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HOW A PANDEMIC PLUS RECESSION FORETELL THE POST-JOB-BASED HORIZON OF HEALTH INSURANCE

*Allison K. Hoffman**

INTRODUCTION

For many years, the health insurance that people received through their jobs was considered the gold standard, so much so that it came to be called “Cadillac coverage.” Just as Cadillac has lost its sheen, so has job-based health insurance coverage in many cases. This decline predated the COVID-19 pandemic, yet it has been, and will continue to be, hastened by it. The changes to job-based coverage have prompted people to ask: what’s next? This Article suggests that the lessons from the pandemic could offer an opportunity fundamentally to rethink the way to pay for healthcare in the United States, perhaps opening a window for reform. Meaningful reform should imagine a better overall financing system ten to twenty years from now, rather than just trying to plug the most egregious holes in the existing system. This long view might produce counterintuitive results, likely focusing on reforms that will, in part or in whole, reach people who already have health insurance, rather than taking a laser focus to address the needs of the uninsured. But doing so could eventually produce a simpler and more equitable structure.

In Part I, I briefly describe the origins of the job-based health insurance system, often called employer-sponsored health insurance (ESI), and how and why that system has weakened over the past two decades plus. In Part II, I chart how the COVID-19 pandemic has both hastened this decline and illuminated the deep illogic of tying health insurance to a job.

Finally, in Part III, I consider how to move beyond job-based health coverage. Various ideas have been floated or even implemented, but the trick is to settle on one that could gain political support and that

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will result in workers and their families retaining quality access to medical care without incurring financial insecurity. Most of the more popular ideas do not fulfill these dual goals. For example, Medicare for All (MFA) might create the most equitable and efficient system, but, for reasons discussed below, is a political nonstarter, at least for now. In contrast, doubling down on individually funded savings accounts or vouchers to buy individual coverage have been political wins but produce a system in which people are assured to find themselves with a maze to navigate and with hefty out-of-pocket expenses if they should need medical care. Finally, I discuss the possibility of an employer public option—a way for employers to enroll their workers in a Medicare-based public plan—an idea I have developed with professors Howell Jackson (Harvard Law School) and Amy Monahan (University of Minnesota Law School).¹ I describe why this approach could offer a politically palatable pathway to solve short run problems with job-based coverage and simultaneously set the foundation for a more equitable and secure long-term healthcare financing structure.

I. THE HISTORY AND PRESENT STATE OF JOB-BASED HEALTH INSURANCE

A. *The Origin of Employment-Based Health Insurance*

The United States is unique in the central role that employers have in healthcare financing.² Over the twentieth century, when European nations were creating systems of public healthcare delivery or financing, or both, the United States instead saw the growth of private pre-paid health plans tied to employment.³ These pre-paid healthcare funds guaranteed people access to medical care up to a certain level, for an annual payment.⁴

Employers became the primary locus of health coverage in the United States over the twentieth century.⁵ Several public policies fostered the growth of employer-based coverage. Even though some suggest that wage controls during the war prompted employers to compensate with benefits instead of cash wages, the growth in job-based health benefits was relatively small in the wartime period, as

1. See generally Allison K. Hoffman et al., *A Public Option for Employer Health Plans*, 20 *YALE J. HEALTH POL'Y, L., & ETHICS* 299 (2021).

2. PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* 237–40 (1982).

3. T.R. REID, *THE HEALING OF AMERICA: A GLOBAL QUEST FOR BETTER, CHEAPER, AND FAIRER HEALTH CARE* 16–28 (2009); STARR, *supra* note 2, at 295–96.

4. STARR, *supra* note 2, at 297–98.

5. TIMOTHY JOST, *DISSENTLEMENT? THE THREATS FACING OUR PUBLIC HEALTH-CARE PROGRAMS AND A RIGHTS-BASED RESPONSE* 77–80 (2003).

compared to the years prior to and after the war.⁶ A 1948 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 were among the forces that spurred the job-based system that predominates today.⁷

The tax treatment of ESI continues to have an important role in preserving the tie between jobs and health benefits, but other factors contribute.⁸ Since it is difficult for most people to get high-quality coverage outside of a job, employers offer a benefit that employees cannot get elsewhere, making robust health plans a recruiting and retention tool. Large employers also benefit from natural risk pooling that makes group medical care spending relatively predictable, and economies of scale mean that administrative costs per enrollee are lower in employers' plans than in either individual or small group coverage, although still higher than in public health insurance programs, like Medicare.

While the Patient Protection and Affordable Care Act (ACA) significantly improved the availability and affordability of coverage someone could buy on his or her own in the so-called individual, or nongroup, market, ESI continues to be the best and dominant source of private coverage. Considering the entire U.S. population, about 50% are covered by ESI, 6% by private individual market coverage, 20% by Medicaid, 14% by Medicare, 1.4% through military coverage, and 9% remain uninsured.⁹

For decades now, experts have questioned whether employers should continue to play a fundamental role in providing health coverage.¹⁰ But until recent years, job-based coverage has seemed unyielding, and it has been difficult to imagine a solution that could diminish

6. *Id.*

7. *Id.* at 78–79.

8. 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, 23–25 (2001).

9. *Health Insurance Coverage of the Total Population*, KAISER FAM. FOUND., <https://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D> (last visited Apr. 27, 2022) (numbers are rounded).

10. *See, e.g., INST. MED., 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 . . .”).

reliance on it without creating health or financial insecurity for workers or their families.

B. The Changing Nature of Work and Employment-Based Health Insurance

1. The Slow Decay of Job-Based Health Insurance Coverage

Even before the COVID-19 pandemic, the quality of job-based health insurance was diminishing as its costs increased. The number of companies offering health benefits has declined. In 2020, 56% of firms offered at least some employees health benefits, as compared to 68% two decades prior,¹¹ and the share of the nonelderly population covered fell 8 percentage points from 1998 to 2018.¹² Low-income workers and their families are less likely to have job-based coverage, including only a quarter of full-time workers earning under the federal poverty level and under half of those workers earning between the poverty level and 250% of it.¹³ Low income workers are also much more likely to decline coverage even when offered to them, increasingly so over the past twenty years, because their own contributions to that coverage are unaffordable.¹⁴

Relatedly, the cost of job-based health benefits has skyrocketed over the past two decades, far outpacing wage growth and inflation.¹⁵ The average annual premiums in 2020 were \$7,470 for single coverage and \$21,342 for family coverage.¹⁶ Employers' contributions toward these premiums have grown, but that only means that healthcare spending is now making up a larger share of total worker compensation.¹⁷ Employee contributions have also increased substantially; for family coverage, employee contributions have increased 13% over the last five years and 40% over the last ten years.¹⁸ Not surprisingly,

11. GARY CLAYTON ET AL., KAISER FAM. FOUND., EMPLOYER HEALTH BENEFITS: 2020 ANNUAL SURVEY 46 (2019), <https://www.kff.org/report-section/ehbs-2020-section-1-cost-of-health-insurance/>. Note, the offer rates have remained steady for large firms but declined for all others. *Id.* at 47.

12. Matthew Rae et al., *Long-Term Trends in Employer-Based Coverage*, PETERSON-KFF HEALTH SYS. TRACKER (Apr. 3, 2020), <https://www.healthsystemtracker.org/brief/long-term-trends-in-employer-based-coverage/>.

13. *Id.*

14. *Id.*

15. CLAYTON ET AL., *supra* note 11, at 40, 42, fig.1.10, fig.1.12.

16. *Id.* at 7.

17. Laurel Lucia & Ken Jacobs, *Increases in Health Care Costs Are Coming Out of Workers' Pockets One Way or Another: The Tradeoff Between Employer Premium Contributions and Wages*, U.C. BERKELEY LAB. CTR. (Jan. 29, 2020), <https://laborcenter.berkeley.edu/employer-premium-contributions-and-wages/>.

18. CLAYTON ET AL., *supra* note 11, at 96.

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 worker contributions of \$7,226 (close to 40% of the total).¹⁹

Even as total costs and worker contributions have increased, the quality of coverage has not. Employer plans have little control over the prices they pay for each healthcare item and service, as discussed further below. Thus, to control total *employer* costs, they have responded to overall cost growth in two ways. First, they have increased cost-sharing obligations, like deductibles or copayments that people must pay when they use care. The percentage of workers with single coverage whose policy had an annual deductible increased from 55% in 2006 to 83% in 2020.²⁰ In 2020, over half of all covered workers were in plans with an average annual deductible of over \$1,000, up 23% in the last five years.²¹ Second, many plans have placed limits on the network of providers someone can see or charged more for seeing doctors out of network, in a mostly futile attempt to check runaway price increases.²²

C. *The Changing Nature of Work*

The nature of work is also shifting in ways that may increasingly leave workers without health benefits over time. Contingent work—sometimes called alternative work arrangements, 1099 work, precarious work, or, in its most recent iteration, the “gig workforce”—is rising, although studies differ on the exact definition of such work and how quickly it is rising.²³ By one count, Brookings estimates that these

19. *Id.* at 91.

20. *Id.* at 105.

21. *Id.* at 106.

22. *Id.* at 203. 47% of workers are in PPOs; 31% in HDHP/SOs; 13% in HMOs; 8% in POS plans; and 1% in conventional plans. *Id.* at 9.

