

A Public Option for Employer Health Plans

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Abstract:

Employer-based private health coverage—long the gold standard of health insurance—is in decline. Employers are increasingly unable to manage the escalating prices that consolidated health care systems can command. In response, over the past two decades, fewer employers are offering health benefits, and, when they do, they cabin their own spending through plans that shift more of the costs to employees to pay on their own. Employers are increasingly exasperated with their secondary role as health benefits companies. This changing picture offers an opportunity to rethink the role that employers play in designing and managing health plans, a role that is often described as an accident of history and that is an impediment to a better health care financing system. Major health reform ideas have tended largely to neglect the employer space (e.g., the Affordable Care Act) or to propose to displace it swiftly and in its entirety (e.g., Medicare for All).

This Article instead proposes a public option targeted at employers, which can both improve job-based health coverage and also build a foundation for a sounder health care financing system overall. 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.

We review the policy, regulatory, fiscal, and business arguments in favor of this form of public option, which we argue is less disruptive than a reform like 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

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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 overreliance 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 in the United States, two opposing truths are evident. Fundamental change is needed, and fundamental change is impossible. Even a decade after the Patient Protection and Affordable Care Act (ACA) addressed some of the gaps in how Americans pay for health care, many people still struggle to afford care in a system that remains uncoordinated, inefficient, and inequitable. Perhaps the ACA's 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. Most notably, these efforts were incremental and relatively small-scale. They did little to lay the groundwork in the United States for the longer-term structures needed to pay for health care more efficiently and equitably.

This Article sets out to build on existing policy proposals and 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 giving employers 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.

Recent health reform proposals suffer from being too disruptive or too limited in scope to warrant the political capital they demand. On the one hand, Medicare for All (MFA) would swiftly transform the current system. If designing from scratch today, this option that is closer to what exists in many peer nations would most certainly produce a lower cost system with better outcomes.¹ Yet, MFA dislocates a large number from existing coverage quickly and is demonized as antithetical to individual autonomy and free choice. It raises the specter of government overreach and evokes uncomfortable memories of President Obama's much-repeated assurance that under the ACA people who like their health care

¹ 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.”).

could keep it.²

The budgetary price tag for MFA is an equally substantial impediment. The cost of operating a fully implemented MFA program is estimated to run into the trillions of dollars, necessitating a substantial increase in federal taxes.³ 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.⁴ Moreover, standard labor economics predicts that universal public coverage could help workers by reducing the share of their compensation consumed by ever-rising health care spending.⁵ 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 drowns out all else.

On the other end of the spectrum are ideas for incremental expansion, building on the successes of the ACA. One example is adding a public option based on Medicare to the ACA Marketplaces, in theory to compete with private plans already offered.⁶ It is targeted narrowly at those who purchase individual coverage—those who are not offered employer-based coverage and who are ineligible for Medicaid. In contrast to MFA, the main selling points of a public option are, first, that it retains a high degree of individual choice and, second, it has a relatively small fiscal footprint. But a public option for individuals would reach only a tiny fraction of the population.⁷ This incremental reform would not

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

3 See *infra* Table One (estimating the net fiscal impact of Senators Sanders' and Warren's Medicare for All proposals at \$12.95 trillion and \$6.1 trillion, respectively).

4 Tikkanen & Abrams, *supra* note 1.

5 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).

6 During the 2019-2020 Democratic presidential primaries, Pete Buttigieg coined it "Medicare for all who want it." Scott Simon & Heidi Glenn, *"Just The Right Policy": Pete Buttigieg On His "Medicare For All Who Want It" Plan*, NPR (Nov. 8, 2019), <https://www.npr.org/2019/11/08/774716877/just-the-right-policy-pete-buttigieg-on-his-medicare-for-all-who-want-it-plan> (providing a video and summary of an interview with Pete Buttigieg regarding his health plan proposal during the 2019-2020 Democratic primaries); see also Letter from Frank Pallone, Jr., Chairman, H. Comm. on Energy & Com. & Patty Murray, Chair, S. Comm. on Health, Educ., Lab. & Pensions, to All Interested Persons (May 26, 2021), https://energycommerce.house.gov/sites/democrats.energycommerce.house.gov/files/documents/Public%20Option.2021.5.26._FINAL.pdf (requesting information from stakeholders on potential public option legislation).

7 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 people. See COMM. FOR A RESPONSIBLE FED. BUDGET, PRIMARY CARE: ESTIMATING DEMOCRATIC CANDIDATES' HEALTH PLANS 2 (Feb. 26, 2020), <http://www.crfb.org/papers/primary-care-estimating-democratic-candidates-health-plans>.

address, and could deepen, structural problems in the system.⁸ 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 has envisioned any significant movement away from our hefty reliance on job-based coverage.

Health policy experts in the United States have long lamented the centrality of employer-sponsored, or job-based, 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.⁹ 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. 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.¹⁰ 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.

Our proposal has the potential to reverse the trend of creeping costs and less generous coverage by taking advantage of the government's ability to deliver lower prices for a large section of the health care market. The United States has the most expensive, inefficient, and inequitable health care system among its OECD peer nations.¹¹ 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.¹² What most drives high health care spending is high prices (we use less care per capita than most other countries).¹³ Prices are high because of a lack of governmental rate-setting, a financing system inefficiently fragmented into too many payers, and consolidation among providers, who in many geographies can name their reimbursement rates in negotiation with private payers, even the largest ones.¹⁴ Public payers, like Medicare, in contrast, have more successfully controlled health care cost growth.

We all three believe that fixing how we pay for health care in the United States

8 See Allison K. Hoffman, *The Irony of Health Care's Public Option*, in *POLITICS, POLICY, AND PUBLIC OPTIONS* (Ganesh Sitaraman & Anne Alstott eds., 2021) (describing the limitations of an individual public option).

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

10 See *infra* Section I.C.

11 Tikkanen & Abrams, *supra* note 1.

12 *Id.*

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

14 See *infra* Section II.A.

must involve moving away from a primarily employer-based private financing system, and that such a shift needs to happen gradually given political and administrative realities. We think the best way to accomplish that gradual shift 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. We propose that this employer public option build on Medicare because it offers good coverage, an excellent provider network, and the ability to rely on governmental price negotiations. It is not perfect, but it offers an excellent starting point. If workers like it, which we believe many would for reasons described below, it could warm people to the benefits of public coverage more broadly.¹⁵

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 health care. According to recent estimates, 158 million individuals had employer-sponsored health insurance as compared with 18.7 million with individual coverage and roughly 29.3 million uninsured (the remainder of the population already has public coverage).¹⁶ In other words, three times more people have coverage through an employer than the sum of current individual market enrollees and the uninsured. Any effort to streamline the overall health care financing system must include this population. While our approach would not likely result in Medicare for All, an employer public option might 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. First, it offers a coordinated way to test an expansion of public coverage to the working-age population. We advocate for focusing first on large employers to take advantage of these employers' relative expertise in health insurance and ability to support roll out and testing of the idea to a significant number of people.¹⁷ If even just a handful

15 An interesting question is whether people would understand this plan as public coverage, even if it is based on Medicare and administrated by the government, if offered through the workplace. In addition, to the degree the employers are financing the coverage, as before, it is somewhat of a public-private partnership. Yet, since regulators design the benefits, set the prices, and pay the bills, it retains more public than private characteristic.

16 *Health Insurance Coverage of the Total Population*, KAISER FAM. FOUND., <https://www.kff.org/other/state-indicator/total-population/> (reporting 2019 data).

17 In 2020, over two-thirds of private sector employees worked for firms with more than 100 employees, with some 50.9% at firms with over one thousand employees, and a similar share of employees in these categories of firms had employer-sponsored insurance (ESI) coverage. These

of large employers chose to participate in a public option, it could provide valuable information about the benefits and costs savings possible from moving toward a national system of health care financing.¹⁸ The experience gained through this transition—including understanding the number and type of employers that choose 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, decisions made by employers with substantial expertise in choosing health care plans.

Employers also offer an efficient distribution channel to reach some of the remaining uninsured, especially lower-income uninsured. Recent surveys reveal that now, unlike before the ACA, the majority of uninsured people are employed either full-time or part-time.¹⁹ Some of these workers, who are disproportionately low-income, are offered workplace coverage that they cannot afford and others are not offered it at all.²⁰ 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 could offer an appealing alternative to private plans for employers, who are increasingly frustrated with administering private health benefits. There are good reasons to believe that many employers, both small and large, would not only choose to participate in a public option but would also help advocate for it, even if there may be some initial hurdles to overcome. 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. Increasingly, they address cost increases by limiting the provider networks in their plans or by shifting more costs onto employees. The possibility for relief from this financial and regulatory morass

estimates are derived from AGENCY FOR HEALTHCARE RESEARCH AND QUALITY, U.S. DEP'T OF HEALTH & HUM. SERVS., MEDICAL EXPENDITURE PANEL SURVEY (2020) [hereinafter 2020 MEPS DATA]; *see also* KAISER FAM. FOUND., EMPLOYER HEALTH BENEFITS: 2020 ANNUAL SURVEY 11 (2020) [hereinafter KFF Employer Health Benefits 2020], <https://files.kff.org/attachment/Report-Employer-Health-Benefits-2020-Annual-Survey.pdf> (finding that most workers work for large firms that offer health benefits).

¹⁸ For example, if one focuses on just the top ten ESI programs as reported on Forms 5500 (the annual report filed by employee benefit plans with the Department of Labor) in 2018, covered individuals total more than 4.2 million. The largest reporting plan—Walmart Inc. Associates' Health and Welfare Plan—reports over 1.5 million employees covered. *See* FREEERISA, <https://freerisa.com> (last visited Mar. 11, 2022).

¹⁹ *See infra* text accompanying notes 125-127.

²⁰ *See* Matthew Rae 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/> (showing that employer offer rates and employee take-up rates are both strongly correlated with household income level, with lower-income employees much less likely to be offered coverage by an employer and, even when offered coverage, much less likely to enroll in such coverage).

would motivate some employers to select a public option, so long as their employees were guaranteed high-quality coverage. And at employers where unions have had a role in shaping benefits in the past, they could be given a voice in whether and how to transition to a public option.

Our proposed public option is voluntary, not compelled, which helps with optics and politics. Employers would choose whether to participate, consistent with the choice a company faces today when it decides whether to ship its goods with the U.S. Postal System or Federal Express and whether to prioritize employee travel by Amtrak or airlines. Employers, especially large employers, are comparatively well-equipped to evaluate the relative value of health plans, while hopefully taking into account what their employees need. While a public option is usually touted on the grounds that private insurers “need real competition,”²¹ 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.²² Although not perfect, corporate human resources departments can better navigate these waters.

An employer public option also offers significant fiscal advantages. Current employer and employee contributions for employer-sponsored health insurance can 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. One disadvantage, as compared to Medicare for All or other all payer approaches, is that it would not lead to the same level of administrative simplification from the provider perspective.

