trillion</b>	<b>-\$6.1 trillion</b>

*Negative numbers add to the debt. Estimates rounded to nearest \$100 billion for larger policies and \$50 billion for smaller policies.*

Table One: Central Estimates of the Ten-Year Fiscal Impact of Candidates' Health Proposals

Table One illustrates the different fiscal presentations of the two different kinds of health care reform. Due to their mandatory nature, the Sanders and Warren proposals reflect substantial new revenues in the form of employer and worker contributions along with substantial additional tax increases, generating between \$15 and over \$20 trillion in new revenues over the ten-year window (but still adding substantially to the federal deficit). The Biden and Buttigieg plans have a much smaller fiscal footprint and not just because they are less ambitious programs. The scoring for neither of these proposals includes direct offsets for premium payments that individuals would pay toward premiums for the public option, consistent with the treatment described above of offsetting collections in market-based transactions government entities. To be sure, both the Biden and Buttigieg plans entail additional federal expenditures to expand coverage (reflecting subsidies and tax credits), but they do not reflect the entire cost of health care coverage for individuals who choose to participate in the public option on a voluntary basis. While these differences may sound technical in nature, the very large amount of new taxes required to finance the Sanders and Warren MFA proposals proved to be a significant impediment in public debates over the course of the democratic primaries and are likely to continue to act as serious impediments to passage of such proposals.

### C. Designing a Public Option for Employers with Budget Scoring in Mind

So with this background in mind, how should an employer public option be designed to capture current employer and employee contributions as offsets to

expenditures, which would produce a budgetary impact that accurately reflects the net costs to the federal government? First and foremost, the public option program should be voluntary in nature and designed to compete with private employer plans, as discussed above. Contributions should be made directly to the public option plan, from both employers and employees, as is currently the case with private health insurance plans. Structuring these payments as voluntary premiums instead of as new taxes on employers who opt into the public option and on their employees is critical. For budgetary purposes, taxes would likely be mandatory and considered government revenues rather than offsetting collections and therefore included into budgetary aggregates.<sup>168</sup>

The precise budgetary impact of a public option for employers will depend on numerous design choices discussed in detail in Part II: reimbursement rates for medical care, whether contributions for an employer include experience adjustments to reflect the health characteristics of its employees, the quality of the benefits provided as well as out-of-pocket charges, and the amount and design of any subsidies.<sup>169</sup>

Following other public option proposals that have focused on employer participation, we assume upward adjustment in hospital reimbursements rates above current Medicare rates may be necessary. These adjustments would make a public option for employers more palatable for many key constituencies (like hospitals and other providers) but it should not generate the need for additional public expenditures as premiums for current ESI plans support reimbursements at even higher levels. While these upward adjustments would somewhat reduce savings for employers and employees, our assumption is that the overall efficiencies of the public option will still generate residual cost savings.

To the extent that public option plans retain some degree of out-of-pocket expense for workers and dependents, flexible spending accounts offered under an employer's cafeteria plan could continue to be used to allow for the payment of these out-of-pocket expenses with pre-tax dollars.<sup>170</sup> To the extent that a public option for employers altered the extent of out-of-pocket expenditures for participating employees, this aspect of a public plan would also have a fiscal impact, either positive or negative.

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<sup>168</sup> Several public option proposals that envision mandatory employer payments to cover employees who opt out of employer ESI and into a public option offered through an ACA exchange would also run the risk of being denominated government revenues as opposed to offsetting collections.

<sup>169</sup> Another potentially important consideration is the extent to which a public option for employers might have an impact on the number of Medicare eligible employees choose to stay on their employer-sponsored plans. Movement of significant numbers of elderly away from Medicare could reduce revenues for that program, but replacing it with, most likely, greater revenues for the public option, as combined employer and employee contributions to the public option would likely be greater than Medicare premiums. But the effects would need to be considered in a comprehensive scoring exercise.

<sup>170</sup> If the public option made high-deductible coverage available, health savings accounts could be used to pay out-of-pocket expenses. A separate question might arise if employees participating in an employer-based public option were to purchase Medigap-style supplement plans. The need for such plans would depend on the features of the public option. Medigap premiums cannot generally be paid with pretax dollars. You can deduct them, but only to the extent they, along with any other medical expenses, exceed ten percent of annual income. *See* I.R.C. §213

It is beyond the scope of this Article to offer a complete assessment of the budgetary impact of the system of subsidies outlined in Part II. Clearly there would be a direct budgetary impact as the federal government would be expanding the scope of ACA subsidies beyond policies purchased on Exchanges. In addition, the availability of these subsidies as well as the integration of Medicaid coverage into employer-sponsored plans would reduce the costs of employer-provided insurance (especially for lower income workers) and therefore likely increase the amount of employer-sponsored coverage for those workers – a key benefit of our proposal, but also an effect that would increase the level of tax expenditures for employer sponsored health insurance. Furthermore, the approach we describe would likely expand the number of individuals receiving Medicaid benefits (albeit primarily those already eligible for those benefits but currently lacking the wherewithal to claim their entitlements.) Finally, in calculating the overall cost of the program, CBO scorekeepers would need to assess the extent to which Medicaid costs for lower-income workers would be offset by reductions in ACA-style subsidies otherwise directed to employer-provided plans.

#### **D. Using Reconciliation to Enact an Employer Public Option**

While this Article is primarily focused on sketching out a new approach to health care reform, questions understandably may arise in some readers' minds as to the political viability of our proposal, especially given the closely divided composition of the current U.S. Senate. That concern necessarily poses the question whether legislation implementing a public option for employers – or even a simple public option for individuals – could be structured to comply with budget reconciliation procedures and hence avoid the Senate's current filibuster requirements. In truth, a definitive answer to this question would ultimately come from the Senate Parliamentarian, but we believe there are solid grounds to believe that a public option for employers could be structured to be eligible for inclusion in a reconciliation bill.