23. See, e.g., Lawrence F. Katz & Alan B. Kruger, *Understanding Trends in Alternative Work Arrangements in the United States* 3–6 (Nat'l Bureau of Econ. Research, Working Paper No. 25425, 2019), https://www.nber.org/system/files/working_papers/w25425/w25425.pdf (amending their own earlier research findings to estimate a 1-2 percentage point increase in alternative work arrangements from 2005 to 2015, defining such work as temporary agency workers, on-call workers, contract workers, and independent contractors); AHU YILDIRMAZ ET AL., ADP RESEARCH, ILLUMINATING THE SHADOW WORKFORCE: INSIGHTS INTO THE GIG WORKFORCE IN BUSINESS 3 (Feb. 2020), <https://www.adp.com/-/media/adp/resourcehub/pdf/adpri/illuminating-the-shadow-workforce-by-adp-research-institute.ashx> (estimating that between 2010 to 2019 the share of gig workers in the economy grew from 14.2% to 16.4%, which equates to almost 15% growth); but see generally U.S. BUREAU OF LABOR STATISTICS, CONTINGENT AND ALTERNATIVE EMPLOYMENT ARRANGEMENTS (2018), <https://www.bls.gov/news.release/conemp.nr0.htm#> (reporting a slight contraction in the share of total workers engaged in alternative work arrangements, from 1.8% in 2005 to 1.3% in 2017). Katz and Kruger suggest that this BLS data suggest a

nonemployer firms have grown by approximately 2.6% a year since 1997, while traditional payroll employment jobs have grown 0.8% a year during the same period.²⁴

Some research suggests an acceleration in this growth rate of contingent work over time. One study estimates that alternative work arrangements, which it calls the “1099 workforce,” grew 1.9 percentage points between 2000 and 2016, with more than half of the increase between 2013 and 2016, which it explained as due to the growth of the “online platform economy for labor.”²⁵ Yet, the authors hypothesized that much of this growth was due to people layering gig work on top of other primary employment, less so a displacement of more secure employment.²⁶

The most widely cited estimates of the total gig economy define “independent work” to include such individuals who have a second job in addition to their main form of employment and estimate up to 35% of U.S. workers were at least partially dependent on some gig, “ad-hoc” employment.²⁷ Not surprisingly, women and people of color are the most likely to engage in “the lowest paid, least flexible, and most exploitative types of work.”²⁸ Of course, some of the workers with secondary gig employment might have healthcare through their primary job, which makes it difficult to know how much the increased gig work affects job-based health benefits overall.

What is clear, however, is that work, whether a primary or secondary job, may be structured in contingent ways to avoid the provision

modest upward trend with a closer look at the use of proxy respondents and the business cycle. Katz & Kruger, *supra*, at 12.

24. Robert Maxim & Mark Muro, *Rethinking Worker Benefits for an Economy in Flux*, BROOKINGS INST.: THE AVENUE (Mar. 30, 2018), <https://www.brookings.edu/blog/the-avenue/2018/03/29/rethinking-worker-benefits-for-an-economy-in-flux/>. See also DOUGLAS HOLTZ-EAKIN ET AL., ASPEN INST., *THE GIG ECONOMY: RESEARCH AND POLICY IMPLICATIONS OF REGIONAL, ECONOMIC, AND DEMOGRAPHICS TRENDS* (2017), <https://www.aspeninstitute.org/publications/the-gig-economy-research-and-policy-implications/> (estimating that the gig economy grew between 8.8 and 14.4% between 2002 and 2014).

25. Brett Collins et al., *Is Gig Work Replacing Traditional Employment? Evidence from Two Decades of Tax Returns* 3 (IRS SOI Joint Statistical Research Program, Working Paper, 2019), <https://www.irs.gov/pub/irs-soi/19rpgigworkreplacingtraditionalemployment.pdf>.

26. *Id.*

27. Xavier de Souza Briggs & Wingham Rowan, *Wanted: A Public Option for Finding Work in the Gig Economy*, BROOKINGS INST.: THE AVENUE (Mar. 19, 2021), <https://www.brookings.edu/blog/the-avenue/2021/03/19/wanted-a-public-option-for-finding-work-in-the-gig-economy/>. See also JAMES MANYIKA ET AL., MCKINSEY GLOBAL INST., *INDEPENDENT WORK: CHOICE, NECESSITY, AND THE GIG ECONOMY* (Oct. 10, 2016), <https://www.mckinsey.com/featured-insights/employment-and-growth/independent-work-choice-necessity-and-the-gig-economy> (estimating that between 20-30% of the U.S. working age population is part of the gig economy).

28. de Souza Briggs & Rowan, *supra* note 27.

of health and other benefits since independent contractors generally do not have access to benefits through their jobs. Bureau of Labor Statistics data from 2018 revealed that only 23% of gig workers were eligible for employer-sponsored retirement plans in 2017, which is about half the rate of workers in more permanent employment arrangements.²⁹

In California, legislators passed a state law that attempted to clarify when workers should be classified as employees and, therefore, should receive certain employee benefits, but Uber, Lyft, Instacart, DoorDash, and Postmates spent over 200 million dollars on a ballot measure that effectively nullified the law.³⁰ The proposition exempts these companies, who are chief among those classifying workforces as independent contractors, from the state law.³¹ When making a case for the proposition, these companies argued that their drivers receive health benefits, but, in fact, they do not receive traditional health plans; rather, drivers who meet an hours requirement receive a stipend to help fund a relatively low-value individual plan through Covered California, the state ACA marketplace.³² This plan, called a Bronze plan, on average pays for about 60% of covered services.³³ It is a far cry from traditional job-based health plans with comprehensive coverage and access to top-notch providers. Similar trends will continue unless legislation, regulation, or litigation intervenes, and fewer workers will have classic-style jobs with secure health benefits.

D. Employers' Growing Frustration with Health Benefits

Companies' management teams are increasingly frustrated with the growing cost of healthcare and, even for large employers, their inability to move the needle on prices.³⁴ Providers charge prices to private plans that are on average twice what Medicare pays for hospital ser-

29. U.S. BUREAU OF LABOR STATISTICS, *supra* note 23. See also John Scott & Alison Shelton, *How Well Are Independent Workers Prepared for Retirement?*, PEW CHARITABLE TRS. (June 28, 2019), <https://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2019/06/how-well-are-independent-workers-prepared-for-retirement>.

30. Cheri Murphy, *Uber Bought Itself a Law. Here's Why That's Dangerous for Struggling Drivers Like Me*, THE GUARDIAN (Nov. 12, 2020, 6:00 AM), <https://www.theguardian.com/commentisfree/2020/nov/12/uber-prop-22-law-drivers-ab5-gig-workers>.

31. Sara Ashley O'Brien, *Prop 22 Passes in California, Exempting Uber and Lyft from Classifying Drivers as Employees*, CNN (Nov. 4, 2020, 4:02 PM), <https://www.cnn.com/2020/11/04/tech/california-proposition-22/index.html>.

32. Rachel Bluth, *App-Based Companies Pushing Prop. 22 Say Drivers Will Get Health Benefits. Will They?*, POLITIFACT (Oct. 28, 2020), <https://www.politifact.com/factchecks/2020/oct/28/lyft-lyft/app-based-companies-pushing-prop-22-say-drivers-wi/>.

33. 42 U.S.C. § 1302(d) (2010).

34. *The High Price of Lowering Health Costs for 150 Million Americans*, TRADEOFFS PODCAST (Feb. 18, 2021), <https://tradeoffs.org/2021/02/18/the-high-price-of-lowering-health-costs/>.

vices and 1.5 times what Medicare pays for physician services.³⁵ Providers attempt to justify the price discrimination as making up for losses on Medicare patients, but most hospitals' losses on Medicare are relatively small (-9.9% in aggregate in 2017), and efficient hospitals nearly break even on Medicare reimbursement.³⁶ In any case, the shortfalls pale in comparison to the markup charged to private plans, and hospital profitability was at its highest point in decades prior to the pandemic.³⁷

The reality of these inflated prices is unlikely to improve on its own and may get worse. The provision of healthcare has become extremely consolidated, and providers in many markets can name their prices, especially because employers want to offer employees access to the best hospitals and providers available.³⁸ Some experts believe that the pandemic will only accelerate consolidation because weakened hospitals and physician groups will become acquisition targets.³⁹

In a recent survey by the Kaiser Family Foundation and Purchaser Business Group on Health of decisionmakers at over 300 large private employers, nearly all were concerned with the "excessive costs" of health benefits.⁴⁰ In fact, a strong majority expressed the need for a greater government role in containing healthcare costs and providing coverage.⁴¹ These employers overwhelmingly expressed that a heavier regulatory hand would be better for the business (83%) and better for the employees (86%).⁴² Among the government tools that they supported include increased antitrust enforcement, greater price trans-

35. ERIC LOPEZ ET AL., KAISER FAM. FOUND., HOW MUCH MORE THAN MEDICARE DO PRIVATE INSURERS PAY? A REVIEW OF THE LITERATURE (Apr. 15, 2020), <https://www.kff.org/medicare/issue-brief/how-much-more-than-medicare-do-private-insurers-pay-a-review-of-the-literature/>.

36. MEDPAC, REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY 66 (Mar. 2019), http://www.medpac.gov/docs/default-source/reports/mar19_medpac_entirereport_sec.pdf?sfvrsn=0.