No doubt, the political lift will still be herculean. Certain vested interests who have sunk health reform efforts in the past—most obviously private health insurance companies and providers—will resist an initiative of this sort. Medical providers, from hospitals to doctors to medical device and pharmaceutical companies, who gain great profit off the current system will fight against it, intuiting, correctly, that it would mean lower reimbursement rates than they currently enjoy from private health plans. Even labor unions who might support the idea on a blank slate could resist it if they saw the effort as threatening the loss

21 Press Release, JoeBiden.com, Biden-Sanders Unity Task Force Recommendations 31 (July 8, 2020), <https://joebiden.com/wp-content/uploads/2020/08/UNITY-TASK-FORCE-RECOMMENDATIONS.pdf>.

22 See *infra* Section I.C.

of bargained-for health benefits. Any effort at national health care reform, regardless of the policy, will see resistance from these same groups, but a public option for employers offers transformative potential that makes it worth working through this resistance.

This Article is organized as follows. In Part I, we provide a brief overview of the U.S. health care finance system and the leading proposals for health reform. We then describe 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. HEALTH CARE 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-twentieth century as medical care became more advanced and expensive.²³ In Europe, what emerged were public systems of health care finance in two forms, often characterized coarsely as Beveridge and Bismarckian systems.²⁴ 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 Bismarckian 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 United States charted a wholly different path, leading with private health

23 PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE: THE RISE OF A SOVEREIGN PROFESSION AND THE MAKING OF A VAST INDUSTRY* 237-40 (1982).

24 See T.R. REID, *THE HEALING OF AMERICA* 16-27 (2009).

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.²⁵ 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.²⁶ These types of hospital service plans spread and eventually evolved into Blue Cross. Within a short period, Blue Shield followed, offering a similar a structure for monthly prepayment of fees for guaranteed access to outpatient, physician care.²⁷

Through the mid-twentieth century, employers grew as a source of health coverage in the United States, coinciding with the moment that many other countries were doubling down on the government's role.²⁸ In the United States, several public policies fostered the growth of employer-sponsored insurance (ESI) 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.²⁹ 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 benefits, and most importantly a 1954 rule by the Internal Revenue Service excluding dollars spent on health benefits by employers and employees from taxation.³⁰ 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 these factors, ESI and the centrality of private insurance took hold.

25 STARR, *supra* note 23, at 295-96.

26 *Id.*

27 *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.

28 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).

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

30 *Id.*; see also Jost, *supra* note 9, at 157-58 (describing how the expansion of private health employer-based health insurance was driven by several policies following World War II, including a National Labor Relations Board clarification that “terms and conditions of employment” subject to bargaining include employee benefits and explicit recognition in the Internal Revenue Code that health benefits are not taxable).

The tax benefits associated with ESI continue to be an important driver of its primacy today, but other factors also contribute.³¹ 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).³²

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,³³ 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 individuals. Across 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.³⁴

Hundreds, or perhaps thousands, of proposals have promised to reform the dysfunctional health care financing system in the United States. Many of these, dating back decades, have questioned whether employers should continue to play a fundamental role in health coverage.³⁵ As context for our proposal, we mention 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. We describe why we believe that an employer public option provides an attractive path forward that avoids the downfalls of either extreme. Finally, 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, counterintuitively, be the best place to begin systemic reform.

A. *Medicare for All*

At its passage in 1965, some believed Medicare would eventually become the

31 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).

32 See *infra* text accompanying notes 90-92.

33 *Health Insurance Coverage of Nonelderly 0-64*, KAISER FAM. FOUND., <https://www.kff.org/other/state-indicator/nonelderly-0-64/> (last visited Aug. 6, 2021).

34 KAISER FAM. FOUND., *supra* note 16 (figures do not add up to 100% due to rounding).

35 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 . . .”).

health insurance program for all Americans.³⁶ Momentum in this direction slowed right away with the simultaneous passage of Medicaid, a program that insured what were considered 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.³⁷

Yet, the idea of building on Medicare has reemerged in various forms after a period of dormancy. 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 that we should 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,³⁸ and it served as the basis of his health policy in his candidacy in the 2016 and 2020 Democratic primaries.³⁹ Following the 2016 election, more politicians began to follow in Senator Sanders’ footsteps. The Medicare for All Act of 2019 included fourteen co-sponsors, including prominent members such as Senators Harris, Leahy, Markey, and Warren.⁴⁰ Notable about Senator Sanders’ version of Medicare for All are its ideological commitments and truly universal and comprehensive nature, which for many made it more symbolic than realistic.⁴¹ 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.⁴² Yet, many experts estimated that

36 THEODORE R. MARMOR, *POLITICS OF MEDICARE* 173 (2d ed. 2000).

37 *Id.* at 60.

38 For the most recent version, see Medicare for All Act of 2019, S. 1129, 116th Cong. (2019). The 2019 House version was sponsored by Representative Pramila Jayapal. Medicare for All Act of 2019, H.R. 1384, 116th Cong. (2019).

39 *Bernie Sanders on Healthcare*, FEELTHEBERN.ORG, <https://feelthebern.org/bernie-sanders-on-healthcare/> (last visited Mar. 5, 2020) (stating Medicare for All “[c]overs primary and preventive 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”).

40 S. 1129.

41 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, copayments, co-insurance, and balance billing that vex and financially strain many Americans. *Id.*

42 COMMITTEE FOR A RESPONSIBLE FEDERAL BUDGET, *CHOICES FOR FINANCING MEDICARE FOR ALL 1* (Mar. 17, 2020), <http://www.crfb.org/papers/choices-financing-medicare-all>.

this plan that would leave no one uninsured or underinsured would result in little or no growth in total health care spending.⁴³ Nonetheless, 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.⁴⁴

In response to concerns raised over an abrupt shift to Medicare for All, several 2020 Democratic presidential candidates, including Senators Sanders, Warren, and Harris, introduced “phase-in” plans on how to transition from the current system to MFA.⁴⁵ Perhaps most relevant now are the details—albeit few—of then-Senator Harris’ 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.⁴⁶ Harris’ transition period included some structural components to lubricate more fundamental long-term transformation, including automatically enrolling all newborns and uninsured people into the Medicare program.⁴⁷ 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.”⁴⁸ Even though delayed, this idea of governmentally imposed coverage generated significant opposition.

Some other proposals, like Medicare for America sponsored by Congresswomen Rosa DeLauro and Jan Schakowsky and informed by Jacob Hacker, also offer transition to public health insurance in a way that imagines possible reforms to the employer market.⁴⁹ This proposed legislation would fold

43 See, e.g., Josh Katz et al., *Would ‘Medicare for All’ Save Billions or Cost Billions?*, N.Y. TIMES (Oct. 16, 2019).

44 Sanders proposed a variety of mechanisms for progressive financing, including increased taxes that also provided his opponents fodder for attack. *How Does Bernie Pay for His Major Plans?*, BERNIESANDERS.COM, <https://berniesanders.com/issues/how-does-bernie-pay-his-major-plans/> (last visited Dec. 23, 2020).

45 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> (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).

46 Kamala Harris, *My Plan for Medicare for All*, MEDIUM (July 29, 2019), <https://medium.com/@KamalaHarris/my-plan-for-medicare-for-all-7730370dd421>. The Sanders and Warren transition plans also allowed this individual opt-in.

47 *Id.*

48 *Id.*

49 Medicare for America, H.R. 2452, 116th Cong. (2019). It would leave other programs, including the Veteran’s Health Care Services, Indian Health Service, and Federal Employees Health Benefits Program intact. There are other proposals that have offered opportunities for employer-buy in, but in very limited ways. For example, the Medicare-X Choice Act of 2019 sponsored by Senator Bennet and several co-sponsors makes a very limited effort to allow employers to enroll employees

those people currently insured by Medicare, Medicaid, and the ACA Marketplaces into a new public plan, and people in employer plans or employers could opt in as well. Eventually, it would subsume private coverage by enrolling all newborns at birth.⁵⁰ But before that point, individuals, even those who have access to ESI, can opt into the public plan and employers could enroll their entire employee pool in Medicare for America. It is this last feature, which in some ways seemed an afterthought of this proposal, that we focus on in our proposal and that we think is the right starting point for more fundamental, structural change.

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

The public option has been described by its proponents as 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. Various pieces of recent proposed legislation have included a public option, including the majority of health insurance reform bills proposed in Congress in the 2019 session.⁵¹

What most defines the prominent public option 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. Pete Buttigieg promoted it on the

in a public option. Medicare-X Choice Act of 2019, S. 981, 116th Cong. (2019). Public option plans have also been proposed at the state level, including some that would allow employer participation. Jaime S. King et al., *Are State Public Option Health Plans Worth It?*, 59 HARV. J. ON LEGIS. (forthcoming 2022) (manuscript at 15-16) (on file with authors) (noting that proposals in Massachusetts, Texas, Wisconsin, and Wyoming would allow employers to elect public option coverage).

⁵⁰ Sarah Kliff & Dylan Scott, *We Read 9 Democratic Plans for Expanding Health Care. Here's How They Work*, VOX (June 21, 2019), <https://www.vox.com/2018/12/13/18103087/medicare-for-all-explained-single-payer-health-care-sanders-jayapal> (“Medicare for America makes another policy decision that would erode employer-sponsored coverage: It automatically enrolls all newborns into the public program. That means a new generation of Americans likely won’t get coverage through their parents’ workplaces—and would assure the Medicare plan a constantly growing subscriber base.”).

⁵¹ Choose Medicare Act, S. 1261, H.R. 2463, 116th Cong. (2019); Medicare for America, H.R. 2452, 116th Cong. (2019); CHOICE Act, S. 1033, H.R. 2085, 116th Cong. (2019) (seeking, with the co-sponsorship of Representative Jan Schakowsky and Senator Sheldon Whitehouse, to create a federal public plan option on the Affordable Care Act (ACA) marketplaces under existing procedures and rules); Medicare Buy-In and Health Care Stabilization Act of 2019, H.R. 1346, 116th Cong. (2019) (working to allow individuals age 50 and older to opt into Medicare, with the sponsorship of Representative Brian Higgins); State Public Option Act, S. 489, H.R. 1277, 116th Cong. (2019) (seeking, with the co-sponsorship of Senator Brian Schatz and Representative Ben Ray Luján, to allow a state public option for Medicaid buy-in); Medicare at 50 Act, S. 470, 116th Cong. (2019) (seeking, with the sponsorship of Senator Debbie Stabenow, to allow individuals age 50 and older to opt into Medicare early); Keeping Health Insurance Affordable Act, S. 3, 116th Cong. (2019) (working to create a federal public option on ACA exchanges, with the sponsorship of Senator Ben Cardin).

campaign trail: “Medicare for all who want it.”⁵² 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.”⁵³

Although the policy details have evolved, the main contours remain 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. Some versions of the public option, like the Sanders-Biden Unity Task Force recommendations, imagine that people who are offered employers plans could opt in too. These recommendations, similar to what Vice President Biden proposed on the campaign trail, offer the following:

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 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.⁵⁴

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 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, the addition of

⁵² See Dylan Scott, *Pete Buttigieg's Medicare-for-all-who-want-it Plan, Explained*, VOX (Sept. 19, 2019), <https://www.vox.com/2019/9/19/20872881/pete-buttigieg-2020-medicare-for-all>.

⁵³ JACOB S. HACKER, *THE CASE FOR PUBLIC PLAN CHOICE IN NATIONAL HEALTH REFORM 2* (2008).