The chief impediment to inclusion of legislation in reconciliation bills is the Byrd Rule.<sup>171</sup> A number of the Byrd Rule's limitations are inapplicable, such as the prohibition on changes in social security, or relatively easy to meet through advanced planning, such as the requirement that the legislation not fall outside of the jurisdiction of the submitting committee or does not match the specifications of the authorizing budget resolution. In addition, the budgetary effects of the public option would need to be anticipated in the budget resolution issuing reconciliation instructions. There are, however, several elements of the Byrd Rule that could present challenges.

First is the Byrd Rule's prohibition on provisions in a reconciliation bill that do not "produce a change in outlays or revenue, including changes in outlays and revenues brought about by changes in the terms and conditions under which outlays are made or revenues are required to be collected."<sup>172</sup> To meet this requirement, the

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<sup>171</sup> See Congressional Research Services, *The Budget Reconciliation Process: The Senate's "Byrd Rule"* (Dec. 1, 2020).

<sup>172</sup> See Section 313(b)(1)(A) of the Congressional Budget Act of 1974, as amended.

public option for employers would need to be crafted, in the first instance, as an expansion of the traditional Medicare program to cover a new group of participants on terms that would be competitive in the employer sponsored market. A provision of this sort would fairly clearly increase federal outlays. As a second step, the legislation could authorize the Centers for Medicare and Medicaid Services (or some other governmental entity) to establish a premium schedule for employer and employee contributions to cover the costs of the public option. As discussed elsewhere, these fees would not be denominated revenues in budgetary aggregates, but they would reduce federal outlays as they would offset the costs of the programs. Again, this approach would seem to meet the Byrd Rule's requirements of directly affecting (that is, decreasing) federal spending. Finally, to the extent that ACA subsidies or some variant thereon were included in a public option, that expansion would also seem to fall squarely within the permissible limits of reconciliation bills as it directly increases in federal spending in the same manner as the creation of a new tax expenditures.

To be sure, drafters would need to be careful not to include in any reconciliation bill additional provisions with budgetary effects that are "merely incidental to non-budgetary components."<sup>173</sup> For this reason, there could be advantages of hewing as closely as possible to the existing Medicare program with delegated rulemaking authority to CMS to adopt programmatic adjustments, along the lines discussed elsewhere in this article, in order to make the public option a viable alternative to employer sponsored health insurance. Many reconciliation bills in the past – including both the Affordable Care Act and Trump era tax reform legislation -- have included such delegated authority and the purpose of such delegation would be to fix "the terms and conditions under which outlays are made," that would seem to protect them from challenges that they were merely incidental to budgetary effects. In a similar vein, CMS should also be authorized to determine the extent to which employers adopting a public option would be relieved of regulatory burdens under other federal provisions, such as ERISA, again justified against Byrd Rule attack on the grounds that it determines the terms and conditions under which outlays are made, as the terms of the public option for employers would be different (and quite likely infeasible) were the programs subject to conflicting federal statutory requirements.

A final issue under the Byrd Rule would be whether the public option for employers increased the projected federal deficit beyond the current budget window, presumably but not necessarily ten years.<sup>174</sup> The application of this requirement would ultimately turn on scoring decisions by the Congressional Budget Office. While it is conceivable that labor market effects of this public option would increase employment growth and tax revenues beyond ten years and have other positive budgetary effects related to increase competition in the private sector, one should probably assume that over the ten year window the public option would increase the projected deficit, particularly if ACA style subsidies were included. To address this

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<sup>173</sup> *Id.* Section 313(b)(1)(D).

<sup>174</sup> Here the relevant subsection of the Byrd Rule reads: "a provision shall be considered to be extraneous if it increases, or would increase, net outlays, or if it decreases, or would decrease, revenues during a fiscal year after the fiscal years covered by such reconciliation bill or reconciliation resolution." *Id.* Section 313(b)(1)(E).

issues, proponents could explore pay-for options that would be expected to offset outlays in the outyears, either related to health care reform or otherwise. An alternative response would be to include a sunset provision – as has often been done with tax legislation passed through reconciliation – in the final year of the budget window. While arguably diminishing the attractiveness of the program for employers contemplating adoption, a sunset in this case might actually be justified here to the extent that one regards the public option for employers as experimental measure, which over the coming decade will either prove itself to be a productive step forward or not. But this final element of the Byrd Rule is one which would need to be addressed in order to survive points of order in the Senate.

## CONCLUSION

While recent health reform discussions have centered around Medicare for All and an individual public option, we have proposed in this Article a novel employer public option that addresses the shortcoming of such proposals. Medicare for All moves all Americans onto a publicly-financed system which, while effective in addressing many of the shortcomings of the U.S. system, does so in a highly disruptive way that is likely to face strong political opposition. On the other hand, the more politically-palatable individual public option may help improve coverage at the margins, but is unlikely to significantly reform the U.S. health care system. Our proposal attempts to find a middle ground, by allowing employers to lead the movement toward public coverage to the extent they find doing so to be in their interests. Creating a voluntary mechanism lead by sophisticated decisionmakers should not only help lessen political opposition, but will also improve budget scoring and fiscal impact. Most importantly, it has the ability to begin to meaningfully address some of the most pressing health policy issues in the United States and can serve as a genuine test of the viability of a broader system of public coverage.