37. See generally AM. HOSP. ASS'N, TBL. 4.1: AGGREGATE TOTAL HOSPITAL MARGINS AND OPERATING MARGINS (2018), <https://www.aha.org/system/files/2018-05/2018-chartbook-table-4-1.pdf>.

38. Karyn Schwartz et al., *What We Know About Provider Consolidation*, KAISER FAM. FOUND. (Sept. 2, 2020), <https://www.kff.org/health-costs/issue-brief/what-we-know-about-provider-consolidation/>.

39. Lovisa Gustafsson & David Blumenthal, *The Pandemic Will Fuel Consolidation in U.S. Health Care*, COMMONWEALTH FUND (Mar. 9, 2021), <https://www.commonwealthfund.org/blog/2021/pandemic-will-fuel-consolidation-us-health-care>.

40. GARY CLAXTON ET AL., KAISER FAM. FOUND., HOW CORPORATE EXECUTIVES VIEW RISING HEALTH CARE COSTS AND THE ROLE OF GOVERNMENT 2 (Apr. 2021), <https://www.pbgh.org/wp-content/uploads/2021/04/9704-How-Corporate-Executives-View-Rising-Health-Care-Costs-and-the-Role-of-Government-v2.pdf>.

41. *Id.* at 7.

42. *Id.*

parency, and even government price caps.⁴³ Many also voiced support for allowing their employees to enroll in Medicare at age sixty or a public option plan for their employees.⁴⁴

Short of governmental action, employers said that they would try to manage healthcare costs by either limiting provider networks—through direct contracting with provider systems or offering narrow-network plans—or by increasing cost sharing, since these are the tools that they can control.⁴⁵

This survey encapsulates the possible futures of job-based coverage in the coming years. One possible route is increased government intervention. The second is the continued shifting of costs of expensive health plans onto workers and their families or the offering of plans with less coverage.

II. WHAT COVID-19 REVEALED ABOUT HAVING HEALTH INSURANCE TIED TO WORK

A. *The Effects of a Co-Terminus Recession and Pandemic on Access to Healthcare*

One could imagine seldom worse times to be without good health insurance than during a pandemic, when someone might, without warning, need prolonged and expensive medical care. Yet, a system rooted in job-based health insurance for 175 million people invites exactly that possibility. Early estimates were that, as of May 2020, as many as 27 million workers lost the jobs where they and their families received their health insurance, although later estimates halved that amount.⁴⁶

Fortunately, a much smaller number, 2-3 million people, became uninsured during 2020.⁴⁷ The numbers of uninsured lagged the unem-

43. *Id.* at 7–8.

44. *Id.* at 8–9.

45. *Id.* at 6.

46. Paul Fronstin et al., *Update: How Many Americans Have Lost Jobs with Employer Health Coverage During the Pandemic?*, COMMONWEALTH FUND (Jan. 11, 2021), <https://www.commonwealthfund.org/blog/2021/update-how-many-americans-have-lost-jobs-employer-health-coverage-during-pandemic> (Between February and June 2020, another estimate found that only 7.7 million workers lost jobs with ESI and that these workers' plans also covered roughly 6.9 million dependents, for a total of 14.6 million affected individuals.).

47. Daniel McDermott et al., *How Has the Pandemic Affected Health Coverage in the U.S.?*, KAISER FAM. FOUND. (Dec. 9, 2020), <https://www.kff.org/policy-watch/how-has-the-pandemic-affected-health-coverage-in-the-u-s/> (estimating 2-3 million people may have lost coverage between March and September 2020, using data available from the fully-insured marketplace and extrapolating to self-insured workers); JESSICA BANTHIN ET AL., URBAN INST., *CHANGES IN HEALTH INSURANCE COVERAGE DUE TO THE COVID-19 RECESSION: PRELIMINARY ESTIMATES*

ployed for several reasons. First, job losses were heavy in industries that tend to have lower rates of offering job-based coverage in the first place, such as retail, service, and hospitality.⁴⁸

Second, many workers and their dependents covered in job-based plans—as many as half—were able to keep their health coverage even when they lost their jobs.⁴⁹ Some employers voluntarily retained coverage in group plans for temporarily furloughed or laid off workers. About 42% of employers reported continuing to pay a portion of health insurance premiums for laid off workers in a Bureau of Labor Statistics study.⁵⁰ Even without an employer's help, other workers elected to keep their group coverage through the Consolidated Omnibus Budget Reconciliation Act (COBRA),⁵¹ a program that allows qualifying workers and dependents to retain health benefits for at least eighteen months, sometimes longer, after leaving or losing a job, by paying the full cost of those benefits.⁵²

Finally, people were able to enroll in other plans. Estimates suggest that in the early months of the pandemic (up until June 2020), one-third of people who lost job-based coverage joined a family member's plan, another third were covered by Medicaid and the Children's Health Insurance Program (CHIP), and a small number enrolled in the ACA marketplace.⁵³ Medicaid and CHIP enrollment increased by 4.3 million (6.1%) during this early period.⁵⁴ In part because policies in the Families First Coronavirus Response Act (Families First Act) encouraged states to preserve enrollment,⁵⁵ it has continued to grow significantly since.⁵⁶

USING MICROSIMULATION 1, 4 (July 13, 2020), https://www.urban.org/sites/default/files/publication/102552/changes-in-health-insurance-coverage-due-to-the-covid-19-recession_4.pdf (estimating 2.9 million net increase in uninsured in the last three quarters of 2020).

48. McDermott et al., *supra* note 47.

49. Fronstin et al., *supra* note 46.

50. *Id.*

51. McDermott et al., *supra* note 47.

52. COBRA is a law that amended the Employee Retirement Income Security Act of 1974 (ERISA) and other laws to require temporary continuation of group health coverage for private employers with twenty or more employees, as well as state and local governments. Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, 100 Stat. 82, 222-37 (1986). A worker must have at least sixty days to elect coverage for herself and/or qualifying beneficiaries. *Id.*

53. BANTHIN ET AL., *supra* note 47, at 1-2.

54. *Id.*

55. Pub. L. No. 116-127, 134 Stat. 178 (2020).

56. Bradley Corallo & Sophia Moreno, *Analysis of Recent National Trends in Medicaid and CHIP Enrollment*, KAISER FAM. FOUND. (Feb. 2, 2022), <https://www.kff.org/coronavirus-covid-19/issue-brief/analysis-of-recent-national-trends-in-medicaid-and-chip-enrollment> (showing an increase of 12.4 million or 17.4% from February 2020 through July 2021).

New sources of health coverage, however, often come with a disruption in healthcare, such as a loss of familiar providers, new pre-approval processes for accessing care, or increased cost-sharing. Some new marketplace enrollees, for example, likely faced higher out-of-pocket obligations than in their job-based coverage, as well as a smaller network of available providers.⁵⁷

People who ended up uninsured or underinsured during the pandemic and who contracted COVID-19 faced astounding medical bills.⁵⁸ For people without insurance or with high cost-sharing obligations, expenses could add up quickly. In a study of 173,942 hospitalized COVID-19 patients, the median hospital charge was \$43,986.⁵⁹ Among patients with ICU and mechanical ventilation usage, the median hospital charge increased to \$198,394.⁶⁰ The obligation to pay even a small share of these costs could sink many American families.

B. The Regulatory Lift to Respond to the Health Benefits-Related Costs of Job Loss

Because of the high costs and stakes of COVID-19 care, the federal government and states scrambled to try to keep people insured even as they lost jobs and to provide access to testing and some medical care even if not insured. The patchwork of policies enacted to pursue these goals perfectly captures the overly complicated healthcare financing system in the United States.

The Trump administration was rightly criticized for not creating a special enrollment period on the federal ACA marketplace, HealthCare.gov, as early job loss numbers mounted, but other policies did offer help when people lost job-based health coverage. For example, the Trump administration made it easier for someone to retain their job-based coverage post-employment through COBRA, by extending the time to elect to keep a plan to sixty days after the end of the

57. Shelby Livingston, *Most ACA Exchange Plans Feature a Narrow Network*, MODERN HEALTHCARE (Dec. 4, 2018, 12:00 AM), <https://www.modernhealthcare.com/article/20181204/NEWS/181209976/most-aca-exchange-plans-feature-a-narrow-network>.

58. See, e.g., Sarah Kliff, *A \$22,368 Bill That Dodged and Weaved to Find a Gap in America's Health System*, N.Y. TIMES (Mar. 10, 2021), <https://www.nytimes.com/2021/03/10/upshot/covid-bill-health-gap.html> (describing a man who was uninsured and not formally diagnosed with COVID-19 because of negative molecular tests, even with a positive antibody test, and who received a bill for over \$20,000); Sarah Kliff, *Covid Killed His Father. Then Came \$1 Million in Medical Bills*, N.Y. TIMES (May 21, 2021), <https://www.nytimes.com/2021/05/21/upshot/covid-bills-financial-long-haulers.html?referringSource=ArticleShare> [hereinafter Kliff, *Covid Killed His Father*] (describing people battling with high COVID-19 bills for a variety of reasons).

59. Manuela Di Fusco et al., *Health Outcomes and Economic Burden of Hospitalized COVID-19 Patients in the United States*, 24 J. MED. ECON. 308, 310 (2021).