⁵⁴ Press Release, *supra* note 21, at 31.

a public option might help keep premium prices in check.⁵⁵

Yet, the problem with these proposals is that they will almost certainly fail to catalyze more fundamental change. It is unlikely that an individual public option—even in the best-case scenario—will reach very many people, which, in turn, limits its potential. As of now, only 6% of the non-elderly population (just under 20 million people) have individual market coverage.⁵⁶ In the unlikely case that every uninsured person were added to this market, it would grow to just under 50 million people.⁵⁷ By comparison, employer plans cover three times as many individuals as the best case coverage scenario for an individual public option—about 150 million currently with the potential to cover more with a well-designed employer public option.⁵⁸ If the goal of a public option is to drive systemic change, an employer public option is much better suited to the task than one available only to individuals.

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.⁵⁹ 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, selecting among health insurance plans demands having preferences about things that most people have never experienced before. For example, to make a fully informed health insurance purchasing decision, individuals would need to evaluate their preferences for medical care they might eventually need but have no direct experience with—such as hospitalization or cancer care. Even more, in deciding how much to pay for health insurance, they must weigh the risk of ever needing such care against possible 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

55 See Jon R. Gabel et al., *Competition and Premium Costs in Single-Insurer Marketplaces: A Study of Five Rural States*, 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 the number of insurers in some states' Marketplaces led to relatively faster premium growth).

56 KAISER FAM. FOUND., *supra* note 33.

57 *Id.*

58 KAISER FAM. FOUND., *supra* note 16. An additional 26 million individuals are employed or have an employed family member, but either are not offered coverage through an employer, or are offered such coverage and decline it. Rae et al., *supra* note 20.

59 See Allison K. Hoffman, *The ACA's Choice Problem*, 45 J. HEALTH POL., POL'Y & L. 501, 504-06 (2020) (describing a selection of these studies); 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).

much a plan costs, cost-sharing features, and what benefits are covered.⁶⁰ Furthermore, choosing a health plan requires making calculations regarding deductibles, cost-sharing, and premiums that exceed many Americans' literacy and numeracy skills.⁶¹ A volume of empirical work illuminates the many ways and reasons why individuals—regardless of education, income, or smarts—make poor choices among health plans.⁶²

60 Deborah W. Garnick et al., *How Well Do Americans Understand their Health Coverage*, 12 HEALTH AFFS. 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 overreported that their plans covered long-term care); George Loewenstein et al., *Consumers' Misunderstanding of Health Insurance*, 32 J. HEALTH ECON. 850, 855 (2013) (noting that in a survey of insured adults, only 14% correctly answered four simple multiple-choice questions about cost-sharing features like a deductible or copayment).

61 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, for example, ZSOFIA PARRAGH & DEANNA OKRENT, HEALTH LITERACY AND HEALTH INSURANCE LITERACY: DO CONSUMERS KNOW WHAT THEY ARE BUYING (Jan. 6, 2015), http://www.allhealthpolicy.org/wp-content/uploads/2017/01/Health-Literacy-Toolkit_163.pdf (describing and summarizing studies on health insurance literacy).

62 The many studies showing these problems span different insurance marketplaces that have plan choices, including employer, ACA, and Medicare Part D. See, e.g., 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% 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); Vicki Fung et al., *Nearly One-Third of Enrollees in California's Individual Market Missed Opportunities to Receive Financial Assistance*, 36 HEALTH AFFS. 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); Florian Heiss et al., *Plan Selection in Medicare Part D: Evidence from Administrative Data*, 32 J. HEALTH ECON. 1325, 1377-78 (2013) (estimating that only about 10% of Medicare Part D enrollees choose the least-expensive plan option); 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). 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 BEHAV. SCI. & POL'Y 1, 7-8, 10 (2017) (simulating purchase on ACA exchanges to find that only one-third of respondents chose the cost-minimizing plan, based on their own anticipated medical care

The bottom line is that public option proposals focused on the individual market are unlikely to provide real movement towards more coherent and equitable health care financing. 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. 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. All of these reasons suggest looking to another locus for a more meaningful public option: employers.

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

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 higher quality parts of a health care financing system that has many more critical gaps to fix, including the fact that approximately 10% of the population under age 65 is still uninsured.⁶³ Yet, job-based coverage is currently in decline. As costs rise, fewer employers are offering coverage and many more are increasingly dissatisfied with the status quo. Moreover, even when ESI is offered, workers must pay a larger share of the costs, and policies have more restrictions, like limited provider networks. The declining value of ESI benefits leads some workers to decline coverage.

Even before the COVID-19 pandemic, the quality of job-based health insurance was diminishing and costs increasing. Fewer companies offer benefits today. In 2020, 56% of firms offered at least some employees health benefits, as compared to 66% two decades ago,⁶⁴ and the share of the nonelderly population covered fell eight percentage points from 1998 to 2018.⁶⁵ 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.⁶⁶ Low-income workers are also much more likely to decline coverage, even when offered to them, increasingly so over the past 20 years, because their own contributions to that

needs). 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.

⁶³ KAISER FAM. FOUND., *supra* note 33.

⁶⁴ KAISER FAM. FOUND., EMPLOYER HEALTH BENEFITS: 2020 ANNUAL SURVEY 46 (2019). Note, the offer rates have remained steady for large firms but declined for all others. *Id.* at 47.

⁶⁵ Rae et al., *supra* note 20.

⁶⁶ *Id.*

coverage are unaffordable.⁶⁷

In addition, without beginning to re-think employer-provided coverage, it is hard to imagine tackling fundamental issues such as cost containment and the provision of universal and equitable coverage. So, employers' strain under the weight of managing health care benefits and costs might provide an opportunity to shift away from job-based private plans and toward something better.

There are of course several reasons why employers might prefer to remain at the center of the U.S. health care financing 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.⁶⁸ Some employers use health benefits to try to maintain a healthy, and presumably productive, workforce, including wellness programs, gym membership, and health coaching for chronic or serious conditions.⁶⁹ These types of factors make the current structure sticky, but not unyielding to change, as we explore in the discussion in Section II.C of why employers might want change. There are also reasons to want to keep employers as part of the system, including as a good channel to test expansion of public coverage to a working-age population and, most importantly, to retain their current contributions toward health benefits, which we also explore in Section II.C. First, this Section offers a quick landscape of the employer market and its challenges to illuminate why we think targeting a public option here is beneficial.

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

An estimated 158 million nonelderly individuals were enrolled in an employer plan in 2019 (49.6% of the total U.S. population).⁷⁰ 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.⁷¹ Seventy percent of workers covered by health insurance

⁶⁷ *Id.*

⁶⁸ 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).

⁶⁹ See Jeffrey Pfeffer et al., *Employers' Role in Employee Health: Why They Do What They Do*, 62 J. OCCUPATIONAL & ENV'T 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 randomized controlled trial of a workplace wellness program, which found that such programs neither lower medical costs nor improve health outcomes or worker productivity).

⁷⁰ KAISER FAM. FOUND., *supra* note 16.

⁷¹ KFF Employer Health Benefits 2020, *supra* note 17, at 45.

are employed at large firms.⁷²

Larger firms are more likely to offer better health insurance. 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, as compared to smaller firms.⁷³ Large firm plans generally offer several health plan options but they have only small differences among them with respect to the treatments and services covered.⁷⁴

The cost of health benefits for employers has skyrocketed over the past two decades, far outpacing wage growth and inflation.⁷⁵ The average annual premiums in 2020 were \$7,470 for single coverage and \$21,342 for family coverage.⁷⁶ Employers have been paying more toward that coverage, with the average employer contribution for single coverage increasing 232% between 1999 and 2020, and for family coverage increasing by 271% during the same time period.⁷⁷ Employees have also faced significantly increased costs, with employee contributions for single coverage increasing by 291% between 1999 and 2020, and by 262% for family coverage.⁷⁸

In addition to premiums, employees also face increasing out-of-pocket costs for medical care, in the form of deductibles, co-insurance, and co-pays. For example, in 2020, 57% of covered workers were in plans with an annual deductible of \$1,000 or more for single coverage, while 26% were in plans with an annual deductible of \$2,000 or more.⁷⁹ By contrast, just over ten years ago only 22% of covered workers were in plans with annual deductibles of \$1,000 or more, and only 7% were in plans with deductibles of \$2,000 or more.⁸⁰

⁷² *Id.*, Figure M.6, at 25.

⁷³ *Id.* at 41.

⁷⁴ DEP'T OF LAB., 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>.

⁷⁵ KFF Employer Health Benefits 2020, *supra* note 17, Figure 1.10, at 40, Figure 1.12, at 42.

⁷⁶ *Id.* at 7. 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%).

⁷⁷ Percentage increase calculated by authors using data provided by *id.* at 83-84. The relevant employer contributions for single coverage were \$1,878 in 1999 and \$6,227 in 2020, while the figures were \$4,247 and \$15,754 for family coverage.

⁷⁸ *Id.* at 83-84. Today, employees are required to contribute on average 17% of the premium for single coverage and 27% of the premium for family coverage. *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.*

⁷⁹ *Id.* at 106.

⁸⁰ *Id.* at 109-10. When premiums and cost-sharing obligations are combined, employees on average pay 34% of total health care costs (21% premiums, 13% all other costs), up from 32% a decade earlier. Matthew Rae, Rebecca Copeland & Cynthia Cox, *Tracking the Rise in Premium*

Even as the cost of employer plans has increased, the breadth of provider networks offered by such plans is becoming more limited, meaning that beneficiaries might increasingly find their doctor or hospital to be out of network.⁸¹ Most ESI plans have some limits on the network of providers someone can see, or charge more for seeing doctors out of network.⁸² Shrinking provider networks will almost certainly continue since limiting networks is the most feasible mechanism under employers' control to try to manage prices paid for care.

The overhead costs for plans vary significantly, although they are difficult to estimate precisely because of the inconsistent and malleable ways that both private and public plans categorize various costs. The Congressional Budget Office (CBO) found that private fully insured health plans have, on average, overhead expenses equal to 15% of premiums,⁸³ significantly higher than the 2-5% administrative overhead for Medicare and Medicaid.⁸⁴ 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 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

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.*

81 KFF Employer Health Benefits 2020, *supra* note 17, Fig. 5.1, at 78.

82 *Id.* at 77. Forty-seven percent of workers are in Preferred Provider Organizations (PPOs); 31% in a High Deductible Health Plan with Savings Option (HDHP/SO); 13% in Health Maintenance Organizations (HMOs); 8% in Point of Service (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. Even among firms with 5000 workers or more, one-third consider their largest plan's provider network somewhat or very narrow. *Id.* at 205.

83 CONGRESSIONAL BUDGET OFFICE, PRIVATE HEALTH INSURANCE PREMIUMS AND FEDERAL POLICY 27 (2016), https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/51130-Health_Insurance_Premiums.pdf. Self-insured plans appear to have lower administrative expenses than fully insured plans, although there are no reliable measures of such amounts. *Id.* at 28.

84 *Id.*

do so gladly.⁸⁵

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, Consolidated Omnibus Budget Reconciliation Act (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.⁸⁶ 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,⁸⁷ informing eligible employees of their choices and allowing them to make an election within a specified window. Plus, they must establish technical processes to 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-

⁸⁵ See, e.g., Pfeffer et al., *supra* note 69, at e604 (describing how even employers interested in employee health promotion offered employees high deductible health plans based on an apparent belief that such plans were “the only option”).

⁸⁶ See I.R.C. § 125(d). Without a cafeteria plan in place, an employee's share of health plan premiums must be paid with after-tax dollars (i.e., dollars that are taxable as wages and subject to both payroll and income taxes) rather than with tax-free dollars.

⁸⁷ An annual open enrollment process is required by the tax code provisions allowing pre-tax payment of premiums through a cafeteria plan. See Prop. Treas. Reg. § 1.125-2(a)(1), 72 Fed. Reg. 43938, 43955 (Aug. 6, 2007).

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.⁸⁸ Although ERISA was designed primarily with pension plans in mind,⁸⁹ it imposes significant reporting and disclosure and claims and appeals procedures on health plans.⁹⁰ 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 and Accountability Act (HIPAA) and a small number of mandated benefits.⁹¹

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.⁹² The calculation of the penalty 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.⁹³ The tax code also incorporates many of ERISA's

⁸⁸ 29 U.S.C. § 1001. The exclusion for governmental and church plans is found in 29 U.S.C. § 1003(b).

⁸⁹ James A. Wooten, “*The Most Glorious Story of Failure in the Business*”: *The Studebaker-Packer Corporation and the Origins of ERISA*, 49 BUFF. L. REV. 683, 735-36 (2001).

⁹⁰ See 29 U.S.C. §§ 1021-1025 (containing ERISA's reporting and disclosure requirements); 29 U.S.C. § 1133 (containing ERISA's claims and appeals procedures, which are further detailed in regulations promulgated at 29 C.F.R. § 2560.503-1 (2022)).

⁹¹ See 29 U.S.C. § 1161 (providing Consolidated Omnibus Budget Reconciliation Act requirements); 29 U.S.C. §§ 1181-1184 (providing Health Insurance Portability and Accountability Act requirements). 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).

⁹² I.R.C. § 4980H.

⁹³ Treas. Reg. § 54.4980H-5 (as amended in 2021); see also David Gamage, *Perverse Incentives Arising from the Tax Provision 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

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.⁹⁴ 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 may drop or add coverage altogether.⁹⁵ Similarly detailed rules apply to health care flexible spending accounts, which may only be offered through a cafeteria plan.⁹⁶

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.

While quantifying the economic costs of these administrative and regulatory requirements is difficult, it is important to understand that the 5-11% administrative expenses for large employer self-insured plans cited above⁹⁷ does not include or reflect these other costs.⁹⁸

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

provisions).

94 I.R.C. § 4980D.

95 See Treas. Reg. § 1.125-4 (as amended in 2001).

96 See Prop. Treas. Reg. §1.125-5, 72 Fed. Reg. 43938, 43957 (Aug. 6, 2007).

97 See *supra* text accompanying note 91.

98 See Alain C. Enthoven & Victor Fuchs, *Employment-Based Health Insurance: Past, Present, and Future*, 25 HEALTH AFFS. 1538, 1541 (2006) (noting that administrative costs do not "include the costs to employers to purchase and manage health care spending, including armies of consultants, benefits managers, and brokers").

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.⁹⁹ 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.¹⁰⁰ That independent review is conducted *de novo*, and is binding on the plan.¹⁰¹ If those appeals are unsuccessful, the covered individual has the right to file suit under ERISA to challenge the claim denial.¹⁰²

While the financial impact of these claims disputes may be relatively limited,¹⁰³ 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 can also damage morale within the broader employee community. The effects of such disputes can undermine the ability of an employer to rely on health benefits as a recruitment and retention tool.

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.¹⁰⁴ 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.¹⁰⁵ 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

99 29 C.F.R. § 2560.503-1 (2022).

100 Patient Protection and Affordable Care Act, Pub. L. No 111-148, § 2719, 124 Stat. 119, 887-88 (2010).

101 Treas. Reg. § 54.9815-2719(d)(2)(iii)(B)(5) (*de novo* review); (7)(v) (binding decision).

102 29 U.S.C. § 1132(a)(1)(B). 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.

103 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.

104 *See, e.g.,* U.S. Airways v. McCutchen, 569 U.S. 88 (2013) (suit by self-funded health plan to recover amounts paid for injured participant's medical care, where participant had received a settlement from a third party related to automobile accident that resulted in the need for medical care).

105 *Montanile v. Bd. of Trustees of Nat'l Elevator Industry Health Benefit Plan*, 577 U.S. 136, 136 (2016) ("Employee benefits plans regulated by [ERISA] often contain subrogation clauses requiring a plan participant to reimburse the plan for medical expenses if the participant later recovers money from a third party for his injuries.").

lawsuits, these reimbursement actions often damage the employer-employee relationship and have at times resulted in unfavorable media coverage of the employer.¹⁰⁶

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.

II. OUR PROPOSAL: AN EMPLOYER PUBLIC HEALTH INSURANCE OPTION

In this Article, we propose a better way forward than either Medicare for All or an individual public option. This Article makes the case for 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 greater 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 paramount goal of health care reform is to move toward efficient and equitable coverage, then providing employers with the ability to offer employees coverage through a Medicare-based public insurance program presents a meaningful and politically plausible opportunity in that direction. Most employers, even those with a will to do so, will not be able to reverse the trend of cost increases in their plans. An employer public option can do so, offering immediate benefits for both employers and employees. At the same time, it can build the foundation for larger systemic reform by testing a meaningful expansion of public coverage.

1. *Fixing Problems with Job-Based Health Coverage*

One of the key benefits of an employer public option is the ability to address the declining reach, value, and reliability of ESI. It provides a mechanism to decrease prices for care and plan administrative expenses, increase the number of workers and their families with health insurance coverage, and deliver subsidies to low- and moderate-income workers.

¹⁰⁶ See, e.g., Andrew Clark, *Wal-Mart Drops Bid to Sue Brain-Damaged Former Shelf-Stacker*, GUARDIAN (Apr. 2, 2008); Tara Parker-Pope, *Injured Woman Wins Wal-Mart Saga*, N.Y. TIMES (Apr. 4, 2008); Andrew Wolfson, *Walmart Changed Policy After Claiming an Injured Worker's Settlement Became a PR Nightmare*, LOUISVILLE COURIER J. (Apr. 5, 2018).

a. Addressing the Rising Cost of Private Job-Based Coverage

A key feature of an employer public option, and advantage over private coverage, is the ability of the government to negotiate down prices and still retain a large network of providers. Medicare prices are on average one-half that of private health insurance plans.¹⁰⁷ Over the past decade, Medicare has controlled per enrollee spending much better than private health insurance.¹⁰⁸ Health spending growth has far outpaced economic growth, ballooning from just under 7% of GDP in 1970 to nearly 20% now.¹⁰⁹ Even over the last decade, from 2008-2019, a period when the rate of spending has slowed, private health insurance cumulative growth in per enrollee spending is over 50%, as compared to half that rate (just over 26%) for Medicare.¹¹⁰

During this same period, health care providers—including hospitals and physicians—have merged and become increasingly consolidated.¹¹¹ 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.¹¹² Even when Amazon, Berkshire Hathaway, and JPMorgan Chase joined together to attempt to wield their collective power to improve employer-provided health care, they found that they lacked the market power to negotiate prices down.¹¹³ Large insurers generally cannot and do not push back on providers in market-based negotiations. In some cases they lack the ability to do so in the face of provider consolidation, and, in others, they lack the incentive to find the edge of negotiations when they can pass price increases off onto employers (and eventually employees).¹¹⁴ When insurers do push back, providers still often have the upper hand when they are critical to a local network, as in the case of “must-

¹⁰⁷ Eric Lopez et al., *How Much More Than Medicare Do Private Insurers Pay? A Review of the Literature*, KAISER FAM. FOUND. (Apr. 15, 2020), <https://www.kff.org/medicare/issue-brief/how-much-more-than-medicare-do-private-insurers-pay-a-review-of-the-literature/>.

¹⁰⁸ 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/>.

¹⁰⁹ *Id.*

¹¹⁰ *Id.*

¹¹¹ *Examining the Impact of Health Care Consolidation: Hearing Before the Subcomm. on Oversight and Investigation of the H. Comm. on Energy and Commerce*, 115th Cong. 8-9 (2018) (statement of Martin Gaynor, E.J. Barone Univ. Professor of Econ. and Health Pol’y, Heinz College, Carnegie Mellon Univ.) [hereinafter Gaynor Statement].

¹¹² *Id.*

¹¹³ 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.”).

¹¹⁴ Gaynor Statement, *supra* note 111 at 9.

have” hospitals or large integrated networks of hospitals and physicians.¹¹⁵

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 and 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 subsidized by privately insured patients. Efficient hospitals were able, until recently, to break even based on Medicare reimbursement rates.¹¹⁶

A public option that uses Medicare’s rates as a starting point would substantially reduce prices paid for health care. In addition, a public option can provide benefits at lower administrative costs compared to current employer plans due to economies of scale and simplification. This means that even if beneficiaries used the same amount of care as they do today, the total cost would be considerably less.

A public option can achieve cost savings while preserving a large provider network by tying participation in Medicare to participation in the public option. It would be necessary to set rates carefully to ensure total reimbursement is sufficient for participating providers (we discuss further below this delicate task). For employers and employees, an employer public option thus offers the possibility of lower health care costs delivered by, in many cases, a less restricted network of providers than is available under the status quo.

Savings should, at least in theory, translate into wage growth and increased employment, since we know that rising health care costs have done the inverse.¹¹⁷ 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.¹¹⁸ Curbing health care cost growth through an employer public option

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

116 *Id.*

117 Katherine Baicker & Amitabh Chandra, *The Labor Market Effects of Rising Health Insurance Premiums*, 24 J. LAB. ECON. 609 (2006). 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 make the idea of Medicare for All 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>.

118 Mark J. Warshawsky & Andrew G. Biggs, *Income Inequality and Risking Health-Care*

could help ameliorate wage stagnation.

b. Expanded Coverage, Especially for Low-Wage Workers

An employer public option also presents an opportunity to expand job-based coverage to the currently uninsured, through a combination of lowering premiums and incorporating ACA-style subsidies for low- and moderate-income households, many of whom are uninsured.

Assuming the plan delivers lower reimbursement rates and administrative expenses, the resulting lower premiums should result in more employees electing offered coverage.¹¹⁹ There are currently 26 million employees who either are not offered coverage by their own firms or are offered and decline coverage.¹²⁰ In 2020, only 58.3% of employees at large firms enrolled in ESI.¹²¹ Roughly 20% of employees were ineligible for ESI because of waiting periods or part-time or temporary work status.¹²² Of those eligible for insurance, only 76% elected to purchase it.¹²³ Many of those declining to take up ESI offers likely did so because they obtained coverage elsewhere (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 of their required contribution toward it.¹²⁴

According to research by the Commonwealth Fund, the composition of uninsured Americans has shifted dramatically since 2010 so that a larger portion are now working uninsured.¹²⁵ Back when the ACA was enacted, 50% of working-age uninsured Americans were unemployed. By 2018, only 38% of the working-age uninsured were unemployed. Conversely, over 60% were employed. The share

Costs, WALL ST. J. (Oct. 6, 2014), <https://www.wsj.com/articles/mark-warshawsky-and-andrew-biggs-income-inequality-and-rising-health-care-costs-1412568847>.