60. *Id.*

national emergency period ends and allowing a longer period to make “timely” payments to retain COBRA coverage.⁶¹

Congress included provisions in the Families First Act to keep people insured, such as a maintenance of effort requirement for CHIP and Medicaid.⁶² It provided that states could get higher federal Medicaid matching rates and pay a smaller share of total Medicaid enrollee healthcare costs, contingent on the state not making enrollment or eligibility requirements more restrictive than in January 2020 and not terminating coverage during the period of the public health emergency.⁶³ The Families First Act also provided \$64 million to the Indian Health Service for COVID-19 related services.⁶⁴

In 2021, after taking office, President Biden quickly pursued additional stop gap measures. His administration issued a special enrollment period for HealthCare.gov, initially from February 15 to May 15, 2021,⁶⁵ later extended through summer 2021.⁶⁶ In March 2021, the American Rescue Plan Act (ARPA) increased the subsidies that help people buy coverage in these marketplaces.⁶⁷ From the beginning of the Biden administration to mid-July 2021, two million more people enrolled.⁶⁸ Enrollment continues to grow into 2022.⁶⁹

61. Extension of Certain Timeframes for Employee Benefit Plan Participants, and Beneficiaries Affected by the COVID-19 Pandemic, 85 FED. REG. 26351, 26354 (May 4, 2020) (to be codified at 26 C.F.R. pt. 54 and 29 C.F.R. pts. 2560, 2590), <https://www.federalregister.gov/documents/2020/05/04/2020-09399/extension-of-certain-timeframes-for-employee-benefit-plans-participants-and-beneficiaries-affected>.

62. Families First Coronavirus Response Act § 6008, 42 U.S.C.A. § 1396d(ii) (West 2020). See also Corallo & Moreno, *supra* note 56.

63. Families First Coronavirus Response Act § 6008, 42 U.S.C.A. § 1396d(ii).

64. Families First Coronavirus Response Act, Pub. L. No. 116–127, 134 Stat. 178, tit. IV.

65. *Fact Sheet, 2021 Special Enrollment Period in Response to the COVID-19 Emergency*, CTRS. FOR MEDICARE & MEDICAID SERVS. (Jan. 28, 2021), <https://www.cms.gov/newsroom/fact-sheets/2021-special-enrollment-period-response-covid-19-emergency>.

66. News Release, U.S. Dep’t of Health & Hum. Servs., 2021 Special Enrollment Period Access Extended to August 15 on HealthCare.gov for Marketplace Coverage (Mar. 23, 2021), <https://www.hhs.gov/about/news/2021/03/23/2021-special-enrollment-period-access-extended-to-august-15-on-healthcare-gov-for-marketplace-coverage.html>.

67. American Rescue Plan Act of 2021, Pub. L. No. 117–2. See also Matthew Rae et al., *How the American Rescue Plan Act Affects Subsidies for Marketplace Shoppers and People Who Are Uninsured*, KAISER FAM. FOUND. (Mar. 25, 2021), <https://www.kff.org/health-reform/issue-brief/how-the-american-rescue-plan-act-affects-subsidies-for-marketplace-shoppers-and-people-who-are-uninsured/>.

68. News Release, U.S. Dep’t of Health & Hum. Servs., Health Care Sign Ups Surpass 2 Million During 2021 Special Enrollment Period Ahead of Aug. 15 Deadline (July 14, 2020), <https://www.hhs.gov/about/news/2021/07/14/health-care-sign-ups-surpass-2-million-during-2021-special-enrollment-period-ahead-of-aug-15-deadline.html>.

69. See Katie Keith, *Marketplace Enrollment Reaches New Record of 14.5 Million*, HEALTH AFF. (Jan. 31, 2022), <https://www.healthaffairs.org/doi/10.1377/forefront.20220131.636186/>.

ARPA continued efforts to help people maintain group coverage through COBRA.⁷⁰ It provided for temporary COBRA premium subsidies for eligible people for up to six months during 2021.⁷¹ In contrast to normal COBRA enrollment, where the enrollee pays the full cost of coverage (both former employee and employer contributions), under ARPA, employers pay the full cost of coverage and are later reimbursed by the federal government, which means enrollees are spared the expense and the administrative hassle.⁷² ARPA also allowed enrollment for up to one year after job loss, or sixty days after the end of the public health emergency.⁷³

Some efforts, although more limited, aimed to provide access to free medical care, mostly focused on COVID-19 testing and vaccination. The Families First Act was the first effort to require free COVID-19 testing to insured and some uninsured, but it proved thorny to implement when the clinics, hospitals, and labs conducting the testing figured out how to work around the Act's requirements, and people found themselves facing sizeable bills.⁷⁴ The Coronavirus Aid, Relief, and Economic Security (CARES) Act added additional consumer protections; it broadened the definition of what testing must be done for free to patients to include any testing provided by labs on an emergency basis and developed by or authorized by a state or the Department of Health and Human Services (HHS).⁷⁵ In these relief bills, Congress also required insurers to cover COVID-19 vaccinations without cost-sharing, including the office visit and other services necessary to administer it.⁷⁶ Finally, providers who chose to participate in the Centers for Disease Control and Prevention (CDC) COVID-19

70. Karen Pollitz, *How the American Rescue Plan Will Improve Affordability of Private Health Coverage*, KAISER FAM. FOUND. (Mar. 17, 2021), <https://www.kff.org/health-reform/issue-brief/how-the-american-rescue-plan-will-improve-affordability-of-private-health-coverage/>.

71. *Id.*

72. *Id.*

73. *Id.*

74. Carmen Heredia Rodriguez, *COVID Tests Are Free, Except When They're Not*, KAISER HEALTH NEWS (Apr. 29, 2020), <https://khn.org/news/bill-of-the-month-covid19-tests-are-free-except-when-theyre-not/>.

75. Coronavirus Aid, Relief, and Economic Security Act, Pub. L. No. 116-136 (2020).

76. Katie Keith, *New COVID-19 Rule Addresses Coverage, Medicaid Waivers*, HEALTH AFF. (Oct. 30, 2020), <https://www.healthaffairs.org/doi/10.1377/hblog20201030.291472/full/> (describing CARES Act provisions and related regulations); Katie Keith, *New Guidance on COVID-19 Testing and Vaccines*, HEALTH AFF. (Mar. 3, 2021), <https://www.healthaffairs.org/doi/10.1377/hblog20210303.284998/full/> (describing updated guidance by the Departments of Health and Human Services, Labor, and Treasury to implement the CARES Act and Family First Act requirements).

Vaccination Program could not seek any payment from vaccine recipients, regardless of their insurance coverage.⁷⁷

Beyond testing and vaccination, efforts to address the cost of treatment, especially for the uninsured but even for the insured, many of whom have considerable cost-sharing obligations as discussed above, have been more limited. For example, Congress established the Health Resources and Services Administration (HRSA) Uninsured Program to provide reimbursement at Medicare rates to healthcare providers who provide COVID-19 testing, treatment, or vaccination services to uninsured individuals.⁷⁸ However, participation in the HRSA Uninsured Program is voluntary, and a provider who chooses not to participate can bill a patient the full cost of treatment.⁷⁹ Plus, the program only reimburses treatment for individuals with a primary diagnosis of COVID-19, which is often not the case even when someone suffers from the virus.⁸⁰ The CARES Act Provider Relief Fund reimburses healthcare providers for expenses or lost revenue due to COVID-19 and prohibits providers who accept these funds from balance billing patients for the difference between the provider charge and the insurer payment.⁸¹ However, enforcing such bans has proven difficult.⁸²

Many private health insurers initially chose to waive deductibles, copays, and other out-of-pocket costs for COVID-19 treatment. A Kaiser Family Foundation study released in November 2020 found that 88% of individual market and fully-insured group market enrollees were in a plan that had at least temporarily waived cost-sharing

77. COVID-19, CTRS. FOR MEDICARE & MEDICAID SERVS., <https://www.cms.gov/covidvax-provider> (last visited Jan. 29, 2022).

78. COVID-19 Claims Reimbursement, HEALTH RESOURCES & SERVS. ADMIN., <https://coviduninsuredclaim.linkhealth.com/> (last visited Jan. 29, 2022).

79. Karyn Schwartz & Jennifer Tolbert, *Limitations of the Program for Uninsured COVID-19 Patients Raise Concerns*, KAISER FAM. FOUND. (Oct. 8, 2020), <https://www.kff.org/policy-watch/limitations-of-the-program-for-uninsured-covid-19-patients-raise-concerns/>.

80. *Id.* See also Blake Farmer, *Hospital Bills for Uninsured COVID Patients Are Covered, but No One Tells Them*, KAISER HEALTH NEWS (Oct. 29, 2020), <https://khn.org/news/hospital-bills-for-uninsured-covid-patients-are-covered-but-no-one-tells-them/>.

81. CARES Act Provider Relief Fund: General Information, DEP'T OF HEALTH & HUM. SERVS., <https://www.hrsa.gov/provider-relief/past-payments/terms-conditions> (last visited Jan. 29, 2022); see also AMA, ISSUE BRIEF: BALANCE BILLING FOR COVID-19 TESTING AND CARE – FEDERAL AND STATE RESTRICTIONS (2020), <https://www.ama-assn.org/system/files/2020-05/issue-brief-balance-billing-covid-19-testing-care.pdf>.