119 See, e.g., Philip F. Cooper & Jessica Vistnes, *Workers' Decision to Take-Up Offered Health Insurance Coverage: Assessing the Importance of Out-of-Pocket Premium Costs*, 41 MED. CARE III-35 (2003) (finding that reducing employee contributions for health insurance coverage will increase take-up rates).

120 KFF Employer Health Benefits 2020, *supra* note 17, at 58.

121 2020 MEPS DATA, *supra* note 17.

122 KFF Employer Health Benefits 2020, *supra* note 17, at 58.

123 *Id.*

124 See, e.g., David M. Cutler, *Employee Costs and the Decline in Health Insurance Coverage*, 6 F. FOR HEALTH ECON. & POL'Y 27 (2003) (illustrating the relationship between increased employee health insurance costs and a decline in employee enrollment in health insurance); Michael Chernen et al., *Increasing Health Insurance Costs and the Decline in Insurance Coverage*, 40 HEALTH SERVS. RSCH. 1021 (2005) (finding that more than half of the decline in health insurance coverage rates during the study period was attributable to an increase in health insurance premiums).

125 Munira Z. Gunja & Sarah R. Collins, *Who Are the Remaining Uninsured, and Why Do They Lack Coverage?*, COMMONWEALTH FUND 11 (Aug. 2019), https://www.commonwealthfund.org/sites/default/files/2019-08/Gunja_who_are_remaining_uninsured_sb.pdf.

of the uninsured who work full-time has increased from 30% in 2010 to 42% in 2018, while the share of those who work part-time stayed constant at 19% during this period. 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,¹²⁶ with heavy concentrations in the service sector and agriculture.¹²⁷

In addition to bolstering affordability by reducing plan cost, it would be relatively straightforward to integrate ACA-style subsidies for low-wage workers into a government-administered public option. Under the current system, employees who are offered what the ACA has defined as affordable and adequate employer coverage are ineligible for the premium tax credits that are available to subsidize individual coverage on its Marketplace, even if their employer coverage is less affordable than subsidized individual coverage.¹²⁸ An employer public option offers an attractive mechanism to equalize subsidies between employer and individual coverage, likely increasing the take up of job-based coverage by low-wage and part-time workers. This approach, which we detail further in the next part, could improve the equity of health coverage among workers, regardless of income or work hours.

c. Addressing Churn and Portability

An employer public option, particularly if widely adopted, could also help address other problems caused by relying on employers for health benefits, 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 they become unemployed or move between jobs.

For example, if an employer public option were 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, an employer public option could be designed to allow low-income individuals to retain their employer-provided coverage even when their income

126 THE KAISER COMMISSION ON MEDICAID AND THE UNINSURED, KAISER FAM. FOUND., ARE UNINSURED ADULTS WHO COULD GAIN MEDICAID COVERAGE WORKING? 2 (Feb. 2015), <http://files.kff.org/attachment/fact-sheet-are-uninsured-adults-who-could-gain-medicaid-coverage-working>.

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

128 *See infra* Section II.B.6, for more details on subsidy design.

dips to Medicaid-eligibility levels. And if enough employers decide to participate, over time, workers can change jobs while retaining the same health plan and providers, which would reduce job lock, the tendency to stay in a job to retain health benefits. A well-structured employer public option would thus reduce costs and inefficiencies that inevitably occur when individuals must switch coverage when changing jobs. We discuss all of these points in greater detail below.

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 a large number of younger participants into a public Medicare-based plan to test the transition toward a single-payer system.¹²⁹ 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 opportunity to test the feasibility of expanding to more populations over time. It would also allow refinement 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.

Importantly, it would provide regulators access to data needed for large-scale reforms. Right now, most of the data on employer health plans, including on utilization, is not transparent. Through an employer public option, regulators could have access to that data, which would help inform fine tuning the public option and also broader analyses and reforms that require understanding and tracking health care use over time.

3. *Fiscal and Political Advantages*

In Part III below, we describe in detail the fiscal benefits of this approach to expanding public coverage to a working-age population. A major stumbling block to expanding public coverage is typically the need for new taxes to offset the loss of employer contributions and most ideas, including Medicare for All, do not offer a straightforward way to retain those contributions.

In contrast, because an employer public option does not fully dislodge benefits from the workplace, it is easier to retain current employer and employee contributions. These contributions would, in turn, finance a significant share of the cost of public coverage especially considering the cost saving that would result from shifting from private plan reimbursement rates to ones based on Medicare

129 LINDA J. BLUMBERG ET AL., ESTIMATING THE IMPACT OF A PUBLIC OPTION OR CAPPING PROVIDER PAYMENT RATES viii–ix (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>.

rates. As a result, the amount that would need to be financed through new taxes would be significantly lower than under other reform proposals.

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 to appeal to employers and employees on dimensions like covered benefits and provider network while also controlling costs. The design details will, of course, determine political feasibility and whether employers, especially large employers, will trade current private coverage for a public alternative.

This Section explores the key design features that will be necessary to navigate carefully. Although we do not intend to solve 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 some readers might have different preferences, but proceeding under the assumption that there is value in setting forth a concrete proposal. As explained below, aspects of our proposal would work better if implemented alongside an individual public option sold through ACA exchanges, but one could also envision the proposal as providing a public option exclusively for employers.

1. Voluntary Employer Adoption

Critically, there would be no mandatory change in employer health care plans, which has been a political stumbling block for Medicare for All. Participation would be entirely voluntary on the part of employers and would be subject to the same labor market pressures that currently inform their health plan decision-making. Large employers are among the most sophisticated health finance decision-makers in our current system and would hopefully smartly assess the benefits of the public option over their private plans.¹³⁰

Many individuals would be more receptive to a public option if selected and offered by their employers than if imposed on them by the government—although we do not want to imply that it would be completely smooth sailing since some

¹³⁰ 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 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 62. But compared to individuals navigating options, many employers, especially large ones, should be able to identify a public option that is better than what they offer privately.

workers who currently have several private plan options might lose that menu if their employer pivots to the public option. 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. Employers could manage the transition from their current offering(s) to the public option by communicating the most salient benefits, such as broad provider networks and lower costs, to employees. They could offer explanations of common coverage situations and a comparison to their current employer plan options.

Making employer adoption voluntary is critical for two reasons. First, it insulates the approach from the charge of government overreach. Employers will only adopt a public option plan if they conclude that it is in their best interest and, hopefully, in the best interest of their employees. 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. 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 voluntary public option for employers has considerable advantages over other approaches.

2. *Target Market*

Focusing initially on firms with over one thousand employees would enable a smooth roll-out to a large number of people in a more streamlined way. It would also allow partnering with a handful of large employers to test and refine the idea to demonstrate effectiveness and to refine policy details in the initial years of implementation, before attempting more widespread implementation.

Roughly 62.4 million or 50.9% of all private sector employees in the United States are located in these larger firms.¹³¹ Approximately twelve thousand firms have more than one thousand employees, an average of roughly six thousand employees per firm.¹³² By way of contrast, according to census data from 2017, there are nearly six million U.S. firms with fewer than fifty employees and more than five million of these have fewer than twenty employees, making it much

¹³¹ See 2020 MEPS DATA, *supra* note 17.

¹³² 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. 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>.

harder to roll out to a significant number of people through smaller firms.¹³³

Another advantage of focusing on larger employers is that nearly all 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, through their own human resources staff and outside benefit consultants.¹³⁴ To the extent that an employer public option offers a strong value proposition, large employers should be well equipped to recognize it.

3. *Exclusivity Requirements*

We suggest requiring employers to opt either to retain their private plan(s) or to move all employees to the public option exclusively. Although it would be possible to do otherwise and offer the public option side-by-side with private plan options, it would significantly diminish many of the benefits of our proposal.

Exclusivity would maximize equity and reduce concerns that employers might encourage, explicitly or implicitly, employees with greater medical needs to choose the public option.¹³⁵ An exclusivity requirement would in turn lessen the need for experience-based pricing and similar safeguards to counteract such sorting.

Exclusivity is necessary for achieving the cost savings, noted above, as well as reduced employer responsibility for managing and arranging health benefits. If some employees opted for a public plan and others for private, administrative costs and internal hassles might in fact increase.

Even though employers and employees, especially at large firms, are used to a menu of options, there is no evidence that employees choose among health plan options effectively and in a way that feels meaningful. In fact, there is much evidence to the contrary: that people agonize over and dislike making health plan choices and that they often fail to make good choices, as discussed above.¹³⁶

Some studies have looked specifically at decision-making among options of workplace coverage. One showed that over one-third of all workers in the University of Michigan employee plan enrolled in a plan that was identical to another option in every way, except that it had a more restricted provider

133 U.S. CENSUS BUREAU, *supra* note 132.

134 Employers would likely continue to rely on benefits consultants and brokers and so any policy targeting this market must account for how to involve these parties effectively in shaping plan choices.

135 Amy Monahan & Daniel Schwarcz, *Will Employers Undermine Health Care Reform by Dumping Sick Employees?*, 97 VA. L. REV. 125, 181-88 (2011) (describing the financial incentives employers have to encourage high-cost employees to seek coverage outside of the employer's group health plan).

136 *See supra* notes 60-63 and accompanying text.

network.¹³⁷ Another study of a large U.S. firm similarly found that a majority of employees chose a “dominated” option, which was otherwise identical to a higher-deductible option (in terms of benefits, provider network, administrator, etc.) but would cost them more at every level of possible health care use, and which resulted in 24% excess employee spending on premiums.¹³⁸ Lower-income employees were more likely to select dominated plans.¹³⁹ Allowing employers to offer the public option on a menu would simply redouble the problems with individual-level health plan decision-making.

An exclusivity requirement instead offers an opportunity to rewrite the script that choice of health plan is so valuable, a script penned by the insurance industry.¹⁴⁰ When pressed, people care more about access to providers they know and trust than access to choice of health plans.¹⁴¹ Consumers appear to have conflated provider choice with health plan choice, or used health plan choice to proxy provider choice.¹⁴² Since the public option would deliver a wide provider network, more so than many of today’s private plan options, it will likely maximize choice on the dimension that people genuinely value. Over time, the notion that having choices among various health plans is important will likely dissipate.