82. Jack Hoadley, *The Provider Relief Fund: How Well Does It Protect Patients from Surprise Medical Bills for COVID-19 Related Services?*, GEO. U. CTR. ON HEALTH INS. REFORMS: CHIR BLOG (May 15, 2020), <http://chirblog.org/the-provider-relief-fund-how-well-will-it-protect-patients/>.

for in-network COVID-19 treatment.⁸³ Yet, most waivers quickly expired; UnitedHealthcare, Anthem, Aetna, and Cigna all terminated their waiver programs by February 2021.⁸⁴ Even with these waivers in place, people were left with exorbitant amounts owed.⁸⁵

This description of policies illustrates some of the public and private efforts to try to patch a broken system at a moment of critical need, with limited reach and success. Even more, it illustrates the problems with a system that is so complex. Policies fell short of covering all the care people needed and were only temporary in duration. And even though legislative efforts tried to protect people from out-of-pocket costs for COVID-19 testing and vaccination, treatment for the virus did not receive the same protection, leaving uninsured or underinsured people vulnerable to high medical bills. If there were ever a moment to rethink a system where primary coverage is job-based, now seems prime.

III. THE FUTURE HORIZON OF HEALTH INSURANCE

A. *Divorcing Health Benefits from Work*

1. *The Imperative to Divorce Health Benefits from Work*

Transitioning away from job-based health coverage could address some of the above problems evident before and during the pandemic and could also produce other benefits, such as a more equitable system. As noted above, low-wage workers are less often offered group plans and are less likely to enroll even when offered.⁸⁶ Higher-wage workers get a greater discount on their contributions to plan premiums because these contributions are excludable from taxes, which means someone with higher marginal tax rates saves more.

A second benefit is less employer involvement in their employees' health and health data. Although firewalls limit who can access private health data collected by employers, the uncomfortable connection between work and healthcare becomes salient in various ways. For example, 84% of large employers offer wellness programs and dis-

83. Daniel McDermott & Cynthia Cox, *Cost-Sharing Waivers and Premium Relief by Private Plans in Response to COVID-19*, PETERSON-KFF HEALTH SYS. TRACKER (Nov. 20, 2020), <https://www.healthsystemtracker.org/brief/cost-sharing-waivers-and-premium-relief-by-private-plans-in-response-to-covid-19-nov-2020-update/>. Self-insured employer plans may have instituted these policies as well, but likely less comprehensively.

84. *Health Insurance Providers Respond to Coronavirus (COVID-19)*, AM.'S HEALTH INS. PLANS (Apr. 8, 2021), <https://www.ahip.org/health-insurance-providers-respond-to-coronavirus-covid-19/#K>.

85. Kliff, *Covid Killed His Father*, *supra* note 58.

86. Rae et al., *supra* note 12.

count insurance contributions for people who participate.⁸⁷ These employers typically ask employees to disclose “extensive personal health information,” and in half of these programs, employers use financial incentives to encourage workers to do so.⁸⁸ Yet, participation is still relatively low, possibly because workers do not want to share their health information.⁸⁹ Ongoing debates question the legality of these programs under the Americans with Disabilities Act and Genetic Information Nondiscrimination Act of 2008.⁹⁰ Employers may legally ask for health or genetic information in “voluntary” wellness programs, but the meaning of voluntary is contested, especially when significant discounts are on the line, and employers are not allowed to require employees to disclose genetic information or information about a disability if it directly relates to their ability to perform a job.⁹¹

Third, it could reduce tension between companies and workers over what plans cover and when. Employers and employees can end up in claims disputes when an employer plan denies a claim. The beneficiaries have the right to an internal appeal of a decision with which they disagree.⁹² In addition, under the ACA, participants have the right to an external appeal of denied claims to an independent medical expert.⁹³ These appeals processes pit employers and workers against each other, regardless of how they are resolved.

Finally, reliance on job-based coverage has also long been criticized for creating what economists call “job lock,” or the unwillingness to leave a job or start a business if it means losing job-based health insurance.⁹⁴ In a recent poll, one in six adult workers said they are staying in jobs that they might otherwise leave to keep their health insur-

87. Karen Pollitz & Matthew Rae, *Trends in Workplace Wellness Programs and Evolving Federal Standards*, KAISER FAM. FOUND. (June 9, 2020), <https://www.kff.org/private-insurance/issue-brief/trends-in-workplace-wellness-programs-and-evolving-federal-standards/>.

88. *Id.*

89. *Id.*

90. *Id.*

91. *Id.*

92. 29 C.F.R. § 2560.503-1 (2020).

93. 45 C.F.R. pt. 147; Group Health Plans and Health Insurance Issuers: Rules Relating to Internal Claims and Appeals and External Review Processes; 76 Fed. Reg. 37208 (June 24, 2011) (codified at 45 C.F.R. pt. 147), <https://www.govinfo.gov/content/pkg/FR-2011-06-24/pdf/2011-15890.pdf>.

94. Austin Frakt, *Job Lock: Introduction*, THE INCIDENTAL ECONOMIST (Mar. 19, 2014), <https://theincidentaleconomist.com/wordpress/job-lock-introduction/>.

ance.⁹⁵ Black and low-wage workers, earning under \$48,000 in annual household income, were disproportionately likely to say so.⁹⁶

2. *The Challenges of Divorcing Health Benefits from Work*

The case for moving away from job-based health coverage is compelling from employers' and workers' perspectives, but doing so is no easy endeavor, practically and politically. Practically, both workers and companies resist change. Sometimes this resistance is warranted. For example, unionized workers who have gained extremely comprehensive benefits through years of collective bargaining fear losing that bargained-for compensation. Employers who offer gold-plated benefits and access to high-end providers see it as a tool to recruit the best talent.

Yet, in the long run, economists show that most workers, including unionized labor, would be better off with a system like Medicare for All because of the regressivity of job-based health benefits.⁹⁷ Health benefits cost a fixed dollar amount, but that amount constitutes a higher percentage of low- and middle-wage workers' total compensation than of higher-income workers' total compensation.⁹⁸ Low- and middle-income workers would do better to see that amount in the form of wages, on which they would pay relatively lower taxes than their higher-earning colleagues. Companies could use some of the resources they now spend on health benefits to increase wages or offer other fringe benefits to recruit talent.

It is an understatement, however, to say the transition away from job-based coverage would be difficult. Perhaps the greatest barriers to change are political—considering over a half century of building a system reliant on private insurance companies and where providers have grown accustomed to the spoils of commercial insurance—increasingly so over the past two and a half decades of rapid consolidation.

Attempting to develop policies that do not generate resistance by insurers or providers could undermine good policy. It may be better to build other constituencies in favor of reform to counterbalance resistance. One obvious possibility is large employers (apart, of course, from the insurance companies and health providers and suppliers

95. Dan Witters, *1 in 6 U.S. Workers Stay in Unwanted Job for Health Benefits*, GALLUP (May 6, 2021), <https://news.gallup.com/poll/349094/workers-stay-unwanted-job-health-benefits.aspx>.

96. *See id.*

97. Emmanuel Saez & Gabriel Zucman, *Make No Mistake: Medicare for All Would Cut Taxes for Most Americans*, THE GUARDIAN (Oct. 19, 2019, 2:00 AM), <https://www.theguardian.com/commentisfree/2019/oct/25/medicare-for-all-taxes-saez-zucman>.

98. *Id.*

which themselves are key members of groups like the Chamber of Commerce and the Business Roundtable).⁹⁹ In health policy, the political economy of change from the status quo is always thorny, and shifting away from job-based health coverage would be no exception.

B. Proposals for the Post-Job-Based Horizon of Health Insurance

Efforts to transition away from job-based coverage are not new. The ACA included a provision that came to be called the “Cadillac Tax” that capped the dollar amount of job-based health benefits per worker or family that was excludable from employer taxes.¹⁰⁰ The goal was to create an incentive for employers to invest less in health benefits and more in cash wages by reducing, increasingly over time, the tax-preferential treatment of health benefits over other compensation.¹⁰¹ This provision fell to an effective lobbying campaign by a coalition called the Alliance to Fight the Forty (i.e., a 40% tax on plans above the annual thresholds), which included nonprofit organizations, labor unions, and for-profit companies, and the Cadillac Tax was repealed in early 2020 before it was ever implemented.¹⁰²

Despite the strong resistance to the Cadillac Tax, efforts continue to consider alternatives to job-based coverage in ways ranging from the incremental and small scale to the totally transformative.

1. Remove the ACA Firewall Between Group and Nongroup Coverage

One idea is to allow people to receive subsidies to buy ACA nongroup marketplace coverage, regardless of whether their employer offers health insurance—a possibility the ACA explicitly disallowed.

99. For example, the Business Roundtable is comprised of “chief executive officers of leading U.S. companies,” including Abbvie, Anthem, Inc., Baxter International, Carlyle Group (due to their holdings in the healthcare space), Cigna, CVS Health, Eli Lilly and Company, Humana, Johnson & Johnson, Kaiser Permanente, Medtronic, Pfizer, and Walgreen Boots Alliance, Inc. BUSINESS ROUNDTABLE, Members, <https://www.businessroundtable.org/about-us/members> (last visited Jan. 29, 2022). Although this is a minority of the member organizations, it is clear evidence of the money to be made in healthcare. *Id.*

100. See Matthew Fiedler, *How to Interpret the Cadillac Tax Rate: A Technical Note*, BROOKINGS (Feb. 1, 2018), <https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2018/02/01/how-to-interpret-the-cadillac-tax-rate-a-technical-note/>.

101. *Id.*

102. Mark Mauer, *Finance Chiefs Relieved After Repeal of Cadillac Tax*, WALL ST. J. (Dec. 23, 2019), <https://www.wsj.com/articles/finance-chiefs-relieved-after-repeal-of-cadillac-tax-11577137387>. Interestingly, the group formerly known as Fight the Forty is now called “Alliance to Fight for Healthcare,” with a stated mission to save employer-sponsored healthcare coverage. *Alliance to Fight for Healthcare (AFH)*, INFLUENCE WATCH, <https://www.influencewatch.org/non-profit/alliance-to-fight-the-forty/> (last visited Jan. 29, 2022); ALLIANCE TO FIGHT FOR HEALTH CARE, <https://www.fightforhealthcare.com/> (last visited Jan. 29, 2022).

Just a decade ago, as the ACA was moving through Congress, there was much hand wringing about the potential erosion of employer-sponsored health plans in large part because of the potential fiscal costs.

These concerns were born out of the ACA's effort to make individual, or nongroup, coverage more accessible. Before the ACA, three in five people who sought out nongroup coverage were either denied altogether or offered a plan at rates so high that they were effectively priced out.¹⁰³

The ACA changed this underwriting model, where commercial insurers could consider an applicant's individual risk and charge her based on it. Now, insurers must accept all applicants for nongroup coverage despite pre-existing conditions, known as "guaranteed issue."¹⁰⁴ Premiums charged can vary based on only four factors: age, geography, family size, and tobacco-use status.¹⁰⁵ All nongroup policies must include benefits similar to those offered in most employer plans in ten categories of "essential health benefits," and these policies may no longer impose annual or lifetime coverage limits on these mandated benefits.¹⁰⁶ Plus, the ACA provides subsidies to help people afford a plan and healthcare once they have a plan, which take two forms: premium subsidies for anyone earning 100 to 400% of the federal poverty level and cost-sharing reductions for anyone earning 100 to 250% of the federal poverty level.¹⁰⁷ (These subsidies were increased temporarily under ARPA, as discussed above, and the increases might be made permanent).

With people newly able to get good nongroup health insurance on the ACA's marketplaces, there was concern that firms would stop offering coverage, especially those who employed a disproportionate number of workers who qualified for subsidies. To create incentives for companies to maintain their plans and to avoid driving up the federal cost of subsidies, the ACA contained an employer mandate,

103. MICHELLE M. DOTY ET AL., COMMONWEALTH FUND, FAILURE TO PROTECT: WHY THE INDIVIDUAL INSURANCE MARKET IS NOT A VIABLE OPTION FOR MOST U.S. FAMILIES 1–3 (2009), https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_issue_brief_2009_jul_failure_to_protect_1300_doty_failure_to_protect_individual_ins_market_ib_v2.pdf.

104. Patient Protection and Affordable Care Act § 1201, 42 U.S.C. § 300gg-1 (2012); *Guaranteed Issue*, HEALTHCARE.GOV, <https://www.healthcare.gov/glossary/guaranteed-issue/> (last visited Mar. 2, 2022).

105. Patient Protection and Affordable Care Act § 1201, 42 U.S.C. § 300gg-1.

106. *Id.* at § 1302, 42 U.S.C. § 18022; *Id.* at § 1001, 42 U.S.C. § 300gg-11. *See generally* 42 U.S.C. § 300gg-13.

107. *Id.* at § 1401, 26 U.S.C. § 36B (providing for "premium tax credits"); *Id.* at § 1402, 42 U.S.C. § 18071 (providing for "cost-sharing reductions").

which subjects employers with over fifty full time equivalent employees to a financial penalty if they fail to offer an affordable and adequate group health plan.¹⁰⁸ The calculation of the penalty is complicated, but it is roughly \$3,000 per employee per year if an employer fails to offer qualifying coverage to an employee who then gets subsidies to help purchase an ACA plan.¹⁰⁹

Simultaneously, the ACA erected a “firewall” between group and individual coverage to keep people from fleeing their group policies in favor of subsidized marketplace coverage. If someone is offered a plan by an employer that meets the ACA standards for what is affordable and adequate, she is not eligible to receive subsidies to buy an ACA marketplace plan.¹¹⁰ Without access to these subsidies, the marketplace plans tend to be more expensive than a worker’s contribution for group coverage, creating incentives to stay in the group plan.

Even more, a policy that has come to be known as the “family glitch” created an overly strong incentive for workers to enroll their dependents in the employer plan. To calculate whether an employer plan is affordable, ACA regulations consider the required contribution for *employee-only* coverage, even if the employee wants family coverage.¹¹¹ If employee-only coverage is deemed affordable, it disqualifies everyone in the worker’s household from subsidies to buy coverage on the ACA marketplaces, even if the worker’s contribution amount for a family plan is unaffordable, both practically and under the statutory definition.¹¹² Experts estimate that as many as 6 million people may be made *worse off* when a household member is offered employer-provided coverage that renders them ineligible for premium

108. I.R.C. § 4980H (2018).

109. Treas. Reg. § 54.4980H-5 (2014). 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, 671–72 (2012) (detailing some of the labor market distortions that are likely to result from the ACA’s tax provisions).

110. The statute says a plan is adequate if the actuarial value of the plan is at least 60% and sets affordability at 9.5% of income, subject to future annual adjustments based on growth in income and growth in premiums. I.R.C. § 36B(c)(2)(C)(ii) (2021). For 2022, affordability is set at 9.61% of income. Rev. Proc. 2021-36, 2021-35 I.R.B. 357. Note that this calculation does not account for the part of healthcare costs that the employer funds. So, with a typical 70/30 employer/employee split, affordability is measured only with respect to 30% employee contribution.

111. Treas. Reg. § 1.36B-2(c)(3)(v)(A)(1) (2020).

112. Timothy S. Jost, *Eliminating the Family Glitch*, COMMONWEALTH FUND (May 18, 2021), <https://www.commonwealthfund.org/blog/2021/eliminating-family-glitch>.

subsidies that would otherwise be available based on household income.¹¹³

Experts have questioned the wisdom of this firewall between employer plans and ACA marketplace coverage, and policymakers are considering removing it and allowing employees and their families to receive subsidies for nongroup coverage, regardless of whether they are offered health benefits through a job. One study estimates that between 6 and 13% of people in households covered by employer health insurance would pay lower premiums for a marketplace plan if allowed to access subsidies (although the coverage would also differ).¹¹⁴ Removing the firewall would especially help lower-income people, eligible for relatively greater premium subsidies. A quarter of people earning below 200% of the poverty level (\$25,520 for an individual and \$52,400 for a family of four in 2021) were spending more than 8.5% of household income on premium contributions for a job-based plan.¹¹⁵ If eligible for ACA subsidies, their marketplace premiums would have to be capped at 6.52% of household income prior to enhanced subsidies under ARPA and at 2% following it.¹¹⁶

A risk, however, of removing the firewall is that people will leave employer plans enticed by lower premiums but then end up underinsured—with fewer benefits or considerably higher cost-sharing—in a marketplace plan. This risk would be mitigated for people earning under 250% of the poverty level, who are also eligible for cost-sharing reductions in marketplace plans.¹¹⁷

2. Voucherization of Health Insurance

A second idea also imagines a shift from employer plans to non-group plans. Although some in the Trump administration, including one economist who headed up the Council of Economic Advisers,

113. Matthew Buettgens et al., *Marketplace Subsidies: Changing the ‘Family Glitch’ Reduces Family Health Spending but Increases Government Costs*, 35 HEALTH AFF. 1167, 1173 (2016).

114. Jesse C. Baumgartner et al., *Removing the Firewall Between Employer Insurance and the ACA Marketplaces: Who Could Benefit?*, COMMONWEALTH FUND (Dec. 15, 2020), <https://www.commonwealthfund.org/publications/issue-briefs/2020/dec/removing-firewall-employer-insurance-aca-marketplaces>.

115. *Id.*

116. Jason Levitis & Daniel Meuse, *The American Rescue Plan’s Premium Tax Credit Expansion—State Policy Considerations*, BROOKINGS (Apr. 19, 2021), <https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2021/04/19/what-does-the-american-rescue-plans-premium-tax-credit-expansion-and-the-uncertainty-around-it-mean-for-state-health-policy/>; *Explaining Health Care Reform: Questions About Health Insurance Subsidies*, KAISER FAM. FOUND. (Oct. 29, 2021), <https://www.kff.org/health-reform/issue-brief/explaining-health-care-reform-questions-about-health-insurance-subsidies/>.

117. 42 U.S.C. § 18071(c)(2) (2010).

have resisted alternatives to job-based coverage,¹¹⁸ at least one Trump administration policy actively offers an alternative. Through a 2019 rule, HHS, with the Departments of Labor and Treasury, loosened regulations governing Health Reimbursement Accounts (HRAs), individual account-based health benefits that employers provide and workers can use toward premiums, cost-sharing, and medical services.¹¹⁹ This new rule created tax-advantaged individual coverage health reimbursement accounts, or ICHRAs for short.¹²⁰ They allow employers to contribute pre-tax to coverage for employees in the individual market.¹²¹

Employers can contribute to an ICHRA in any amount, creating a defined contribution approach to benefits.¹²² Employers of any size can offer them, but these ICHRAs and an earlier form, also with a snappy name (Qualified Small Employer Health Reimbursement Arrangements), may appeal especially to small employers, who do not have enough employees to pool risk well, and to large employers with less healthy workforces.¹²³ While offering their own plans is more expensive for firms with a sicker workforce, the marketplace plans are community rated, which, as discussed above, means that premiums do not vary based on health status. That means that companies could offload sicker workers and dependents onto the marketplaces without subjecting the workers to higher premiums based on their poor health.¹²⁴ ICHRAs may, however, produce undesirable distributional effects. Older workers will face age-rated premiums on the ACA marketplaces and thus will be subject to relatively higher premiums than younger workers.¹²⁵ Furthermore, ICHRA contributions, if high enough, can disqualify workers from receiving ACA subsidies, possi-

118. See generally, Casey B. Mulligan, *The Value of Employer-Sponsored Health Insurance* (Nat'l Bureau of Econ. Research, Working Paper No. 28590, 2021), <https://www.nber.org/papers/w28590>.