Some employers—especially larger employers—do, however, regard the ability to provide gold-plated health care plans as an important tool in attracting top talent. Unions, as well, may object to a strict exclusivity requirement as reducing the potential dimensions of negotiation for collective bargaining agreements. One way to meet these concerns would be to require employers to

137 Sinaiko & Hirth, *supra* note 6262, at 453.

138 Saurabh Bhargava et al., *Choose to Lose: Health Plan Choices From a Menu With Dominated Options*, 132 Q.J. ECON. 1319, 1321-22 (2017) (studying an employer where employees can “build” their own plans by choosing four cost sharing elements—deductible, copayment, coinsurance, and out-of-pocket maximum—for plans that otherwise are identical in terms of, for example, covered benefits, provider network, and plan administrator). To illustrate a dominated plan, for employees to lower their deductible from \$1000 to \$750, they had to pay \$528 more in premiums per year, spending \$278 more than they would in any scenario under the \$1000 deductible plan. *But cf.* Benjamin R. Handel, *Adverse Selection and Inertia in Health Insurance Markets: When Nudging Hurts*, 103 AM. ECON. REV. 2643 (2013) (showing that in one employer setting, correcting inertia that leaves people in dominated plans exacerbates adverse selection and leads to an overall welfare reduction).

139 Bhargava et al., *supra* note 138, at 1322.

140 Wendell Potter, *How the Health Insurance Industry (and I) Invented the “Choice” Talking Point*, N.Y. TIMES (Jan. 14, 2020), <https://www.nytimes.com/2020/01/14/opinion/healthcare-choice-democratic-debate.html>.

141 See DAVID BETTS ET AL., DELOITTE, WHAT MATTERS MOST TO THE HEALTH CARE CONSUMER 3 (2016), <https://www2.deloitte.com/content/dam/Deloitte/us/Documents/life-sciences-health-care/us-lshc-cx-survey-pov-provider-paper.pdf> (explaining that what consumers most want is “to be known and understood in order to get a personalized health care experience”).

142 *See id.*

adopt the public option as an exclusive base health care plan for all employees,¹⁴³ but allow supplemental policies with more extensive benefits for all or some of their workforce, including, for example, those covered by collective bargaining agreements. Doing so would reduce some of the simplification offered by the public option, but, importantly, it would still mean considerable cost savings over the status quo.

4. *Benefits and Cost-Sharing*

An employer public option needs to offer benefits that are roughly comparable to current large employer plan benefits, recognizing that plan details, of course, vary across such employers. Current Medicare coverage would have to be modified 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 aligned, both as a matter of equity and to facilitate transitions between the two forms of public option when people face changing employment status.¹⁴⁴

A public option for employers should, at a minimum, cover the treatments and services typically covered by large employer plans.¹⁴⁵ This will mean augmenting Medicare in some ways already contemplated, like vision and dental benefits, and in others that become more obvious when thinking about covering younger workers and their families, including children. Another wrinkle is how to handle prescription drug coverage, which is an optional, private add on for Medicare enrollees through Medicare Part D, a program that is currently under fire for questionable administrative structures and high prices. Drug benefits would need to be included as part of the employer public option, ideally without requiring enrollees to select among private plans. But if building on Part D, the addition of a new population might offer the right moment to establish price regulation in the program.

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

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

144 As discussed below, this alignment is especially important for gig economy workers who repeatedly transition between traditional employment and self-employment. See Section II.B.8, *infra*.

145 For an overview of the benefits typically offered by large employer plans, see DEP'T OF LABOR, *supra* note 74 (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).

perhaps should be revisited for Medicare as well in the future). And cost-sharing design would have a different framework for the employer public option since many people would enroll in family plans, unlike in Medicare.

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. At firms with 500 or more employees, the average health plan actuarial value is 86%.¹⁴⁶

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, which enrollees must pay first before insurance pays, or just copayments and co-insurance so that they pay a share of costs as they go along? Will copayments for a specialist be higher than those 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.

While mirroring the amount of cost-sharing in the large employer market may be necessary to generate employer participation, the public option could attempt to alleviate some of the burden employees have borne with recent increases in cost-sharing requirements.¹⁴⁷ This shift might help build early employee support for the plan. The public option may also present an opportunity to simplify cost-sharing design based on the growing research that most people do not understand or act according to the complex financial incentives embedded in their plans complicated cost-sharing structures.¹⁴⁸ It might be unrealistic to expect an employer public

146 ACTUARIAL RSCH. CORP., FINAL REPORT: ANALYSIS OF ACTUARIAL VALUES AND PLAN FUNDING USING PLANS FROM THE NATIONAL COMPENSATION SURVEY 9 (2017), <https://www.dol.gov/sites/dolgov/files/ebsa/researchers/analysis/health-and-welfare/analysis-of-actuarial-values-and-plan-funding-using-plans-from-the-national-compensation-survey.pdf>; see also 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 AFFS. 1339, 1342 (2012) (finding that 23.9% of employer plans had actuarial values that exceeded 90%).

147 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 17, at 133 Fig. 8.2, 135 Fig. 8.4.

148 See, e.g., Michael Chernenov et al., *Are Health Care Services Shoppable? Evidence from the Consumption of Lower Limb MRI Scans* (Nat'l Bureau of Econ. Rsch., Working Paper No. 24869, 2019), 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 AFFS. 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

option to be as generous as some of the best employer plans are today, but individual employers could choose to fill in the gaps through supplemental coverage or by increasing wages.

5. *Pricing and Financing of the Employer Public Option*

The public option would retain employer contributions—in part or whole—to finance benefits, but there are various ways that these contributions could be designed. The simplest way would be to set a *minimum* flat per employee contribution for participating employers, for example, 70% of the total cost of community-rated coverage, based on the average cost of covering workers and their families in the plan. Employers could pay a larger share of costs, if they want. Employees would contribute whatever amount employers do not. The downside with this simplified approach is that it could decrease current employer contribution shares if employers who are currently paying a larger share default to this minimum level. That said, if total plan costs decrease, employees' actual costs might not increase even if their share does.

An alternate, although more complicated approach, is to require employers to maintain the share of premiums they currently cover, at least for some period, possibly gradually moving to an employer minimum contribution requirement. Employers offering ESI for the first time could be required to pay a minimum flat contribution percentage from the start.

Although it is possible to use experience-based pricing—that is, pricing that varies by employer group based on its employees' recent 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 (83.8%) self-insure their health care coverage and thus pay more when plan members use more care,¹⁴⁹ and fully-insured policies for large employers are generally experience rated.¹⁵⁰ But if one goal of an employer public option is to encourage employers to cover lower-wage workers, who will disproportionately have more costly health care needs, experience-rating would undermine that goal.¹⁵¹ It is also unlikely that

tests, and screenings).

¹⁴⁹ See 2020 MEPS DATA, *supra* note 17 (derived from Table I.A.2.a).

¹⁵⁰ 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 20.9% of employers with fewer than 50 employees have two or more plans in 2020. See 2020 MEPS DATA, *supra* note 17 (derived from Table I.A.2.d). On the other hand, a very high percentage—88.2%—of employers with more than one thousand employees offer two or more health care plans. *Id.*

¹⁵¹ 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

a community-rated employer public option would deter employers with a healthier-than-average employee population because the savings from lower prices and administrative costs would likely offset any cross-subsidization of less-healthy employer groups.

Regardless of the pricing method, it would be important to limit the growth of employers' costs over time. Since they will no longer have the tools in hand to limit their own spending through reduced benefits, increased cost sharing, or smaller networks, employers would need a guarantee that spending will not skyrocket once they opt in. Such guarantees are relatively low risk since, as noted above, Medicare has done much better than private coverage in controlling health care cost growth over time.

6. *Incorporating ACA Subsidies*

To maximize enrollment of low-income workers, ACA subsidies could be rolled into the employer public option coverage. While adding to fiscal costs, this feature might contribute substantially to the number of workers covered, especially among those who currently decline enrollment in ESI for financial reasons or whom employers predict would do so and thus exclude from coverage.¹⁵²

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.¹⁵³ Individuals who are offered

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* 52 (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 health care 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.

¹⁵² 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.

¹⁵³ I.R.C. § 36B. The benchmark plan is the second lowest-cost silver level plan available to the individual. § 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

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,¹⁵⁴ 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.¹⁵⁵ 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.¹⁵⁶ As this example known as the “family glitch” illustrates, under the current system, individuals can be made *worse off* by being offered employer-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

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, 2019-32 I.R.B. 620.

154 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, 2019-32 I.R.B. 620. 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 the 30% employee contribution.

155 Treas. Reg. § 1.36B-2(c)(3)(v)(A)(1) (as amended in 2020).

156 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.

silver-level coverage on an exchange.¹⁵⁷ 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 maximums¹⁵⁸ 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.

These problems need to be fixed regardless, but an employer public option might offer a more elegant and equitable solution. Most proposals attempt to fix this incongruity for low-income workers by removing the firewall between employer and individual coverage and allowing workers to receive subsidies on the ACA Marketplaces, even if their employer offers them adequate and affordable coverage.¹⁵⁹ The problem with this approach is that low-income workers and their families may end up in lesser Marketplace health plans than their higher income peers, given that the average large employer plan is more generous than even “gold” level exchange coverage.¹⁶⁰ An employer public option, however, presents an attractive mechanism to help address the shortcomings and distortions present in these two affordability tools by doing the opposite: weaving the ACA subsidies

¹⁵⁷ 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.

¹⁵⁸ 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.

¹⁵⁹ 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., *Affordability in the ACA Marketplace Under a Proposal Like Joe Biden’s Health Plan*, KAISER FAM. FOUND. (2020), <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.

¹⁶⁰ The average actuarial value of a health plan offered by firms with 500 or more employees is 86%, compared with gold-level coverage, which has an actuarial value of 80%. See ACTUARIAL RSCH. CORP., *supra* note 146.

into job-based coverage.

Specifically, the public option could incorporate premium subsidies that are consistent with those offered on the individual market and could vary cost-sharing schedules by household income.¹⁶¹ 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. While cost-sharing subsidies are relatively straightforward to apply to job-based coverage, 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 the employer public option and individually purchased coverage, while providing employers with a simplified method of satisfying the existing employer mandate.

Imagine the public option specified, for example, a 70% minimum required employer contribution percentage for all coverage tiers (employee-only, employee plus spouse, and family coverage).¹⁶² 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. If premium subsidies continue to be based on the percentage of household income a family is required to pay for health insurance, public option administrators could gather household income information from the IRS and inform the employer of the required employee contribution amounts. That would ensure that each eligible employee's payroll deduction reflects no more than their subsidized cost of public option coverage.¹⁶³

If the employer's contribution to coverage is enough that the full federal subsidies are not needed to reduce the employee's share, any excess could 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

161 One complexity is that employers would only have data on worker income and subsidies are based on household income so, as with the ACA subsidies, the public option administrators would need to have access to tax data on household income.

162 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.

163 One potential downside of this approach is that a participating employer could theoretically gain information about an employee's household income by referencing the employee's required employee contribution for public option coverage. While we acknowledge that some employees may be uncomfortable with their employer gaining access to such information, we believe the benefits of advanced subsidy calculation outweigh the downsides, given how critical cash flow can be to the subsidized population. For example, if employees could only receive their premium subsidy upon filing their tax return for the year, many eligible individuals might decline to enroll in coverage because they could not afford to pay the unsubsidized price upfront.