119. Health Reimbursement Arrangements and Other Account-Based Group Health Plans, 84 Fed. Reg. 28888 (June 20, 2019) (codified in various parts of 26 C.F.R., 29 C.F.R., and 45 C.F.R.), <https://www.govinfo.gov/content/pkg/FR-2019-06-20/pdf/2019-12571.pdf>.

120. *Id.*

121. *Id.*

122. *Id.* at 28969.

123. CHRISTEN LINKE YOUNG ET AL., USC-BROOKINGS SCHAEFFER INITIATIVE HEALTH POL'Y REP., EVALUATING THE ADMINISTRATION'S HEALTH REIMBURSEMENT ARRANGEMENT PROPOSAL 1, 3–4, 6, 17 (2018), https://www.brookings.edu/wp-content/uploads/2018/12/Linke-Young_Levitis_Fiedler_HRA-paper_12.11.18.pdf.

124. *Id.* at 6–8.

125. 42 U.S.C. § 300gg(a) (allowing rates to be three times as high for older enrollees than younger ones).

bly making them worse off than if their employer did not contribute to an ICHRA.¹²⁶

The benefits of ICHRAs largely accrue to companies, rather than to workers. Companies save money on health benefits. Yet, the plans employees buy with an ICHRA on the marketplaces will not be as good as most employer plans. And since, as noted, an employer's contributions to an ICHRA can disqualify employees from receiving marketplace subsidies, workers may face higher premium costs than if their employer offered nothing, unless the employer contributes generously enough to the ICHRA to make up for any lost subsidies.

Structurally, displacing job-based coverage by moving people into the individual market is not ideal, at least in the short term. The plans in the individual market tend to have more limited networks, since the commercial insurers would otherwise struggle to craft competitively priced plans, and to have relatively high cost-sharing. For enrollees without subsidies, the premiums are also very expensive. ARPA has tried to address this problem by removing the subsidy cliff at 400% of the federal poverty level and enhancing subsidies below it.¹²⁷ But, even if these temporarily enhanced subsidies are made permanent, they cap premiums for someone buying the benchmark plan at 8.5% of household income, which means it still costs over \$4,388 for an individual earning \$51,040 to buy a plan with relatively high cost-sharing.¹²⁸ If, over time, more people were moved into these plans, it would amplify the need to improve the quality of their networks and affordability.

3. *Medicare for All*

On the opposite extreme is Medicare for All, which would, within a fairly short period of time, displace private employer plans altogether. Various high-profile politicians have come out in favor of MFA, and increasingly so. Senator Bernie Sanders in 2016 and a longer bench of proponents in the 2020 Democratic primaries, including Senator Elizabeth Warren and then-Senator Kamala Harris, have supported MFA. Representative Pramila Jayapal has introduced legislation in favor of MFA in the House of Representatives.¹²⁹ Although people have different conceptions of what precisely MFA would mean, the basic idea is to move everyone to public Medicare coverage, creating a single-

126. YOUNG ET AL., *supra* note 123, at 9.

127. Rae et al., *supra* note 67.

128. Pollitz, *supra* note 70.

129. Medicare for All Act of 2019, H.R.1384, 116th Cong., <https://www.congress.gov/bill/116th-congress/house-bill/1384>.

payer, simpler system, more akin to the financing systems in various Organisation for Economic Co-operation and Development (OECD) countries.¹³⁰

Senator Sanders's proposal, for example, imagines a single-payer public health insurance program where everyone would be automatically enrolled in government-funded coverage.¹³¹ Senator Sanders's version of MFA is comprehensive, with more complete benefits and less cost-sharing than Medicare currently provides beneficiaries.¹³² In part because of the generosity of this particular conception, estimates projected \$25 to \$35 trillion in increased federal government outlays over the first ten years.¹³³ Yet—and this is the most important bottom line—many experts estimated that this plan, which would leave no one uninsured or underinsured, would result in little or no growth in total national healthcare spending.¹³⁴

Because the federal government would have to raise the financing through taxes, the fiscal case for MFA has proved challenging to overcome so far. MFA, especially as Senator Sanders imagines it, would also cause significant and quick disruption to the current financing system. Although also a benefit of the proposal, it would make it difficult to implement and riskier if the initial implementation period is rocky.

In the 2020 Democratic presidential primaries, some candidates, including Senators Warren and Harris, imagined longer “phase-in” periods to transition from the current system to MFA.¹³⁵ For example,

130. *But see* Stuart M. Butler, *Medicare Advantage for All, Perhaps?*, 1 JAMA F., July 2020, <https://jamanetwork.com/journals/jama-health-forum/fullarticle/2769097> (proposing a complex version of MFA built on Medicare Advantage, the private health plan offerings that Medicare beneficiaries can select).

131. For most recent version, see Medicare for All Act of 2019, S.1129, 116th Cong., <https://www.congress.gov/bill/116th-congress/senate-bill/1129/text?q=%7B%22search%22%3A%5B%22%5C%22medicare+or+all%5C%22%22%5D%7D&r=2&s=4>. This version contained fourteen co-sponsors, including prominent members such as Senators Harris, Leahy, Markey, and Warren. *Id.*

132. After a short four-year transition period, he envisions that every American would be automatically enrolled in coverage with benefits more comprehensive than what Medicare covers today, including dental, vision, and long-term care benefits, and with no cost-sharing, also quite different than Medicare for current beneficiaries. *Id.*

133. *Choices for Financing Medicare for All*, COMMITTEE FOR A RESPONSIBLE FED. BUDGET (Mar. 17, 2020), <http://www.crfb.org/papers/choices-financing-medicare-all>.

134. *See, e.g.*, Josh Katz et al., *Would ‘Medicare for All’ Save Billions or Cost Billions?*, N.Y. TIMES (Oct. 16, 2019), <https://www.nytimes.com/interactive/2019/04/10/upshot/medicare-for-all-bernie-sanders-cost-estimates.html> (showing various projections of the cost of MFA, many of which would result in the same or less total U.S. healthcare expenditures than under existing financing structures).

135. 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/>

then-Senator Harris proposed a ten-year transition period, during which people who wanted to buy into Medicare more quickly could do so.¹³⁶ Harris's transition period included some structural characteristics to lubricate more fundamental long-term transformation, including automatically enrolling all newborns and uninsured people into the Medicare program.¹³⁷ Even, however, with a longer transition period, the fiscal footprint of MFA is high, and political resistance would be as well, because of the total reimagining of healthcare finance.

C. *A New Proposal: A Public Option for Employer Health Plans*

In search of a way to transition away from job-based coverage in a manner that is incremental, fiscally responsible, and politically imaginable (or at least not a non-starter), Howell Jackson, Amy Monahan, and I have developed a new proposal for an employer public option.¹³⁸ In contrast to its more famous relative, the individual public option, our idea would allow employers to enroll all members of their group health plans into a Medicare-based public option, rather than continuing their existing private group plans.

For us, the goal is a policy that simultaneously offers an alternative to employer plans in the short term and builds a foundation for a more equitable and efficient health insurance system in the long term. The United States now has the most expensive, inefficient, and inequitable healthcare system among its OECD peer nations.¹³⁹ We spend twice as much as the average OECD nation and get worse outcomes than most of them on critical metrics, such as life expectancy, chronic disease burden, and avoidable death.¹⁴⁰ What drives our high healthcare spending is high prices, because we use less care per capita than

m4a-transition [<https://perma.cc/L3LW-W4JJ>] (last visited Jan. 29, 2022) (detailing Warren's plan for transitioning to MFA, which included immediate and free coverage for children under age eighteen and anyone earning under 200% of the federal poverty level).

136. 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 and Warren transition plans also allowed this individual opt-in.

137. *Id.*

138. See generally Hoffman et al., *supra* note 1.

139. Roosa Tikkanen & Melinda K. Abrams, *U.S. Health Care from a Global Perspective, 2019: Higher Spending, Worse Outcomes?*, COMMONWEALTH FUND (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.").

140. *Id.*

most other countries.¹⁴¹ Any productive health reform must address high prices, which our proposal would do.

Why would employers want to enroll employees in Medicare? First, it would get them out of the business of health insurance, which for many is an expensive and stressful distraction, while still enabling them to offer employees quality health benefits. In terms of regulatory relief, the Employee Retirement Income Security Act of 1974 (ERISA) could be amended to provide that employer participation in the public option does not create an employee benefit plan, relieving employers of all ERISA obligations if they elect the employer public option. The employer's responsibilities would instead be limited to facilitating employee enrollment, processing payroll contributions, and transmitting enrollment information to the public option.

Second, and more importantly, it would save employers money on health benefits, even if they were required to continue to contribute to their employees' coverage in a public option, by giving employers access to Medicare's bargaining power on prices. Health spending growth has far outpaced economic growth, with health spending increasing from just under 7% of GDP in 1970 to nearly 20% now.¹⁴² Even over the last decade, from 2008 to 2019, during a period when the rate of spending has slowed, private health insurance's cumulative growth in per enrollee spending is over 50%, as compared to half that rate (just over 26%) for Medicare.¹⁴³ As noted above, Medicare now pays hospitals, on average, half as much as private health insurance plans do, and it pays a fraction of the price for outpatient care as well.¹⁴⁴

Obviously, some of that difference might be narrowed if Medicare were expanded so that hospitals and doctors see more Medicare patients and fewer privately insured ones. Setting reimbursement rates for an employer public option would be a delicate task, but somewhere in between Medicare's rates and those twice as high in private plans could be a starting point. Over time, and depending on numbers of enrollees, rates could be adjusted to ensure provider participation, especially by providers who are important to the large employer market.

141. *Id.* (showing lower rates of physician visits, similar hospitalization, but greater use of MRI scans per capita).

142. Rabah Kamal et al., *How Has U.S. Spending on Healthcare Changed Over Time?*, PETERSON-KFF: HEALTH SYS. TRACKER (Dec. 23, 2020), <https://www.healthsystemtracker.org/chart-collection/u-s-spending-healthcare-changed-time/#item-start>.

143. *Id.*

144. LOPEZ ET AL., *supra* note 35.

In terms of broad policy strokes, we imagine that an employer public option would be based on traditional Medicare which has reasonably comprehensive benefits and a large network of participating providers. That said, benefits would need to be adapted for a working-age population and their dependents, and, ideally, cost-sharing would also be modified to be more akin to that in group plans today. Medicare does not cover many items that are standard in employer plans, such as dental, hearing, and vision benefits, and it has higher cost-sharing, requiring most beneficiaries to seek out supplemental coverage.¹⁴⁵ Cost-sharing amounts are reflected by actuarial value, which measures how much of total healthcare costs a plan covers, with the remainder left to the insured. Among large employer plans, almost one-quarter have actuarial values of more than 90%, with an average actuarial value well above 80%.¹⁴⁶ In contrast, 83% of current enrollees in traditional Medicare today have supplemental coverage to manage the higher levels of cost-sharing.¹⁴⁷

Employers would elect whether to participate. Although not perfect, especially large employers are comparatively well-equipped to evaluate the relative value of health plans, while considering their employees' needs. Evidence overwhelmingly shows that individuals struggle in making health insurance decisions in their own interest.¹⁴⁸

Some firms might prefer to retain their existing plans if they think it is necessary as part of their strategy to recruit and retain workers, a position that is generally supported by employee surveys.¹⁴⁹ Yet, even if a handful of large employers opted in, which is where we think this policy should initially focus, it would still mean many new enrollees—

145. *Gaps in Medicare and Supplemental Coverage*, NAT'L ACAD. SOC. INS., <https://www.nasi.org/learn/medicare/gaps-in-medicare-and-supplemental-coverage/> (last visited Mar. 2, 2022).

146. 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%); ACTUARIAL RESOURCES CORP., ANALYSIS OF ACTUARIAL VALUES AND PLAN FUNDING USING PLANS FROM THE NATIONAL COMPENSATION SURVEY 11 (May 17, 2017) (showing AV of 89% at the 70th percentile and 91.7% at the 80th percentile).

147. Wyatt Koma et al., *A Snapshot of Sources of Coverage Among Medicare Beneficiaries in 2018*, KAISER FAM. FOUND. (Mar. 23, 2021), [https://www.kff.org/medicare/issue-brief/a-snapshot-of-sources-of-coverage-among-medicare-beneficiaries-in-2018/#:~:text=Among%20Medicare%20beneficiaries%20in%20traditional,supplemental%20coverage%20\(Figure%202\).](https://www.kff.org/medicare/issue-brief/a-snapshot-of-sources-of-coverage-among-medicare-beneficiaries-in-2018/#:~:text=Among%20Medicare%20beneficiaries%20in%20traditional,supplemental%20coverage%20(Figure%202).)

148. For a summary of evidence, see Allison K. Hoffman, *Health Care's Market Bureaucracy*, 66 UCLA L. REV. 1926, 1972 (2019).

149. See, e.g., AM.'S HEALTH INSURANCE PLANS, THE VALUE OF EMPLOYER-PROVIDED COVERAGE (2018) (reporting results of an employee survey where 71% reported satisfaction with their employer's health plan; 46% 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).

significantly more than for a public option targeted primarily for individuals—which could begin to streamline the overall healthcare financing system.¹⁵⁰ Approximately 12,000 firms have more than 1,000 employees, roughly 6,000 employees on average per firm.¹⁵¹ If a small share of these firms were to transition to the employer public option, it would offer a meaningful expansion opportunity and, with it, the ability to collect data and to test the feasibility of expanding Medicare over time. If several major employers make the leap and it works, it might persuade others that private plans are not worth maintaining.

The employer public option would be financed through premiums paid by employers and workers directly into the plan. The contributions could be designed in a variety of ways, but the basic concept is that employers and employees would each continue to pay a similar share of the costs of coverage as they do today. However, with lower Medicare prices for medical care and items, the actual dollar amount of both employer and worker contributions would decrease in many instances. From a fiscal perspective, such premiums would be voluntary payments by employers and employees collected by the government. Therefore, the employer public option would not need to be funded by taxes, which could make this approach more politically feasible than a quick step to Medicare for All.¹⁵²

Another benefit of an employer public option is the possibility to integrate employer contributions and ACA-style subsidies so that someone who qualifies for ACA subsidies could use them toward an employer public option. For the lowest-income workers, the subsidies might more than fully cover their employee contribution, and any excess could reduce the employer's contribution for that worker too. Although providing subsidies to enrollees in an employer public option would increase the federal cost of a program, it creates an incentive for employers to expand coverage to the people who are not offered it now or cannot afford it even when it is offered. These part-time, gig,

150. LINDA J. BLUMBERG ET AL., ESTIMATING THE IMPACT OF A PUBLIC OPTION OR CAPPING PROVIDER PAYMENT RATES, HEALTH POLICY CENTER (Mar. 2020), <https://www.urban.org/sites/default/files/2020/03/23/estimating-the-impact-of-a-public-option-or-capping-provider-payment-rates.pdf>.

151. U.S. BUREAU OF LABOR STATISTICS, DISTRIBUTION OF PRIVATE SECTOR FIRMS BY SIZE CLASS, https://www.bls.gov/web/cewbd/table_g.txt (last visited Jan. 29, 2022). These figures are substantially consistent with more comprehensive Census Department data for 2017, which reports on both firms and establishments. See U.S. 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>.

152. GOV'T PUBL'G OFFICE, ANALYTICAL PERSPECTIVES, CHAPTER 12: OFFSETTING COLLECTIONS AND OFFSETTING RECEIPTS, 141 (2020), <https://www.govinfo.gov/content/pkg/BUDGET-2019-PER/pdf/BUDGET-2019-PER-6-2.pdf>.

and low-wage workers are especially in need of good coverage and make up a sizeable share of the uninsured today.¹⁵³

If enough employers adopt a public option—and especially if it were designed in conjunction with an individual public option—there would be less coverage disruption for workers in between jobs and when switching jobs, reducing job lock. An employer public option could also 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. For any months during which an individual's projected income falls below 138% of federal poverty, the Medicaid program could pay the premium for the public option, enabling continuity of coverage through the employer plan and reducing care disruptions.

Finally, in considering the political feasibility, this proposal might fit within the Byrd Rule limitations, enabling it to pass the Senate through a budget reconciliation bill.¹⁵⁴ It would need to be crafted as an expansion of Medicare for a new group of participants and delegate authority to HHS to hammer out details like premium schedules, adapting benefits to a working population, and determining the contours of regulatory relief for employers.

The bottom line and motivation for this policy idea is that future efforts for health insurance reforms should focus on policies with greater potential for long-term structural improvements. Many of the policies noted above, like enhanced marketplace subsidies under ARPA or removing the firewall between employer and ACA marketplace coverage, will benefit some, likely a small number of people, but they are a patch and will not make major improvements in the system. In contrast, an employer public option that builds out on Medicare in a meaningful way to replace weaker parts of the employer system could start to craft a stronger foundation for the long-term, post-pandemic future of health insurance.

CONCLUSION

The COVID-19 pandemic laid bare the chaos inevitable when people lose jobs—and job-connected health insurance—during a public health emergency. Although such a dramatic concurrence of events will hopefully not recur anytime soon, it illustrated in a large-scale way what happens on a smaller scale every day. People who are too sick to work lose their jobs and, at the same time, their health insur-

153. See Hoffman et al., *supra* note 1, at 330.

154. See discussion in *id.* at 359–60.

ance, when they need it most. Or people with job-based coverage still cannot afford the care they need, as their own contributions to their coverage and their cost-sharing obligations grow. Or someone who changes jobs must find a whole host of new doctors and medicines in a new job-based plan. This system no longer serves many people well during the best of times, and even less so during a public health crisis. With these shortcomings in such clear relief, it is an ideal time to begin to invest in policies that can foster a more secure, less complicated, and more equitable post-pandemic horizon of health insurance.