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.¹⁶⁴

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. As noted above, providing subsidies through an employer public option promotes more equitable coverage among lower and higher earning workers. Moving the subsidies into an employer public option, rather than moving employees into the ACA Marketplaces, also enables low-income workers to benefit from both employer subsidies and ACA subsidies. In effect, many would get no-cost coverage with the combination of the two. It also places less burden on low-income individuals who, if pushed into ACA Marketplaces, must learn of individual market subsidies and decide if they are better off with those subsidies and an ACA plan versus employer subsidies and an ESI plan. Harnessing the ability of employers, particularly large employers, to educate employees, facilitate enrollment, and subsidize coverage offers distinct advantages over solutions that rely on individual initiative.

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 benefits 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 2021.¹⁶⁵ Because this subsidy takes the form of an exclusion from otherwise

¹⁶⁴ 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.

¹⁶⁵ JOINT COMMITTEE ON TAXATION, ESTIMATE OF FEDERAL TAX EXPENDITURES FOR FISCAL YEARS 2020-2024, at 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.*

taxable income, the amount of the subsidy varies with an individual's marginal tax rate, with the result that those in the highest tax brackets receive a larger subsidy in absolute dollars (a structure commonly referred to in the tax literature as an "upside-down" subsidy), although lower income employees might receive a larger subsidy as a share of income. 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.¹⁶⁶

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. Most hospitals and many doctors accept reimbursement from Medicare, which means that someone who has 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 compelled to accept it for reimbursement, but that tipping point could take time.

A major political and technocratic question is whether the public option is based on traditional, public Medicare, which has an open network, or Medicare Advantage, Medicare plans operated by private insurers that have more narrow networks. 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, and greater excuse for retaining profits, enrollees might be worse off, certainly in terms of network and in other regards as well.¹⁶⁷ Since evidence

166 The employer public option might feasibly offer an opportunity to scale back the tax exclusion for employer-provided coverage, if desired. For example, particularly if the public option is expected to lower premiums significantly, Congress could specify that premiums for the public option are ineligible for pre-tax payment while, at the same time, adding ACA-style premium subsidies for low- and moderate-income enrollees to address affordability for the population most in need. With such a change, the public option could begin a shift away from a highly criticized tax policy. That said, the political opposition to such a move might prove insurmountable.

167 *See, e.g.,* DANIEL R. LEVINSON, INSPECTOR GEN., MEDICARE ADVANTAGE APPEAL OUTCOMES AND AUDIT FINDINGS RAISE CONCERNS ABOUT SERVICE AND PAYMENT DENIALS 7 (Sept.

has not yet suggested a strong benefit of privately administered Medicare plans after several decades of testing and because insurers can command a larger share of program budget, we think it is better policy to build the employer public option on traditional Medicare.

One of the most complicated aspects of this proposal is how to set reimbursement rates to preserve this wide provider network and in cases where adequacy can be a particular problem, like behavioral health, to grow it. 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—although necessarily somewhat higher than current Medicare 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.¹⁶⁸ In recent years, the rates have dipped slightly below break-even, but would require very little upward adjustment to enable profitability.¹⁶⁹ Reimbursement rates could be marked up considerably over current Medicare rates to ensure adequate provider participation, while still offering cost savings as compared to current private reimbursement rates.

Over time, and as more employers adopt a public option, rates could be adjusted to ensure continued 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, 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 should not be fully equalized, but finding the right level of reimbursement that will maintain provider supply and still trim overall spending will be one of the

2018), <https://oig.hhs.gov/oei/reports/oei-09-16-00410.pdf> (“High overturn rates of appealed denials, and widespread and persistent CMS audit findings about inappropriate denials, raise concerns that some Medicare Advantage beneficiaries and providers were denied services and payments that should have been provided”); AMANDA STARC, WHO BENEFITS FROM MEDICARE ADVANTAGE? (2014), <https://repository.upenn.edu/cgi/viewcontent.cgi?article=1019&context=pennwhartonppi> (describing limited networks). 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 (July 2020), <https://joebiden.com/wp-content/uploads/2020/08/UNITY-TASK-FORCE-RECOMMENDATIONS.pdf>.

¹⁶⁸ Lopez et al., *supra* note 107.

¹⁶⁹ *Id.*

hardest aspects of this or any rate-based reform.

8. *Designing for Portability and Integrating with Medicaid*

An employer public option could be designed to address two common challenges with job-based benefits: 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.¹⁷⁰ 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 fluctuate. This churn is not only inefficient but has been shown to result in significant care disruptions.¹⁷¹

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 a worker'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. One complexity would be that while most of the Medicaid funding for the expansion population is federal and thus easy to transfer to the public option, a small share is state-funded and will require a mechanism to redirect state dollars. This accounting challenge is similar to the clawback that drew state Medicaid dollars into Medicare when the initiation of Medicare Part D drug coverage alleviated state Medicaid programs of significant drug spending responsibility for people eligible for both Medicare and

170 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.

171 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. Sommers & Sara Rosenbaum, *Issues in Health Reform: How Changes in Eligibility May Move Millions Back and Forth Between Medicaid and Insurance Exchanges*, 30 HEALTH AFFS. 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 AFFS. 85 (2020). In states that had not expanded Medicaid, 23.8% of Medicaid 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.*

Medicaid.

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 the second issue of care disruptions caused by job loss or changes, the employer public option again provides some unique solutions. The easiest scenario is for an employee who leaves one employer that has selected the public option for another that 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, someone 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.

9. *Regulatory Relief*

While employers play an important role in providing health insurance coverage to 154 million Americans,¹⁷² the current system demands that employers navigate complex legal requirements and make significant financial and health policy decisions, as described above. An employer public option offers the possibility of greatly simplifying their role.

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. To accomplish this simplified employer experience, ERISA 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

172 KAISER FAM. FOUND., *supra* note 16.

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 some reservations about abandoning private coverage that 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.¹⁷³ 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.¹⁷⁴ One survey found that 64% of employers would consider 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.¹⁷⁵ Another survey, conducted of companies mostly with one thousand 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.¹⁷⁶ In a recent survey of corporate executives by the Kaiser Family Foundation and Purchaser Business Group on Health, 87% said they believe the cost of providing private health insurance to workers will become unsustainable in the next 5-10 years.¹⁷⁷ Over 80% responded that a stronger government role in providing coverage and containing costs would

173 See G. EDWARD MILLER & PATRICIA KEENAN, TRENDS IN HEALTH INSURANCE AT PRIVATE EMPLOYERS, 2008-2020 (2021), https://meps.ahrq.gov/data_files/publications/st536/stat536.pdf.

174 See, e.g., 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/>; 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>.

175 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.

176 *Pulse of the Purchaser: Views on Affordability and Health Reforms*, NAT'L ALL. HEALTHCARE PURCHASER COALS., <https://www.nationalalliancehealth.org/www/resources-new/pulse-of-the-purchaser> (last updated Feb. 2020).

177 GARY CLAXTON ET AL., HOW CORPORATE EXECUTIVES VIEW RISING HEALTH CARE COSTS AND THE ROLE OF GOVERNMENT 7 (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>.

be better for their business and their employees.¹⁷⁸ Finally, recent polling by Data for Progress suggests a majority of likely voters supports an employer public option, which could influence employer receptivity.¹⁷⁹

While these polls do not precisely measure employer receptivity to our proposal, conceptually they suggest that 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 in early 2018 to create a new venture, Haven Healthcare, to attempt to fundamentally restructure how their collective employees get health care. They recruited Atul Gawande, a leading voice on health care innovation to run Haven.¹⁸⁰ 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.¹⁸¹ In January 2021, the whole enterprise folded.¹⁸² Likewise, Walmart created Care Clinics for its employees that it is now rolling out to the broader public, whose impact remains to be seen.¹⁸³ Employers increasingly want better health care options 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, and Home Depot, alone employed on the order of ten million people.¹⁸⁴ If even just a few of them were to

178 *Id.*

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

180 Atul Gawande, *A Message from Our Chairman*, HAVEN HEALTH CARE, <https://havenhealthcare.com/> (last visited Dec. 23, 2020).

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

182 Sebastian Herrera & Kimberly Chin, *Amazon, Berkshire Hathaway, JPMorgan End Health-Care Venture Haven*, WALL ST. J. (Jan. 4, 2021), <https://www.wsj.com/articles/amazon-berkshire-hathaway-jpmorgan-end-health-care-venture-haven-11609784367>.

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

184 *List of Largest United States-Based Employers Globally*,

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, in partnership with the early adopters who would be able to help shape the program.

A public option program could be designed with additional 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 to those private plans. Such practices are possible, at least in some regions where providers 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.¹⁸⁵ 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 the best 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 technological 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 its official launch in 2016.¹⁸⁶ Today, SHOP exchanges barely exist.¹⁸⁷ While many factors contributed to the general failure of

https://en.wikipedia.org/wiki/List_of_largest_United_States%E2%80%93based_employers_global_y (last visited Mar. 11, 2022).

¹⁸⁵ See James Robinson, *Hospitals Respond to Medicare Payment Shortfalls by Both Shifting Costs and Cutting Them, Based on Market Concentration*, 30 HEALTH AFFS. 1265 (2011).

¹⁸⁶ U.S. GOV'T ACCOUNTABILITY OFF., GAO-19-306, *Private Health Insurance: Enrollment Remains Concentrated Among Few Issuers, Including in Exchanges* 30 (2019).

¹⁸⁷ In 2017, CMS announced that effective January 1, 2018, the federal government would no longer handle small business health options program (SHOP) functions for states that chose not to operate their own SHOP exchanges. Timothy Jost, *CMS Announces Plans to Effectively End the SHOP Exchange*, HEALTH AFFS. BLOG (May 15, 2017), <https://www.healthaffairs.org/doi/10.1377/hblog20170515.060112/full/>; *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>. As of 2021, only ten states and the District of Columbia maintain any type of SHOP platform. See Louise Norris, *Can Small Businesses*

SHOP, early technical problems and broker opposition were key elements.¹⁸⁸

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.¹⁸⁹ Perhaps the key takeaway of the SHOP experience 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.¹⁹⁰ Efforts to create a public option in 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.¹⁹¹ Yet, if a federal public option focused on the largest employers, insurance opposition might be easier to manage. Most of the largest employers self-insure,¹⁹² 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 typically a less profitable sector than insurance, which allows the insurer to keep at least a certain percentage of “experience gains.”¹⁹³ That said, providing

Use the ACA’s Health Insurance Marketplaces (Exchanges)?, HEALTHINSURANCE.ORG (June 1, 2021), <https://www.healthinsurance.org/faqs/ive-heard-a-lot-about-health-insurance-exchanges-but-what-are-shop-exchanges/#yearround>.

188 LINDA J. BLUMBERG & SHANNA RIFKIN, *EARLY 2014 STAKEHOLDER EXPERIENCES WITH SMALL-BUSINESS MARKETPLACES IN EIGHT STATES* 3, 6 (2014), <https://www.urban.org/sites/default/files/publication/22851/413204-Early-Stakeholder-Experiences-with-Small-Business-Marketplaces-in-Eight-States.PDF>; see also RHETT BUTTLE ET AL., *SMALL-BUSINESS OWNERS’ VIEWS ON HEALTH COVERAGE AND COSTS* 4 (2019) (69% reporting they rely on a broker to choose a health plan); 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> (detailing the significant financial incentives available to brokers who help small employers select group health coverage outside of SHOP exchanges).

189 See, e.g., Press Release, Hunter Railey, Colo. Dir. for Small Bus. 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).

190 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-reform/>.

191 *Id.*

192 KFF Health Benefits 2020, *supra* note 17, at 161. Ninety-two percent of firms with 1000 or more workers self-insure. *Id.* at 162, Fig. 10.2.

193 While there is almost no publicly available information on the relative profitability of

administrative services for self-insured plans is a core part of most health insurers' business. Insurer opposition to an employer public option might be lessened to the extent that a public option retains an explicit role for private insurers as administrators, although it would be naïve to expect insurers to embrace an idea that would eventually erode much of their business and profits. Likewise, many providers will resist the idea since it will, by definition, mean a decrease in revenue for them.¹⁹⁴ Already opposition is brewing to efforts to replace job-based health benefits, as evinced by a July 30, 2021, letter from all Republican members of the House Energy and Commerce Committee to Health and Human Services Secretary Xavier Becerra and Labor Secretary Marty Walsh emphasizing the “critical importance of employer-sponsored health insurance.”¹⁹⁵

Some large employers, however, 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.¹⁹⁶ 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. Other unions oppose it because they do not want to give up their bargained-for health benefits, when more generous than Medicare.¹⁹⁷

A key advantage of a public option for employers is that it allows union plans to stay in place, consistent with President Biden's campaign promise: “If you have a generous union-backed plan and you have given up union wages to get that plan,

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”).

194 It may be possible, however, to win over some providers with the administrative simplification that a widely adopted employer public option could bring. *See* Sandeep Jauhar, *The Crushing Burden of Healthcare Microregulation*, WALL ST. J. (Apr. 28, 2021) (describing physician dissatisfaction with the administrative burdens created by multiple payors).

195 Letter from Comm. on Educ. and Lab., U.S. H.R., to Xavier Becerra, Sec'y of Health and Hum. Servs. and Martin Walsh, Sec'y of Lab. (July 30, 2021), https://republicans-edlabor.house.gov/uploadedfiles/esi_letter_-_final.pdf.

196 Helen A. Halpin & Peter Harbage, *The Origins and Demise of the Public Option*, 29 HEALTH AFFS. 1117, 1121 (2010).

197 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>; Ian Kullgren & Alice Miranda Ollstein, *Labor's Civil War Over 'Medicare for All' Threatens its 2020 Clout*, POLITICO (Feb. 18, 2020); 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>.

you can keep it.”¹⁹⁸ 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 could easily accommodate differing union preferences in a way that Medicare for All could not. For example, transition to an employer public option could be tailored in a way to preserve bargained-for benefits as supplemental coverage, or translate them into increased wages, and unions could be given a role in deciding whether to shift to the public option at all. This flexibility may allow greater union support for an employer public option than for other reform proposals under serious consideration. A coalition of large employers and some unions in favor could go a long way politically, although, as with any major health reform, it would still be a substantial effort to overcome opposition.

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 health care 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 established in the President’s Commission on Budget Concepts in 1967.¹⁹⁹ 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 fees, from flood insurance to land leasing programs, where members of the public chose to make payments to government entities in exchange for goods

¹⁹⁸ Becker, *supra* note 197.

¹⁹⁹ See MICHELLE RODGERS & DAN SULLIVAN, HARV. L. SCHOOL, RECONSIDERING THE PRESIDENT’S COMMISSION ON BUDGET CONCEPTS OF 1967 (2006), https://scholar.harvard.edu/files/briefingpapers/files/30_-_rodgers_sullivan_-_reconsidering_the_presidents_commission_on_budget_concepts_of_1967.pdf.

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.²⁰⁰

As the report explained, when dealing with "enterprise-type" government activities, net cost to the government—that is, expenditures less offsetting receipts—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."²⁰¹ 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 FY2021 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

²⁰⁰ See REPORT OF THE PRESIDENT'S COMMISSION ON BUDGET CONCEPTS 65 (1967), https://budgetcounsel.files.wordpress.com/2016/10/report_of_the_presidents_commission_on_budget_concepts.pdf.

²⁰¹ *Id.* at 64.

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 healthcare 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.²⁰²

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.²⁰³ Although these premiums reflect private payments to government entities, they are not counted as government revenues or taxes in budgetary aggregates.²⁰⁴ This approach accurately makes these programs look less 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.

202 Off. of Mgmt. & Budget, *Chapter 0: Offsetting Collections and Offsetting Receipts*, in ANALYTICAL PERSPECTIVES 97 (2021), http://www.whitehouse.gov/wp-content/uploads/2021/05/ap_9_offsetting_fy22.pdf (emphasis added).

203 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 2* (1973); Julian E. Zelizer, *How Medicare Was Made*, NEW YORKER (Feb. 15, 2015), <https://www.newyorker.com/news/news-desk/medicare-made>. See generally Eric M. Patashnik & Julian E. Zelizer, *Paying for Medicare: Benefits, Budgets, and Wilbur Mills's Policy Legacy*, 26 J. HEALTH POL., POL'Y & L. 7 (2001) (chronicling the political compromises that led the funding mechanisms included in the original Medicare legislation).

204 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 former produces additional budget authority and thus funds received as offsetting collections is available for expenditure without further legislative action. As the Government Accountability Office has explained, “Generally, offsetting collections are collections resulting from business-type or market-oriented activities, such as the sale of goods or services to the public” See U.S. GOV'T ACCOUNTABILITY OFF., GAO-16-464SP, PRINCIPLES OF FEDERAL APPROPRIATIONS LAW 2-6 (4th ed. 2016). 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 and would thereby produce new budget authority to finance expenditures.

B. An Overview of Scoring Estimates for Leading Reform Proposals

Public debates over the cost of leading reform ideas illustrate how these scoring conventions play out in practice and were detrimental to MFA proposals. Table One below reproduces a chart from a Committee for Responsible Federal Budget publication comparing the costs of health care plans for candidates in the Democratic presidential primaries of 2020.²⁰⁵ The table focuses on the central estimates for four different plans from the 2019-2020 primaries: then-Vice President Biden’s and then-Mayor Pete Buttigieg’s public option plans and two MFA plans, Senator Sanders’ 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.

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
Subtotal	-\$2.25 trillion	-\$2.85 trillion	-\$30.6 trillion	-\$31.75 trillion
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
Subtotal	\$0.45 trillion	\$1.2 trillion	\$1.7 trillion	\$4.7 trillion
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
Subtotal	\$0.35 trillion	\$0.4 trillion	\$12.2 trillion	\$14.2 trillion
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
Subtotal	\$0.65 trillion	\$1.7 trillion	\$3.75 trillion	\$6.75 trillion
Net Fiscal Impact	-\$800 billion	\$450 billion	-\$12.95 trillion	-\$6.1 trillion

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

205 COMM. FOR A RESPONSIBLE FED. BUDGET, PRIMARY CARE: ESTIMATING DEMOCRATIC CANDIDATES’ HEALTH PLANS 2 (Feb. 26, 2020), <https://www.crfb.org/papers/primary-care-estimating-democratic-candidates-health-plans>.

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 had a much smaller fiscal footprint, and not just because they are less ambitious programs. The scoring for neither of these proposals includes the amount of 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 with government entities. To be sure, both the Biden and Buttigieg plans entailed 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 an Employer Public Option 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 and to more accurately reflect 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 be mandatory and considered government revenues rather than offsetting collections and therefore included into budgetary aggregates.²⁰⁶

The precise budgetary impact of an employer public option will depend on numerous design choices discussed in detail in Part II: reimbursement rates for

²⁰⁶ 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.

medical care, the quality of the benefits provided as well as out-of-pocket charges, and the amount and design of any subsidies.²⁰⁷ The amount of out-of-pocket spending would also have a fiscal impact since higher levels will reduce total premium costs.²⁰⁸

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), but it would also increase the level of tax expenditures for employer-sponsored health insurance as more low-income workers are covered by it.²⁰⁹ 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 public option coverage. So the details of producing a complete score for our proposal would be complicated, but the key point is that the overall impact of the proposal on budgetary aggregates—both total revenues and total spending—would be significantly lower than a mandatory program affecting a similar number of individuals, because voluntary paid premiums for both employers and employees would offset outlays for health care for covered employees and their families.

207 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 who 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. Another wrinkle is that some Medicare-eligible workers now choose to stay on employer plans rather than opt into Medicare. If their employer plan became a Medicare-based public option, and if the cost of Medicare were less to them than the public option, more people might opt for Medicare, causing quicker depletion of the Trust Fund.

208 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. 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 10% of annual income. *See* I.R.C. § 213.

209 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).

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 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.²¹⁰ 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."²¹¹ To meet this requirement, the 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 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

210 See CONG. RSCH. SERV., RL30862, THE BUDGET RECONCILIATION PROCESS: THE SENATE'S "BYRD RULE" (2021) (including a short history of the Byrd Rule and its applications over the years).

211 Congressional Budget Act of 1974 § 313(b)(1)(A), 2 U.S.C. § 644 (adopted in substantially its current form in the Budget Enforcement Act of 1990, Pub. L. No. 101-595, § 13214, 104 Stat. 1388-621, 1388-621 to -622 (Nov. 5, 1990)).

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.”²¹² 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. This authorization should again be justified under the Byrd Rule 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 employer public option increased the projected federal deficit beyond the current budget window, presumably but not necessarily ten years, which would need to be addressed in order to survive points of order in the Senate.²¹³ 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 these issues, proponents could explore pay-for options that would be expected to offset outlays in the outyears, either related to health care reform or in other areas, including tax increases. An alternative response would be to include a sunset provision—as has often been done with tax legislation passed through

212 § 313(b)(1)(D).

213 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.” § 313(b)(1)(E).

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 be justified to the extent the public option for employers is seen as an experimental measure, which over the coming decade will either prove itself to be a productive step forward or not.

CONCLUSION

Our system of job-based coverage leads to variability in access to medical care among workers and inefficiently asks each employer also to be a health benefits company and manage the impossible task of escalating health care prices. It no longer makes sense to preserve this system, and this Article offers a smooth transition to something better for workers and companies.

We have proposed a novel employer public option that could ameliorate problems facing employer-sponsored health insurance and build a foundation for a more efficient and equitable health care financing system. Health financing reform is for good reason a highly contested issue. It is no exaggeration to say it is life or death, since it shapes who can afford life-improving and sustaining access to medical care. Simultaneously, it is also a big dollar concern for many invested parties, who may or may not want changes to the status quo. These concerns demand cautious and slow adjustments. Yet, moving responsibly should not preclude making fundamental changes when needed.

We think an employer public option offers a responsible and politically plausible means to begin to make necessary fundamental changes in job-based health coverage. In contrast, Medicare for All moves all Americans onto a publicly financed system but, while effective in addressing many of the shortcomings of the U.S. system, does so in a highly disruptive way that cements political opposition. On the other hand, the more politically palatable individual public option may help improve coverage at the margins, but such an approach has limited ability to improve the health care financing 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 and their employees' interests. This voluntary mechanism could lessen political opposition to change and also improve budget scoring and fiscal impact. Most importantly, an employer public option offers a means to address inequities in coverage among today's workers and serve as a genuine test of the viability of a broader system of public coverage in the future.